Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 06 April 2017**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

Main Member	Substitute Member	Representing
Mr P Gilmour	Vacancy	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Ms E Corlett	Ms S Whitaker	Norfolk County Council
Dr K Maguire	Ms L Grahame	Norwich City Council
Mr M Carttiss	Mr N Dixon/ Mrs S Gurney/Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon/Mrs S Gurney/Mrs A Thomas/Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon/ Mrs S Gurney/ Mrs A Thomas	Norfolk County Council
Mrs A Claussen-Reynolds	Mr G Williams	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mrs E Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mrs M Stone	Mr N Dixon/ Mrs S Gurney/ Mrs A Thomas/Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council

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Tim Shaw on 01603 222948 or email committees@norfolk.gov.uk

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A g e n d a

1 **To receive apologies and details of any substitute members attending**

2 **NHOSC minutes of 23 February 2017** **Page 5**

3 **Declarations of Interest**

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4 **Any items of business the Chairman decides should be considered as a matter of urgency**

5 **Chairman's Announcements**

6 **10.10 - 11.20** **Children's mental health services in Norfolk** **Page 11**

An examination of the development of services under the Local Transformation Plan and the early outcomes for service users

Appendix A (Page 15) - The CAMHS commissioners' report

Appendix B (Page 30) - Children's Emotional Wellbeing and Mental Health Task & Finish Group report

		11.20 - 11.30 Break at the Chairman's discretion	
7	**11.30 - 12.15**	**IC24's NHS 111 and GP Out of Hours service in central and west Norfolk** **Appendix A** (Page 62) - Update from IC24	**Page 59**
8	**12.15 - 12.25**	**Potential joint health scrutiny committee for Norfolk and Waveney** Preparation of terms of reference for a potential joint health scrutiny committee with Suffolk to cover the Norfolk and Waveney Sustainability Transformation Plan footprint	**Page 73**
9	**12.25 - 12.30**	**Forward work programme**	**Page 81**

Glossary of terms and abbreviations

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Date Agenda Published: 29 March 2017

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 23 February 2017

Present:

Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs E Corlett	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Dr K Maguire	Norwich City Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs S Young	King's Lynn and West Norfolk Borough Council

Also Present:

Alex Stewart	Chief Executive, Healthwatch Norfolk
Rachael Peacock	Head of Continuing Care, Norwich CCG
Nikki Cocks	Director of Operations and Delivery, Norwich CCG
Jeanette Patterson	Continuing Healthcare Lead, Norfolk County Council
Rob Jakeman	Integrated Commissioning Manager, West Norfolk CCG and Norfolk County Council, Adult Social Care
Caroline Fairless-Price	Service User
Mark Harrison	Equal Lives
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr P Gilmour, Mrs M Stone and Mr P Wilkinson. There were no substitute members present at the meeting.

2. Minutes

The minutes of the previous meeting held on 12 January 2017 were confirmed by the Committee and signed by the Chairman.

3. **Declarations of Interest**

3.1 There were no declarations of interest from members of the Committee.

4. **Urgent Business**

There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman pointed out that Mr P Gilmour had filled the County Council vacancy on the Committee that arose from the death of Mr C Aldred and that North Norfolk District Council had re-appointed Mrs A Claussen-Reynolds to the Committee.

6 **Continuing Healthcare**

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report that provided an update on the effects of the new policy and guidance introduced by Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups in 2016 regarding the provision of NHS Continuing Healthcare.

6.2 The Committee received evidence from Alex Stewart, Chief Executive, Healthwatch Norfolk, Rachael Peacock, Head of Continuing Care, Norwich CCG, Nikki Cocks, Director of Operations and Delivery, Norwich CCG, Jeanette Patterson, Continuing Healthcare Lead, Norfolk County Council, Rob Jakeman, Integrated Commissioning Manager, West Norfolk CCG and Norfolk County Council, Adult Social Care. The Committee also heard from Caroline Fairless-Price, Service User and Mark Harrison, Equal Lives.

6.3 The following key points were noted:

- The speakers said that the four CCGs aimed to ensure fairness and equity in provision of NHS Continuing Healthcare (CHC) for patients who were assessed as eligible under the National Framework and to prevent delays in assessment or decision making. However, each CCG remained individually responsible for making their own arrangements for decision making for those patients they were responsible for.
- It was pointed out that NHS Great Yarmouth and Waveney CCG (GY&W CCG) had not adopted the same NHS CHC policy and guidance as the other four CCGs in Norfolk.
- The speakers said that no NHS Continuing Healthcare patients had been asked to change nursing homes as a result of the new policy. Also, no patients had declined a Continuing Healthcare Assessment on the grounds that they were resident in a nursing home that was not in contract with the CCGs and might be at risk of being asked to move.
- The speakers said that the four CCGs aimed to ensure a consistency of decision-making and service delivery across the four Complex Case Review Panels (CCRPs).
- The speakers explained the domains used in CCRP decision making that could be found at page 89 of the agenda.
- It was noted that in planning for the implementation of the new NHS CHC policy, the four CCGs had decided not to implement the following reference to a 5% difference rule in the options for care: "A CCRP (Complex Case Review

Panel) will ensure all domains are considered at the point where there is a more than 5% difference in the options for care being considered." In response to questions the CCG representative confirmed that the reference to this rule in the policy (page 32 of the agenda) was obsolete and would be removed from the policy.

- In reply to a question from the Chairman on behalf of Mrs Stone (who had given her apologies for the meeting) the speakers outlined the practical difficulties with instigating a single joint CCRP for the four CCG areas which they said it was not possible to introduce at this time. They added that it might be possible to move in stages towards a single panel as the CCGs developed plans for joint working through a single business unit.
- The speakers acknowledged that there was a large disparity in average waiting times between NHS CHC referral and assessment between the three central CCGs and West Norfolk CCG where referral to assessment waiting times remained much longer. The average waiting time in West Norfolk was said to be 70 days and one individual was known to have waited longer than 6 months. This compared with the Department of Health standard of 28 days.
- The numbers of complaints in West Norfolk had changed little since the introduction of the new policy (a slight increase from five complaints in 2015/16 to seven complaints so far in 2016/17). The lessons learnt from complaints were continuing to be shared between the CCGs.
- The four CCGs were looking to characterise complaints into a number of sub headings. In doing so they hoped to get a better understanding of the issues that led to complaints.
- Alex Stewart said that Healthwatch Norfolk (HWN) had undertaken an evaluation of complaints and feedback from patients since the adoption of the new arrangements. This internet based survey had identified no specific areas of complaint about the CHC policy. The survey had, however, identified an underlying concern about the format and tone of written communication with patients about the NHS continuing healthcare referral and assessment process i.e. what to expect, eligibility and what each decision meant. There was a need for more clear and accurate verbal and written communication of information about the different stages of the NHS CHC process, the outcome of each stage and particularly about the notification of decisions, including funding decisions with reasons why and in written requests for payment for NHS continuing healthcare. While issues to do with the communication of information had been found to be of some concern, most people giving feedback on current NHS continuing care packages were satisfied with the quality of the care being received.
- Heathwatch Norfolk was willing to follow up on some of the key issues that were identified in their report. Healthwatch was willing to do this though a more sophisticated method than the earlier on-line internet based survey.
- In reply to questions about the length of time patients had to wait for a NHS CHC assessment, the speakers said that the four CCGs continued to have efficient arrangements in place with social care as well as with hospitals and nursing homes for patient discharge. Getting the assessment process right was important in order to avoid delayed transfers of care. As the assessment was about planning for long term care it was important that it was undertaken at the right time to reflect long term needs.
- The speakers said that the NHS CHC not only acted as a vehicle for the delivery of long term care, but also provided an interface to a number of care pathways across health and social care.
- NHS CCG provision might take the form of a care home placement, or a package of care in the individual's own home, or elsewhere.

- Services were purchased from private providers in Nursing and Residential Care settings, by Domiciliary Care agencies and more recently via carers directly employed by an individual under a Personal Health Budget arrangement.
- Some of the wide range of measures that were taken to maintain NHS CHC standards in nursing homes and for home visits by NHS and social services staff and for visits by carers, were explained to Members. The speakers said that the quality standards within the service contracts helped to ensure that the CCGs were able to hold providers to account for the quality of care they provided.
- The speakers said that in order to receive positive feedback from patients, the training plans that the CCGs prepared for NHS and County Council staff and for CCRP members took account of equality, disability and human rights legislation and the Harwood Care and Support Charter.
- It was pointed out that very few patients were placed out of county and only where specific clinical needs could not be met locally.
- It was noted that details about the numbers of NHS CHC patients and the average cost per patient per week for each of the four CCGs could be found in table 7 on page 104 of the agenda. There was no significant geographical variations within Norfolk in the costs of providing NHS CHC.

6.4 Caroline Fairless-Price, Service User, spoke about the issues that are mentioned in Appendix A to these minutes.

6.5 Mark Harrison, Equal Lives, said that he was concerned that patients' needs and the outcomes patients wished to obtain from their CHC assessment could be lost if there continued to be a low take up in Norfolk of carers directly employed by individuals under Personal Health Budget arrangements. He said PHBs provided individuals with greater flexibility than contracts through care agencies. The maintenance of quality standards within service contracts were essential in ensuring that the CCGs were able to hold providers to account for the quality of care they provided. Due to Government austerity measures, for many vulnerable individuals in society who were not financially self-sufficient there remained little medical provision outside of a hospital setting other than through a CHC package and yet continuing health care was becoming increasingly difficult to obtain.

6.6 The Committee **agreed** to ask Norwich CCG (on behalf of the four CCGS) to provide a full written response to the questions that can be found at Appendix A to these minutes from Caroline Fairless-Price (a service user). The Committee also asked the Norwich CCG to comment on the points made by Mark Harrison (Equal Lives) and for both responses to be circulated to Members.

6.7 The Committee **noted** the information contained in the report and that provided by the speakers during the meeting. In so doing it was **noted** that Healthwatch Norfolk had agreed to liaise with the four CCGs about how they could help to obtain more patient feedback on the CHC service in the future.

6.8 The Committee **agreed** that:

- Recommendations to the NHS CHC Commissioners would be drafted, based on Members' discussions at today's meeting.
- The draft recommendations would be circulated to Members for comment.
- The final recommendations would be approved by the Chairman and Vice Chairman for despatch to the Commissioners.

7 **NHOSC Appointments**

7.1 The Committee received a report that asked Members to appointment a Member to Great Yarmouth and Waveney Joint Health Scrutiny Committee and a link member for the James Paget University Hospitals NHS Foundation Trust.

7.2 The Committee **agreed** to appoint Margaret Stone to Great Yarmouth and Waveney Joint Health Scrutiny Committee.

7.3 The Committee **agreed** to appoint Lana Hempsall as NHOSC link with the James Paget University Hospitals NHS Foundation Trust.

8. Forward Work Programme

8.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out the current forward work programme.

8.2 The agenda items for 6 April 2017 were **agreed** as the following:-

- Children's mental health services in Norfolk
- IC24's NHS 111 and GP Out of Hours Service in central & west Norfolk.

8.3 The following subjects were suggested for the forward work programme:

- Availability of acute mental health beds – concerns about prolonged detentions in police cells / out of area placements.
- Speech and language therapy – concerns about long waiting times for children.
- Children's autism and sensory processing assessment / therapy – concerns about availability of services and waiting times.
- Sustainability Transformation Plan – progress in Norfolk and Waveney.

8.4 It was **agreed** that the Chairman and Vice Chairman should draw up an order of priority for these subjects for NHOSC to consider at its next meeting in April 2017.

Chairman

The meeting concluded at 13:15 pm

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APPENDIX A
Comment by Caroline Fairless-Price, Service User

My first point is that I object to any policy that proposes a review of a domiciliary care package when it is over the cost of a residential placement by more than 5%. To me it is outrageous to suggest that someone who could be looked after safely at home might be forced into an institution. CCGs have said that the policy won't be used in

this way, but I and others see it as a constant background threat. It's only a matter of time before a CCG sees it as a public duty to minimise care costs by "warehousing" disabled people in institutions.

Will the CCGs ensure that this is removed from all their documentation once and for all?

Secondly, the processes do not ensure that people are protected when they are at their most vulnerable.
There is a duty under the Care Act to ensure that needs are met. Currently needs are assessed, budgets and training of staff are assessed but no-one actually performs a review that checks you are getting what you need.

Can I ask the CCGs to effectively review and record whether identified needs are being met, as a process separate from assessment?

Third, contingency planning is a problem for personal budget holders. This was confirmed by NHS managers in correspondence and discussions. We can't expect staff who are experienced and capable of dealing with our complex needs to be solely available for any occasional unplanned needs that may arise. We need a shared, umbrella organisation that can respond and allow us to become familiar with each other. If Swifts or Night Owls were to come to me during an unplanned episode we would really struggle. It is becoming increasingly obvious that there needs to be an ability to project-manage the service for people with chronic and fluctuating conditions.

Will the CCGs and NCC work together to create a 24/7 response service for people who cannot be re-abled but still need to continue coping with long-term conditions at home?

Finally, both NCC and the CCGs are signatories of the Care Charter, I would like to bring to their attention that commissioning from services that are also signatories of the Charter will encourage formation of contingency plans as far as is possible. It will also make sure that if there are problems people can report back when they are in need.

Are the CCGs and NCC going to develop commissioning, recording and safety-netting using the Harwood Care and Support Charter?

Children's Mental Health Services in Norfolk

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

This report examines the development of children's mental health services under the Local Transformation Plan and the early outcomes for service users

1. Background

1.1 On 3 December 2015 NHOSC received a report from Child and Adolescent Mental Health Services (CAMHS) commissioners addressing issues and concerns that were set out in scrutiny terms of reference agreed by the committee on 3 September 2015. NHOSC also received Norfolk and Waveney's Local Transformation Plan (LTP), which had recently attracted additional recurrent funding for CAMHS in Norfolk.

1.2 NHOSC returned to the subject on 8 September 2016 to examine progress with the implementation of the LTP and agreed to return to the subject again at today's meeting to look at any further developments and the early outcomes for service users.

The previous reports and minutes are available on the County Council's website:-

3 December 2015
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/389/Committee/22/Default.aspx

8 September 2016
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/517/Committee/22/Default.aspx

1.3 Healthwatch Norfolk has commissioned several pieces of research on young people's experience of mental health services. The results of a study by MAP (Mancroft Advice Project) on experiences of tier 3 services were referenced in the last report to NHOSC on 8 September 2016. Results of research on tier 1 and 2 services are expected at the end of April 2017.

2.0 Purpose of today's meeting

2.1 The CAMHS commissioners have been asked to report on the following:-

(a) Developments to services under the LTP since the last report (8 Sept 2016) and an indication of the early outcomes of the LTP, including:-

i. Funding uplifts – have the CCGs received the funding and has it been made available for children's mental health services?

ii. The situation regarding staffing of the services. Has it been possible to recruit all the staff envisaged in the LTP and what is the situation regarding staff turnover?

iii. What difference has the development of the service made in terms of waiting times for children's mental health services (all tiers) before and after the changes; other KPIs from the LTP (or negotiated within contracts during implementation of the LTP) to show current performance and the trend in performance.

(b) Developments under the Norfolk and Waveney Sustainability Transformation Plan (STP) as they affect the LTP.

(c) The commissioned mental health related work at Children's Centres.

The commissioners have also been asked to address within their report two areas that NHOSC discussed at the last meeting:-

Self-harm – an update on the progress of services in the context of addressing the needs of children who self-harm, e.g. the establishment of the Crisis Bank of staff for short notice deployment in a crisis (within 2 hours) and the increased staffing for Point 1.

Looked After Children – information on the current situation regarding delivery of Annual Health Assessments and Strength and Difficulty Questionnaires and the linkage between the two.

The CAMHS commissioners' report is attached at **Appendix A**.

2.2 On 23 January 2017 Children's Services Committee received the report of its Children's Emotional Wellbeing and Mental Health Task & Finish Group and agreed the recommendations. The Task & Finish Group was chaired by Cllr Emma Corlett and NHOSC was also represented on the Group by Cllr Margaret Stone. A copy of its report is attached at **Appendix B**.

The CAMHS commissioners have been asked to make reference to the Task & Finish Group's recommendations in their report (Appendix A), where relevant to their work.

2.3 The following representatives will be in attendance to answer Members' questions:-

- CAMHS Strategic Commissioner - representing Norfolk County Council and Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth and Waveney CCGs
- Assistant Director of Commissioning Mental Health and Learning Disabilities – representing the five CCGs listed above and Norfolk County Council
- Head of Social Work, Children's Services, Norfolk County Council
- Head of Services and Partnerships (Great Yarmouth), Children's Services, Norfolk County Council.

3.0 Suggested approach

3.1 After the commissioners have presented their report, Members may wish to discuss the areas set out in paragraph 2.1.

Members may also wish to address the following areas:-

(a) Extra provision in the Crisis Pathways service and an extension to the opening hours of Norfolk & Suffolk Foundation Trust (NSFT) CAMH Service were expected to go live on 1 April 2017. Did both of these developments proceed as scheduled?

(b) Funding for the LTP comes via the 5 CCGs. They have guaranteed to allocate a minimum of £1.9m per annum, which is the amount originally allocated in 2015-16. NHS England includes uplifts to the LTP funding within the CCGs' baseline core funding. For 2017-18 NHS England announced an expected uplift which would increase the budget available to the CCGs up to £3.1m. However, the uplifts are not ringfenced and have to be considered against all other cost pressures affecting CCGs. Do the CCGs take full account of parity of esteem for mental health services and the preventative nature of children's mental health services when they make their funding decisions?

(c) The commissioners' report (Appendix A, paragraph 11.2.2) notes that Clive Rennie, Assistant Director of Commissioning Mental Health and Learning Disabilities will be able to provide a verbal update on the development of community Perinatal Mental Health provision across Norfolk & Waveney following a successful application to NHS England.

3.2 Members may wish to note that the Task & Finish Group on Children's Emotional Wellbeing and Mental Health recommended:-

'That the Local Transformation Plan be scrutinised on a regular basis by Children's Services Committee in order to ensure it is delivering for the children and young people of Norfolk' (recommendation K).

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Report by CAMHS Strategic Commissioner on behalf of the 5 CCGs in Norfolk and Waveney

Children's Mental Health Services in Norfolk

1. This report (produced on behalf of all 5 CCGs in Norfolk & Waveney) provides an update for Members on progress made to implement a range of service developments set out in the original Norfolk & Waveney LTP (Nov 2015) and the 2016/17 refreshed LTP (submitted to NHS England in October 2016). The report gives an indication of the early impact of those service developments that are now fully operational. The report also responds to the other lines of enquiry set out in the cover note from Maureen Orr.

2. CCGs welcome the interest from Members on this key service area and appreciate the role that NCC plays to keep children's emotional wellbeing and mental health high on our list of joint priorities. NCC Children's Services hosts the CAMHS Joint Commissioning Team and contributes to the section 75 Pooled Fund which is held by this Team on behalf of the 5 CCGs and NCC.

3. All the service developments promised in the original LTP are either now fully operational or very close to being so – i.e. have been negotiated as contract variations, with providers currently completing recruitment rounds to fill the remaining vacancies for the new/extra posts. These developments are therefore moving into 'business as usual' arrangements for management and performance review, with the attention of commissioners and partners focusing increasingly on work to redesign the entire mental health system for children and young people.

4. The 2016/17 refreshed LTP is deliberately brief and focuses on two key strategic priorities, namely:

    1. To ensure all 8 LTP recurrent service developments are fully implemented and operational as soon as feasible.

    2. To undertake an extensive re-design and re-engineering of the entire system for children and young people with mental health needs over the next 2 years to maximise the opportunities for integrated pathways and economies of scale. The redesign's scope is to be finalised but will include core targeted and specialist CAMHS activity commissioned by CCGs and NCC.

5. While the LTP funded service developments provide very welcome increased capacity, there are a number of long standing systemic issues and barriers to effective integration that led CCGs and NCC to agree that a whole system redesign is required.

6. Each of the questions posed in the covering report are now addressed in turn.

7. ***Question (a) – Developments to services under the LTP since the last report (8 Sept 2016) and an indication of the early outcomes of the LTP, including:-***

7.1 **i. Funding uplifts – have the CCGs received the funding and has it been made available for children's mental health services?**

7.1.1 Via the LTP process central government allocated in 2015/16 £1.9m of additional funding to the 5 CCGs in Norfolk & Waveney to deliver the joint Plan they had successfully submitted in October 2015. For 2016/17, NHS England announced the uplift it expected to be applied to LTP budgets – which would increase the budget available to the 5 CCGs in 2016/17 up to £2.7m. NHS England announced a further uplift it expects to be applied in 2017/18, which would increase the budget available to the CCGs up to £3.1m. These LTP uplifts appear in CCGs' baseline core funding, are not ringfenced and have to be considered against all other cost pressures affecting CCGs.

7.1.2 The 5 CCGs committed to continue to allocate a minimum total of £1.9m LTP funding each year. In 2016/17 the CCGs allocated a total of £1.9m of LTP funding at full year effect plus the following additional amounts:

- £443k of LTP non-recurrent funding for extra temporary CAMHS Eating Disorders capacity within NSFT
- £168k of additional recurrent core CAMHS funding for increased specialist CAMHS capacity in the Thetford area
- £452k of non-recurrent funding from NHS England to reduce waiting times in core CAMH Services.

7.1.3 CCGs will consider use of the LTP uplifts to baseline budgets on a year by year basis, alongside other cost pressures.

7.2 **ii. The situation regarding staffing of the services. Has it been possible to recruit all the staff envisaged in the LTP and what is the situation regarding staff turnover?**

7.2.1 For those service developments operational on or before 1st April 2016, all posts were recruited to. Any current vacancies are due to normal staff turnover and are filled in the usual way. The service developments which are fully operational are increased capacity within Eating Disorder teams, Point 1 and mental health support within the Police Control Room. The service developments where providers are currently completing final preparations before enhanced provision 'goes live' are the Crisis Pathways (extra provision goes live 1st April 2017), the Link Work function for education and primary care settings (in the final stages of recruitment), children affected by sexually harmful behaviours (in the final stages of recruitment), and an extension to the opening hours of Norfolk & Suffolk Foundation Trust (NSFT) CAMH Service (which goes live 1st April 2017).

7.3 **iii. What difference has the development of the service made in terms of waiting times for children's mental health services (all tiers) before and after the changes; other KPIs from the LTP (or negotiated within contracts during implementation of the LTP) to show current performance and the trend in performance**

7.3.1 Performance of our two largest CAMHS providers against their waiting times standards is summarised in **Appendix 1**.

The difference these service developments have had include:

7.3.2
- **CAMHS Eating Disorder (ED) increased capacity** – more children and young people are being seen by the service which itself is a much more stable, safe service. CAMHS ED services are subject to a new set of standards, including challenging waiting time standards, with all routine referrals needing to be seen within 4 weeks of referral and urgent referrals within 1 week (100% compliance rate to be achieved by 2020/21). Formal reporting against the new standards is bedding in currently, with some refinements to reporting likely to be needed to ensure accurate and validated data is submitted to commissioners. Presently, there are some discrepancies between the data supplied to commissioners each month and data supplied by NSFT via its 'Unify' returns to NHS England, which information specialists are working to resolve. However, verbal reports from service managers and lead clinicians indicate that performance is good against the waiting times standard, with the NHS England access rate targets being met for the vast majority of patients well in advance of the national deadline of 2020/21.

- **Point 1 increased capacity** – more children and young people are being seen by the service, and the service is now available in Waveney

- **Specialist CAMHS capacity in the Police Control Room** – maintaining and developing specialist CAMHS advice for police officers who encounter children and young people with mental health needs.

7.3.3 Please see **Appendix 2** to view a table showing the KPIs that relate to the LTP. The KPIs that have been agreed and signed off as part of providers' contracts are highlighted in grey.

8. ***Self-harm – an update on the progress of services in the context of addressing the needs of children who self-harm, e.g. the establishment of the Crisis Bank of staff for short notice deployment in a crisis and the increased staffing for Point 1.***

8.1 The service developments from the LTP which will impact most directly on children who self-harm are the enhancements to the Crisis Pathway and the dedicated CAMHS specialist advice funded for the Police Control Room to provide advice to police officers who encounter children with potential mental health issues. The Crisis Pathway enhancements include:

- Extended opening hours of the core team/service – 8am-8pm week days.
- Expanded specialist CAMHS crisis assessment function (from 1st April 2017) – available up until midnight during the week, and for at least 4 hours on weekend and bank holiday days (with cover provided out of those hours by the adult Crisis Teams).
- Crisis Support Workers (from 1st April 2017) – to provide intensive support for those patients in crisis who require it in acute General Hospitals and selected Foster Care placements. **Note to Members** – this is the 'Crisis Bank' of staff referred to in the question above.
- First responder training – delivered to 'first responders' who initially respond to and support children experiencing a mental health crisis.
- Increased liaison work with hospitals, social care, police and other services whose work brings them into contact with children in crisis.
- Increased capacity for Point 1 – Point 1 sees children and young people with mild to moderate levels of mental health issues (self-harm included). The extra capacity funded within Point 1 went live during 2016/17 and has enabled the service to see more children and young people.

9. ***Looked After Children – information on the current situation regarding delivery of Annual Health Assessments and Strength and Difficulty Questionnaires (SDQ) and the linkage between the two.***

Ricky Cooper, Head of Social Work, Children's Services, provided the following information:-

9.1 For all the children who are looked after, 1110 at end of February 2017, 87.03% have an up to date health assessment. Over the last year there were 45 refusals of health assessments, in the previous year there were 52 refusals.

9.2 As at 2 March 2017, of 44 children completing 30 working days in LA care, 38 (86.4%) had completed initial health assessments, 79.5% of which were within the statutory timescale of 20 working days.

9.3 At the end of March 2017, Children's Services are due to file their annual SDQ returns to the DFE. In January 2017, SDQ's were sent to carers and children and young people to complete and return as part of this return. As at 24 March 2017 86.8% of those SDQs have been returned. These SDQs are uploaded onto the Health Systems for consideration by the Clinician completing the Review (Annual) health assessment for children and young people in LA care for the next annual health assessment. For children and young people due to have an annual health assessment in April 17 and May 2017 the SDQ will be available to the Clinician from the March 17 return. For children and young people scheduled to have an Annual Health Review for June 2017 onwards, updated SDQs will be sent out two months in advance. This will ensure that for Review (Annual) Health Assessments SDQ's will be aligned so that the Clinician conducting the Health assessment has an up to date tool to assist in detecting and

identifying potential emotional and mental health needs so that these can be included in the child/young person's health plan.

9. ***Developments under the Norfolk and Waveney Sustainability Transformation Plan (STP) as they affect the LTP***

9.1 The STP has a mental health workstream, which is chaired by Dr Tony Palframan, who is also the Chair of the Steering Group overseeing the redesign of the mental health system for children in Norfolk and Waveney. Dr Palframan is also the Chair of the Mental Health & Learning Disabilities Commissioning Network, where clinical and commissioning leads from the 5 CCGs meet monthly to agree how best to take forward strategic priorities for mental health commissioning across the STP footprint. The CAMHS Local Transformation Plan (LTP) is cited within the STP, thereby providing a potential governance route for further joint working and decision making at a broader, higher level.

10. **Mental Health services provided via Children's Centres**

Phil Beck, Head of Services and Partnerships (Great Yarmouth), Children's Services, provided the following information:-

All Children's Centres in Norfolk are expected to : - **SW3a Work with partners to support children living with parents/carers that experience poor mental health.**

10.1 **Background**

Children's Centres have recognised that there appears to be an increase in the number of parents who present with mental health challenges. This is often disclosed after an initial piece of work has started, as trust and confidence with the family support worker develops or at a universal group to a trusted worker. It has also been recognised that the number of services available for Children's Centres to signpost or refer on to is variable and very limited in some areas of the county. As appropriate, Children's Centres refer to and work with organisations such as the Wellbeing Service, Adult Mental Health Services and Point One.

10.2 **Targeted Family Support**

10.2.1 Centres recognise the key role they have in supporting families and have a number of ways of supporting both parent and child mental health. Most families experiencing poor mental health receive targeted family support either at single agency or multi-agency Family Support Process (FSP). Although most are not specifically trained in mental health, Centres can and do provide low level support to families. This works as a provider of containment for families until the appropriate level of support can be accessed.

10.2.2 Case Study - Mum had been trafficked in Italy and as a result fell pregnant. Mum is now seeking asylum in the UK. Mum was very isolated and upset when she arrived in Norwich after settling briefly in London. Mum has lots of mental health problems as a result of the experiences she had whilst being trafficked. Mum was supported by a Family Support Worker (FSW) to build up trust in the local community- by regularly accessing English Classes and courses at the centre. The centre used hardship funding to ensure Mum could maintain medical appointments for her daughter and for her own mental health. Hardship funding also supported Mum to feel safe/ secure in her own home by purchasing curtains to stop people from outside from being to see in when the lights are on. This case is closed but Mum continues to regularly attend the children's centre, Mum can now use some basic English and has made a close friend.

10.3 **Targeted Groups**

10.3.1 Centres also offer targeted group activities for parents experiencing poor mental health. For example: -

- Baby Massage in the Centre or in the home

One Stalham Mum says "I have a history of anxiety and depression and was really worried I would get postnatal depression (PND) and not bond well with my baby. Kimberley came to our house to do baby massage and it made a huge difference. I was so glad to see someone because I was quite lonely and she taught me massage that my baby loves and we use it every day. It helped me bond really well."

- Watton Children's Centre has developed "chit chat café", a weekly group whereby parents can come along have a cup of tea and cake and speak to friends and to a family support worker. This group has been very successful and has a consistently high attendance of individuals.

- Norfolk Community Health and Care (NCH&C) led centres offer "Creative Time for Me" which is a referral only group which supports increased emotional wellbeing, aspirations, self-esteem, confidence, social skills and is used as a transitional pathway into universal groups and further educational training, learning and chances of employment. One mother fed back that 'She thought the group made her feel that she could be creative and can achieve and be successful', and said 'she will definitely attend another course at Sure Start'. This parent has since gone on to complete the volunteering course and is now a volunteer at the Centre.

10.4 **Parenting Programmes**

10.4.1 Pathway to parenting is a universal 4 week antenatal education programme offered in Children's Centres across the county primarily for first time "parents to be", delivered in partnership with Midwifery and healthcare practitioner (HCP) colleagues. It is underpinned by the Solihull Approach. There is an expectation that all staff delivering it are trained to at least foundation level. In Week 1, participants are introduced to baby brain development and infant attachment and the importance of it on the developing baby. In Week 4 there is a focus on post-partum mental health. As well as identifying sources of support for low mood and post-natal depression, participants are also introduced to the Wellbeing Service and the range of support that Children's Centres can offer.

10.4.2 All Centres in Norfolk have Solihull trained staff and use this approach within their family support work. Most Centres deliver Solihull Parenting Programmes or work in partnership with other organisations/Centres locally to deliver it, as well as other programmes that have a focus on attachment such as Circle of Security and Parents as First Teachers (PAFT) which is delivered in the home.

11. **The CAMHS commissioners have been asked to make reference to the report & recommendations of the Children's Services Committee Task & Finish Group on children's emotional wellbeing (Appendix B), where relevant to their work**

11.1 The Task and Finish Group on children's emotional wellbeing received input from the CAMHS joint commissioning team and a number of specialists from services commissioned by CCGs. The report provides a helpful set of insights and recommendations, all of which will be fed into the newly formed Steering Group overseeing the redesign of the mental health system for children.

11.2 Some comments regarding the report's recommendations most directly pertinent to the NHS now follow.

11.2.1 **Recommendation C re. the role of schools and how they are supported/advised:**

Recommendation C: *Although schools do not come under the direct management of Norfolk County Council we feel that our overall, collective responsibility for safeguarding and championing children and families means that we need to develop a Norfolk standard together. This should clearly show what is expected of schools in relation to emotional wellbeing and encouraging positive mental health. Norfolk County Council's role is to help provide information and recommendations to assist schools in developing a whole school approach which can be evaluated to ensure approaches reflect best practice. It is on this basis that we recommend a guide be produced for schools as to what services exist along with the recommended route in to them. This guide should be produced in*

partnership with schools (including Governing bodies) and young people to ensure it is relevant. The senior management team in Children's Services are asked to identify relevant staff to take this forward.

Comments: Via LTP funding 5 new Link Worker posts are currently being recruited to provide advice, training and support to staff in education (and primary care settings) to build mental health expertise and confidence in those settings. The aim is to ensure that staff working in those settings know how to build the emotional wellbeing and resilience of children and also know when and how to seek specialist mental health advice or to make a referral to one of our targeted or specialist services.

11.2.2 ***Recommendation H and B re. impact of parental mental health on children:***

Recommendation H: *We highly recommend that the Mental Health Trust responsible for mental health service provision in Norfolk (currently NSFT) collect (as part of triage), collate and share data associated with parental responsibilities for those accessing their services. This links to recommendation (B) to lower the threshold and give priority to individuals with parental responsibilities and will assist all relevant organisations to ensure that any safeguarding concerns can be quickly addressed through improved communication and understanding.*

Recommendation B: *We recognise the impact parental mental health can have on a growing child. Therefore we recommend that our colleagues on the Adult Social Care Committee review the threshold for access to Adult Mental Care provision in relation to parents and individuals with parental responsibilities (especially those with young children under the age of 8yrs). In addition we would ask that priority also be given to individuals.*

Comments:

CCGs will explore with the Mental Health Trust the most effective ways of identifying and where appropriate sharing data associated with parental responsibilities for adults accessing its services.

CCGs and NSFT submitted a successful application to NHS England several months ago to develop community Perinatal Mental Health provision across Norfolk & Waveney. Specialist provision will be enhanced to provide additional direct treatment for parents with mental health issues who have young children, where those mental health issues (if not treated) are likely to impact negatively on the wellbeing of infants and children. The service will treat (when fully operational) 530 patients per year, with highly complex and severe perinatal mental health needs. Clive Rennie will be able to provide a verbal update for Members at the HOSC session if that would be helpful.

11.2.3 **Recommendations I & J re. encouraging schools to work together to share best practice relating to mental health and wellbeing of pupils**

Recommendation I: *We recommend that schools be encouraged to work together to share best practice in relation to mental health and emotional wellbeing of pupils in Norfolk.*

Recommendation J: *Linked to (I) that the Education and Strategy Group be asked to support the production of an evaluation of best practice in Norfolk in connection to mental health and emotional wellbeing activity in schools. This piece of research should then be used to inform the re-design, where necessary of existing CAMHS services.*

Comment: CCGs fully support these recommendations. The CCG funded Link Worker posts will be able to provide some capacity to help provide shared learning of good practice and experience. The redesign provides a further opportunity to review good practice and ways of supporting and influencing effective practice within education settings.

11.2.4 **Recommendation K re. improving accessibility to mental health services**

Recommendation K: *Mental health services need to be accessible, particularly for young people. Part of achieving this involves and understanding and recognition of the entire 'workforce' involved in improving mental health and understanding the skills and needs of our young people when addressing all levels of mental health need. Ensuring a broad range of professionals are available and aware of all available services. We recognise this is not an easy task but we recommend that:*

- *We develop a common language for social care, medical professionals and schools*
- *We develop a map which can be used to signpost between services*
- *Joint ways of working including opportunities for professionals to come together to discuss best practice be encouraged and their importance recognised in order to create better join up across Norfolk.*
- *That the Local Transformation Plan be scrutinised on a regular basis by Children's Services Committee in order to ensure it is delivering for the children and young people of Norfolk.*

Comment: CCGs and partners via our LTP are committed to simplifying referral routes into our targeted and specialist mental health pathways – ideally by creating a genuine Single Point of Contact/Access for all requests for mental health advice and referrals. This issue is being taken forward under the auspices of the redesign, with 2 or 3 mental health teams taking steps in the meantime to provide simplified routes into their services.

Appendix 1: CAMHS waiting time and referral trend data

The following service information relates to Norfolk's two largest commissioned CAMH Services:

- The Specialist (Tier 3) CAMH Service provided by Norfolk & Suffolk Foundation NHS Trust (NSFT)
- The Targeted (Tier 2) CAMH Service, known as *Point 1* - provided by a consortium, made up of Ormiston Children & Families Trust (lead provider), Mancroft Advice Project and Norfolk & Suffolk Foundation NHS Trust (NSFT)

Specialist (Tier 3) CAMHS – *Norfolk & Suffolk Foundation Trust (NSFT)* - Waiting times data

As set out in the Revision to the Operating Framework for the NHS in England 2010/11, performance management of the 18 weeks waiting times target by the Department of Health has ceased, however, referral to treatment data continues to be published and monitored. Standards and quality should be maintained pending the development of more outcomes-focused measures. The current locally agreed Norfolk waiting time standard for NSFT is 8 weeks for referral to treatment – a standard that is far more ambitious than many areas in England. The local standard is that 80% of CAMHS patients should be seen within 8 weeks of their referral being received by NSFT. The table below shows a breakdown of month by month performance against the local standard (covering the period of April 2016-January 2017).

The mean average waiting time for England (source NHS Benchmarking 2016) is 17 weeks.

Where there are 'breaches' of the waiting time standard, exception reports are submitted to the lead commissioner outlining the reasons for the breach, action taken and (where appropriate) how any clinical risks are being managed/contained. The main reason cited for the months where breaches occurred was team capacity issues. Exception reports are available on a case by case basis and are reviewed at Performance and Contract meetings.

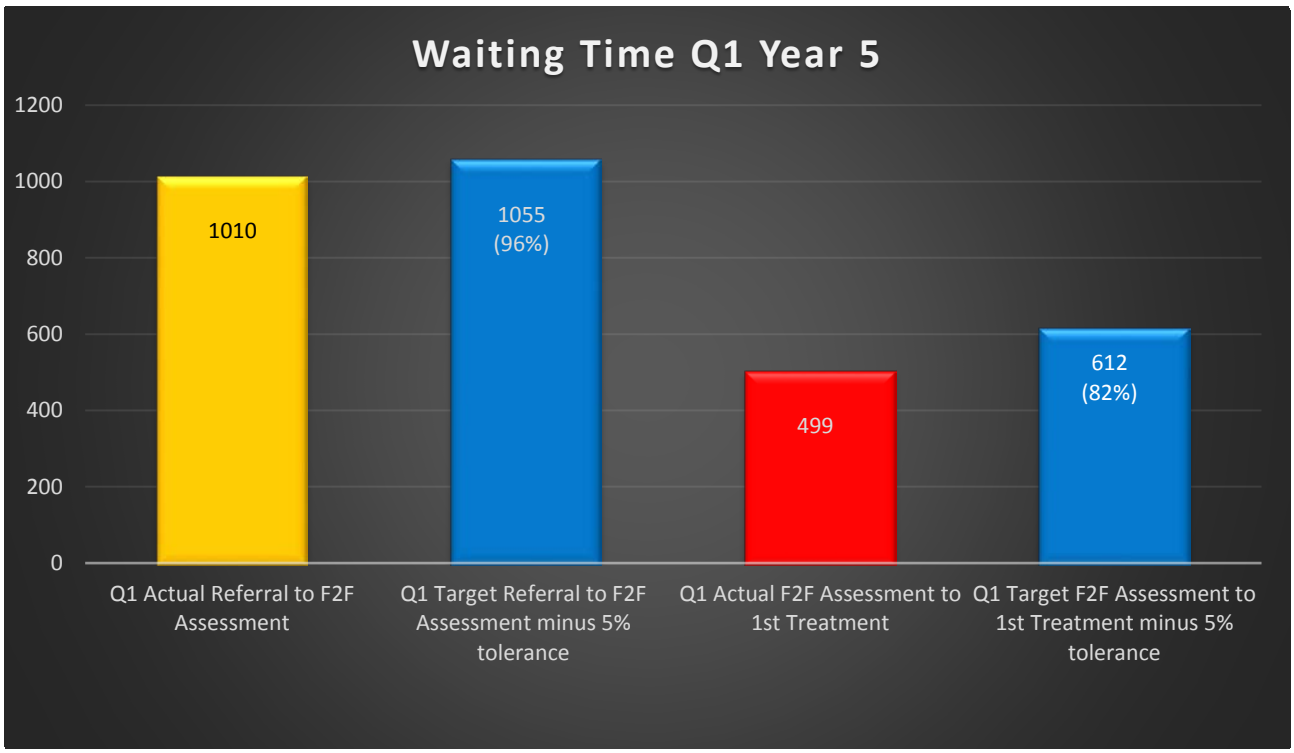
Norfolk and Waveney CCGs

Target	Key	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
80%	Actual	200	212	204	184	168	151	147	181	113	147			1707
	Denom	237	255	242	203	196	192	170	194	121	163			1973
	%	84.39%	83.14%	84.30%	90.64%	85.71%	78.65%	86.47%	93.30%	93.39%	90.18%			86.52%

Both the numbers of referrals and the number of active service users continue to increase significantly year on year. In 15/16, NSFT's active service users at year end increased by 10% from the previous year from 1338 to 1478. Increased numbers in active service users equates to an increase in caseload the following year.

Targeted (Tier 2) CAMHS - *Point 1* - Waiting times data

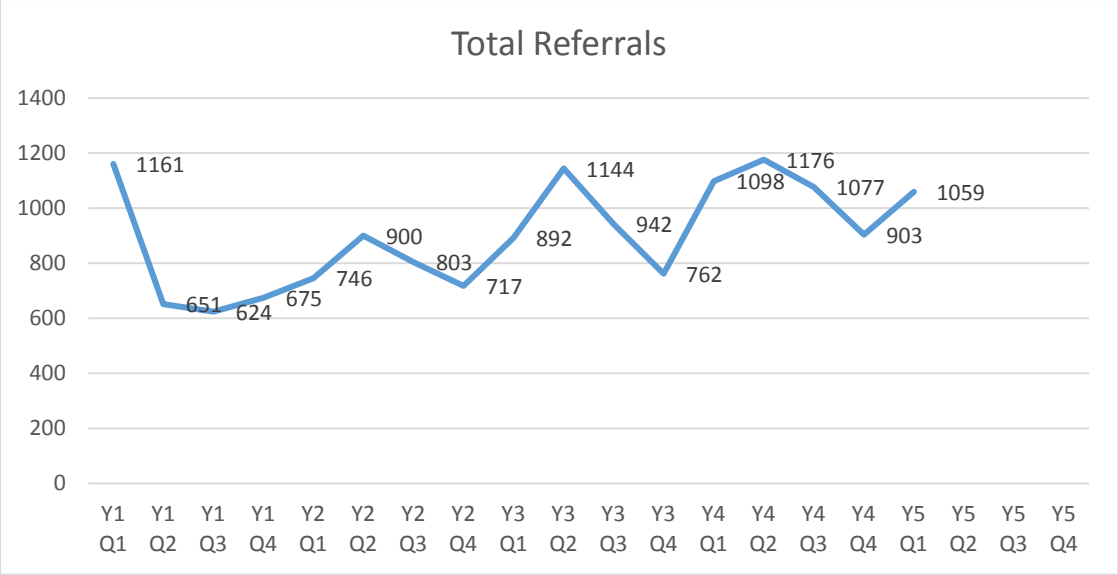
Point 1 is a county wide Targeted service that commenced in October 2012. It works to 6 KPIs, one of which relates to waiting times. The service's waiting time KPI is a two part indicator requiring that the child or young person waits no more than 28 days between their referral and a face to face assessment. The second part requires that the Child or Young Person (CYP) waits not more than 28 days between that assessment and their first treatment session. This KPI fluctuates frequently depending on the quarter and how that relates to the school year. It also fluctuates depending whether CCGs have been able to award extra money to reduce waiting lists (via NHS England awards) The most recent quarter results are shown below (October 2016 – December 2016):



Performance Summary – In the Quarter ending 31st December 2016, Point 1 assessed 1055 new clients and of those 96% were assessed face-to-face within 4 weeks of their initial referral. This affords a KPI RAG rating for the period of = **AMBER**.

Of the 612 clients who were provided with their first treatment session, 82% had this within 4 weeks of their initial face-to-face assessment. The second part of this KPI has a RAG rating of = **RED.**

An increase in demand/referrals is being experienced by Point 1 as shown below. The provider also reports that the waiting times target is problematic when CYP and or their parents aren't able to accept any appointments offered to them that would enable them to be seen within the specified waiting times.


Total Referrals
1400
1200
1000
800
600
400
200
0
1161
651
624
675
746
900
803
717
892
1144
942
762
1098
1176
1077
903
1059
Y1 Q1
Y1 Q2
Y1 Q3
Y1 Q4
Y2 Q1
Y2 Q2
Y2 Q3
Y2 Q4
Y3 Q1
Y3 Q2
Y3 Q3
Y3 Q4
Y4 Q1
Y4 Q2
Y4 Q3
Y4 Q4
Y5 Q1
Y5 Q2
Y5 Q3
Y5 Q4

Appendix 2: CAMHS LTP KPIs

The KPIs that have been agreed and signed off as part of providers' contracts are highlighted in grey.

Pathway/Description	KPI
Eating Disorders	
Deliver the nationally prescribed waiting times standard for patients with eating disorders in full by April 2017 (3 years earlier than the national deadline of 2020/21)	Treatment will start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases. In cases of emergencies the ED service should be contacted to provide assessment and initial support within 24 hours (the local Norfolk & Waveney agreed standard is 4 hours for emergencies)
Crisis Pathway	
An extended hours core service from NSFT, including evening, weekend and bank holiday working as detailed in the Service Delivery Hours section of this specification.	All CAMHS and Youth pathways will be available 8am-8pm Monday to Friday, with additional dedicated assessment and treatment slots operating for a minimum of 5 hours on Saturdays, Sundays and Bank Holidays (with the exception of Christmas Day and Boxing Day).
Provision of specialist out of hours CAMHS face to face assessment of crisis cases in the community and Acute General Hospitals (including weekends and bank holidays), in addition and complementary to the current Crisis Team functions. Access to the service to be available to Acute General Hospitals, the Police, Primary Care and other first responders via the existing published NSFT Out of Hours phone number. The offer to include advice and support to those professionals providing ongoing treatment and care to crisis cases.	Assessments will take place within 4 hours of receipt of referral. Responsive telephone advice out of hours for professionals via the on call telephone CAMHS Consultant Psychiatrist. Regular audit re. the awareness levels of the Out of Hours pathway among first responders

Delivery of a rolling programme of training and group consultation to 'first responders' who initially respond to and support cases that present in crisis - including General Hospital ward staff, Police, Social Care, Primary Care and Crisis Support Workers	As a minimum, the Provider will deliver the following volumes of training activity per annum: • 15 First Responder training and/or group consultation sessions • 30 Group Consultation sessions. Delivery of induction and ongoing training, group consultation and supervision to staff recruited to the new Bank
Provision of Crisis Support Workers (from NSFT) to deliver 24/7 intensive support for patients in crisis to contain risks, provide support, prevent unnecessary admissions and minimise the length of inpatient stays in Acute General Hospitals and selected Foster Care placements (under the PEEP protocol)	• Crisis Support Worker/s mobilised and providing intensive support within 4 hours of a request being made by the NSFT assessing clinician (for at least 95% of cases) • Crisis Support Workers to provide intensive support in Acute General Hospital settings and selected Foster Care placements for the most risky, complex cases while specialist staff complete assessments and put in place the next stage of the child's treatment and care (which may include de-escalation and admission avoidance or keeping a child safe while sourcing a specialist CAMHS or LD CAMHS inpatient bed) • Crisis Support Workers should be available for up to 3 days. The workers will be deployed in partnership with Children's Services and LD/CAMHS services under the PEEP protocol.
The Specialist Assessment and Crisis Support Workers to undertake joint assessments and joint case work in partnership with Specialist Learning Disabilities Teams and Norfolk County Council	A joint working protocol to be co-produced and signed off between the three providers setting out how/when they will jointly work cases, governance and safeguarding arrangements.

Early Help and Prevention	
Establishing the Link Work function for schools and primary care settings	• Recruit and maintain a register of named mental health leads in schools and GP practices • Provide each school and GP practice with a named Link Worker, and their contact details • Deliver a rolling programme of group consultations and training events (including webinars) for named mental health leads • Produce an annual communication plan for schools and GP practices, to include termly newsletters and other effective forms of communication
Accessibility	• A Single Point of Contact is implemented • Experience of Service Questionnaire indicate clients/patients finding services more accessible • % of complaints about difficulty accessing services reduces • A min % of routine appointments take place on line • a min % of clients make use of apps, self-help, etc • Usage of the online platform increases year on year for 3 successive years • An increased number of children and young people are seen by our services – numbers to be proportionate to the additional funding allocated to each service • Workforce remodelled to include 'junior' posts with dedicated training attached • Audit schedule produced, implemented and improvements made to pathways based on findings

Review of access to support and interventions for children's emotional wellbeing and mental health

Report by the Members Task and Finish Group

January 2017

"If I'd had the help in my teens that I finally got in my thirties, I wouldn't have lost my twenties."

Quote from the NHS Five Year Forward View of Mental Health

Chair's Forward

Young people in Norfolk have consistently told us though their 'make your mark' ballot that mental health is a priority issue for them. Half of all mental health problems appear before the age of fourteen [1], and it's recognised that children, young people and families often have to wait years from when problems first emerge to finding their way to any meaningful help.

Young people, families and those who work with young people have told us they find mental health services bewildering and often do not know what help is out there or how best to access it. We will not solve these issues without listening to young people and families with experience of mental ill-health and meaningfully engaging them in designing and evaluating mental health support; be it in schools, community based or specialist services.

Mental health does not sit in isolation from other issues. The key to protecting young people's mental health is to ensure that they are protected from harm and abuse, have a safe and secure home, a supportive social network, an education curriculum that they can access and opportunities for play and leisure.

This task and finish group wanted to gain a better understanding of the issues faced by Norfolk children and young people, and the things about living in Norfolk that impact on mental health; be it positively or negatively. We have examined the available evidence base to try and understand when the greatest opportunities for making a positive impact on mental health are, and looked at whether services are strongest where need is greatest and considered geographical variation.

We selected the places and organisations that we visited to ensure a geographical spread, mix of urban and rural, age range and setting. We appreciate that there are other schools and organisations doing good work that we did not visit. Due to time constraints and the volume of work we were unable to sufficiently explore the mental health needs of looked after children and other vulnerable or excluded groups, transition in to adulthood or the impact of childhood poverty. I would urge committee to consider whether these issues warrant further exploration.

It was a pleasure to Chair this piece of work on behalf of Children's Services Committee, and I thank fellow members of the task and finish group for their engagement and enthusiasm. On behalf of the group I thank the many expert witnesses who gave us their time and shared their ideas and knowledge.

In particular, I would like to thank members of the Norfolk In Care Council, Youth Council (Norfolk and Suffolk NHS Foundation Trust) and Youth Parliament who have participated in this piece of work. This was a genuine attempt to engage young people and enable them to contribute their expertise. It proved challenging but I would encourage the County Council to learn from this and develop ways of enabling young people to participate in future task and finish work where their expertise and experience can help inform our decision making.

1. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005) Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602.

Vice Chair's Forward

It was a real pleasure to be involved in this piece of work. I was fascinated to see how many different beliefs and opinions there were regarding mental health in one room and how they've gradually changed in to something more positive over the course of this work. Although things didn't go quite smoothly at times I was able to contribute to the group from a young person's perspective such as how things have progressed since I left high school and what could help engage a young person. I believe that the county council should consider involving young people in the future, we have a lot to offer given the chance.

Meghan Teviotdale co-opted co-chair

1.0	**Summary**
1.1	'*Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'* The World Health Organisation (WHO) definition of mental health
1.2	As a Group we have found this to be a complex, emotive and challenging piece of work. However, we have consistently found the following principles to be at the heart of promoting good emotional wellbeing and mental health amongst children and young people: • Support must be offered as early as possible, in a straightforward and consistent way which is non-stigmatising and involves the family as a whole where appropriate And • The needs of the individual, especially children and young people must be listened to at all times. We recognise that the pressures being experienced by all of the organisations within the system are immense and we should not underestimate the challenges involved. However, it is vital that we get this right. Mental health is something we all have, it is precious and we need to ensure that children and young people are able to develop and grow their emotional and mental health as much as their physical health.
2.0	**Recommendations**
2.1	In recognition of the complexity and 'reach' of services to improve emotional wellbeing and mental health of children and young people the following recommendations have been separated in to those that are relevant to services delivered by Norfolk County Council and those that are delivered by other organisations.
	Recommendations for Norfolk County Council Services
A	All of the evidence we have found has highlighted the importance of early help/intervention in improving mental health and emotional wellbeing. We recommend that Children's Services ensure that the current emphasis on early help is continued and focus given to ensuring this approach is fully adopted when it comes to all service delivery associated with mental health and emotional wellbeing

B	We recognise the impact parental mental health can have on a growing child. Therefore we recommend that our colleagues on the Adult Social Care Committee review the threshold for access to Adult Mental Care provision in relation to parents and individuals with parental responsibilities (especially those with young children under the age of 8yrs). In addition we would ask that priority also be given to individuals with parental responsibilities in order to reduce the impact upon their family of not receiving treatment.
C	Although schools do not come under the direct management of Norfolk County Council we feel that our overall, collective responsibility for safeguarding and championing children and families means that we need to develop a Norfolk standard together. This should clearly show what is expected of schools in relation to emotional wellbeing and encouraging positive mental health. Norfolk County Council's role is to help provide information and recommendations to assist schools in developing a whole school approach which can be evaluated to ensure approaches reflect best practice. It is on this basis that we recommend a guide be produced for schools as to what services exist along with the recommended route in to them. This guide should be produced in partnership with schools (including Governing bodies) and young people to ensure it is relevant. The senior management team in Children's Services are asked to identify relevant staff to take this forward.
D	Connected to (C) we recommend that Norfolk County Council develop a core offer of services connected to mental health provision for children and young people. In addition this should include more complex services that could offered at a cost via Educator Solutions. This should also link in to the re-design of CAMHS services. The core offer should be developed in partnership with schools and young people based upon a clear business case to be developed in partnership with Public Health.
E	Public Health are looking to deliver a year of positive action towards mental health. We heard from young people how important it is that they feel informed and involved in services to help them understand and take charge of their own health. We therefore recommend that any activity specific to children and young people involve them its design and commissioning, ensuring that it is relevant to them. This should then be promoted in schools to be used as a resource within lessons, providing them with a fully endorsed 'product' that ties in generally with schemes by Public Health to improve awareness of mental health issues amongst young people.
F	Given the scope of the issues impacting upon mental health it has been impossible to cover everything within the time limitations of this Task and Finish Group. The following are specific areas that the Group feel warrant attention: • Looked After Children (LAC) • Post 16yrs education To this end Children Services Committee may wish to consider commissioning further work either through officers, to be reported back, or in the form of further Task and Finish work
G	During the course of our work we were talked through in detail the impact of attachment for children and their families. In order to improve Members knowledge of this we recommend that all Members be invited to a workshop to improve general understanding and assist in informed decision making

	Recommendations affecting services outside of Norfolk County Council
H	We highly recommend that the Mental Health Trust responsible for mental health service provision in Norfolk (currently NSFT) collect (as part of triage), collate and share data associated with parental responsibilities for those accessing their services. This links to recommendation (B) to lower the threshold and give priority to individuals with parental responsibilities and will assist all relevant organisations to ensure that any safeguarding concerns can be quickly addressed through improved communication and understanding.
I	We recommend that schools be encouraged to work together to share best practice in relation to mental health and emotional wellbeing of pupils in Norfolk
J	Linked to (I) that the Education and Strategy Group be asked to support the production of an evaluation of best practice in Norfolk in connection to mental health and emotional wellbeing activity in schools. This piece of research should then be used to inform the re-design, where necessary, of existing CAMHS services.
K	Mental health services need to be accessible, particularly for young people. Part of achieving this involves an understanding and recognition of the entire 'workforce' involved in improving mental health and understanding the skills and needs of our young people when addressing all levels of mental health need. Ensuring a broad range of professionals are available and aware of all available services. We recognise this is not an easy task but we recommend that: • We develop a common language for social care, medical professionals and schools • We develop a map which can be used to signpost between services • Joint ways of working including opportunities for professionals to come together to discuss best practice be encouraged and their importance recognised in order to create better join up across Norfolk • That the Local Transformation Plan be scrutinised on a regular basis by Children's Services Committee in order to ensure it is delivering for the children and young people of Norfolk
3.0	**Background**
3.1	'Mental Health and Emotional Wellbeing' are something we all have. It impacts upon us even before we are born and will continue to be shaped as we go through life.
3.2	The NHS Five Year Forward View of Mental Health (click here to view) published in February 2016 by the independent Mental Health Taskforce looked at services and attitudes towards mental health. This paper follows on from Future in Mind, published in 2015, which focused on how we can make it easier for children and young people to access high quality mental health care when they need it. The five year review describes how despite improvements in services 'people who would go to their GP with chest pains will suffer depression or anxiety in silence.' Attitudes towards mental health and emotional wellbeing have improved but it remains an area of significant underinvestment and misunderstanding, often described as second class to physical health conditions. The reality is that mental and physical health impact heavily upon each other.

3.3	During the course of this work we received a presentation from Andy Bell (Deputy Chief Executive Centre for Mental Health). The following statistics from his presentation in relation to children and young people provide difficult reading: • **Over 20% of children** experience a mental health problem at some point between ages 3 and 11* • Children from low income families are **four times more likely** to suffer mental health problems than those from more affluent families* • **86% of children** with mental health problems will have difficulties in adult life • **75% of adults** with mental health problems were first unwell in childhood or adolescence • Children with a conduct disorder (persistent, disobedient, disruptive and aggressive behaviour) - are twice as likely to **leave school without any qualifications**, three times more likely to **become a teenage parent**, four times more likely to become **dependent on drugs** and 20 times more likely to **end up in prison** • On average **it takes ten years** from a mental health issue surfacing to the point at which the individual will **get help** (this is not unique to the UK) ** Information source:* Children of the New Century: Mental health findings from the Millennium Cohort Study *by Centre for Mental Health.* Findings relate mainly to the mental health of children around the age of 11 as recorded in the Millennium Cohort Study (MCS), a multi-purpose longitudinal study which is following a large sample of children born in the UK at the start of the 21st century. Data was collected mainly in 2012 using the Strengths and Difficulties Questionnaire (SDQ), a widely used screening instrument in which parents and teachers report on a child's mental health in the previous six months.
3.4	We have all heard that issues such as exam pressure, social media and a lack of future prospects are major concerns for young people. In recognition of this, Youth Parliament have identified mental health as one of their top five issues for young people today.
3.5	One of the members of the Group (who also sits on Norfolk In Care Council (NICC)) spoke about the importance of involving young people in addressing their own health concerns. The approach gives the young person an opportunity to learn about what is the right way of handling a situation for them, keeping their mental health positive and being able to develop coping mechanisms to help them deal with the world. As a group we feel this is a really important message, especially as too often young people, specifically teenagers are left in a 'gap' between child and adult services without appropriate ways of transitioning. This is recognised through Norfolk County Council's involvement strategy and links to the UN Convention on the Rights of the Child.
4.0	**Norfolk County Council's definition of positive mental health**
4.1	Norfolk County Council Children's Services have the following definition of what we mean by positive mental health: '*A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.'*

5.0	**Understanding the factors contributing to and impacting on children's emotional wellbeing and mental health**
5.1	During the course of our work we heard from a number of professionals that diagnosable psychiatric conditions are not increasing statistically and represent a small proportion of the problems faced by young people today (to note ten per cent of children and young people (aged 5-16 years) have a clinically diagnosable mental problem but 70% of children and adolescents who experience mental health problems do not have appropriate interventions at a sufficiently early age (Fundamental facts about mental health 2015 – Mental Health Foundation). However, in contrast, concerns linked to mental distress such as self-harm and attachment are increasing, impacting upon children right from conception.
5.2	Overall this proved a challenging area to get to grips with, forming the majority of our work. The complexity of factors involved mean that it is impossible to cover everything within this report and has resulted in a recommendation (F) to consider carrying out more detailed work on certain factors. We acknowledge that each and every child will have a unique set of factors/experiences that will impact upon them as they grow. Some issues are heavily dependent upon the wider environment in which the child is living and can suddenly change – for example the loss of a parent's employment or the death of a family member.
5.3	In order to better understand the effect of early life on a child's emotional and mental development, Committee members may wish to watch 'Growing an emotional brain' – a film by NSPCC which examines some of the key factors that can impact upon us from pre-birth onwards.
5.4	The following sections of the report are loosely based around stages of development in a child's life to look at the issues that may impact upon them.
5.5	**Pre-Birth, Early Years and Primary School**
5.6	NHS statistics show that one in five mothers suffer from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. The same figures show that suicide is the second leading cause of maternal death, after cardiovascular disease (reference Five Year Forward View for Mental Health – report by Mental Health Taskforce for NHS England Feb 2016).
5.7	The following quote from the Future in Mind report shows the financial implication of this 'maternal perinatal depression, anxiety and psychosis together carry a long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, equivalent to a long-term cost of just under £10,000 for every single birth in the country. Nearly three-quarters of this cost (72%) relates to adverse impacts on the child rather than the mother. Some £1.2 billion of the long-term cost is borne by the NHS'.
5.8	In December 2015 Mumsnet and the ITV News launched a survey to look in more detail at the reality of postnatal depression. The survey results showed that out of 724 new mums, 631 reported suffering from postnatal depression, 29% of whom never sought help for the condition. The reasons given included fear that their child would be taken away if they couldn't cope, symptoms not being 'serious enough' to seek medical help and a feeling of 'letting their family down by getting ill'. Statistics from the NHS also show that although not quite as high (1 in 25) new dads reported suffering from postnatal depression. This means that right from the start of life some children will have challenges to developing positive mental health

	outside of their control and not necessarily connected to a diagnosable medical condition.
5.9	In addition to the conditions mentioned above other influences on parents such as drug / alcohol abuse, smoking, domestic violence and poverty can have a long lasting impact upon the family, affecting the emotional, social and cognitive development of the child. A study carried out by Reiss revealed that 'there is greater prevalence of mental health problems in children whose parent had no educational qualification (17%) compared to those with degree level qualification (4%) and in families where the household reference person was in a routine occupational group (15%) compared with households whose reference person was in the higher professional group (4%).' Reiss F (2013) Socioeconomic inequalities and mental health problems in children and adolescents: A systematic review. *Social Science and Medicine.* 90. p. 24-31.
5.10	Representatives from Leeway, an organisation who helps families suffering with domestic violence issues explained that fewer women are currently coming in to their care as a result of an escalation in violence due to pregnancy. However, they have noticed an increase in women needing help after a baby has been born, during early infancy and when the child is a toddler.
5.11	Once born, a baby needs someone to act as a 'buffer' between them and the rest of the world. This is often referred to as 'attachment', a biological instinct in which proximity to an attachment figure like a parent is sought when the child senses or perceives threat or discomfort. However, if the adult is suffering from mental health issues or any of the external factors mentioned in section 5.9, 'attachment' may be challenging for both the parent and the child.
5.12	Positive parenting is another term often used when talking about the influence a parent has on emotional and mental development of their child. The term means dealing with difficult behaviour in a consistent and positive rather than punitive way, an important step in development, especially in the early years. Before the age of two we are not just learning how to communicate and skills like walking but also how to manage and understand our own emotions. The physical pathways in our brain are still developing, mapping the person we will be in later life through our experiences.
5.13	However, for all parents, especially new parents, helping and guiding their child's development requires skills and techniques that they may not needed before. The early years of parenting are a stressful and challenging time for everyone and can be, at times, isolating. Parents can often be without a readily available support network as families are now more geographically 'spread' and issues such as financial pressure can all add to the feeling of not being able to cope with day to day issues let alone if a child has more complex needs. We also heard accounts of parent's behaviour and attitude being influenced by their own experiences of growing up. Some teachers explained how parents were at times reluctant to engage with the school if their own experiences of school had not been positive.
5.14	During the course of our work we spoke to staff at Children's Centres and Primary Schools about the impact that parenting can have both intentionally and unintentionally. Parenting programmes are an effective way of helping parents learn new skills as well as an opportunity to ask questions, meet

	other families (who may have similar experiences) and reduce isolation which can be particularly important for first time parents. In section 5.7 of this report we spoke about the financial and social cost of not dealing with conditions such as post-natal depression. A study by the LSE estimated savings of £8 for every pound spent on parenting programmes to prevent conduct disorder over the course of a child's lifetime. This means that for example for every £1000 spent on parenting courses there is an overall saving of £8000. The report also states that "the economic returns from school-based programmes to deal with bullying and other behavioural problems are even larger."
5.15	From an early age we are influenced by people and situations outside of family life. Experiences from early life start to surface in our behaviour and the way we interact with others. Statistically boys experience more behavioural issues at this stage in life than girls often mislabelled as 'naughty' behaviour, leading to further labels like 'disruptive'. We discussed as a Group on several occasions whether this could be a contributory factor to why exclusions seem to be rising. Teachers described the challenges in balancing the needs of a child exhibiting this kind of behaviour with the needs of the wider class and the implications of getting it 'wrong'. In order to understand more about the ramifications of this, Committee members are encouraged to refer to the final report of the Exclusions Task and Finish Group shown elsewhere on this agenda.
5.16	As well as the impact on the individual child and family, mental health problems in children and young people result in an increased cost to wider society. A study by Friedli and Parsonage estimated additional lifetime costs of around £150,000 per case or around £5.3bn for a single cohort of children in the UK. Costs relating to crime are the largest component of the overall figure, accounting for 71% of the total. This is followed by costs resulting from mental illness in adulthood (13%) and differences in lifetime earnings (7%).
5.17	Throughout the course of our work we heard about the importance of early, appropriate support in order to avoid more serious consequences later on. Many parents who start to experience problems linked to their child's behaviour will ask for help. However, this request will tend to be directed towards professionals such as a GP or a teacher rather than seeking more specialist support. Although this is positive we heard on several occasions from teachers how difficult this can be, especially as many do not consider themselves equipped to provide adequate help.
5.18	Debbie Whiting, Head Teacher at North Denes Primary told us about a programme that they are involved in which links them to the local Police force. This has proved invaluable in informing them of children within their care who have experienced domestic violence while away from school, enabling school staff to support the child during their school day, offering someone neutral to talk to and helping the teachers to better understand the child's behaviour. Without this information, Debbie described situations where a child would either be reluctant to engage or exhibit violent/disruptive behaviour because of what was happening to them outside of the knowledge of the staff. Towards the end of our work we were pleased to hear that this pilot is going to be extended to other schools and hope that this kind of collaborative working will continue to evolve.

5.19	We heard that teachers felt generally that there had been an increase amongst very young children in their knowledge of what was described as 'grown up issues' such as debt and relationship difficulties. The teachers we spoke to felt that this was a reflection of modern society, that children are being exposed to these kinds of issues at an age where they are not necessarily emotionally ready to understand them. This can have a profound impact upon their behaviour as they are unable to interpret the things they are feeling leading them to be disruptive or withdrawn.
5.20	We heard a number of examples of individuals, including parents, 'chasing a diagnosis' or looking to 'treat the condition rather than the person' because a child was exhibiting disruptive behaviour. One Head Teacher described how some children in their care were being treated for Attention Deficit Hyperactivity Disorder (ADHD) without really understanding the underlying cause of the child's behaviour. This was echoed by representatives from Leeway who described young children being diagnosed with ADHD but actually exhibiting hyper vigilance caused by their home situation. Although as a Group we are not equipped to draw a conclusion from this it does highlight the difficulty that some families face in getting a comprehensive diagnosis in order to help their child.
5.21	**Secondary School**
5.22	Between the ages of 11 and 16 years a child starts to become more independent, using the skills and information they have learnt during their early years of life. Although this independence can be a positive experience it is not without issues.
5.23	At this stage, parents may not be as aware of their child's emotional wellbeing as in previous years. A young person who is struggling with their mental health or emotional wellbeing will turn to friends or look online for help rather than speaking to parents or authority figures. Experiences such as bullying, sexual pressure, parental pressure and exam pressure may all contribute to a complex mixture of emotions and feelings that the young person may not be fully ready to deal with.
5.24	Statistically girls start to overtake boys as far as negative impacts on their mental health after 11yrs. However, there is some evidence that this assumption is partly linked to socially accepted norms i.e. girls are more likely to speak about their emotional and mental health than boys are. Increasing pressure on both sexes means that all young people could be at risk.
5.25	We heard from Dan Mobbs, representing MAP (Mancroft Advice Project) who described seeing more young people with issues like self-harm, suicide and suicidal thoughts. Dan described that 'it seems to be that young people are deeply worried, to a level which is serious about a variety of issues'. This was echoed by professionals from NSFT who reported an increase in the rates of mental distress generally.
5.26	We spoke about the impact of social media on teenagers (although it was recognised that this is another area that is starting to impact upon people at an even younger stage than before). Cyber bullying is well documented as a concern for young people and unlike previous generations bullying and social exclusion no longer just exist within school hours. Many of the young people we heard from described it as 'never ending' and something that you 'just can't get away from'. This is concerning as it can not only have an

	impact upon young people's emotional and mental development but could have long term implications for their future.
5.27	The definition of 'friend' has been changed significantly as a result of social media. Facebook and other social media sites have given young people access to the world rather than just connecting with people in their community / school. This has led to a shift in the nature of friendship and support networks as young people may never actually physically meet their 'friends'. This shift may hide a negative impact on emotional wellbeing, as someone who appears to have a lot of 'friends' and be socially active, may in reality be lonely and isolated.
6.0	**Understanding the current arrangements and the Local Transformational Plan ambition for improving access to and support from emotional wellbeing and mental health services**
6.1	Although we did not approach this work as a review of service delivery we did examine the Local Transformational Plan to understand what it means for young people in Norfolk.
6.2	The plan sets out the following vision for Norfolk and Waveney: We want children and young people to have the opportunity to build good attachments and relationships with their families and peers leading to more children having good emotional wellbeing and mental health from the outset. For those that do have problems, we want to help more recover with a positive experience of care and support so that fewer children suffer avoidable harm. a) We want fewer children and young people to experience stigma and discrimination and will protect them from abuse and harm. b) All children and young people will be able to access support for emotional wellbeing and mental health needs at the earliest opportunity through one stop shops and online alternatives out of hours. We will provide understanding when responding to crises with the aim of reducing emergency admissions and inpatient care by using alternatives to hospital wherever possible.
6.3	We agree that the vision (above) and the principles of transformation (below) remain important and relevant: a) Ensuring agencies work together when they commission and provide services to children and young people. b) Being whole person focused, achieved through joined up commissioning, provision and specialist and targeted interventions. c) Creating the conditions within our communities, schools and settings that enable all children and young people to thrive and feel confident knowing where to seek help should they need it. d) Providing good transitions at all stages of childhood starting with joined up parent and infant mental health support to ensure families stay together. e) Promoting emotional and wellbeing support in schools and active and healthy lifestyles.

	f) Being inclusive in all areas.
6.4	We were pleased to hear of a lot of really good work being done to make these principles happen, however, we recognise there remain significant challenges.
6.5	In 2015 the Future in Mind report said 'complexity of current commissioning arrangements. A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall though the net has been highlighted in numerous reports'.
6.6	Unfortunately, we heard consistently from service representatives that this remains a significant challenge. There is still inadequate join up in the system and the mixture of services are complicated to navigate and difficult at times to access. Although we recognise that children's mental health is not alone in this complexity as a result of competing pressures and finite resources this is a vital area to improve.
6.7	Anecdotal evidence shows that where a family experiences a less successful first contact with services it will affect their willingness to seek help in the future.
6.8	David Ashcroft, Chair of the Norfolk Safeguarding Children's Board expressed views that some of the problem may lie in the approach taken when commissioning services. He felt that within the current financial climate the process can lead us to focus heavily upon the commercial view point to the exclusion of gathering the views of young people / service users. The approach can also lead to commissioning services in isolation of each other, without understanding how someone would navigate through them, especially someone with challenges such as emotional wellbeing and improving their mental health.
6.9	As a Group we were particularly struck by his description of services needing to be adaptable and able to change to meet the needs of a growing child. Some services can effectively 'lock in' individuals, as they lack the ability to provide help when required alongside the ability to pull back when not.
6.10	We heard of thresholds such as age and level of severity of need becoming a potential barrier for some to accessing services. Although we recognise that thresholds are necessary and can be helpful in making sure those that need help receive it they should be easy to understand, consistently applied and with enough flexibility as to not become a barrier.
6.11	For example we heard from adult mental health services that there appears to be a lack of knowledge regarding the parental status of someone accessing their service. This is concerning as although our main focus was the services aimed at children and young people, as discussed earlier in this paper there is a profound effect on a child whose parent(s) are dealing with such issues. This could ultimately lead to an individual who does not meet the threshold for the service continuing with problems that will eventually impact upon their family and ability to nurture positive mental health in their child. This is an unintended consequence that could be avoided by ensuring that parental status is known and that thresholds are re-examined with regard to the potential impact on the wider family of not getting help.

6.12	We were pleased that the need to treat a family as a whole is part of some service provision. We heard about projects in children's centres and schools involving the whole family and even helping to bring families together who are experiencing similar issues. However, this sort of approach needs to be something that all families can access, not just the ones that are lucky enough to attend a school or children's centre that offers it. We are fully aware that all services are stretched both financially and capacity wise, however, these sort of early, low cost interventions should be encouraged as they reduce the need for long term, expensive and intensive treatments later on.
6.13	We were encouraged by the work going on in Children's services to focus on early help through children's centres and the Healthy Child Programme. We saw and heard about some fantastic work going on in primary schools to help children develop not only academically but also emotionally (more can be read in section 7.0 of this report). However, there does appear to be inconsistency in approach. It is important that we have flexibility in what is available to families but this needs to be backed by an evidence base of what really works. This is one area that we found is severely lacking, not just in Norfolk but on a national basis. Work is underway through certain projects such as the one we heard about at North Denes Primary School and Neatherd High school to start developing evidence but this will be specific to their approach.
7.0	**To consider the impact and relationship between children's mental health and education including the role of schools in supporting children and their ability to access specialist support**
7.1	This was a complicated area to explore which the Group divided in to Primary and Secondary school. The following are just some of the practices currently in place in some schools in Norfolk.
7.2	**Freethorpe Community Primary School**
7.3	Freethorpe is a leading 'PATHS' school (click here to find out more about the approach). The approach includes work to understand: • Risk taking in learning • Building confidence in pupils (for example 'great as you are' is a project on raising self-esteem, it also works on developing emotional literacy) • Developing a child's emotional literacy Freethorpe is a leading PATHS school which means that other schools visit it to learn how to use the approach. Cards and 'feelings dictionaries' are made available to the pupils so they can understand, record and learn about their emotions. The school also works with the Benjamin Foundation and has a parent support advisor who works within the cluster. Members of the group visited the school to find out what this looked like and found amongst other good work that activities to help children understand and accept compliments was particularly positive. They also found it interesting that the school recognised the impact of rural isolation on children.
7.4	**Bignold Primary School**
7.5	The school has 4 trained pastoral workers and two Teaching Assistants trained in the THRIVE (please click here to learn more about the approach). Work with the children: • Mainly focuses on attachment issues

	• Where necessary it is supported by professional services such as CAMHS, Point One and the Unthank Family Centre • The school's approach involves looking at the whole child, including their background and culture The school believes that it is their responsibility to ensure that children achieve the best they can by recognising each child's unique barriers and strengths. Parental mental health is a key factor in achieving this so the school works with social care and offers practical help like parenting courses. The school has a large and diverse community with 500 pupils and 47 individual languages spoken. Because of the school's diverse nature it also deals with issues associated with isolation. However, rather than the rural isolation which Freethorpe experiences, it is the isolation that some families may feel in the wider community due to their culture or language barriers. It recognises how important working with the whole family is and therefore operates an open door policy to encourage parents as well as pupils to ask for help when they need it.
7.6	**North Denes**
7.7	The school has a special team created by the school through a partnership with the NHS. The team is designed to help with wellbeing issues, supported by Pupil Premium money. It includes the Head Teacher, a family support worker and a male worker who has experience in working with domestic violence as well as drawing upon individuals from the health service. The team are able to offer: • 1:1 or group sessions • Assistance during school holidays through home visits • 'Mulberry' sessions working with groups of families who are experiencing similar issues to work together and gain confidence and experience from each other. The school also maintains good links with the local Police force through a project called 'compass' (see section 5.18 of report for more information). A social worker sits on the Governing body and provides overall specialist advice that Governors might not otherwise be able to access. Although it was recognised that providing such a bespoke service is expensive it does seem to work for the school. Since it has been in place there have been no exclusions.
7.8	**Compass School and Outreach**
7.9	Compass School provision was set up in 2008/9 to bridge difficulties in the existing system. Schools were set up at Belton, Lingwood and Pot Row, each with a capacity of up to 30 children at any one time, working in most cases with families who have already been through statutory services. Pupils include children who had been excluded or referred to CAMHS but had either not engaged or did not met the threshold for access to services. The school offers: • Access to a psychologist, an assistant psychologist and projective therapy • Weekly access to reflective therapy, family work, and outreach • The ability to work with the whole family

	• Within the last 2 years the school has also opened up to key stage 1 as well as key stage 2 and 3. • The school undertakes training for teams from other educational establishments The success of the schools has been in uniting or bringing together systems. This has been fundamental in engaging families as some have described previously being bounced from service to service and a feeling of being 'blamed' by other professional services. In order to redress this the school focuses on the way forward and developing solutions where possible. Recruitment has been a really important factor in the schools success. By employing the right people and educating them the school has been able to build a strong and resilient workforce with little turnover. The most significant change that the school has experienced lately is an increase in referrals for primary age pupils. Although overall this is worrying it is seen as positive recognition of the issues faced by younger children when it comes to developing positive mental health. The school is also seeing a lot more pupils who are Looked after Children or LAC (50% of the pupils currently attending Belton are looked after children). A lot of the children at the school come under the edge of care bracket so an important element of the work the school does is in encouraging families to get to a place where going in to care is no longer an option. When a child is no longer eligible to attend Compass they are referred to another organisation such as 'On track' or 'Futures'. However these organisations are not always able to provide the same level of support, especially once a child reaches key stage 4 and beyond. As a result of this individuals are often referred back to Compass for further help.
7.10	The Compass outreach programme was set up through DfE (Department for Education) Innovations funding. It was developed through a partnership between Norfolk County Council, Benjamin Foundation and Norfolk and Suffolk Foundation Trust (NSFT) mental health trust. The programme builds upon the partnership's collective experience of current service delivery in order to build strong relationships and improve outcomes. There is only one referral route which is through a children's services panel which meets once a week. The young person must have an active social worker who will present their case at panel who will then decide the best outcome for that individual. The service has a capacity is 55 cases at any one time. When it was started there were a high number of Looked after Children (LAC) in Norfolk so this formed part of the focus for the work. A full team was put in place October 2015, which included 4 family development workers, a team of psychotherapists trained in working with art in a therapeutic way, a family systemic therapist, social worker and psychiatrist. In first year of pilot it worked with 170 young people.

	The approach means that the team were able to go in to people's homes and visit LAC at their placements, including those living 'out of County' in order to determine what was needed so that the child could return home. In order to achieve this social care and schools were helped to work together 'around the child' and encouraged to take calculated risks in order to achieve positive outcomes. In the first year the project noticed that a significant amount of time was taken up by parental mental health, rather than working with the child. This involved adults who didn't meet the threshold for access to adult mental health services. Some cases involved trauma they had experienced in their own childhood or issues with domestic violence. In order to address these issues the project concentrates on developing opportunities for the family to do fun things together rather than traditional therapy sessions. Approaches include things like taking a kite out on the beach in order to get the family working together on a shared activity. The approach has also been used in relation to foster care, getting the system to slow down and explore ways in which the young person can stay safely in the county, near to their family and friends. To assist with the join up of services all of the team have been trained in signs of safety so they can work alongside our social workers, using the same tools and techniques, offering a County wide service.
7.11	**Neatherd High School**
7.12	Neatherd has adopted a whole school approach to wellbeing and mental health founded upon the 'time to change' approach (please click here to read more about this approach). Time to change means that staff agree to do some form of activity on mental health once a month which can include anything from a special assembly to a poster campaign. The school also holds mindfulness sessions and silent reflection is part of lessons. The school nurse carries out some activities and the school employs a talk therapist and a school counsellor. In order to support pupils the curriculum is flexible – for example it includes a self-esteem course involving groups of 9 young people at one time in 6 two hour sessions. The school also: • Encourages links to the CAMHS service through their talk therapist • Encourages pupils to take regular breaks from social media by rewarding those that do • Has a section in the library devoted to emotional wellbeing / mental health The Head Teacher describes Neatherd as 'a listening school' where as well as lessons, pupils have mentoring sessions with tutors. The Head Teacher is also vice chair of the behaviour and wellbeing sub-group of Norfolk Secondary Education Leaders (NSEL) who are currently looking at developing a good practice toolkit to be shared with all schools in order to share best practice around mental health and emotional wellbeing. In order

	to help with this the school is carrying out work to monitor the impact of its own activities.
7.13	**Flegg High School**
7.14	The approach taken by the school follows a model developed in Norway around working with families. This involves schools becoming 'community sites', encouraging things like use of the gym and library during school hours and making space available to other services such as the local GP surgery. The school employs a clinical psychologist in order to make the most of the approach, assisted and supported by CAMHS. The role was created, advertised and interviewed for in partnership with CAMHS in order to ensure the right person was employed. In order to support the overall approach the school has put in place: • Yoga and mindfulness sessions as part of core PE (sessions are also run for staff too) • A 'core group' from within school staff who meet to discuss individual cases every two weeks. These sessions help the staff to map a strategy for each pupil based upon the provision they are currently getting • Joined data from the cluster in order to look at key trends and identify where joint therapy sessions for families with similar issues may be beneficial • A system to offer support to families with issues outside of school
7.15	**Alderman Peel**
7.16	The Head Teacher described how the approach has been adopted across all schools in the cluster in order to create an overall strategy that covers pupils from 3yrs to 18yrs. When setting up this model the school undertook various conversations with commissioning officers before determining the right approach. One of the main issues faced was rurality as the nearest professional support is an hour away despite high demand (42% of parents in the Wells parish access some form of Mental Health support). In order to address these issues the cluster has put in place: • A single referral system for all 6 schools in the cluster • A therapist to carry out staff training around the culture and understanding of mental health issues and what support children might need. • Work to improve resilience and anger management amongst pupils (in Wells Primary 16% of the pupils had a CIN plan) • Pupils experiencing emotional abuse and neglect are referred to the school therapist and will be seen within 2 weeks (sometimes with parents). In some cases it is necessary for the school to refer in to more specialist services. However any referral will have initially gone through the school therapist, enabling the school to 'triage' cases so that only cases that will benefit from support the school cannot provide are sent on.

	The cluster has gathered feedback from parents, staff and students to determine the impact of the approach. The next step is to demonstrate that it is also useful in financial terms both for the cluster and for the services that would be called upon if the support was not available in the school.
7.17	**Notre Dame**
7.18	The school has a clear structure for in school support for pupils and its status as a Catholic school means that there is also a spiritual support network in place should pupils want to access it. However, the school does have a disparate intake which can cause problems when trying to engage parents due to the wide geographical catchment area. The school has: • A school nurse available once a week to pick up health issues • Links with MAP (Mancroft Advice Project) which provides staff training to improve their confidence in dealing with issues associated with mental health. This has also helped to improve staff wellbeing • Family mediation. • PHSE curriculum and employs the 'mindfulness' approach Success for the school lies in promoting emotional wellbeing and positive mental health. It is about working jointly and information sharing whilst recognising that this remains a challenge for everyone. The school also has some very keen students who want to push positive mental health and emotional wellbeing forward on the school agenda.
7.19	**City Academy**
7.20	The school, similar to Notre Dame is part of the MAP project and the Head Teacher acts as a representative for all schools on the project board. MAP have carried out staff training on mental health issues which has helped to reinforce the fact that it is important to act early. Pupils have reacted well because the service is provided in the setting rather than having to go to a 'specialist' facility. The school provides: • Counsellors within the school 3 days a week • Children are able to self-refer or a Teacher can refer them with their agreement • The school has its own system that tracks pupil behaviour to determine the effectiveness of the work • The school has a family worker and they employ their own school nurse (4 days a week) as well as the one they are automatically provided The school currently has 126 kids attending a 6 week programme about emotional wellbeing. They also offer other 'wellbeing' linked activities such as cooking, outward bound, personal and social development (linked to bullying) and anger management. Work is also carried out with families in order to see what can be done to deescalate behaviour. The school currently has 67 kids who require ADHD medication which the additional nursing capacity assists with. By offering this service the school has also managed to improve attendance.

7.21	**Summary for schools**
7.22	We were encouraged to see some really positive work being carried out in schools to improve mental health and emotional wellbeing of pupils (and in some cases staff as well). Although we were only able to speak to a relatively small sample of schools, all recognised the importance of this and were working hard to address the challenges they faced in doing so.
7.23	Increased pressure of exams and achieving academically not only apply to individual pupils but also the schools they attend. Representatives from the schools talked of increasing pressure to perform well as far as Ofsted inspections and also overall performance tables are concerned.
7.24	This has seemingly created tension and a narrowing of the curriculum which means that the reality for some pupils is that school may not be able to offer what they need in a way they need in order to develop. One Head Teacher described that the school currently has ten pupils doing 'alternative' courses, each of them doing well, enjoying the course and staying in school. However, the impact of this for the school has been a reduction in overall academic performance. Another Head Teacher spoke of the areas of development that are forgotten by taking a purely academic approach to learning rather than covering equally important societal issues such as sexual violence, which he saw as a growing issue that young people need to be aware of. All of the Teachers we spoke to agreed that schools have a vital role to play in the growth and development of young people as human beings. They also recognised that pupils need to be able to access the type of learning that works for them.
7.25	All of the schools we spoke to described a complicated and at times difficult path in to specialist services. Many had felt the need to employ specialist help not only to deal with issues 'in-house' but also to provide a professional to professional discussion regarding pupils that needed more specialist support.
7.26	Knowing how and when to refer pupils and their families in to specialist help was something that both the schools and the specialist services felt needs to be improved. Schools gave examples of pupils being 'bounced back' as not meeting thresholds and specialist services described additional time added to waiting lists caused by pupils that should not have been referred to them in the first place.
7.27	This confusion as to what issues should be referred on and what should be dealt with by schools was described by one Head Teacher as an issue between 'professionals'. He described teachers as non-health professionals who are starting to feel added pressure to deal with issues linked to emotional wellbeing and mental health without having the confidence, appropriate training or knowledge.
7.28	On more than one occasion we discussed the different interpretations of what a 'school counsellor' meant. One school we spoke to explained that they deliberately didn't employ a professional school counsellor due to cost and the expectation that this gave to families.
7.29	Although we were encouraged at the importance given to improving emotional wellbeing and mental health in schools, we were concerned that the inconsistency of approach has the potential to cause unintentional harm. Head Teachers described services offered to schools by third parties but a lack of guidance meant that although some had systems in place, including

	those developed 'in-house' there is a lack of guidance and evidence to be able to tell if they are really adopting the right approach.
7.30	All of the organisations we spoke to, including schools were starting from very different places as far as this area of work is concerned. For schools this can mean a confusing and potentially expensive landscape with issues such as poor attendance and even exclusion being the downside of getting it wrong. Together this points towards the need for a much wider discussion than just CAMHS services when it comes to promoting positive mental health and emotional wellbeing amongst young people.
7.31	Jon Wilson, consultant psychiatrist from NSFT described how 'a treatment regime won't deal with social factors that impact upon mental health.' We also spoke about the futility of 'treating' a child impacted upon by social factors and then returning them to the same environment. Many of these factors and issues are co-dependent, leading to a complex picture where tackling just one element may unwittingly create unforeseen tensions.
7.32	The 'whole school approach' promoted by the Department for Education requires prioritisation from the top and backing from the senior leadership team in order to work. It also requires schools to recognise that investment in promoting good mental health of pupils does contribute towards improving school performance. However, there seems to be uncertainty about what the 'whole school approach' really means.
7.33	The Institute for Policy Research have produced a paper which talks about the 'whole school approach' which says: • By the end of parliament all schools should be guaranteed access to at least a day a week on site support from a CAMHS professional, rising to two days per week by 2022/23 • All CCGs should convene a regular Head Teachers mental health forum for the local area to influence funding decisions • All CCGs should identify beacon schools to spread good practice within local areas • A national recruitment drive will also be held for school counsellors with better quality regulation of the role and a school ready kite mark for the profession
7.34	As an approach we would back all of the actions above as a positive step forward. One Head Teacher described their role as 'providing beautiful things for pupils that may not have them at home', in recognition that some pupils have a very challenging a difficult home life. All of the schools we spoke to recognised the importance of their role in the growth of children not just academically but also emotionally. However, we all recognise that there remain some really difficult questions about the practicality of achieving this alongside the other pressures and challenges facing schools at the moment.
7.35	**Healthy Child Programme**
7.36	The Health Child Programme was extended to cover 0 to19yrs (used to be 0 to16yrs) and includes services such as health visitors, healthy weights and the national child measurement programme. It is designed to support community capacity projects as well as 'mandated' work such as immunisations. The programme also includes a universal 'plus' element

	which targets particular issues and involves a variety of providers such as Children's Centres.
7.37	The programme includes specific health assessments such as parental and child mental health, even prior to birth. One way in which this is being delivered if through 'CHAT Health', a text service that has been introduced, partly in response to the lack of school nurses. The text messaging service is available to 11 to 19yrs old and is manned by a school nurse who can give advice or guide young people to where they can get help. Predominantly the service is about wellbeing of young people. Individuals can request 1:1 support, unique to them and they don't have to discuss anything with peers or teachers.
8.0	**Understanding NCC's Children's Services spend on mental health services and the impact this has for children including innovative programmes of support associated with alternatives to care and looked after children**
8.1	The overall amount of core funding available to the five Clinical Commissioning Groups (CCG's) in Norfolk and Waveney for mental health services for children and young people in Norfolk is approximately £14m. In addition to this £1.9m recurrent funding has been allocated to support implementation of the Local Transformation Plan. A paper (Fundamental Facts about mental health) by Mental Health Foundation published in 2015 showed that 'Child and Adolescent Mental Health Services (CAMHS), the number of NHS funded beds for children and adolescents rose from 1,128 in 2006 to 1,264 in January 2014. In Leicestershire and Lincoln, there was the greatest increase, by 19%, in bed occupancy, followed closely by 15% in East Anglia. In England, extensive disinvestments in Child and Adolescent Mental Health Services have been observed.' Research in 2014/15 undertaken by Young Minds revealed the following in connection to Child and Adolescents Mental Health Services (CAMHS) budgets: • 75% of Mental Health Trusts have frozen or cut their budgets between 2013-2014 and 2014-2015. • 67% of Clinical Commissioning Groups (CCGs) have frozen or cut their budgets between 2013-2014 and 2014-2015. • 65% of Local Authorities have frozen or cut their budgets between 2013-2014 and 2014-2015. • 1 in 5 Local Authorities have either frozen or cut their CAMHS budgets every year since 2010. • It has been estimated that the tens of millions of pounds in cuts equates to almost 2,000 staff that could otherwise be supporting mental health problems across the UK.
8.2	This shows that under investment over a number of years across all of the services involved, including the NHS, means that funding for mental health services have not kept pace with demand for many years across the UK. However the argument for additional funding is complicated, many of the measures needed to improve emotional wellbeing and mental health are long term and each person needing help will come with a unique set of issues and needs.
8.3	Overall, we have found that it is not possible to say exactly how much is spent on children and young people's mental health in the County. This is due to the complexity of the different funding sources and organisations involved in delivery and as a result it is also hard to determine whether or

	not spend is based upon the level of need. National research points towards a significant gap in funding for mental health as opposed to physical health conditions. However, the lack of a clear evidence base suggests that further work is required to understand what is really working before we can determine how it should be funded.
9.0	**Conclusion**
9.1	This has proved a complicated and at times emotive piece of work.
9.2	We heard about the impact of a number of factors on people right from the early stages of life. How much an individual is shaped by their experiences and environment and the importance of parents, schools and organisations in promoting positive emotional wellbeing and mental health from early life onwards. However, it remains a challenging area to get right.
9.3	Elements like flexibility of service delivery and join up still remain an area of concern despite numerous activities and very passionate individuals. We recognise that there is a danger of 'locking in' people to services, particularly in relation to young people as they are still growing and developing. We heard about the difficulties experienced by young people trying to get help and support in a very 'adult', clinical type setting. However we must recognise that current financial constraints impacting upon service delivery mean that more than ever it is important that resources are directed towards need and where they can have the biggest impact.
9.4	We need to get away from thinking of 'thresholds' as access points to services or believing that a diagnosis signals the end of the journey. Improving mental health and emotional wellbeing are not quick fixes and they cannot be easily addressed through a single approach.
9.5	The Mental Health Foundation explains that 'data for Children's and Adolescent mental health in the UK is grossly outdated. The most recent British Child and Adolescent Mental Health surveys carried out by the Office for National Statistics (ONS) were conducted in 1999 and 2004' (to note - the Government has recently commissioned the ONS to undertake a new prevalence survey of the rates of mental health problems in children and young people).This, along with the lack of an evidence base on which organisations such as schools can identify what 'good practice' looks like means that, although well intentioned some existing activity may be misplaced. Although this problem is UK wide we cannot emphasise enough the importance of developing this knowledge base as part of any work to improve services in Norfolk.
10.0	**Recommendations for Norfolk County Council Services**
A	All of the evidence we have found has highlighted the importance of early help/intervention in improving mental health and emotional wellbeing. We recommend that Children's Services ensure that the current emphasis on early help is continued and focus given to ensuring this approach is fully adopted when it comes to all service delivery associated with mental health and emotional wellbeing
B	We recognise the impact parental mental health can have on a growing child. Therefore we recommend that our colleagues on the Adult Social Care Committee review the threshold for access to Adult Mental Care provision in relation to parents and individuals with parental responsibilities (especially those with young children under the age of 8yrs). In addition we would ask that priority also be given to individuals with parental

	responsibilities in order to reduce the impact upon their family of not receiving treatment.
C	Although schools do not come under the direct management of Norfolk County Council we feel that our overall, collective responsibility for safeguarding and championing children and families means that we need to develop a Norfolk standard together. This should clearly show what is expected of schools in relation to emotional wellbeing and encouraging positive mental health. Norfolk County Council's role is to help provide information and recommendations to assist schools in developing a whole school approach which can be evaluated to ensure approaches reflect best practice. It is on this basis that we recommend a guide be produced for schools as to what services exist along with the recommended route in to them. This guide should be produced in partnership with schools (including Governing bodies) and young people to ensure it is relevant. The senior management team in Children's Services are asked to identify relevant staff to take this forward.
D	Connected to (C) we recommend that Norfolk County Council develop a core offer of services connected to mental health provision for children and young people. In addition this should include more complex services that could offered at a cost via Educator Solutions. This should also link in to the re-design of CAMHS services. The core offer should be developed in partnership with schools and young people based upon a clear business case to be developed in partnership with Public Health.
E	Public Health are looking to deliver a year of positive action towards mental health. We heard from young people how important it is that they feel informed and involved in services to help them understand and take charge of their own health. We therefore recommend that any activity specific to children and young people involve them its design and commissioning, ensuring that it is relevant to them. This should then be promoted in schools to be used as a resource within lessons, providing them with a fully endorsed 'product' that ties in generally with schemes by Public Health to improve awareness of mental health issues amongst young people.
F	Given the scope of the issues impacting upon mental health it has been impossible to cover everything within the time limitations of this Task and Finish Group. The following are specific areas that the Group feel warrant attention: • Looked After Children (LAC) • Post 16yrs education To this end Children Services Committee may wish to consider commissioning further work either through officers, to be reported back, or in the form of further Task and Finish work
G	During the course of our work we were talked through in detail the impact of attachment for children and their families. In order to improve Members knowledge of this we recommend that all Members be invited to a workshop to improve general understanding and assist in informed decision making
	Recommendations affecting services outside of Norfolk County Council
H	We highly recommend that the Mental Health Trust responsible for mental health service provision in Norfolk (currently NSFT) collect (as part of triage), collate and share data associated with parental responsibilities for those accessing their services. This links to recommendation (B) to lower

	the threshold and give priority to individuals with parental responsibilities and will assist all relevant organisations to ensure that any safeguarding concerns can be quickly addressed through improved communication and understanding.
I	We recommend that schools be encouraged to work together to share best practice in relation to mental health and emotional wellbeing of pupils in Norfolk
J	Linked to (I) that the Education and Strategy Group be asked to support the production of an evaluation of best practice in Norfolk in connection to mental health and emotional wellbeing activity in schools. This piece of research should then be used to inform the re-design, where necessary, of existing CAMHS services.
K	Mental health services need to be accessible, particularly for young people. Part of achieving this involves an understanding and recognition of the entire 'workforce' involved in improving mental health and understanding the skills and needs of our young people when addressing all levels of mental health need. Ensuring a broad range of professionals are available and aware of all available services. We recognise this is not an easy task but we recommend that: • We develop a common language for social care, medical professionals and schools • We develop a map which can be used to signpost between services • Joint ways of working including opportunities for professionals to come together to discuss best practice be encouraged and their importance recognised in order to create better join up across Norfolk • That the Local Transformation Plan be scrutinised on a regular basis by Children's Services Committee in order to ensure it is delivering for the children and young people of Norfolk

Appendix A

The following provides background information to the working of the Group.

Meetings

Date	Focus	Attendance
22/6/16	First meeting to establish the Group, focus and appointment of Chair	Cllr Margaret Stone, Cllr James Joyce, Cllr Shelagh Gurney, Cllr Richard Bearman, Cllr Emma Corlett, Jess Read (MYP), Katie-Louise Davis and Megan Teviotdale (NSFT Youth Group), Megan and Tom (ICC), Jonathan Stanley, Ali Gurney, Chris Butwright
6/7/16	Presentation by Andy Bell (Centre for Mental Health) and appointment of Vice Chair	Cllr Emma Corlett (Chair), Katie-Louise Davis and Megan Teviotdale (NSFT Youth Group) – (joint Vice Chair), Cllr Margaret Stone, Cllr James Joyce, Cllr Richard Bearman, Megan (ICC), Tom (ICC), Jonathan Stanley, Ali Gurney, Chris Butwright, Stephanie Gallop
14/9/16	Pre-Birth	Cllr Emma Corlett (Chair), Megan Teviotdale (NSFT Youth Group) – (Vice Chair), Cllr Margaret Stone, Cllr James Joyce, Cllr Richard Bearman, Ali Gurney, Stephanie Gallop.
28/9/16	Pre-School	Cllr Emma Corlett (Chair), Megan Teviotdale (NSFT Youth Group) – (Vice Chair), Cllr Barry Stone, Cllr James Joyce, Cllr Richard Bearman, Stephanie Gallop,
19/10/16	Primary School	Cllr Emma Corlett (Chair), Katie-Louise Davis and Megan Teviotdale (NSFT Youth Group) – (joint Vice Chair), Cllr Barry Stone, Cllr Margaret Stone, Cllr James Joyce, Cllr Richard Bearman, Rose Smith (ICC), Stephanie Gallop, Jonathan Stanley, Chris Butwright.
9/11/16	Secondary school	Cllr Emma Corlett (Chair), Cllr James Joyce, Cllr Richard Bearman, Rose Smith (ICC), Stephanie Gallop, Jonathan Stanley
23/11/16	Expert Witness Panel	Cllr Emma Corlett (Chair), Cllr Richard Bearman, Jonathan Stanley, Rose Smith (ICC), Cllr Barry Stone, Cllr Margaret Stone

Visits

As part of the work carried out by the Group we undertook the following visits:
15/9/16 – Great Yarmouth Children's Centre
27/9/16 – Bowthorpe Childrens Centre
30/9/16 – Broadland/Stalham Children's Centre
12/10/16 – Freethorpe Primary School and Bignold Primary School

1/11/16 and 17/11/16 Notre Dame High School 16/11/16 – Flegg High School
The Group would like to thank the following people and organisations for supporting this work and providing valuable insight in to current service delivery.
• Irene Kerry (assisting Norfolk In Care Council) • Ben Dunne (assisting Members of Youth Parliament) • Judi Garrett (Service Development Manager - Alternatives to Care) • Andy Bell (Deputy Chief Executive - Centre for Mental Health) • Claire Gummerson (Advanced Public Health Information Officer - Public Health) • Alison Simpkin (Head of Social Care - Adult Mental Health) • Margaret Hill and Michelle Frazer (Leeway) • Dr Richard Pratt, Dr Sarah Hill and Dr Catherine Thomas (Norfolk and Suffolk Foundation Trust (NSFT)) • Juliette Branch (Freethorpe Primary) • Debbie Whiting (North Denes Primary) • Sian Welby (Early Years Learning – Education Achievement Service) • Dite Felekki (Psychologist NSFT) • Clare Jones (Bignold Primary) • Kirsty Pitcher (Benjamin Foundation) • Nicki Bramford (NSFT Compass Outreach) • Nishi Puri (Psychiatrist NSFT) • Dr Pete Southam (NSFT Compass Outreach) • Mary Sparrow (City Academy) • Alistair Ogle (Alderman Peel School) • Nick O'Brien (Neatherd High School) • Julie Brazell (Notre Dame) • Dr Simon Fox (Flegg High School) • Dan Mobbs (Mancroft Advice Project (MAP)) • Jon Wilson (Consultant Psychiatrist NSFT) • David Ashcroft (Chair Norfolk Safeguarding Children Board) • Mette Ohrvik (Sue Lambert Trust) • Jenny Myhill (Head of Locality, North and Broadland Norfolk Healthy Child Programme) • Sarah Barnes (Public Health Commissioning Manager for Children and Young People) • Rita Adair (Senior Educational Psychologist) • Sarah Hatfield (Senior Educational Psychologist) • Jean Hall (Bowthorpe Children's Centre) • Andrew Forrest (Great Yarmouth Children's Centre) • Lisa Nicholson (Broadland and Stalham Children's Centre)

	Appendix B
Glossary of terms used throughout the report (not in any particular order)	
CAMHS	Child and Adolescent Mental Health Services
NSPCC	National Society for the Prevention of Cruelty to Children
ADHD	Attention Deficit Hyperactivity Disorder
LAC	Looked After Child - Children Act 1989. A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours
CCG	Clinical Commissioning Group - are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England
NICC	Norfolk In Care Council
MYP	Member of Youth Parliament
PSHE	Personal, Social and Health Education
PATHS	A program for promoting emotional and social competencies and reducing aggression and behavior problems in Primary school-aged children while simultaneously enhancing the educational process in the classroom.
THRIVE	Based upon neuroscience and attachment theory the approach provides a powerful way of working with children and young people that supports optimal social and emotional development. In particular, it equips the teacher to work in a targeted way with children and young people who have struggled with difficult life events to help them re-engage with life and learning.
Emotional wellbeing	This includes being happy and confident and not anxious or depressed (NICE definition)
Psychological wellbeing	This includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive (NICE definition)
Social wellbeing	Has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully. (NICE definition)
Mental health	A persons condition with regard to their psychological and emotional wellbeing (Oxford English Dictionary)
UN Convention on the Rights of the Child (UNCRC)	The basis of all of Unicef's work. It is the most complete statement of children's rights ever produced and is the most widely-ratified international human rights treaty in history
Friend	A person with whom one has a bond of mutual affection, typically one exclusive of sexual or family relations (Oxford English Dictionary)
School Counsellor	https://www.gov.uk/government/publications/counselling-in-schools
Whole School Approach	https://www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing

Healthy Child Programme	https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
Cohort	A group of people who share a characteristic – usually age. In terms of this report it relates to an age range attached to the academic system
Diagnosable psychiatric conditions	Psychiatric (mental illness) which can be identified / diagnosed from a person's symptoms or signs.
Mental illness	Mental illness is a term that describes a broad range of mental and emotional conditions. Mental illness also refers to one portion of the broader ADA term mental impairment, and is different from other covered mental impairments such as mental retardation, organic brain damage, and learning disabilities. (Centre for psychiatric rehabilitation)
Postnatal depression	A depressive illness which affects women having a baby. The symptoms are similar to those in depression at other times including low mood and other symptoms lasting at least two weeks (Royal College of Psychiatrists)
Attachment	A biological instinct in which proximity to an attachment figure like a parent is sought when the child senses or perceives threat or discomfort.
Organisations referred to in the report	
World Health Organisation (WHO)	Primary role is to direct and coordinate international health within the United Nations' system.
Centre for Mental Health	Previously known as the National Unit for Psychiatric Research and Development (NUPRD), founded by the Gatsby Charitable Foundation. Since July 2010, it has been known as Centre for Mental Health, an independent charity, working to create a fairer chance in life for people with mental health problems through research.
Mental Health Foundation	The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.
London School of Economics and Political Science (LSE)	http://www.lse.ac.uk/About-LSE/LSE-at-a-glance
MAP (Mancroft Advice Project)	http://www.map.uk.net/pages/
Norfolk and Suffolk Foundation Trust (NSFT)	http://www.nsft.nhs.uk/Pages/Home.aspx

IC24's NHS 111 and GP Out of Hours service in Central and West Norfolk

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

A report from IC24 and Norwich CCG on progress with the NHS 111 and GP Out of Hours service in central and west Norfolk.

1. Background

1.1 Members were informed about the re-procurement of NHS 111 and the GP Out of Hours (OOH) service in central and west Norfolk plus Wisbech in the April 2015 edition of NHOSC Briefing. The contract was let by Norwich Clinical Commissioning Group (CCG) on behalf of four CCGs (Norwich, North Norfolk, South Norfolk and West Norfolk) and was won by IC24, which took over from the previous provider, the East of England Ambulance Service NHS Trust, on 1 September 2015.

1.2 IC24 also provides NHS 111 and GP OOH services in Great Yarmouth and Waveney (GY&W) under a contract let by Great Yarmouth and Waveney CCG. IC24 started to provide the GY&W GP OOH service in September 2011, and the GY&W NHS 111 service in June 2012.

1.3 On 14 April 2016 IC24 and Norwich CCG reported to NHOSC about the progress of the service following concerns raised during an unannounced CCG visit in November 2015. The report and minutes of the meeting can be found on the County Council website:-

http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/514/Committee/22/Default.aspx

1.4 On 10 May 2016, at the invitation of the Chief Executive of IC24, four members of NHOSC visited the NHS 111 care co-ordination centre at Reed House, Broadland Business Park, Norwich and saw the service in action. Notes of that visit were circulated to Members in the NHOSC Briefing, 21 July 2016.

1.5 The Care Quality Commission inspected the service in March 2016 and its report was published on 15 July 2016. The CQC told IC24 that it 'must'

- Ensure all out-of-hours staff who triage patients have been adequately trained to make clinical decisions by telephone and have been assessed as competent to do so. In addition, protocols and guidelines

must be implemented to guide staff to make safe and appropriate decisions with regard to how people's needs are assessed and dealt with.

- Prioritise ongoing work to investigate and tackle the causes of delays relating to patient care.
- Ensure medicines held at primary care centres are within the manufacturers' recommended expiry dates and make sure there is an effective process for managing this.
- Put systems in place to ensure that staff files and recruitment procedures are effectively recorded.
- Undertake Disclosure and Barring Service checks for all staff in a timely and orderly manner.
- Ensure sufficient and appropriately trained staff are present at all primary care centres and that contingency arrangements for staff to follow are agreed for when gaps in GP cover arise.

The CQC also advised IC24 that it 'should' make the following improvements:-

- Learning relating to incidents should be shared with all relevant staff to encourage a culture of on-going improvement.
- Staff should always use the correct prescription pads when prescribing medicines.
- The provider should ensure all staff receive timely mandatory training and are supported in undertaking this.
- The provider should take action to ensure all staff are aware of who the safeguarding leads are within the service.
- All controlled drugs should be ordered from a wholesaler using the correct form, in line with Regulation 14 of the Misuse of Drugs Regulations 2001.
- Ensure a robust process is in place for monitoring clinical equipment, to make sure that it is fit for purpose.

The full report is available on the CQC website
http://www.cqc.org.uk/location/1-2192943954#accordion-1

2. Purpose of today's meeting

2.1 On 14 April 2016 NHOSC agreed to invite representatives from IC24 and Norwich CCG to return in a year's time to update the committee on the progress of the service. IC24 has been asked to provide the following information for today's meeting:-

- performance of the service in the past year in relation to its performance indicators
- the staffing situation (i.e. current number of vacancies for each type of staff in both the NHS 111 and GP OOH services)
- information on the volume of work compared to the commissioned capacity

- progress against the remedial actions plans set by NHS England and any remedial actions that were set by the CCGs.
- information on whistle-blowing in the service (i.e. have there been any instances since April 2016?)

IC24's report is attached at Appendix A (*to follow)* and representatives from IC24 and Norwich CCG will attend to answer Members' questions.

3. Suggested approach

3.1 After the representatives from IC24 presented their report Members may wish to discuss the following issues with them and the representatives from the CCG:-

(a) Has IC24 completed the improvement actions required by NHS England, the CCG and the CQC?

(b) In April 2016 it was IC24's intention that more call handling would be transferred from Ipswich to Norwich, meaning the more staff with local knowledge of Norfolk would be dealing with local calls. Has this happened?

(c) In April 2016 member of the Committee described a case where a west Norfolk patient with a Peterborough postcode who lived near the Queen Elizabeth Hospital was advised by IC24 to travel to Peterborough or Norwich (based on Care Co-ordination Centres making use of pre-set postcodes). IC24 was aware of the case and were investigating the cross-border issues that it raised. Has there been progress in this respect?

(d) The issue of rising indemnity costs for GPs undertaking out of hours work has been raised nationally as one of the factors that discourages GPs from working in the out of hours services. IC24 previously advised that it had trialled a range of initiatives to reduce the impact of indemnity costs on GPs elsewhere in the country and was considering introducing some of these initiatives in Norfolk. Has there been any progress in this respect?

Norfolk Health Overview and Scrutiny Committee
6th April 2017
Norfolk and Wisbech Integrated 111 and Out of Hours Service

1. INTRODUCION

IC24 Integrated Care 24 Ltd (IC24) is a "not-for-profit" social enterprise providing urgent care services for almost 30 years. IC24 has been providing the Integrated NHS 111 and Out of Hours service in Norfolk and Wisbech since the 1st September 2015.

IC24 provide a range of urgent care services (including four 111 contracts) to around six million patients across the following areas:

- Sussex
- East Surrey
- North and West Kent
- Northampton
- Essex
- Great Yarmouth & Waveney
- Norfolk and Wisbech

IC24 delivers NHS 111 from three geographically dispersed Care Co-Ordination Centres (CCC):

- Ashford (Kent)
- Ipswich
- Norwich

The Norfolk and Wisbech service is an outcome based contract focused on providing a 24/7 111 and an Out of Hours (OOH) urgent primary care service. The service provides 24/7 telephone assessment supported by the NHS Pathways assessment tool (111) and the OOH service (18:30hrs until 08:00hrs on weekdays and the whole of weekends, bank and public holidays) that provides both routine and urgent clinical telephone advice and face to face care for patients that cannot wait until their in hours primary care service opens.

The service specification that we have been commissioned to provide in Norfolk and Wisbech is different from historical OOH and 111 services and in line with the national future direction of integrated urgent care services.

- Larger geographical footprint - introduction of Wisbech

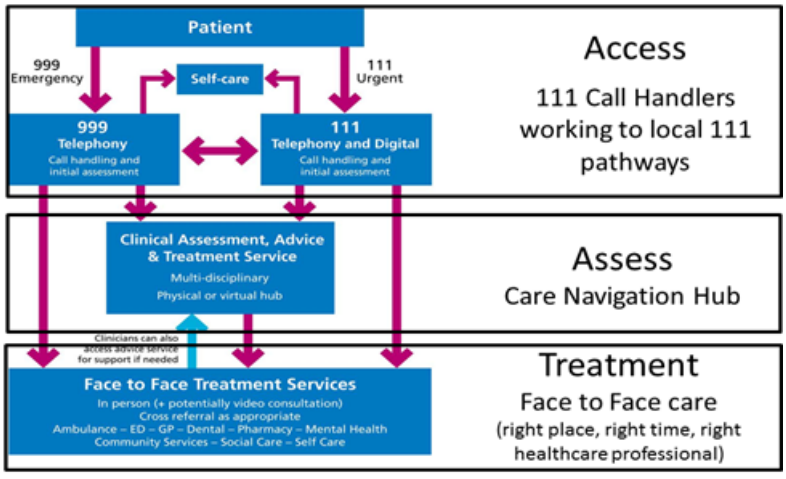
- GP Led service - this encourages and supports a wider use of skill mix reflecting what is seen within the in hours primary care setting
- Integrated 111 and OOH - commissioned as one service and not two separate workstreams

By having an integrated service model we have been able through close working with our co-ordinating commissioners to continue to develop and evolve the delivery model to improve services for patients. This is evident by the introduction of the Clinical Assessment Service (CAS) which is currently operational three evenings a week and for six hour periods on a Saturday and Sunday. The CAS is an initiative integral to NHS England's 5 year forward view and underpinned by the emerging Integrated Urgent Care Strategy.

The 5 year forward view emphasises the importance of integrated supportive working to bridge the gaps between services operating in urgent and emergency care to make sure patients see the right clinician first time as often as possible. The CAS provides enhanced telephone clinical assessment delivered by senior clinicians (GPs) earlier in a patients urgent care journey.

Through the introduction of the CAS we now have three very clear service components:

- Access
- Assess
- Treatment



The benefits of our service model achieved through the integration of 111 and OOH service include:

- Increased clinical support for the 111 staff; co-location of the clinical staff offers support to the call handlers, reduces the amount of cases passed inappropriately to the Out of Hours element of the service as urgent, ensuring that patient care is improved as true urgent cases are seen in a more timely manner.

- Responsibility for the whole patient journey – The impact of high urgency rates can be seen by the integrated team and they work together to ensure the appropriateness of these.

2. ACCESS – Norfolk & Wisbech 111

The 111 service is answered and delivered from our Care Co-ordination Centre in Reed House, Norwich. The service is delivered by NHS 111 Pathways Advisors and NHS 111 Clinicians supported by on site clinical and operational leadership. IC24 has its own NHS Pathways trainers. (NHS Pathways is the nationally licensed delivery model for NHS 111). As an early implementer of NHS 111 we have been able to build and enhance the training we deliver which exceeds that prescribed at a national level.

- **NHS 111 Clinicians**

Our NHS 111 Clinicians include senior Nurses or Paramedics who have undergone a minimum of 84 hours NHS Pathways training in additional to their core clinical training. IC24 operate a skill mix of a minimum of 1 clinician to 4 Pathways Advisors (PAs) where nationally the accepted standard tends to sit around 1 clinician to every 6 PAs.

- **NHS 111 Pathways Advisors (PA)**

IC24 currently have 38 WTE PAs in post and have six undergoing training. Our workforce plan is based on an optimum level of 44 WTE PAs.

The training required to be an NHS 111 PA includes;

- 64 hours (minimum) class room training on NHS Pathways
- Exam based assessment
- Exposure to the live environment (listening to calls and contact centre familiarisation)
- 1-2-1 supervision

Once signed off against all the levels above, the PA progresses to our Graduation Bay. The Graduation Bay is an environment within the CCC that is slightly removed from the main centre and benefits from higher clinical intervention. This enables the new PAs to feel supported in their new role, reduces the attrition rates and ensures a higher standard of care for our patients.

As with all call centre environments employee attrition is a challenge. Within the NHS 111 environment this is exacerbated by the unique healthcare aspects of the role. To mitigate against this we do provide enhanced training and high levels of support.

PA recruitment was very challenging during the early transition stage of the contract and this was significantly impacted by negative publicity which resulted in increased attrition and recruitment challenges. However, as the service has become more established and with the introduction of a

new pay framework and associated opportunities for career progression, recruitment of PAs has improved.

Through our recruitment strategy we have also introduced Recruitment and Assessment Days which have enabled us to identify the right candidate at an early stage.

Performance – 111

Improvement in NHS 111 performance has been a priority. As identified above, the stability of the workforce is a key factor in achieving and maintaining call centre performance. We are continuing to drive performance and quality and while this is monitored on a monthly basis with our commissioners we review performance in real time.

As NHS 111 is a national service, we have nationally set key performance and quality metrics on access that include:

- % of calls answered within 60 seconds (Target >95%)
- % of abandoned call (target <5%)

Whilst we have seen improvements against the metrics above, under times of extreme pressure we still experience performance challenges with answering calls within 60 seconds.

During this winter period the whole of the NHS has been under significant pressure. These pressures have been experienced across the Norfolk and Wisbech Health and Social Care system and the NHS 111 and OOH service has been no different. We are however able to report an improvement in performance when compared with the previous year despite a 14% increase in the number of calls offered to the service.

The table below is a comparison of activity and performance over Christmas 2015 and 2016.

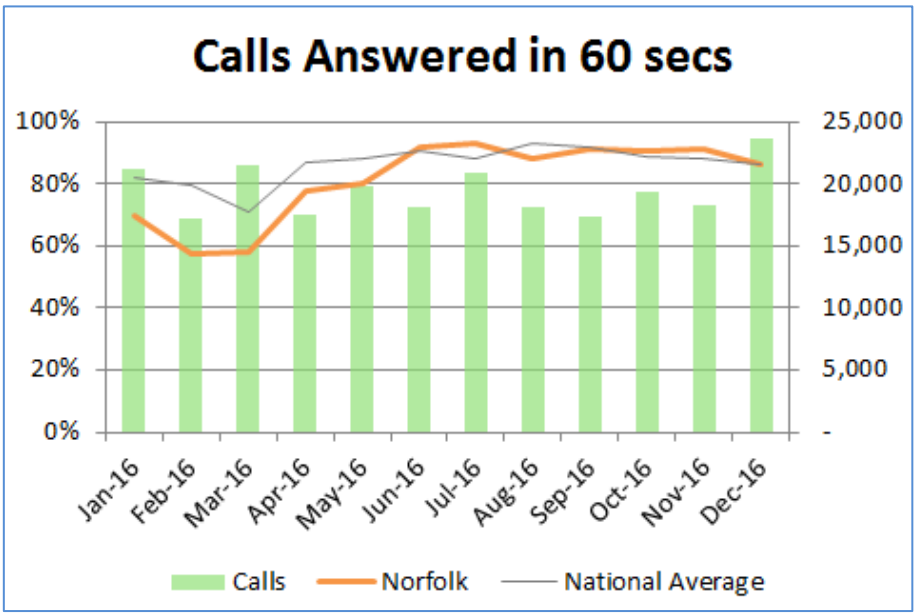
	December 2015	December 2016
Calls Offered	23,854	27,142
Calls Answered	22,528	23,680
Percentage of Abandoned Calls	5.56%	4.47%
Calls Answered in 60 seconds	18,283	20,368
Percentage Calls Answered in 60 seconds	81.16%	86.01%

Summary

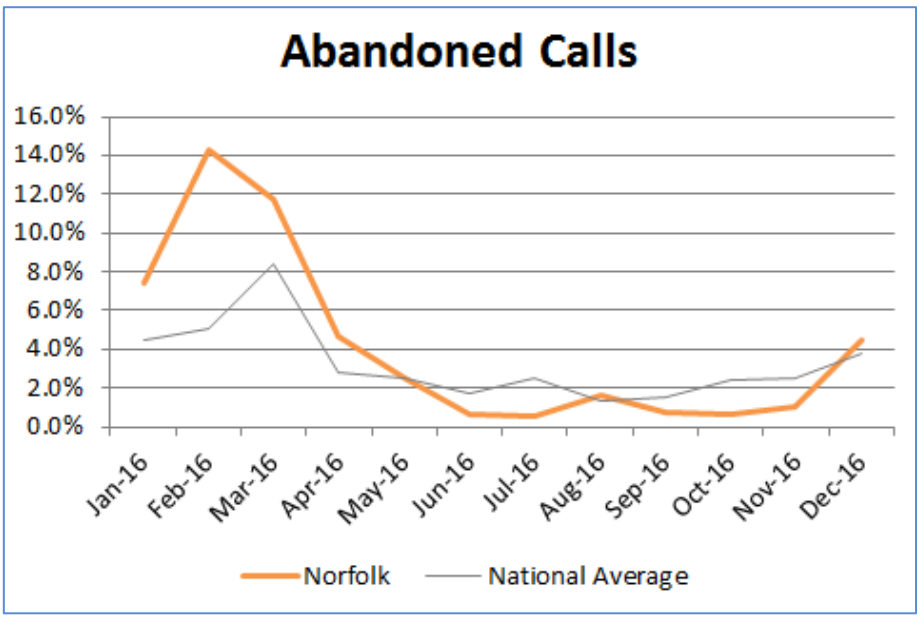
- We were offered 3,288 more calls compared to December 2015
- We answered 2,085 more calls within 60 seconds compared to 2015

- Call answering performance in December 2016 was 4.86% higher compared to December 2015

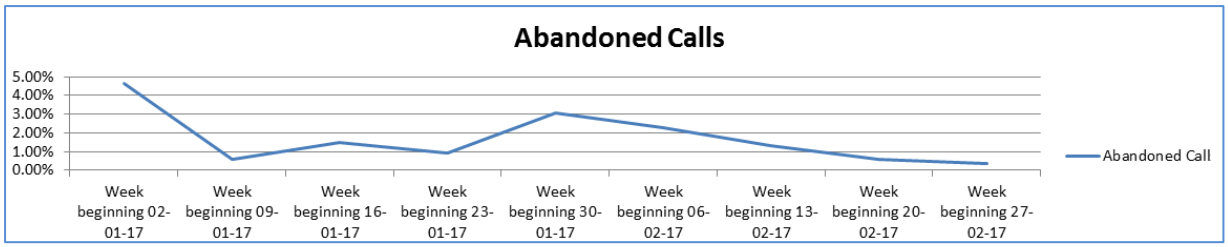
The charts below demonstrate performance for 2016 against both call answering within 60 seconds and calls abandoned.

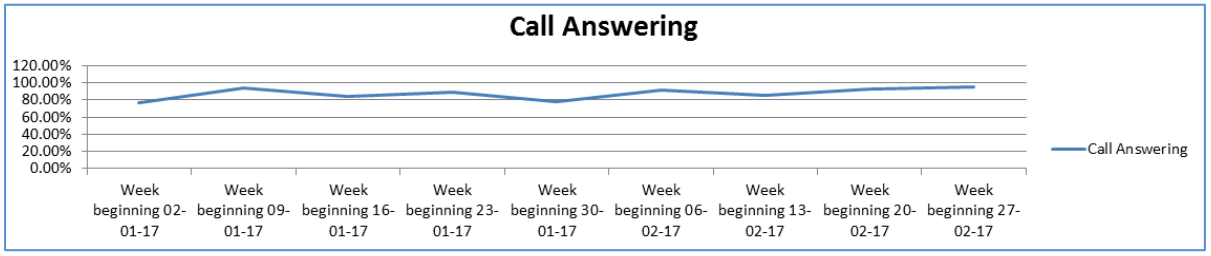


Tracked against the national average there is improvement with both the calls answered within 60 seconds and the levels of abandonment over 2016.



For 2017 January and February so far performance in more detail is as follows:





Calls abandoned have dropped significantly and it is not unusual to see performance of 0% abandonment during the week. On Sunday 19th March no calls were abandoned.

3. ASSESS – Clinical Assessment Service

As previously identified part of our commitment to service improvement we have continued to work with our commissioners to expand the scope of the integrated NHS 111 and OOH service, this includes the CAS. We have developed the CAS in line with the NHS England Integrated Urgent Care Strategy. A clear priority of this strategy is to increase senior clinical input in a patients urgent care journey.

Working closely with the Norwich CCG (as the co-ordinating commissioners) we have completed Phase One of the CAS

- Operational since July 2016,
- Developed in line with CQUIN,
- Set up to deal with non-urgent 999 (Green 2 & 4 ambulance dispositions) and non-urgent A&E Dispositions,
- Operational Hours - 6 hours on each Saturday, Sunday and Bank Holiday; recently expanded to include three weekday evenings.

Due to operating hours of Phase One, the patient sample size referred to the clinical hub was relatively small (due to criteria) however we have seen a significant impact, detailed below:

- After speaking with a hub clinician 86% of patients were directed away from the 999 and A&E services
- 13% of patients reviewed by the hub were provided self-care
- 71% of patients were directed to the OOH service for a Face to face review.
- 2% of patients were referred to other services

We are currently working with our commissioner's quality and clinical leads to expand this service further. In addition to providing a more responsive appropriate and local service to patients, we are also using the CAS as a system integrator and are developing relationships with other providers to develop fully integrated responses across organisational boundaries. This is key in helping us to overcome a number of our challenges specifically around available workforce

4. TREATMENT - Out of Hours (OOH)

The Out of Hours element of the integrated service was commissioned as a 'GP led' service, with Commissioning colleagues taking into account the national GP shortage crisis and recognising that OOH care should be delivered in a similar way to the in hours service. Consequently, the OOH service is delivered by a team consisting of GPs, Advanced Nurse Practitioners (ANPs) and Urgent Care Practitioners (UCPs).

The locality clinical and operational management team are co-located with the Care Coordination Centre in Reed House, Norwich. To effectively deliver face to face treatment across the Norfolk & Wisbech area we deliver care from eight primary care bases:

- A - Dereham PCC
- B - Fakenham PCC
- C - King's Lynn PCC
- D - North Walsham PCC
- E - Norwich PCC
- F - Thetford PCC
- G - Long Stratton PCC
- H - Wisbech PCC
- I - Locality Office & Care Co-ordination Centre

Workforce

ANPs (Autonomous Nurse Practitioners) are registered nurses who have acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice. They hold additional prescribing qualifications, which mean they can both prescribe and write prescriptions. Urgent Care Practitioners are qualified Registered Nurses and Paramedic

Practitioners. All have enhanced skills in minor illness and physical examination. This group can issue medications under a **Patient Group Directive** (PGD), which has been validated by the local Clinical Commissioning Group Medicine Management Committee.

The multi-disciplinary skill mix works well in primary care and does so in the Out of Hours environment. We also introduced an additional level of clinical oversight at weekends in January 2016; the Oversight GP. This clinician monitors the demand on the OOHs in general and ensures that patients are allocated to the most appropriate clinicians at the very busy times. This role is undertaken by Senior GPs who are based at the Contact Centre in Norwich alongside the 111 staff and the Out of hours Dispatch staff and triage clinicians.

There are now some 503 GPs working within the Norfolk & Wisbech area, but only 83 of the local GPs work in the OOHs service. However, GPs from neighbouring CCG areas work within Norfolk and we are fortunate to have a stable GP workforce who remain committed to providing OOHs care. These GPs work alongside the 16 ANPs and 17 UCPs we have working within the service.

HOSC colleagues may be aware of the national issues relating to GPs working in OOH period and the reasons for this include the challenges of increased indemnity costs, additional responsibilities within their own practices and also the competition for their services from other areas such as Urgent Care Centres and A&E Departments.

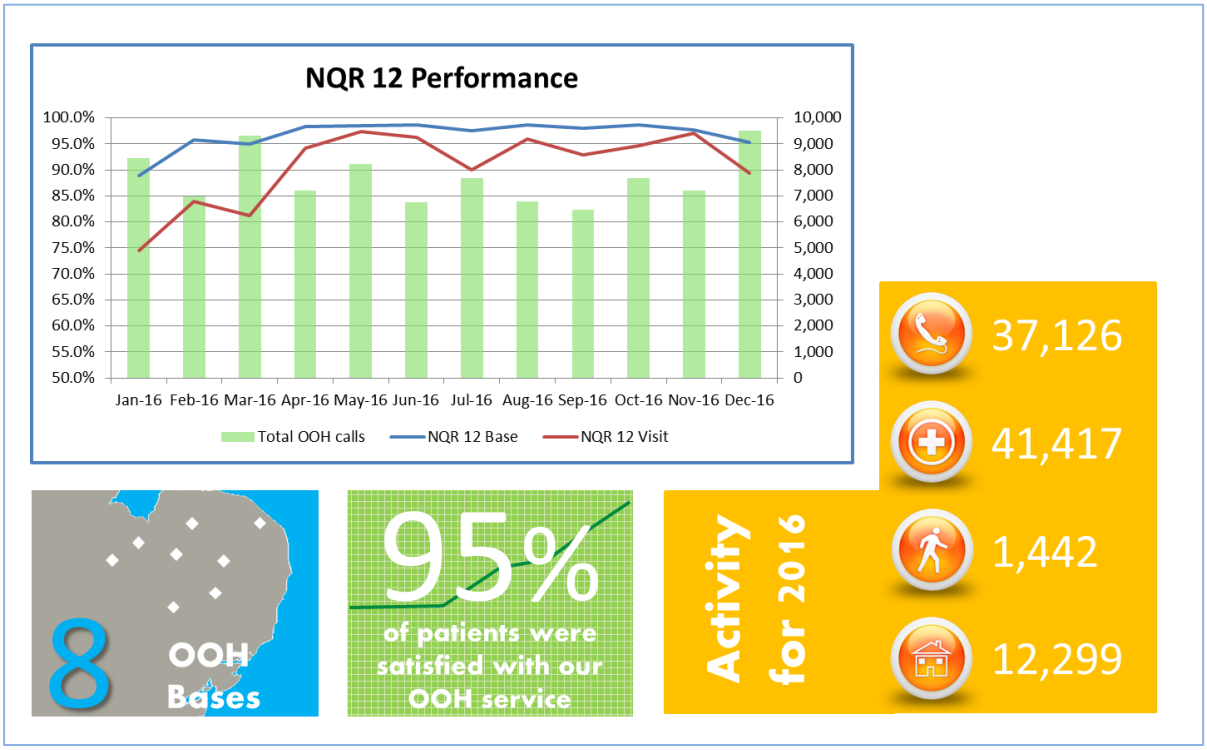
The lack of GPs generally has driven the changes to the skill mix in practices and we also see this reflected in OOHs. Although the numbers of GPs working in the OOHs has not increased, the shift cover has improved and the agency usage has decreased.

- All clinical roles - agency usage decreased from 33.24% to 18.49%
- of that 18.49%, less than 2% consists of GPs

Performance

The performance of the OOHs improved significantly during 2016 and this has continued into 2017, including over the busy Christmas period when the Norfolk system (in common with the whole of the NHS and Social Care) was so severely challenged.

The diagram below provides a visual representation of the activity and performance of the Norfolk & Wisbech OOH during 2016.



The table below tracks that progression against the key targets over a twelve month period. The comparison of December 2015 with December 2016 demonstrates that the service has settled and is also reflective of the improved levels of shift fill.

Date	WIC Urgent	WIC Routine	Urgent Base	Routine Base	Urgent Visit	Routine Visit	1hr	2hr	6hr
Dec-15	100.00%	100.00%	65.20%	94.50%	49.30%	74.90%	58.64%	68.99%	83.93%
Jan-16	100.00%	100.00%	75.50%	95.10%	58.40%	80.80%	79.17%	89.54%	92.31%
Feb-16	75.00%	100.00%	88.50%	99.00%	69.00%	88.50%	92.42%	98.97%	100.00%
Mar-16	100.00%	100.00%	88.40%	97.70%	69.50%	88.50%	85.05%	87.08%	98.93%
Apr-16	100.00%	100.00%	96.60%	99.50%	92.00%	95.00%	88.37%	93.64%	99.18%
May-16	100.00%	100.00%	96.00%	99.70%	95.00%	98.30%	95.04%	99.12%	100.00%
Jun-16	100.00%	100.00%	95.70%	100.00%	94.30%	97.00%	90.14%	95.35%	100.00%
Jul-16	100.00%	100.00%	92.50%	99.60%	86.90%	91.90%	90.13%	95.44%	99.52%
Aug-16	100.00%	95.80%	95.70%	100.00%	92.03%	97.20%	95.23%	97.36%	100.00%
Sep-16	100.00%	98.40%	95.04%	99.50%	87.30%	95.01%	95.04%	96.43%	100.00%
Oct-16	100.00%	100.00%	96.40%	99.90%	93.40%	95.07%	95.84%	98.33%	100.00%
Nov-16	100.00%	98.70%	95.60%	98.80%	99.60%	96.20%	96.67%	98.06%	100.00%
Dec-16	100.00%	100.00%	92.40%	96.50%	90.90%	89.00%	88.78%	94.90%	99.09%

This improvement has continued into 2017 with, performance as follows (please note that this is up to March 20th):

Date	WIC Urgent	WIC Routine	Urgent Base	Routine Base	Urgent Visit	Routine Visit	1hr	2hr	6hr
Jan-17	100.00%	100.00%	93.60%	96.20%	95.50%	91.80%	89.61%	95.23%	97.00%
Feb-17	100.00%	100.00%	95.40%	99.10%	97.30%	95.40%	89.32%	92.25%	98.62%
Mar-17	100.00%	100.00%	96.90%	99.90%	97.90%	95.30%	94.29%	96.81%	97.67%

5. PARTNERSHIP WORKING

We established a Stakeholder Partnership Board in 2016 which has been well attended by colleagues from other local organisations. This has helped to not only foster more collaborative partnership working, but also provide an open forum to discuss key local issues and pass on developments and information. We have focused on such things palliative care, winter planning, mental health and verification of death.

We are particularly grateful to Healthwatch for their input and feedback and they are welcome at a number of our meetings.

We have welcomed local MPs into our Contact Centre throughout the year and one local MP also visited one of our local Out of Hours Base to meet the staff and Clinicians on duty, to understand how the service operates from the 111 initial entry for the patient through to the contact with the Out of Hours clinician.

We are keen for this engagement to continue alongside the interest from patient groups who have also been welcomed in the Contact Centre. Clive Lewis MP has been particularly keen to understand how increased indemnity has affected the ability of GPs to work in Out of hours, as well as looking at the potential shortfall in the clinical workforce in the area as a whole.

The opportunity for patients to see the service working and understand the detail and process in more depth if particularly important at a time when there is so much concern about the system as a whole. We are keen to build on this have also planned in visits from other healthcare providers in the Community, such as those already undertaken by EEAST's patient group, to offer a detailed insight into both 111 and OOHs and understand how services might work more closely together.

6. COMPLAINTS, INCIDENTS AND COMPLIMENTS

We closely monitor any complaints and incidents that are received for both 111 and OOHs and these are reported on and examined in detail at out our Clinical Quality Review Groups with our Commissioners.

We encourage those working within our service to raise incidents if they have any concerns.
The tale below shows the numbers of incidents etc. that have been received over a twelve month period.

	2015/16				2016/7			
	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan
Complaints	19	11	10	15	7	6	8	14
Incidents	39	30	26	45	20	21	17	28
Serious Incidents	1	4	1	0	0	1	1	0
Compliments	5	2	7	8	33	40	40	56

Compliments from patients are received in a number of ways, either from specific letters or responses made within a patient questionnaire (sent out to a random sample of patient contacts monthly).

We have recently introduced a texting method for immediate feedback from patients following a contact with 111. We are able to monitor the patient feedback in the live environment and it can be a good barometer for the level of service especially during busy periods.

7. ASSURANCE

Over the past twelve months, we have had three "peer" visits and any points raised have been addressed. An example of a change introduced as a result of feedback after one visit, is the implementation of local "open door" sessions scheduled between staff meetings, to allow staff to meet with a member of the senior management team locally to talk through any concerns or suggestions they might have.

There have been no whistle blowing incidents during 2016.

IC24
March 2017

Potential joint health scrutiny committee for Norfolk and Waveney

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to approve terms of reference for a potential joint health scrutiny committee with Suffolk, on a task and finish basis, to cover the Norfolk and Waveney Sustainability Transformation Plan (N&W STP) footprint.

1. Norfolk and Waveney STP and health scrutiny

1.1 On 8 December 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a presentation from Dr Wendy Thomson, Managing Director of Norfolk County Council and Lead for N&W STP.

1.2 As the STP footprint includes Waveney, members of Suffolk Health Scrutiny Committee who represent the Waveney area were invited to attend the meeting and were given the opportunity to ask questions and make comments during the N&W STP item.

1.3 On that occasion the Suffolk Councillors were not joining with Norfolk Health Overview and Scrutiny Committee members in the formal sense of establishing a joint health scrutiny committee and they did not have voting rights at the meeting. That was not felt to be necessary while the N&W STP was still a high level strategic plan and there were no specific proposals for substantial changes on the ground.

1.4 During the meeting it was acknowledged that consultation on any specific proposals for substantial change which emerge from the N&W STP would be received by an appropriate health scrutiny committee, depending on the geographic 'footprint' affected by the proposed changes.

1.5 There is already a standing joint health scrutiny committee for Great Yarmouth and Waveney, which reflects the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area. However, to receive consultation on proposals that span Waveney, Great Yarmouth Borough and other parts of Norfolk it would be necessary to establish a joint health scrutiny committee with wider representation.

2. Proposal for a potential joint health scrutiny committee on a task and finish basis

2.1 Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires a joint committee to be established if Norfolk and Suffolk health scrutiny members wish to respond to a consultation that affects both counties. Only a joint committee may exercise health scrutiny powers in those circumstances.

2.2 It is therefore proposed that NHOSC makes preparations with Suffolk Health Scrutiny Committee to establish a joint health scrutiny committee on a task and finish basis in the event that the N&W STP proposes substantial changes to services on a cross-border footprint which goes wider than the Great Yarmouth and Waveney area.

2.3 Draft terms of reference for a potential joint health scrutiny committee are attached at **Appendix A**.

2.4 Appointment of members to such a joint health scrutiny committee would take place at a later date.

2.5 The intention would be that the Norfolk and Waveney Joint Health Scrutiny committee would meet on the same day as NHOSC.

3. Action

3.1 The Committee is asked to:-

(a) Agree the draft terms of reference at Appendix A.

(b) Authorise the draft terms of reference at Appendix A to be used, subject to the agreement of Suffolk Health Scrutiny Committee, to establish a joint health scrutiny committee with Suffolk County Council on a task and finish basis in the event of consultation on proposals for substantial changes to health and care services on a cross-border footprint which goes wider than the Great Yarmouth and Waveney area.

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Appendix A

NORFOLK AND WAVENEY JOINT HEALTH SCRUTINY COMMITTEE

DRAFT TERMS OF REFERENCE

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate.
1.3	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that joint committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.4	This joint committee has been established on a task and finish basis, by Norfolk County Council and Suffolk County Council.
2.	**Purpose**
2.1	The purpose of the joint committee is:- To receive, consider and respond to proposals for reconfiguration of services arising from the implementation of Norfolk and Waveney Sustainability Transformation Plan and affecting patient pathways for the populations of Norfolk and Waveney in relation to: • the extent to which the proposals are in the interests of the health service in Norfolk and Waveney; • the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable
2.2	To make a timely response to the consulting body and other appropriate agencies on the proposals.

2.3	To consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account.
2.4	The joint committee may receive, consider and respond to a number of consultations during the implementation of the Norfolk and Waveney Sustainability Transformation Plan and may adjourn for periods between consultations.
2.5	The joint committee will not receive, consider or respond to consultations on proposals for which the geographic footprint corresponds to the areas covered by Norfolk Health Overview and Scrutiny Committee or Great Yarmouth and Waveney Joint Health Scrutiny Committee. The joint committee may receive consider and respond to consultation on proposals for which the geographic footprint includes Waveney and any part of Norfolk beyond the Great Yarmouth Borough area.
3.	**Membership/chairing**
3.1	The joint committee will consist of the 17 members including the 15 members of Norfolk Health Overview and Scrutiny Committee and 2 members of Suffolk Health Scrutiny Committee. One of the Suffolk Health Scrutiny Committee representatives will be the Waveney District Council representative on Suffolk Health Scrutiny Committee and the other will be a County Councillor member of Suffolk Health Scrutiny Committee.
3.2	Each authority may nominate a substitute member for each member of the joint committee. Only a nominated substitute may attend in the event of a member's absence.
3.3	The proportionality requirement will not apply to the joint committee, provided that each authority participating in the joint committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	The individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The Chairman of Norfolk Health Overview and Scrutiny Committee will chair the joint committee. The joint committee will elect a Vice-Chairman at its first meeting.
3.6	The joint committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the joint committee will have one vote.
4.	**Co-option**

4.1	The joint committee may co-opt representatives of up to a maximum of four organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights.
4.2	Any organisation with a co-opted member may send a substitute member.
5.	**Supporting the Joint Committe**
5.1	The lead authority will be Norfolk County Council.
5.2	The lead authority will act as secretary to the joint committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and joint committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.
5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	Where the joint committee requires advice as to legal or financial matters, the participating authorities will agree how this advice is obtained and any significant expenditure will be apportioned between participating authorities. Such expenditure, and apportionment thereof, would be agreed between the participating authorities before it was incurred.
5.5	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the joint committee. Other costs will be apportioned between the authorities. If the joint committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.6	Suffolk County Council will appoint a link officer to liaise with the lead officer and provide support to the members of the joint committee.
5.7	Meetings shall be held at venues, dates and times determined by the lead authority.
6.	**Powers**
6.1	In carrying out its function the joint committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information about the proposals;

	• obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a joint committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations; • refer the proposal to the Secretary of State if the joint committee considers: ➢ it is not satisfied that consultation with the joint committee has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area.
7.	**Public involvement**
7.1	The joint committee will meet in public, and papers will be available at least 5 working days in advance of meetings
7.2	The participating authorities will arrange for papers relating to the work of the joint committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
7.3	A press release will be circulated to local media at the start on the establishment of the joint committee and when it is reconvened after any period of adjournment..
7.4	Local media will be notified of all meetings.
7.5	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
7.6	Members of the public attending meetings may be invited to speak at the discretion of the Chairman.
8.	**Press strategy**
8.1	The lead authority will be responsible for issuing press releases on behalf of the joint committee and dealing with press enquiries
8.2	Press releases made on behalf of the joint committee will be agreed by the Chairman or Vice-Chairman of the joint committee.
8.3	Press releases will be circulated to the link officers.
8.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the joint committee.

9.	**Report and recommendations**
9.1	The lead authority will prepare a draft report on the deliberations of the joint committee, including comments and recommendations agreed by the committee. The report will include whether recommendations are based on a majority decision of the committee or are unanimous. The draft report will be submitted to the representatives of participating authorities for comment.
9.2	The final version of the report will be agreed by the joint committee Chairman.
9.3	In reaching its conclusions and recommendations, the joint committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority concerned.
9.4	The report will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised.
9.5	If the joint committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are "reasonably practicable" to try to reach agreement in relation to the subject of the recommendation.
9.6	If the joint committee does not comment on the proposals, or the comments it provides do not include recommendations, the joint committee must inform the NHS body as to whether it intends to exercise its power to refer the matter to the Secretary of State and, if so, the date by which it proposes to do so.
9.7	In the event that the joint committee refers the matter to the Secretary of State the report made will include:- • an explanation of the proposal to which the report relates; • the reasons why the joint committee is not satisfied; • a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area; • an explanation of any steps taken to try to reach agreement in relation to the proposal; • evidence to demonstrate that the joint committee has complied with arrangements for appropriate notification of timescales for its decision to refer; • an explanation of the reasons for the making of the report; and • any evidence in support of those reasons.
9.8	The joint committee may only refer the matter to the Secretary of State:- • in a case where the joint committee has made a recommendation which the NHS body disagrees with, when;

	i) the joint committee is satisfied that all reasonably practicable steps have been taken by the NHS body and the joint committee to reach agreement; or ii) the joint committee is satisfied that the NHS body has failed to take all reasonably practicable steps to reach agreement. • if the requirements regarding notification of the intention to refer above have been adhered to.
10.	**Quorum for meetings**
10.1	The quorum will be a minimum of five members with at least one from each of the participating authorities.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2017

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
25 May 2017	Availability of acute mental health beds – concerns about prolonged detentions in police cells / out of area placements. Children's autism and sensory processing assessment / therapy – concerns about availability of services and waiting times.	
20 July 2017	Speech and language therapy – concerns about waiting times for children.	
7 Sept 2017		

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for report to the Committee / items in the Briefing in 2017

Provisional – 26 Oct 2017 – Ambulance Response and Turnaround Times in Norfolk - on 13 Oct 2016 NHOSC received a report from the East of England Ambulance Service NHS Trust and the Norfolk & Norwich University Hospitals NHS Trust. Agreed that it *may* wish to look at the subject again in a year's time.

26 Oct 2017 – *In the NHOSC Briefing* – Introduction of the Primary Care Education and Training Tariff – update from Mr I Newton, Department of Health (follow up to Members' informal meeting with Mr Newton on 29 Sept 2016).

Provisional – February 2018 – Continuing healthcare – an update on progress since Feb 2017.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mrs M Stone (substitute Ms E Corlett)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Mrs M Stone)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mrs L Hempsall (substitute Mrs M Stone)
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

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Glossary of Terms and Abbreviations

ADA	Americans with Disabilities Act 1990
ADHD	Attention Deficit Hyperactivity Disorder
A&E	Accident and Emergency
ANP	Advanced Nurse Practitioner
ANP	Autonomous Nurse Practitioner
CAMHS	Child And Adolescent Mental Health Services
CAS	Clinical Assessment Service
CCC	Care Coordination Centre
CCG	Clinical commissioning group
CIN	Child in need
CQC	Care Quality Commission
CQUIN	Commissioning For Quality And Innovation
CYP	Child or young person
DfE	Department for Education
ED	Eating disorder
EEAST	East of England Ambulance Service NHS Trust
F2F	Face to face
FSP	Family Support Process
FSW	Family Support Worker
GP	General Practitioner
GY&W	Great Yarmouth And Waveney
HCP	Healthcare practitioner
KPI	Key performance indicator
LA	Local Authority
LAC	Looked After Children
LD	Learning difficulties / disabilities
LSE	London School of Economics
LTP	Local Transformation Plan
MAP	Mancroft Advice Project – a charity providing advisers, counsellors and youth workers from centres in Norwich and Great Yarmouth and working in schools, health centres, youth centres etc. around Norfolk and Suffolk
MCS	Children of the New Century: Mental health findings from the Millennium Cohort Study
MYP	Member of Youth Parliament
NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICC / ICC	Norfolk In Care Council
NSEL	Norfolk Secondary Education Leaders

NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
NSPCC	National Society for the Prevention of Cruelty to Children
NUPRD	National Unit for Psychiatric Research and Development
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan
ONS	Office of National Statistics
OOH	Out of hours
OSC	Overview and Scrutiny Committee
PA	Pathway Advisor
PAFT	Parents as first teachers
PATHS	Promoting Alternative Thinking Strategies
PCC	Primary Care Centre
PEEP	Protocol for exceptional, emergency placements
PGD	Patient Group Directive
PND	Postnatal depression
Point 1	A consortium of 3 organisations – Ormiston Families (the consortium's lead agency), Mancroft Advice Project (MAP) and Norfolk and Suffolk Foundation Trust (NSFT) providing Norfolk's county wide targeted mental health service (2015)
RAG	Red, amber, green (performance ratings)
SDQ	Strengths and difficulties questionnaire
STP	Sustainability & transformation plan
UCP	Urgent Care Practitioner
UN	United Nations
WHO	World Health Organisation
YTD	Year to date