Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 3 December 2015**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

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 C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Mr A Dearnley	Norfolk County Council
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Ms S Bogelein	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/ Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr N Smith	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mrs S Matthews	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

Mrs S Young	Vacancy	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 15 October 2015. (Page 5)

3. Members to declare any Interests

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. **To receive any items of business which the Chairman decides should be considered as a matter of urgency**

5. **Chairman's announcements**

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: November 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 15 October 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Mr B Bremner	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
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs M Stone	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs S Young	Borough Council of King's Lynn and West Norfolk

Substitute Member Present:

Ms L Grahame for Ms S Bogelein, Norwich City Council

Also Present:

Robert Morton	Chief Executive Officer, East of England Ambulance Service NHS Trust
Matt Broad	Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust
Richard Parker	Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust
Mark Burgis	Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group
David Russell	Member of the public
Ross Collett	Head of Norfolk and Suffolk Workforce Partnership, Health Education East of England
Dr Boaventura Rodrigues	Consultant in Public Health Medicine, Norfolk County Council
Mark Burgis	Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group (representing the central System Resilience Group)
Tracey Parkes	Head of System Integration Development, Great Yarmouth and Waveney CCG (representing the east System Resilience Group)
Dr Imran Ahmed	Urgent Care Lead, West Norfolk Clinical Commissioning Group (representing the west System Resilience Group)
Dr Tim Morton	Chairman, Norfolk and Waveney Local Medical Committee
Mr C Walton	Head of Democratic Services

Maureen Orr Democratic Support and Scrutiny Team Manager
Tim Shaw Committee Officer

1. Apologies for Absence

Apologies for absence were received from Ms S Bogelein, Mrs L Hempsall and Mrs S Matthews.

2. Minutes

The minutes of the previous meeting held on 3 September 2015 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements.

5.1 The Chairman welcomed Ms Lesley Grahame to her first meeting of the Committee as a substitute Member for Ms Sandra Bogelein of Norwich City Council.

5.2 All Members of the Committee joined the Chairman in asking for a card to be send to Ms Sandra Bogelein, on behalf of the Committee, congratulating her on the birth of her son, Samwell.

6. Ambulance response times and turnaround times in Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to an update from the East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and North Norfolk Clinical Commissioning Group about ambulance response times and turnaround times in Norfolk and the action underway to improve performance. The Committee also received additional information from EEAST and UNISON and public questions from Mr David Russell.

6.2 The Committee received evidence from Robert Morton, Chief Executive Officer, East of England Ambulance Service NHS Trust (EEAST), Matt Broad, Locality Director for Norfolk, Suffolk and Cambridgeshire, East of England Ambulance Service NHS Trust, Richard Parker, Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH FT) and Mark Burgis, Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group.

6.3 In the course of discussion the following key points were made:

- Robert Morton, Chief Executive Officer, East of England Ambulance Service NHS Trust said that EEAST was faced by three strategic challenges. The first challenge was for EEAST to stabilise its operational performance at a time of unprecedented demand for ambulance services and at a time when

the work expected of EEAST was becoming more complex. The second challenge was for EEAST to "reinvent" itself in a way that enabled it to engage in more collaborative ways of working with the other organisations that were operating in the local health economy. The third challenge was for EEAST to introduce the kinds of changes in its organisational structure that were needed if it was to provide for a more consistent range of services across the region and to refocus its activities on a wider range of outcomes than just meeting its performance targets.

- The witnesses said that the performance targets for A1 and A2 calls were set at a simple pass / fail standard that did not reflect the length of time that a 'failed' response actually took.
- It was suggested by the witnesses that the performance targets should place more emphasis on achieving patient outcomes rather than just ambulance response and turnaround times.
- The quality of care that patients received from EEAST was of a high standard.
- Across the region as a whole, there were on average between 70 and 80 Red 1 calls a day.
- EEAST was meeting the national target for responding to A1 calls but falling far short of the national target for A2 calls which had increased by over 15% in the current year.
- At the same time as the demand for ambulance services was rising, EEAST was having to send an increasingly complex range of resources and clinical expertise to A1 and A2 calls thus stretching its capacity and staff and those of other "blue light" services.
- The witnesses acknowledged that one of the most important issues in Norfolk was getting the right skill mix when responding to ambulance calls, resulting from the temporary position of having a large number of student paramedics requiring mentoring and training abstraction, versus the actual number of qualified paramedics.
- In recent months, there had been an increase in the number of call outs for stroke incidents. The increasing overall demand for stroke patients to arrive at a hyper-acute stroke centre within 60 minutes of a 999 call was proving to be difficult to achieve in a rural county like Norfolk.
- The witnesses pointed out that 10 % of all the ambulance call out calls in Norfolk were for patients living in care homes.
- In response to questions, the witnesses said that they were exploring the possibilities for providing care homes with a wider range of paramedic services than were provided at present, so as to cut down on the need for responses by ambulance crews.
- The witnesses also said that there might be opportunities for rapid response teams to be based at Cromer hospital and at some of the community hospitals in the North Norfolk area. The witnesses said that they would explore this suggestion.
- It was estimated by the witnesses that between 70% and 80% of ambulance call outs were prevented by the GP triage service.
- The "handover to clear" performance by EEAST crews at the Norfolk & Norwich University Hospital (NNUH) and the Queen Elizabeth Hospital (QEH) had stabilised.
- The introduction of Hospital Ambulance Liaison Officers at the NNUH had proved to be very successful in reducing ambulance turnaround times. The NNUH was the only hospital in the EEAST region to have improved its ambulance turnaround times over the last year.

- Across the region as a whole, EEAST had approximately 270 vacancies that were in the process of being filled and a further 300 posts for which funding had not yet been identified. In Norfolk, very few vacancies remained to be filled.

6.4 Mr David Russell, speaking as a member of the public, asked the following questions:

1. **Question**: Recent statistics revealed that ambulance transports to the NNUH were up by almost 12% in May-August 2015 compared to the same period in 2014. Attempts to reduce this with GPs assessing ambulance needs did not appear to be working. Would the introduction of the new Computer Aided Dispatch system, due to come into operation at the Norwich Emergency Operations Centre in February 2016, help reduce the transports? The transport figures for 2014 were 16771 and for 2015 18768.
   Answer given by the witnesses: This was not the case. It was estimated that somewhere between 70% and 80% of ambulance calls received a successful outcome without the need for an ambulance to take a patient to hospital.
2. **Question**: Contracted activity for Norwich was over and above contracted levels and pulling in ambulances from rural areas. What did the Commissioners intend to do about this and why did they not commission sufficient levels in the first place?
   Answer given by the witnesses: The Commissioners based the contracted levels of activity on historic trends and anticipated increases in demand.

6.5 The Committee noted that they might return to the subject of ambulance response times and turnaround times in Norfolk in a year's time.

7 **NHS Workforce Planning in Norfolk**

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to responses to the recommendations agreed by the Committee on 16 July 2015 and current planning to ensure that NHS services were adequately staffed during the forthcoming winter. Representatives from the three NHS System Resilience Groups in Norfolk, Norfolk County Council Public Health and Health Education East of England were in attendance to discuss the responses. The System Resilience Group representatives had an overview of the workforce planning and vacancies situation for the forthcoming winter.

7.2 The Committee received evidence from Ross Collett, Head of Norfolk and Suffolk Workforce Partnership, Health Education East of England, Dr Boaventura Rodrigues, Consultant in Public Health Medicine, Norfolk County Council, Mark Burgis, Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group (representing the central System Resilience Group), Tracey Parkes, Head of System Integration Development, Great Yarmouth and Waveney CCG (representing the east System Resilience Group), Dr Imran Ahmed, Urgent Care Lead, West Norfolk Clinical Commissioning Group (representing the west System Resilience Group) and Dr Tim Morton, Chairman, Norfolk and Waveney Local Medical Committee.

7.3 In the course of discussion the following key points were made:

- The Committee was pleased to note that the responses to the recommendations which had been agreed by the Committee were mainly positive.
- One recommendation, originally intended for Norfolk MPs, was 'To raise the issue of Service Increment Funding for Teaching (SIFT) with the Department of Health, with a view to speeding up the progress towards fair share for Norwich Medical School'. The Committee had previously decided to raise this issue directly with the Department of Health in the first instance. Members considered the response to this particular recommendation to be disappointing in that it did not say whether anything would be done to bring Norwich Medical School more quickly towards a fair share of SIFT.
- Whilst SIFT was seen as an important issue for the longer term, the Committee was very concerned about immediate workforce availability for the forthcoming winter, especially in primary care.
- It was pointed out by the witnesses that Norfolk and Waveney Local Medical Committee (LMC) shared this concern. Several GP practices in the county had closed their waiting lists due to inability to recruit and the LMC had raised concerns about staffing the out-of-hours service this winter.
- The Committee considered that consolidation of current primary care services should be the top priority so that local people were guaranteed comprehensive in-hours provision and adequate out-of-hours provision for urgent needs seven days a week. Plans to extend general practice opening hours might become more realistic in future years when workforce shortages began to ease.
- The Committee was also disappointed that the Local Enterprise Partnerships (LEPs) in Norfolk and Cambridgeshire LEPs were not able to accept the recommendation that the LEPs work with local NHS organisations and Higher Education Institutes to consider innovative ways to support recruitment of healthcare students and workers to Norfolk'.

7.4 The Committee **agreed** to write to:-

1. The Secretary of State for Health expressing disappointment at the Parliamentary Under Secretary of State's response to the Committee's enquiry regarding progress towards a fair share of Service Increment Funding to Teaching Increment for Norwich Medical School and raising the issue of primary care workforce availability for the forthcoming winter, with copies to the Parliamentary Under Secretary of State for Care Quality and Norfolk MPs.

2. The Local Enterprise Partnerships in Norfolk and Cambridgeshire expressing disappointment that they did not accept the Committee's recommendation to work with local NHS organisations and Higher Education Institutes to consider innovative ways to support recruitment of healthcare students and workers to Norfolk.

8. Forward work programme

8.1 The forward programme was **agreed.**

Members who had items which they wished to have considered for inclusion in the forward work programme were asked to contact Maureen Orr, Democratic Support and Scrutiny Team Manager in the first instance.

Chairman

The meeting concluded at 12.05 pm

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Children's Mental Health Services in Norfolk

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

This report addresses the issues and concerns raised in the terms of reference for scrutiny of children's mental health services agreed by the committee in September 2015.

Members will have the opportunity to discuss the services and the issues with commissioners and providers and to comment on Norfolk and Waveney's Local Transformation Plan for children and young people's mental health.

1. Background

1.1 In July 2015 a member of the committee proposed that Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Children's Mental Health Services in Norfolk' to its forward work programme for scrutiny. This was because of concerns about the level of service provided and perceived changes to the service in recent years. The committee agreed to include the subject in its programme and on 3 September 2015 approved the terms of reference attached at **Appendix A**.

1.2 Nationally, the Children and Young People's Mental Health Taskforce, hosted by the Department of Health and NHS England, published its report 'Future in Mind, Protecting, promoting and improving our children and young people's mental health and wellbeing' in March 2015. The report is available on the Gov.uk website:-

https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

The Taskforce proposed that each local area should develop Local Transformation Plans for Children and Young People's Mental Health and Wellbeing. The Plans were to cover the whole spectrum of services from health promotion and prevention work to the interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

NHS England committed to making a financial contribution to areas where Local Transformation Plans accord with the principles and ambitions set out in the 'Future in Mind' report. In November 2015 NHS England approved the Norfolk and Waveney Local Transformation Plan and confirmed additional recurrent funding of £1.9 million for child and

adolescent mental health services (CAMHS) in Norfolk. The funding will be received by the five Clinical Commissioning Groups (CCGs).

1.3 During its first year of operation in 2013 Healthwatch Norfolk carried out research into young people's experience of specialist tier 4 inpatient mental health services in Norfolk. Healthwatch Norfolk has submitted an information paper at **Appendix B** setting out an overview of its findings regarding tier 4 services and detailing research that it has commissioned on young people's experiences of tier 1, 2 and 3 services. The research on tier 1- 3 services will be completed in early 2016.

2.0 The services

2.1 Local CAMHS have generally been organised as follows over the last decade or so:-

Norfolk's Child and Adolescent Mental Health Services model

Tier 1 – Universal services for good mental health for all children. Multi-agency training is given to underpin delivery of universal services to enhance emotional health and wellbeing and increase resilience. Service is delivered by school staff, special schools, the voluntary sector, GPs, children's centres and extended schools services, early years providers (0-5 years), parent support advisors, parent programmes, health visitors, midwives, school nurses, healthy schools partnership.

Tier 2 – Targeted services for in need or vulnerable children with mild to moderate mental health problems. Service is delivered by Point 1, voluntary sector agencies, school nursing teams, autistic spectrum disorder (ASD) nurse and ASD support team, Starfish team, Education Psychology Support Safeguarding.

Tier 3 – Specialist mental health services for moderate to severe mental health problems. Service is delivered by Norfolk and Suffolk NHS Foundation Trust (NSFT) CAMHS teams, Starfish team, Community Paediatricians, Early Intervention in Psychosis team (EPSS), Youth Mental Service, Intensive Support Team

Tier 4 – Highly specialised and intensive services for severe mental health difficulties. Intensive community support, residential and inpatient units. NSFT provides an 8 bedded unit for 14-18 year olds in Lowestoft. There are two other units in Norfolk run by other providers.

2.2 Tiers 1-3 are commissioned locally by a Joint Commissioning Group made up of partners from health (Clinical Commissioning Groups) and Norfolk County Council Children's Services. Tier 4 services are commissioned by NHS England Specialised Commissioning.

2.3 As indicated in paragraph 1.2, the services are provided by a range of teams working in the health, children's services, voluntary, community and private sector. Some of the main providers are:-

Norfolk and Suffolk NHS Foundation Trust (NSFT) (Tier 3 and 4)
Point 1 (Tier 2)
Norfolk Community Health and Care (NCH&C) (Tier 2 and 3) – Starfish team for children and young people up to the age of 18 who have complex learning disabilities and the Attention Deficit Hyperactivity Disorder Nursing Service.

Point 1 is delivered by a partnership of Ormiston Families, MAP (Mancroft Advice Project, a youth charity) and NSFT.

3. Comments from referrers to the services

3.1 The terms of reference suggest that NHOSC hears from people who have experience of referring children to the mental health services. The following, who either have direct experience of making referrals or work with those who do, responded to invitations to comment:-

3.1.1 Norfolk and Waveney Local Medical Committee (LMC)

'The LMC views Children's Mental Health Services as an important resource. This service cannot be viewed in isolation as helping children and adolescents in mental distress often requires co-ordination across other disciplines such as education, social services and community and hospital paediatrics. The question the LMC would raise is whether the service is adequately resourced, are the clinical guidelines for referral clear, is the communication from the children's mental health teams adequate regarding management plans and whether as a clinical discipline it should be aligned with community and hospital paediatrics rather than as an offshoot of the mental health trust.

We look forward to hearing the outcome of the HOSC enquiries.'

3.1.2 Service Development Manager Alternatives to Care, Children's Services (regarding the Children's Case Advisory Services (CCAS))

The CCAS' exclusive aim is to enable families to stay together either through avoiding the need for entry to care or through supporting reunification. It does this through providing:

- Multi-disciplinary consultation (which includes representatives from NSFT, Youth Offending team and other professionals)
- Access to specialist in-house and external resources.

The CCAS aims to ensure that social workers have access to the support and resources they need to manage the most complex, challenging and critical cases, including cases with a mental health element.

Evidence of the effectiveness of the multi-agency working particularly with mental health services are noted in the recent OFSTED report, from which the following extracts are taken:-

135. There is evidence that, in addition to improving core services, Norfolk is being ambitious in trying to tackle some hard-to-address areas of practice through innovative partnership working. Examples of this include the Parent Infant Mental Health Attachment Project's work on high-risk child protection cases, offering intensive assessment and therapeutic intervention for families through a multi-agency team.

136. For older children, the Compass Outreach project referred to earlier in this report has been set up in April 2015 as part of the Department for Education's Innovation Programme. This demonstrates a positive example of partnership working between social care, mental health colleagues and a voluntary organisation. Although part of the early help offer and on the 'edge of care', it includes looked after young people who are placed out of authority, those who require support to move from residential care to foster care and those who require intensive support to return home. Young people were involved in designing the specification for the service. OFSTED 19 October 2015

In addition NSFT work closely with Children's Services in house therapy services, providing clinical supervision.

3.1.3 **An Assistant Headteacher, Pastoral and Academic Support** – as an example of a school's experience of the services.

Addressing the 'Reasons for Scrutiny' in the terms of reference at Appendix A, the Assistant Head Teacher, Pastoral and Academic Support gave evidence of 96 referrals to mental health services from one school cluster since November 2013 and made the following points based on experience:-

1. There is a long waiting list for Point 1 and what were emerging needs are often in crisis by the time they are seen and then the case is too severe for Point 1. Point 1 have done a lot of work in improving waiting times. Waiting times for Thurlow (mental health service in King's Lynn) or Bethel (mental health service in Norwich) are still too long and no idea of timescale is given when referrals are made.

2. We are finding that all too often, children are not receiving the treatment they need and parents are often not involved in the process, leading to increased anxiety and frustration and no real resolution.

3. Mild to moderate cases only receive 6 appointments for treatment - This is the case with Point 1 and I am concerned that children are then just left with no support. They are told they can re-refer, but then they have to wait again and they are not guaranteed support.

4. Insufficient support for children who have attended A&E following attempted suicide - I know of cases where children were discharged from A&E with no support in place.

5. A more systemic and family based approach is needed when working with children with mental health issues – I totally agree. This approach is working brilliantly in school and really moving children on.

4. Purpose of today's meeting

4.1 **Dr Martin Hawkings**, Consultant in Public Health, will present a children's mental health needs analysis for Norfolk (**Appendix C**).

4.2 The areas set out in the terms of reference are addressed in reports from the service commissioners.

The Joint Commissioners, responsible for commissioning Tier 1 – 3 services have provided the report at **Appendix D**. As well as addressing the scrutiny terms of reference their report details Norfolk and Waveney's Local Transformation Plan, which is attached at **Appendix E**.

NHS England Specialised Commissioning, responsible for commissioning Tier 4 services, has provided the report at **Appendix F**. The Tier 3 commissioners and NSFT provided the estimate of waiting times for Tier 4 in-patient beds included in section 6 of the report.

4.3 Service commissioners and providers have been invited to the meeting to answer Members' questions:-

Commissioners

Norfolk CAMHS Joint Commissioning Group:-
Jonathan Stanley – CAMHS Strategic Commissioner, Norfolk County Council & Clinical Commissioning Groups
Clive Rennie – Assistant Director of Commissioning Mental Health and Learning Disabilities, NHS and Norfolk County Council

NHS England Specialised Commissioning:-
Denise Clark, Interim Head of Specialised Mental Health (East of England)

Providers

Norfolk and Suffolk NHS Foundation Trust (NSFT):-
Andy Goff - Improvement and Development Manager
Dr Catherine Thomas – CAMHS Consultant Psychiatrist
Dr Sara Ramirez-Overend – CAMHS Consultant Psychiatrist
Dr Kiran Chitale – CAMHS Consultant Psychiatrist

Point 1
Dan Mobbs – Chief Executive of MAP

3. Suggested approach

3.1 After the Consultant in Public Health has introduced the subject and the commissioners have presented their reports Members may wish to discuss the following areas, as set out in the terms of reference:-

1. The protocol and follow-up treatment of children after a suicide attempt.
2. The link between mental health services and other specialist services for children.
3. Waiting lists for children's mental health provision in the various tiers of service.
4. General mental health provision for children (which programmes are available, how many appointments are available) and treatment outcomes, as well as re-referrals.
5. Complaints about the provision of children mental health services.
6. Capacity to deliver a more systemic and family based approach to children's mental health services.
7. Future plans for meeting increased need for children's mental health services.
8. The changes to services planned in the Local Transformation Plan for children and young people's mental health services.

Members may also wish to address questions in relation to capacity, use of resources and transition between services :-

9. Recruitment of suitably qualified and specialised mental health staff is challenging at present. What is the situation regarding staffing in all levels of the CAMHS service?
10. Moving from children's services to adult services was one of the areas where the national 'Future in Mind' report highlighted a need for improvement. What work has been done around transition from CAMHS to adult mental health services in Norfolk and between different tiers of the CAMHS service?
11. The Norfolk and Waveney Local Transformation Plan has been successful in attracting £1.9 million additional funding for CAMHS. Three of Norfolk's CCGs have agreed that their portions of the additional funding should go directly to the pooled commissioning fund but the other two, West Norfolk CCG and Great Yarmouth and Waveney CCG do not intend to pool their portions of the funding. What are the implications of these decisions?

4. Action

4.1 NHOSC is asked to consider:-

(a) Whether it has completed its examination of children's mental health services, or if there is additional information it wishes to receive at a future meeting.

(b) Whether it wishes to comment on the Norfolk and Waveney Local Transformation Plan for children and young people's mental health.

(c) Whether there are any specific recommendations that the committee wishes to make to the commissioners or providers of the services.

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Appendix A

Terms of Reference

Norfolk County Council
Norfolk Health Overview and Scrutiny Committee (NHOSC)
Terms of reference for scrutiny of Children's mental health services in Norfolk
Scrutiny by Full committee
Reasons for scrutiny Concerns because of perceptions that:- 1. It is difficult to get an appointment for assessment of children with emotional, behavioural and mental health issues. 2. Following assessment, children with a level of need may not get the appropriate level of intervention. 3. Mild to moderate cases only receive 6 appointments for treatment. 4. There is insufficient joining up between mental health services and other specialist services for children, such as the autism service, for considering co-diagnosis or for other services to receive advice from mental health professionals about specific cases. 5. There is insufficient support for children who have attended A&E following attempted suicide. 6. A more systemic and family based approach is needed when working with children with mental health issues. 7. There has been a decrease in proactive support especially during the school holidays. 8. Reductions in third sector organisations' funding means that they are unable to bridge the gaps in NHS services.
Purpose and objectives of scrutiny 1. To receive information about the level of mental health service provided to children in Norfolk. 2. To ascertain how services have changed in recent years. 3. To comment on Norfolk's Local Transformation Plan for children and young people's mental health.

Areas to be addressed

1. The protocol and follow-up treatment of children after a suicide attempt.
2. The link between mental health services and other specialist services for children.
3. Waiting list for children's mental health provisions.
4. General mental health provision for children (which programs are available, how many appointments are available) and treatment outcomes, as well as re-referrals.
5. Complaints about the provision of children mental health services.
6. Capacity to deliver a more systemic and family based approach to children's mental health services.
7. Future plans for meeting increased need for children mental health services.
8. The changes to services planned in the Local Transformation Plan for children and young people's mental health services.

People to speak to

- The commissioners – Child and Adolescent Mental Health Services (CAMHS) in Norfolk are commissioned by a Joint Commissioning Group made up of partners from health (Clinical Commissioning Groups) and Norfolk County Council Children's Services. Tier 4 in-patient services for complex cases are commissioned by NHS England Specialised Commissioning.
- The key providers:-
    - Point 1
    - Norfolk and Suffolk NHS Foundation Trust (NSFT)
    - Norfolk Community Health and Care NHS Foundation Trust
- Referrers of children to mental health services.

Style and approach

Full NHOSC meeting with witnesses.
The subject may be dealt with in one or two meetings.

Planned outcomes

An information report to Norfolk Health Overview and Scrutiny Committee and comments by the committee about the Local Transformation Plan for children and young people's mental health, as appropriate.

Terms of reference agreed by	**Date**
Norfolk Health Overview and Scrutiny Committee	3 September 2015

Children's Mental Health Services in Norfolk

Norfolk HOSC - 3 December 2015

1. Introduction

Prior to Healthwatch Norfolk (HWN) being fully operational from 1 April 2013, the shadow HWN Board identified a number of priority projects to be undertaken during the first year of operation. One of these project was to review the Young Persons' Perspectives and Experiences of Specialist Tier 4 In-Patient Mental Health Services in Norfolk. A brief overview of the subsequent report published in January 2014 is outlined below.

Following on from this work and as a result of discussions at event in October 2014 to launch the Healthwatch Norfolk Children and Young Peoples' Engagement Strategy, the HWN Board identified a need to gather more evidence on the most pressing needs and gaps in children and young peoples' services in Norfolk. Therefore as part of our ongoing work relating to the needs of Children and Young People, HWN commissioned two separate pieces of work as follows:

- Young peoples' views on access to local mental health care; barriers and suggestions to promote help seeking in Norfolk (CAMHS Tiers 1 and 2) – UEA and NSFT partnership

- Young person review of Mental Health Services (CAMHS Tier 3) – MAP (Mancroft Advice Project

Both of these projects will be completed during the early part of 2016 and HWN would be pleased to report back to HOSC once the work is completed.

2. Young Persons' Perspectives and Experiences of Specialist Tier 4 In-Patient Mental Health Services in Norfolk.

The School of Nursing Sciences, Faculty of Medicine and Health Sciences, University of East Anglia was commissioned by HWN to undertake a project to make sure that children and adolescents in Norfolk can easily access a specialist mental health service (CAMHS) that provides high quality, appropriate care.

The aims were as follows:

- To gain insight into the experiences of young people (14-18) who are users of Tier 4 in-patient services in Norfolk, Including looked after children (service users, families and carers)

- To obtain a comprehensive picture of the current in-patient services available to young people locally (ease of access and quality of provision) and establish how places are funded and agreed

A report was duly published by HWN in Spring 2014 – the report is available via our website -

(http://www.healthwatchnorfolk.co.uk/sites/default/files/young_persons_perspectives_and_experiences_of_specialist_tier_4_in-patient_mental_health_services_in_norfolk.pdf

The report included a number of recommendations as follows:

a) In-patient units to update their website, with easy to access information on policies and things to expect whilst on the unit. A virtual (website) tour and introduction to staff would also help prepare young people for admission.
b) Upon admission to an in-patient unit, young people to be given clear information about unit boundaries; procedures and so on, preferably in a 'treatment folder' also containing copies of individual care plans and goal setting.
c) Review of the current capacity of community services and if warranted, a strengthening of community services.
d) There should be a frequently updated list of units who are currently accepting emergency admissions.
e) Streamline the referral process, with a centralised form to avoid multiple forms needing to be completed for multiple units.
f) Service users to be consulted about ways to enhance the 'feel' of the unit through the décor.
g) Explore ways of enabling service users to continue to engage and stay connected with friends and family via use of technology.

Appendix A provides a summary of the outcome of those recommendations to date.

3. Young peoples' views on access to local mental health care; barriers and suggestions to promote help seeking in Norfolk (CAMHS Tiers 1 and 2) – UEA and NSFT partnership

A partnership comprising members of the UEA and Norfolk and Suffolk NHS Foundation Trust has been commissioned by HWN to undertake a research project on mental health literacy and access to CAMHS Tiers 1 and 2 in young people aged 14 – 25 years.

The project is being undertaken in 2 phases as follows:

Phase 1: focus groups with young people to identify themes in response to each research question.

Phase 2: drawing on the results of phase 1 and the national and international literature on young person's views of mental health a cross-sectional survey is being carried out to measure the distribution of knowledge and views of young people across Norfolk.

Finally the partnership will synthesise these findings with existing literature (along with directly soliciting suggestions from young people in phase 1) to make recommendations regarding the design of services to promote timely help. and write up a final report for presentation to HWN to include actionable recommendations.

The specific design of both phases with respect to recruitment, specific methods, incentivisation etc has been designed in collaboration with young people from the INSPIRE PPI group.

A final report will be presented to HWN Norfolk by the partnership on completion of the project in April 2016. The report will include actionable recommendations and will be published in April/May 2016.

4. Young person review of Mental Health Services (CAMHS Tier 3) – MAP (Mancroft Advice Project

The Mancroft Advice Project (MAP) has been commissioned by HWN to undertake an extensive young person led review of CAMHS Tier 3/young people's mental health services in Norfolk delivered by the Norfolk and Suffolk NHS Foundation Trust (NSFT).
The review aims to answer three key questions:

1. What services are provided?
2. How do young people access services?
3. What are the outcomes from and quality of services?

The project includes the following:

- An enquiry/brief survey to the lead commissioners for Tier 3 services in Norfolk regarding what is commissioned at this point in time.

- A service-user led exploration of CAMHS Tier 3, scrutiny of the service specification, how young people have been engaged in developing the service (is it 'young people shaped?') what is being commissioning and what is being provided by NSFT.

- Youth Support Workers undertaking interviews and focus groups with young people aged 14-25 years, to gather experiences of using Tier 3 services and mapping the pathways in to Tier 3 service.

- A mystery shopping exercise conducted by young people of CAMHS access points; face to face, drop in, website, telephone, etc. A review of what is expected from the service compared to what young people actually experience.

A final report will be presented to HWN Norfolk by MAP on completion of the project at the end of December 2015. The report will include actionable recommendations and will be published in early 2016.

Conclusion

Based on feedback from service users, providers and commissioners, HWN recognises that access to a high quality service provision of mental health services to children and young people in Norfolk is a priority for all those involved and HWN is confident that its work as outlined above will help commissioners and providers to fully recognise the importance of those views expressed by service users

YOU SAID

Young Persons' Perspectives and Experiences of Specialist Tier 4 In-patient Mental Health Services in Norfolk
January 2014

healthwatch Norfolk

WE DID

Why did we do this project?

- Prior to our inception, the Board decided that Child and Adolescent Mental Health Service (CAMHS) Tier 4 was a priority for exploration.
- There were concerns surrounding the speed of access and overall capacity within Norfolk.
- This project met one of our key principles by increasing the extent in which underrepresented groups are heard.
- The aim was to gain insight into young people's experiences of CAMHS.

What did we do?

- We commissioned the University of East Anglia (UEA) to carry out the project.
- They collected qualitative interview data from service providers; clinicians and service users.

Recommendation: There should be a frequently updated list of units who are currently accepting emergency admissions.

Outcome: One central register of places available for emergency admissions is now maintained by NHS England (NHSE).

Recommendation: Inpatient units to update their website, with 'easy to access' information on policies and things to expect whilst on the unit.

Outcome: Inpatient units have updated their websites to improve access to information on policies and suggest that Norfolk and Suffolk Foundation Trust (NSFT) prepare a leaflet on the Tier 4 service made available to young people who are receiving community based services.

Recommendation: Streamline the referral process, with a centralised form to avoid multiple forms needing to be completed for multiple units.

Outcome: One referral form introduced for use by all referrers.

Recommendation: Service users to be consulted about ways to enhance the 'feel' of the unit - through the décor.

Outcome: NHSE liaising directly with NSFT about ongoing engagement with young people in creating an environment to which they feel comfortable.

Recommendation: Upon admission to an inpatient unit, young people to be given clear information about the unit; boundaries; procedures and so on, preferably in a 'treatment folder' also containing copies of individual care plans and goal setting.

Recommendation: Review of the current capacity of community services and if warranted, a strengthening of community services.

Outcome: NSFT commissioning UEA to carry out a review of literature on integrating services for children. Norfolk County Council and Clinical Commissioning Group's committed to reviewing 24/7 community care and also committed to working collaboratively with NHSE on outcome of review of CAMHS Tier 4.

Recommendation: Explore ways of enabling service users to continue to engage and stay connected with friends and family via use of technology.

Outcome: NSFT introduced a video link to communicate electronically.

Outcome: NHS England (NHSE) liaising directly with NSFT to suggest availability of 'easy read' leaflets on the unit as they recognise that not all admissions are planned.

Norfolk CAMHS Transformation Needs Analysis

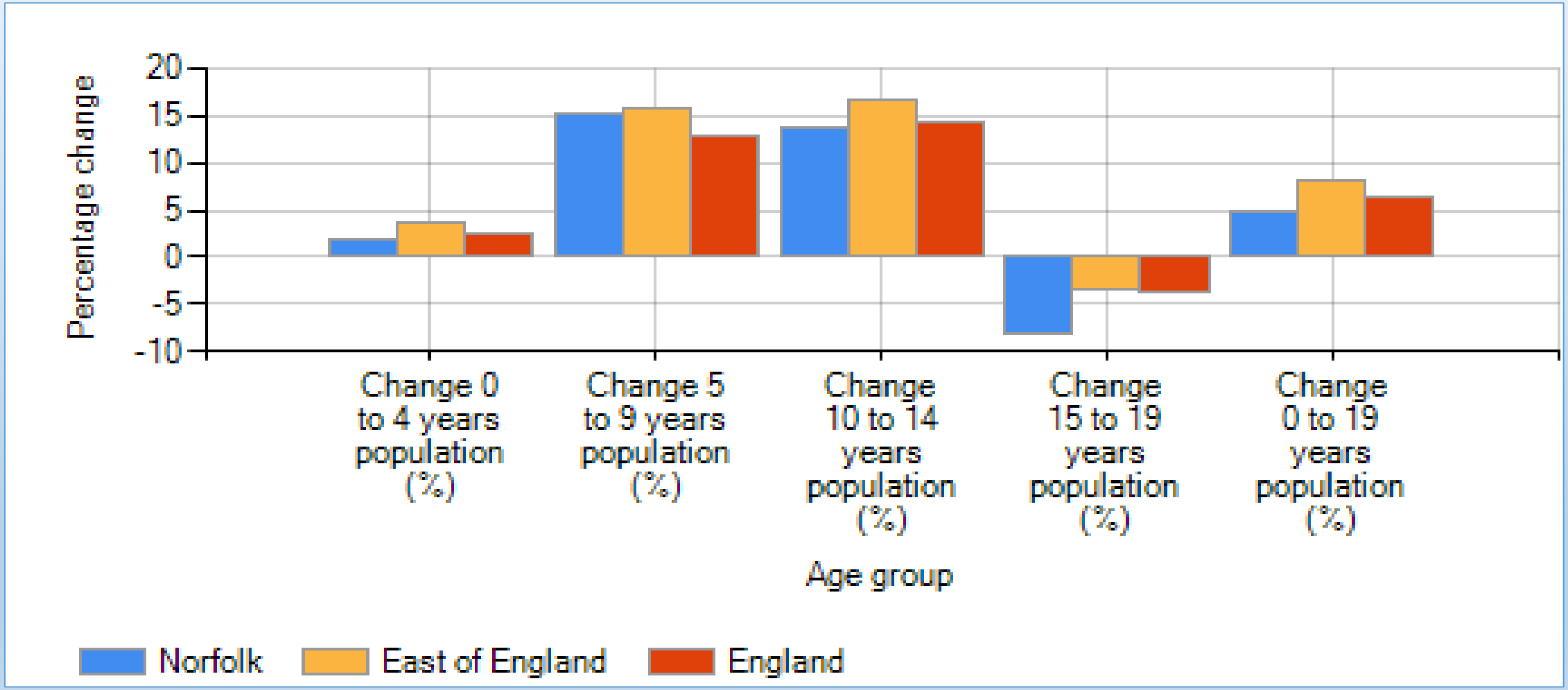
Dr Martin Hawkings
Consultant in Public Health
Norfolk County Council
20/11/2015

Norfolk child and young person population by age and sex

	0-4 years	5-9 years	10-14 years	15-19 years	Total
Male	24,401	23,959	22,256	25,140	95,756
Female	23,536	22,530	21,187	24,488	91,741
Total	47,937	46,489	43,443	49,628	187,497

Source: Local authority mid year resident population estimates for 2014 from Office for National Statistics.

Norfolk projected population change in 0-19s between 2012 and 2022



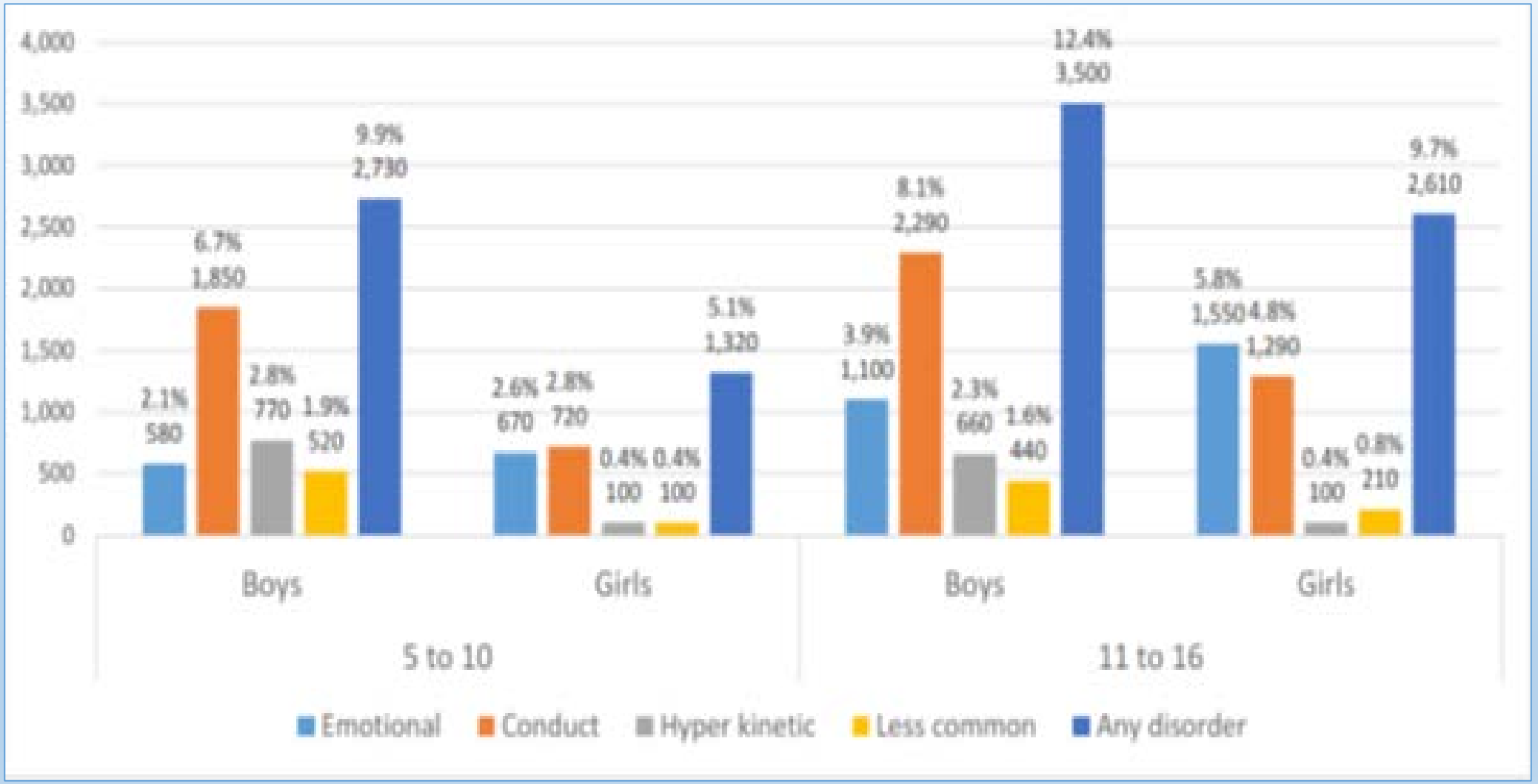
Source: Office for National Statistics

Estimated number of children with mental health disorders by age and sex in Norfolk 2014

Boys age 5-10 yrs	Boys age 11-16 yrs	Boys age 5-16 yrs	Girls age 5-10 yrs	Girls age 11-16 yrs	Girls age 5-16 yrs
2,785	**3,425**	**6,210**	**1,360**	**2,645**	**4,005**

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Estimated percentage and number of children and young people affected by mental health problems in Norfolk



Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014). Green, H. et al (2004).

Pupils in primary schools at School Action Plus or with a statement of special education need: rate per 1,000 pupils

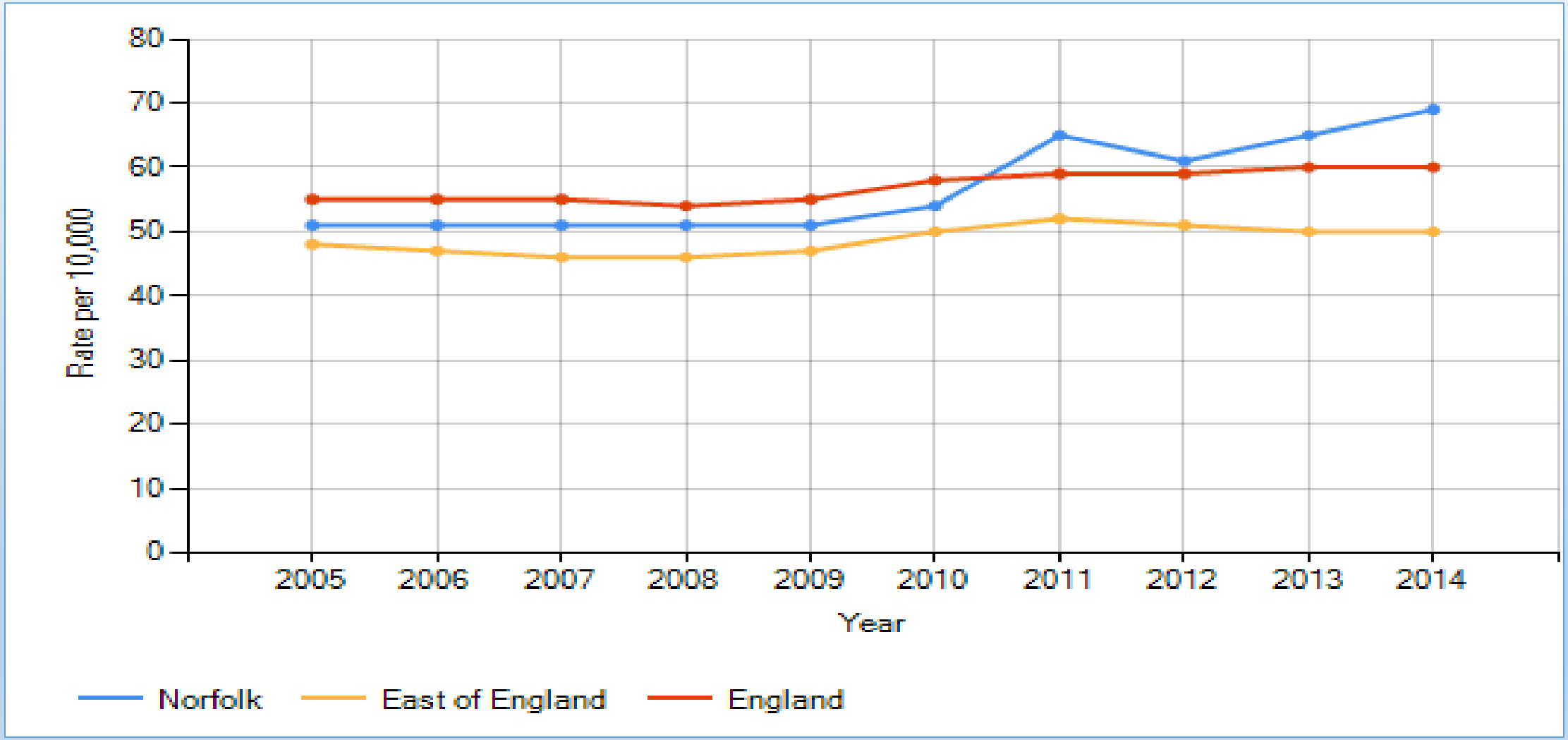
Special Educational Need Category	Norfolk	East of England	England
Speech, language and communications needs	30.0	28.0	31.6
Moderate learning difficulty	17.2	20.7	19.1
Behaviour, emotional and social difficulties	17.1	19.1	18.4
Specific learning difficulty	7.8	9.1	8.7
Autistic Spectrum Disorder	6.7	9.0	8.3
Other difficulty / disability	4.9	4.6	4.3
Physical disability	3.4	3.9	4.1
Hearing impairment	1.7	2.1	2.3
Severe learning difficulty	1.0	1.4	1.3
Visual impairment	0.9	1.3	1.3
Profound and multiple learning difficulty	0.3	0.5	0.4
Multi-sensory impairment	0.2	0.2	0.2

Source: Department for Education (2014)

Emotional and behavioural health of looked after children – Strengths and Difficulties Questionnaire (SDQ)

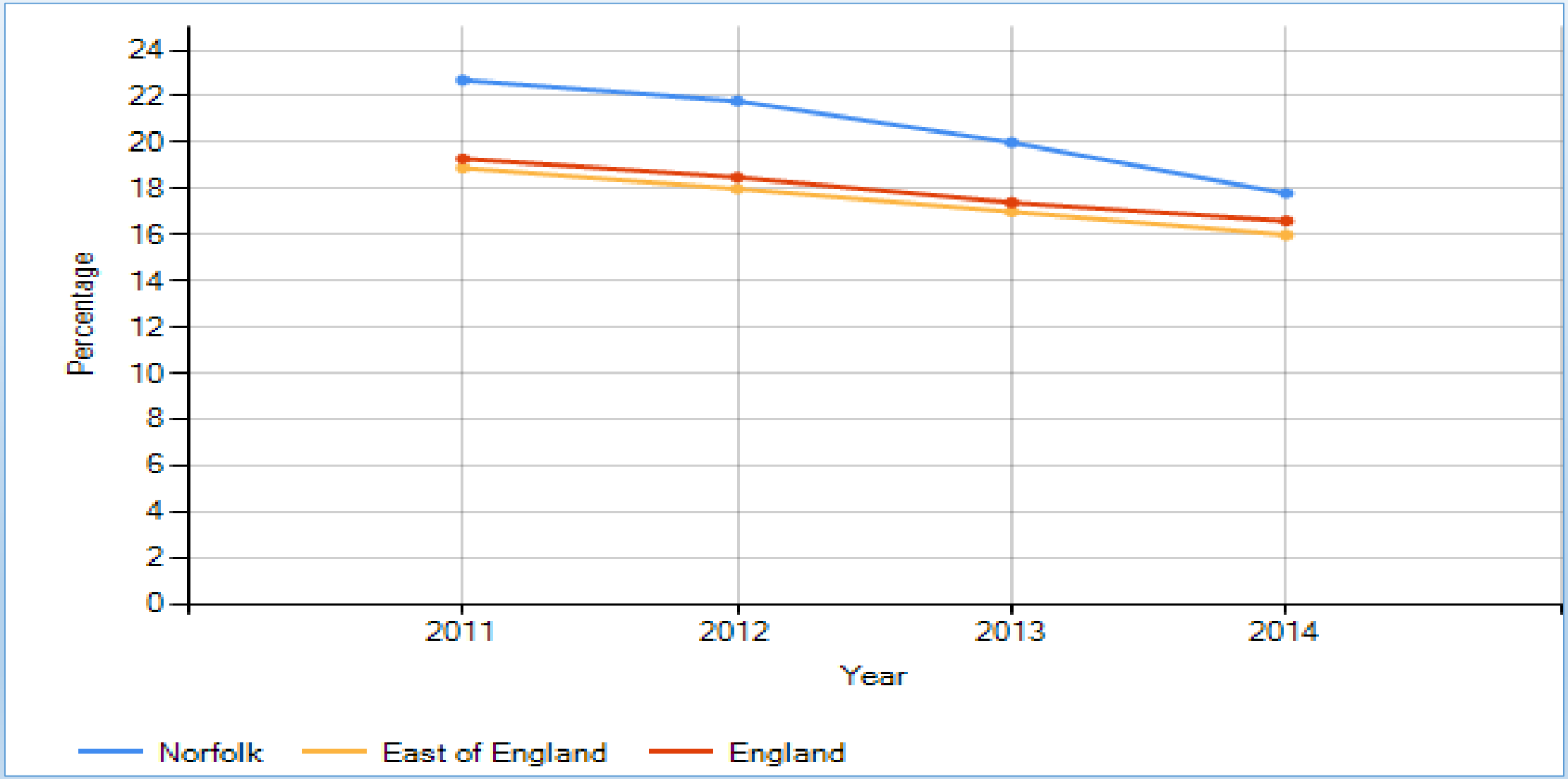
	Average Score 2011/12	Average Score 2012/13	Average Score 2013/14
Norfolk	9.9	14.5	14.5
East of England	13.2	14.2	14.2
England	13.9	14.0	13.9

Looked after children: rate per 10,000 population age 0 to 18 yrs



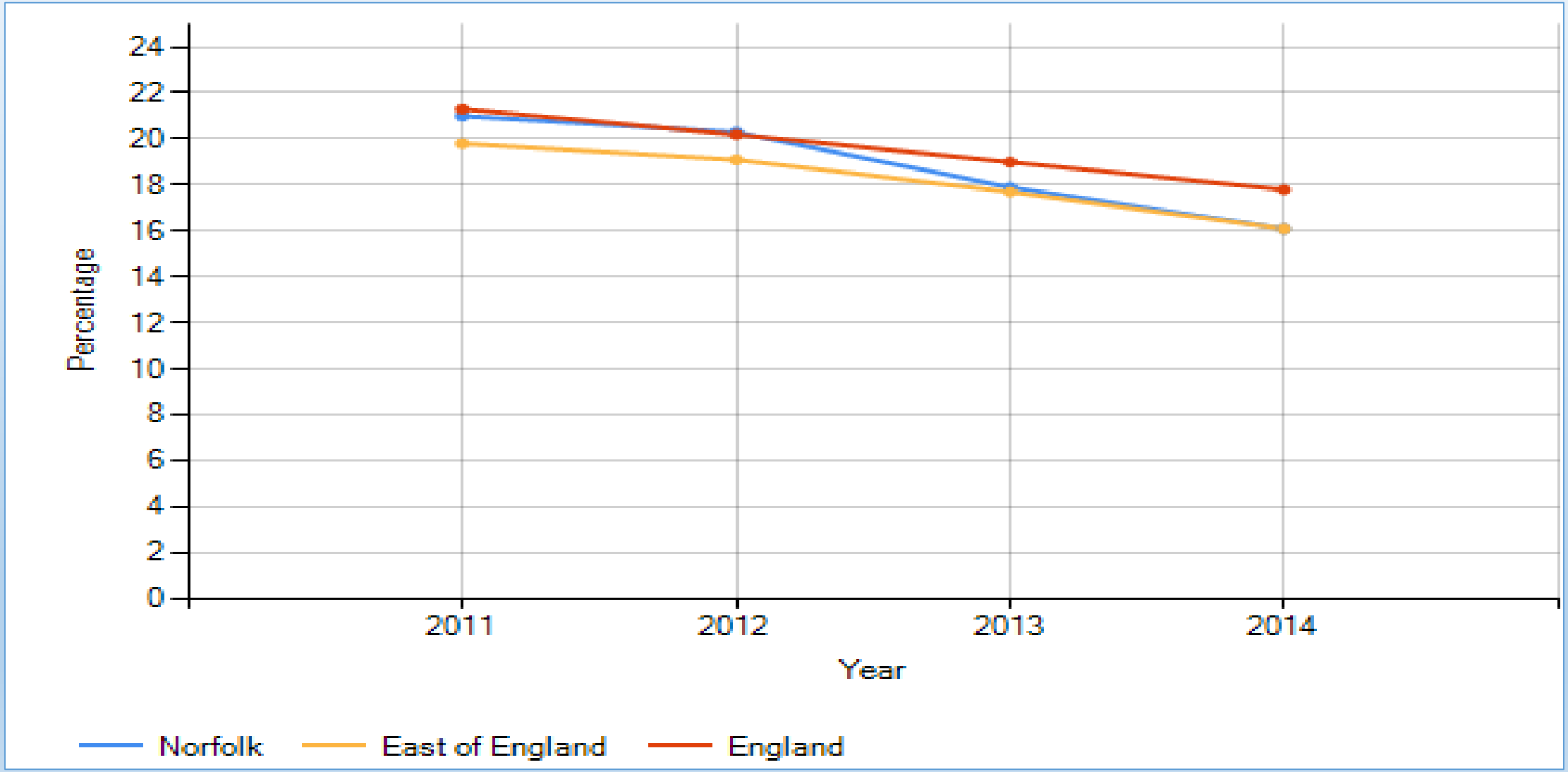
Source: Department for Education

Percentage of children in primary schools with SEN 2011-2014



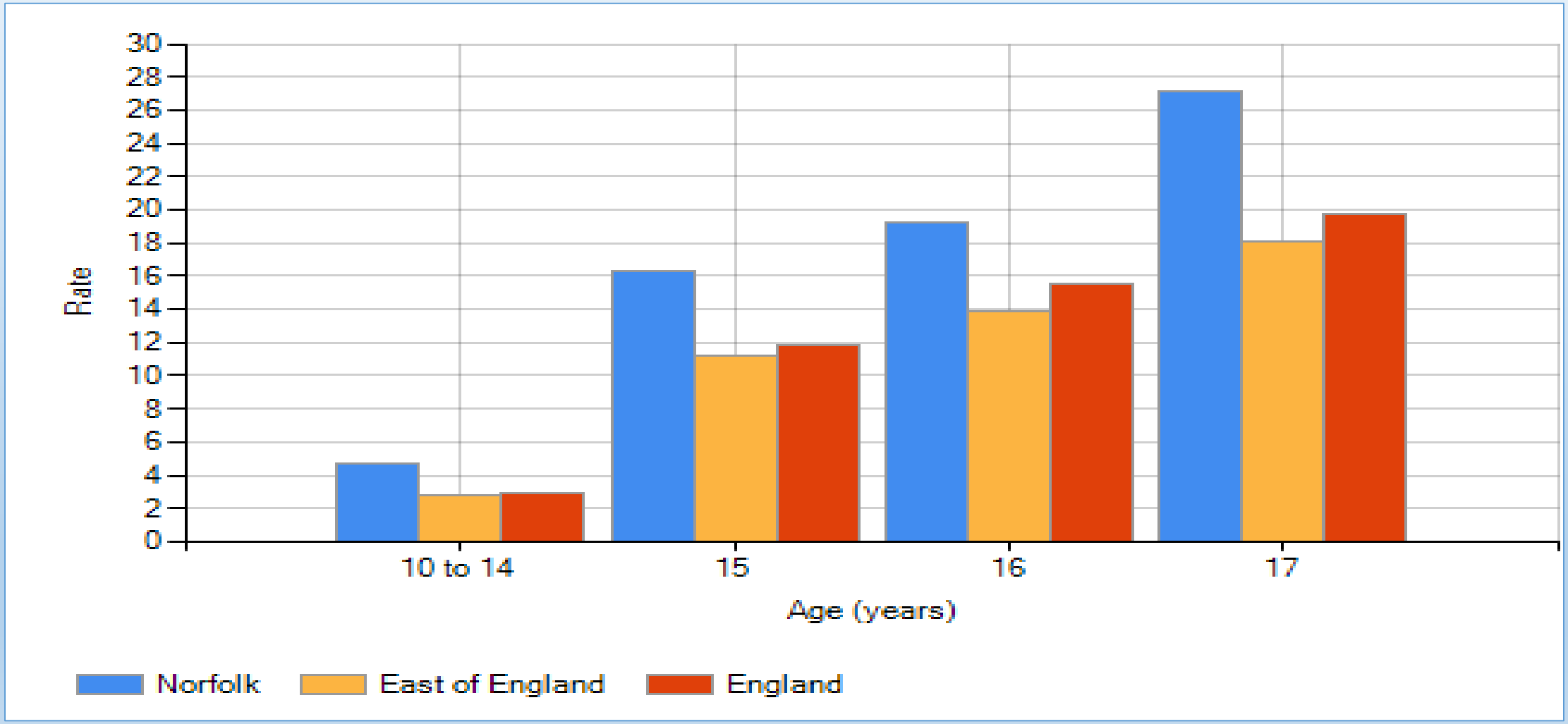
Source: Department for Education

Percentage of children in secondary schools with SEN 2011-2014



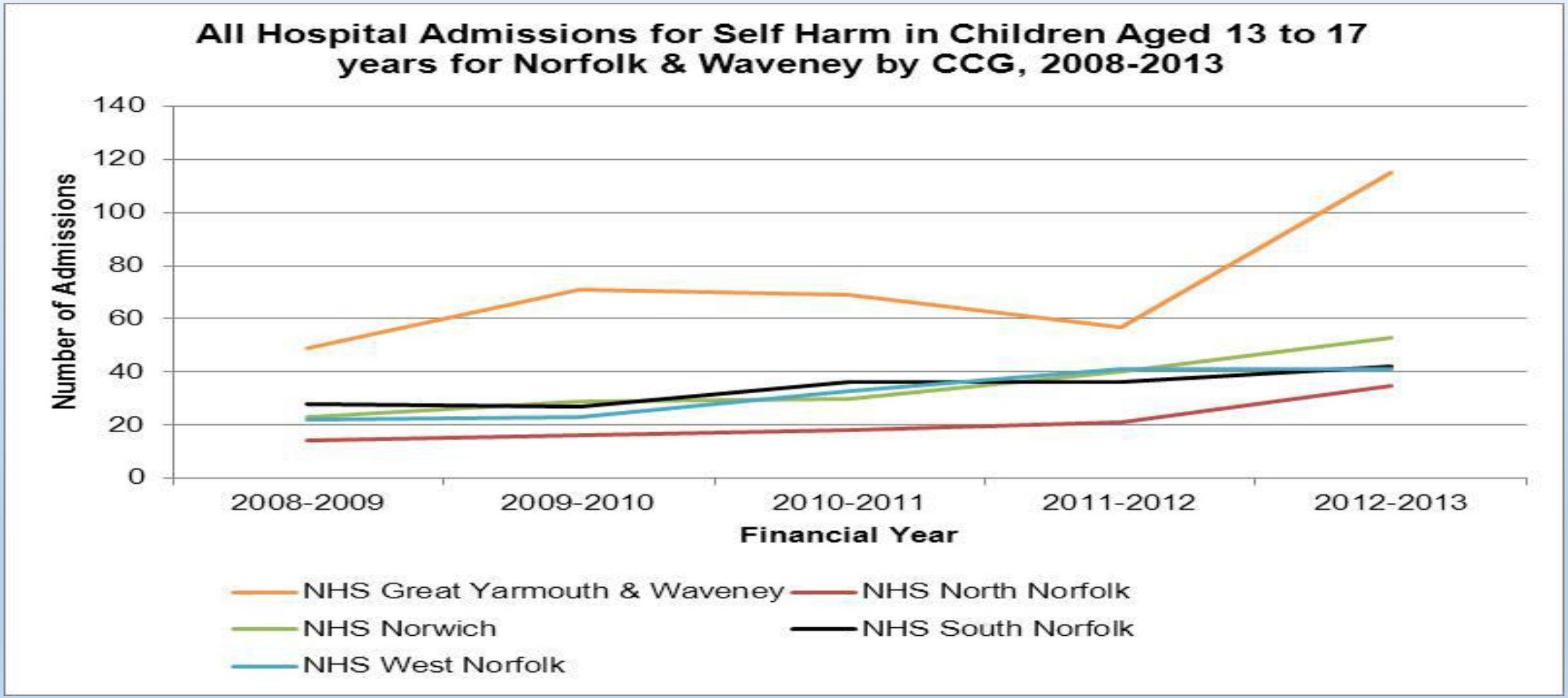
Source: Department for Education

Children and young people who have formally entered the Youth Justice System: rate per 1,000 population in (2013/14)

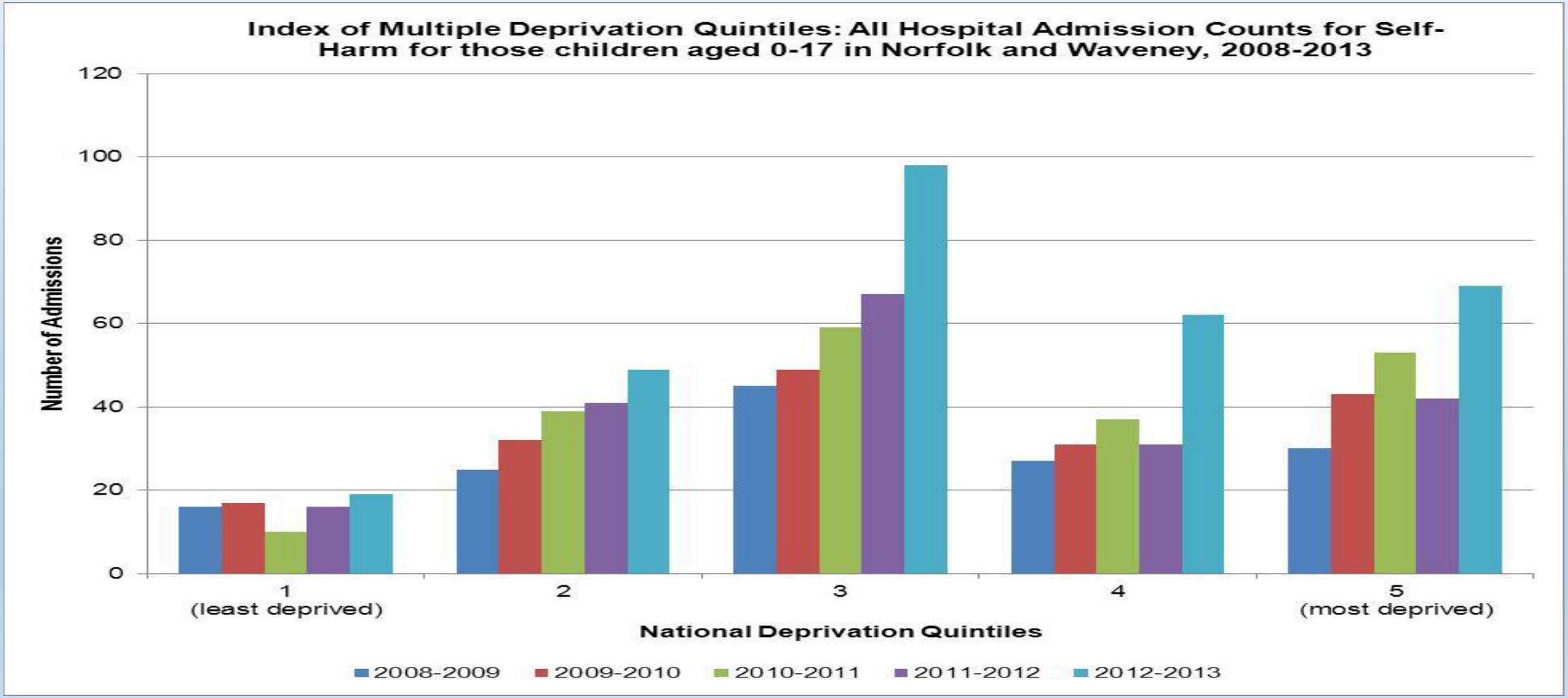


Source: Ministry of Justice, Office for National Statistics

Self-Harm by Children aged 13-17 by Clinical Commissioning Group – Numbers



Self-Harm Counts by National Deprivation Quintiles for Children age 0-17 for Norfolk & Waveney.



Children's Mental Health Services in Norfolk – Norfolk HOSC – 3rd December 2015

Purpose of Report

The Committee's interest in mental health provision commissioned for children and young people is welcome. As the Committee will have heard from our Public Health colleagues, we are faced with the challenge of meeting the needs of increasing numbers of children and young people with mental health problems. Meeting that increased need has been difficult, given the pressure that public sector finances have been under. Which is why the award of an extra £1.9m per year of Government funding to develop local provision for children and young people is so positive.

This report responds to the terms of reference agreed by HOSC in September, particularly the 'Reasons for scrutiny' and 'Areas to be addressed' sections. It also summarises the key new service developments to be funded by CCGs in order to deliver Norfolk and Waveney's Local Transformation Plan. The Local Transformation Plan was approved by NHS England in November 2015 and will result in £1.9m per year of additional funding being invested by CCGs directly into improving provision for children and young people in Norfolk and Waveney. The Plan addresses many of the issues noted in the HOSC terms of reference and is attached as Appendix E to this report. **Members are asked to review the Plan and to consider how fully it, when implemented, will tackle the Committee's concerns.**

Each of the key issues raised in Committee's terms of reference are addressed in turn.

"It is difficult to get an appointment for assessment…"

We recognise that a number of children, families and fellow professionals find it difficult to understand mental health services. It can be hard to know when to ask for help and to know which team or service to ask for help. Our Local Transformation Plan, when implemented, will result in the introduction of a genuine single point of contact for advice, support and referrals. We will also commission improvements to our online 'presence' so that when people search online for help they are able to easily navigate our web based information and to access self-help materials, apps and direct support online.

"Mild to moderate cases only receive 6 appointments"

This relates to one of the services CCGs commission in partnership with the County Council – Point 1 – which is our county wide Targeted service. The service offers a maximum average of 6 sessions per clients for most of its clients. A 'maximum average' means that some clients will receive significantly more than 6 sessions, as well as some receiving fewer than 6 sessions. Targeted services are explicitly commissioned to work with mild to moderate cases that may benefit from some short term support. The maximum average figure was set in the Point 1 contract to ensure that the service would have the capacity in place to see the number of children and young people we thought would need such a service, and to prevent long waiting times becoming common place (a problem that hampered Point 1's predecessors). Clients of Point 1 are encouraged to re-refer themselves at any time in the future

when they feel they may benefit from the service. One group of Point 1's clients routinely receive more than 6 sessions – namely infants and their parents/carers. Point 1 delivers targeted interventions to infants and their parents/carers, where there is not a strong, stable attachment. Such work, due to the age of the infants, requires more than 6 sessions per client in order to bring about meaningful improvements.

It is worth noting that the average number of appointments/sessions that NSFT provided to patients during 2014/15 was 7. As our main specialist provider NSFT deals with the most complex and risky cases.

"There is insufficient joining up between mental health services and other specialist services for children, such as the autism service…"

This is an issue that commissioners and providers acknowledge and are working on via a formal joint review of pathways for children with autism. A key part of the challenge is that there are a number of different providers and commissioners who each play a role in different parts of the pathway. The formal review is underway and is being led by the Commissioning Support Unit.

The broader agenda of enabling as good a 'join up' between services as possible is being taken forward through a few priorities in our Local Transformation Plan. As mentioned earlier, the delivery of a genuine single point of contact will assist greatly. Additionally, under the Plan £200k per year will be invested to develop a link work function to help staff from schools and other universal settings to better understand how they can support their young people and how (when needed) they can access the mental health system in a timely, efficient a way. Another development from our Plan that will improve the 'join up' in our system is described immediately below – the new shared 'Bank' of staff to support children and young people in crisis.

"There is insufficient support for children who have attended A&E following attempted suicide"

Our Local Transformation Plan will commit over £0.5m per year worth of extra staff to support children and young people in crisis, which will include those who self-harm and those who attempt suicide. In particular, there will be dedicated senior specialist CAMHS clinicians working on call, available to provide advice and direct face to face assessment and support to cases in crisis, wherever those cases present – including in community settings, acute hospitals and criminal justice settings. In addition, the Plan will fund the establishment of a new Bank of staff to provide short term intensive support for crisis cases who need it. This will include cases who have been assessed as needing a specialist inpatient CAMHS bed, but a bed is not immediately available, and cases on acute general hospital wards who need additional specialist mental health support.

A review of child suicides is being conducted in Norfolk by the Child Death Overview Panel. The Panel's findings and recommendations are expected to be published shortly and will no doubt help to inform further refinements to pathways.

"Capacity to deliver a more systemic and family based approach to children's mental health services"

Initially with start-up funding from Norfolk 's CAMHS Joint Commissioning Group, NSFT has been delivering accredited training in systemic ways of working with children and families for the last 2-3 years. The training is delivered to a mixed cohort of staff from Children's Services, the voluntary sector as well as CAMHS staff from our targeted and specialist services.

Additionally, Norfolk was successful in applying to join the national Children & Young People's IAPT (Improving Access to Psychological Therapies) in the summer. By joining the programme we have gained access to a wide range of accredited training (fully funded by Government) for a number of our staff. Family based and systemic approaches feature prominently in the training provided through the programme.
At a broader level, we are currently in discussions with Children's Services about enabling more shared access to Children's Services case recording/management systems for 'approved' CAMHS teams. Discussions include use of CareFirst (which some CAMHS staff already have a level of access to) and the newly commissioned online joint case management system being developed by the Early Help & Prevention Teams of Children's Services – known as DOREIS (Dynamic Online Recording Early Intervention System). By enabling access to a wider group of staff to such tools, joint and systemic ways of working together will only be encouraged.

"There has been a decrease in proactive support especially during the school holidays"

NHS funded CAMHS are contracted to work 52 weeks of the year and to have arrangements in place to manage periods when annual leave is most often taken (including school holidays). We are not aware of a particular decrease in our provision during school holidays. Traditionally, demand for our services tends to drop a little at these times due to families taking holidays and children and young people generally feeling more able to manage and cope. If members have any specific examples in mind that have concerned them we would encourage them to approach us about them and we will look into them.

"Reductions in third sector organisations' funding means that they are unable to bridge the gaps in NHS services"

Like statutory services, third sector organisations have had to deal with funding reductions in recent years. Some services have had to reduce their offer accordingly.

Two third sector providers play an integral role in delivering Norfolk's county wide targeted mental health service (Point 1). The service is delivered by a consortium of 3 organisations – Ormiston Families (the consortium's lead agency), Mancroft Advice Project (MAP) and Norfolk & Suffolk Foundation Trust (NSFT).

"Waiting list for children's mental health provisions"

The national waiting time standard for NHS commissioned CAMHS is 18 weeks from referral being received until the client/patient is seen. In Norfolk and Waveney we have for some years applied a much higher standard of 8 weeks.

For NSFT, during the financial year 2014-15 the average waiting time was 4.5 weeks per patient.

For Point 1, its waiting times are broken down into 2 parts:

- The time between referral being received and the first face to face appointment (4 week standard). Currently 85% of clients are being seen within the standard
- The time between the first and the second face to face appointments (4 week standard). Currently 89% of clients are being seen within the standard

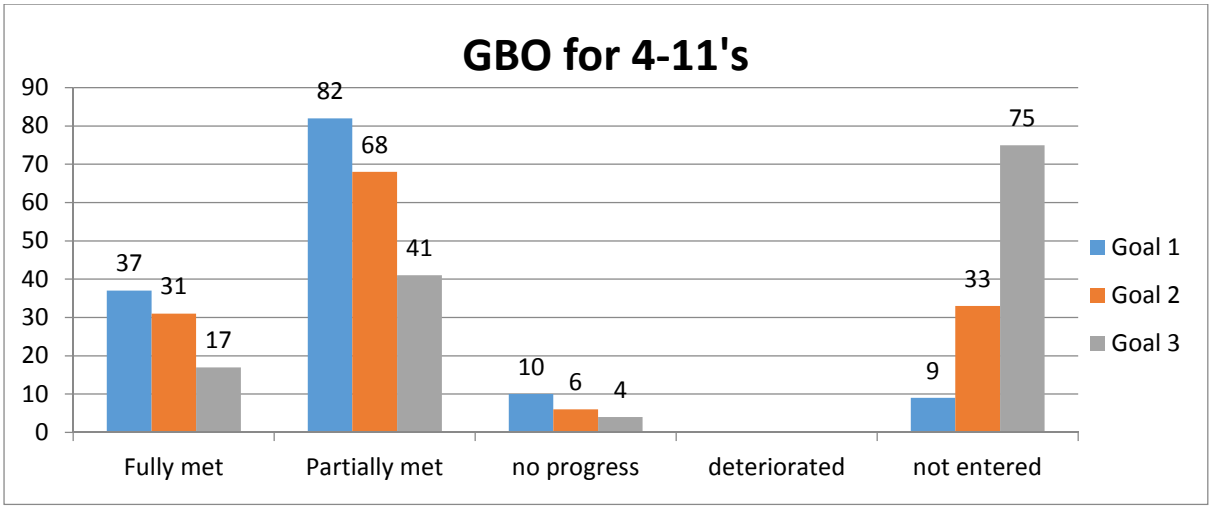
"…treatment outcomes, as well as re-referrals"

Re-referrals to our services are not routinely reported to commissioners. As mentioned earlier, clients/patients are encouraged to re-refer themselves if they feel they need further support. Re-referral is not a clear indicator of the success or otherwise of interventions previously delivered, as many factors can trigger a relapse or a different mental health issue. We could ask our providers to explore whether this data could be provided for the Committee, but we are unsure of the value of doing so.

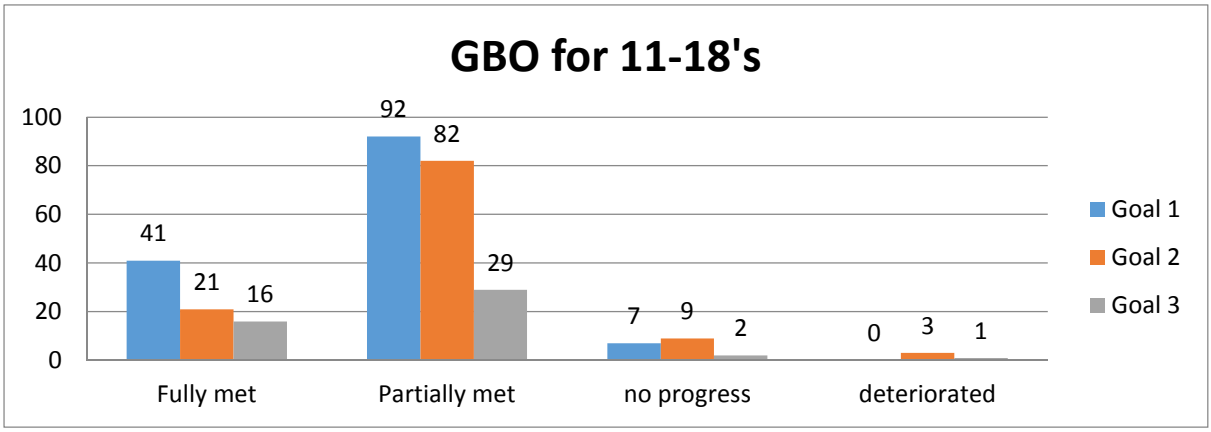
Our services use a range of outcome measures and patient satisfaction measures, which include the Goals Based Outcome (GBO) measure, Strength and Difficulties Questionnaire (SDQ) and the Experience of Service Questionnaire (ESQ). Examples of recently collated outcome results are illustrated below.

The GBO measure is a validated outcome measure, approved for use by the CAMHS Outcomes Research Consortium (CORC). Clients are asked to identify three elements or goals they would like to see improve as a result of the input/support received at the point of entry (known as the T1/Time 1 measure). A simple rating scale is used to record progress made at the point of discharge (the T2/Time 2 measure) – i.e. how fully their 'goals' were achieved. The graph below shows the GBO results for the April-June 2015 Quarter for 278 Point 1 clients for whom data was reported (140 were 11-18 yr olds and with 138 were 4-11 yr olds)

GBO results for 4-11 year olds in Q3, Year 3 (n=138)



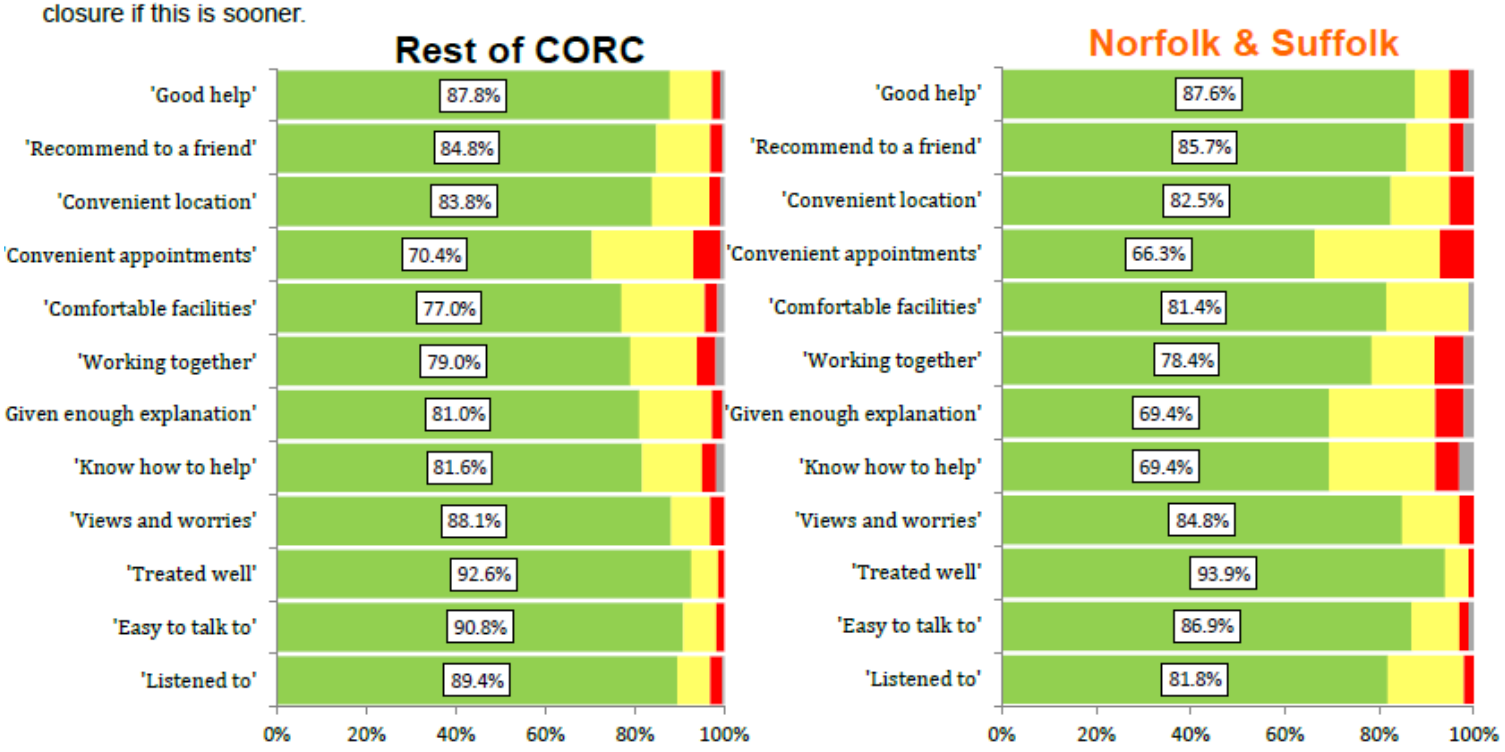
GBO results for 11-18 year olds in Q3, Year 3 (n=140)



The Experience of Service Questionnaire asks service users and/or their parents to assess how 'happy' they were with key aspects of the service and how they were treated. The table below shows the most recent results from NSFT, compared to the results of some similar services in other areas.

Parental satisfaction with service

Based on: parental responses on the Experience of Service Questionnaire, completed either 6 months after first contact or case closure if this is sooner.



When comparing 'certainly true' responses to CHI-ESQ items, parents of children seen by Norfolk & Suffolk rated their satisfaction with the service similarly to parents of children seen by Rest of CORC services

Don't know
Not true
Partly true
Certainly true

CORC Child Outcomes Research Consortium

Norfolk & Suffolk	N= 99 *(14.2% of all cases)*
Rest of CORC	N= 218 *(2.7% of all cases)*

"Changes to services planned in the Local Transformation Plan"

In August 2015 NHS England published guidance setting out the requirement for all CCGs in England to produce a Local Transformation Plan (LTP). LTPs had to demonstrate how local areas proposed to respond to the key priorities set out in the Government's *Future in Mind* report, which had been published earlier in the year. If approved by NHS England LTPs would draw down significant new recurrent funding for CCGs to invest. Norfolk & Waveney's Local Transformation Plan (LTP) was submitted on time to NHS England (Specialised Commissioning) on Monday 12th October, after being formally approved by:

- West Norfolk CCG
- North Norfolk CCG
- Norwich CCG
- South Norfolk CCG
- Gt Yarmouth & Waveney CCG
- Norfolk Health and Wellbeing Board
- Suffolk Health and Wellbeing Board

The Plan successfully cleared the two assurance rounds of NHSE (Specialised Commissioning) and we were notified on 3rd November that the Plan was robust enough for NHS England to release the recurrent funding to Norfolk & Waveney's 5 CCGs. Of the 125 LTPs submitted to NHS England ours was one of only 47 that were 'fully assured' by NHSE (i.e. funding was fully/immediately released), 60 were 'partially assured' (i.e. revisions were required to the Plan) and 18 needed to be re-submitted (i.e. a major re-drafting was required before funds would be released).

Norfolk & Waveney's LTP consists of the main Plan and 12 appendices. Most of the appendices are brief technical documents that NHSE required to be submitted on behalf of each CCG. For that reason, only the main Plan is attached as an appendix to this report. The Plan was produced under the auspices of Norfolk's CAMHS Strategic Partnership, which has member organisations from the voluntary and statutory sector – both providers and commissioners – and was led by a Steering Group that met on a weekly basis from May until mid-September.

The Plan seeks to transform provision in four key areas:

1. **Early help and prevention** – Developing a 'link work' function and adding capacity to support emotional well-being and mental health in universal settings

2. **Accessibility** – Introducing a genuine single point of contact for advice, support and referrals. Commissioning an online 'platform' and a range of online self-help software, apps, through which an online treatment offer can be safely delivered. Increasing capacity in targeted and specialist CAMHS and improving their join up (particularly for vulnerable groups). Extension of the opening hours of Specialist CAMHS. Re-modelling of the targeted and specialist CAMHS workforce. Building on the work of existing Centres and the

developing Early Help Hubs to ensure one-stop-shops are rooted in the local communities. Implementing a Norfolk-wide audit schedule to regularly review pathways.

3. **Eating disorders** – Increasing the size of our specialist Eating Disorder teams that work across Norfolk & Waveney so they comply with the newly published guidance and can safely handle the number of referrals they receive. This will also enable them to provide earlier intervention, and liaise and support lots of different referrers including schools and GPs.

4. **Crisis pathways** - Improving integrated crisis and out of hours CAMHS and Learning Disability/CAMHS pathways. Improving integrated pathways, to ensure they meet the needs of children and young people in a timely fashion (in hours and out of hours) and comply with good practice and the Mental Health Crisis Care Concordat

The Plan (attached at Appendix E) contains detailed proposals for each of the above four areas. **Members are asked to review Plan and to consider how fully the Plan, when implemented, will tackle the Committee's concerns.** A range of colleagues from our providers and commissioning organisations will be present as witnesses at the HOSC session to respond to any questions and comments that Members may have.

Appendix E

Children & Young People's Mental Health

Norfolk & Waveney's Local Transformation Plan

Produced collaboratively by Norfolk's CAMHS Strategic Partnership

Submitted on behalf of:

West Norfolk CCG

South Norfolk CCG

Norwich CCG

Gt Yarmouth & Waveney CCG

North Norfolk CCG

Assured by the Health and Well Being Boards of Norfolk and Suffolk

October 2015

Finding your way around the Local Transformation Plan

Norfolk & Waveney's Local Transformation Plan (LTP) is made up of several documents. This document contains:

Accompanying this document, and integral to it are the following Appendices:

Appendix 1: Detailed Local Transformation Plan for Eating Disorders Pathways

Appendix 2: Spreadsheet showing a breakdown of the current and proposed new staffing for Norfolk & Waveney's CAMHS Eating Disorders pathways

Appendix 3: Detailed Local Transformation Plan for Crisis Pathways for CAMHS & LD CAMHS

Appendix 4: Needs Analysis of Norfolk & Waveney's children and young people

Appendix 5: NHS England Annex: LTP High Level Summary

Appendix 6: NHS England Annex: Self-Assessment Checklist for Assurance Process

Appendix 7: NHS England Tracker Spreadsheet – North Norfolk CCG

Appendix 8: NHS England Tracker Spreadsheet – West Norfolk CCG

Appendix 9: NHS England Tracker Spreadsheet – Norwich CCG

Appendix 10: NHS England Tracker Spreadsheet – Gt Yarmouth & Waveney CCG

Appendix 11: NHS England Tracker Spreadsheet – South Norfolk CCG

Appendix 12: Annual Declaration Spreadsheet – service mapping, activity, waiting times, staffing and current spend by commissioning agencies

1 Our Vision

1.1 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.

c) 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.

2 We will transform our services by:

2.1

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.

3 The outcomes we want for our children and young people

3.1

1) More people will have good mental health
2) More people with mental health problems will recover
3) More people with mental health problems will have good physical health
4) More people will have a positive experience of care and support
5) Fewer people will suffer avoidable harm
6) Fewer people will experience stigma and discrimination
7) More infants, children and young people will be able to remain at home for the long term with their parents/carers in safe, stable and nurturing circumstances
8) More vulnerable parents/carers who receive targeted and/or specialist support will be confident in their parenting abilities

9) More people will be able to make and maintain positive, supportive relationships
10) More people will be able to be engaged with and achieving in education, training and employment

3.2 These outcomes are taken from our existing CAMHS[1] Strategy (2015-17), which adopted the 6 shared outcomes from the existing National Mental Health Strategy (*No health without mental health*). Outcomes 7-10 were added by Norfolk's CAMHS Strategic Partnership.

4 Principles

4.1 The following principles from our CAMHS Strategy guided our work to produce this Local Transformation Plan (LTP) and will continue to guide our joint planning and commissioning priority setting processes in the future. Our work will be influenced by:

a) the outcomes that we want children and young people to achieve
b) the relative levels of need of Norfolk's children and young people
c) feedback from children, young people and their parents/carers
d) local, national and international research and good practice
e) opportunities to provide joined up pathways of treatment and care
f) a desire for our services to provide equal access, taking into account the needs of a diverse population
g) a strong emphasis on education, mental health promotion, prevention, early intervention, safeguarding and harm minimisation
h) a desire for our services to be provided as close to home as possible
i) information about how well local services are performing
j) legal and/or statutory responsibilities and duties
k) the priorities set by government and local organisations
l) the political weight applied locally and nationally to particular priorities
m) value for money/cost effectiveness
n) the advice and judgement of external advisers and inspectors

5 Background and Governance Arrangements

5.1 This Local Transformation Plan (LTP) is submitted on behalf of the 5 CCGs who serve Norfolk and Waveney, namely:

- West Norfolk CCG
- South Norfolk CCG
- Norwich CCG
- Gt Yarmouth & Waveney CCG
- North Norfolk CCG

[1] CAMHS stands for Child & Adolescent Mental Health Services. CAMHS are provided by a range of statutory, voluntary and private organisations.

5.2 In April 2015 all 5 CCGs agreed to align and pool their joint planning capacity and the anticipated new funding allocations in line with the intentions of both *Future in Mind* and NHS England's guidance regarding LTPs – which recommended that (at least for specialist Eating Disorder and Crisis Pathway provision) CCGs collaboratively commission for populations of over 500,000. None of our CCGs serve a population anywhere near that size, but the 5 CCGs together serve a population of 986,000. Our CCGs therefore agreed to produce a single LTP, and to do so by working with a range of partner organisations from the statutory and voluntary sector, under the auspices of Norfolk's long established CAMHS Strategic Partnership.

5.3 The joint planning and commissioning of CAMHS is led in Norfolk by the CAMHS Strategic Partnership (SP) and the CAMHS Joint Commissioning Group (JCG). Both bodies are accountable to Norfolk's Health & Well Being Board and Norfolk's Children & Young People's Strategic Partnership. As one of our 5 CCGs (Gt Yarmouth & Waveney CCG) serves the Waveney area, which lies in Suffolk, for the purpose of this LTP our partnership working is also held to account by the Suffolk Health & Well Being Board. Great Yarmouth and Waveney CCG will continue to ensure alignment of the CAMHS LTP with the remaining two Suffolk CCGs and Suffolk County Council through the Emotional Health and Wellbeing group and the Children's Trust group in Suffolk. Great Yarmouth and Waveney CCG has submitted a similar LTP with Suffolk County Council that aligns with this Plan. We are seeking to increase integration across the counties' borders over the transformation period where this makes sense for families.

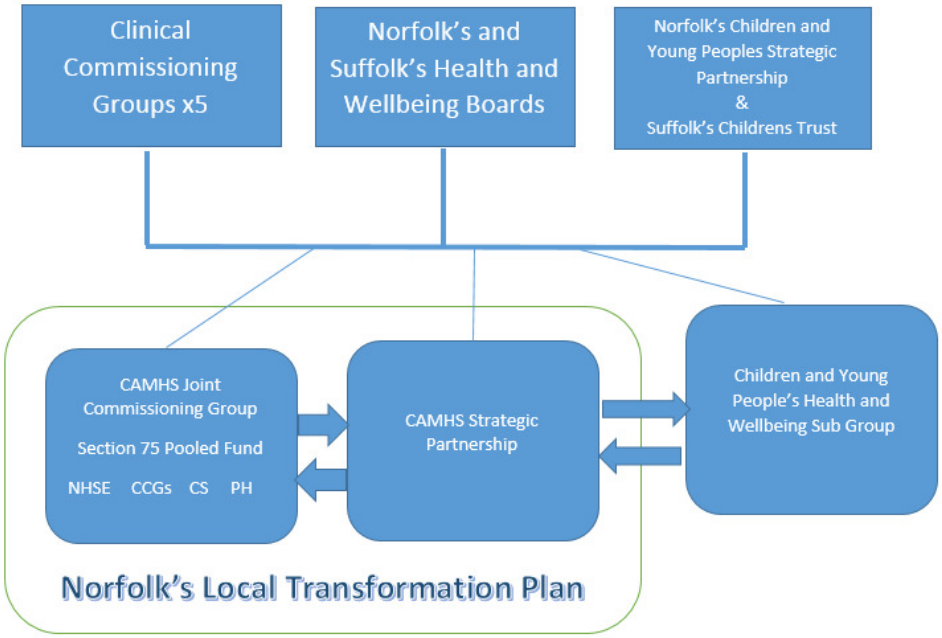
5.4 The CAMHS JCG co-ordinates the strategic commissioning and performance management of CAMHS across Norfolk. This includes making recommendations about the allocation of all CAMHS related funding. The CAMHS JCG has representatives from Norfolk's main mental health commissioning agencies – Norfolk County Council, the 5 CCGs, NHS England and Public Health. The CAMHS SP co-ordinates needs assessment work and produces, monitors and regularly revises the CAMHS Strategy and implementation plans. The CAMHS SP's membership consists of a range of senior practitioners and managers from the Voluntary Sector Forum, specialist and targeted CAMHS, Education, Norfolk HealthWatch, Healthy Norfolk Schools Programme, the Police, Youth Offending Team and Health & Well Being Board – along with the members of the CAMHS JCG.

5.5 Norfolk's mature joint planning and commissioning arrangements for CAMHS continue to develop, in line with national and local policy and the leadership of CCGs, NCC, Health & Well Being Boards and other lead bodies. A recently established Children & Young People's Strategic Partnership superseded Norfolk's Children's Trust and is taking a strong lead role to streamline and integrate commissioning arrangements. Our CAMHS SP and CAMHS JCG report to both the Children & Young People's Strategic Partnership and the Health and Well Being Boards – with these bodies being asked to formally sign off this LTP as well as the CCGs.

5.6 The governance arrangements as they relate to the LTP are illustrated in the diagram overleaf.

6 Governance arrangements for Norfolk & Waveney's Local Transformation Plan

6.1



7 How our Local Transformation Plan was co-produced

7.1 Under the auspices of Norfolk's CAMHS Strategic Partnership, a Local Transformation Plan Steering Group was formed in April 2015. The Steering Group met weekly until mid-September and had representatives from the CAMHS Strategic Partnership, the Health & Wellbeing Board alongside Norfolk County Council's lead Member Champion for mental health.

7.2 The Steering Group used the nationally 'recommended' Self-Assessment Matrix (SAM) tool (produced by Associate Development Solutions) to benchmark pathways in Norfolk against the 49 recommendations from *Future in Mind*, and to help identify and weight potential priority developments for Norfolk's LTP.

7.3 In terms of Eating Disorders provision in Norfolk, a great deal of groundwork had recently been completed to establish current levels of need, gaps and priority developments, particularly in the Central CCGs area (North, Norwich & South CCGs). The work had been undertaken in response to reports that the existing CAMHS Eating Disorders Team was struggling to cope with unprecedented levels of demand.

7.4 A project (supported by NHS England) was also well underway to review CAMHS and Learning Disability (LD) CAMHS Crisis Pathways when the LTP guidance was published. Our Crisis Pathway review work is also linked to Project Domino – a Norfolk System Resilience project. The information from the CAMHS & LD Crisis Pathway review work fed into the LTP planning process.

7.5 The SAM exercise highlighted a number of key service development needs or gaps. On reviewing the findings of the SAM exercise along with the expressed views of children, young people and stakeholders, the LTP Steering Group organised the main priority development needs into four key areas which form the main sections of the LTP. These are:

a) Early Help and Prevention
b) Accessibility
c) Eating Disorders Pathways
d) Crisis Pathways

7.6 This LTP will be published on the www.norfolk.gov.uk/CAMHS in November 2015.

8 The involvement of children, young people, frontline staff and other stakeholders

8.1 Our LTP has been informed by a range of involvement and engagement activity, including:

a) Feedback from children and young people who have used our services, via routine service user experience of service questionnaires, structured interviews with young people, group work with Norfolk's Youth Parliament, workshop activity with our Mental Health Trust's Youth Council, and quality concerns/complaints raised by children and young people and their parents/carers
b) Feedback from staff in schools and other universal settings
c) Workshops and interviews with front line staff from targeted and specialist mental health teams
d) Interviews with staff who depend on our targeted and specialist mental health teams for advice and support regarding children/young people they are concerned about – including those who most commonly act as 'first responders' to children and young people during a mental health crisis

8.2 A stakeholder workshop was held on 20th July to receive formal feedback from a particular intensive and innovative piece of user involvement undertaken over the Easter period. The involvement exercise was led by design students from the University of Arts, London, who worked with groups of young people, staff and commissioners over a week, using a range of arts and design approaches to elicit feedback about existing provision, but more importantly to imagine and design what outstanding provision would look and feel like. Those at the 20th July event (young people, design students, commissioners, providers and other stakeholders) considered how the feedback correlated with the emerging priority gaps/service development needs from the Future in Mind Self-Assessment Matrix. It was reassuring to learn at the event that the proposed priorities from both pieces of work were closely aligned.

8.3 Norfolk CAMHS Strategic Partnership has an Involvement Pledge, which states our collective commitment to continuous meaningful involvement activity with children, young people, families, carers and other stakeholders. In completing the review work for this LTP we recognised that while our involvement work is much more meaningful than a few years ago, it is in need of further development. Hence, a re-fresh of our Involvement Pledge is a priority development in this Plan, with dedicated capacity being made available to better co-ordinate involvement activity across our Partnership,

so that the key messages from involvement activity are regularly collated, reviewed and place in front of decision makers to more directly influence the design and development of services.

8.4 A high level summary of messages from children and young people now follows, with further details set out in each of the four sections of the LTP.

9 Children and young people have told us they want:

9.1
a) Much better information and emotional wellbeing support in schools
b) Fast, non-stigmatising access to support in schools – evidence based and consistent
c) One stop shops where mental health is one of a range of services provided, including 'virtual' one stop shops that provide outreach across the county
d) Services to be open when young people actually want to access them i.e. outside of school and college hours
e) Self-referral
f) Peer workers that help you navigate your way to the right person to help
g) Access to activities which reduce isolation
h) Alternatives to hospital such as outreach, youth focussed crisis team, crisis houses
i) Psycho-social support – help that doesn't pathologise, medicalise or label a range of emotional responses/distress
j) To be protected from abuse and harm

10 Links to existing local Strategies and Developments

10.1 Improving the mental health of children and young people is the sole emphasis or a key cross cutting theme in a number of local strategies. This LTP when approved will build on or deliver key elements of these.

10.2 Norfolk has two Strategies that focus solely on improving the mental health of children and young people:

- **CAMHS Strategy 2015-17** – produced by the CAMHS Strategic Partnership (described earlier), the Strategy addresses Universal, Targeted and Specialist need/settings
- **Emotional Wellbeing & Mental Health Strategy (Norfolk and Suffolk)** – produced by Children's Services and endorsed by the Health & Well Being Boards, with a strong focus on prevention and early help

10.3 Improving the mental health of children and young people are key priorities within the Health and Wellbeing Board Strategies of both Suffolk and Norfolk. Norfolk Health & Wellbeing Board's Strategy has a discreet priority dedicated to promoting the social and emotional wellbeing of preschool children.

10.4 Norfolk has an Early Help and Prevention Strategy, signed off by the Children's & Young People's Strategic Partnership. The Strategy has a broad brief, but includes a sharp focus on developing locality Early Help Hubs through which a range of teams and services (including mental health teams) can collaborate to better meet the needs of the population. This LTP intends to make good use of the Early Help Hubs to deliver a

consistent offer of training, advice and support to those in schools, children's centres and other universal settings.

10.5 In terms of innovative local service developments that this LTP will build on, these include:

a) delivery of the evidence based Promoting Alternative Thinking Strategies (PATHS) programme to primary schools

b) some specialist mental health teams offering treatment beyond the age of 18, thereby removing an arbitrary transition to adult services at the age of 18

c) delivery of cutting edge Perinatal Infant Mental Health provision for infants on the edge of care (and their primary care giver/s), preventing them coming into care – funded as a 1 year pilot project by the Department for Communities and Local Government, with external evaluation to build the evidence base. A leading candidate for funding from the new recurrent Government funding for Perinatal Infant Mental Health. Such a pilot also serves the Waveney area.

d) Compass Centres - specialist school provision with on site, integrated therapy and specialist support/training for carers of children with mental health needs and challenging behaviour. The DfE 1 year funded Compass Outreach project extends the Compass offer to delivery of intensive support, training and treatment for looked after children and their carers, along with specialist input to support the reunification of looked after children to their family (or extended family)

e) Integrated Mental Health Team – specialist mental health nurses based in the Police Control Room providing advice and support to police staff and others

f) A vibrant and diverse voluntary sector offer for children young people with mental health needs

g) High quality substance misuse service offer for children and young people and their families. We wish to seek further opportunities to collaborate and ensure pathways are as integrated as possible for those children and young people affected by substance misuse and mental health issues

11 Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

11.1 Allocation of the new national CAMHS funding is conditional on areas joining one of the CYP IAPT Learning Collaboratives. A joint Norfolk & Waveney application was submitted to join the CYP IAPT programme in June 2015. We were formally notified in July 2015 that our application had been successful and Norfolk is now a member of the London and South East CYP IAPT Learning Collaborative. By joining the programme, we will benefit from being able to send a range of staff from Targeted and Specialist CAMHS on accredited training in evidence based therapies (fully funded – including backfill - by the national CYP IAPT programme). Joining the CYP IAPT programme also formally commits our Partnership to a range of service and system improvement and transformation activity, including introduction and reporting of a range of routine outcome measures into local services.

12 Local Transformation Funding & how we will manage and monitor spend and slippage

12.1 The new national funding allocations available to CCGs from 2015/16 are as follows:

CCG	Initial allocation of funding for ED and planning in 2015-16	Additional funding available for 2015/16 when Transformation Plan is assured	Minimum recurrent uplift for 2016/17 and beyond if plans are assured. Includes £30m for ED
West Norfolk	99,800	249,810	349,611
Great Yarmouth and Waveney	133,363	333,821	467,184
North Norfolk	93,740	234,642	328,382
Norwich	103,167	258,238	361,405
South Norfolk	113,563	284,260	397,823
Totals	**543,633**	**1,360,771**	**1,904,404**

12.2 The 5 CCGs and Norfolk County Council (NCC) have a CAMHS Pooled Fund that they all contribute to. The Pooled Fund is administered via a section 75 Agreement. The CAMHS JCG performs the 'Executive Group' function required under a section 75 agreement. The Pooled Fund is held by NCC and managed by the CAMHS JCG officers. The Fund is primarily committed to the CAMH Targeted Service contract, Point 1. In addition the Pooled Fund pays for the JCG's officers who support and co-ordinate the work of the CAMHS JCG and CAMHS SP.

12.3 Three out of the Five CCGs have formally agreed that their LTP funding will be held and managed in the CAMHS section 75 Pooled Fund. The main advantages of doing so are to make the process of monitoring spend as straightforward as possible (fewer transactions), and that any underspend/slippage can be easily and lawfully carried forward across financial years. Two CCGs (West Norfolk CCG and Great Yarmouth and Waveney CCG) have indicated they are likely to retain the funding within their internal budget, while continuing to jointly commission and invest their funding with the other CCGs.

12.4 The following is a helpful, brief statement from West Norfolk CCG and Great Yarmouth and Waveney CCG on the subject:

"West Norfolk CCG is not minded to use the existing CAMHS Section 75 arrangement to pool the new allocations for Eating Disorders and additional funding which will be released after NHS England have assured the Local Transformation Plan. West Norfolk CCG is committed to working with partner agencies across Norfolk to secure improvements in Eating Disorder services and in CAMHS for Children & Young People in

West Norfolk. The CCG Senior Management Team will take an oversight of the engagement needed with the Strategic Commissioner to ensure that the activities identified within the Plan are reported on quarterly and as required."

''Great Yarmouth and Waveney CCG fully supports Norfolk and Waveney's Local Transformation Plan to improve the health and wellbeing of our children and young people. Great Yarmouth and Waveney CCG is fully committed to working with partner agencies across Norfolk and Waveney to ensure the delivery of the plan and to maximise the combined commissioning opportunities. Great Yarmouth and Waveney CCG is keen to maintain existing contractual arrangements already established within mental health and therefore we will not be contracting through the existing CAMHS Section 75 arrangement to pool the new allocations for eating disorders and CAMHS. The CCG Senior Management Team will take an oversight of the engagement needed with the CAMHS Strategic Commissioner to ensure that the activities identified within the Plan are reported on quarterly and as required."

12.5 The benefits we have experienced of formally aligning or pooling funding and joint commissioning arrangements include:

a) Better integration of service pathways, joint commissioning strategies/cycles, performance management and back-office support functions

b) Whole system planning becomes more straightforward

c) Reduction in unnecessary duplication or barriers in pathways of treatment and care

d) A better unit price can be secured due to the increased bargaining/purchasing power of commissioners

e) The efficiency of service provision is enhanced through economies of scale being built in to the system

f) Fewer separately funded and performance managed contracts for providers to deal with – freeing up more resources to commit to direct service delivery

13 Norfolk & Waveney's Annual Declaration

13.1 The NHS England LTP Guidance sets out how our Plan needs to demonstrate our commitment to transparency by commissioning agencies and providers publishing an Annual Declaration. The Annual Declaration has to include:

a) "Local commissioning agencies giving an annual declaration of their current investment and the needs of the local population across the full range of provision for children and young people's mental health and wellbeing

b) Providers declaring what services they already provide, including staff numbers, skills and roles, activity (referrals received, referrals accepted, waiting times and access to information" (section 4.5.1, LTP Guidance, NHS England, 2015)

13.2 The guidance states that the Annual Declaration should relate to the 12 month period ending 31st March 2015. Given the wide range of providers covering what is a large area, our Annual Declaration is given in a separate spreadsheet accompanying our LTP (**Appendix 12**). The exception to this relates to the summary of the needs of the Norfolk & Waveney population. A summary of the data available about our population is attached as a separate stand-alone document accompanying the LTP (**Appendix 4**).

The needs data will be updated regularly and will indeed be superseded by a soon to commence Public Health led full mental health needs assessment.

13.3 **Parity of Esteem funding** - In Central Norfolk (North Norfolk, Norwich and South Norfolk CCGs) the requirement to deliver Parity of Esteem for mental health has been achieved by ensuring that the inflationary uplift provided to CCG's was passed to the Mental Health system (mainly to Norfolk & Suffolk Foundation Trust). The way in which this was achieved in Central Norfolk was through the commissioning of a 12 bedded Unit (Thurne Ward) and a step down facility (Ashcroft). West Norfolk CCG is committed to ensuring mental health funding is directed to improve the wellbeing of people with mental health problems. As such all Parity of Esteem funding has been used to improve service provision within mental health, including enhancing the Crisis Support Team and Mental Health Liaison Service, ensuring sufficient acute beds are available within the West Norfolk system and directing funds to support the reduction in caseloads currently held by mental health staff in the community. Great Yarmouth and Waveney CCG is committed to ensuring mental health funding is directed to improve the wellbeing of people with mental health problems. As such all Parity of Esteem funding has been used in the following ways to date, contracts with 3rd Sector providers were not deflated, funded the Adult Community Eating Disorders Service provided by NSFT, funded an adult ADHD service provided by NSFT, additional funding was also given to NSFT.

13.4 In terms of our commitment to using the new LTP funding for the purposes for which it was intended, the following statement is included here on behalf of all 5 CCGs and our partners.

14 Managing and monitoring spend and slippage – our shared commitment

14.1 Norfolk's 5 CCGs understand and will adhere to the explicit conditions laid out in the NHS England Guidance regarding LTPs. The Guidance clearly states that the new funding has conditions attached to it, including CCGs must be able to demonstrate that:

a) *"…the additional money is being spent for the purposes intended" (Section 5.2.4)*
b) *"…confirmation that the ED monies are recurrent and release of further funds will be conditional on the assurance process" (Section 5.3.1)*

14.2 We are committed to spending every penny of this allocation on provision to improve the mental health of children and young people in Norfolk.

14.3 To this end, our LTP gives as full, clear a breakdown of our planned investments as possible, including how we intend to use slippage. Due to a range of factors, it is possible that our slippage figures will change – potential delays in recruitment being the most likely to affect us. When and if this happens, our figures will be revised and published in refreshed versions of our LTP. Our slippage is currently calculated on the assumption that the new funding will be fully utilised from December 2015, thereby leaving circa 8 months of slippage to allocate.

14.4 Assuming our LTP is approved by NHS England and funding is released, further revisions to the detail (and planned investments) are likely to be made. These could

happen for a variety of reasons, including previously unreported gaps in provision coming to light, changes in pricing of any of our providers, economies of scale that could be achieved by bundling a number of proposed investments into a single investment, or if we are directed to divert some of our planned investments from one mental health priority for children to another.

13.5 A summary of our planned investments and how we intend to use slippage is set out overleaf, with more detailed breakdowns described in each of the four sections of this Plan.

Funding breakdown and Slippage Proposals

Recurrent Funding

	West Norfolk	Great Yarmouth & Waveney	North Norfolk	South Norfolk	Norwich	**Total**	Slippage (8 months)
Early Help and Prevention	£36,800	£49,000	£34,400	£41,800	£38,000	**£200,000**	£133,333
Accessibility	£95,639	£127,344	£89,401	£108,631	£98,756	**£519,771**	£346,514
Eating Disorders	£99,800	£133,363	£93,740	£113,563	£103,167	**£543,633**	£362,422
Crisis Pathways	£117,944	£157,045	£110,252	£133,969	£121,790	**£641,000**	£427,333
	£350,183	£466,752	£327,793	£397,963	£361,713	**£1,904,404**	£1,269,602

Slippage

	West Norfolk	Great Yarmouth & Waveney	North Norfolk	South Norfolk	Norwich	**Total**
Early Help and Prevention	£24,533	£32,667	£22,933	£27,867	£25,333	**£133,333**
Accessibility	£63,759	£84,896	£59,600	£72,421	£65,838	**£346,514**
Eating Disorders	£66,533	£88,909	£62,494	£75,708	£68,778	**£362,422**
Crisis Pathways	£78,629	£104,697	£73,501	£89,313	£81,193	**£427,333**
						£1,269,602

Notes:

Each CCG total funding figure is based on a percentage figure of total funding and therefore differs slightly with allocation figure due to decimal rounding

£19,797 of Accessibility will go to Crisis pathway slippage proposals , please see relevant section for details

Local Transformation Plans

Priority Area	Early Help and Prevention
Key Partners	Universal Settings – including, schools, early years settings, colleges, health services, voluntary and community provision Targeted & specialist providers of mental health services, including but not limited to: • Voluntary organisations such as Point 1, MAP, The Benjamin Foundation, YMCA, Young Minds and Nelsons Journey • Healthy Norfolk Schools Team • Educational Psychology Specialist Services • Norfolk Community Health and Care NHS Trust • Norfolk & Suffolk Foundation NHS Trust • East Coast Community Healthcare
1 Our self-assessment tells us:	
There is a rich supply of providers and services in Norfolk and Waveney, some of whom are nationally recognised. These services, which the majority of which are provided by the voluntary sector offer a wide variety of provision, including training, evidence based whole-school programmes, group work, drop-in session's and one to one support. Examples include, PATHS, Thrive, Nurtured Heart Approach, Young Mental Health Champions, Early Action and Time For You. The Healthy Schools Programme has been effective, well regarded and embraced by most schools within the county, but changes to this offer are yet to be fully understood. However, the information on the services and support available to universal settings, in particular schools, can be inconsistent and sporadic with little sense of what the common core offer is. There are many programmes and initiatives that schools can 'buy in', but there is a lack of understanding of how they all fit together and who should provide and pay for such services. Organisations can find it hard to get into and engage schools, but sometimes the expectations on schools can be unrealistic and their capacity can be limited. Communication in this area can be poor and insufficient. As a result conflicting messages and duplication can give the impression that services are not joined up or collaborative. Schools and other universal settings are unsure of referral routes and where they can access	

support and advice. Due to the changes in the governance of schools, e.g. academies, local authority influence over the way in which school's meet the emotional well-being needs of its pupils has reduced and there is a need to adapt our approach to working with schools.

There is a wide variety of training available across the multi-agency partnership, which is well regarded, and the offer is flexible and well equipped to respond to changing demands. This is upskilling the workforce to build more capacity within these settings to identify early signs, deal with emerging issues and escalate when required. This provision, however, is not currently co-ordinated and consistent, and needs to expand to meet demand. The training needs to become more mainstream and be part of the core offer of training within universal services. Support and advice for these workforces needs to be co-ordinated and enhanced. There is limited follow up and evaluation of the impact of training and advice.

The majority of the current provision and programmes are aimed at and delivered via schools, and the wider use of other universal settings such as children's centres, early help hubs and community provision has not been fully utilised yet.

2 Young people have told us:

In schools they want better information and emotional wellbeing support that is accessed fast and is non-stigmatising

They would like more places to access support where mental health is one of a range of services provided, such as one stop shops. This should include 'virtual' one stop shops that provide outreach across the county.

Services need to be open when young people actually want to access them i.e. including outside of school and college hours

Self-referral is important and should be available for all services

It would be good to have peer support that assists you to navigate your way to the right person to help

They want access to activities which reduce isolation

That they are concerned about exam stress and anxiety.

3 We intend to:

1. Ensure every school and universal setting has a named 'lead' within its establishment with identified time for emotional well-being and mental health. We will work with schools and other universal settings to define this role and expectations, but this role will include providing information, support and the referral point within the setting. These leads will receive an enhanced level of training to ensure a minimum level of understanding and delivery.

   In return, we will provide each setting with access to a 'link work' function, which will be locally based and will be specific role to support emotional well-being and mental health in universal settings. This specialist function will champion the mental health services available, ensuring settings are enabled to access them in a timely and appropriate manner via the correct pathways and referral routes. They will facilitate local networks of support, share practice and ensure joined up working with other early help services such as school nurses, safer schools, healthy child programme, EPSS and the early help hubs. This function will also add capacity to the system so that practitioners can have regular consultation and supervision by specialist mental health practitioners, and where possible have specialist provision take place in universal settings.

   Working closely with service providers we will develop peer to peer approaches and look at how we develop one to one support and small group work in all settings. We want to create a sense of offer, set clear guidance and create a menu of services for universal settings. This will set out what they are entitled to receive from the statutory services and other services we endorse that are available to them, including those that charge.

2. Provide a core training offer for practitioners in universal settings that is co-ordinated centrally and includes evidence based emotional literacy and attachment training programmes, this could include PATHS, circle of security, Nurtured Heart Approach, Time 4 You, Thrive and Youth Aware of Mental Health (YAM). The offer will be reviewed and endorsed by the CAMHS strategic partnership. This offer will align with other strategies and complementary provision such as the parenting strategy and health child programme to ensure the offer does not duplicate effort and give mixed messages. This function will include the follow up on the impact of training on practice and evaluation of the outcomes being met.

3. Endorse the Time to Change anti-stigma campaign and develop a local action plan for Norfolk. This will ensure that children and young people have been involved in its design and delivery.

4 This will mean:
We will accelerate the pace of developing whole school approaches to promoting emotional well-being and mental health. Improved communication, referrals and access to support through named points of contacts, ensuring support and services are delivered in a timely manner. Our frontline workforce will be better equipped to build resilience within children and young people to cope with emotions and respond to emerging issues and support those who need help. They will be able to identify those who need more specialist help and to access support and intervention at the earliest point. Emotional well-being and mental health is fully embedded and integrated into Norfolk's Early Help offer and will endorse the 'no wrong door' approach. Norfolk's Early Help offer aims to address issues before or as soon as they become apparent. Early help is about engaging with children, young people, their families and communities at the first point of need and maximising opportunities for them to achieve their potential without the need for long term support or intervention. Our transformation plan will complement and deliver against priority actions and objectives set out in the CAMHS Strategies for Norfolk and Suffolk, Norfolk's Joint Health and Wellbeing Strategy 2014-2017, Children's Services' Emotional Well-being and Mental Health Strategy and out Early Help Strategy 2015-2016.

5 This will be resourced by:

New Funding and Anticipated 2015/16 Slippage

CCG	National Recurrent Funding Allocation	2015/16 Slippage based on 8 months unspent
West Norfolk	£36,800	£24,533
Great Yarmouth and Waveney	£49,000	£32,667
North Norfolk	£34,400	£22,933
South Norfolk	£41,800	£27,867
Norwich	£38,000	£25,333
TOTAL	**£200,000**	**£133,333**

Proposal	Cost
Develop a 'link work' function and add capacity to support emotional well-being and mental health in universal settings. Further consultation and service design is required before a final delivery model is agreed and implemented, e.g. who is best place to deliver the services.	£200,000

Slippage Proposals	Costs
Core train offer and co-ordination	£50,000
Anti-Stigma Campaign	£10,000
Slippage allocated to Norfolk Infant Attachment Project (NIAP) – part funding the Project for one Quarter to sustain provision until new national Perinatal Infant Mental Health recurrent funding is made available (expected April 2016)	£73,333
Total	**£133,333**

Note: Some of the allocations in the accessibility section links will also strengthen support to universal settings.

6 The risks and opportunities are:
• The main risk is that we may create another layer to the already complex system and referral routes within early help and universal settings. There is a risk that we could end up creating a signposting service for these settings and this would not meet the outcomes we want it to. We will need to ensure that we use the funding to create extra capacity within these settings to provide prevention and resilience, and they have the skills to deal with emerging issues and concerns. • With the recent development of the Early Help Hubs in Norfolk, there is an opportunity to link in with this multi-agency working and ensure that emotional wellbeing and mental health is fully embedded and integrated in the hubs offer.
7 The key milestones will be:
By end of 2015 - Following an options appraisal and consultation, agree on how best to deliver the link work function - Establishment of a 'common offer' and guidance for all settings By April 2016 - Every universal setting has a named lead or contact point for emotional well-being and mental health - Workforce training plan is set up and being delivered - Refresh our involvement pledge - Launch anti-stigma campaign
8 We will measure success by:
Early Help Outcome: Children and Young People are Healthy and Resilient Outcome Measure: Maximise the emotional wellbeing of children and young people. Impact could be measured by the following outputs: • Number of settings that have a named lead

- Requests for support are dealt with in a timely manner
- A minimum volume or % of intervention/treatment sessions are delivered in universal settings
- Annual audit/evaluation activity to assess impact of training, consultation and support
- A minimum no of training/group consultation sessions attended by range (and minimum number) of practitioners
- Increased positive perception of emotional wellbeing and mental health by children and young people
- Increase in the number of practitioners feeling equipped to support children's and young people's emotional well-being
- Reduction in the number or percentage of inappropriate referrals made to specialist and targeted CAMH Services

Priority Area	**Accessibility**
Key Partners	Targeted and Specialist providers of mental health services Universal and non-mental health settings

1 Our self-assessment tells us

1. Referrals to Targeted and Specialist mental health teams for 0-18 yr olds are increasing significantly with particular pressure points applying to the
    a. Specialist Eating Disorder services (see the ED section of the Plan for details)
    b. Existing Targeted and Specialist CAMHS in Norfolk (see needs assessment section)
    c. ADHD pathway in Norfolk and Waveney, where a number of children are having to wait in excess of the 18 week waiting time standard. The ADHD pathways for Norfolk and Waveney are in need of a review, with an improved, faster, more fully integrated pathway being the goal. Presently there are differential age thresholds that apply in West Norfolk compared to the rest of Norfolk. Norfolk also as a higher than average proportion of children on ADHD prescribed medication.

2. Only around a quarter of those with a diagnosable mental health problem actually access support and treatment from mental health teams

3. The capacity and skill of the workforce to cope with demand is stretched
    a. Recruitment of qualified staff is a significant challenge, only set to escalate in the short term as most of England's CAMHS compete to recruit with the newly allocated funding
    b. There are no in-house training places in organisational structures for 'junior' staff (those wishing to get into the profession, but without the core qualifications)
    c. There are a number of teams of staff in Norfolk whose work is/should be complementary, but do not work together routinely as an integrated system or 'team around a child'

4. Finding out how to get advice, support or treatment is hard for children, young people, families, and partner agencies. There are several 'Single Points of Contact' which causes confusion and delay and can lead to dis-engagement at a key stage of pathways

5. Very limited use of modern technology (the web, electronic self-help software, apps, therapy on line, etc) is made to reach, engage and support children and young people and others concerned about mental health

6. We do not record, report and review rigorously how well our system meets the needs of groups with protected characteristics and other particular needs that may make them more vulnerable to mental health problems.

7. There is very limited targeted and specialist capacity built into the Norfolk system to assess and treat:

    a. the mental health needs of children and young people on the edge of care and those who are looked after or adopted

    b. the mental health needs of looked after children being considered for reunification with their family

    c. children and young people who have been affected by domestic abuse, sexual exploitation (or at risk of) and trauma

    d. the particular needs of children and young people who display sexually inappropriate or harmful behaviours

    We have the (1 year) DfE funded Compass Outreach project (a partnership project involving Norfolk & Suffolk Foundation Trust and The Benjamin Foundation) delivering training, consultation and supervision to foster carers and those caring for children on the edge of care, in combination with the existing (recurrently funded) Compass Centre Schools. The Compass Centre Schools provide a therapy and education for vulnerable children with behavioural and mental health issues. Norfolk County Council has teams that work therapeutically with vulnerable children, including the Child & Family Therapeutic Team. Norfolk County Council has introduced a specialist offer for some children with sexually inappropriate behaviour within its residential settings. The Norfolk Youth Offending Team delivers a small Sexually Appropriate Behaviour Service. Norfolk Domestic Violence and Abuse (DVA) needs assessment (Dec 2014) indicated both the range and level of impact that DVA has on children's mental health and highlighted the limited service offer to those children affected by DVA. Norfolk is keen to ensure it has robust provision in place to support those at risk of and those who have been subjected to sexual exploitation. There is scope to better align and integrate existing provision, and potential to boost capacity via the funding attached to the Local Transformation Plan.

8. The routine opening hours of Specialist CAMHS are not adequate and flexible enough – currently 9am-5pm, Mon-Fri

2 Young people have told us they want
• One stop shops where mental health is one of a range of services provided, including 'virtual' one stop shops that provide outreach across the county • Services to be open when young people actually want to access them, i.e. including outside of school and college hours • Alternatives to hospital, such as outreach, youth focused crisis team, crisis houses • To be protected from abuse and harm
3 We intend to
1. Simplify the routes for those needing advice and help by moving to a genuine Single Point of Contact for requests for help, advice and referrals 2. Ensure prevention and early intervention are always prioritised 3. Proactively target, reach & engage those that would benefit from engagement but who currently remain off the radar, by increasing the visibility, accessibility and capacity of targeted and specialist services 4. Invest recurrently in establishing and developing a unified, safe range of online support and treatment options for children, young people and families 5. Prevent unaddressed need presenting itself as a more significant demand later in the person's life 6. Reach the unreached (¾ of the population with diagnosable mental health problems, who never receive treatment), while coping with the extra demand that would place on the system. 7. Improve the skills of staff in non-specialist mental health settings to identify, recognise, source and/or provide effective mental health support for children and young people

a. Improve the skills of designated lead staff within universal settings to meet the early intervention needs of some children and young people
b. Improve the understanding and skills of the workforce in universal settings with regard emotional wellbeing of children and young people

8. Commission a re-modelled, integrated workforce with sufficient numbers of staff and skills to manage the number of children and young people who need help, including those from vulnerable or hard to reach groups

9. Commission additional targeted and specialist capacity, including better aligning and boosting existing capacity built into the Norfolk and Waveney system to assess and treat:
    a. the mental health needs of children and young people on the edge of care and those who are looked after or adopted
    b. the mental health needs of looked after children being considered for reunification with their family
    c. children and young people who have been affected by domestic abuse, sexual exploitation (or at risk of) and trauma
    d. the particular needs of children and young people who display sexually inappropriate or harmful behaviours

9. Audit existing targeted and specialist CAMH pathways to identify any 'reasonable adjustments' required to enable particular groups of children and young people to access the interventions they need (for example young carers)

10. Ensure that client/patient/family views feedback is captured, reported and reviewed robustly and regularly via CYP IAPT and implementation of reporting against the CAMHS National Minimum Dataset – with audit activity incorporated to focus on the experience of vulnerable groups

11. Extend the hours when core Specialist Mental Health services are open and able to deliver routine appointments

4 This will mean

1. Introducing a genuine Single Point of Contact in Norfolk (via telephone and on line) for advice, support and referrals, covering either:

    a. As a minimum, Norfolk's main county wide Targeted and Specialist mental health services (Point 1 and Norfolk & Suffolk Foundation NHS Trust), OR

b. A wider variety of services for children and young people in Norfolk, including but not limited to mental health teams – potentially all services other than frontline Child Protection teams

   Commissioners would prefer the above to be developed and delivered by providers. If, however, agreement is not reached between providers on a preferred model by December 2015, commissioners will implement a solution via the commissioning and/or procurement route.

2. Encouraging services to align and integrate their practice and (where appropriate) to co-locate staff or functions

3. A communication plan to widely promote the mental health 'offer' to children & young people, their families/carers, and those who provide universal services to them

4. Commissioning an online 'platform' and a range of online self-help software, apps, therapy on line are accessed to engage, support and treat children and young people, and continuing to invest heavily in Norfolk's online offer as a key way of increasing the reach of our services

5. An increase in the capacity of core targeted and specialist services and a better join up of existing provision to manage
   a. the waiting times for the ADHD pathway in Norfolk and Waveney
   b. the anticipated continued increase in 'routine' referrals to targeted and specialist CAMHS
   c. the mental health needs of children and young people on the edge of care and those who are looked after or adopted
   d. the mental health needs of looked after children being considered for reunification with their family
   e. children and young people who have been affected by domestic abuse, sexual exploitation (or at risk of) and trauma
   f. the particular needs of children and young people who display sexually inappropriate or harmful behaviours

6. Establishment of a training programme for new or 'junior post holders in targeted and specialist CAMHS – up to IAPT practitioner level

7. A rolling programme of training and group consultation for all those in non-specialist mental health settings, including universal settings (as set out in the Early Help & Prevention section of the Plan)

8. Re-modelling of the specialist and targeted mental health workforce to address the need to gain maximum value for money - addressing the difficulties in recruiting qualified staff, introducing formal training posts and adding to specific outreach roles for professionals to target and engage hard to reach/vulnerable groups gain maximum value for money

9. Making good use of the new national Mental Health Services Dataset (MHSD), using it to analyse how accessible our services are for key groups of children, including those with protected characteristics and other vulnerable groups, such as young carers. Using such data to inform continuous service improvement

10. Producing and implementing a Norfolk-wide audit schedule to regularly review key pathways that are dependent on an effective joint or inter-agency response

11. Extension of the opening hours of Specialist CAMHS (as set out and costed in the Crisis Pathways section of this Plan)

12. Build on the work of existing Centres and the developing Early Help Hubs to ensure one-stop-shops are rooted in the local communities

5 This will be resourced by

	Proposal	**Cost**
	Recurrent cost of online 'platform' and a range of online self-help software, apps, therapy online	£100,000
	An increase in the capacity of the countywide targeted CAMHS to manage the anticipated continued increase in 'routine' referrals to targeted CAMHS ○ 6 WTE new Posts added to the Point 1 Service	£241,696
	An increase in the capacity of the ADHD pathways in Norfolk and Waveney	£28,075
	An increase in the capacity of core targeted and specialist CAMHS to manage • the mental health needs of children and young people on the edge of care and those who are looked after or adopted • the mental health needs of looked after children being considered for reunification with their family • children and young people who have been affected by domestic abuse, sexual exploitation (or at risk of) and trauma • the needs of children and young people who display sexually inappropriate or harmful behaviours Option appraisal to be conducted by commissioners to agree the most cost effective investment strategy	£150,000
	Total	**£519,771**

New Funding and Anticipated 2015/16 Slippage

CCG	National Recurrent Funding Allocation	2015/16 Slippage based on 8 months unspent
West Norfolk	£95,639	£63,759
Great Yarmouth and Waveney	£127,344	£84,896
North Norfolk	£89,401	£59,600
South Norfolk	£108,631	£72,421
Norwich	£98,756	£65,838
TOTAL	**£519,771**	**£346,514**

	Slippage Proposals	
	High profile recruitment campaign for Norfolk's new posts in Targeted and Specialist services	£10,000
	Commissioning new online platform and initial set of functions/apps	£100,000
	Training programme for new or 'junior' post holders in targeted and specialist CAMHS	£50,000
	Additional staff hours for Targeted and Specialist services to reduce waiting times to a minimum	£100,000
	Total	**£260,000**
	Remaining Slippage allocated to Norfolk Infant Attachment Project (NIAP) – part funding the Project for one Quarter to sustain provision until new national Perinatal Infant Mental Health recurrent funding is made available (expected April 2016)	£66,667[2]
	Allocated to crisis pathway to make up its slippage proposals	£19,797

[2] NIAP is a 12 month pilot project funded by Dept of Communities and Local Government, working intensively with 0-2 yr olds on the edge of coming into Care, with the aim of improving the attachment with primary care giver, and avoiding cases coming into the Care system. NIAP costs £156k per Quarter. NIAP's funding expires in December 2015.

6 The risks and opportunities are

1. That a complex system may not reach consensus over how best to deliver a Single Point of Contact, which would hamper efforts to simplify and improve pathways
2. Gaining the joint approvals required for our mental health providers to be able to operate safely from one online platform to deliver online support may be complex and will require a range of safeguards to be built in
3. Opportunities exist to join up with other mental health services locally (and potentially regionally) to jointly develop and commission some of the online presence – Norfolk Wellbeing Service for example is ahead of us on this matter and is keen to collaborate
4. Recruitment may be difficult as Norfolk will be recruiting at the same time as the rest of England. Opportunities to offer posts at a lower grade, with training and supervision (including via the CYP IAPT Programme) are being actively explored as one way of mitigating the risk
5. Aligning or integrating the work of several teams currently working with vulnerable children will be challenging (on the edge of care, in care, sexually inappropriate behaviours, those affected by domestic violence and abuse), even with additional funding available. However, this presents opportunities to expand the offer for Norfolk's children and young people

7 The key milestones will be

By December 2015	New posts recruited to
By December 2015	Single Point of Contact Option and integration appraisal completed, preferred option proposed to commissioners
By February 2016	If consensus not reached, Commissioners publish their intended commissioning or procurement route to deliver an effective single point of contact and greater integration
By March 2016	Communications Plan produced and signed off
By March 2016	Online Platform and initial set of applications and software commissioned
By March 2016	Training programme for new/junior posts commissioned
By July 2016	Review and remodelling of the specialist and targeted workforce – report completed
By March 2016	Audit schedule for 2016/17 agreed
By December 2016	Single Point of Contact operational (if delivered via providers as a collaborative venture)
By October 2017	Single Point of Contact operational (if delivered via commissioning/procurement route)

8 We will measure success by
A range of KPIs will be developed and implemented. These need to be formally negotiated, but may include: a. A Single Point of Contact is implemented b. Experience of Service Questionnaire indicate clients/patients finding services more accessible c. % of complaints about difficulty accessing services reduces d. A min % of routine appointments take place on line e. a min % of clients make use of apps, self-help, etc f. Usage of the online platform increases year on year for 3 successive years g. 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 h. Workforce remodelled to include 'junior' posts with dedicated training attached i. Audit schedule produced, implemented and improvements made to pathways based on findings

Priority Area	**Eating Disorders** – See also Appendix 1 (Detailed LTP for Eating Disorders) & Appendix 2 (Spreadsheet showing breakdown of current and proposed new staffing for ED pathways)
Key Partners	West Norfolk CCG - Commissioner Great Yarmouth and Waveney CCG - Commissioner Norwich CCG - Commissioner South Norfolk CCG - Commissioner North Norfolk CCG - Commissioner Norfolk and Suffolk Foundation Trust (NSFT) – Current provider

1 Our self-assessment tells us:
CQC and our self-assessment tell us that we are doing a good job on eating disorders (ED) but that our team is very small considering the number of referrals we receive, which like the national average, are increasing year on year. We know that it's a complex system and a large challenge to ensure that services are consistent across Norfolk, but also take into account local arrangements. We also know that because our young people transition to the adult service (provided by another provider) at 18, that this can be a very difficult time for them and that it needs to be a robust and inclusive process. We also know that due to the size of the team we can only provide services to very sick children and young people and that we don't have the capacity to work on early intervention services which would help with chances of recovery and reduction in relapse.
2 Young people have told us (as detailed on our 'Vision for Children and Young People's Emotional Wellbeing and Mental Health Services')
Young people have told us they'd like more support in schools. They also told us they'd like to self-refer. They would like peer workers. Another thing young people have identified is access to alternatives to hospital.
3 We intend to:
We intend to meet the waiting times guidelines as quickly as possible and to do this we plan to:

Increase the size of our teams that work across the county so they can safely handle the number of referrals they receive. This will also enable them to provide earlier intervention, and liaise and support lots of different referrers including schools and GPs.

We want to move to community settings for as much work as possible and to work towards this being an alternative to hospital settings.

We want to improve our online presence so that there is a lot more support available to referrers, parents and carers as well as the children and young people themselves. We want this to include the ability for young people to self-refer and have an interface to communicate that they are comfortable using and that gives them confidence to get in touch. We want to promote the improved online presence to schools.

In less than two years our adult ED service is up for re-tender and we want to take the opportunity to see whether we need restructure the entire ED service to provide a more robust and transition neutral system that benefits all patients. For example, in the Gt Yarmouth & Waveney area an all age eating disorder service is currently offered. We will want to consider whether this is the way we would like to support people with eating disorders across the whole of Norfolk and Waveney, or if a different model might work better.

We plan to gather data in line with the MHSDS and have factored this in to our structures.

We also plan to train staff in NICE recommended therapies via CYP IAPT or other accredited providers.

We want to continue our peer based support during transitions and also introduce parent support workers.

4 This will mean:

We need to recruit more staff.

We need to start gathering information that fulfils the MHSDS.

We need to start planning for community based services.

We need to improve our online presence.

We need to recruit parent support workers.

We need to plan for how we provide services to all ages and how this impacts on the 0-18yr old age group.

We need to identify and recruit staff who are keen to attend the CYP IAPT training.

We need to look at our partners in the voluntary sector, and consider the added value they add now, or could add in the future.

5 This will be resourced by:

At the present time CCGs have made an emergency funding decision to provide £184k to the ED service to enable recruitment to take place. This will be repaid out of the national funding.

Table 1: National funding allocations by CCG

NHS Great Yarmouth and Waveney CCG	£133,363
NHS North Norfolk CCG	£93,740
NHS Norwich CCG	£103,167
NHS South Norfolk CCG	£113,563
NHS West Norfolk CCG	£99,800
TOTAL	**£543,633**

Table 2: Funding recalculated to consider emergency funding provided by Central CCGs

Emergency funding allocated by the central CCGs (North, South, Norwich) for the central ED team	£184,000
Central CCGs national funding allocation	£310,470
Central CCGs national funding allocation minus emergency funding	**£126,470**

Table 3: Rebalanced national funding

NHS Great Yarmouth and Waveney CCG	£133,363
NHS West Norfolk CCG	£99,800
Central CCGs	£126,470
TOTAL	**£359,633**

This entire allocation will be used to recruit and retain staff over the 5 year period of national funding. The slippage as shown below, will be used for training, improving the web presence, parent support workers. The planning for ED provision once the adults contract ends will be cost neutral, as will any community based service planning.

Table 4: slippage

CCG	**ED National Funding Allocation**	**Slippage based on 8 mths unspent**
West Norfolk	£99,800	£66,533
Great Yarmouth and Waveney	£133,363	£88,909
North Norfolk	£93,740	£62,494
South Norfolk	£113,563	£75,708
Norwich	£103,167	£68,778
TOTAL	**£543,633**	**£362,422**

6 The risks and opportunities are:
The risks are: • Admissions will continue to rise without a robust service to treat them • Only the riskiest cases will be prioritised leaving others to potentially deteriorate before they receive a treatment plan • Referrers will be left unsupported • There will be no online presence for referrers, parents and young people • We won't be able to fulfil any of the things that children and young people have asked for • Transition to adult services will remain risky and difficult • We won't be able to provide community based services By funding these changes to our existing service we can begin to provide enhanced services that children and young people have told us they want to see and use. We can provide a robust service that supports children, young people, their families, referrers, and enables them to approach us in ways they find comfortable. This funding would enable us to move services to the community to help facilitate a better environment for people to receive their treatment and recover. We would be able to significantly transform ED services to provide what our users have told us they want to see, and what national guidance is stating is best practice.
7 The key milestones will be:
• Meeting the waiting times guidelines. • Providing community based treatment. • Having a clear, all-inclusive website that covers CAMHS and ED services in Norfolk regardless of who provides them. • A robust and well-staffed ED service. • Peer support to children and young people, and parents and families. • Training our staff in NICE approved therapies.

8 We will measure success by:
• Reporting on the waiting times targets. • Reporting on the MHSDS. • Involving young people and their families in how we design our services. • Asking young people and their families to tell us what they think about the services they received and their personal wellbeing and recovery. • Seeing how many people use our new online services to contact us.

Priority Area	**Crisis Pathways -** see also Appendix 3 (Detailed LTP for Crisis Pathways)
Key Partners	West Norfolk CCG Great Yarmouth and Waveney CCG Norwich CCG South Norfolk CCG North Norfolk CCG Norfolk and Suffolk Foundation Trust (NSFT) NHS England Norfolk Community Health and Care

1 Our self-assessment tells us:

1. Specialist assessment and support of children and young people in crisis in Norfolk and Waveney is very limited.
2. There is a growing number of children and young people who experience a mental crisis that needs specialist assessment and support.
3. Out of hours staff availability is inadequate to meet the growing need.
4. It is a considerable challenge to ensure that services are consistent across Norfolk.
5. A clear shortfall in the current Crisis Pathway is the absence of adequate places of safety when a young person is experiencing Crisis.
6. We also know that due to the limited service offer, there are cases that deteriorate unnecessarily due to not having their needs met in a timely fashion.
7. Finding out how to get advice, support or treatment is hard for children, young people, families, and partner agencies. There are several 'Single Points of Contact' which causes confusion and delay and can lead to dis-engagement at a key stage of pathways
8. There is a very clear need for the pathway to accessing crisis services, to be simplified.
9. There is also a very urgent need for access to specialist inpatient CAMHS beds to be improved as the current waiting period can contribute to escalating cases, a number of whom have to be contained in inappropriate settings.
10. There is a need for an agreed transport protocol, to provide transport both to and from inpatient provision.

2 Young people and community service providers have told us:

- Some early opportunities to receive help missed as young people saw the specialist school based provision as 'closed' to them. They wanted an opportunity to talk but it was never seen as available for them.
- More needs to be done to ensure that 'School based/funded social emotional provision' can be perceived as prioritising pupil needs over the impact on improving the school.
- A serious lack of capacity to meet young people's mental health needs when in crisis in the community
- A lack of empathy sometimes when presenting to professionals and specialist services in the community.
- Dismissal of some children and young people when they make efforts to communicate their concerns about their mental health
- Help line operators sometimes hanging up, responses giving a message to young people that their mental health needs are not serious/important.
- Waiting times sometimes allow mental health symptoms and states to escalate.
- Often scheduled appointments are not reflective of young people's preferences, nor their level of need
    - They also told us they'd like to self-refer.
- Capacity limited one community Crisis Team to provision for exclusively over 18 year olds
- Some providers were not aware of the existing Out of Hours crisis pathway.
- Increase in call outs (ambulance) where mental health presentation is the primary concern, with mental health call outs taking the longest to deal with. Frequently, a mental health related call out does not in fact require input from the ambulance service.
- There was a perceived need for enhanced mental health training to meet the increased prevalence of mental health related call outs.
- There was an overwhelming desire for increased crisis services to be available in the community specifically.
- Frequently mental health call outs turn out to be to young people who have very recently been discharged from specialist services. Often crises follow withdrawal of services.
- More information is required when responding to mental health call outs
- Strong belief that A+E is the only first point of contact for mental health crises Out of Hours

3 We intend to:
1. Extend the emergency and Out of Hours offer/availability of CAMHS and LD CAMHS Crisis services. 2. Extending the core hours of specialist CAMHS to enable more children and young people to access them at times that are convenient to them 3. Increase the size and capacity of our teams that work across the county so they can safely handle the number of crisis referrals they receive. This will also enable them to intervene earlier, and liaise and support lots of different referrers including acute general hospitals, the police, schools, GPs and general community. 4. We want to improve our online presence/availability so that there is a lot more support available to referrers, parents and carers as well as the children and young people themselves. 5. We plan to more routinely gather data to more accurately monitor the age, presentation type and time to feedback into more accurate service provision for Children and Young People. 6. We intend to offer a rolling programme of training to enhance the versatility of the skill set of staff who act as 'first responders' to a young person in crisis 7. Our aim is to speed up more wide reaching information sharing. 8. The plan will endeavour to work more closely with acute trusts to ensure more tailored and timely transition in and out inpatient beds.
4 This will mean:
1. We need to build a service which offers reliability and availability that builds faith in our ability to offer a service that comprehensively meets service users' needs. 2. Extending the core hours of specialist CAMHS from the current 9am-5pm, Mon-Fri, to 8am-8pm Mon-Fri, with additional dedicated routine treatment slots over the weekend. 3. 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. 4. Establishment of a Bank of staff who can be deployed at short notice by either specialist CAMHS or specialist LD CAMHS staff following an assessment.

5. Increasing the proportion of Approved Mental Health Practitioners on the rota who come from a child and family speciality (almost all existing AMHPs come from an adult speciality).

6. Funding a proportionate amount of the revenue required to sustain the Integrated Mental Health Team in the Police Control Room.

7. Allocation of non-recurrent slippage to fund provision of an alternative 'place of safety' to Acute General Hospitals for those cases who need it.

8. Delivery of a rolling programme of training and consultation to 'first responders,' General Hospital ward staff and others who respond to cases that present in crisis.

9. Revising transition protocols in Norfolk to ensure that arrangements are planned in advance for those clients/patients approaching 18 for whom it is predicted there may be ongoing concerns and potential further crises.

10. Establish robust collaborative commissioning arrangements with NHS England for patients requiring inpatient specialist CAMHS bed.

11. Production of a Norfolk-wide agreed Transport Protocol setting out clearly the procedure to promptly source patient transport without delay for patients in crisis, and how the lead agency can seek reimbursement from the responsible commissioning CCG. A cost neutral development.

12. Continuing to find ways of enabling teams to work in an integrated, joined up fashion sharing information, assessment and intervention work as appropriate unhindered by unnecessary organisational boundaries.

13. We need to improve our online presence. Commissioning of a range of web and mobile phone app based routes for known service users to make use of self-help, peer and professional support both in and out of hours.

5 This will be resourced by:

	Proposal	**Cost**
	Extension of Core Hours for each of the 3 Specialist CAMHS Teams – Admin cover for Mon-Fri 8am-8pm, Sat 9am-1pm, Sun 9am-1pm, B/H 9am-1pm x 3 WTE Band 3 staff Extension of Core Hours for each Team – Clinical provision for Sat 9am-1pm, Sun 9am-1pm, B/H 9am-1pm in each of the 3 Areas X 3 WTE Band 6 staff	£105k £122k
	Increased capacity of Intensive Support Team workforce X 1.5 WTE Band 4 staff	£49k
	Out of Hours Crisis Assessments – on call from 5pm-9am, 7 days per week (45 hours per week of Band 7 staff – 15 hours per team/locality)	£150k
	Trainer/Adviser for Ambulance, Police, Hospitals, Social Care & Bank staff -0.5 WTE Band 6	£30k
	Recurrent cost of new Crisis Intervention Bank	£155k
	Integrated Mental Health Team – recurrent cost of CAMHS capacity at the Police Control Room	£30k
	Total	**£641k**

Breakdown of funding by CCG	
CCG	**Cost**
West Norfolk	£117,944
South Norfolk	£133,969
Norwich	£121,790
North Norfolk	£110,252
Great Yarmouth and Waveney	£157,045
TOTAL	**£641,000**

Slippage Proposals	
Recruitment and Training of new Bank Staff	£26,330
First Responder E learning module commissioned for those staff unable to attend face to face training	£30,000
Securing and equipping premises for crisis staff to operate out that also has capacity to act as an alternative 'place of safety' to Acute General Hospitals	£300,000
Reimbursement of CCGs funding specialist CAMHS inpatient beds and Agency staff to support patients in crisis, when NHS England is unable to source specialist inpatient beds	£90,800
TOTAL	**£447,130**[3]

[3] £19,797 'shortfall' to be made up from slippage associated with the Accessibility section of the Local Transformation Plan. See overall summary table for details.

6 The risks and opportunities are:

1. The lack of skills and understanding of first responders regarding the existing crisis pathways means it is likely that children and young people receive inappropriate care and may not have their needs met – with needs either being inappropriately escalated or de-escalated. The planned rolling programme of training and increase in specialist staff able to assess and intervene will address this.
2. Limited capacity to work with acute trusts to manage increasing cases admitted to acute wards. The planned increase in specialist staff and the 'Bank' staff will address this.
3. Recruiting to the new specialist roles could be challenging, as Norfolk & Waveney will be competing for qualified staff with services from across England. Offering some posts with in built on the job support and access to accredited training could help to mitigate this risk.
4. Unless collaborative commissioning arrangements with NHS England (Specialist Commissioning) improve, access to specialist inpatient CAMHS beds may not improve.

7 The key milestones will be:

By December 2015	New posts recruited to in specialist services
By December 2015	• Recruitment and training begins of bank staff roles with a responsibility to provide intensive support to CAMHS & LD CAMHS crisis cases following a specialist assessment. • Internal staffing role review completed to ensure Band 7 roles operating to deliver out of Hours Crisis Assessments – on call from 5pm-9am, 7 days per week (45 hours per week of Band 6 staff – 15 hours per team/locality) – operational **from Jan 2016**
By February 2016	• Liaison and Joint Working arrangements/protocols in place for crisis cases who present via CAMHS, LD CAMHS, Local Authority, Emergency Duty Team, Police and the Liaison and Diversion Scheme.

By March 2016	• First Responder E-learning module commissioned • Revised Crisis Pathway (in and out of hours) published and widely promoted • Revision of transition protocols begins (for CAMHS crisis cases approaching adult services in Norfolk). Revised protocol/s published • Robust collaborative planning structure put in place between NHS England, local CCGs, the Local Authority and other agencies re. pathways for patients needing inpatient specialist CAMHS beds ○ Agreement reached regarding new standards (including waiting times) to be added to the pathway, e.g. no patient will wait more than x hours/days from referral to being admitted to the inpatient unit
During 2016/17	• Funds committed to sustain the Integrated Mental Health Team in the Police Control Room • Audit/Evaluation project report completed and revisions to new provision made to adapt to changing patterns of need and to meet KPIs • Production of a Norfolk-wide agreed Transport Protocol to promptly source patient transport without delay for patients in crisis ○ Decision made on how the lead agency can seek reimbursement from the responsible commissioning CCG to finance prompt, crisis patient transport. • Establishment of a process/system to be embed a day to day, modified Care Programme Approach (CPA) practice. • Impact of improvements to the collaborative commissioning arrangements re. inpatient pathways audited and further modifications agreed • Bank of staff who can be deployed at short notice by either specialist CAMHS or specialist LD CAMHS staff becomes fully operational • Ongoing commissioning development of a range of web and mobile phone app based routes to support clients/patients at risk of or in crisis and to enable them to seek help • Full delivery of rolling programme of training and consultation to 'first responders,' to include acute hospital staff, police, social care, ambulance staff, community/voluntary agencies, Primary Care. • First Responder E-learning module active, widely promoted and reviewed
By February 2017	12 Month monitoring research conducted.

8 We will measure success by:
A range of KPIs will be developed and implemented. These need to be formally negotiated, but may include: a. A minimum of 10% of routine treatment sessions to be delivered outside of these hours/days. b. A specialist CAMHS practitioner to attend 90% of calls for an assessment of a patient in crisis within 1 hour of the request being received and 100% within 2 hours (5% tolerance for exceptional circumstances) c. Annual audit re. the awareness levels of the Out of Hours pathway among first responders d. A minimum of 10 training sessions per year in West Norfolk, 10 sessions per year in Gt Yarmouth and Waveney and 15 per year in Central Norfolk e. A minimum of 10 group case consultation sessions per Acute General Hospital per year, including those wards providing support to Eating Disorders patients needing re-feeding f. Delivery of induction and ongoing training, group consultation and supervision to staff recruited to the new Bank – a minimum of x sessions per month g. Bank staff to be mobilised and providing intensive support within 2 hours of a request being received by the Bank h. Bank staff are paid to receive (at least monthly) specialist training and group supervision from a combination of mental health, learning disability and local authority from existing services (delivered 'free') i. Percentage of those who meet the criteria for CPA who receive a multi-disciplinary and social care assessment and care plan, including: • psychiatric, psychological family relationships and social functioning • impact of medication • risk to individual and others • crisis and contingency planning. • clear information for adult services including information about education, training, Social Services • clear agreed time scales for transition

j. A minimum percentage (To be Agreed locally) of those who are 16 & 17 who receive CPA whose details are shared and successfully added to the Norfolk County Council Adult Services held register of cases 'at risk,' identified for joint transition planning.

k. A joint audit of an agreed percentage of such cases to review quality and effectiveness of CPA for this population and to make recommendations to improve pathways.

l. Co-producing the ongoing design and delivery of services with Young People, families and service providers.

m. Asking young people and their families to tell us what they think about the services they received and their personal wellbeing and recovery.

n. Quality concerns and complaints monitoring/review

o. Seeing how many people use our new online services to contact us.

Norfolk Health Overview and Scrutiny Committee

Children's Mental Health Services in Norfolk

2.3 NHS England Specialised Commissioning, responsible for commissioning Tier 4 services, have been asked to provide information as follows:-

1. **The number of tier 4 places currently commissioned for or available to children from Norfolk.**

   NHS England, Midlands and East (East of England) specialised commissioning team is responsible for the children and young people from the east of England irrespective of where they are placed in the country. The east of England specialised commissioning team is also responsible for the quality oversight and all of the T4 units within the patch (hosted).

   There are approximately 1,411 beds nationally across England. Children and young people from Norfolk have access to these, although the units that they are considered for is dependent on each individual's clinical need and risk.

2. **Who are the providers of tier 4 CAMHS for children from Norfolk?**

   As Point 1, children and young people from Norfolk can access the national beds, however there are a wide range of beds within the east of England available to children and young people from Norfolk.
   More locally to Norfolk:

   - Partnerships in Care – Ellingham House Hospital (Norfolk) (LD – Low Secure/General - ASD/LD/ADHD specialism) – 24 beds
   - NSFT – 5 Airey Close (Suffolk) (General) – 7 beds
   - Huntercombe Hospital, Norwich (PICU/Low Secure) – 26 beds
   - Cambian (Wisbech) (General) – 13 beds
   - Cambridge and Peterborough NHS FT – Darwin (General) – 12 beds
     - The Croft (Child and Family Centre) – 8 beds
     - Phoenix (Eating Disorder) – 12 beds

3. **The number of tier 4 places currently commissioned within the county of Norfolk**

   As Point 2.

4. **The numbers of children from Norfolk who have been placed in a tier 4 bed outside of Norfolk in the past year**

55 children and young people from Norfolk were admitted to T4 services within the past year. Out of the 55, only 5 were admitted out of region (out of the east of England).

5. **The most distant location in which a child from Norfolk has been placed in the past year**

   In miles:
   - West Norfolk – 98
   - North Norfolk -133
   - Norwich - 137
   - South Norfolk – 101

6. **Waiting times for tier 4 treatment**

   This information would be held by T3 teams.

   Note – the Tier 3 commissioners and Norfolk and Suffolk NHS Foundation Trust have advised that the waiting time for a Tier 4 bed can be between an hour and 5 days, depending on the bed situation and type of bed required.

7. **Feedback received on tier 4 service within the past year (e.g. complaint trends)**

   - Environment-related issues
   - Some parents have commented on the distance to travel
   - Models of care issues raised by community services
   - Parents and decision making
   - Parents anxiety about the child returning to community services
   - Young people concerned at point of discharge about the 'wrap around' care available
   - Interface with social care colleagues regarding plans to support the discharge process

8. **Any planned developments for tier 4 CAHMS, or any other info of which they think the committee should be informed.**

   - National Tier 4 Procurement – NHS England completed a 1st stage procurement exercise in 2014. NHS England is now planning to go out to formal national procurement of CAMHS T4 services in 2016

   - Collaborative Commissioning – NHS England and local CCGs have developed a collaborative commissioning oversight group, with one of the agenda items specifically focussing on CAMHS. A separate group has been established to consider collaborative working going forward

   - CYP-IAPT – Work is underway nationally to identify how this goal-based therapeutic intervention can be introduced into T4 services

   - Transformation Plans – CCGs have recently developed and submitted their local Plans which identify areas for development across the CAMHS

tiers. The Plans included the input from specialised commissioning teams and regional teams as part of development and agreement.

Stroke Services in Norfolk

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

The Norfolk and Waveney Stroke Network will update the committee on developments in stroke services following the recommendations made by Norfolk Health Overview and Scrutiny Committee in July 2014.

1. Background

1.1 On 17 July 2014 Norfolk Health Overview and Scrutiny Committee (NHOSC) approved a report by its Stroke Services in Norfolk Task and Finish group with 21 recommendations for organisations involved in local stroke care.

1.2 The Norfolk and Waveney Stroke Network (the Network) undertook to co-ordinate responses to NHOSC from each of the organisations concerned and presented a report in November 2014. The committee's recommendations were all accepted or partially accepted and the Network explained the action that had already been taken in respect of each of them.

1.3 The Network was asked to return in a year's time to update the committee on the progress made in all areas of stroke care.

2. Purpose of today's meeting

2.1 The Network's progress report, drawing together updates from all the organisations to which NHOSC originally made recommendations, is attached at **Appendix A**. Public Health, Norfolk County Council and the Norfolk and Waveney Stroke Network's 'Review of Stroke Rehabilitation in the Community' is attached at **Appendix B.** This review was undertaken at NHOSC's recommendation. The Appendices to the review are not included with these papers but are available on request from the Democratic Support and Scrutiny Team Manager:-
Appendix 1 – National Guidance
Appendix 2 – 2015 SSNAP Post-acute Organisational Audit – Phase 1: Post-acute stroke service commissioning audit
Appendix 3 – Stroke Rehabilitation – Provider Questionnaire
Appendix 4 – Literature Search terms for BNI, Medicine and CINAHL

2.2 Representatives from the Network will attend today's meeting and members will have the opportunity to discuss progress with stroke services.

3. Suggested approach

3.1 After the Network representatives have presented the update report NHOSC may wish to discuss developments in stroke services, particularly in the following areas:-

(a) The Norfolk and Waveney Stroke Network was newly established when the NHOSC task and finish group was conducting its review of stroke services. Is the Network functioning as expected in terms of engagement with the regional Strategic Network and in its ability to drive the development of local services?

(b) What developments have there been in terms of stroke prevention and what are the current trends in the incidence of stroke in Norfolk?

(c) During discussions with the Chief Executive of the East of England Ambulance Service NHS Trust on 15 October 2015 NHOSC heard his opinion that it would be more useful to measure the time taken to deliver the complete pathway from initial call to thrombolysis rather than measuring the Stroke 60 ambulance target. Is this something that the Network would consider locally?

(d) NHOSC is aware of the current workforce shortages across NHS services. Does the Network consider that the stroke services at the three acute hospitals in Norfolk and in the community are adequately staffed in terms of consultants, specialist nurses and supporting staff (including psychology and the rehabilitative disciplines)?

(e) Following the Review of Stroke Rehabilitation in the Community report, what is likely to change in terms of the specific services commissioned in Great Yarmouth and Waveney, central and west Norfolk?

Norfolk Health Overview and Scrutiny Committee – Stroke Services in Norfolk

Strategic Overview		**To**	**Response in November 2014**	**Updates for December 2015**
1.	The members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county. (Paragraph 2.7)	Norfolk and Waveney Stroke Network	Accepted – The wider strategic clinical network, The Norfolk and Waveney Stroke Network now meets on a regular two month cycle, with dates diarised well in advance. Members of the Norfolk and Waveney Stroke Network already hold key roles within the regional Network. Dr Kneal Metcalf is chair of the East of England Stroke Network and Dr Raj Shekhar is chair of the Telemedicine Subgroup. The standing agenda items for the Norfolk and Waveney Stroke Network will be amended to receive reports from the Strategic Network meetings.	**AUG:** Meetings are ongoing on a two monthly cycle. The local network receives reports from the Strategic Network meetings.
2.	That the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified. (Paragraph 2.7)	Norfolk and Waveney Stroke Network NHS England East Anglia Area Team	Accepted - NHS England East Anglia Area Team has proposed that the Manager of the NHS England East of England Cardiovascular Strategic Clinical Network represent the Area Team on the Norfolk and Waveney Stroke Network. The role of clinical lead for the network will be shared between the three consultants who are members of the Norfolk and Waveney Stroke Network; Dr Kneale Metcalf, Dr Raj Shekhar and Dr Hilary Wyllie.	**AUG:** The Manager has been attending recent meetings and is on the distribution list. The sharing of the clinical lead role has worked well.
Preventative				
3.	That the Norfolk and Waveney Stroke Network	Norfolk and Waveney	Accepted - The Network will consider the Health Needs Assessment at its meeting on the 9th	**AUG:** Public Health has provided data at CCG level. This was shared with all

	takes up the recommendations of the Health Needs Assessment and oversees collective work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke. (Paragraph 3.2)	Stroke Network	December 2014 and will also agree with Public Health a process for accessing additional data sources and reporting these back to the network. Public Health will look for and identify additional data sources and carry out further analysis. Including: • benchmarking acute providers via the royal college of physicians data or Dr Foster or other national tools • highlighting areas of unwarranted variation in secondary prevention at GP practice level • looking at primary prevention services at a GP practice level e.g. stop smoking service provision and take up • Looking at local schemes to reduce salt use. These to be reported at Network meetings in March 2015.	CCG Accountable Officers in May 2015. **OCT**: No responses yet received. CCG members to check with AO's how data has influenced plans, particularly with regard to unexplained variation in secondary prevention. **NOV:** The Network meeting in December (8th), will consider responses from CCG AOs.
4.	That NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies. (Paragraph 3.4)	NHS England East Anglia Area Team	Accepted: The Network will ask for a review of the evidence base for Blood pressure checks in these locations and report on the effectiveness of existing schemes involving community pharmacies. As NHS England is currently restructuring its area teams and is likely to combine East Anglia with Essex and also is developing mechanisms for 'co-commissioning' services with CCG's, it is proposed that collection of evidence and data be completed by February 2015, with agreement on next steps at the Network meeting with NHS England in March 2015. Public Health has a spread-sheet with the practice level offer and take-up of health checks. This will be augmented with quality metrics from the stroke and AF QOF information compared to health check uptake. This will assist in highlighting areas of	**MAY:** Information pack regarding health checks was sent to all the CCG's Accountable Officers on 1st May 2015 **AUG:** NHS England has advised any scheme would be the responsibility of NCC (Public Health) under its statutory responsibilities for health promotion. **SEPT:** Papers from Consultant Public Health (SD) circulated. **OCT:** Need an indication from Public Health whether introduction of Blood Pressure checks will go forward at Dental Surgeries and Pharmacies.

			unwarranted variation.	CCGs to respond on AF QOF *Public Health position 20/11/15 - Pharmacies already provide Healthchecks. The health check contract is applicable to dentists who want to provide health checks. However none do in Norfolk at present. Health check commissioners think opportunities to reduce risk in vulnerable groups could be better addressed by targeting the following:* • *annual health check for people with learning disability* • *GP physical health check of MH patients* *Supported housing residents* **NOV:** CCG responses to be considered at the December Network meeting (8th).
5.	That Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check	Norfolk County Council Public Health	Accepted: The data will be produced by April 2015 and reported back to the new NHS England local team for dissemination to practices and further action under the new co-commissioning process currently being proposed.	**AUG:** Data was presented at August 2015 Network meeting and then shared with the CCGs. **OCT:** Need an indication from Public Health on current position. **NOV:** Public Health will be asked to report to the Stroke Network on their future plans for Health Checks in the context of the Public Spending Review.

	and make the information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up (Paragraph 3.4)			*Public Health position update 20/11/15:-* *The Healthchecks Programme is run on a 5 year repeating cycle* *Number of eligible people during the year 2015/16 = 275,235* *<u>Q2 data for Health Checks have just been reported</u>* *Healthcheck Offered : 15,773* *Healthcheck Delivered: 6,382* *Uptake is therefore 40.83% of all offered Healthchecks* *Delivery is up overall and the highest for all quarters except (Q4, Yr1 & Q4 Yr2)* *GP delivery is the highest of any quarter since 2013 – date including (Q4 Yr1 & Q4 Yr2)*
Pre hospital				
6.	That EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county.	EEAST	Accepted: Local ambulance stroke 60 audit should be the first step to discuss further reorganisation/pathway variations EEAST has already undertaken a comprehensive review of all its locations across Norfolk and Waveney, both in number and location. Talks are ongoing with Norfolk Fire & Rescue Services to co-locate in some of their premises where this would	**AUG:** The Network has received updates on new bases and performance metrics are reviewed, but still poor performance in some geographic areas. **SEPT:** email sent to TH 18.9.15 requesting an update. **OCT:** Watton active but an existing

	(Paragraph 4.10)		prove of benefit to improving the responses to all categories of patients, but especially where there is a time factor to definitive treatment. New locations have been identified in line with the recently published Clinical Capacity Review undertaken by ORH (Organising or Optimising Resources for Health) in January 2014. These locations are in places such as Watton and Hoveton. Travelling times across the county are often challenged by seasonal demands, poor infrastructure, and time of day. There are some parts of Norfolk and Waveney where even if an ambulance was close to a patient, they would not reach a hyper-acute stroke unit within 60 minutes. The map of driving times on page 20 of the report highlights this geographical challenge. It is proposed and being worked on that these new locations are active before the end of financial year 2014/15 (31st March 2015). Staffing challenges prevent these being active sooner than this.	response post, Hoveton not progressed due to the staffing, demand and funding challenges. As Watton was existing post, no change in performance. Experienced staff moving on to other organisations leaving larger proportion of junior staff. Norfolk recording increasing demand, against the national trend. Norwich 12% activity above contract, West Norfolk 5% above contract. Levels now significantly impacting on performance delivery. Recognition of the adverse 'drawdown' effect pulling EEAST crews into surrounding areas and Harlow site closure.
7.	That the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the	Norfolk and Waveney Stroke Network EEAST	Accepted: EEAST have established a new Stroke lead for Norfolk who will attend the Network meetings. At the meeting of 21st October 2014, process agreed for a robust collection of failures of pre-alerts at hospital using DATIX system. Data will be reported back at all future Stroke Network meetings by EEAST.	**AUG:** Some meetings are in place but no consistent arrangements. There is an EEAST stroke lead in place and issues regarding pre-alerts at each of the acute hospitals are discussed regularly at the network. **OCT:** Regular dialogues ongoing at NNUH. JPUH undertaking monthly breach report interrogation. QEH to provide information. **NOV:** Still awaiting response from QEH.

	hospitals can liaise consistently. (Paragraph 4.12)			
8.	That the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke. (Paragraph 4.13)	NNUH JPUH QEH EEAST	Accepted - At the Norfolk and Waveney Stroke Network Meeting on 21st October, Network members agreed to hold meetings based around each Hospital system and to then collectively share their work at the Network meetings. This will be on the Agenda for the Network Meetings scheduled for 2015.	**AUG:** The outcome from local hospital systems pathway work is discussed regularly at the Stroke network. **OCT:** Regular dialogues ongoing at NNUH. JPUH undertaking monthly breach report interrogation. QEH to provide information. **NOV:** Still awaiting response from QEH.
9.	That EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay. (Paragraph 4.15)	EEAST	Accepted: EEAST - EEAST remodelled its delivery of service in Norfolk by converting 3 rapid response vehicles (RRVs) to double staffed ambulances (DSAs). These additional hours meant the provision of extra ambulances in Cromer, Fakenham, and Diss. Further DSA hours have also since been put into Kings Lynn. The EEAST stroke lead has also introduced a process of auditing all stroke coded calls highlighting time spent on scene by the crew and completion of the care bundle. This in turn reinforces the need to reduce on scene times for the crew. This is completed monthly by the local manager. It is however a challenge to improve the time taken to get a patient a hyper-acute stroke unit given the locations of these units in relation the rural communities. EEAST will review how other rural areas within the UK manage the challenges and feed this back to the network meetings. Success will see improved DSA provision and a reduction in	**AUG:** See update re recommendation 6. **SEPT:** email sent to TH 18.9.15 requesting an update. **OCT:** TH reported that enquiry had been made of other Ambulance Trusts covering rural areas. No different approaches were identified.

			average response time to stroke patients, and an improvement in the numbers of patients arriving at a hyper-acute stroke unit within 60 minutes.	
Hyper acute and acute				
10.	That the stroke team at the NNUH should be a standalone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines. (Paragraph 5.3.2)	NNUH	Accepted: NNUH support this recommendation. This is progressing and they aim to have this in place by December 2014. The staff to support this structure are in place. They now have six stroke consultants and have appointed additional nursing and therapy staff. Manjari Mull to share the report produced by the Strategic Clinical Network.	**AUG:** There is now a standalone team at the NNUH.
11.	That the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service. (Paragraph 5.6)	JPUH	Accepted: This is an urgent priority for the Trust. Funding has been identified for several years for a third stroke consultant. They are currently advertising nationally for a stroke specialist consultant, this time with a substantial "golden hello" attached to the post. They also booked a stand at the British Geriatrics Society Autumn meeting to advertise the James Paget Hospital and the current opportunities in stroke and geriatrics. In the last 12 months the Trust has successfully recruited a neurologist with a special interest in stroke, whose main commitment is to the stroke unit. In Sept 2014 an additional middle grade doctor	**AUG:** JPUH still unable to recruit to substantive post. **10TH SEPT:** HW has advised that there is now a longer term locum in place in the vacancy and out to advert for the permanent post. **OCT:** Response from (JPUH) 1.10.15 - Despite repeated efforts we have not yet been able to fill the third full time stroke specialist post. There remains a severe shortage of appropriate specialist trainees in stroke both locally and nationally. The post has been advertised twice nationally in the last 12 months,

			joined the stroke team on a long term locum basis. If the Trust is unsuccessful in recruiting a stroke specialist consultant this year, the Executive team have agreed that they will seek a locum stroke consultant for a period of at least 6 months in 2015. This will give the team better support while exploring other recruitment options, including European recruitment agencies. They are also looking at options for increased out of hours specialist support for stroke via a telemedicine link to another unit.	including a substantial recruitment bonus. We have also made use of a headhunting agency and a European recruitment agency, as well as advertising JPUH and the Norfolk area at the British Geriatrics Society conference last year. We have had tentative interest from a couple of local trainees finishing in 2016, but they are not yet eligible to apply. We will continue to work with the European agency but suitable candidates are still rare. We have however just recruited a locum stroke consultant with extensive stroke specialist experience who will be working with us until at least February 2016. This has been a significant uplift to our consultant staffing from 2.1 WTE to 3.1 WTE. The neurology consultant with an interest in stroke recruited last year is now an integral part of the team and has been helping to push forward our involvement in stroke research and education. In regard to improving weekend stroke specialist review, we are about to embark on a pilot of telemedicine consultant ward rounds, which if successful may make it possible for us to link more closely with another specialist unit in the long term. We continue to use the successful regional telemedicine service for stroke thrombolysis.

				Telemedicine consultant ward rounds not yet commenced at JPUH. Awaiting delivery of equipment to facilitate these.
12.	That the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e. people actually in post, not the number of posts in the establishment), and the availability of staff in post in supporting disciplines, to assess the clinical safety of the services. (Paragraph 5.6)	Norfolk & Waveney Stroke Network	Accepted: The Network will conduct a review by April 2015.	**AUG:** **OCT:** NNUH & JPUH to produce combined spreadsheet, agreeing criteria. **NOV:** Spreadsheet awaited from NNUH on behalf of all acute hospitals.
13.	That the Local Education and Training Board explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway. (Paragraph 5.6)	Health Education East of England	HEEoE acknowledges the challenges in filling stroke posts but continues to provide, through a national process, opportunities for trainees to access stroke educational out of programme opportunities as part of a training programme that leads to a Certificate of Completion of Training (CCT). Stroke is a sub specialty post. Trainees who apply for posts must already hold a national training number in another specialty. Often, these are in geriatric medicine. Stroke as a sub specialty has had difficulty recruiting country wide from Aug 2014 and this, it is in part believed, is linked to changes in the way that at a national level the Specialty Advisory Committee for Medicine for the Elderly no longer credits this as an out of programme experience towards a trainees CCT. Prior to Aug	Despite a request from HOSC manager on 21 July 2014 and follow on emails from the Stroke Network on 17th September 2014 and 24th September 2014 no written response has been received. **AUG:** Awaiting response to further emails. **OCT:** email sent to Ross Collett and Chris Sykes on 18.9.15 asking for an update . **NOV:** No response received as at 23rd November 2015.

			2014 HEEoE has always recruited to between 6-8 posts each year; from Aug 2014 intake only 4 of 8 posts have been filled. This issue is being picked up by HEEoE at a national level. In addition to the issue described above there is already a shortage of trainees choosing to apply for stroke posts. Given that these posts are filled on a competitive basis trainees appear not to be valuing these out of programme experiences on their training career path towards a CCT. HEEoE continues to create training opportunities for stroke as a sub specialty and pursues several rounds of recruitment in order to fill these posts each year. HEEoE can only offer the opportunity it cannot mandate trainees to take up these opportunities in what is a competitive process but continues to work with service colleagues to make these opportunities as attractive as possible.	
14.	That the Norfolk and Waveney Stroke Network undertakes an assessment of how many patients are delayed at acute and community hospitals due to waiting for NHS Continuing Care assessment or funding and establish what the cost is. (Paragraph 5.7)	Norfolk and Waveney Stroke Network	Accepted: NNUH support this recommendation. Data is currently collected. They will look at this for Stroke and bring information to the December meeting. QEH – accepted. Data is being monitored within the organisation and will be analysed specifically for Stroke and reported to the Network and West Suffolk SRG. NNCCG - Happy to support CHC assessment delay exercise noting this will cut across both CSU & NNUH as they have their own assessment team. For Central Norfolk the SRG will oversee this piece of	**AUG**: Capture of data for this purpose is not routine within the local CHC process. The Network has contacted the System Resilience Groups across Norfolk to ask if they have access to this data. The Stroke Network is not aware of the impact of any changes to CHC processes on this issue. **OCT:** Difficulty in obtaining data on this. Investigating if Central Norfolk holds this through their Capacity Planning Group and if NNUH have data.

			work. JPUH support this GY&WCCG - The number of specialist nurse posts at JPUH to undertake CHC has increased. Currently a review of the CHC process at JPUH for all patients is being undertaken with the aim of involving the ward staff in the process. This will be a great benefit to stroke patients as the hospital staff that have cared for them during their in-patient stay will be involved in making recommendations on eligibility moving forward, although many stroke patients will not be ready for assessment whilst at the hospital or whilst undergoing active rehabilitation. Recent statistics demonstrate that form Checklist to DST there is a mean of 5 working days being achieved. This is minimising delays once in the process however there is further work to do to reduce the wait (at times) for a checklist to be completed. There are no delays at JPUH with agreeing recommended funding as all CHC recommended eligible patients then have their on-going care funded on a 'patient without prejudice' basis. Any delays following eligibility are associated with lack of provider provision.	
Rehabilitative				
15.	That the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to	Norfolk and Waveney Stroke Network	Accepted: The Network will request staffing data from NHS providers across Norfolk, including specialist rehabilitation providers. In addition it will request staffing data for generic rehabilitation that follows the period of specialist care. This will be reported to the Stroke Network meeting in March 2015.	**AUG:** The draft report was presented to the August meeting and a final version will be circulated in late September 2015. **OCT:** Differences in data submission for East and West. Final version awaited. **NOV:** Final version has been received.

	ensure the appropriate level of support. (Paragraph 6.2.4)			
16.	That the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits. (Paragraph 6.2.6)	Norfolk and Waveney Stroke Network	Accepted: The Network agrees that clinical outcomes based assessment be progressed to consider the effectiveness of Stroke Rehabilitation. It requests this is led by Public Health and a project plan be agreed by the network in February 2015. The outcomes of this work will be reported to the Network and shared with the Commissioners who retain statutory responsibility for Commissioning of Services.	**AUG:** The draft report was presented to the August meeting and a final version will be circulated in late September 2015. **NOV:** Final report received from Public Health, November 2015.
Long term				
17.	That the Local Education and Training Board explains what is being done to improve the availability of trained Psychologists. (Paragraph 7.4)	Health Education East of England	The LETB is currently in the cycle of commissioning regional programmes as part of the annual investment plan and when indicative numbers are known early in the new year we will be in a position to provide a detailed response.	Despite a request from HOSC manager on 21 July 2014 and follow emails from the Stroke Network on 17th September 2014 and 24th September 2014. No written response has been received. **AUG:** A further email has been sent to HEE in view of no response. **OCT:** email sent to Ross Collett and Chris Sykes HEE asking for an update 18.9.15 **NOV:** No response received as at 23rd

				November 2015.
18.	That Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and public sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home spectrum. (Paragraph 7.7)	Norfolk County Council Adult Social Care Norfolk Independent Care NCH&C ECCH	Accepted: Norfolk Independent Care has met with Norfolk County Council, NCH&C and ECCH. Information about the current training for new and existing care home workers in relation to the long term care of stroke survivors has been obtained in relation to each organisation. An action plan to drive forward consistency of training has been developed (see attached document). A Task and Finish group will be convened to support and develop a consistent approach to the training of care workers in relation to the long term care of stroke survivors. The Task and Finish group will also review how training is tracked and agree a system for sharing good practice. Notes of the Task and Finish group will be available to all key stakeholders. NNUH support this recommendation. We are supporting training of a number of nurses for Tracheostomy for the Oak Farm Nursing Home. We have provided honorary contract for the Oak Farm staff to come and observe our staff. This model should be transferable to other settings. NCH & C: Our stroke team have been involved in attending the steering group and will be part of the action group chaired by Norfolk Independent Care. The Network also support Integrated training programmes e.g. UEA module which is easily	**AUG:** The Stroke Association is investigating a possible scheme for 'gold standard' care in homes. This is being progressed nationally as a pilot and it is hoped some Norfolk Providers will be part of the pilot programme. **OCT:** No more information available at this time.

			accessible to varied staff groups	
19.	That the five Norfolk CCGs should work together to commission an integrated prevention, information, communication and six month stroke review service across Norfolk. (Paragraph 7.8)	North Norfolk CCG South Norfolk CCG Great Yarmouth & Waveney CCG West Norfolk CCG Norwich CCG	Accepted: Great Yarmouth and Waveney CCG will be working with providers to review options regarding stroke follow up pathways, including consultant, nurse, ESD and Stroke association services. This will be included in our commissioning intentions for 2015/16. NHS South Norfolk CCG recognises the value of a collaborative approach to prevention, information and communication, particularly from the point of view of consistency and, to a lesser extent, economies of scale. As six month follow up needs to be delivered at an individual Patient level there may be considerations that preclude a Norfolk County model (i.e. distinct Community Providers), however NHS SNCCG will commit to engaging with the Norfolk and Waveney Stroke Network, and the Norfolk Stroke Advisory Group on these, and all matters relating to Stroke Care to ensure that patients within its geography receive a service that is at least better than the National average, or meets National standards where average performance is not met Nationally. WNCCG will continue to commission support services in the community for West Norfolk and we would welcome the opportunity to work with the other CCGs to deliver equity of service across Norfolk. The Network will review the Commissioning outcomes of the CCG's in August 2015 and report on the effectiveness of services in place.	**AUG:** The CCGs have been asked to provide an update for the August meeting. The final report by Public Health will review current commissioning of this service. **OCT:** Public Health final report awaited. **NOV:** Public Health report received, November 2015.
The cost of stroke and				

stroke services				
20.	That Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county. (Paragraph 8.2)	Norfolk and Waveney Stroke Network	Partially Accepted – The Network recognises that such a project would be of considerable interest but has concerns that the cost and time of this work represents a significant piece of work, likely to be at PhD level. It will explore this with the UEA and Public Health and receive a report on the feasibility of this progressing at its meeting in February 2015.	**AUG:** The Network has received a report from Public Health that costs would be prohibitive.
Next steps				
21.	*That representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee. (Paragraph 10.1)*	Norfolk and Waveney Stroke Network	Accepted – The Network met with HOSC task group on 19th August 2014.	**AUG:** Close.

Norfolk County Council
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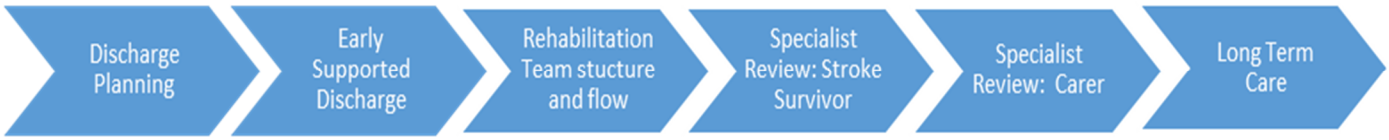
Norfolk and Waveney
Stroke Network

Review of Stroke Rehabilitation in the Community



November 2015

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Acknowledgements

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- Carmel Austin, Stroke Prevention Co-ordinator, West Norfolk Stroke Association
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- Evie Cooper, Stroke Therapy Team Leader, James Paget University Hospital
- Dr Simon Horton, Lecturer, School of Health Sciences, University of East Anglia
- Anna Morgan, Director of Nursing & Quality, Norfolk Community Health & Care NHS Trust
- Kim Peach, Information, Advice and Support Co-ordinator, West Norfolk Stroke Association
- Oliver Redmayne, Stroke Nurse Specialist, James Paget University Hospital
- Gemma Smith, Communications and Long Term Support Co-ordinator, West Norfolk Stroke Association
- Nick Turrell, Information, Advice and Support Co-ordinator, Great Yarmouth and Waveney Stroke Association
- Carly West-Burnham, Senior Service Manager, Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
- Deborah Wooler, Head of Specialist Rehabilitation, Norfolk Community Health and Care NHS Trust
- Nicola Wyatt, Specialist Stroke Nurse, Norfolk Community Health and Care NHS Trust

Glossary of definitions and abbreviations

AHP	Allied Health Professional
ECCH	East Coast Community Healthcare
CCG	Clinical Commissioning Group
ESD	Early Supported Discharge
GP	General Practitioner
JPUH	James Paget University Hospital
KPIs	Key Performance Indicators
MDT	Multidisciplinary Team
NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NICE	National Institute for Health and Clinical Excellence
NNUH	Norfolk and Norwich University Hospitals
OT	Occupational Therapist
NHOSC	Norfolk Health Overview Scrutiny Committee
PANSI	Projecting Adult Needs and Service Information
PEG	Percutaneous endoscopic gastrostomy feeding (tube into stomach via abdominal wall)
PT	Physiotherapist
QIPP	Quality, Innovation, Productivity and Prevention, an NHS programme of improvements in quality and productivity
RA	Rehabilitation Assistant
RCP	Royal College of Physicians
SA	Stroke Association
SALT / SLT	Speech and Language Therapist
SIGN	Scottish Intercollegiate Guidelines Network
SS	Stroke Survivor
SSR	Specialist Stroke Rehabilitation
SSNAP	Sentinel Stroke National Audit Programme
TIA	Transient Ischaemic Attack
VCSE	Voluntary, Community and Social Enterprise
WTE	Whole time equivalent

Executive Summary

Background

In early 2015, the Norfolk and Waveney Stroke Network requested that the Public Health team at Norfolk County Council undertake a review of stroke rehabilitation services, focussing on services provided in the community. This request followed a recommendation made by the Norfolk Health Overview and Scrutiny Committee following a review of stroke services in Norfolk.

This review of community stroke rehabilitation services in Norfolk aims to support future commissioning by:

- providing an improved understanding of the different ways that specialist stroke rehabilitation service is provided across Norfolk.
- mapping care pathways for stroke rehabilitation (identifying providers, activity, workforce, location and timeliness of services).
- benchmarking stroke rehabilitation services, locally and against national standards.
- identification of current good practice and opportunities for improvement.
- building on local, national and wider research knowledge towards providing evidence-based recommendations for future service development.

Methods

This review is based on information obtained in three ways:

- Data from local, regional and national level stroke related sources.
- A descriptive literature review of Specialist Stroke Rehabilitation in the community.
- Benchmarking local services using a questionnaire completed by service providers.

Qualitative data about service provision has been included in this review alongside descriptive statistics on staffing, readmission and level of disability of stroke survivors in Norfolk.

Findings

Viewing the whole system has made it clear that there are local differences across Norfolk (categorised as West, Central and East for the purposes of this review).

There are differences in the population demographics, the ways Norfolk CCGs have chosen to commission services and also in service provision.

This has resulted in only a few parameters that are directly comparable between the three areas. However, despite these differences, this review found consistent progress in line with the following national 'gold standards'. Across Norfolk:

- ✓ All stroke survivors referred to providers from acute rehabilitation/hospital have a personalised transfer of care or discharge plan/document.
- ✓ All providers involve stroke survivors in discharge planning processes.
- ✓ All providers have established ways of involving family/carers in discharge planning.
- ✓ All providers have processes for informing the GP of discharge.
- ✓ Joint decision making across the multidisciplinary teams and between stroke survivor/carers for discharge and rehabilitation is embedded.
- ✓ All providers carry out a home assessment where required.
- ✓ Discharge is always led by Specialist Stroke Team.
- ✓ Early Supported Discharge /Specialist Stroke Rehabilitation is available at the stroke survivor's place of residence, or other appropriate community setting according to individual preference.
- ✓ Early Supported Discharge /Specialist Stroke Rehabilitation (OT/PT/SLT) is available at least 5 days per week.
- ✓ All providers employ core Rehabilitation Practitioners: OT/ PT/ SLT.
- ✓ OT/PT/SLT is available for up to 45 minutes per session (as required).
- ✓ OT/PT/SLT is offered at least to the same standard/intensity as in hospital.
- ✓ Decisions on the level or intensity of therapy and support is decided on an individual basis.
- ✓ Rehabilitation assistants provide support, progress rehabilitation goals and ensure continuity in all areas.
- ✓ Signposting to support agencies occurs at every Early Supported Discharge /Specialist Stroke Rehabilitation transfer/discharge.
- ✓ All providers have processes for gaining consent for others to be involved in their long term care and support.
- ✓ Promoting independence, empowerment and self-help is a fundamental objective of all Early Supported Discharge /Specialist Stroke Rehabilitation services.

Recommendations

Some aspects of current service provision are not consistently provided at the 'gold standard' across Norfolk. The Stroke Network, CCGs (commissioners) and service providers should work together to further the following actions:

1. Commission outcomes which encourage integrated care and support with long term goal planning and direct routes back into specialised rehabilitation for all stroke survivors.

2. Adopt consistent quality and performance indicators across Norfolk, taking the lead from the new NICE quality standards.

3. Increase the number of people reviewed at six weeks, six months and one year.

4. Provide equitable access to screening and assessment for psychological problems.

5. Increase the number of carers receiving regular assessments.

6. Provide improved, consistent information for stroke survivors and their families across Norfolk.

7. Embed feedback, satisfaction surveys, friends and family tests in quality improvement.

8. Encourage a wide range of Voluntary, Community and Social Enterprise activities, for example peer-led groups, carer and peer-support and community asset mapping.

9. Use standardised communication and assessment tools for transfer between services.

10. Improve the SSNAP data compliance.

Further recommendations

It was not possible to have equal involvement of stroke survivors, carers, providers and VCSE's at all stages of this review. More in-depth work could be done to ascertain the value of rehabilitation services through patient-recorded outcome measures and qualitative descriptions of the 'lived experience' of stroke survivors.

This review did not include the role of stroke prevention and integrated care and support teams although it would be useful to examine these developing areas further.

1.0 Introduction

In early 2015, the Norfolk and Waveney Stroke Network ('the Network') requested that the Public Health team at Norfolk County Council undertake a review of stroke rehabilitation services. This request followed a recommendation made by the Norfolk Health Overview and Scrutiny Committee (NHOSC) in July 2014, following a review of stroke services in Norfolk. The NHOSC report (NCC, 2014) outlined concerns regarding inequities in the current provision for stroke rehabilitation across Norfolk and recommended that the Network:

> "*assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available funding limits.*"

This report sets out the findings and recommendations of the subsequent review of Stroke Rehabilitation services undertaken in 2015.

1.1 Related documents

This report should be read in conjunction with:

- NHS Midlands and East (2012) *Stroke Services Specification*
- National Institute for Health & Clinical Excellence (2013) *Stroke rehabilitation: Long-term rehabilitation after stroke*
- Norfolk County Council [NCC] (2014) *Norfolk Health Overview and Scrutiny Committee Stroke Services in Norfolk Report*
- Norfolk County Council (2015) *Health Needs Assessment Stroke or Transient Ischaemic Attacks*
- NHS England (2014) *East of England Strategic Clinical Network (Cardiovascular) Stroke Review: Progress Report and Transfer Document* (see references)
- Sentinel Stroke National Audit Programme (2015) *Regional Results*
- The Stroke Association State of the Nation: Stroke Statistics (2015)

1.2 Aims of the review

This review of the current stroke rehabilitation services in Norfolk aims to support future commissioning by:

- providing an improved understanding of the different ways that specialist stroke rehabilitation is provided across Norfolk and Waveney.
- mapping care pathways for stroke rehabilitation (identifying providers, activity, workforce, location and timeliness of services).
- benchmarking of stroke rehabilitation services, both locally and against national standards.
- identification of current good practice and opportunities for improvement.

- building on local, regional, national and wider research knowledge towards providing evidence-based recommendations for future service development.

1.3 Scope of the review

This review includes:

- Specialist Stroke Rehabilitation (SSR) services provided for adult stroke patients in the community, registered with a GP, in one of the five Norfolk and Waveney CCGs.

Due to timescale limitations this review does not include:

- Scoping generic care provided to stroke patients by General Practice, generic community services, social care (including provision of equipment) and care homes – although the interface between these services may be explored where necessary. The review may include any established integrated working with these services.
- Post-acute, inpatient rehabilitation prior to hospital discharge. The interface between post-acute inpatient and specialist community stroke rehabilitation will be explored.
- Paediatric services.
- End of Life Care

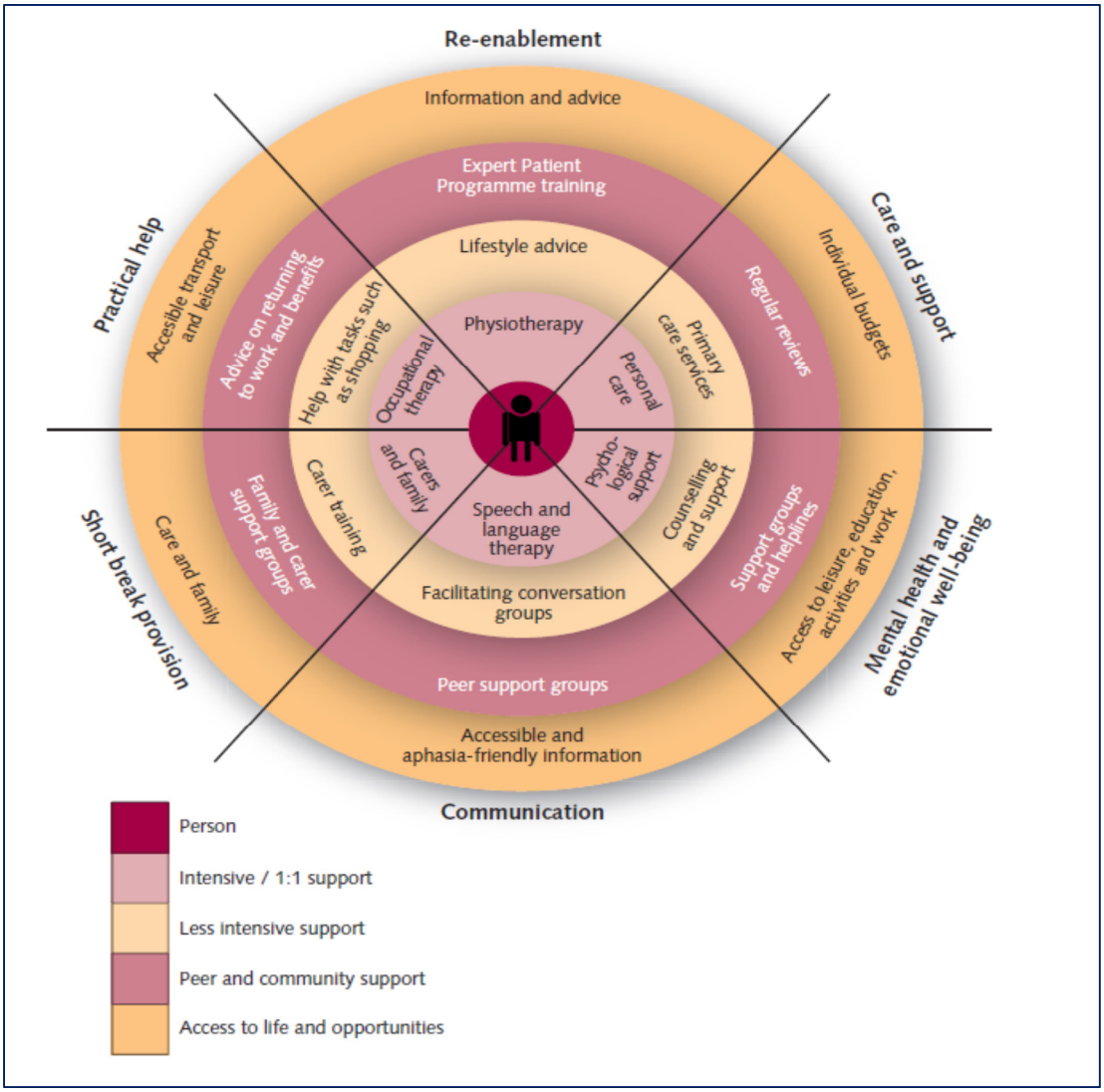
2.0 Background

2.1 National context

A stroke occurs approximately 152,000 times in the UK each year. Death rates from stroke have been falling steadily since the late 1960s and most people now survive a first stroke. As a result, stroke survivors often have poor health and significant disabilities. Over a third of stroke survivors are dependent on others, of those 1 in 5 are cared for by family and/or friends (Stroke Association [SA] 2015).

Stroke not only affects an individual's physical health, but also their emotional wellbeing, relationships, and ability to function at home, at work and in the community. Stroke rehabilitation is a multi-dimensional process, which is designed to help a stroke survivor restore or adapt to the loss of daily activities of living and participation in society, as illustrated in Figure 1.

Figure 1*: The range of support someone may need after a stroke Source: The National Stroke Strategy*



The Department of Health launched the National Stroke Strategy in 2007 with the aim of reducing variability in care and support. Subsequent evidence-based clinical guidelines and service specifications from the NHS Midlands and East (2012), Royal College of Physicians [RCP] (2012a) and the National Institute for Health and Care Excellence [NICE] (2013) have set standards for the provision of acute and intermediate care, rehabilitation at home and for up to six months after the initial stroke (Appendix 1).

2.2 Regional / local context for stroke rehabilitation

Since 2013, it has been the responsibility of CCGs to commission stroke services from acute care to rehabilitation. Representing all commissioners and providers of stroke care in Norfolk, The Norfolk and Waveney Stroke Network leads the strategic overview of stroke care across the county, promoting collaboration and commitment from the whole health community, to deliver positive outcomes for stroke survivors throughout the patient journey, from prevention through to rehabilitation and end of life care.

In 2014, The Sentinel Stroke National Audit Programme (SSNAP) made enquiries to all CCGs in all areas of England and Wales about their provision for stroke rehabilitation. Despite a positive response, the SSNAP reported widespread variation in the documentation and provision of stroke rehabilitation services, both regionally and locally. SSNAP made several recommendations to improve these inconsistencies and provide care equitably (Appendix 2) (SSNAP 2015a).

Several other reports have informed the Norfolk and Waveney Stroke Network of the differences in provision of care and support locally (NCC 2014, NHOSC 2014, NHS England, 2014). One of the main themes of these reports is that, although stroke care and support has been responsive to the requirements of different communities, providers and commissioners, there is a continued call for standardising provision across the county.

3.0 Methodology

This review is based on information obtained in three ways:

- Data from local, regional and national data collections.
- Recent evidence from a descriptive literature review of Specialist Stroke Rehabilitation in the community.
- Benchmarking current community-based rehabilitation services through:
    - Development of a structured questionnaire using the 'gold standard' for community stroke rehabilitation outlined by the NHS Midlands and East Stroke Rehabilitation Service Specification (2012).
    - Pilot of the questionnaire with clinicians and managers at one provider.
    - Self-completion of the questionnaire by all remaining providers identified via members of the stroke network.
    - Follow up interviews for clarification either face to face or by telephone
    - The questionnaire responses were used to identify best practice, variation and gaps between providers in the different parts of Norfolk.

4.0 Literature review

A review was undertaken of recent contemporary literature relating to specialist community stroke rehabilitation in order to:

- support the development of the questionnaire for benchmarking services.
- identify national policy and guidelines.
- identify the latest evidence, to support best practice recommendations.
- identify examples of good practice from other areas.

The evidence was drawn from a range of sources, including:

- Department of Health (DH) policy documents and national clinical guidelines
- Cochrane database
- Published peer reviewed literature
- Case studies
- Individual NHS organisations and expert opinion.

4.1 National Strategy and Guidance

Four main guidance documents were identified setting out national or regional gold standard practice for stroke rehabilitation, which can be used as a quality framework to assess local services and address health inequalities relating to stroke. These documents are:

- National Stroke Strategy (2007)
- Royal College of Physicians (RCP) National Clinical Guideline for Stroke (2012a)
- NICE guidance (CG 162, 2013)

- NHS Midlands and East Stroke Service Specification

These documents were assessed for their similarities and differences (Appendix 1) and then used to form the framework for the questionnaire.

4.2 Defining stroke rehabilitation

There are many definitions of rehabilitation and reablement in use. One generic definition, developed by NHS England is:

> "*the restoration to the maximum degree possible, of an individual's function and/or role, both mentally and physically, within their family and social networks, and within the workplace where appropriate"* (NHS Improving Quality, 2014).

More specifically for stroke survivors, the National Stroke Strategy sets out the aim of rehabilitation as:

> "*For those who have had a stroke and their relatives and carers, whether at home or in care homes, to achieve a good quality of life and maximise independence, well-being and choices*" (Department of Health, 2007, p.34).

There is widespread agreement that stroke rehabilitation should begin as soon as possible after a person has a stroke, and continue for as long as appropriate goals can be set, to ensure the best possible recovery.

4.3 Benefits of stroke rehabilitation

Following a stroke, many people are left with severe and long term disabilities. Stroke impacts on the economy through direct costs to health and social care services, productivity losses and benefit payments. Informal care costs are estimated at £2.42 billion a year in the UK (SA 2015).

There is evidence that patients categorised with mild to moderate stroke can be managed successfully at home with similar outcomes to acute care with lower costs, and that patients can be classified into meaningful groups based on assessment scores (Bland 2015).

There is a high risk of unplanned re-admission to hospital (31-49%) within twelve months of a stroke. (Lainey et al, 2015). A Canadian study of 524 stroke survivors, found reductions in hospital readmission rates following the introduction of a timely, intensive home-based rehabilitation service (Langstaff et al, 2014).

After specialist community rehabilitation has ended, a single point of contact and fast access to specialist review is deemed essential for admissions avoidance (McDonald 2014).

4.4 What constitutes post-acute stroke care?

A portfolio of different services is required to provide comprehensive post-acute stroke care and support (SSNAP, 2015).

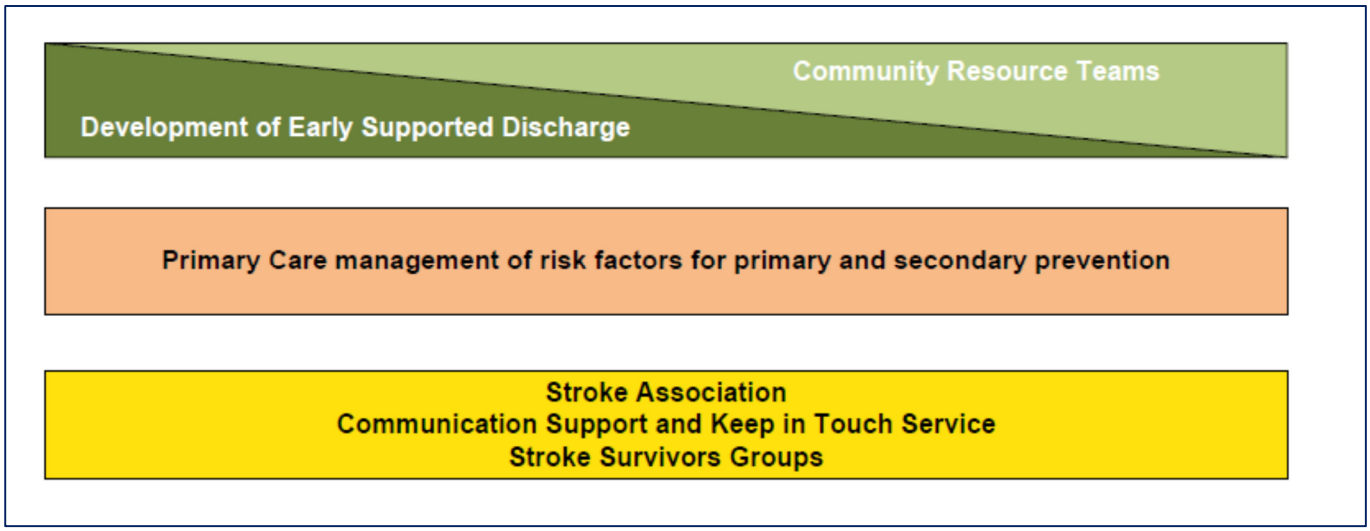
In line with national guidelines (Appendix 1), the RCP (2012a) recommend the following services should be commissioned:

- *Early supported discharge to deliver stroke specialist rehabilitation at home or in a care home*
- *Rehabilitation services capable of meeting the specific health, social and vocational needs of people of all ages*
- *Services capable of delivering specialist rehabilitation in outpatient and community settings in liaison with inpatient services*

The RCP state that rehabilitation following a stroke should be provided in a variety of settings, including in acute and community hospitals, outpatient departments and a person's home. Rehabilitation should also be provided by a range of services, from specialist stroke rehabilitation teams, to generic teams for the achievement of longer term rehabilitation goals.

Figure 2 illustrates a simple post-acute stroke care model developed by NHS Wales (2014).

Figure 2: NHS Wales Model for Stroke Service Redesign (post-acute)



4.5 Early Supported Discharge (ESD)

The 2012 Midlands and East Service Specification (Appendix 1) states that Early Supported discharge (ESD) should enable stroke survivors with mild and moderate disabilities to leave hospital 'early' through provision of intense rehabilitation in the community at a similar level (intensity) to the care provided in hospital. An ESD team consists of nurses, therapists, doctors and social care staff working collaboratively as a team with patient and families. The ESD team is then able to provide intensive rehabilitation in the stroke survivor's home for a set period of time, reducing the risk of re-admission into hospital and supporting increasing independence and quality of life. The Midlands and East Service Specification includes service outcomes, education and training, workforce, equipment and aids and performance standards.

Since 2012, there continues to be good quality literature to support the delivery of an ESD service for patients with mild to moderate stroke.

A Cochrane review (Fearon and Langhorne 2012, referenced in Teasell et al 2013) found:

> "*appropriately resourced ESD services provided for a selected group of stroke patients can reduce long-term dependency and admission to institutional care as well as reducing the length of hospital stay. We observed no adverse impact on the mood or subjective health status of patients or carers."*

International examples of ESD focus on accelerated discharge of patients with the provision of community based rehabilitation support provided by a co-ordinated MDT with stroke expertise (Langstaff, 2014). However it is hard to identify optimum interventions as the services have different timings and types of interventions.

Fisher et al, 2011 developed a consensus view for use when implementing an ESD service, from an international panel of ten experts, which was used to support the development of the East of England service specification. Key points included:

- Stroke specific rehabilitation provided by a multidisciplinary team (MDT), including a speech and language therapy, physiotherapy, occupational therapy, and specialist nursing.
- Co-ordinated and planned discharge
- Continued rehabilitation at home
- Maintaining strong links between the acute and ESD services
- Community stroke rehabilitation services are distinct from ESD programmes but offer complimentary services for ongoing rehab needs.

A recent paper (Chouliara et al, 2015) based in Nottingham explored the views of professionals based in Nottingham who had implemented ESD, and found the overall perception of ESD was positive. The findings included:

- The need for adaptable workforce, the importance of the role of rehabilitation assistants and cross-service working arrangements.
- The impact included reduced inpatient stay, aiding seamless transfer, providing intensive stroke specific therapy
- Challenges included a lack of clarity re referral decision making process, delays in social care input, and lack of follow up services
- Specific eligibility criteria was advocated

4.6 Multidisciplinary teams

The national guidance draws strongly on input from allied health professionals (AHP) to support specialised rehabilitation. *"Stroke toolkit: How AHPs improve patient care and save the NHS money A guide for healthcare commissioners"* (NHS London 2012) was produced during London's Stroke service redesign in 2012 and is a comprehensive literature review, providing general and research evidence of clinical

and cost effectiveness, concluding that AHPs are not optional but integral to the necessary treatment of patients in stroke rehabilitation pathways.

In particular there is good evidence for multidisciplinary working in:

- Early Supported Discharge (ESD)
- Longer term neurological rehabilitation
- Exercise programmes
- Vascular risk reduction
- Longer term follow up and intervention for those who deteriorate.

4.7 Long term care and support

There is a need to ensure a transfer of care to community based teams for the achievement of longer term rehabilitation goals, and to ensure referral pathways back to specialist teams if needs change over time.

The 2014 Health Overview and Scrutiny Committee Stroke Services in Norfolk reported concern about the handover of patients from intensive stroke rehabilitation services to the generalist community services.

In some areas of the UK, longer term specialist community stroke rehabilitation is provided through regular specialist reviews and integrated services specifications. These detail how patients will access community rehabilitation services following discharge from a stroke unit or following ESD. These services include the transfer of care between providers and collaboration between health and social services, the independent and third sectors.

The importance of regular and thorough reviews of a stroke survivor's health and wellbeing in the long term, 6-month and annual reviews are highlighted in the national guidelines. The 6-month review should also include interventions to support secondary prevention of stroke. Secondary prevention interventions are mandated in England as part of the CCG Outcome Indicator Set (SSNAP, 2015, p8).

4.8 Promoting wellbeing and psychological support

Depression affects about 30% of stroke survivors and can happen any time after the stroke event. Up to 75% of stroke survivors are thought to experience cognitive impairment (Hackett et al 2005).

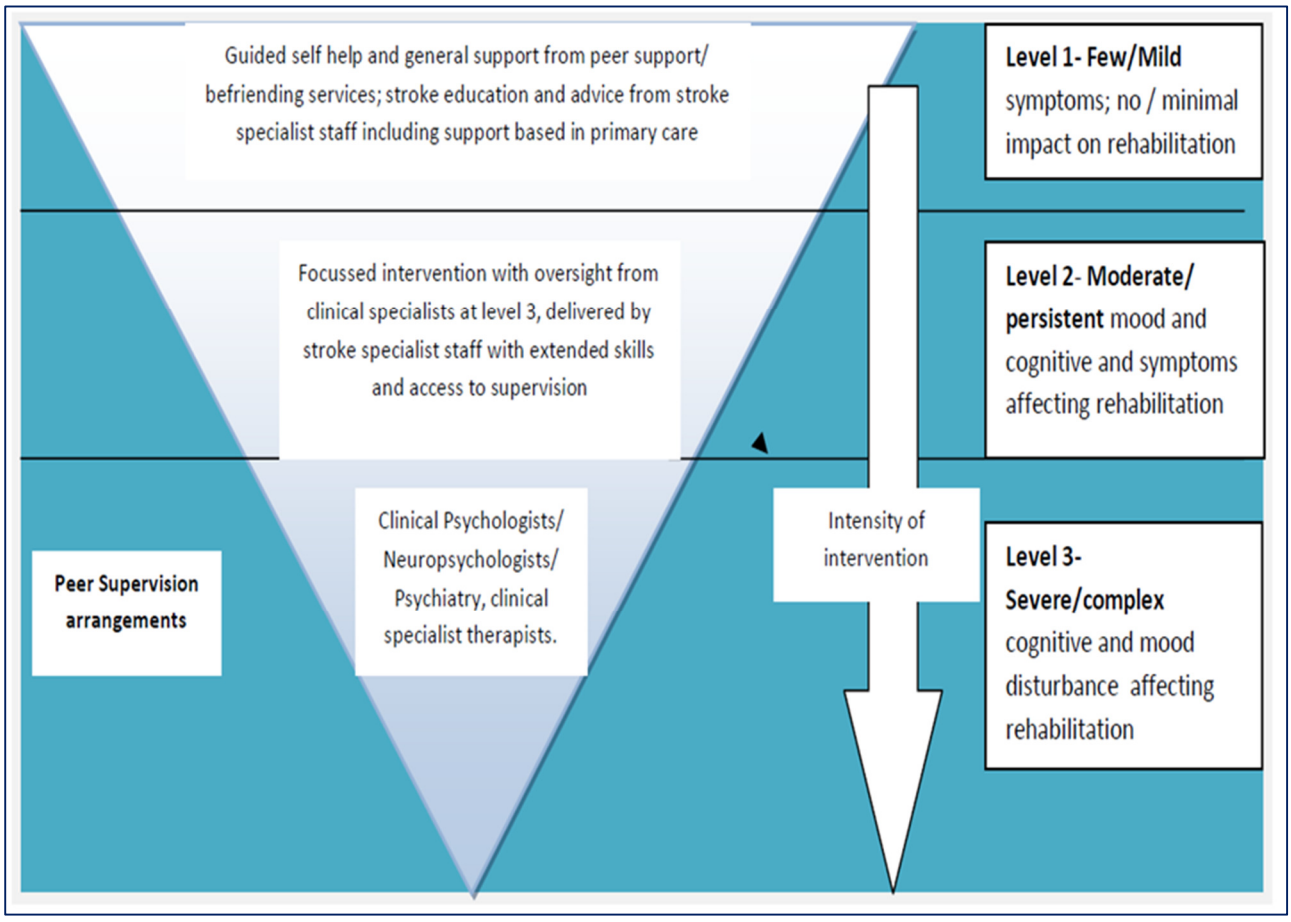
The psychological needs of stroke survivors was highlighted as a priority in the 2010 Accelerated Stroke Improvement Programme (NHS Improvement 2010) and has been called for by NICE in its Quality Standards (NICE 2010, NHS Improvement 2011). This includes a metric requiring at least 40% of people to be assessed and/or treated by a psychological support service capable of managing mood, behaviour or cognitive disturbance by six months post stroke.

Following a comprehensive review of literature, 2010 SIGN guidelines advocated that all stroke survivors should be screened for mood disturbance using some formal screening, e.g. the Stroke Aphasic Depression Questionnaire (SAD-Q) or General Health Questionnaire of 12 items (GHQ-12) at regular intervals after discharge but that clinical judgement should be used to determine how regularly mood should be re-assessed. SIGN also states that routine psychological therapies following a stroke are not recommended to prevent post-stroke depression, rather, promoting psychological principles from motivational interviewing and problem solving should be incorporated into health education programmes.

For those with early-onset post-stroke depression a recent meta-analysis advocates specialist follow-up and the long-term monitoring of mood in people who have had a stroke and remain at high risk of depression (Allan et al 2013). A systematic review of the effectiveness of community-based rehabilitation interventions in reducing depression, facilitating participation and improving quality of life after stroke (Graven et al 2011) examined 54 studies and concluded that exercise interventions significantly reduced depression immediately after the intervention compared with usual care. Insufficient evidence of effect was found for reduction in depressive symptoms for single- discipline or comprehensive rehabilitation models.

The British Psychological Society (2013) recommends a model for stroke survivors and their families, as in Figure 3.

Figure 3: BPS 2013 Model of Psychological Support for Stroke Survivors



4.9 Self-management

Self-management, with a single point of contact if problems develop, appears key to long term stroke care and support (McDonald 2014). The Stroke Association has published its own *Manifesto* (Stroke Association 2010), with support for a self-management model. Several studies have shown that empowering people with the confidence, techniques and tools to help them make choices about healthy behaviours and collaborate with agencies who support them (e.g. Blennerhassett et al 2012, Scobbie et al 2013, de Sliva 2011) is fundamental to sustaining the benefits of rehabilitation in the long term (Allen et al 2014, NIHR 2014, Stroke Association 2010).

A recent systematic review of the implementation of home-based stroke rehabilitation (Siemonsma et al 2014) identified client satisfaction with services, coordination of services, inter-professional collaborations, and availability of appropriate training, equipment, and costs as being the most influential factors in effective home-based rehabilitation.

In an NHS London burden of disease analysis, follow-up data collected by the prospective South London Stroke Register (SLSR) recorded and followed all patients of all ages in an inner area of South London after their first-ever stroke since 1995 (Wolfe et al 2011). The researchers found that after 3–12 months the outcomes remain relatively constant. During this phase, however, accessing support through a single point of contact (McDonald 2014) is a key component of integrated care and self-management.

4.10 Services for residents in care homes

The RCP recommendations state:

"All people with stroke in care homes should receive assessment and treatment from stroke rehabilitation services in the same way as patients living in their own homes"

and

"All staff in care homes should have training on the physical, psychological and social effects of stroke and the optimal management of common impairments and activity limitations". (RCP 2012, p128)

A 2011 census of BUPA care homes found stroke to be the second most common neurological/mental condition among BUPA care home residents, after dementia (CPA 2011).

A recent SSNAP audit of post-acute stroke services (SSNAP, 2015), highlighted concerns regarding the services provided to care home residents. Only 49% of community rehabilitation teams were reported as seeing patients in care homes compared to 84% seeing patients in their own homes.

In 2012 a large randomised controlled trial of 1042 care home residents with a history of stroke or transient ischaemic attack, reported no evidence of benefit for the provision of a routine occupational therapy service, including staff training, for care home residents living with stroke-related disabilities. The authors recommended that providing and targeting care and support in this clinically complex population requires alternative strategies, particularly for those stroke survivors with cognitive impairment and depression. However, it may be the case that individual referrals to occupational therapy may be of benefit to residents with lower levels of impairment (Sackley et al, 2015).

The 2014 Health Overview and Scrutiny Committee review of stroke services in Norfolk made recommendations that basic training in the long term care of stroke survivors should be delivered and monitored for care home staff in private and public sector care homes across Norfolk.

4.11 Integrated care

The rising costs of care and support for stroke survivors will be a challenge facing the whole of the public sector. Despite knowledge that integrated care can deliver better outcomes for people with long term conditions (NHS England 2013), many organisations are still working in isolation with their caseloads, with fragmented commissioning responsibilities being a barrier to changes in practice (Kings Fund 2015).

A theme running throughout the literature is the importance of communication and joint working with social care and other NHS providers (with joint care plans, transfer between teams, shared assessment, paperwork, and shared information).

A Delphi –consensus process in Midlands and East (Fisher et al 2013) concluded that flexible care pathways should be commissioned and provided through strategic and collaborative leadership across health and social care, with specialist healthcare teams being ready to hand over responsibility to non-specialist services once specialist rehabilitation goals have been met.

4.12 Variation in the commissioning of services

The SSNAP audit (2015) highlighted “variation in types of post-acute stroke care currently being provided” across the country, and there is very little information available about provision in the community. A recent report from the Stroke Association highlighted that 48% of stroke survivors and their carers reported problems caused by either poor or non-existent co-working between health and social care provider (SA 2015). Phase 2 of the post-acute SSNAP audit will endeavour to extract more information regarding the quality and coverage of services. Providers should be encouraged to take part in this to benchmark services and identify good practice:

"It is important that services are commissioned coherently, from prevention to longer term care, without duplication or gaps, which could result in poor patient outcomes" (SSNAP, 2015).

Examples of good practice are available to support commissioners, including:

- Midlands and East Specification
- Local guidelines and pathways (e.g. NHS Improvement, 2010, South London a Cardiac and Stroke Network 2010)

At the time of writing, the National Institute for Health & Clinical Excellence have published a Stroke Quality Standard for consultation and have in development a quality standard for transition between health and social care, detailing several indicators which can support commissioning in the future.

5.0 Local needs assessment data

5.1 Prevalence

In 2013/14 the Quality and Outcomes Framework (QOF) prevalence of diagnosed Stroke or Transient Ischaemic Attack for Norfolk and Waveney was 2.2%, 0.5 % higher than the England average rate of 1.7%. The highest prevalence was recorded in North Norfolk (2.6%) and the lowest in Norwich (1.7%) (Table 2).

Differences could be attributed to a number of variables and risk factors for cardiovascular disease in the CCG population, for example, age distribution differences, smoking, obesity, uncontrolled hypertension and lower levels of exercise.

Stroke or Transient Ischaemic Attack (TIA) Prevalence	2009/10		2010/11		2011/12		2012/13		2013/14	
	Number	%	Number	%	Number	%	Number	%	Number	%
GY&W	4,707	2.0	4,882	2.1	4,958	2.1	4,931	2.1	4,957	2.1
North Norfolk	4,082	2.5	4,207	2.5	4,292	2.6	4,183	2.5	4,307	2.6
Norwich	3,430	1.8	3,497	1.7	3,569	1.7	3,501	1.7	3,590	1.7
South Norfolk	4,188	1.9	4,274	2.0	4,339	2.0	4,344	1.9	4,439	2.0
West Norfolk	3,617	2.2	3,744	2.3	3,954	2.4	4,005	2.4	4,148	2.5
Norfolk and Waveney	20,024	2.1	20,604	2.1	21,112	2.1	20,964	2.1	21,441	2.2

Stroke or Transient Ischaemic Attack (TIA) Prevalence	2009/10		2010/11		2011/12		2012/13		2013/14	
	Number	%	Number	%	Number	%	Number	%	Number	%
Midlands and East of England	NA	NA	NA	NA	NA	NA	291,717	1.7	297,364	1.8

Table 1: Prevalence of diagnosed Stroke or Transient Ischaemic Attack (TIA) on Norfolk and Waveney GP registers – trends over time by CCG (Number and % on register 2009/10 – 2013/14. Source: http://www.hscic.gov.uk/catalogue/PUB15751

5.2 The impact of an ageing population

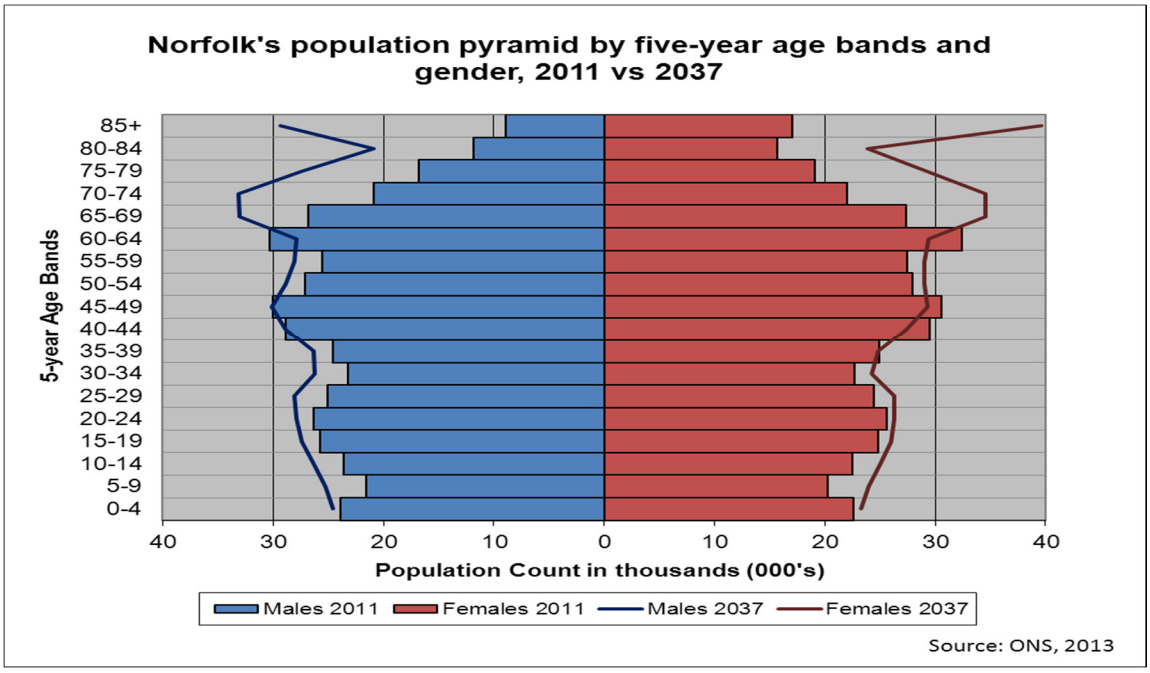
A worldwide study of the burden of major diseases found that though years of life lost due to stroke have reduced by 41 per cent between 1990 and 2010, years lived with a disability as a result of stroke has increased by 50 per cent over the same period (Murray et al 2013).

This is due to a combination of reducing the number of people who die from stroke and therefore increasing the number of people continue to live with associated disabilities.

The ageing population is also likely to increase the numbers of people living with a disability from stoke over time, (and therefore the need for ongoing rehabilitation and support) because the likelihood of having a stroke increases with age.

Figure 4 shows the expected population profile of Norfolk in 2037. By 2037, people aged 65+ will make up 30.4% of the total population in Norfolk (306,000/1,005,900). This is a 10% proportion increase in those aged 65+ than in 2011. This will mean 120,000 more people aged 65+ in 2037 than in 2011.

Figure 4: Population pyramid 2011 vs 2037 Source: PH Health Intelligence Team, 2014

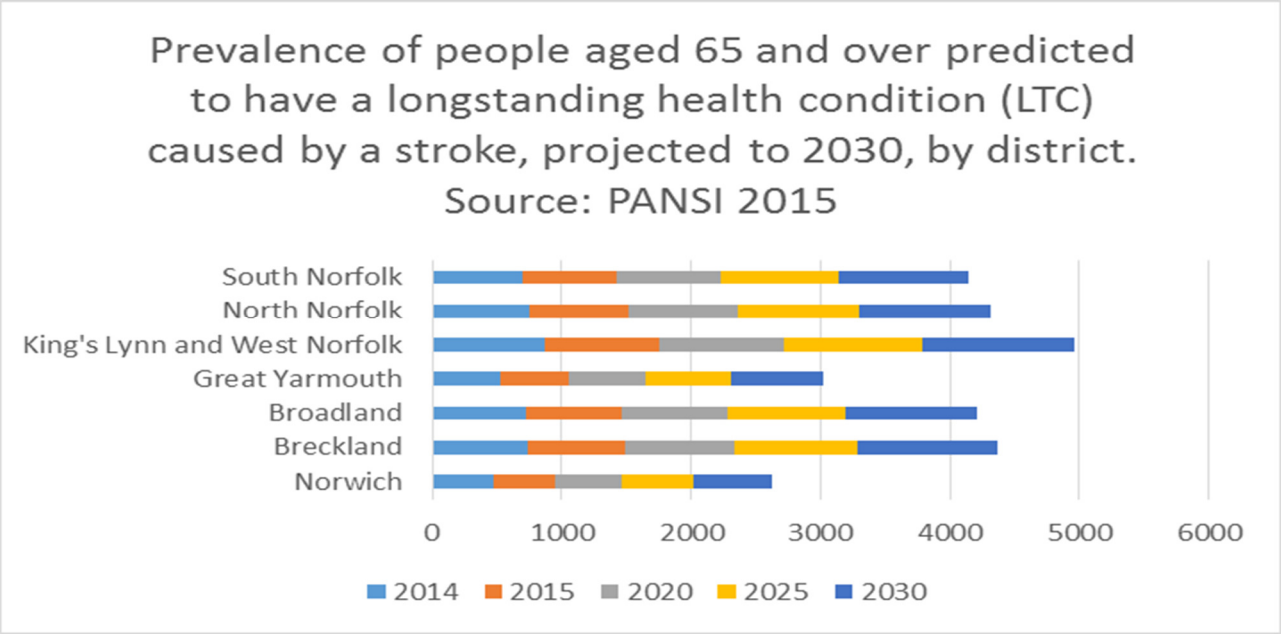


5.3 Projecting longstanding health conditions due to stroke

Over a third of stroke survivors in England, Wales and Northern Ireland are discharged from hospital requiring help with activities of daily living (SA 2015). The Projecting Adult Needs and Service Information (PANSI) estimated that there would be 6,507 adults living at home with a longstanding health condition caused by a stroke across Norfolk in 2015, which is around 30% of all people registered with stroke by GP practice on the QOF registry.

PANSI predicts that the number of people with a longstanding health condition caused by a stroke across Norfolk will increase from 6,507 cases in 2015 to 7,650 cases in 2025 (PANSI 2015). Figure 5 below illustrates PANSI's projections for the districts of Norfolk.

Figure 5: People aged 65 and over predicted to have a longstanding health condition caused by a stroke, projected to 2030 Source: PANSI, 2015



5.4 Deprivation

A useful tool to illustrate the effect of deprivation on years lived with a disability is available from the Global Burden of Disease (GBD) *Compare – Public Health England* online data tool (IHME 2015), which ranks the burden of disease from stroke from 1990-2013 by region and deprivation. 'Burden' of disease can be measured by 'Years Living with a Disability' (YLDs). Figure 6 illustrates the differences in YLD across all age groups when comparing the least and the most deprived areas in the East of England. Higher numbers of years living with a disability due to stroke may be due to the higher overall prevalence of stroke in deprived areas, as people from the most economically deprived areas of the UK are around twice as likely to have a stroke than those from the least deprived areas (Stroke Association 2015). In Norfolk, where there

are more numbers of deprived households in certain areas, this may have an impact on rehabilitation services.

5.5 Co-morbidity, disability, length of stay and re-admission

There are a number of other factors which might be associated with length of stay in hospital or ESD and with longer term outcomes such as readmission after discharge.

One of these factors is pre-existing co-morbidity on admission to hospital with a stroke.

The SSNAP collects data on this, Figure 7 illustrates the case mix across the CCGs. From SSNAP recorded data, West Norfolk CCG is recorded as having a higher percentage (around 5% higher) of stroke survivors with 3 co-morbidities compared to the other CCGs (14.1% vs 7.1-9.3%) and also those recorded with 4 co-morbidities. The Central Norfolk CCGs are recorded as having the highest percentages of those with 2 comorbidities (South Norfolk-26.8%, North Norfolk -25.4% and Norwich- 24.4% compared with Great Yarmouth and Waveney- 22.1% and West Norfolk 21.3% respectively), and Great Yarmouth and Waveney have the most recorded with one co-morbidity. This may be a result of different coding and recording practices when reporting SSNAP data or may reflect a true difference in the populations served by the CCGs.

Figure 6 East of England Differences in YLD: least deprived, most deprived. Source: PHE Compare 2015

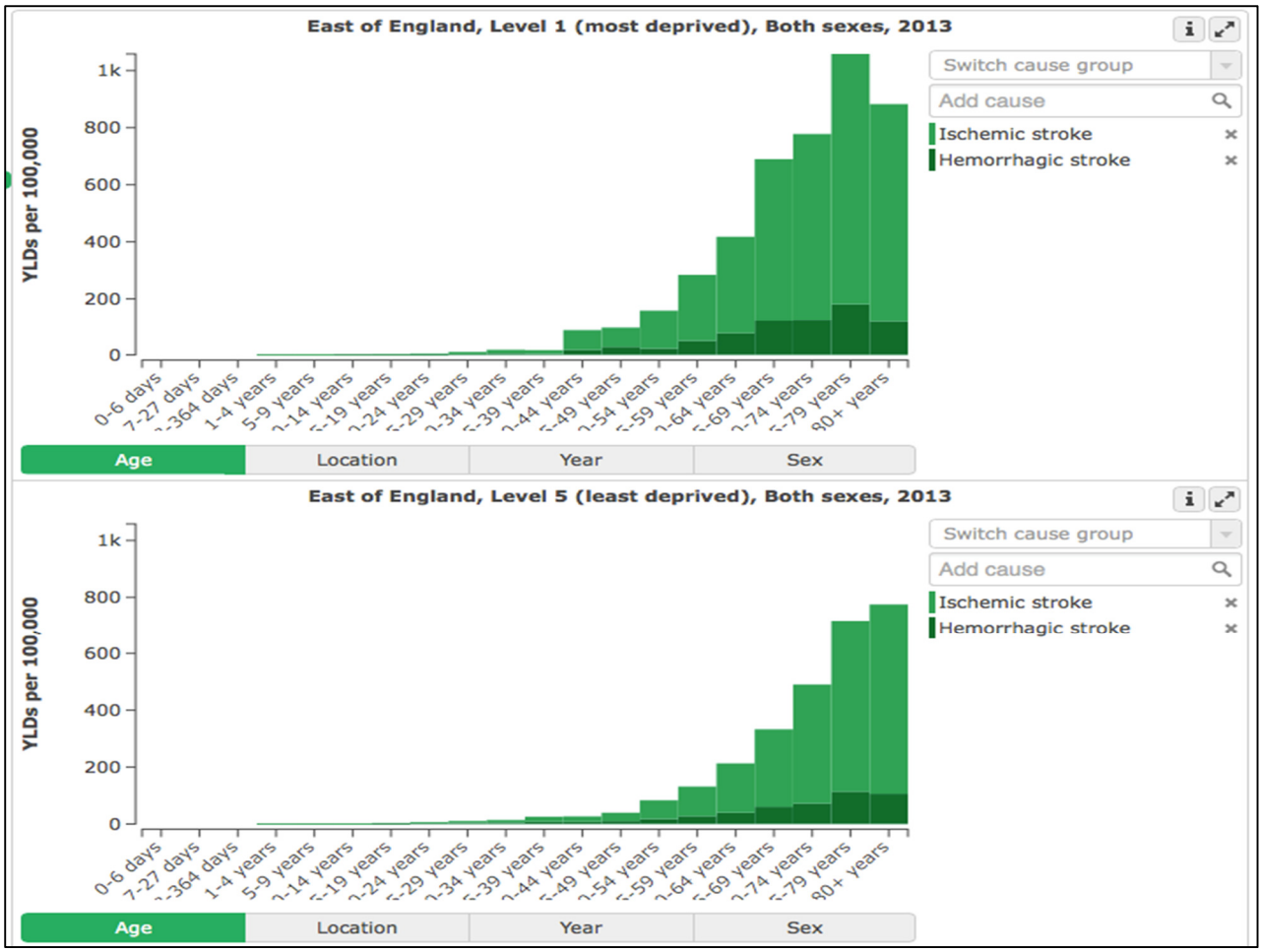
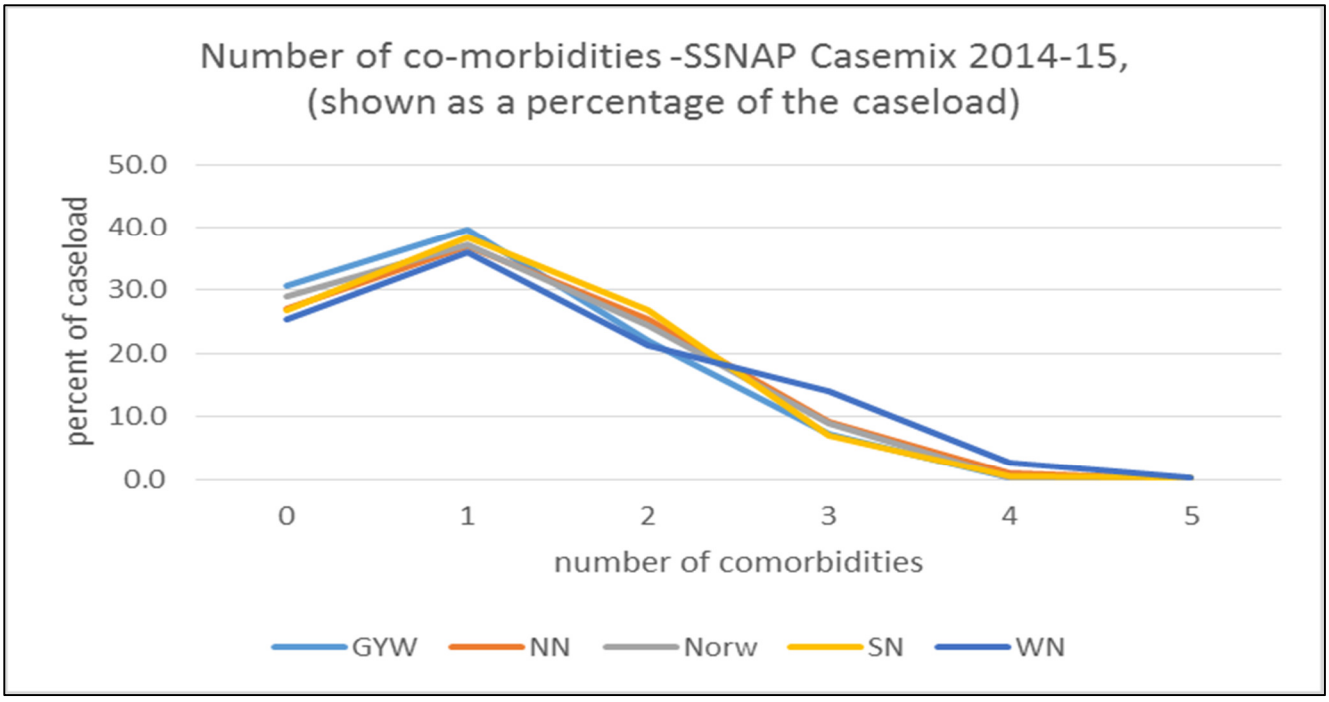
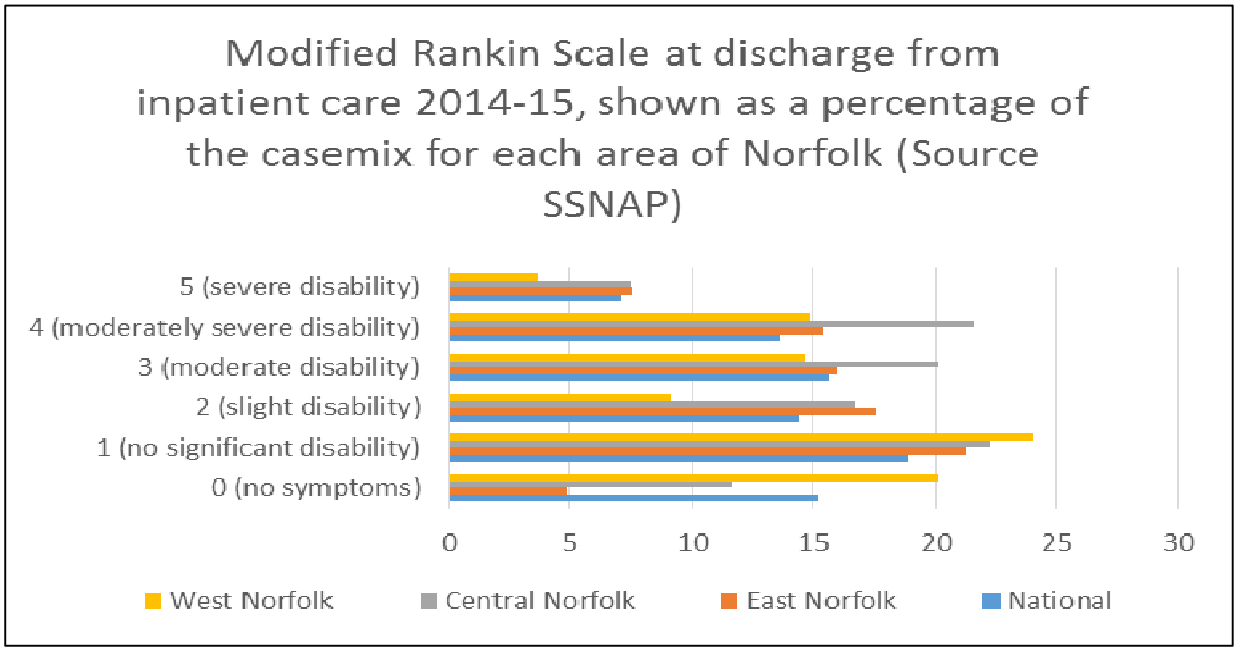


Figure 7: Pre-stroke co-morbidities by CCG Source: SSNAP 2015



The SSNAP also collects 'level of disability on discharge' for each stroke survivor, scored by clinicians using a validated 'Modified Rankin Score'(MRS) measurement (Banks et al 2007). Figure 8 shows variation in levels of disability on discharge from inpatient care recorded in SSNAP data, including a higher level of disability on discharge for central Norfolk stroke survivors. Again this may be a true reflection of the different populations served by the acute hospitals or differences in local practice or interpretation of the scoring systems.

Figure 8: Level of disability on discharge. Source: SSNAP 2015



If the data is an accurate representation, the higher levels of moderate and severe disability in central Norfolk may reflect the different type of provision and complexity in the discharged case mix. Community hospital-based rehabilitation at NCHC provides post-acute, inpatient rehabilitation for stroke survivors, with a small number of outliers from anywhere in Norfolk (for more detail see section 5). This may also be the reason for higher levels of readmission at 30 days for NCHC as in Figure 9 below.

Figure 9: Stroke superspell LoS vs readmission at 30 days by East of England provider. Source: Dr Foster 2015

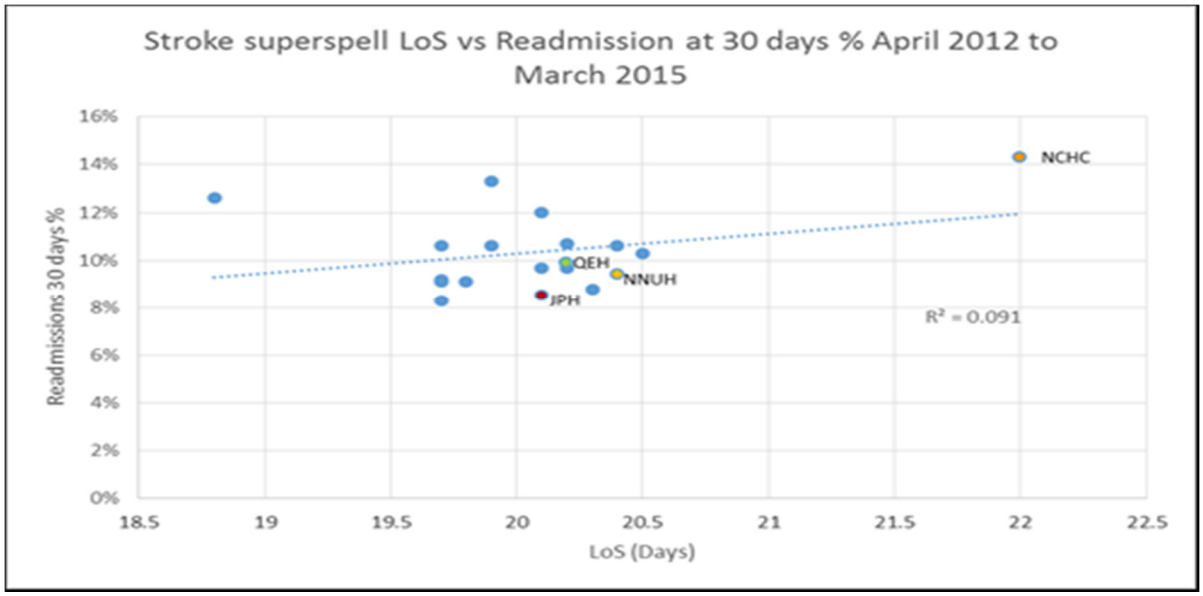


Figure 10 shows that between 2012 and 2015 across the East of England statistically there is little or no relationship between length of stay (LOS) and readmission to hospital at 30 days ($R^2 = 0.091$). Most acute providers recording a mean LOS of between 19.5 and 20.5 days, and readmission between 8% and 11 % at 30 days.

At 90 days after discharge from an acute hospital, the rate of readmission between the three areas of Norfolk has a wider variation.

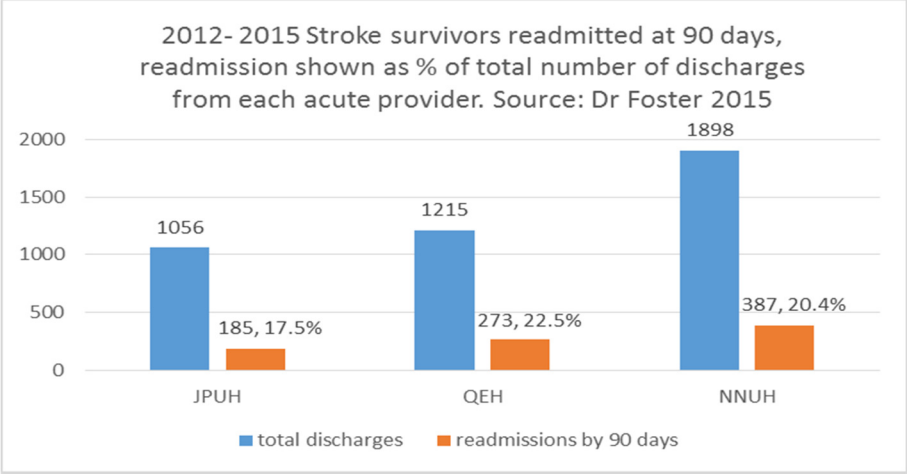


Figure 10 : 2012-2015 Stroke survivors admitted home, readmission at 90 days. Source, Dr Foster 2105

The reasons for this difference in readmission at 90 days should be investigated in more depth, taking both epidemiological and the wider 'systems of care and support' differences into account. The future SSNAP post-acute audit from both inpatient outcomes (Appendix 5), post-acute (ESD) and integrated care and support data collections will also inform further analysis (NICE 2015). At the current time, this data is not collected routinely by providers in any area.

6.0 Benchmarking Exercise

A benchmarking exercise was carried out in July 2015 to compare and contrast the different modes of stroke rehabilitation in the post-acute phase across Norfolk.

The questionnaire used for this was based on the NHS Midlands and East (2012) Stroke Services Specification. The questionnaire (Appendix 3) was piloted and discussed through a focus group meeting with one of the providers of Early Supported Discharge (ESD). Some of the sections of the questionnaire require qualitative, descriptive answers and some questions asked about quantitative information, such as staffing.

6.1 General information

For the purposes of this analysis, Norfolk was split into three areas around the existing acute stroke services:

- West Norfolk: commissioned by West Norfolk CCG
- Central Norfolk: commissioned by North Norfolk, Norwich and South Norfolk CCGs
- East Norfolk: commissioned by Great Yarmouth and Waveney CCG

Table 3 provides general information regarding stroke rehabilitation for 2014/15, including activity.

Table 2: 2014-15 numbers of stroke survivors discharged to their usual place of residence (Source : provider questionnaire- self reported)

General Operational Information 2014/15			
	West Norfolk (QEH)	**Central Norfolk (NCH&C)**	**East Norfolk (JPUH/ECCH)**
Numbers of stroke survivors discharged home 2014-15 (+ percentage of total admitted pts with stroke, discharged home. (Source Dr Foster)	394 (74.1%)	(NNUH+NCH&C) 605 (51.4%) + 71 (21.5%) = 676 (44.8%)	352 (67.3%)
Numbers of new referrals in 2014/15	PT & OT= 475 SLT= 134 Total PT/OT/SLT= 609 Psychology (inpatient and community)= 127 Dietetics (inpatient and community) = 159	ESD=424	ESD=174 *(+ follow on by ECCH Neurology = 268 SLT=348)*

General Operational Information 2014/15			
	West Norfolk (QEH)	**Central Norfolk (NCH&C)**	**East Norfolk (JPUH/ECCH)**
Settings ESD/SSR is provided in	Provided in a range of community settings, e.g. home and clinics	SS' home, 6-month follow up = clinic or home	Home, residential home, workplace (ESD) *Outpatients, Home & Community (ECCH Neuro)*
6-month review provision	As requested	6-month follow up= 1285	As requested
Service Specification/Agreement in place	2008, clarity being sought around PT/OT provision	Yes, (provided)	In process (copy provided) (ESD) Yes (ECCH Neuro)
Key performance indicators agreed	-KPIs for acute rehab as is a continuous service	Yes	Yes

According to Dr Foster data, the percentage of stroke survivors discharged from hospital care to their usual place of residence in 2014/15 was:

- 74.1% (n=394) discharged from QEH in West Norfolk,
- 67.3% (n=352) discharged from JPH in East Norfolk and
- 44.8% (n=676) discharged from NNUH and NCHC in Central Norfolk.

As discussed in the previous section, a separate cohort of people discharged from NCHC may have a higher level of disability and therefore may be less likely to be discharged to their usual place of residence.

Data for overall provision of ESD/SSR on discharge was not available for SSR provision in the West due to the way that the different AHP contact is recorded (see Table 3 below). In East Norfolk and Central Norfolk
ESD or SSR was provided for:

- 49% (N=174) of people discharged from JPUH (East Norfolk) and
- 62% (N=424) of people discharged from NNUH and NCH&C (Central Norfolk).

This is consistent with the higher level of disability on discharge in Central Norfolk, found in the SSNAP although this may not be the only reason and further work is needed to explore these differences.

6.2 Stroke rehabilitation models

In this section the data that has been provided is descriptive and qualitative and is self-reported from the provider perspective. Although this is rich in detail and accuracy, it provides fewer parameters that are directly comparable.

It is anticipated that commissioners and providers will discuss this qualitative data in the context of what is known quantitatively in order to understand a clearer picture of the pathway and potential future developments.

6.2.1 East Norfolk service model

In the East Coast, there are three main routes of care and support on discharge from acute care (Figure11):

- Early Supported Discharge (ESD) – provided by JPUH
- Community Neurology – provided by ECCH
- General Community Nursing/ reablement care (not covered by this review).

This is supported by Voluntary, Community and Social Enterprises and other specialised services.

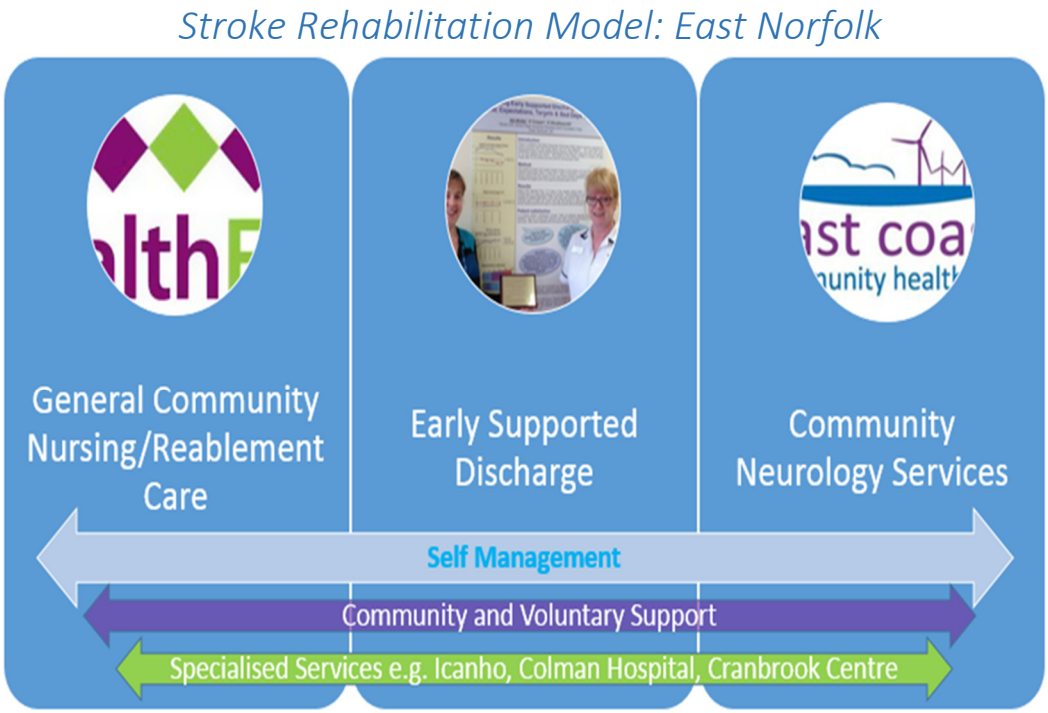


Figure 11 East Norfolk - routes of care and support on discharge from acute care

6.2.1.1 East Norfolk: ESD service- JPUH

a. Outline of service

The ESD service at JPUH provides care and support for up to 16 weeks with PT/OT/SLT/RAs and a 0.5WTE stroke nurse.

Providing the core intensive rehabilitation and goal setting according to the Stroke Strategy, this service focuses on:

- cognitive, physical and domestic rehabilitation,
- community access,
- social re-integration (sport and leisure)
- average length of stay with ESD is 7 weeks

Specialist rehabilitation can be in combination with reablement care from integrated services, the admission prevention service, or from the out-of-hospital community (generic) service.

The service is also able to assess symptom control, driving, medication and secondary prevention on request

Mood screens are embedded within both acute and ESD pathways. Level 2 psychological support is available to patient and carers, with signposting to other mental health and wellbeing agencies as necessary.

b. Improvement to the service

The JPUH ESD team reported they would like to improve their service with:

- 100% provision of a 6-month review (currently in discussion with commissioners)
- Integrated social care within ESD and
- Integrated longer term community rehabilitation to provide seamless care.
- The ESD team are able to provide Level 2 wellbeing assessments but there is no specialist stroke psychology service at the current time.

Best Practice
Examples of best practice with the East Norfolk ESD were given as:

- *Working as one organization (seamless care from inpatient to ESD under the same provider)*
- *Integrated care,*
- *Support and discharge planning with the ward therapy team (e.g. a full time discharge co-ordination in post facilitates forward planning and communication between all community services, stroke survivor and carers),*
- *Excellent generic skills,*
- *Holistic care and individualised treatment planning.*

c. Transfer between agencies: JPUH ESD and ECCH

There is a continuation of specialist community based support when East Coast Community Healthcare (ECCH) CIC Neurology Services take over from JPUH ESD if outstanding goals have been agreed between all parties.

Smooth transition to this service is facilitated by Neurology staff attending MDT meeting held at GP surgeries or joint sessions can be arranged with both services to handover patients with complex needs. A Stroke survivor is assigned a keyworker by ECCH. This can also be transitional pending on changing need.

6.2.1.2 East Norfolk: Community Neurology, Self-Management Caseload - ECCH

a. Outline of service

- Specialized rehabilitation managed on a self-management caseload.

- Regular review dates and long-term timescale mutually agreed.
- Caseload, remains open, facilitating a fast-track pathway back to further specialist review if necessary.
- Personal health care plan on how to self-manage their condition.
- GP receives progress summaries following reviews and can access specialist advice/services directly.

b. Improvements to the service

Gaps in current provision reported:

- No community-based Stroke Nurses in the East
- Not enough Community–based Speech Therapists
- Botox clinic is no longer accepting referrals for patients post-stroke.

Possible other improvements for the future are cited as:

- '*To develop into a specialist service rather than General Neurology'*

Best practice
The ECCH Neurology Service manager describes examples of best their practice as:

- *Developing integrated working across acute, ESD and Community, joint training and clinical supervision between the two sectors.*
- *Development of a specialist interest group involving OTs and PTs to share best practice, review guidelines and discuss complex cases.*
- *Joint home visits between acute, ESD and community prior to discharge to ensure patient safety through peer review.*
- *Service specification based on National Service Framework for Neurological Conditions (NSF 2005).*
- *Communication café and communication maximization groups: total communication groups, eight sessions available across ECCH boundaries.*
- *Piloting a successful carers' group.*

- '*More opportunities for intensive therapy' for SLT.*

6.2.1.3 East Norfolk: Voluntary, Community & Social Enterprise (VCSE)

a. Outline of service

In 2014/15, 437 stroke survivors had support from the Stroke Association in East Norfolk, either through contact on the Stroke Unit, in the community or at home.

With the patient's consent, the Stroke Association liaises with all of the statutory health and social care and support agencies in order to achieve several of the essential quality markers for rehabilitation specified in the National Stroke Strategy (2007):

- Self-management and accessing informal community and voluntary-based support,
- Communication Café run by volunteers and supported by the SLT service

- Stroke Information & Advice Co-ordinator (28 hours a week) offering the service to each for up to 12 months following initial referral
- Varied support depending on clients' needs.
- Stroke survivors, carers and family able to directly access the service.
- Personalised information; advice and support to enable them to make informed choices

b. Improvements to the service

When asked "How would you like to improve the current service?" the Stroke Association answered:

"We are a very busy service and we are having to reduce the scope and level of service we provide, following a reduction in hours as a direct result of failure to secure a uplift in funding over the life of the service (6 years). An increase in funding would allow us to bring back this level of service to its former state."

Also when asked, "Are there any gaps in current provision?" the reply was:

"We haven't got capacity or funding to provide a Prevention Service, this is much needed and would have a positive impact on stroke prevention and related health issues locally."

Best practice: Stroke Association in the East of Norfolk

A Best Practice example of the Stroke Association's service in the East of Norfolk is a weekly drop-in café for clients to obtain healthy lifestyle information, combined with a drop-in facility from a representative from the Jobcentre Plus.

The co-ordinator also gave two individual examples of cases where due to cognitive impairment or disability, a client needed extended episodes of support and liaison between several different agencies. The service was able to provide advice, liaison and support in order to promote self-care and problem-solve, avoiding re-admission or heavy use of statutory care and support services.

Examples like these illustrate how the commonly recorded experience of 'abandonment' after discharge can be avoided, ensuring appropriate information support for the continuation of life after stroke.

In this way, the Information, Advice and Support Service helps to build confidence in stroke survivors, appropriately signposting them and ensuring they are given the opportunity to engage with local groups/agencies towards their rehabilitation goals.

6.2.2 Central Norfolk service model

In Central Norfolk there are two main routes of care and support on discharge from acute care (Figure12):

- Early Supported Discharge (ESD) – provided by NNUH and NCHC
- General Community Nursing /reablement care (not covered by this review).

This is supported by Voluntary, Community and Social Enterprises and other specialised services.

Figure 12: Central Norfolk - routes of care and support on discharge from acute care

6.2.2.1 Central Norfolk: Beech Ward NCHC and ESD service NNUH

a. Outline of service

The multi-disciplinary team of healthcare practitioners comprises PT/OT/SLT and specialist stroke nurses and therapy assistants. Rehabilitation is based on NICE Quality Standards and the RCP Guidelines, as in Figure 13.

- Beech Ward: post-acute, community based 24- bedded stroke rehabilitation ward for inpatient rehabilitation and an intensive packages of support
- NNUH senior clinicians having regular input (5 days a week), overseeing the referral process from acute care into and between Beech Ward and to ESD
- ESD team provides a rehabilitation service over 7 days a week.
- The average length of stay with this service is 6 weeks (or less); the maximum is 16 weeks.
- 6-month follow-up in outpatient clinics and patients' homes.
- NB: Beech Ward also takes patients from the whole of Norfolk.

Figure 14 illustrates the process of ESD for six weeks after discharge. This is the average time that stroke survivors require the service.

Beyond specialised stroke rehabilitation within the ESD there is no specific long-term pathway for stroke survivors. Discharges are planned with the patient and carer and onward referral to other NHS Community (generic) services, voluntary groups etc. are made with the agreement of the patient and carer, if appropriate.

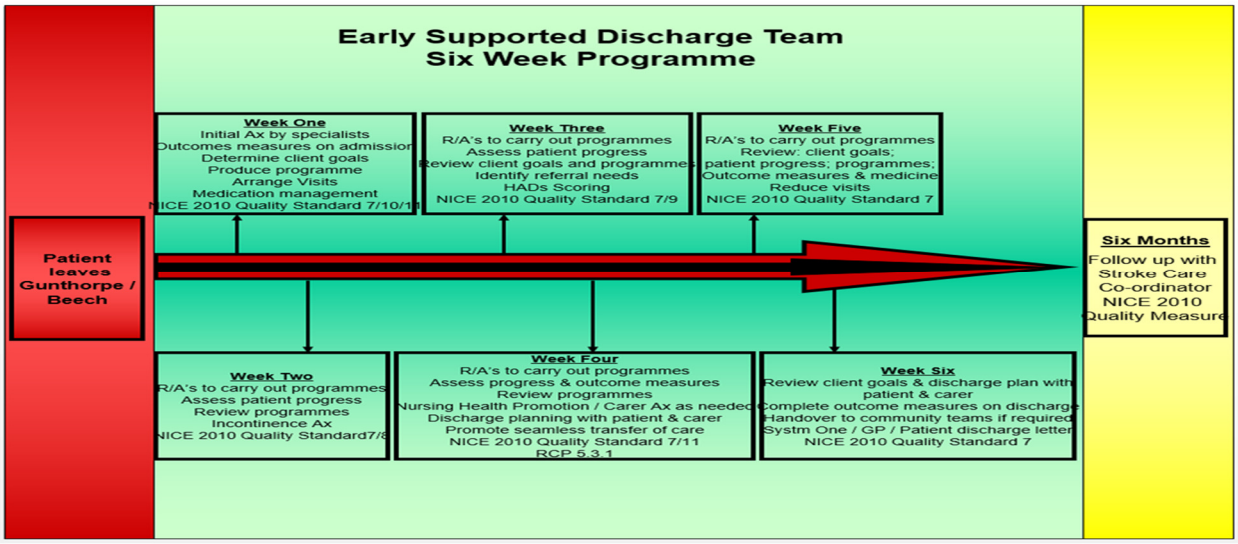


Figure 13: Typical programme of rehabilitation for a stroke survivor - NCH&C ESD (source: Provider)

b. Improvements to the service

There is no direct route back into specialized rehabilitation other than in the event of another acute stroke.

The ESD services reported that they have worked closely with their community colleagues and on two occasions have provided assessment and time limited intensive support for two stroke survivors who showed physical improvement (after they had been discharged off the current stroke pathway) that suggested an intense specialist intervention would be beneficial.

Both patients were transferred back to their community teams for slower rehabilitation and continued improvement. These were used as case studies to demonstrate the potential benefits of a community stroke service/flexible pathway. NCH&C are currently discussing how future integrated care caseloads might be managed.

When asked, what would improve the current service, the service manager stated,

"*I would like to develop a community stroke service which is less intensive than ESD, but still time limited. Referrals route would be via community teams or GPs using specific criteria. Existing ESD service could be enhanced with extra staff to support this community service and retain specialist expertise and knowledge".*

The ESD service in Central Norfolk describe examples of best practice as:

- *Packages of care*
- *Packages of support*
- *Integrated working*
- *Training delivered to stroke survivors/carers*

An example of integrated working is the delivery of stroke specific training to the Norfolk First Response (NFS) reablement carers, who support stroke patients on discharge from the inpatient stroke rehabilitation ward and ESD.

There has been a recent collaboration with the Independent Care Sector, highlighting the specific needs of stroke survivors who are living in the care home environment; this has resulted in a 'Ten Top Tips' guide to support awareness.

The nurses within ESD have identified skills/training to support patients who require 24hr cardiac monitoring by delivering a service to the patients' home.

There is stroke/carer support group which runs over a 3-week period, providing training and information as well as encourage support from fellow stroke survivors.

All rehabilitation services, ESD and 6-month follow-up provide a feedback questionnaire to patients and theirs carers.

Regular Transfer of Care meetings involving clinicians in the stroke pathway and community teams.

Gaps in the ESD service were listed as:

- No dedicated community stroke team
- 6-week follow- up
- 12-Month follow up
- No family support worker (not provided by health services)

6.2.2.2 Central Norfolk: Voluntary, Community & Social Enterprise (VCSE)

There is no commissioned activity from the Stroke Association or other community, voluntary or social enterprise in Central Norfolk. However some stroke survivors access support from:

- A volunteer-led Norwich Stroke Survivors Group, supported by the Stroke Association that meets once a week.
- An Aphasia Café , supported by the School of Rehabilitation Sciences, University of East Anglia, whose 'Conversation Partner' scheme sees all first year Speech and Language therapy students provide stroke survivors with stimulating conversation once a week for 6 months.

6.2.3 West Norfolk service model

In West Norfolk there are two main routes of care and support on discharge from acute care (Figure14):

- Community outreach specialist stroke services – provided by QEH
- Secondary prevention service- provided by the Stroke Association
- General Community Nursing /reablement care (not covered by this review).

This is supported by other Voluntary, Community and Social Enterprises and other specialised services.

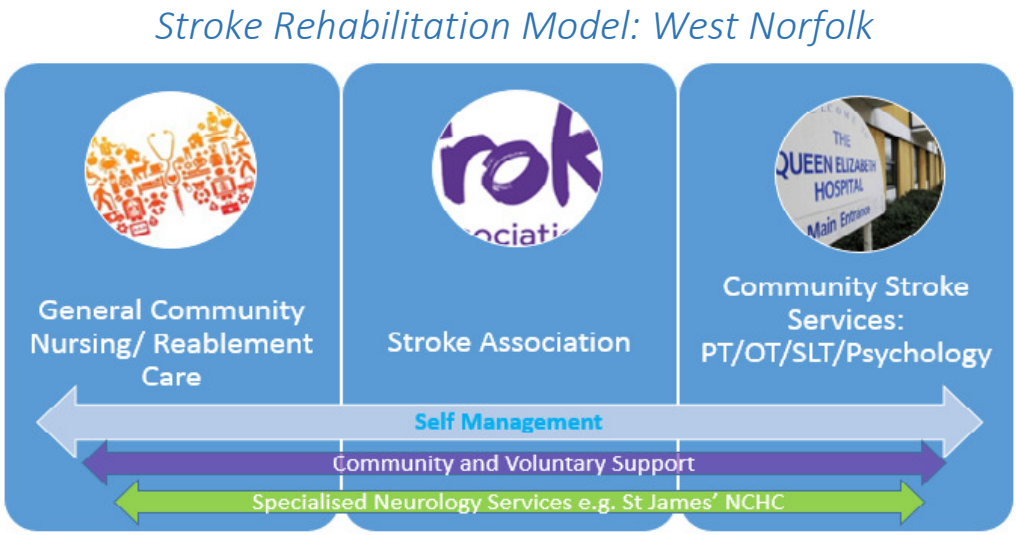


Figure 14: Central Norfolk - routes of care and support on discharge from acute care

6.2.3.1 West Norfolk: Community outreach stroke specialist rehabilitation - QEH

Based at the QEH, Kings Lynn, the community outreach-based stroke specialist rehabilitation team operates as an outreach Specialist Stroke Rehabilitation service from the QEH Stroke Unit and provides both intensive and slow-stream therapies at the core recommended, 'gold standard' intensity and availability of therapy sessions.

The team can provide a PT/OT and SLT, also a specialist psychology and dietetic service. However, this is not formally recognized as an ESD service. An ESD service specification has not yet been agreed with commissioners beyond the acute stroke pathway, which was drawn up several years ago in 2008.

The Stroke Association is also commissioned to provide part of the rehabilitation and prevention service.

a. Outline of service

- PT and OT provided in a range of community settings including home/sports facilities and shops
- SLT therapy in the patient's own home, care homes/nursing homes, in the community rehabilitation gym or community centres for group work.
- Long-term therapy is continued for as long as is clinically indicated.

- No ‘average’ timeframe for each of the services. Length of rehabilitation for all practitioners is described as being dependant on patients’ goals, which are usually reviewed in 6 week blocks for PT/OT/SLT.
- Referrals are usually seen within 3 days. If a new stroke survivor is referred as urgent, they will be seen within 24hrs but all patients are seen within one week
- Clinical Psychology and Dietetics have initial contact in the hospital setting, with follow up at outpatient clinics and in the community if a particular need exists.
- Dieticians also provide presentations and training to staff in care settings, re PEG feeds
- The service managers state that they have no access to generic community services at present so as a result we do not co-produce any integrated care/support with them.

b. Improvements to the service

The provider of this service has given the following statement regarding improvements to the service:

“We provide a very high standard of rehabilitation to our patients, but clarification around the commissioned pathway for patients requiring ESD would enable us to improve the services which we offer”.

The psychology service would like to implement the following improvements in line with British Psychological Society recommendations:

- For all patients to receive a mood screen prior hospital discharge and at identified points thereafter.
- To meet the metric of 40% of stroke patients receiving psychological support within 6 months.
- For all patients returning to cognitively demanding activity to receive a neuropsychological assessment 6 months post-stroke. Referrals on a case by case basis.
- To reduce the waiting time (currently 9 months for routine cases) for psychological input.

Best Practice reported by QEH Specialised Stroke Rehab Team included:

- *7th best Stroke service nationally*
- *No therapy waiting list for patients to be seen*
- *Delivery of training packages for Care Homes*
- *Well established Service User group*
- *Well established patient satisfaction interviews*
- *Spasticity training*
- *Hydrotherapy service (coordinated by Integrated team)*
- *One provider - Seamless service from acute to long-term care*
- *No waiting lists for SLT*
- *MDT Stroke Specific botulinum toxin clinic.*
- *The use of Electirical Stimulation and Functional Electrical Stimulation for upper limb and lower limb, for acute and community patients.*
- *Vocational rehabilitation at the appropriate time for individual patients.*

- *SLT team won the East of England Excellence in Stroke Care Award 2012*
- *SLT Assistant won the National Royal College of Speech and Language Therapists Assistant Practitioner of the year 2014*
- *The SLT stroke team have delivered training packages to Care homes/nursing homes, Stroke Association volunteers and Stroke Association support groups*

- *Local Costa Coffee staff to raise community awareness of post-stroke communication difficulties and how to support those with communication difficulties in order to facilitate the Communication Café*
- *GP awareness campaign: aphasia and communication difficulties post-stroke, jointly with the Stroke Association*
- *Aphasia awareness campaign involving stroke survivors*

6.2.3.1 West Norfolk: Voluntary, Community & Social Enterprise (VCSE)

a. Outline of service

- In 2014/15 the Stroke Association in West Norfolk had 505 new referrals who were supported either on the stroke unit, in the community or through home visits.
- A commissioned secondary prevention service from the Stroke Association also exists, with co-ordinators who work with the Stroke Unit and the Specialist Community team.
- There are regular MDT meetings on the ward which one member of Stroke Association staff attends weekly. There are monthly Community MDT meetings which all three Stroke Association staff attends where possible.

- Stroke Association to provide relevant and accurate advice to patients in the community regarding diet and stroke.
- The Stroke Association are able to refer directly to specialist rehabilitation for SLT if it is felt necessary, even if it is several years on from a person having a stroke. Likewise, with OT/PT they are able to discuss whether it is appropriate to be directly referred back or they can be referred back by the GP.
- Joint running of the communication support group and Communication Café with the Stroke Association.
- Setting up and delivering a high-level communication group jointly with Stroke Association when clinically indicated.
- There are also two Stroke Association Voluntary Groups (SAVGs) running once a week in Downham Market and Hunstanton; both groups welcome carers along with stroke survivors. Within both groups there are separate relaxation sessions for carers on a regular basis.
- Carers are also welcome onto the Healthy Lifestyle Programme (HLP) and there is also a separate wellbeing session for carers within the HLP. There is also a monthly drop-in group providing info for stroke survivors & carers. Carers are also welcome to other groups run by the Stroke Association such as Art and Tai Chi.

b Improvement to the service

The Stroke Association are concerned that some stroke survivors are struggling as although admitted to the QEH, they are 'out of geographical area' for the Stroke Association. For example, if they live at Thetford or Wisbech there is a gap in Stroke Association provision.

With the patient's permission, the Stroke Association give the following case example (names have been changed*):

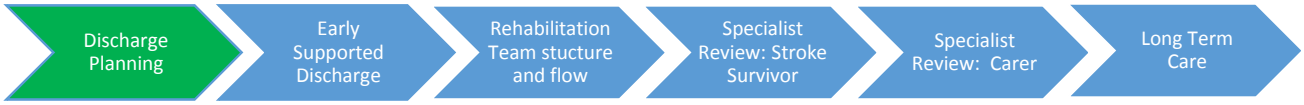
"Susan had her stroke 18 months ago...her husband has long-term disabilities and Susan was his carer before her stroke. However, her husband Matt* contacted us again last week saying they are in crisis and they have had mental health team visit who feel the problem is stroke related. We (the SA) have spoken to Matt on the phone, gave him some information and told them about the website and how to get more information-however that is all we can offer."*

Best Practice

The Stroke Association in West Norfolk gives their own examples of 'best practice' as:

- *Integrated working – the Stroke Association co-ordinators regularly attend MDT meetings on the ward.*
- *In 2015 the Stroke Prevention Co-ordinator received a Stroke Forum award for Excellence in Care.*
- *Know your Blood Pressure (KYBP) events in the community and give Life after Stroke talks to many groups wanting to know what services are available for stroke survivors in West Norfolk.*
- *Outbound referrals to other Life after Stroke co-ordinators for patients admitted to the Queen Elizabeth Hospital who are out of area are recommended*
- *The Information, Advice & Support co-ordinator sends an introductory letter to stroke survivors on discharge, explaining the different services provided in West Norfolk and enclosing a service leaflet with all contact details on.*
- *Two long-term support groups in Hunstanton and Downham Market have regular speakers giving information/ training to survivors and carers such as SLT, OT/PT, psychology as well as other organizations such as West Norfolk Carers, so they are informed of what is available in the community.*
- *Hydrotherapy for Stroke survivors*
- *Groups: Drop-in, art & crafts, Tai Chi & Healthy Lifestyle Programme (HLP) – all of them include survivors & carers.*
- *Downham Stroke Association Voluntary group (SAVG) received a Life After Stroke award in 2012*

7.0 Similarities and Variations across Norfolk



7.1 Discharge planning

Despite the differences in how the three different systems work for Stroke Rehabilitation, several core quality markers are achieved by all providers in discharge planning:

- ✓ **All Stroke Survivors referred to providers from acute rehab/hospital have a personalised transfer of care or discharge plan/document**
- ✓ **All providers involve stroke survivors in discharge planning process**
- ✓ **All providers have processes for involving family/carers in the discharge process**
- ✓ **All providers have processes for informing the GP of discharge**
- ✓ **Joint decision making across the MDT and between survivor/carer for discharge and rehabilitation**
- ✓ **All providers carry out a home visit where required**
- ✓ **Discharge is led by Specialist Stroke team**

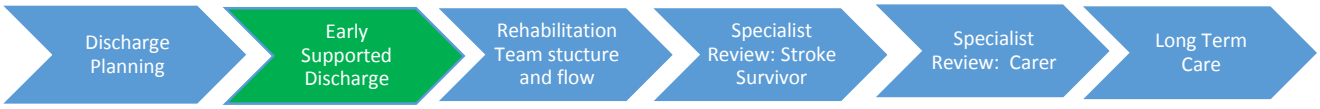
Table 3: Variations in assessment and transfer documents. Source: self-reported provider questionnaire

	West Norfolk	Central Norfolk	East Norfolk
Assessment tools to aid discharge planning/transfer of care	OT/PT/Dietetics tool Mood screen, Clinical Psychology /cognitive tools used (OCS, MoCA) Berg balance scale Mesupes arm Discharge summary-onward referral, Barthel & Rankin score. OT home visit report	MoCA, OCS, Berg, Western Aphasia Battery, PHQ9, GAD7, BASDEC, DISCS	MoCA, Barthel & Modified Rankin Score Detail in JPUH discharge front sheet /ESD acceptance sheet and Neuro service specification
Protocol/referral for integrated care and support	Protocol in place	Referral Letter proforma	JPUH & ECCH working towards, case manager supports coordination, Joint care documented and kept by SS "My Stroke"

Table 4 illustrates the variations in practice.

There is variation in different assessment tools used for assessing stroke-related disability and outcomes of treatment/ therapies, with no universally agreed standard across the county. This is potentially an issue for both stroke survivors and carers being assessed for and accessing integrated care from any number of different independent providers.

In particular, it is not clear how '*previous level of function'*, or disability of the stroke survivor is communicated. According to NICE, comprehensive assessments of Stroke Survivor's previous functional abilities, impairment of psychological functioning (cognitive, emotional and communication), body functions, including pain activity limitations and participation restrictions and environmental factors (social, physical and cultural) should be conveyed to and understood by all those involved in the care and support of stroke survivors, including the person themselves and their carer (NICE 2013).



7.2 Early Supported Discharge (ESD)

In all areas, the ESD and SSR teams provide the core quality markers of a home-based model of rehabilitation in which interventions are tailored to each stroke survivors' individual needs and priorities:

- ✓ **ESD/SSR is available at the stroke survivor's place of residence, or other appropriate community setting according to individual preference.**
- ✓ **ESD/SSR (OT/PT/SLT) is available at least 5 days per week**
- ✓ **OT/PT/SLT available for up to 45 minutes per session (as required)**
- ✓ **OT/PT/SLT is offered at least to the same standard/intensity as in hospital**
- ✓ **Decisions on the level or intensity of ESD therapy support is decided on an individual basis**

Variations exist in the referral criteria, timescale for provision, number of days of the week that the service is available and commencement of treatment.

In Central Norfolk, the ESD service has a 3-point referral acceptance:

- *Mild to moderate stroke*
- *Able to transfer from bed to chair with one helper and a piece of equipment*
- *Must be able to summon help in emergency if living alone*

In the East, the ESD acceptance criteria is more detailed. Stroke survivors should:

- *Have realistic rehabilitation goals.*
- *Be able to provide consent.*
- *Have continence needs that can be managed at home.*
- *Have nutrition and hydration needs that can be managed orally or by PEG, and have family and carers support to meet those needs where necessary.*
- *Be cognitively able to cope with rehabilitation.*

- *Have functional sitting balance and be able to transfer alone or with the support of one person (and equipment if necessary). If unable but wants early discharge, liaise with ESD prior to referral.*
- *Be in agreement to participate in home-based rehabilitation and recognise that it is offered for approximately 6 weeks*
- *Record a Barthel Index score of 50 – 85. If outside of this score, liaise with ESD prior to referral.*
- *Not have been in hospital for more than 4 weeks. If they have, liaise with ESD prior to referral.*
- *Have a safe home environment suitable for rehabilitation.*
- *Be medically stable (may not be documented medically fit for discharge).*

In the West, rehabilitation is blocked into 6 week blocks and continues on as long as rehabilitation goals are being met. The service does not pass care onto the generalist community team. Our involvement can be as long as 10 years post stroke currently. There are ongoing discussions with commissioners about the scope and overlap of these services.

This '*specialist stroke rehabilitation (SSR)'* provision is not strictly an ESD service, therefore does not follow the same model for acceptance or transfer. However, staffing levels are similar, the service provides a comprehensive dietetic and psychology service and works alongside the Stroke Association, commissioned for secondary prevention, advice, support and communication groups.

In all areas, although the core team of OTs, PTs and SLTs is available for at least 5 days per week the Midlands and East Specification states that 7-day working should be achieved as a long-term goal

Table 4: Working days. Source: provider questionnaire

	West Norfolk	Central Norfolk	East Norfolk
ESD/core SSR Availability	PT =6days SLT=5days OT=6days	ESD OT/PT/SLT/Stroke Nurse 5 days Assistant practitioners weekends (ESD practitioner always on duty at w/e)	ESD = OT/PT 5 days Mon-Fri, SLT 2.5 days SLT assistant practitioner support 2.5 days (+ECCH Neuro SLT 5 sessions/week)

7.3 Specialist Stroke Rehabilitation (SSR) team structure

- ✓ **All providers employ core AHP Rehabilitation Practitioners: OT, PT, SLT**
- ✓ **Rehabilitation assistants provide support, progress rehabilitation goals and ensure continuity in all areas.**

Specialist Stroke Rehabilitation team structure - Variation				
	West Norfolk WTE (WTE per 100 referrals) SS	Central Norfolk WTE (WTE per 100) SS	East Norfolk WTE (WTE per 100) SS	NHS Midlands and East recommendation WTE per 100 cases
Occupational Therapist OT	3.6 (for OT&PT this is 1.1 per 100 SSR referrals)	3.24 (number per 100 not available)	2 (1.3 per 100 cases) [+ 3 WTE Generic Neuro]	1
Physiotherapist PT	1.8 (for OT&PT this is 1.1 per 100 SSR referrals)	3.64 (number per 100 not available)	2 (1.8 per 100 cases) [+8 WTE Generic Neuro]	1
Speech and Language Therapist SLT	1.5 (1.1 per100)	1.08	0.5 (0.7 per 100 cases) [+0.5 WTE Generic Neuro]	0.4
Stroke physician	0	0	0	0.1
Stroke Consultant Nurse	0	0	0	
Stroke Nurse	0	5.18	0.5 (0.3 per100 ESD cases)	0-1.2
Social Worker	0	0	0	0-0.5
Rehab/Therapy Assistant	2.17	7.6	2.8 (1.6per 100 ESD cases) [+5 WTE Generic Neuro]	0.25
Clinical Psychologist	0.4 (0.15 per 100 cases)	0.8	0	
Psychology Assistant	0	1	0	

Assistant Practitioner	2.22	3	0	
Dietician	0.64	0	0	
Orthotics	0	0	0	
Orthoptics	0	0	0	
Other e.g. admin, voluntary support	0.63	1.6	1	

Table 5: Specialist Stroke Rehabilitation team structure

The survey showed that the composition of teams was similar in terms of provision of core allied health practitioners and assistant practitioners (Table 6), but it was not possible to compare levels of staffing as some areas did not have the data available.

An important factor to note is that across Norfolk, Rehabilitation Assistants (RAs) provide support, progressing goals, may take over the care of less complex cases and deliver everyday continuation of treatment plans. In Central Norfolk RAs work at the weekend, visiting people at home, with practitioner on-call cover, facilitating a full 7-day service.

There were wide variations on access to other specialist interventions, for example, there is no psychologist support in the East and no community stroke nurse in the West. Consultant time is not available to ESD in Norfolk on a formal basis although all providers stated that the teams work in a multidisciplinary way throughout the pathway.

7.4 Specialist review (Stroke Survivor)

The Midlands and East Stroke Services Specification (NHS Midlands and East 2012) states that all stroke survivors should receive a review at 6 weeks, 6 months and 12 months and then annually that facilitates a clear pathway back to further specialist review, risk factor screening, advice, information, support and rehabilitation where required is provided.

At 6 weeks, medical review is normal practice, with ESD/SSR continuing to review interventions and goals as appropriate.

At 6 months, central Norfolk is the only provider which fulfils the basic requirement of assessments, recommended by all National Guidelines.

Table 6: Variation in practice for specialist review Source: Self-reported provider questionnaire

Variations in practice Specialist Review (Stroke Survivor)			
	West Norfolk	**Central Norfolk**	**East Norfolk**
6 weeks post discharge	Medical MDT review monthly PT/OT intervention reviewed in 6 wk blocks SLT as indicated	None stated for ESD	Consultant review (plans for ESD to review at 6 wk and cons to take on 6 mth)
6 months post discharge	None stated	ESD Stroke Nurse – assessment targeted at all stroke survivors (N=1285) Wellbeing, Self-Management (Mgt), Medicines Mgt , Lifestyle, Mood screen, AF Mgt	None at present
12-month follow up	Stroke Association Members stay on register for 12 months from joining	Stroke Association Members stay on register for 12 months from joining	Stroke Association Members stay on register for 12 months from joining
Other eg case by case basis	Psychology Dietetics 1st week post d/c if PEG. SLT long term caseload Stroke Association Prevention Service/SA Advocacy	SA Advocacy	ECCH neuro team, active or self-managed & self-referral SA Advocacy

7.5 Specialist review (Carer)

The Midlands and East Stroke Services Specification (NHS Midlands and East 2012) states that **all carers** should be involved with the care management process from the outset, and should be encouraged to participate in an educational programme (on stroke, care and management, secondary prevention and should be provided with clear guidance on how to find help if problems develop.

Carers should have the opportunity to though peer support, facilitated by charitable or voluntary groups. A carer's assessment should be completed for each carer with the opportunity to access long-term emotional and practical support.

There is currently no consistent way of achieving this for carers of stroke survivors in Norfolk.

Table 7: Variations in practice Carer Reviews Source: self-reported provider questionnaire

Variations in practice- Specialist Review (Carer)			
	West Norfolk	***Central Norfolk***	***East Norfolk***
Written information	(PT/OT/SLT) As required	Information Pack	Information pack, self-management caseload
Training	Dietetics as required (esp PEG feeding) PT/OT as required e.g. hoist,		Keyworker, Personal Health Care plan
Assessment	Clinical Psychology – referral from SSR team or GP	Informal assessment/ mood screen at 6 months review for ESD carers	Level 2 Psychological assessment – ESD carers
Interventions	Clinic based Psychology	Informal only	Level 2 psychological support
Other support	SA: Peer Group/ relaxation sessions/ Healthy lifestyle programme/Prevention/Information & advice/advocacy	SA: Signposting/referral to Carers Agency Partnership, Social Services/advocacy	Signposting SA Advocacy

7.6 Long term care

The Department of Health, Public Health England and NHS England are now in strong agreement that prevention, community building, addressing the wider determinants of health, co-production and engaging those at particular risk of poor outcomes are vital in the new health and care systems.

The NHS Midlands and East Stroke standard states that survivors and their carers should be enabled to participate in meaningful occupation. A number of different 'entities' with this universal goal are emerging locally however, these are only commissioned on a short term basis, if at all. Voluntary, community and social enterprise activity appears quite different across all areas and services; community asset mapping and equity of access has not been fully assessed.

- ✓ **Signposting to support agencies occurs at every ESD/SSR transfer/discharge**
- ✓ **All providers have processes for gaining consent for others to be involved in their long term care and support**
- ✓ **Promoting independence, empowerment and self-help is fundamental to all ESD/SSR/ VCSE services**

Table 8: Variations in practice: Long Term Care Source: self-reported provider questionnaire

Variations in practice *Long Term Care*			
	West Norfolk	**Central Norfolk**	**East Norfolk**
How is long-term care and support planned and organised?	SA: Peer support groups have varied programmes planned so a variety of practical information is given from mind-body exercise (Tai Chi) and Art to healthy living presentations OT/PT/SLT provide the whole pathway for stroke & continue to see patients from acute care through to long term care for as long as is indicated. Monthly MDT meetings	No service plans in place beyond current ESD at current time. Aphasia Café at the forum, local informal peer support groups	SA: Client led goal setting as appropriate, up to 12 months (JPUH) None in place (ECCH) SLT Goal planning and review appts, Comm Café first Tuesday of the Month in Gt Yarmouth (ECCH) Neuro SS assigned a keyworker (transitional)* (ECCH) Self-management caseload (*NB not specialised

Variations in practice *Long Term Care*			
	West Norfolk	**Central Norfolk**	**East Norfolk**
	in the community		Stroke service)
How does long term care involve the GP	A formal discharge report/letter is sent to the GP. If required, they will also be involved via telephone/letter/report	Discharge – GP letter. Follow-up telephone call if needed e.g. for medicines management, driving and mental health cognitive decline. Secondary prevention. GP Practices vary in their engagement	Progress summaries sent to GP (ECCH Neuro) MDT held at GP surgeries
Pathway back to further specialist assessment/review	By attending the LTS groups SA staff are able to chat to them about accessing rehab again. SA are able to refer directly to SLT if it is felt necessary even if several years on form stroke and can support self-referral or GP referral back to OT/PT/SLT If required, they are referred onto the St James Service PT/OT – self-referral or via the GP/Consultant. Dietetics – If discharged, then a GP referral would be required Clinical Psychology –re-referrals from the GP or HCP. At the point of discharge, the patient is encouraged to seek a re-referral in the future if required.	Currently no direct route back into specialized rehabilitation	Direct self-referral (SA) Direct self-referral (ECCH Neuro, SLT (info pack provided) GP/Community matron/Specialist nurse for dysphagia GP referral to Stroke Consultant or Specialist Rehabilitative Centre

Variations in practice *Long Term Care*			
	West Norfolk	**Central Norfolk**	**East Norfolk**
Guidance re problems developing	PT/OT will advise the patient to self-manage and to contact the team if there are any changes Yes – advice on how to access services is given (verbal) in addition they are signposted to the Stroke Association for further support. Dietetics – The department may be contacted during office hours; 24hr helpline provided by the home enteral feeds SLT – contact details are given to patient/family Clinical Psychology – advice is given on how to access further support/input at time of discharge from psychology.	Prior to discharge and at 6 month follow-up guidance and sign posting discussed with SS. Literature is identified and discussed SS & carers.	(ECCH) Neuro –Service information leaflets (self-referral) Management plan – patient held (ECCH) SLT signposting to other websites (JPUH) support via GP
Single point of contact?	GP may refer back to dietician	Stroke nurse provides details at 6 mth review	(ECCH)-neurology self-referral, signposting, discharge letter All SS have contact details for direct access (SA) No re-referral point beyond GP (JPUH ESD)
Other e.g. evaluation	Service user interviews SLT piloted aphasia friendly questionnaire Dietetics- satisfaction questionnaire F&F test (Psychology)		

Variations in practice *Long Term Care*			
	West Norfolk	**Central Norfolk**	**East Norfolk**
Community Support	Stroke Association Information, Advice and support service (up to 12 months post referral) Red Cross Driveability Gym referral	Age UK, The Stroke Association, Different strokes, Wiltshire Farm Foods, Night Owls/Swifts, Smoke free Norfolk, Norwich Door to Door, Trusted Traders, Equal Lives, CAB, Voluntary Norfolk (dependent on availability)	Stroke Association, Information, advice and support service (up to 12 months post referral) Community Matrons, Local voluntary stroke support groups, Admission Prevention, East Coast Community Services, Re-ablement Care, Out of Hospital Community Services

8.0 Discussion

Since the publication of the National Stroke Strategy, significant progress has been made in working towards a 'Gold Standard' of Early Supported Discharge and specialist support for stroke rehabilitation in Norfolk.

It is helpful to use current research, national guidance and 'gold standard' service specifications towards promoting integrated care and self-management as a normal, monitored and sustainable mode of stroke care and support. However, fundamental differences in the organisational structures and models of delivery across the three areas of Norfolk means that the transferability of best practice between both national and local models may not be possible at the current time.

There is no consistent package of care across Norfolk, yet the journey for a stroke survivor in any of the three provider areas does feature several common aspects of a 'gold standard' service. Where there are notable differences in provision, these are listed as recommendations below.

Commissioning a full range of system-wide support for rehabilitation and self-management means that structured education programmes, community activities and peer support networks should form a significant part of future provision. In order to achieve this level of support, both the Department of Health, NHS England and Public Health England state that it is imperative that commissioners move away from short funding cycles which inevitably lead to a lack of stability for stroke survivors and their carers. Without commissioning for long term outcomes, providers will be unable to make plans for integrated services or demonstrate that they make a difference over time.

In 2011, *Psychological Support for Stroke: A guide for commissioners* (NHS East of England 2011) reported on the variation and quality of psychological support across the East of England. The HOSC is aware of the variability of access to psychological support and has made enquiries to the Stroke Network and local NHS East of England education and training board regarding the availability of trained psychologists. Further mapping of the levels of support across the entire pathway, from the inpatient, post-acute rehabilitation phase to long term and self-managed care would be a useful to inform this work further.

The psychological effects of stroke affect many aspects of life after stroke and the recommendations within national guidance are relevant to many other areas of service provision. For example, simple screening using validated tests at universally provided reviews (RCP 2008). For stroke survivors who require longer term specialist health and support for activities of living, ways of sharing assessments, interventions and documenting these processes need to be robust and readily understood across the different agencies that provide care and support, including carers and the stroke survivors themselves.

For the effectiveness of care and support to be monitored as services develop, standardised communication tools can produce local data profiles; data sets can then be used to demonstrate equality of access to care and support. This may also reduce the unnecessary duplication of assessments across services, support joint performance monitoring and inform future planning.

At the current time, national data collections on performance outcomes with the SSNAP are mainly focussed on the early, hyper acute to post- acute inpatient stages, with a smaller number of indicators focused on long term care. SSNAP intends to increase its data collection for the rehabilitative phase over the next 2 years, which will provide a new focus on long term outcomes, for example, at the 6-month review. SSNAP continues to report inconsistencies in the way that providers participate in the audit; embedding the SSNAP and any other forthcoming quality frameworks is therefore one of the main recommendations of this report. New NICE Stroke Quality Standards (QS), due to be published in April 2016, will provide advice to commissioners and providers on further sources of data for monitoring quality improvement in rehabilitation. This quality standard will contribute to the improvements outlined in the Department of Health, Adult Social Care and Public Health Outcomes Frameworks (NICE 2015).

It is widely recognised that as resources become scarce across our local systems of health and support, co-production with the voluntary, community and social enterprise sector will become an important resource for in enhancing quality of life for people with long-term conditions. The Department of Health, Public Health England and NHS England are now in strong agreement that to achieve these outcomes, prevention, community building, addressing the wider determinants of health, co-production and engaging those at particular risk of poor outcomes are vital.

Rehabilitation can continue for many years after a stroke, so it is important that commissioners consider how to provide access to services over the long-term and in the wider community. Many stroke survivors go home without ESD or SSR and may struggle to adapt to their new condition (Stroke Association 2015). As well as at home, specialist rehabilitation can be found in sports clubs, shops, community centres, gyms and outpatient departments. Although minor components of the overall pathway, these models are now being recognised as crucial to helping people with long-term conditions self-manage their care in the long-term and avoid depression or re-admission. As the impact of a stroke may continue for as long as the person who has had a stroke lives, these services may need to be available for the whole of their life.

Figure 15 Long term Stroke rehabilitation, co-production with the VCSE sector. Source: Provider questionnaire

Further research and robust statistical analysis would be advisable before conclusions are drawn about the effectiveness of any one component of specialist community stroke rehabilitation reported here. This is because the population structure and other environmental variables in each of the three areas may influence results. In addition, higher levels of disability on discharge in certain areas might anticipate a higher 'burden of care'. It should also be noted that in services where clarification between providers is lacking, specialist teams may be taking on non-specialist work and vice-versa, which does not allow a true picture of activity and performance.

All of the providers have plans for service improvement in the near future and hope for support from commissioners for this. The current national drivers and focus on a new Quality Standards may therefore be a timely opportunity to agree longer term, outcomes-based commissioning framework for stroke rehabilitation, allowing providers to reorganise or 'refreeze' certain elements of best practice within these new incentives.

8.1 Limitations of this review

Given the timescale for this work it was not possible to have equal involvement of stroke survivors, carers, providers and VCSE's at all stages of this review.

In particular, more in-depth work should be done in the future to ascertain the value of rehabilitation services through patient recorded outcome measures and qualitative descriptions of the 'lived experience' of stroke survivors.

This review did not include the role of stroke prevention although would be useful to examine this further in relation to rehabilitation.

It has not been possible to gather enough information about the potential impact of integrated services. Norfolk County Council and local health and social care stakeholders are developing service specifications for care and support at the current time. Future benchmarking of the integrated services across the three areas of Norfolk will be supported by SSNAP and NICE quality frameworks in the future

9.0 Recommendations

Some aspects of current service provision are not consistently provided at the ‘gold standard’ across Norfolk. The Stroke Network, CCGs (commissioners) and service providers should work together to further the following actions:

1. Commission outcomes which encourage integrated care and support with long term goal planning and direct routes back into specialised rehabilitation for all stroke survivors.

2. Adopt consistent quality and performance indicators across Norfolk, taking the lead from the new NICE quality standards.

3. Increase the number of people reviewed at six weeks, six months and one year.

4. Provide equitable access to screening and assessment for psychological problems.

5. Increase the number of carers receiving regular assessments.

6. Provide improved, consistent information for stroke survivors and their families across Norfolk.

7. Embed feedback, satisfaction surveys, friends and family tests in quality improvement.

8. Encourage a wide range of Voluntary, Community and Social Enterprise activities, for example peer-led groups, carer and peer-support and community asset mapping.

9. Use standardised communication and assessment tools for transfer between services.

10. Improve the SSNAP data compliance.

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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 2015-16

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
14 Jan 2016	MEETING CANCELLED	
25 Feb 2016	Policing and Mental Health Services - an update from Norfolk Constabulary and Norfolk and Suffolk NHS Foundation Trust and (further to the presentation given to NHOSC in October 2014 by the Police & Crime Commissioner for Norfolk).	
14 Apr 2016	Service in A&E following attempted suicide or self-harm episodes - an update to the report presented in April 2015 by Norfolk and Suffolk NHS Foundation Trust and the three acute hospitals.	
26 May 2016		

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 2016

14 Apr 2016 (in the NHOSC Briefing) – Health Assessments for Looked After Children - an update from Norfolk Community Health and Care NHS Trust (further to the piece in the October 2015 Briefing).

October 2016 – Ambulance Response Times and Turnaround Times in Norfolk – an update from East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and North Norfolk CCG (follow up to the reports in October 2015).

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	-	Mr Bert Bremner (substitute Mrs M Stone)

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 S Bogelein)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Norfolk Health Overview and Scrutiny Committee 3 December 2015

Glossary of Terms and Abbreviations

ACAS	Advisory Conciliatory and Arbitration Service
ADHD	Attention Deficit Hyperactivity Disorder
A&E	Accident and emergency
AF	Atrial fibrillation – an abnormal heart rhythm characterised by rapid and irregular beating
AHP	Allied Health Professionals
AMHP	Approved Mental Health Practitioner
AO	Accountable Officer
AQP	Any Qualified Provider
BMA	British Medical Association (which represents the interests of doctors)
CAMHS	Child and adolescent mental health services
CCG	Clinical commissioning group
CCT	Certificate of Completion of Training
CHC	Continuing health care
CORC	CAMHS Outcomes Research Consortium
CPA	Care programme approach
CPT	Contingency Planning Team
CQC	Care Quality Commission
CSU	Commissioning support unit
CYP	Children and young people
DATIX	A leading supplier of patient safety incidents healthcare software
DTOC	Delayed transfers of care
ECCH	East Coast Community Health Care
ED	Eating disorder
dB	Decibel – unit uses to measure sound levels
DfE	Department for Education
DOREIS	Dynamic Online Recording Early Intervention System
DoH	Department of Health
DSA	Double staffed ambulance
DST	Decision support team (for continuing health care)
DVA	Domestic violence and abuse
EADU	Emergency assessment and discharge unit
ECCH	East Coast Community Healthcare
EEAST	East of England Ambulance Service NHS Trust
ESD	Early supported discharge
GBO	Goals based outcome
GP	General practitioner
GY&WCCG	Great Yarmouth Clinical Commissioning Group

HEE	Health Education England
HEEoE	Health Education East of England
(N)HOSC	(Norfolk) Health Overview and Scrutiny Committee
HWN	Healthwatch Norfolk
IAPT	Improving Access to Psychological Therapies
IC24	Integrated Care 24 (organisation providing GP out of hours and NHS 111 services in Norfolk)
IST	Intensive Support Team
IT	Information technology
ITT	Invitation to Tender
JCG	Joint Commissioning Group
JPUH	James Paget University Hospitals NHS Foundation Trust
KPI	Key performance indicator
LAC	Looked After Children
LD	Learning disability
LETB	Local Education and Training Board
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
MAU	Medical Assessment Unit
MDT	Multi disciplinary team
MH	Mental health
MHSD	Mental health services dataset
NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E	NHS England
NIAP	Norfolk Infant Attachment Programme
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NNCCG	North Norfolk Clinical Commissioning Group
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust
OOH	Out of hours
ORH	Organising or Optimising Resources for Health
OT	Occupational therapist
PANSI	Projecting Adult Needs and Service Information
PATHS	Promoting Alternative Thinking Strategies
PAU	Paediatric Assessment Unit

PEG	Percutaneous endoscopic gastronomy feeding (tube into stomach via abdominal wall)
PHE	Public Health England
PICU	Psychiatric intensive care unit
Point 1	A consortium of 3 organisations – Ormiston Families (the consortium's lead agency), Mancroft Advice Project (MAP) and Norfolk & Suffolk Foundation Trust (NSFT) providing Norfolk's county wide targeted mental health service
PT	Physiotherapist
QC	Queen's Counsel
QEH / QEHKL	The Queen Elizabeth Hospital, King's Lynn
QIPP	Quality, Innovation, Productivity and Prevention, and NHS programme of improvements in quality and productivity
QOF	Quality Outcomes Framework – a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice
RA	Rehabilitation Assistant
RCP	Royal College of Practitioners
RRV	Rapid response vehicles
SA	Stroke Association
SALT / SLT	Speech and Language Therapist
SAM	Self Assessment Matrix
SAU	Surgical Assessment Unit
SDQ	Strengths and difficulties questionnaire
SEN	Statement of Educational Needs
SIFT	Service Increment Funding for Teaching
SIGN	Scottish Intercollegiate Guidelines Network
SIGOMA	Special Interest Group of Municipal Authorities
SNCCG	South Norfolk Clinical Commissioning Group
SP	Strategic partnership
SRG	System Resilience Group
SS	Stroke survivor
SSNAP	Sentinel Stroke National Audit Programme
SSR	Specialist Stroke Rehabilitation
T3	Tier 3 mental health service
T4 units	Tier 4 mental health units
TIA	Transient ischaemic attack
UEA	University of East Anglia
VCSE	Voluntary, Community and Social Enterprise
WNCCG	West Norfolk Clinical Commissioning Group
WTE	Whole time equivalent
YAM	Youth Aware of Mental Health
YMCA	Young Men's Christian Association