Norfolk Health Overview and Scrutiny Committee

Date:	**Thursday, 07 September 2017**
Time:	**10:00**
Venue:	**Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

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

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

Membership

Main Member	**Substitute Member**	**Representing**
Michael Chenery of Horsbrugh	Vacancy	Norfolk County Council
Ms E Corlett	Ms C Rumsby/Miss K Clipsham	Norfolk County Council
Mrs S Young	Vacancy	Norfolk County Council
Mr F Eagle	Vacancy	Norfolk County Council
Mr A Grant	Vacancy	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs B Jones	Ms C Rumsby/Miss K Clipsham	Norfolk County Council
Mrs L Hempsall	Mrs J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Ms J Brociek-Coulton	Ms L Grahame	Norwich City Council
Mr R Price	Vacancy	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mr G Williams	Vacancy	North Norfolk District Council
Mrs S Fraser	Mr T Smith	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Officer:

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

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Agenda

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

2 **NHOSC minutes of 20 July 2017** **Page 5**

3 **Declarations of Interest**

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

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

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

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

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member

to a greater extent than others in your ward.

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

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

5 **Chairman's Announcements**

6 **10.10-11.00** **Children's speech and language therapy** **Page 14**

Appendix A (Page 18) - Central & west Norfolk CCGs' report

Appendix B (Page 49) - Great Yarmouth & Waveney CCGs' report

		Appendix C (Page 57) - Family Voice report	
7	**11:00 - 11:40**	**Consultation on the future of Benjamin Court healthcare unit, Cromer** **Appendix A** (Page 87) - North Norfolk CCG consultation document	**Page 81**
	11.40-11.50	**Break at Chairman's discretion**	**Page**
8	**11:50 - 12:40**	**Children's autism and sensory processing assessment / sensory integration therapy** **Appendix A** (Page 113) - CCGs' report	**Page 108**
9	**12:40 - 12:50**	**Forward work programme**	**Page 121**
		Glossary of terms and abbreviations	**Page 123**

Chris Walton
Head of Democratic Services
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Date Agenda Published: 30 August 2017

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 20 July 2017

Present:

Michael Chenery of Horsbrugh	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr A Grant	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Mrs B Jones	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs J Brociek-Coulton	Norwich City Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	Norfolk County Council

Also Present:

Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Clive Rennie	Assistant Director of Commissioning Mental Health and Learning Disabilities, Norfolk's Clinical Commissioning Groups & Norfolk County Council
Inspector Lucy King	Mental Health Team, Norfolk Constabulary
Terry O'Shea	Campaign to Save Mental Health Services in Norfolk and Suffolk
Jonathan Stanley	Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council & Norfolk's Clinical Commissioning Groups
Andy Goff	Improvement and Development Manager, Norfolk and Suffolk NHS Foundation Trust
Mark Scrogie	CAMHS Strategic Lead, Point 1
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1. Apologies for Absence

Apologies for absence were received from Mr R Price and Mr G Williams.

2. Minutes

The minutes of the previous meeting held on 25 May 2017 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

Mrs B Jones declared a disclosable pecuniary interest in items 6 and 7 because her husband worked for the NSFT. Mrs Jones left the room and took no part in any of the Committee's discussions or in the decisions reached regarding these items.

Ms E Corlett informed the Committee that she had an "other interest" as a member of the Campaign to Save Mental Health Services in Norfolk and Suffolk.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcement

5.1 The Chairman welcomed to the meeting the newly appointed Members and those Members who were returning to the Committee following the County Council election in May 2017.

6 Availability of acute mental health beds

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from Norfolk and Suffolk NHS Foundation Trust that provided an update on the availability of acute mental health beds in Norfolk in light of concern about reports in February 2017 of prolonged detention of individuals in police custody awaiting a mental health bed and about the level of out-of-area placements.

6.2 The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust (NSFT), Clive Rennie, Assistant Director of Commissioning Mental Health and Learning Disabilities, Norfolk's Clinical Commissioning Groups & Norfolk County Council and Inspector Lucy King, Mental Health Team, Norfolk Constabulary.

6.3 The following key points were noted:

- Mr Scott summarised the current position with regards to the actions that the NSFT was taking in response to the independent Bed Review that was completed by Mental Health Strategies (MHS).
- Mr Scott said that by undertaking the action on capacity and service transformation issues identified by MHS, and adjusting the pattern of alternatives to admission, then the current number of beds available to the NSFT from within its area should be sufficient.
- The mental health team working on the Norfolk and Waveney STP would include many of the recommendations arising from the bed review within the STP work plan.
- Mr Scott said that the extent to which people with acute mental health needs were being placed out of area provided an indication of the priority that the NSFT gave to finding patients suitable beds.

- In reply to questions, Mr Scott added that the lack of availability of acute mental health beds was to a large extent a problem of hospital discharge and of finding alternatives to admission.
- A number of progressive initiatives to tackle mental health issues that had been shown to work elsewhere in the country were to be introduced in Norfolk.
- The speakers said that these initiatives included providing a small number of additional step down beds and crisis café(s) (starting initially in Norwich) to support people experiencing heightened emotional distress.
- The NSFT accepted that a community personality disorder service that consisted of a small team, specialising in the management and treatment of personality disorder and complex difficulties, would be another useful addition to current services. The new service would not be a replacement for any existing services. It would provide therapy and signposting for those service users whose difficulties were too complex to be managed solely within secondary mental health care teams and provide a Tier 1 - 2 service for service users with mild (Tier 1) and moderate (Tier 2) personality disorders. The design of the service was expected by the end of 2017-18.
- It was noted that regular monthly meetings were held with Commissioners to discuss ways in which the NSFT could meet the increasing demand for its services.
- Mrs Young said that she had taken up with the West Norfolk CCG the continued use of Admiral Nurses who were mental health nurses specialising in dementia care. The Admiral Nurse Service was highly regarded and had been shown to help prevent unnecessary admissions to hospital.
- The speakers said that steps were being taken to address the variation in suicide rates which had continued to increase in the Norwich and Great Yarmouth areas and to identify the reasons for these variations. They said that mental health patients were at the highest risk of taking their own lives in the first few weeks after being discharged from hospital.
- In reply to questions, the speakers said that people with mental health problems were not being discharged from hospital to inappropriate “bed and breakfast accommodation.”
- The speakers added that ensuring service users had a suitable and settled place to live on discharge from hospital aided recovery from mental health problems and prevented suicide attempts. By working in partnership, mental health providers and housing associations could provide better pathways and outcomes for service users. People with mental health problems, particularly those with a serious mental illness, could sometimes find it difficult to secure and maintain good quality single person accommodation.
- A number of examples were given to the Committee of where the CCGs and third party housing providers in the Great Yarmouth area were working together to ensure appropriate step-down accommodation was available. The Committee considered it regrettable that this type of accommodation was not seen as a priority for most social housing providers. Members spoke about how the NSFT and Norfolk’s Local Authorities needed to better align their housing priorities to ensure they were making the best use of their joint resources. The integration of housing with discharge planning was seen as being crucial if delayed discharges were to be avoided.
- It was pointed out by the speakers that Norfolk County Council had received £18m of one off funding to address housing and social care issues related to patient discharge from hospital. Mr Scott said that he would meet with colleagues from the County Council to discuss how this money could be used to help break down the organisational barriers that prevented Mental Health Services and Social Care systems working together in a better way.

- Some Members spoke about what appeared to be a disconnect in terms of overall mental health staffing levels and in particular how the mental health operational teams were struggling to provide the right skill-mix and generally deal with staffing gaps.
- In reply to questions, the speakers accepted that there was a range of variance across Norfolk and Suffolk in mental health service staffing models, in referral and admission rates and in the operation of community mental health teams.
- The speakers explained how the NSFT had engaged in a number of initiatives to improve staffing levels including collaborative recruitment, skill mix reviews and assistant practitioner development. They said that staffing issues in Kings Lynn associated with the pressures and difficulties of managing detention under Section 136 of the Mental Health Act would be addressed at the next meeting of the West Norfolk CCG.
- Upholding people’s human rights was seen by Members of the Committee as being a major issue for many people with mental health issues.
- Inspector Lucy King explained the reasons why individuals who had been assessed as requiring hospital admission had been detained in police custody for long periods of time while waiting to be transferred to mental health facilities. This was usually due to no beds being available and/or because the ambulance/patient transport service was abnormally busy.
- It was noted that Members had been given an opportunity to attend the Norfolk Police HQ to gain an improved understanding of the pressures and difficulties of managing people with mental health problems who had been detained under the Police and Criminal Evidence Act.
- Terry O’Shea of the Campaign to Save Mental Health Services in Norfolk and Suffolk explained the difference of opinion that the Campaign had with the NSFT about the public perception of the current state of affairs with mental health services in Norfolk and Suffolk. He said that the publication of the report of the current Care Quality Commission inspection of Norfolk and Suffolk NHS Foundation Trust could be expected to provide an accurate assessment of the service and should reviewed by the Committee when it became available.

6.4 The Committee **agreed** to ask:

1. The NSFT to supply information on the level of spending in recent months on out of Trust bed days.
2. The Norfolk Constabulary to supply information on the numbers of people who were detained in police custody waiting for a bed following assessment under the Mental Health Act in the past year, once a Data Sharing Agreement between Norfolk County Council & Norfolk Constabulary was put in place.

6.5 The Committee made further comments about the availability of acute mental health beds when considering its forward work programme (see minute 9 below).

7 Waiting times for children’s mental health services in Norfolk

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from the 5 Clinical Commissioning Groups in Norfolk and Waveney on the standards set for referral to treatment at each level of children’s mental health services and on current actual waiting times.

7.2 The Committee received evidence from Jonathan Stanley, Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council &

Norfolk's Clinical Commissioning Groups, Clive Rennie, Assistant Director of Commissioning Mental Health and Learning Disabilities, Norfolk's Clinical Commissioning Groups & Norfolk County Council, Andy Goff, Improvement and Development Manager, Norfolk and Suffolk NHS Foundation Trust and Mark Scrogie, CAMHS Strategic Lead, Point 1.

7.3 The following key points were noted:

- The speakers explained the standards set for referral to treatment at each level of children's mental health services and on current actual waiting times.
- It was noted that the table at paragraph 2.2 of the report explained the current waiting time standards and where they were met. The table also highlighted some areas, particularly within the NSFT service, where current waiting time standards were not being met.
- The Committee discussed the standards set for referral to assessment and assessment to treatment times, and current performance across the service.
- In reply to questions, the speakers said that the local waiting time standard for urgent referrals to NSFT services had been reduced from 72 hours to 120 hours for all except those living in the Great Yarmouth and Waveney area.
- Members expressed the view that additional staffing was required to deal with the demands that were being placed on the crisis element of the service.
- It was pointed out that the 2017/19 contract negotiations with NSFT had led to the local waiting time target moving from an up to 8 week wait (for at least 80% of patients) to an up to 12 week wait (for at least 90% of patients).
- It was noted that approximately 80% of all referrals to NSFT CAMHS were accepted as at June 2017. Approximately 92% of referrals to Point 1 CAMHS were accepted.
- The Government's Five Year Forward View target was that by 2021 at least 35% of children with diagnosable mental health conditions would be able to access NHS-funded community services to meet their needs.
- Members were informed that new national waiting time standards were likely to be introduced by the Government in the autumn.
- The speakers said that CAMHS had extended the hours of support and guidance that it provided for children and young people to between 8am to 8pm. In reply to questions, it was pointed out that this had been achieved by a reallocation of existing staffing resources and the full range of mental health services were not available for all of these hours, but that access to some of the services around tea-time and in the early evening was very useful for some families.
- The speakers elaborated on the plan that they had made for the introduction of the link worker scheme that was referred to in the report. The plan was for five link workers to be taken on to work with named leads within schools across Norfolk and Waveney. Two examples in the Great Yarmouth area of where joint working with schools, families and young children had already proved to be a success were explained to the Committee.
- Members were concerned about the numbers of non-referred children who were not getting the support that they needed but accepted that the five CCGs and the County Council had no alternative than to operate within available resources.
- In reply to questions, the speakers said that the five CCGs and Norfolk County Council spent between £15m and £18m on children's services mental health services. To extend support to children in need of help for whom referral to targeted mental health services was not considered necessary would require increased spending of between two to three times more than was currently being spent on children's mental health services.

- The five CCGs had committed to maintaining the 2015-16 level of increased investment (£1.9m extra per year), but not the potential additional uplift in following years. The uplift to the five CCGs was not ring fenced and had to be considered against all other service cost pressures.
- To gain an understanding of the overall LTP funding picture, the Committee was of the view that the five CCGs should be asked to provide information about the current year's allocation and the 'gap' in terms of government allocation compared to how much CCGs had passed on directly into recurrent CAMHS activity.

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

(a) The Secretary of State for Health expressing the opinion that:-
  i. uplift funding for Local Transformation Plans (LTP) for children's mental health services should be ring-fenced
  ii. the national target of at least 35% of children with diagnosable mental health conditions accessing local NHS-funded community services by 2020/21 sets the target too low.
(b) The five CCGs in Norfolk seeking information on the amount of LTP uplift funding allocated to them and how this money is being spent.

Note: Copies of the letters to the Secretary of State and the CCGs can be found as appendices to these minutes.

7.5 The Committee **agreed** that the Children's Services Committee should take forward regular monitoring of the Local Transformation Plan for children's mental health services, in line with the recommendation of Children's Services Committee Task & Finish Group on Children's Emotional Wellbeing and Mental Health, which was previously endorsed by the Committee on 6 April 2017:-

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

8 Norfolk Health Overview and Scrutiny Committee appointments

8.1 The Committee received a report by Maureen Orr, Democratic Support and Scrutiny Team Manager that asked Members to make appointments to link roles and to a potential Norfolk and Waveney Joint Health Scrutiny Committee.

8.2 The Committee **agreed** to:-

(a) Appoint Mrs Lana Hempsall as a substitute link member with Norfolk Community Health and Care NHS Trust.

(b) Confirm that all members of NHOSC will serve on a potential Norfolk and Waveney Joint Health Scrutiny Committee with Suffolk to receive consultation arising from the Norfolk and Waveney STP on a cross-border footprint which goes wider than the Great Yarmouth and Waveney area.

9 Forward work programme

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

9.2 The forward work programme was **agreed** as set out in the agenda papers with the addition of ‘Consultation on the future Benjamin Court Healthcare Unit, Cromer’, which was added to the agenda for 7 September 2017.

9.3 It was **agreed** to await the publication of the report of the current Care Quality Commission inspection of Norfolk and Suffolk NHS Foundation Trust before deciding whether any further mental health issues needed to be added to the forward work programme.

9.4 In reply to questions, it was **noted** that the issues relating to hospital staff satisfaction surveys were not within the Committee’s remit.

Chairman

The meeting concluded at 13.20 pm

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Appendix A to the minutes

Norfolk Health Overview and Scrutiny Committee
County Hall
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Direct Dialling Number: (01603) 228912
Email: maureen.orr@norfolk.gov.uk

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

26 July 2017

Dear Mr Hunt

Children’s mental health services

Norfolk Health Overview and Scrutiny Committee has been following the implementation of the Norfolk and Waveney Local Transformation Plan (LTP) for children’s mental health services since 2015. We have seen that the local LTP is thorough, that it is making progress and that on average the waiting times for children’s mental health services in Norfolk are shorter than in many other parts of the country. However, we are concerned about rising demand, the needs threshold at which children can access the services and whether the level of resourcing is adequate to respond to children’s needs.

We appreciate the government's emphasis on mental health reform and the additional investment that has come with it. This is reflected in Norfolk and Waveney STP where mental health is a priority. We also appreciate that the national target of access to NHS-funded community services to meet the needs of at least 35% of children and young people with diagnosable mental health conditions by 2020/21 represents a significant improvement on the historic and current position. However, we cannot see how it fits with 'parity of esteem' with other NHS services and we think the target should be higher than 35%.

One action at national level which we believe would support better local access to CAMHS services would be to ring-fence the LTP funding. In Norfolk and Waveney there is a gap of £1.2m per annum between the LTP allocation from NHS England and the amount passed on directly into recurrent children's mental health services activity. We know that locally the funding received from NHS England for the Eating Disorders service is allocated to the service in full and we have seen how much better that service performs in terms of patient waiting times compared to the general children's mental health services.

I have copied this letter to NHS England but would be pleased to hear your views about the level at which the access target is set for NHS-funded community services for children's mental health and about ring-fencing of LTP funding.

Yours sincerely

Michael Chenery of Horsbrugh
Chairman of Norfolk Health Overview and Scrutiny Committee

Copies to:- Mr S Stevens, NHS England

APPENDIX B to the minutes

Norfolk Health Overview and Scrutiny Committee
County Hall
Martineau Lane
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Norfolk
NR1 2DH

Letter to Chief Officers of the 5 CCGs
In Norfolk

Letter sent by email

Direct Dialling Number: (01603) 228912
Email: maureen.orr@norfolk.gov.uk

26 July 2017

Dear

Children's mental health services

Norfolk Health Overview and Scrutiny Committee (NHOSC) has been following the implementation of the Norfolk and Waveney Local Transformation Plan (LTP) for children's mental health services since 2015. We have seen that the local LTP is thorough, that it is making progress and that on average the waiting times for children's mental health services in Norfolk are shorter than in many other parts of the country. However, we are concerned about rising demand, the needs threshold at which children can access services and whether the level of resourcing is adequate to respond to children's needs.

We understand that the financial uplifts for the LTP provided by NHS England in 2016/17 and 2017/18 within CCGs' baseline core funding have not been passed on directly into recurrent children's mental health service activity and that the recurrent funding is now £1.2m below the NHS England allocation to the five CCGs in Norfolk.

We know that the LTP for children's mental health has to be considered alongside all of the other services that you fund and that CCG budgets are under pressure. However, we would like confirmation from you of the amount of LTP uplift funding that NHS England allocated to your CCG in 2016/17 and 2017/18, how this money has been used and your reasons for not passing it directly into the recurrent children's mental health services. We know that there has been additional one-off funding provided for certain elements of children's mental health services in these years but we are interested in your reasons for not passing the full uplift into recurrent services.

NHOSC has written to the Secretary of State for Health expressing concern that the national target of access to NHS-funded community services to meet the needs of at least 35% of children and young people with diagnosable mental health conditions by 2020/21 is too low and does not fit with 'parity of esteem' for mental health services. I attach a copy of the letter for information. It also expresses our opinion that ring-fencing of LTP funding would better support local access to CAMHS services.

We have also written to the other four CCGs in Norfolk.

Thank you for your attention to this matter and I look forward to hearing from you.

Yours sincerely

Michael Chenery of Horsbrugh
Chairman of Norfolk Health Overview and Scrutiny Committee

Encl: Letter to The Rt Honourable Jeremy Hunt MP, Secretary of State for Health

Norfolk Health Overview and Scrutiny Committee
7 September 2017
Item no 6

Children's speech and language therapy

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

A report from commissioners on access to and waiting times for children's speech and language therapy (SLT) in Norfolk.

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Children's speech and language therapy' to its forward work programme in February 2017, following concerns raised by a Member about waiting times.

1.2 NHOSC last looked at the subject in committee in 2009, following an in-depth scrutiny review. At that stage Norfolk County Council was moving towards picking up the full cost of providing speech and language therapy for children who had a need for it identified in their Statement of Special Educational Needs (SEN). Additional Speech and Language Therapists had been recruited, there was an increase in the number of children receiving treatment, a reduction in the number waiting and in the length of time they were waiting.

1.3 In a final briefing to NHOSC in January 2010 it was reported that the SLT service for NHS Norfolk Primary Care Trust's area was seeing approximately 90% of referred cases for a first appointment within 10 weeks. This compared with May 2008 when more than half of patients waited more than 10 weeks for their first assessment. The service teams' workload was decreasing, and this was attributed to improved clinical decision taking around discharge to ensure that cases were closed promptly but without risk to children's progress.

2. Purpose of today's meeting

2.1 The commissioners of SLT services for Norfolk, including the central, west and Great Yarmouth areas, have been asked to report to today's meeting with the following information:-

1. A description of the current commissioned service i.e.
    a. when did the current contracts start and when do they finish;
    b. who commissioned them and the proportion of funding from each party;
    c. the commissioned capacity (i.e. how many children are they expected to see);
    d. who are the providers;

   e. description of the service and the type and numbers of staff involved;
   f. what is the geographic spread of the service and where are the location bases.

2. Workload – what is the current workload; the trend; comparison between commissioned capacity and actual number of referrals

3. Staffing – number and types of vacancies

4. Waiting times – from referral to assessment; from assessment to start of therapy; numbers on the waiting lists.

5. Key performance indicators (KPIs) – current performance against KPIs and trends in performance

6. Complaints / user feedback – numbers of complaints; complaint themes; user satisfaction survey feedback

2.2 Since April 2016 Norfolk County Council Children's Services and 4 of the 5 CCGs in Norfolk (all except for Great Yarmouth and Waveney CCG) have jointly commissioned an integrated speech and language therapy service. They have a Section 75 agreement and a pooled fund which covers the contract from 4th April 2016 to 31st May 2020.

2.3 The service area for the Norfolk County Council educational element of the service is Norfolk-wide, including Great Yarmouth, but the health element of the service does not include Great Yarmouth (& Waveney). The provider for the NCC & 4 CCG Integrated SLT service is East Coast Community Healthcare (ECCH). ECCH is also the provider for the health element of service for Great Yarmouth and Waveney, but under a separate contract with GY&W CCG which started in 2011 and expires in 2019.

2.4 The 4 CCGs and Norfolk County Council Children's Services have provided the report on the integrated SLT service for their area (attached at **Appendix A**) and representatives will attend to answer Members' questions.

Great Yarmouth and Waveney CCG has provided the report on the health element of the SLT service provided in its area (attached at **Appendix B**) and a representative will attend to answer Members' questions.

2.5 Family Voice, a local voluntary organisation which aims to improve the lives of disabled and SEN children and their families, has provided a report based on experiences of the service. The report, which reflects the views of 70 respondents to an online questionnaire during the summer months, is attached at **Appendix C**. SLT services are provided to approximately 2,569 children across Norfolk & Waveney (579 in Great Yarmouth and Waveney; 1990 in the rest of Norfolk).

The Family Voice report also includes key messages and practical pointers on how the service could be improved.

3. Suggested approach

3.1 After the CCGs' representatives have presented their report, Members may wish to discuss the following areas:-

(a) The CCGs (excluding Great Yarmouth & Waveney) report at Appendix A acknowledges that there were some difficulties with the transition to the new integrated SLT service in April 2016, which led to increased waiting times. Waiting times have been reducing and were close to target in the first quarter of 2016-17. Are the CCGs and provider confident that the target will be met in quarter 2?

(b) The model for the integrated service moves away from specialist provision provided through a centralised clinic based system to one where services are provided more locally to a child's home or educational setting to minimise disruption to the child or young person's learning. It includes support and development for parents and the wide range of professionals who work with children with speech, language and communication needs in order to provide more consistent support for the child.

What is the provider's and the commissioners' assessment of the success of this model to date in central & west Norfolk?

(c) By agreement the new integrated service in central & west Norfolk did not start to deliver wider workforce development sessions during the first 6 months of the new contract. Now that wider workforce development is being delivered, how well has this approach been received by schools and other organisations?

(d) Great Yarmouth & Waveney CCG's report (Appendix B) says that the service in its area is very similar to the integrated service commissioned in the rest of Norfolk, but it is not an integrated service. How does the health-funded service in Great Yarmouth and Waveney work with the local authority and schools?

(e) Family Voice's report (Appendix C) reflects concerns that children are too quickly discharged from the service and on re-referral they have to join the end of the waiting list. What is the rationale for the system?

(f) Family Voice's report reflects some parents' dissatisfaction with the level of service provided and has raised a question of whether the new integrated service is a consultation service or a therapy service? How do the commissioners see it?

4. Action

4.1 Following the discussions with representatives at today’s meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting.

(b) There are comments or recommendations that the committee wishes to make as a result of today’s discussions.

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Report produced by the Commissioners and Provider of the Integrated Speech and Language Therapy Service for Children and Young People (CYP) 0-19 Years for presentation to the Norfolk Health Overview & Scrutiny Committee (NHOSC) on 7th September 2017

Representing the commissioned Integrated Speech and Language Therapy Service

Nicki Rider	Senior SEND Manager	Education High Needs SEND Service, Children's Services, NCC
Karin Bryant	Assistant Director of Clinical Commissioning	NHS Norwich CCG, also representing: • NHS North Norfolk CCG • NHS South Norfolk CCG • NHS West Norfolk CCG
Louise Denby	Deputy Director Health Improvement & Children's Services	East Coast Community Healthcare (ECCH)

Background

In line with the recommendations in the Children and Families Act 2014, Norfolk County Council (NCC) and health commissioning partners (NHS North Norfolk CCG, NHS South Norfolk CCG, NHS West Norfolk CCG and NHS Norwich CCG) have jointly procured and commissioned an Integrated Speech & Language Therapy service. As part of this collaborative process, Family Voice Norfolk and Service Users were involved in the commissioning of the Service.

NCC led a review during 2015 and together with the local data and feedback from local consultation and engagement, which resulted in the SaLT Needs Analysis being published in April 2015 (and updated July 2015). Family Voice, Families, Users (ie children and young people) and Professionals were widely consulted with the resulting feedback being considered and incorporated in the development of the Specification.

The service areas for the NCC educational element of the service is Norfolk-wide (including Great Yarmouth) and replaces the previously separately funded functions of the Early Years Team and Education Inclusion Service at NCC (delivered by both East Coast Community Health (ECCH) and Norfolk Community Health & Care (NCH&C). The health element of the service is for those areas of responsibility covered by NHS Norwich CCG (NCCG), NHS North Norfolk CCG (NNCCG), NHS South Norfolk CCG (SNCCG) and NHS West Norfolk CCG (WNCCG) which was previously separately commissioned and funded by the four CCGs from NCH&C

The Integrated Speech and Language Therapy Service (SaLT) is for children and young people (CYP) to the age of 19.

NHS Great Yarmouth & Waveney CCG (GY&WCCG) decided to not participate in the joint commissioning exercise so this report does not cover the health element of service for GYWCCG. For information the population of GYWCCG also receive health funded SaLT from ECCH.

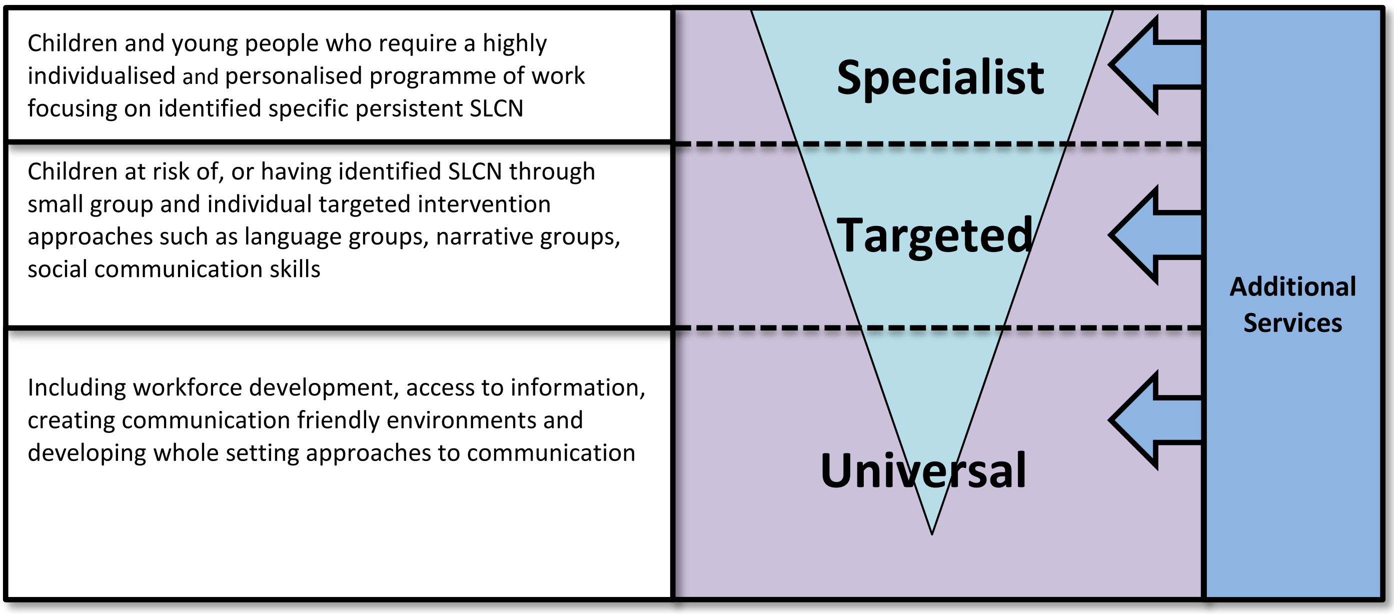
To support the joint commissioning arrangements, a formal Section 75 agreement has been agreed between the Commissioning Partners This requires all Partners to pay into a Pooled Fund which covers the contract length from 4th April 2016 to 31st May 2020 with an option to extend for a further 24 months to 31st May 2022.

The new service model

The new service is significantly different from that previously commissioned. To meet the service specification, ECCH has been required to reshape the way services are organised and delivered. The service inherited from previous Provider had been the subject of earlier NHOSC presentations and CQC report published September 2014.

The development of the new service model is based upon the whole system approach to Speech Language & Communication & Needs (SLCN) as described in:

https://www.rcslt.org/speech_and_language_therapy/commissioning/better_communication
This approach recognises that achieving the best possible outcomes for children with SLCN is dependent upon all those involved in a CYP's life. The provision of SaLT is only one element of the Speech, Language and communication Needs (SLCN) system. The services that have been commissioned through this contract fit into the wider system as below:



Children and young people who require a highly individualised and personalised programme of work focusing on identified specific persistent SLCN

Children at risk of, or having identified SLCN through small group and individual targeted intervention approaches such as language groups, narrative groups, social communication skills

Including workforce development, access to information, creating communication friendly environments and developing whole setting approaches to communication

🟦 East Coast Community Healthcare local service offer

🟪 Services and support provided by the wider children's workforce and families

🟦 East Coast Community Additional Service, purchased directly by families and or setting

Key elements of the new service provision that have been implemented since April 2016 are

- Supporting prevention and early identification through the introduction of quick and easy access for preschool children to qualified speech & language therapist via drop-in sessions in community venues;
- A single point of access for parents and professionals;
- A service advice line for parent and professionals
- Development and delivery of wider workforce training that will support those working with CYP with SLCN;
- A move away from specialist provision being provided through a centralised clinic based system to one where the services can be provided more locally to child's home or educational setting;
- Increased support to deaf resources bases;
- Improved description of the service contribution to the Local Offer based upon clinical pathways and applied equitably across the county;
- The development of additional cost effective services for purchase by families or schools to enhance the Local Offer.

Transition to the new model of service

Following the award of the contract the new provider had a period to support mobilisation of the new service starting on 4th April 2016. At the point of transition the single point of access was operational and children on the previous Provider's caseloads were transferred. There was a month's delay for transfer of children with paper records in Thetford who were previously supported by the West Suffolk Hospital. The process to transition those children already on the caseload was significantly more complex than had been envisaged by the new provider i.e.

- there were a number of families who were dissatisfied both with the length of time they had already waited for service and the total volume of service delivered by the previous provider;.
- the impact of the new ways of working upon staff was underestimated. The result was that it took two months for new communication referrals to start to be seen [urgent eating and drinking referrals continued to be seen throughout this period]. This was in addition to the new referrals held by the previous Provider from the 1st of March 2016;
- the workload from the new single point of access and advice line required far more clinical input than had been anticipated as both families and professionals made enquiries about children already on the caseload;
- the format of the electronic clinical system was not sensitive enough to enable accurate reporting against the service specification;

Although there was a high degree of engagement from both commissioners and the provider the scale of the change demanded in year one of the contract means that the provider has struggled to meet the stakeholders expectations of immediately improved services. It has taken until the start of Quarter 4 for all of the principal elements of service and reporting to be in place. The commissioners have monitored the provider’s progress closely throughout this period and have been supportive of the actions that have been taken.

Staffing in the new service

The new service model demanded a change in the make-up of the provider’s workforce – to support a more local delivery of specialist therapy and the provision of the new pre-school drop-in service. The staff group were TUPE transferred to the provider and were subject to Agenda for Change conditions of service and workforce development is undertaken within these constraints. Throughout Year one of the contract service capacity was reduced due to a number of cases of long term staff sickness.

The prime workforce objective for year one has been a cultural one. That is changing the way the service is delivered and this has proved a significant challenge. To achieve both improved equity of provision (volume) across the geography of Norfolk and improved consistency between practitioners has involved the development and testing of new teams and locations for the delivery of services. The scale of impact has been significant in relation to their day to day practice.

Now there is a normal level of staff turnover and when the provider advertised it has been successful in attracting good quality candidates. There are no long term vacancies.

The link between staff bases and service delivery has been broken with the implementation of this service specification and improved mobile working. Teams have been built around groups of school clusters to ensure that there is a balanced provision across the county with provision of a named Therapist allocated to each Cluster and each Complex and Special Needs Schools. During the transition phase staff moved to new administrative bases across the county. These moves enabled the new elements of service to be introduced equitably and make the move away from a clinic based service. It is anticipated that team size, supervision structures and administrative bases will continue to evolve adapting to changing demand.

Service Delivery

Due to the scale of change in service commissioned, Year one of the contract was planned to be one of transition and benchmarking. Volumes in the key areas of service have been:

Drop- in service

Drop-in services for preschool children are a new element of service. The sessions are located across the county in a variety of settings to enable children to be seen by a speech therapist on the day at a venue closer to home. The drop-in service provides easy access to professionals or families who are concerned about their child's speech, language or communication. Families receive advice, information and strategies to support their child. Where appropriate a child may be referred to a more specialised element of the service. The Service provides a dynamic and flexible response to changing demands and 195 drop-in sessions were provided in Year 1 to reflect needs.

Service Advice Line and referrals

A telephone advice line was included in the specification as a direct result of engagement with families before procurement. . This service is used by families and professionals. The volumes are much higher than anticipated at the time of the award of the contract; it receives on average 480 calls a month.

Of those 480 calls, an average of 277 per month become a referral. The total number of telephone referrals from July 2016 to March 2017 was 2,492. Of these, 73% have received a telephone consultation with a therapist within three working days. Capacity exists for 98% of telephone consultations to take place within target however some referrers' chose consultations times beyond 3 days as this more convenient to them.

Workforce development sessions

50 workforce development sessions are contracted for. During the first two quarter transitional period by agreement no sessions were provided. In third and fourth quarters the contracted volumes were provided and arrangements are in place for contracted volumes to be delivered in year 2.

Deaf Resource Bases (DRBs) and Specialist Resource Bases (SRBs)

Previously input to the deaf and specialist resource bases was not ring fenced or provided equally across the county; in the new service the provision has been defined. The service now provides 4.5 days per week across the 3 DRBs with a further 7 days of support in mainstream schools spread across the whole of Norfolk. The distribution of this resource has been directed through the Virtual School (Sensory Support). In addition 2.5 days per week is provided to each of the Speech and Language SRBs.

Waiting Time

There is a Key Performance Indicator (KPI) included in the contract which requires 95% of CYP to receive their first SaLT intervention within 18 weeks of referral.

There were some significantly long waits during the period of transition and there were a number of complaints associated with this. However performance has improved. In Quarter 4 2016/17, the percentage of children seen within the 18 week standard was 83%. Of the completed waits in this period 56% were seen within 3 weeks. In Quarter 1, 2017/2018 the percentage of children seen within the 18 week standard was 87%. For the month of June 2017 Referrals saw a further improvement of 93% showing consistent improvement over the course of the contract.

On commencement of the new Integrated SaLT Service for CYP on 4th April 2016, there were 805 CYP receiving care in addition to 4000 children known to the service (either waiting assessment or review).

At the start of year 2 (April 2017) the provider has reported there are 1,990 children receiving care (1,137 CYP receiving care in the community and 407 being supported in complex needs schools) and 1097 waiting assessment.

As at 01 04 2017

	Active	Waiting (within the allowed Contracted Period)	Total
Pre school	937	703	1640
School age	1053	394	1447
Total	1990	1097	3087

Performance

A Monitoring, Evaluation and Reporting (MER) Framework is in place with Key Performance Indicators (KPIs) measuring performance against KPIs and identifying trends in performance.

For Year 1, the Service was measured through 11 KPIs with sub-sets for Quarterly Reporting plus 10 MERs with sub-sets with Annual Reporting. For Year 2, the MER Framework was informed by Year 1 Performance and Year 2 Measures subsequently agreed through an evidential and achievable approach.

Compliments and Complaints [MER 10] (End of Year 1 Report)

There has been a period of challenge with introducing the new service, particularly during the first 9 months of the contract. The change in service model and provider introduced a level of uncertainty and concern for families and professionals referring into the service which resulted in the increase of calls with expression of concern.

A number of themes emerge from an analysis of the various pieces of feedback that have been received. This feedback has come via:

- Formal complaints
- Formal compliments
- Informal issues and compliments received via PALS
- Friends and Family Test
- ECCH website
- Twitter
- Norfolk Healthwatch website

Positive observations (Appendix 1) and areas for improvement (Appendix 2) identified are used at monthly Service Assurance Meeting, Team Leader meetings and Locality Team Meeting to inform and develop service through lessons learnt, service action plans and identifying what is working well.

While undoubtedly there remain pressures within the service as due to demand, by the end of Year 1 balance between formal complaints and compliments was 22 to 48, (Appendices 3, 4, 5, and 6).

The Service strives to meet children's needs and the expectations of the adults that care and support them. The Service hope to maintain the positive ratio between compliments and complaints.

In Year 2, the Service plan to distribute a modified friends and family test which is able to gather more specific information, tailored to the MER requirements (Appendix 7) [MER10]. This approach will limit the number of times Service Users are approached in seeking similar information.

Appendix 1: Compliments and positive feedback summary

Theme	Detail	Example feedback comment received
Communication	• Clear information provided to parents	*The assessment was thorough and helpful information sent through quickly.*
	• Quick response to emails correspondence	*Quick responses to emails.*
	• Quick receipt of report	*We received a report very quickly.*
	• Involvement of parents	*They liaised and checked everything with me first*
	• Useful information	*A good amount of time is spent with the child and good feedback given to parent.*
	• Provision of clear information	*Information was clear and understandable and gave good advice to help me help my son.*
	• Thorough explanations	*My child enjoyed it and received very thorough explanation analysis.*
Service processes	• Efficient	*I find your services very fast and efficient*
	• Drop in provision	*We had excellent service when we visited the drop in centre*
	• Drop-in organisation	*Very organised system to check us in.*
Quality	• Inspired confidence	*Outstanding care and expert help always received by all staff*
	• Helpful advice	*the advice and guidance is brilliant and really helps*
	• Good follow up to discussion	*Also everything that was talked about was followed up.*
	• Individualised care	*The intervention they have planned is appropriate and personal to him*
Staff	• Professionalism	*They are friendly and professional. My child felt comfortable when we have a session.*
	• Staff listened	*The Therapist was very communicative and listened to my concerns*
	• Friendly and caring staff	*She was professional but very caring*
	• Good attitude of staff	*Nice speech therapist not condescending like some people can be.*

Appendix 2: Areas for improvement, lessons learned and actions arising from complaints

Theme	Detail	Example comments	Lesson learned and Actions taken
Communication	Returning calls	*…and no one called me back !!*	This is a difficulty with the telephone advice line in Q1 and Q2. We have since put in a more robust process to ensure enquiries are responded to within 48 hours, see appendix
	Need for re-referrals	*My child had to wait so long for this appointment and now been discharged how every I feel that he should not of been*	This is a key element of the service however, therapists however have received advice to ensure parents/carers and professional are aware that children may be re-referred for further advice. Anecdotally Families new to the service accept this approach more easily that those who had previously accessed the former service.
	Access to therapist	*The call centre not great, sometimes you need to speak to actual speech therapists.*	We are now confident that enquiries are received and a therapist will contact a caller within 48 hours of an enquiry being made. This ensures that within 2 working days a therapist is able to provide advice for a child known to the service.
Service processes	Inconsistent therapist	*We have had 5 therapists in 3 years!*	This was particularly due to the need to see children in a timely way, as soon as possible after transfer. Th new service was commissioned and the change in staffing structure to provide locality based provision rather than cluster based provision
	Waiting time for assessment	*The overall time frame is too long.*	This has reduced significantly over the course of Y1. Please see KPI data

	Drop-in – time management	*I would have preferred more time/attention given to assessing my child and less to listening to what I thought.*	We have amended the drop in poster to more closely reflection that screening/informal assessment that is carried out at Drop-in rather than a full assessment. This will enable parents to understand the role this aspect of our service involves
Quality	No interested in specific cohorts of children	*you are uninterested in supporting children with long term and complex conditions - They do not reflect positively to your stats.*	We have been unable to respond to this anonymous feedback directly. However the Providers' local service Offer reflects the higher level of need that children with more complex needs have
	No new advice provided	*I am sure that my child would have benefitted from some focussed SALT. It will be down to funding, no doubt, that my child was discharged and I was told that my child will develop in time. I was told to repeat back…something I've done for 4 and a half years.*	We have invested time over the past year in working with therapists to be able to convey the focus on upskilling others in the child's life and the benefits this brings.
	Level of support offered	*no support offered - Just suggestions to class teacher of 31 children to offer him 1:1 chat.*	Following this element of feedback we will ensure not only that school have the appropriate knowledge and skills to carry out intervention plans but this is communicated to parents/carers to provide reassurance that their children's needs are being met

Appendix 3: Complaints by type

	Type of complaint					
Month	Consent Confidentiality, Communication	Delay in appointment	Delay in treatment	Patient Info, records, documents results etc	Treatment	Total
Apr			1			1
May		1	1			2
Jun			2			2
Jul		2	1			3
Aug				1		1
Sep			1		2	3
Oct			2			2
Nov		1	1			2
Dec					1	1
Jan			2			2
Feb			1		1	2
Mar	1					1
Grand Total	1	4	12	1	4	22

Appendix 4: Friends and Family Test

Month	Extremely Likely	Likely	Neutral	Unlikely	Not at all likely	Don't know	**Total Responses**	**% +ve**
Apr	7	5					12	100%
May	3	2					5	100%
Jun	2	1					3	100%
Jul	4						4	100%
Aug	4	1			1		6	83%
Sep	1						1	100%
Oct		1					1	100%
Nov	10	1					11	100%
Dec	24	10	2	2			38	89%
Jan	20	2	1		1		24	92%
Feb	14	5	2		1		22	86%
Mar	21	9	4	1	3		38	79%

Appendix 5: Number of Compliments Received

April	May	June	July	August	Sept	October	Nov	Dec	January	Feb	March	Total
0	0	0	0	0	3	2	7	5	9	14	8	**48**

Appendix 6: Informal issues raised via PALS

Month	Issue for resolution	Advice and information	Feedback	Other	Grand Total
Apr	3	1			4
May	7	1			8
Jun	8	1			9
Jul	16				16
Aug	2			1	3
Sep	2				2
Oct	4	1			5
Nov	6	2	1		9
Dec	6		2		8
Jan	11	1			12
Feb	6	1	2		9
Mar	14	2	2		18
Grand Total	85	10	7	1	103

Appendix 7: Patient Satisfaction questionnaire

Patient Satisfaction Questionnaire – Children's Speech and Language Therapy

We would love to hear what you think about us! Please take a few minutes to complete this form and tell us what we did well and what we need to do better. It will help us to continually improve our service.

I am a …… (please tick)

○ parent ○ education professional ○ health professional ○ other ☐

I accessed the service in the following ways ……. (please tick all that apply)

○ drop in clinic ○ telephone appointment ○ home appointment ○ school/nursery appointment ○ other appointment

I accessed information from Speech and Language Therapy in the following ways …… (please tick all that apply)

○ drop in posters ○ service website ○ leaflets/handouts ○ alternative website ○ telephone advice

		Please tick (✓)		**Comments**
		Agree	**Disagree**	
1.	The Speech and Language Therapy team member was professional and polite			
2.	I had confidence and trust in the staff seeing my child			
3.				
4.	I was offered a choice of where my child was seen, e.g home, school, nursery			
5.	I was involved in supporting my child's speech and language therapy			
6.	I was informed of decisions about my child's speech and language therapy			
7.	The Speech and Language Therapist/Team member provided advice in a way that I could understand			
8.	The support my child received was effective			

Please return to: Speech and Language Therapy, East coast Community Healthcare, Shrublands Health Centre, Magdelen Way, Gorleston, Norfolk NR31 7BP

Appendix 8

MONITORING, EVALUATION AND REVIEW - KEY PERFORMANCE INDICATORS. All KPIs should be reported on a monthly basis (with KPI 9 is reported monthly, quarterly and annually) plus a selection of indicated MERs also reported on a monthly basis.

YEAR 1 - 2016 -2017 Area for MER: The Educational provision of the service shall be available for all children aged 0-19 with a Speech and Language need, residing or attending a setting in the geographical area of Norfolk (including Great Yarmouth area). The Health provision is for all areas in Nofolk except the Great Yarmouth area. All measures must be separated between Norfolk County Council and the four CCG areas (Norwich CCG, North Norfolk CCG, South Norfolk CCG and West Norfolk CCG).

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A Within tolerance of target (5%) *(Amber)*

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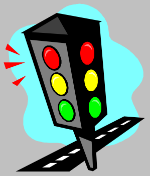

For each and every dataset which scores a **Red** or **Amber** performance rating, please detail the actions being taken to improve performance.

Targets Source: Service Specification for the Integrated Speech & Language Therapy (SaLT) Service for Children & Young People aged 0-19 Years

Provider Name or Establishment: East Coast Community Healthcare (ECCH)

Submission Terms: All KPIs should be reported on a monthly basis

KPIs FOR SERVICE PERFORMANCE FOR NORFOLK CHILDREN WITH A SPEECH & LANGUAGE NEED	KPI	Denominator	Numerator	ECCH Commentary	Accumulative Total
Number of Drop ins held (Advice & Support Drop-in's enabling open access for assessments)	**KPI 1**	Number of Drop in each period (location). 12 per year across the 5 x 12 = 60 sessions	Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec (Jan-Mar scored through for 1st year only as Service commencing April 2016)	There is significant over performance against this KPI. It has been recognised that the contracted figure was set too low in Y1 and that current levels are appropriate (Y2 planning meeting and Q3 review mtg).	**195**
Number of Workforce Development Sessions undertaken in Settings, Localities and Clusters (Refer to Definition for explanation of Workforce Development)	**KPI 2**	Minimum Number of Sessions x 50 supporting Early Years Settings, Localities and Clusters (in lowest performing areas through targeted approach) - by Source and Count of numbers that have been trained.	Jan / Feb / Mar / Apr / May / Jun / Jul / Aug / Sept / Oct / Nov / Dec	The first 2 quarters of the year were a transitional period. By end of year 26 courses have been delivered by year end (52%) of courses will be have been delivered 8% higher than predicted at the end of Q3.	**26**
SaLT Attendance at NCH&C and ECCH hosted ASD assessment panels o 80% first quarter of year 1 of contract o 100% from second quarter of year 1 of contract	**KPI 3a**	Number of ASD panels in the month	Number attended in the month	The one non attendance in Q4 was a result of unplanned carer's leave request.	**80%**
Appropriately trained SaLT professionals to contribute to delivery of EarlyBird, EarlyBird+ and Cygnet. (Courses lead by Health)	**KPI 3bi**	Number of EarlyBird training courses commenced. Split by numbers of Starters in the Month and number of Courses commencing in the month	Number of Parents completing the course - number of courses, number of parents started, number of courses and number of parents completed at end of course duration - completion ratio.	*No courses for this period Quarterly reporting of retention rates are problematic because the courses do not neatly fit into a monthly cycle. It has been agreed that annual report over attendance and retention is made and includes a commentary on course feedback. A quarterly report on the number of families waiting for a course could be made in Y2.	**Completion Ratio** **Parents: 39:35** **Children 9:8**

MONITORING, EVALUATION AND REVIEW - KEY PERFORMANCE INDICATORS. All KPIs should be reported on a monthly basis (with KPI 9 is reported monthly, quarterly and annually) plus a selection of indicated MERs also reported on a monthly basis.

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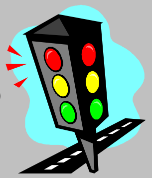

For each and every dataset which scores a Red or Amber performance rating, please detail the actions being taken to improve performance.

Targets Source: Service Specification for the Integrated Speech & Language Therapy (SaLT) Service for Children & Young People aged 0-19 Years

Provider Name or Establishment: East Coast Community Healthcare (ECCH)

Submission Terms: All KPIs should be reported on a monthly basis

	KPI 3bii	Number of Cygnet courses commenced during the Term with number of starting Parents. Split by numbers of Starters in the Month and number of Courses commencing	Number of Comleters and the Number of Courses completed at end of Course duration	Removed	**0**
	KPI 3biii	Number of EarlyBird+ training course commenced in the month during the Term with number of starting Parents. Split by numbers of Starters in the Month and number of Courses commencing	Number of Comleters and the Number of Courses completed at end of Course duration	Removed	**0**
100% compliance with the published Mandatory Timeframe for contributing to reviews for transferring from **existing** Statements to EHC Needs Assessments for requests received after 4th April 2016	**KPI 4a**	The number of EHCPs transferring from statement that require SaLT input	SaLT advice is received within 6 weeks of request in 100% of EHCPs transferring from statement and provided to the LA in the specified format.	*No requests received No requests have been formally received to suuport conversion of statements in EHCPs however our team leaders are aware of therapists supplying reports for annual reviews which are in affect conversion to EHCP.	**50%**
100% compliance with the published Mandatory Timeframe for contributing to **NEW** EHC Needs Assessments as part of the EHCP 20 week process for requests received after 4th April 2016	**KPI 4b**	The number of new EHCPs that require SaLT input	SaLT advice is received within 6 weeks of request in 100% of new EHCPs and provided to the LA in the specified format.	The impact of improved processes has been felt with a significant imporovment in performance however demand continues to increase. In addition to the overall increase in demand across the quarter the pattern of requests is unpredictable i.e. they can come through in batches, this makes resource planning within these tight time constraints harder.	**62%**
To support the EHCP process by responding to Norfolk County Council with information already held on the child or young person within 14 calendar days (Telephone Referrals).	**KPI 4c**	Number of requests due a response within 14 calendar days	Number of requests responded to within 14 calendar days - target 100%		**53%**

MONITORING, EVALUATION AND REVIEW - KEY PERFORMANCE INDICATORS. All KPIs should be reported on a monthly basis (with KPI 9 is reported monthly, quarterly and annually) plus a selection of indicated MERs also reported on a monthly basis.

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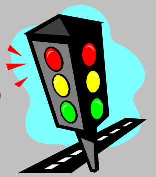

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Targets Source: Service Specification for the Integrated Speech & Language Therapy (SaLT) Service for Children & Young People aged 0-19 Years

Provider Name or Establishment: East Coast Community Healthcare (ECCH)

Submission Terms: All KPIs should be reported on a monthly basis

98% of CYP triaged will receive and be contacted by the SaLT service within 3 working days of referral	**KPI 5**	Number of referrals that require therapeutic plan	Number who are triagered will be contacted within 3 working days of referral	The telephone triage KPI assumes that all those who call want or are able to receive a call within 3 days. Many referrers have chosen to have a triage call beyond the 3 day measure. This issue has been discussed in Y2 planning and has been changed. With the consolidation of the drop in service and further clarification of referrals process we hope to see a reduction in the number of telephone referrals for pre-school children who should usualy be directed to drop-in in the first instance.	**73%**
All Written Referrals will be acknowledged within 5 working days of being received by the Service	**KPI 5.1**	Total number of Referrals	Total Number of Written Referrals will be acknowledged within 5 working days	Total number of paper referrals continues to reduce as the single point of access becomes embedded.	**78%**
95% of children and young people receive their first SaLT intervention (as per therapeutic care plan) within 18 weeks of referral to SaLT Service (Number of children and young people on the waiting list from the date of referral length of time in weeks waiting for intervention to commence, expressed as a level of need.	**KPI 6**	Number referred Example RTT report to be provided by ECCH (Referral to Treatment)	Number receiving first treatment within 18 weeks : 0-3 Weeks / 4-7 wks / 8-11 wks / 12-14 wks / 15-17 wks / 18-21 wks / 22-25 wks / 26-29 wks / 30 wks+ / Longest wait weeks / Ave wait weeks / % within 18 weeks	In Q4 the number of completed waits has significantly increased from Q3 (50%) as a result of the changes made to reporting and recording in December 2016 (as previously reported). In Q3 84% of completed referrals were within 18 weeks and in Q4 82.7% met the target. The dip performance in March is due to the loss of 1.5 wte therapists due to long term sickness.	**91%**
Percentage of children achieving a good level of development in communication and language. Evidenced at discharged as having met the goals within their intervention plan. (NB further evidence to support achievement of service specification outcomes through CYP/family/stakeholder experience which will be included in the Annual Report)	**KPI 7a**	Count of CYP discharged from Service	Using TOMS as the measurement: Number who have **completely** met their goals – should be at least 60%	The low number of goals compared to the total activity in the quarter is because this is the first time that S1 goals have been used and reported. We expected this number to significantly increase as more children reach this stage in their care.	**88%**
	KPI 7b	Count of CYP discharged from Service	Using TOMS as the measurement: Number who have **partially** met (ie at least 50%) their goals – should be at least 90%		**98%**
95% of referrals from neonatal **(Acute)** are assessed face to face within 2 working days	**KPI 8**	Number of Referrals	Number who have completely met their goals – should be at least 60%		**95%**

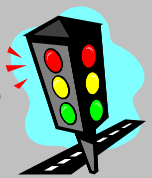
MONITORING, EVALUATION AND REVIEW - KEY PERFORMANCE INDICATORS. All KPIs should be reported on a monthly basis (with KPI 9 is reported monthly, quarterly and annually) plus a selection of indicated MERs also reported on a monthly basis.

YEAR 1 - 2016 -2017 Area for MER: The Educational provision of the service shall be available for all children aged 0-19 with a Speech and Language need, residing or attending a setting in the geographical area of Norfolk (including Great Yarmouth area). The Health provision is for all areas in Nofolk except the Great Yarmouth area. All measures must be separated between Norfolk County Council and the four CCG areas (Norwich CCG, North Norfolk CCG, South Norfolk CCG and West Norfolk CCG).

R Not within tolerance of target (more than 5%) *(Red)*

A Within tolerance of target (5%) *(Amber)*

G Meeting or exceeding target *(Green)*



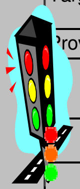
For each and every dataset which scores a Red or Amber performance rating, please detail the actions being taken to improve performance.

Targets Source: Service Specification for the Integrated Speech & Language Therapy (SaLT) Service for Children & Young People aged 0-19 Years

Provider Name or Establishment: East Coast Community Healthcare (ECCH)

Submission Terms: All KPIs should be reported on a monthly basis

Record the number of Tribunals per year that require SaLT input	**KPI 9**	No of Tribunals per year that require SaLT input	100% involvement in Tribunals where SaLT input is required		
YEAR 1 WILL SET THE BASE LINE THRESHOLD (DETERMINING THE DISCHARGE LEVEL). BY THE END OF YEAR ONE OF THE NUMBER OF CHILDREN WHO COMPLETE THE COURSE, 70% OF THOSE WHO FULLY ACHIEVE THEIR EKOS TARGET AT THE END OF THEIR EPISODE OF CARE	**KPI 10**	**BASELINE FIGURE: To be determined AT END OF YEAR ONE**			
Submission of the measures in the MER Framework	**KPI 11**	Report as completed on MER template (Monthly, Quarterly, Annually)	Number who have partially met (ie at least 50%) their goals – should be at least 90%		



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2	**MONITORING, EVALUATION AND REVIEW - MER MEASURES, a selection of indicated MERs are reported on a monthly basis.**	**YEAR 1 - 2016 -2017** Area for MER: The Educational provision of the service shall be available for all children aged 0-19 with a Speech and Language need, residing or attending a setting in the geographical area of Norfolk (including Great Yarmouth area). The Health provision is for all areas in Nofolk except the Great Yarmouth area. All measures must be separated between Norfolk County Council and the four CCG areas (Norwich CCG, North Norfolk CCG, South Norfolk CCG and West Norfolk CCG).				
3	🟥 R Not within tolerance of target (more than 5%) *(Red)*	Targets Source: Service Specification for the Integrated Speech & Language Therapy (SaLT) Service for Children & Young People aged 0-19 Years				
4		Provider Name or Establishment: East Coast Community Healthcare (ECCH)				
5	🟨 A Within tolerance of target (5%) *(Amber)*					
6	🟩 G Meeting or exceeding target *(Green)*					
7					Submission Terms: All MER Measures reported as indicated	
8	**MER MEASURES FOR SERVICE PERFORMANCE FOR NORFOLK CHILDREN WITH A SPEECH & LANGUAGE NEED**	**MER**	**Denominator (where applicable)**	**Numerator (where applicable)**	**ECCH Commentary**	**Accumulative Total**
9	Gather profile data regarding range of activity delivered and locations drop-ins are provided in	**MER 1.1**	Number of parents/carers and professionals accessing drop-in sessions by Activity Type and by outcome of referral (ie onward assessment / signposting / strategies. This to be reported on monthly basis, broken down by location. ECCH would provide a quartly indepth report/presentation to giveinformation on activity type and referal information during monitoring meeting. across the areas.			
10	Number of parents/carers and professionals accessing drop-in sessions by Activity Type and by outcome of referral (ie onward assessment / signposting / strategies	**MER 1.2**	Number of people attending (location). 12 per year across the 5 x 12 = 60 sessions and outcomes. Breakdown of Attendees to be provided			
11	**Total number of Referrals**	**MER 2.1**	**Count of monthly referrals by SaLT Locality Teams (Hubs) and by Referral Source: Parent Carer , GP, School Clusters and Early Years Settings, Acute Service, Community Health and Pathways identified for each Referral and noting if NO ACTION NEEDED**	Number of referrals	The proportion of referrals for Q4 is as follows • family: 31% • health professionals :24% • other professionals: 45%.	
12	**Count of Referrals in to Service**	MER 2.2	Count of monthly referrals by source, number of referrals Screened **by School Clusters and Early Years Settings** and by Tier	Number of Referral	Overall there has been an increase in referrals in the second half of the year.	**1872**
13	Audit whether individuals were given a choice of venue (part of patient users survey as part of annual review)	**MER 2.3**	NUMBERS WILL CHANGING			

	A	B	C	D	F	T
8	**MER MEASURES FOR SERVICE PERFORMANCE FOR NORFOLK CHILDREN WITH A SPEECH & LANGUAGE NEED**	**MER**	**Denominator (where applicable)**	**Numerator (where applicable)**	**ECCH Commentary**	**Accumulative Total**
14	Evidenced discussion with local community to ensure service provision is in most appropriate locations	**MER 2.4**	Captured on post training course/drop in centres/ annual survey - annual report			
15	Count of people accessing the Advice Line	**MER 3**	Count of people accessing the Advice Line		As expected demand reflects the pattern of the academic calendar with drops in demand especially in August but also the longer Christmas break in December. The numbers are above those anticipated at the start of the contract. As our processes have become more streamlined we suspect there are fewer duplicate calls or those from parents who transferred from one provider to another and made calls seeking reassurance about future progress for their children. It is encouraging to know that this service is both known about and readily accessed.	**5761**
16	Proportion of initial contacts for children under 12 months versus over 12 months of age relating to eating and drinking **(DYSPHAGIA)**	**MER 4.**	Count of under and over 12 months			**251**
17						**90**
18	PROFILE REPORT BY CYP ACCESSING SALT SERVICE UNDER 12 MONTHS BY IDENDIFIED NEED and CLINICAL CARE PATHWAY:	**MER 4.1**	COUNT OF PATIENT AND THEIR EPISODES OF CARE		The profile is as expected as the primary need for children under 12 months is dysphagia. The only other child likely to be seen under 12 months are those with an identified hearing impairment and/or cleft palate.	**72**

	A	B	C	D	F	T
8	**MER MEASURES FOR SERVICE PERFORMANCE FOR NORFOLK CHILDREN WITH A SPEECH & LANGUAGE NEED**	**MER**	**Denominator (where applicable)**	**Numerator (where applicable)**	**ECCH Commentary**	**Accumulative Total**
19	NUMBER OF CLINICAL CARE PATHWAYS ACCESSED BY CYP AT THE POINT OF DISCHARGE	**MER 5.1**	Number of CYP requiring Specialist Therapy Interventions	The numbers of multiple Specialist Interventions delivered to an individual child	At the point of discharge 94% of children accessed a single clinical pathway. Multiple pathways will only be accessed by children with a communication need. If a child is seen for dysphagia and communication this is managed as two referrals and not pathways.	**1549**
20	ANNUAL CASE STUDIES TO CAPTURE THE VALUE OF THE STRATEGIES AND WORKFORCE INTERVENTIONS CARRIED OUT WIDER WORKDER ACROSS SERVICE AREAS. Providing Assurance that effective Transition in place – for example between Settings, Schools, SRBs and Adult Services. Documentary evidence of process in place at mobilisation	**MER 5.2**	ANNUAL CASE STUDIES TO CAPTURE THE VALUE OF THE STRATEGIES AND WORKFORCE INTERVENTIONS CARRIED OUT WIDER WORKDER ACROSS SERVICE AREAS - EY, CLUSTER, SPECIAL & COMPLEX NEEDS SCHOOLS, AND SRBS (SLCN AND DRB)	MINIMUM OF 4 CASE STUDIES PER YEAR ACROSS THE MIX ACROSS THE SALT LOCALITY. AS PART OF THE END OF YEAR REPORT.		
21	Number of CYP who did not attend (DNA) the scheduled intervention	**MER 5.3**	STANDARD NHS POLICY RE ON 3RD COMMUNICATIONS THE REFERRAL IS RELEASED AND SAFEGUARDING ISSUES HIGHLIGHTED	STRAIGHT COUNT OF DNA	he DNA rate continues to be low 1% over the full year. We believe this is due to the flexible way in which we offer appointments at a choice of locations and to meet the individual child’s needs wherever possible.	**1%**
22	Captured as part of Feedback form, demonstrate the range of access to provision available during for the interim period between Referral and Initial Assessment (Offered Referral Packs, access to Drop in, Group Sessions). Will be captured as part of the Patient Satisfaction Questionnaire.	**MER 5.4**	ECCH to demonstrate that range of support and also Triage process will provide assurance to the Commissioners			
23	Number of practitioners/settings attending training delivered by SaLT Team	**MER 6.1**				**589**
24	REPORT Of sessions provided to specialist provision (e.g. SRBs and Complex Needs Schools)	**MER 6.2**				
25	Impact of training (Measurement of practitioner’s confidence): Number of delegates reporting increased confidence in supporting children post training.	**MER 6.3**				
26	Evidence of setting development (within setting action plans) - Case Study provided by each Setting that has received direct support	**MER 6.4**				
27	Provision of annual specific training to Settings, Localities, Schools, Portage, HCP, DASH colleagues focusing on risk factors and early identification for SLCN	**MER 6.5**				

	A	B	C	D	F	T
8	**MER MEASURES FOR SERVICE PERFORMANCE FOR NORFOLK CHILDREN WITH A SPEECH & LANGUAGE NEED**	**MER**	**Denominator (where applicable)**	**Numerator (where applicable)**	**ECCH Commentary**	**Accumulative Total**
28	Core offer local training needs reviewed annually.	**MER 6.6**				
29	Number of workplace coaching sessions focusing on generating positive communication environments.	**MER 6.7**	ECCH will report Annually on what enhanced services have been delivered across the board including the number of workplace coaching sessions focusing on generating positive communication environments.			
30	Number of TA's, LSAs, and **Parents and Carers** being included in therapy sessions with SaLT OR SaLTA	**MER 6.8**	COUNT	Monthly Count		**1918**
31						**3704**
32	~~Audit of information sharing e.g.~~ REPORTS TO PARENTS OR SCHOOLS OR GP / APPROPRIATE REFERRAL AFTER COMPLETION OF THE INITIAL ASSESSMENT WITHIN within 2 weeks	**MER 7**				
33	Annual Report to evidence inclusion and participation in Local Communication Networks.	**MER 8**				
34	360 Annual Satisfaction Engagement (360 and subsequent Action Plan to Commissioners	**MER 9**	Annual Engagement undertaken and Action Plan (to include telephone consultation line)	1 per year = 100%		
35	There is a named SaLT for each Children's Centre Lot and Cluster Group and they are available to all the schools and early years settings and child-minders (to be evidenced in Annual Review)	**MER 10**	Early Years Settings includes 36 Children's Centre Lots & 53 individual Children's Centres and there are 46 School Clusters	Early Years Settings includes 36 Children's Centre Lots & 53 individual Children's Centres and there are 46 School Clusters		

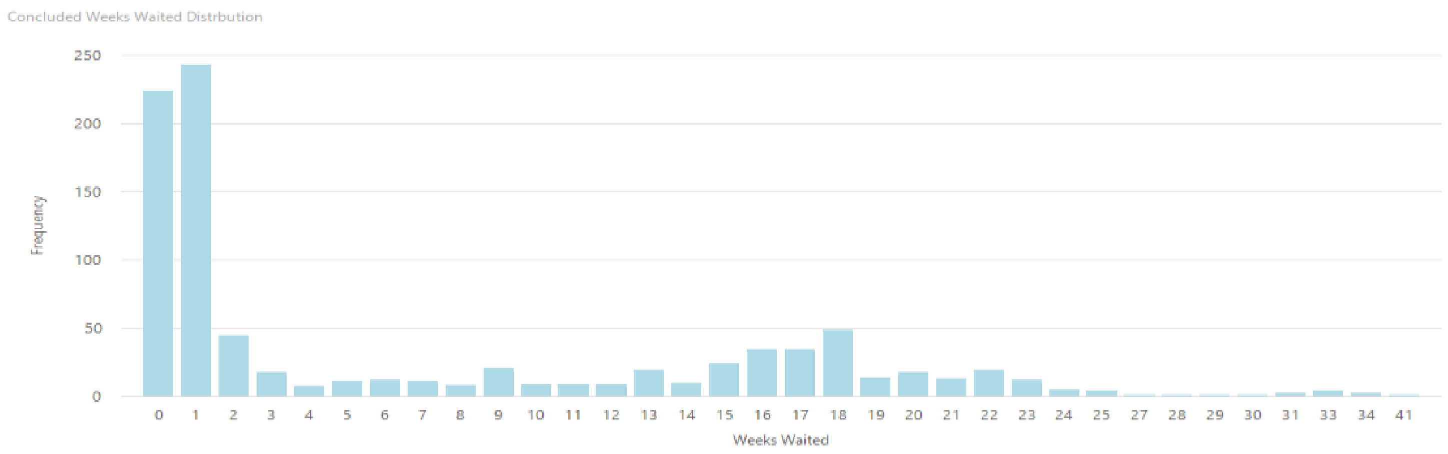
Year 2 - 2017-18, Quarter 1 (April - June) Key Performance Indicator results

KPI Ref	Description	Denominator		Numerator		Threshold	Performance	Latest Commentary
KPI 1	Number of Drop-in sessions delivered (Advice & Support Drop-in's enabling open access for assessments)	Contracted number of drop in sessions - 150 per year. This figure is calculated from the proportion of the year that has passed between 01/04/2017 and 30/06/2017	**37**	Number of drop in sessions delivered	**38**	150 per year	**103%**	Performance to plan. A new venue (Acle) will start in Q2 as a result of identifying previous unmet need. Submitted By: ECCH
KPI 2	Delivery of workforce development sessions per year (0-end of reception year)	Contracted number of workforce development sessions (50). This figure is calculated from the proportion of the year that has passed between 01/04/2017 and 30/06/2017	**12**	Sessions delivered	**12**	50 per year	**100%**	Performance to plan. All contracted Early Years sessions are programmed through to Summer 2018. Submitted By: ECCH

KPI 3a	SaLT Attendance at NCH&C and ECCH hosted ASD assessment panels as per memorandum of understanding	Number of ASD panels in period	**14**	Number attended in the period	**14**	100% Exception reporting for breaches detailing reason	**100%**	Performance to plan. Submitted By: ECCH
KPI 4a	Compliance with the published Mandatory Timeframe for contributing to reviews for transferring from existing Statements to EHC Needs Assessments for requests received after 4th April 2016	The number of EHCPs transferring from statement where SaLT advice is formally requested	**1**	SaLT advice is received within 6 weeks of request in 100% of EHCPs transferring from statement where SaLT advice is formally requested, and provided to the LA in the specified format.	**0**	100%	**0%**	There was one request during period and this missed the target by four days; we continue to investigate the root cause of the failure. Other request were received via schools and were responded to. As previously advised it is not possible to track timescales with requests received via this route. Submitted By: ECCH

KPI 4b	Compliance with the published Mandatory Timeframe for contributing to NEW EHC Needs Assessments as part of the EHCP 20 week process for requests received after 2017	The number of new EHCPs that require SaLT input	**71**	SaLT advice is received within 6 weeks of request in 100% of new EHCPs and provided to the LA in the specified format.	**61**	100%	**86%**	Of the 71 requests 2 were outside of the timescale due to parental choice; 1 request continues to be outstanding due child's on-going ill-health. 2 were not met due to staff illness and then an inability to reschedule within the time-frame. 1 breach was due to the service not receiving the request in a timely manner. 4 breaches were due to capacity demands. Over all this represents a performance of 91% within timescale for the requests that have been totally within ECCH's control. This builds upon earlier improvements since Q3 of Year 1 when internal processes were reviewed. Submitted By: ECCH
KPI 4c	To support the EHCP process by responding to Norfolk County Council with information already held on the child or young person within 14 calendar days	Number of requests due a response within 14 calendar days	**50**	Number of requests responded to within 14 calendar days - target 100%	**48**	100%	**96%**	Of the 50 requests 2 have breached due to service capacity.Submitted By: ECCH

KPI 8	98% of new patient referrals via ECCA are offered telephone assessment within 2 weeks	Number of new patient referrals via ECCA received	**276**	Number of new patient referrals via ECCA offered telephone assessment within 2 weeks of referral	**272**	98%	**99%**	Performance to plan. The revised reporting measure for Year 2 that allows more choice of appointment time for the parent/professional has seen the anticipated improvement in performance. Submitted By: ECCH
KPI 9	Children and young people will receive their first intervention within 18 weeks of referral to the SaLT service	18 Week Waits Completed	**897**	18 Week Waits Completed within 18 Weeks	**797**	92%	**89%**	Within the quarter there was a steady improvement in performance [April 75.6%; May 88.4% and June 93.2%]. Significant effort is being put into addressing the longest waits and staffing pressures in the East pending completion of a recruitment process. Submitted By: ECCH



KPI 10	Percentage of children (where service pathway is subject to EKOS) achieving a good level of development in communication and language. Evidenced at discharged as having met the goals within their intervention plan	Count of patients discharged from service where EKOS appropriate	**59**	Number who have fully met their goals at discharge	**44**	60%	**75%**	Performance to plan. The numerator for this KPI continues to grow as the total number of children for whom clinical goals have been recorded on the electronic record and have completed their package of care increases. Submitted By: ECCH
KPI 11	Percentage of children (where service pathway is subject to EKOS) achieving a good level of development in communication and language. Evidenced at discharged as having met the goals within their intervention plan	Count of patients discharged from service where EKOS appropriate	**59**	Number who have either **partially** (i.e.at least 50%) or **fully** met their goals at discharge	**53**	90%	**90%**	Performance to plan. The numerator for this KPI continues to grow as the total number of children for whom clinical goals have been recorded on the electronic record and have completed their package of care increases. Submitted By: ECCH
KPI 12	Referrals from neonatal are assessed face to face within 2 working days	Number of Referrals	**17**	Number assessed within 2 days	**15**	95%	**88%**	There were 17 relevant referrals. All bar one were seen within standard. The one breach was due to the referral being entered onto S1 when received but this predated the transfer of the child from tertiary centre to NNUH by 3 days. Once at NNUH the child was seen on the day of admission. There is one error within this data which we are discussing with our configuration team. All children were seen with 2 days of referral/admission. Submitted By:.ECCH

Year 2 2017-18 Quarter 1 April - June Monitoring, Evaluation and Review measures

MER Ref	Description	Denominator (Where Applicable)		Numerator (Where Applicable)				
MER 1	Drop-in session attendance rate	Available spaces	**333**	Attendance	**293**			
MER 2	Outcome of drop-in sessions (i.e. onward assessment / signposting / strategies)	Profile report of drop-in session outcomes		Outcomes recorded (one attendee can have multiple outcomes)	**Outcome Onward Assess**	**Outcome Sign-posting**	**Outcome Strategies**	**Outcome Other**
					80	8	168	11
MER 3	Total number of referrals	Profile report of referrals into service to include: - Count of referrals - Referral source - Referral pathway	Count of Referrals	**1305**				
			Referrals by Source					

Referral Source	**Count**	**%**
Community Team for Learning Disability	1	0%
Suffolk Childrens Services	3	0%
ENT/Audiology	4	0%
Specialist Nurse	9	1%
AHP	11	1%
Community Health Service	12	1%
Children Services Teams	12	1%
Community Paediatric Team	14	1%
Carer	22	2%
HV Team	24	2%
Acute Hospital	33	3%
Hospital Med Team	40	3%
GP Team	50	4%
Speech & Language Therapist	105	8%
Norfolk Children's Services	242	19%
Patient / Parent	343	26%
School/ Nursery/ Pre School	380	29%
Total	**1305**	

<table>
<tr>
<td>MER 3</td>
<td>Total number of referrals</td>
<td>Profile report of referrals in to service to include:-

Count of referrals
Referral source
Referral pathway</td>
<td>Referrals by Pathway</td>
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<table>
<tr><th><u>Referral Pathway</u></th><th><u>Count</u></th><th><u>%</u></th></tr>
<tr><td>ASD Panel</td><td>4</td><td>0%</td></tr>
<tr><td>Assessment</td><td>94</td><td>7%</td></tr>
<tr><td>EHCP Assessment Request</td><td>52</td><td>4%</td></tr>
<tr><td>EHCP Information Request</td><td>179</td><td>14%</td></tr>
<tr><td>EHCP TransferRequest</td><td>3</td><td>0%</td></tr>
<tr><td>SLT Assessment</td><td>456</td><td>35%</td></tr>
<tr><td>SLT Childrens AAC</td><td>3</td><td>0%</td></tr>
<tr><td>SLT Childrens Cleft Palate</td><td>2</td><td>0%</td></tr>
<tr><td>SLT Childrens Complex Needs</td><td>12</td><td>1%</td></tr>
<tr><td>SLT Childrens Eating / Drinking</td><td>92</td><td>7%</td></tr>
<tr><td>SLT Childrens Hearing Impairment</td><td>3</td><td>0%</td></tr>
<tr><td>SLT Childrens Language</td><td>133</td><td>10%</td></tr>
<tr><td>SLT Childrens Social Communication</td><td>71</td><td>5%</td></tr>
<tr><td>SLT Childrens Speech</td><td>176</td><td>13%</td></tr>
<tr><td>SLT Childrens Stammering</td><td>25</td><td>2%</td></tr>
<tr><td>Total</td><td>1305</td><td></td></tr>
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		Age Group Category	Patient Count	Care Pathway	Patient Count
MER 3	**Total number of referrals**	**0 to 12 Months**	**37**	SLT Paediatric Cleft Lip/Palate	1
				SLT Assessment	1
				SLT Childrens Cleft Palate	3
				SLT Paediatric Eating/Drinking	8
				SLT Childrens Eating / Drinking	24
				Total Pathways	**37**
		PreSchool	**1620**	SLT Paediatric Selective Mutism	1
				EHCP TransferRequest	1
				SLT Paediatric Drop In - North	2
				SLT Childrens Acquired Communication Disorder	2
				SLT Childrens AAC	3
				SLT Paediatric Drop In - East	3
				SLT Childrens Cleft Palate	3
				SLT Paediatric Drop In - Central	4
				EHCP Information Request	5
				ASD Panel	5
				SLT Childrens Hearing Impairment	7
				Advice & Information	11
				EHCP Assessment Request	11
				SLT Paediatric Drop In - South	11
				SLT Paediatric Drop In - West	12
				SLT Paediatric Stammering	13
				SLT Paediatric Hearing Impairment	13
				SLT Paediatric Learning Difficulties	15
				SLT Childrens Stammering	25
				SLT Childrens Speech Disorder	25
				SLT Paediatric Cleft Lip/Palate	28
				SLT Childrens Complex Needs	31
				SLT Childrens Speech Delay	34

MER 3	**Total number of referrals**	**PreSchool**		SLT Childrens Eating / Drinking	45
				Assessment	45
				SLT Paediatric Social Communication	58
				SLT Childrens Social Communication	89
				SLT Paediatric Eating/Drinking	91
				SLT Paediatric Speech	107
				SLT Childrens Speech	145
				SLT Childrens Language	173
				SLT Paediatric Communication	302
				SLT Assessment	352
				Total Pathways	**1672**
		KeyStage1	**620**	SLT Childrens Cleft Palate	1
				SLT Paediatric Drop In - Central	1
				SLT Paediatric Drop In - West	1
				SLT Childrens Eating / Drinking	2
				SLT Childrens AAC	2
				SLT Childrens Hearing Impairment	2
				EHCP Assessment Request	2
				ASD Panel	3
				EHCP Information Request	3
				SLT Childrens Complex Needs	6
				SLT Paediatric Learning Difficulties	7
				SLT Paediatric Hearing Impairment	8
				SLT Paediatric Cleft Lip/Palate	8
				SLT Childrens Speech Disorder	11
				SLT Paediatric Stammering	12
				SLT Childrens Stammering	13
				Advice & Information	13
				Assessment	15
				SLT Childrens Social Communication	16
				SLT Childrens Speech Delay	16
				SLT Paediatric Eating/Drinking	16
				SLT Childrens Speech	38
				SLT Paediatric Social Communication	46
				SLT Childrens Language	51
				SLT Paediatric Speech	89
				SLT Assessment	106
				SLT Paediatric Communication	144
				Total Pathways	**632**

MER 4	SaLT caseload profile * Caseload active on 29/06/2017	Snap shot of service showing caseload by age group (0- 12 months, pre school, KS1, KS2, KS3 , KS4) , pathway (s) and patient count	**KeyStage2**	**420**	EHCP TransferRequest	1
					SLT Childrens Voice	1
					SLT Childrens Hearing Impairment	1
					SLT Childrens Speech Delay	2
					ASD Panel	2
					Advice & Information	2
					SLT Childrens AAC	3
					EHCP Assessment Request	4
					Assessment	5
					SLT Childrens Speech Disorder	5
					SLT Childrens Eating / Drinking	5
					SLT Paediatric Stammering	7
					SLT Paediatric Cleft Lip/Palate	7
					EHCP Information Request	8
					SLT Paediatric Eating/Drinking	11
					SLT Childrens Social Communication	13
					SLT Childrens Stammering	14
					SLT Paediatric Hearing Impairment	14
					SLT Childrens Speech	18
					SLT Childrens Complex Needs	20
					SLT Paediatric Speech	21
					SLT Paediatric Social Communication	38
					SLT Paediatric Learning Difficulties	39
					SLT Childrens Language	39
					SLT Assessment	62
					SLT Paediatric Communication	88
					Total Pathways	**430**
			KeyStage3	**175**	ASD Panel	1
					SLT Paediatric Speech	1
					SLT Childrens Cleft Palate	1
					EHCP Information Request	1
					SLT Childrens Hearing Impairment	2
					Advice & Information	2
					SLT Childrens Language	2
					SLT Paediatric Cleft Lip/Palate	2
					SLT Childrens Social Communication	3
					SLT Childrens Speech	3
					Assessment	4
					SLT Childrens AAC	4
					SLT Childrens Stammering	5
					SLT Childrens Eating / Drinking	5
					SLT Paediatric Eating/Drinking	5

MER 4	**Salt caseload profile* Caseload active on 29/06/17**	**Snapshot of service showing caseload by age group (0-12 months, pre school, KS1, KS2, KS3, KS4) pathways and patient count**			SLT Paediatric Social Communication	7
					SLT Paediatric Hearing Impairment	13
					SLT Paediatric Communication	24
					SLT Assessment	26
					SLT Childrens Complex Needs	30
					SLT Paediatric Learning Difficulties	38
					Total Pathways	**179**
			KeyStage4	**84**	SLT Paediatric Stammering	1
					SLT Paediatric Speech	1
					SLT Childrens AAC	1
					SLT Childrens Hearing Impairment	1
					SLT Paediatric Cleft Lip/Palate	1
					SLT Childrens Selective Mutism	1
					Advice & Information	1
					SLT Paediatric Voice	1
					SLT Childrens Language	2
					SLT Childrens Stammering	2
					Assessment	2
					SLT Childrens Speech	3
					SLT Paediatric Hearing Impairment	3
					SLT Childrens Eating / Drinking	3
					SLT Paediatric Eating/Drinking	3
					SLT Paediatric Social Communication	6
					SLT Assessment	12
					SLT Paediatric Learning Difficulties	12
					SLT Paediatric Communication	14
					SLT Childrens Complex Needs	17
					Total Pathways	**87**
			KeyStage4+	**63**	Assessment	1
					SLT Paediatric Hearing Impairment	2
					SLT Childrens Language	2
					SLT Childrens Stammering	2
					SLT Childrens AAC	3
					SLT Childrens Eating / Drinking	3
					SLT Childrens Complex Needs	4
					SLT Paediatric Learning Difficulties	7
					SLT Paediatric Communication	7
					SLT Paediatric Eating/Drinking	8
					SLT Paediatric Social Communication	10
					SLT Assessment	19
					Total Pathways	**68**
			Total Patients	**3019**	**Total Pathways**	3105

MER 5	Count Number of children and young people who did not attend (DNA) scheduled intervention	Appointment Count	**4616**	Count of DNAs	**111**	**2%**	

NHS
Great Yarmouth
and Waveney
Clinical Commissioning Group

Briefing for Norfolk Health Scrutiny Committee

7 September 2017

Great Yarmouth and Waveney Clinical Commissioning Group's (GYWCCG) Approach to Delivering Speech and Language Services (SALT) to Children and Young People

Our vision is to provide the best possible services, based on currently available evidence, at the earliest possible time in life, within resources available, giving value for money.

1. Introduction and Background

The Children's and Families Act 2014 places a duty on both the Local Authority and Health to have a joint approach in order to meet the needs of children and young people who have special educational needs and disabilities (SEND).

Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG) have commissioned a SALT service covering both the Norfolk and Suffolk Local Authority areas since 2011. GYWCCG choose not to jointly commission SALT with Norfolk in 2015/16 . GYWCCG did not want to de-stabilise their community provider and would have had potential inequity of provision for children and young people with one offer in Great Yarmouth and potentially a different offer for Waveney. Health funding to the service from GYWCCG has remained unchanged since the joint service across Norfolk has been introduced in April 2016.

2. Current Position

GYWCCG currently commissions a SALT service from East Coast Community Healthcare (ECCH). The service covers the GYWCCG area. Currently this is Health funded. The contract expires at the end of March 2019.

3. Service Model

The service model which has been commissioned by GYWCCG for many years is very similar to that of the new integrated service in Norfolk.

The main purpose of the Speech and Language Service is to provide assessment, diagnosis and therapy for young people who have SALT needs as well as practical advice and training for parents, carers, other professionals and school staff as required. The aim is to ensure children with speech, language, communication, eating and drinking needs reach their full potential.

The focus is on supporting prevention and early identification through the quick and easy access for preschool children to qualified speech and language therapist via drop-in sessions in community venues.

- A single point of access for parents and professionals has been agreed in principle
- A service advice line for parents and professionals is available.
- Training in schools is undertaken as requested and a skill mix team is in place, including clinical support workers who are able to undertake work under the supervision of a qualified speech and language therapist supporting children within schools
- SALT provision is also provided to the 'specialist schools' including John Grant School

Services are provided to children up to their school leaving age and can include children who have the following difficulties:

- Difficulties understanding what people say.
- Late or unusual development of spoken language.
- Unclear speech.
- Stammer
- Voice difficulties.
- Difficulties eating and drinking safely.
- Difficulties using language for social interaction purposes.

Response to the HOSC questions as detailed below. It should be noted that the following information covers both the Great Yarmouth and Waveney area as it has not been possible for this report to separate the Norfolk and Suffolk information but is something that will be rectified for future reports.

Question A) Workload – what is the current workload, the trend, comparison between commissioned capacity and actual number of referrals?

Since April 2016, the SALT service has seen a significant increase in requests for Education, Health and Care Plan assessments (EHCP) from the local authorities for both Great Yarmouth and Waveney. These requests take more than twice the time allocated for a standard assessment and currently make up on average 20% of all new referrals.

Average resource demand for new referrals:

The following resource times are estimated averages, and it should be noted that the time taken can vary significantly depending upon the individual case.

20% - EHCP – 7 hours per assessment

50% - Standard assessment – 2.5 to 3 hours

10% - Autistic Spectrum Disorder (ASD) – 3 hours

10% - Eating & Drinking (Dysphagia) – 6 hours

10% - Drop in referrals – 1 hour

Table 1: GYWCCG Speech and Language Therapy Referrals

Month of referrals (2017)	Count
February	84
March	77
April	65
May	111
June	92
July	104
Total	**533**

Based upon a 77% staff utilisation rate (allowance for holiday entitlement and standard sickness levels), this equates to a resource requirement for new referrals only of 3.3 WTE at 85% productivity.

Resource demand for specialist provision:

Hearing impairment unit – 1 day per week
Specialist resource base – 2.5 days per week (including Outreach)
Cleft palate and velopharyngeal impairment – 1 day per week
Early Bird – 0.5 days per week
Dysphagia – 5 days per week
Complex needs schools:

(Warren school (Waveney area) – 2 days per week
(Ashley school (Waveney area) – 1 day per week
ASD panel attendance – 0.5 days per week
Pre-school liaison group – 0.5 days per week

Total – 14 days = **4.2 WTE** applying the metrics as per referrals.

Active caseload resource demand:

The following table details the current caseload for Great Yarmouth and Waveney SALT (GYWCCG commissioned only)

Key Stage	Patient Count
0 to 12 Months	10
Pre-School	264
KeyStage1	180
KeyStage2	93
KeyStage3	19
KeyStage4	9
KeyStage4+	4
Grand Total	**579**

Intensive intervention – 2 hours (6 x 6 week cycle) – 72 hours x 90 (caseload) = 6500 hours per annum = **5.2 WTE**
Therapist led intervention – 4 hours x 2 per annum – 8 hours x 490 (caseload) = 3920 hours per annum = **3.1 WTE**

Telephone triage demand:

Triage for school age children (Great Yarmouth only) – 0.5 hours x 235 = 117.5 hours per annum = **0.5 WTE**

Total clinical resource demand for NHS GY&W activity:

New referrals –		3.3 WTE
Specialist provision –		4.2 WTE
Active Caseload –	Intensive	5.2 WTE
	Therapist led	3.1 WTE
Telephone Triage		0.5 WTE
Total		**16.3 WTE**

Question B) Staffing – number and types of vacancies?

Actual Staffing levels

Month	Actual clinical resource in post WTE
Feb-17	17.8
Mar-17	16.8
Apr-17	16
May-17	15.8
Jun-17	15.5
Jul-17	15.7
6 Month average	**16.3**

The service has been 1.0 WTE down since February 2017 as a result of a staff member taking on another role. . The vacancy has now been recruited to and we anticipate the new staff member will be in place in September 2017. The figures in the above table include approximately 0.5 WTE bank staff for the past 3 months, with the new permanent employee in place this will bring resourcing back to 16.3 WTE.

Pattern of Demand

The demand on the service fluctuates during the year based on the school calendar. Typically the school holidays see fewer referrals and more pre-school work being carried out. Peak activity is normally related to mid-autumn and summer school terms for which data is not yet available.

Complexity of Cases

Whilst the referral rate is not changing significantly, the complexity of cases is increasing.

Question C) Waiting times – from referral to assessment, from assessment to start of therapy, numbers on the waiting lists.

Waiting times

There is a Key Performance Indicator (KPI) included in the contract which requires 95% of children and young people to receive their first SALT intervention within 18 weeks of referral (see appendix one).

From referral to assessment

The time from referral to treatment over the past six months has been influenced by the vacancies and subsequent recruitment process. Any waits over 18 weeks were primarily children waiting for an assessment as part of the ASD Diagnostic Pathway. These assessments have now been completed. The service 18 week data is now on target, those CYP showing as currently waiting for 16-17 and 17-18 weeks, have had appointments booked and have been seen. GYWCCG will continue to monitor this performance and will be looking to develop a new monitoring, evaluation and performance framework with the provider in the future.

Question D) Complaints/user feedback – numbers of complaints, complaint themes, user satisfaction survey feedback

Complaints/user feedback

The service receives feedback from the following sources:

- Friends and Families test
- Complaints
- Compliments
- Patient Liaison Services (PALS)

The service strives to meet children's needs and the expectations of the adults that care and support them.

There have been no formal complaints received for the Great Yarmouth area.

There have been two PALS contacts for the Great Yarmouth area, and these have been resolved locally.

Two formal compliments were received for the service across Great Yarmouth and Waveney.

4. Next Steps

GYWCCG have recently undertaken a clinical review of SALT as the service specification requires a review (this is in the process of being written up at present). Following the outcome and recommendations of the review GYWCCG are also planning to work with both Norfolk and Suffolk Local Authorities to try to align the service specifications and reporting and performance requirements to ensure a consistent SALT offer for families across the Norfolk and Waveney area.

Patricia Hagan
Senior Commissioning Manager Children, Young People and Maternity services

SaLT Health East Children - 18 Week Waits

The "weeks wait" is presently defined for community care as the time between the initial referral and the first treatment recieved by the patient. This is calculated from SystmOne by taking the difference between the "Clock Started Date" and the "Date Completed" on each 18 week wait.

🟩 Performance 95% or above | 🟨 Performance below 95% but above 90% | 🟥 Performance below 90%

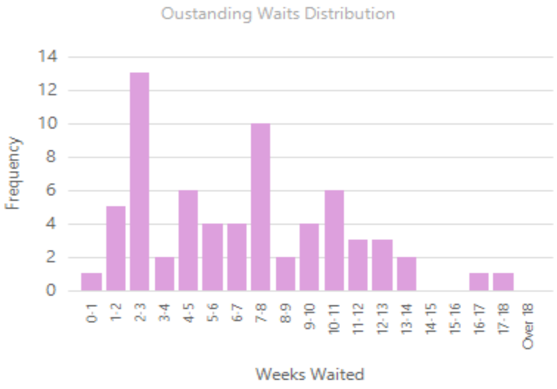
N.B. Due to the S1 unit merge in Jan 2017 in the Children's SaLT Services, HealthEast's concluded wait data is only accurate as of Jan 2017 onwards - previously the majority of these waits were recorded in a different unit which is no longer reflected on this dashboard. The outstanding wait data is accurate and reflects all of the HealthEast outstanding waits in the new unit.

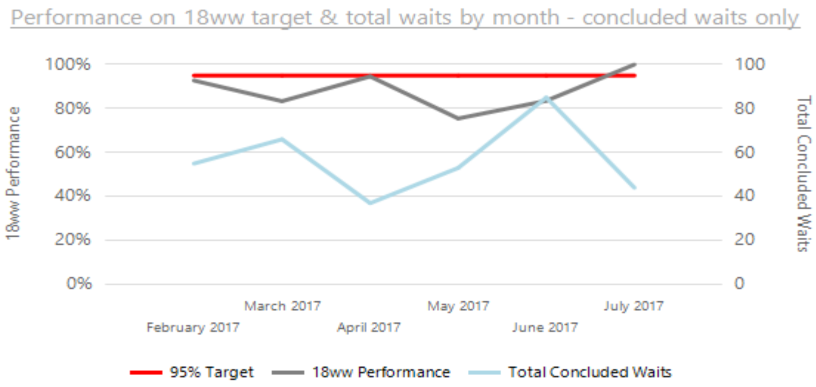
Concluded waits - last updated 02/08/2017 - this reflects data as was recorded on SystmOne at 17:18 on 01/08/2017

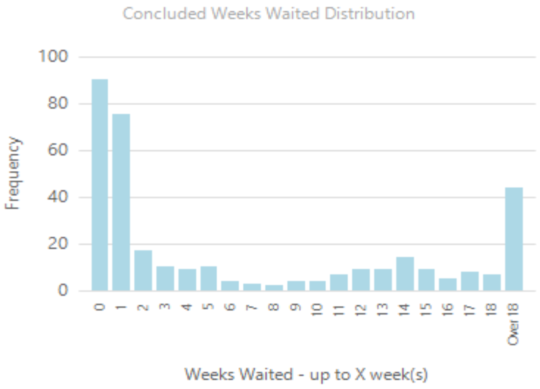
	February 2017	March 2017	April 2017	May 2017	June 2017	July 2017
Over 18 Weeks (S1)	4	11	2	13	14	0
Seen in 18 Weeks	51	55	35	40	71	44
Total Concluded Waits	55	66	37	53	85	44
Longest Concluded Wait (Weeks)	21.9	25.0	21.0	31.0	35.0	17.0
Percentage Performance	🟨 92.7%	🟥 83.3%	🟨 94.6%	🟥 75.5%	🟥 83.5%	🟩 100.0%

Outstanding waits - last updated 02/08/2017 - this reflects data as was recorded on SystmOne at 17:18 on 01/08/2017

Wait so far (weeks)	0-1	1-2	2-3	3-4	4-5	5-6	6-7	7-8	8-9	9-10	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	Over 18
Patients Waiting	1	5	13	2	6	4	4	10	2	4	6	3	3	2	0	0	1	1	0







Norfolk CC HOSC 7 September 2017
Family Voice Norfolk consultation on Children and Young People's Speech and Language Therapy Services from ECCH

Consultation

Parents of children and young people using or wanting to use the speech and language therapy services from Norfolk were consulted via an online survey to inform this paper.

Background

Family Voice Norfolk (FVN) is a collective of parent carers from nearly 700 families across Norfolk including the Gt. Yarmouth and Waveney area. FVN has been the strategic voice of parent carers working in partnership with NCC and the CCGs since 2006. It is funded through a direct DFE grant (administered through Contact a Family) and by Norfolk County Council.

Each of our members was invited to complete a questionnaire online and had the opportunity to write comments on their experiences of the existing service after each question. We had more than 70 responses.

Key messages

Key messages coming out of the discussion on ECCH SALT services were:

- Parents want clear written information about SALT service.
- Parents need to know who to contact to answer their queries / concerns and acknowledge them within a reasonable time limit.
- Parents want a service that identifies their child's needs.
- Parents want a seamless service that works together with various educational settings to provide information, advice and support to Nurseries Keyworkers, Schools and colleges TAs to meet the children and young people's Speech, Language and communication needs(SLCN).
- Parents want to have confidence in the professionals that deliver the service – that they will be compassionate and understanding about their individual child's needs - a person centred targeted service.
- Parents need to know the service is fit for purpose and will deliver the appropriate SMART outcomes for children and young people to achieve their educational targets and fulfill their life's potential – be able to communicate effectively with family, peers and their wider community.

Our online questionnaire asked the following questions:

How long did it take to get a referral?

Of those parent carers that were still waiting for a referral, they have been waiting between 6 and 18 months.

Getting a referral within what parents considered a reasonable time limit was an issue.

Parents made negative comments about the length of the waiting times for initial assessment and received no acknowledgement/information about the service.

"I was told it would be about 12 weeks and it was 6 months."

"Was told it was an 18 week wait which I thought ridiculously long. Turned out to be 30 weeks only because I rang to see what the wait was only to be told I wasn't in the system!!!!"

"My child was referred to the speech and language team in 2013, so transferred as an existing patient. His original referral took about 4-5 months to come through."

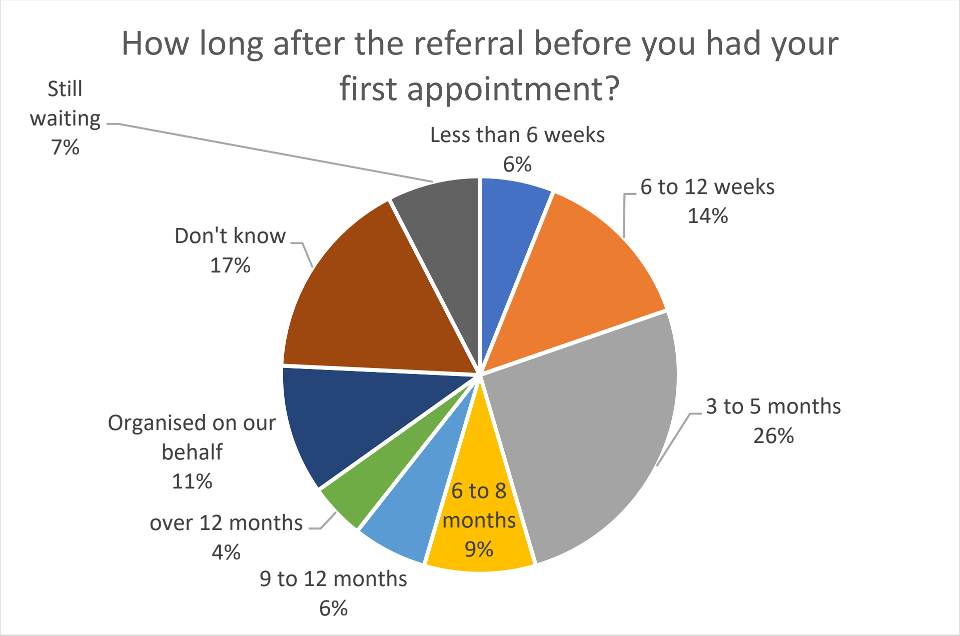
See Appendix A for all the comments relating to referrals

How to improve

Parents value receiving a communication to say the referral had been received, an indication of the likely waiting times as well as a number to call if they had any queries/concerns.

Work with parents to develop written information about the SLCN service, how it works, what to expect and who to contact. The written information should be given to parents when acknowledging their referral. It should also be made publicly available such as on the Local Offer Website, so parents can find out about the service and where to find more information.

How long after the referral before you had your first appointment?



Of those parent carers that were still waiting for their first appointment, they had been waiting between 2 months – over 2 years.

Most of the parents negative comments about referral to assessment timescales are concerned about how quickly the service can identify the child needs and the parents expectations of these waiting times.

An understanding and empathetic approach is deemed essential when dealing with children who have Down Syndrome or Autism – it is not uncommon for children requiring services because of a genetic disorder to also have a SLC need as well.

Under the Children and Families Act 2014 the local authority have 6 weeks to decide if they will agree to assess for an Education Health and Care (EHC) plan. Then the local authority has 10 weeks to get all the assessment information in to decide if they will issue a plan (16 weeks) and then if they decide to issue a draft plan it must be within a 20-week time scale. These timescales are a Statutory requirement on the local authority and if the parents or young person’s feels they have failed to carry out its statutory requirements within these time limits they have the right to take the local authority to the 1st tier SENDS Tribunal.

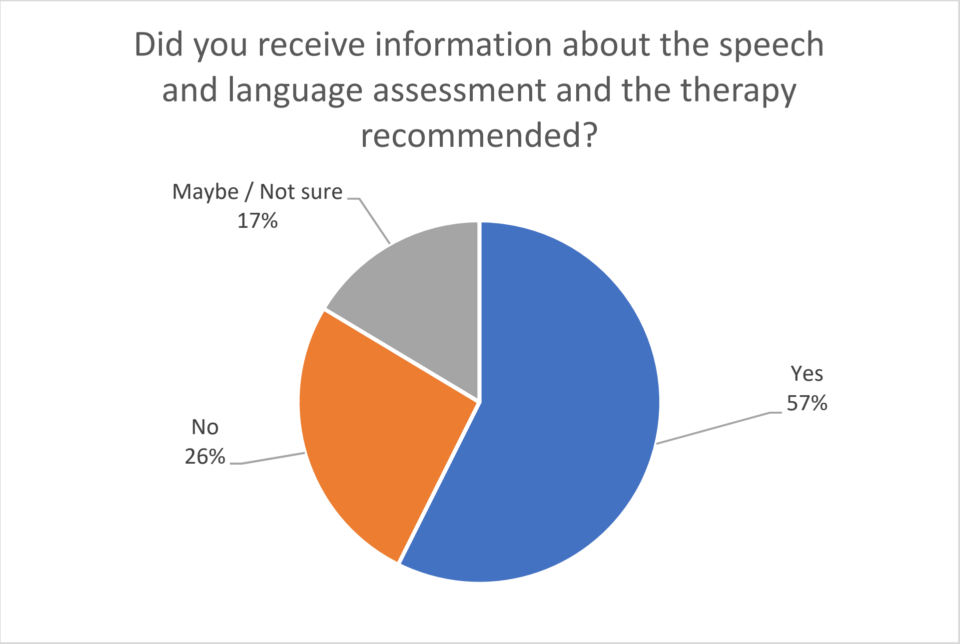
> *"A year! How ridiculous... this service is dreadful."*
>
> *"There was a significant wait between being seen at drop in [month] and commencing therapy [month]. In this case this could have added risk for my [child]. [My child] presents with a stammer and required a specific therapist directed intervention."*
>
> *"Under the terms of his statement of educational needs, my child is now meant to be assessed by an SLT twice each term and the SLT is to provide a programme for the school to implement. [My child] is being seen once or twice a year. The Sendco reports that she must chase a lot to get an appointment. I have also experienced ringing up and leaving messages, but no one calls back, so I would say it is hard to get an appointment."*

See Appendix B for all comments relating to first appointment

How to improve

Training for all staff in the many ways various Special Needs/disabilities and associated challenges that children may present with, an empathy and understanding of how scary and frustrating this situation is for children and their parents too.

Did you receive information about the speech and language assessment and the therapy recommended?



26% of parents said they received no information on the assessment or therapy recommended, 57% of parents said they had received information and 17% of parents were unsure if they had received any information from the service.

Lack of effective communication with parents seems to be the theme amongst the negative comments received. Either parents do not receive any reports, the reports are inaccurate or out dated.

Parents want information after every visit with their children/young people. They want to know what target/goals are being worked towards, what progress their child is making and how they can help.

According to the EHCP coordinators there is an agreement between ECCH and Norfolk County Council that parents and educational settings (Nurseries, schools and Colleges) should receive a report within 2 weeks after being **discharged** from the SALT service.

"SALT from ECCH came to my [child's] school in [term] 2016 - we have had no reports either sent home or to school. We do not know if my [child] has been discharged - even though [my child] has significant SALT communication problems and will for the rest of [my child's] life."

"Children don't receive 'therapy' from a trained therapist, they are assessed and recommendations made and that is it. It is a consultation service, not speech therapy. It is failing the most vulnerable children locally."

"I was given some goals to work towards independently, and discharged. [My child] was not given a diagnosis or summary of [my child's] difficulties (e.g. Expressive/receptive language difficulties/delay etc.), no long-term goals were given, and the goals set were not 'SMART' - despite these being very basic requirements for good clinical assessment and management."

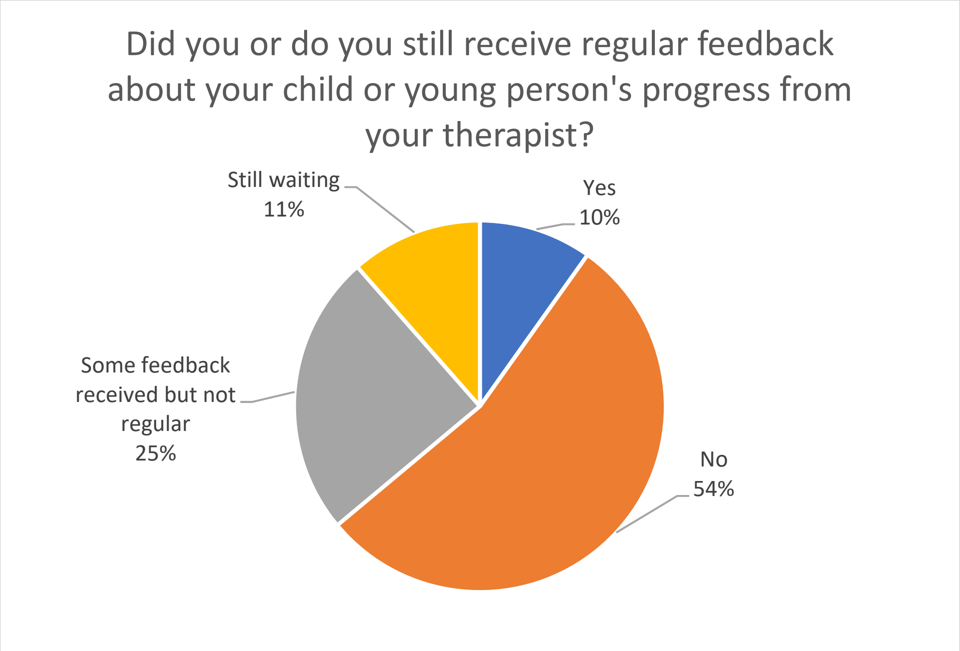
"My child has complex needs - speech and language difficulties being one of [my child's] main areas of difficulty - and yet we were told we could not receive direct 1:1 therapy and 'could not' be kept on the SLT caseload, because the service was not 'able' to. So, we were told to re-refer ourselves once [my child] had either met the goals, or not achieved them (but no time frame given for this). I am a qualified SLT who previously worked for [NHS]: if a patient has active goals they should be kept on the caseload and reviewed, not discharged - because they either need therapy (either direct or indirect) and SLT input: or they do not. It can't be both. My child has received therapy (either direct or indirect) and kept on the caseload of other disciplines, despite her need not being as great."

See Appendix C for all comments relating receiving information and recommended therapy

How to improve

Work with parents and educational settings to set realistic timescales for reports with recommendations and advice for helping children achieve their targets for either their IEPs (individual educational plan) or their EHC plans after every visit not just when the child has been discharged from the service.

Did you or do you still receive regular feedback about your child or young person's progress from your therapist?



The results of our survey showed 10% of parents receive regular feedback from their therapist, 25% of parents said they received feedback but not regularly. 11% of parents are still waiting to receive any feedback and 54% of parent had not received any feedback from their therapist.

There is a statutory duty on the Local Authority and Health providers that their services help identifies needs, put in place provisions to meet the needs with regular monitoring provided to achieve SMART outcomes that help improve children and young people's lives from 0 – 25 years of age as detailed in the Childrens & Family Act 2014 and code of practice 2015.

The graduate approach: Assess, Plan, Do & Review is how evidence is gathered by educational settings. If targets and progress are not being achieved then specialist provision must be put in place to achieve SMART outcomes. Targets/outcomes are used and measured in Individual education plans (IEPs) every half term and Education, Health & Care plan (EHCp) annual reviews.

A SMART outcome is:

S – Specific, M – measurable, A – achievable, R – realistic and T-timely.

The Annual Review process of an EHC plan should look at:

What outcomes/target have already been met by the provision provided – if not why?
What new outcomes/targets are needed for the next stage of the child/young person's life. (The Act follows 0 – 25 years)
Are there any further assessments needed to identify new or changing needs?

"A report was issued but no more feedback has been offered."

"It's more of a transcript of the session than feedback."

"After several years I have received a Speech and Language Therapy Update which failed to mention the eye gaze computer technology which my child has been using for at least 5 years."

"We were discharged after one 30-minute meeting at the school despite my child having severe speech and communication problems that were identified in an assessment by our old SALT provider a year before and by many other professionals. My [child] has been accepted into an SN school this year due to these problems. East Coast are a disgrace."

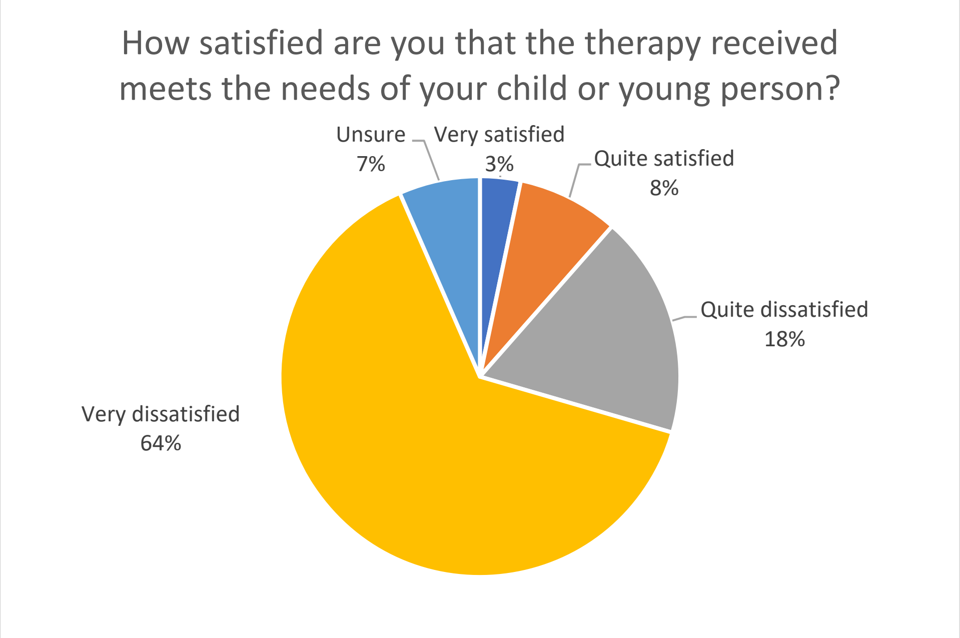
"Not the school, parents or our GP has received anything in writing all year from ECCH. I have made a formal complaint to PALS and intend to take this complaint as far as possible even legal action, I will also be going to tribunal with NCC over EHCP provision of SALT in my [child's] EHC plan."

See Appendix D for all comments relating to progress feedback

How to improve

Work with parents and Sen advisory service to design a monitoring system with feedback forms to use for SEN support (IEPs) and EHC plans. This could be included as evidence in the graduated approach of Assess, Plan, Do and Review (IEPs) and EHC plan annual reviews. Parents should also be told how to get an earlier review or new referral if their child's needs change.

How satisfied are you that the therapy received meets the needs of your child or young person?



The results of our survey are 3% very satisifed, 8% quite satisified, 7% unsure, 18% quite dissatisfied and 64% very dissatified with the service offered.

Most of the parents had no confidence in the current SALT service meeting their child's/young person's needs

"Many more appointments needed, no consistent communication."

"I think it's shocking this new approach of training the schools as there is no actual training."

"No useful information given at the initial meeting and no follow up at all. I am disgusted by this service. We have now gone privately, at a large cost, but I feel for other children and their families who are unable to do this."

"We were so dissatisfied that we complained to ECCH and NNCCG. This has led to face to face meetings with senior figures from both which has provided some reassurance that things will eventually get better but, by ECCH's own admission, its first year has been very difficult. Our child was to be discharged by ECCH based upon [my child's] EHCP report. However, we challenged this and have secured 6 weekly reviews based upon [my child's] progress and abilities. To be honest, SALT has been a nightmare ever since [my child's] first referral 5 years ago. It has not got better to date and the need to fight for every little thing has been constant. We have resorted to private SALT for over 3 years which has been the only source of progress [my child] has made. [My child] would have made no progress at all if it were left to the service provided by the Council/NHS."

"I am dissatisfied with the level of input, which is falling short of what has been recommended in my [child's] statement. I think the service is spread too thinly and it is very difficult to get an appointment. The therapists themselves are good, but there are not enough of them to meet demand. I also find it appalling that every child is discharged after each visit and the onus is on the SENCO and/or parents to request a re-referral. There must be children who are missing out on essential support due to this and it must add an extra layer of admin to already over-burdened staff.

I think it is a cynical attempt to reduce demand on the system. Early intervention will save money in the long run and lead to better outcomes. More investment in this area is needed."

"New procedure to discharge and then re-refer when targets achieved is awful - takes weeks after that re-referral before we can get an appointment. So, weeks of lost opportunities for development and intervention."

"There is no therapy. Having a visit once every 5-6 months isn't therapy."

"Support from feeding specialist is fantastic, we have a different therapist for communication and the experience is unfortunately very different. When talking about my child they described them as a 'Downs child', when I explained my child isn't a 'Downs child', but my child who just so happens to have Down syndrome' the response I received was 'whatever!'
Simply unacceptable, the first time I spoke to said therapist I was told she wouldn't be aiming for my child to speak as long as she could make needs known. If you never aim for speech how are you ever going to help children reach their potential? I pay for private therapy for my children and they are speaking with correct support and encouragement and somebody who believes in them! They haven't received therapy from East Coast, they have been failed and only had assessments from somebody who barely knows them and given targets for myself to complete. If speech therapy was that easy a university qualification would not be required.
East coast should be ashamed of the 'service' (in the loosest possible meaning!) they are providing the children of Norfolk. The most vulnerable children are being failed and this is demonstrated by the number of parents feeling there is no other choice but to fund private therapy for their children."

See Appendix E for all comments relating satisfaction of therapy received

How to improve

A new system is needed – parents are not happy with current system of only receiving 1-6 appointments and then being discharged only to have to re refer again and go on the end of the waiting lists. Parents have concerns about the length of waiting times and children are not being seen consistently in each half term of the academic year. Some children only receiving one visit per academic year.

Work with parents to clearly explain what ECCH SALT service is – is it just a consultation service or is it a therapy service? And who is supposed to deliver the SLC therapy sessions to the children in the educational settings? ECCH SALT or their assistants? or do they train the key workers and TA s to deliver the sessions?

Offer training to all Nursery keyworkers and School and Colleges TAs on how to implement and support individual children 1 – 2 -1 SLC sessions delivered in their educational settings to help children reach their SMART targets/outcomes for IEPs and EHCp

Clearly communicate to parents what is on offer- What is in the initial assessment, how many therapy sessions will take place, where and by whom? And who to contact if they have concerns/queries.

Communicate with parents by letter after each visit with their child/young person. What have you been working on with their child? what new targets/goals have been set? what should educational settings and parents at home be working on – send information to the parents.

To comply with the C&F Act 2014 – monitoring and reviews of all children/ young people should be taking place who have been identified as having a SLCN needs and where ECCH have been referred to provide the provision to meet the SLCN in the EHC plans, they should also be providing effective continuous monitoring systems to check progress towards SMART outcomes as detailed in EHCP. Remember Annual reviews should set new SMART outcomes.

Has your child been allocated any SALT supportive equipment (i.e. iPad, laptop etc.)?

Only one Parent/ Carer had received SALT supportive equipment with a further 3 still waiting. Waiting time was between 3 to 5 months for 2 parent carers and over 12 months for the third.

How long did you have to wait?

The Parent/ Carer who had received SALT supportive equipment had waited 6 weeks.

- The whole point of the Children & Family Act 2014 is for a holistic and person centred approach to Education, Health and Social Care services.
- Parents need a SALT service that cooperates and communicates with other providers of communication aids and equipment.

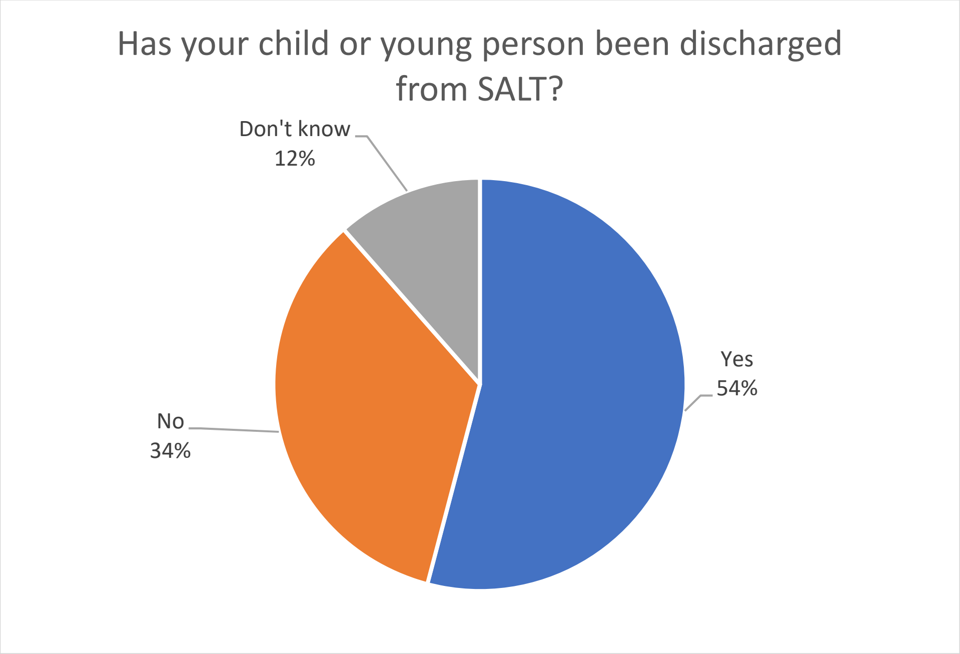
“Our [child] has use of a laptop at school through ATT (Assisted Through Technology service) for [my child’s] communication needs not through the ECCH SALT service – even though ECCH therapist suggested and sent information on ladder techniques used by dyslexics (to help break down tasks) to help aid [my child’s] poor working memory and communication skills.”

“Got a laptop funded through school only.”

How to improve

Work with parents to develop written information about communications aids and equipment, how it works, what to expect, what options parents have and who to contact. This written information should be made publicly available, so parents can find out if their child might be eligible and where to go to find out more information.

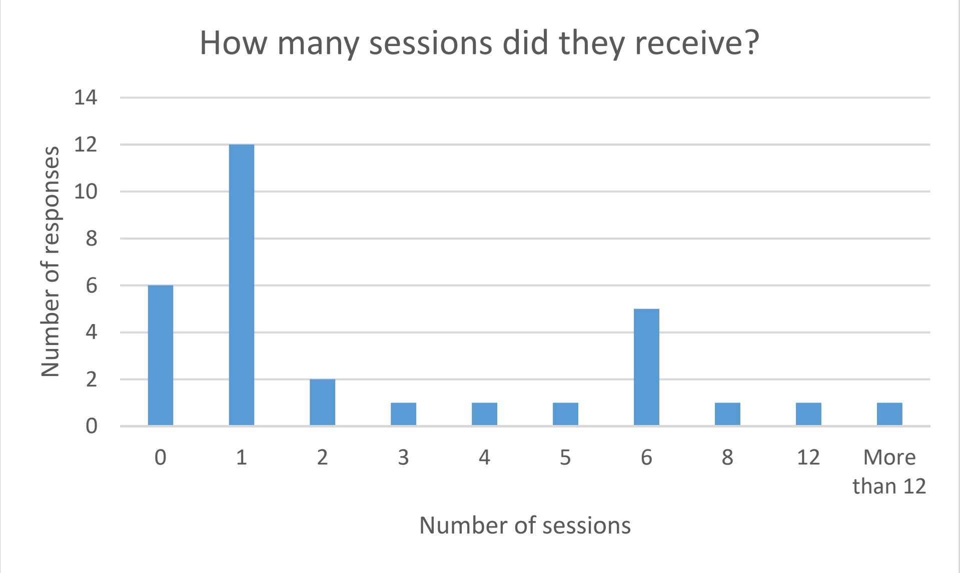
Has your child or young person been discharged from SALT?



34% of parents said no, 12% of parent are unsure and 54% of parents referred to ECCH have been discharged from the service.

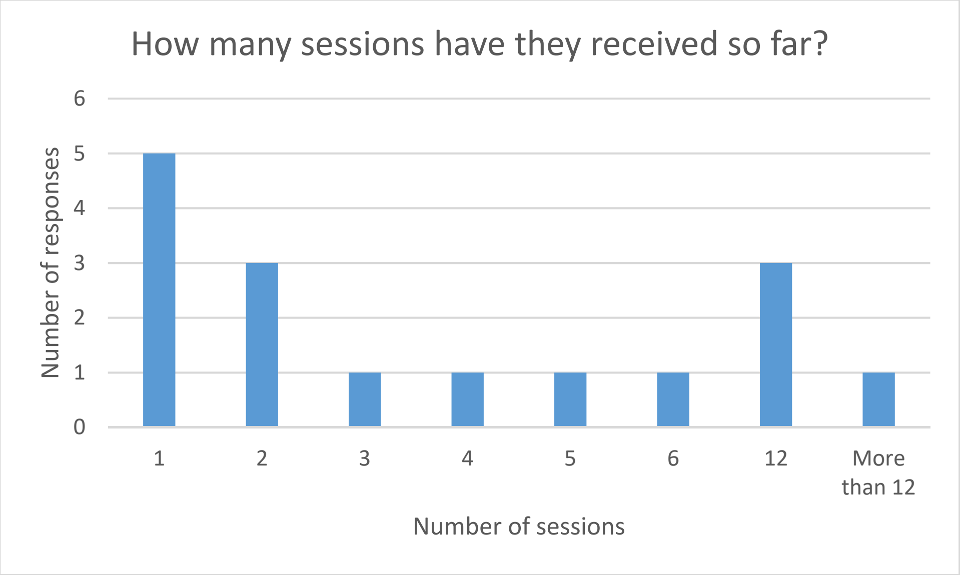
How many sessions were/have been received?

For parent carers that have been discharged, the following chart shows how many sessions the child or young person received.



Parents were offered none to more than 12 sessions before being discharged from the service.

For parent carers that are still receiving SALT services, the following chart shows how many sessions the child or young person has received so far.



Parents have reported that they have received between 1 -12 or more session from the service.

Parent’s negative comments regarding the current SALT service is they are discharge very quickly and must go through the whole process of re referring and waiting again. Those who are discharge with just recommendations and not actual therapy session are extremely dissatisfied with the service. Parents are worried about the time lost between referrals when their child receives no therapy at all – how are children to achieve their outcomes to Improve their language, speech and communication skills with no therapy provision provided consistently throughout the academic year?

“[My child’s] now seen at school. I don't know when, what happens or for how long unless school tell me. When [my child] recently met [my child’s] targets I then received a report in the post and [my child] was discharged with a new set of targets and 2 activities.”

“Discharged my [child] with receptive/expressive disorder of 3yrs 6 months. He was 6 years 5 months.
Despite phoning for two weeks daily informing them my [children’s] EHCP review date with 7 weeks’ notice, they didn't show, they then showed up some weeks after the review, not communicating with the private speech therapist funded by the LA, they knew the therapist had been working with my [child], had her contact details. But went ahead repeated the same TALC test on my [child], within 10 days of the private therapist. (you can't repeat the same test within 6 months) then discharged him.   What are East Coast Commission full?? Failing our children - disgusting service.”

“Our [child] was under SALT but then they discharged [my child] from clinic [my child] has global developmental delay and undiagnosed Autism [my child] was discharged a year ago saying nothing wrong but clearly there is as [my child] struggles with [my child’s] speech and has speech dyspraxia.”

“Crazy system discharge with work then re refer to wait all over again.”

How to improve

Review and redesign the SALT service contract.

Important question to ask now is the current ECCH SALT service fit for purpose?

- Does this service identify the needs of children and young people in a timely manner?
- Does the service meet the needs of the children and young people identified in either SEN support or an EHC plan with a SLC needs in a timely manner?
- Does the service provision currently offer by ECCH and their discharge and re refer system meet the needs and provides effective monitoring of the needs of children with SLCN in Norfolk?
- Does this service have SMART outcomes – set appropriate targets, monitor and measure achievements regularly?
- Are annual reviews of EHC plans taking place to monitor children and young people’s changing needs throughout their lives?

These are the questions that the area inspection by Ofsted/CQC teams will be asking and looking for answers to.

Parents who took the time to fill in our online survey do not have confidence in the current SALT service offered by ECCH.

Finally, some general comments to be passed onto the HOSC Committee:

“The time it took was such a long time that as a family we ended up paying over one thousand pounds for private speech and language. When both my [child’s] nursery and [my child’s] private speech and language therapist spoke to them they stated they did not have enough staff to come see [my child] at present even though they agreed [my child] needed to be seen. They even commented that they have so many children and so little staff that they can't keep up. I was also very disappointed to hear that when my [child] next gets seen it will be with an assistant, not even a qualified therapist. I feel the whole department has let my [child] completely down.”

“The whole system is lacking. We waited ages for our [child] to be transferred across to East Coast. Once transferred we waited ages to see a therapist. We then saw a therapist twice and heard no more. After constant ringing and chasing we found she'd gone on sick leave. It took ages for us to then get a new therapist. My [child] had a further 3 sessions in January, February and March. I have been chasing to find out when [my child’s] next session is to be told by [my child’s] therapist they have been told to see referrals rather than continue with children already in the system! How can my child become the best [my child] can without the proper support and specialist intervention [my child] needs?? Why is it left to parents to chase? Why do we ring a general number, unable to contact our therapist? It is diabolical that children with needs are given such little help.”

“It is disgusting that my [child] is having to wait so long for an assessment. [My child] needs help now and the longer [my child] must wait the more behind [my child] is going to be which will have a huge impact on [my child’s] confidence. [My child] starts school next year and really needs the help now but

as [my child] isn't going to get the help [my child] is going to struggle at school. The system is failing my [child] and we feel totally let down."

"We are and have been seeing a private therapist as our [child] requires regular SALT sessions which are not available on the NHS."

"Two of my children were under assessment for their EHCP within a month of each other & both with different therapists yet the advice given was word for word the exact same for both. One is 16 with Asperger's & no behavioural issues.
The other is 8 with ASD that presents as PDA & ADHD who has severe behavioural issues & been out of school for several months!
It seems that as they both have an ASD they must be the same according to the local SALT's seems they send out advice as a standard letter to all! Not really individualized."

See Appendix F for all general comments

Appendix A

Feel free to add any comments regarding the time to get a referral.

- We were already in the old system & was promised we would just be transferred over. They had no record of my [child] & it was only through lots of hassling that we got any kind of service
- First referral was good but the follow up has never happened!!
- My [child] got seen sooner than others as east coast met with parents at the hamlet centre with a few parents of children with Sen to try and iron out any problems and work with us, which of course they haven't
- Only seen for the EHCP We had a speech therapist for swallow and speech and then the system changed and we now need two Salt not one.
- The service was very disjointed and not able to focus on my specific child's needs, one size fits all just does not work. Lots of phoning from me and no response from them for a long, long time. No personal approach and a great deal of stress.
- Extremely slow, many children receiving 1 appointment at the very end of the year.
- We were already "in the system" so no referral needed. The original referral under NHCH was about 3 months - far too long for a child who was 2 at the time.
- Already 'in the system' took 5 months for 1st appointment when previously seen at least every 6 weeks and just before change-over [my child] was having weekly 1:1 therapy which had been beneficial.
- It was ridiculous my [child] had a block of Therapy last September, I was told [my child] would have another one in January. [my child] is now literally having a block and it's nearly a year. The therapist said [my child] had a severe speech disorder which I had been trying to tell them, [my child] now goes to school in September and I have literally only just been told about this special school [my child] can go to. I am very upset by how long everything has taken.
- Would not give an appointment
- Referred in Feb! Still waiting
- My [child] was originally seeing an NHS salt once a month and was put back on a waiting list for 9 months due to this re-organisation, we chased this appointment several times. I feel that the wait for the appointment has impacted on my child's communication. After waiting so long for NHS input we now have support from a private speech and language therapist and have since seen progress in my child's ability to communicate.
- Ended up going private,

Appendix B

Feel free to add any comments regarding the time to get an appointment.

- Still to attend first appointment 14/08/17
- It was decided they would give my [child] 6 one to one sessions with the view to if they were successful they would help apply for a personal budget for regular therapy after the 6 sessions they said yes then changed their minds and offered another 6 sessions after a 3-month break
- My [child] was receiving weekly SALT. It was stopped I was told because of funding cuts and the fact we were in the process of sorting out her statement. I heard nothing and rang up to be told [my child] was on the waiting list for SALT. I could not believe this as she had been receiving regular SALT prior to this being stopped. I was told she was the top of the list. Still nothing so I made a complaint. A therapist was then sent to assess my [child]. Details of assessment was sent and suggestions of things I and school could do. [My child] was then discharged and we were told could ask to be referred again and wouldn't take so long. My [child] can speak but it is [my child's] lack of understanding and social and emotional issues which are [my child's] problem. These issues have been ignored and we have sort private SALT. Presently we have had an EHCP review and are trying to get a personal budget for SALT on there. Very disappointed as you just seem keen to get the numbers of children being treated down without caring about their full needs.
- We ended up going private for 7 years as wait was too long
- Again, no consideration of my child's individual needs, all was poorly planned
- Met SALT after her first visit with my child at nursery. Second visit to nursery 9 months later I knew nothing about until after the visit and received a report this morning!
- We have been told despite a speech delay we will receive nothing.
- After waiting several months, we were discharged after one appointment.
- Over 2 years-my [child] was diagnosed with verbal dyspraxia by NHS in late 2015. [My child] was then offered 3x4 lots of SLT before ECCH took over.

Appendix C

Feel free to add any comments regarding the assessment and therapy recommended.

- Would not come out to 15-year-old only spoke to school and parent over phone and recommended some things
- Therapy is nonexistent.... only assessments followed by advice
- It's down to the nursery to forward information on.
- After the 3 months break my [child’s] anxiety was so bad [my child] wouldn't do it, leaving the 3 month break for children with Sen isn't good as they need to build relationship. I've told them not to bother as getting therapy caused me so much stress it wasn't worth it now gone private.
- Nothing was said before the assessment date, just during it. And I got sent an info pack on some mouth exercises.
- The information provided was useful, however I was told that my [child] did not need regular input and would be seen in 6 months. The recent educational psychologist reports we received states that my [child] requires regular SALT and that this should be part of [my child’s] EHCP. I am therefore pleased that we decided to approach a private therapist to ensure he gets the support [my child] needs. [My child’s] communication delays are the main reason we are delaying [my child’s] entry to school for a year so that we can ensure [my child] can effectively communicate [my child’s] wants/needs.
- Only had 1 appointment as [my child] is ASD and they don't support that aspect of SALT
- The speech assessment was in a new format I think. It looked none clinical and was not clear.
- The swallow salt changed, I received a letter that I didn't agree with but the salt was rigid in her position, even though she had not known my [child] she said things I didn't agree with and we didn't resolve this. Parts of her assessment were wrong and she would not change them.

- I was very happy with the SLTs who have seen my child and their recommendations were useful.
- What a surprise... no information...
- This took over 3 weeks to come through after the school SENCO chased it up.
- No one seemed to really know what they were doing when the sessions finally began. This was linked information gathering by the services about my [child’s] other associated needs, all very poor.
- My [child] was already in the system but initial assessment under the new service provided [my child] with objectives that were completely unsuitable. I took this further and managed to get them reviewed and completely changed.
- Therapy recommendations weren't great as she hadn't got to know my child. It takes a few sessions for my child to warm up to someone.
- As I am a teacher there was nothing shared with me that I wasn't already doing with my child. It was suggested that there was a follow up appointment and after 9 months this has still not happened, even after frequent phone calls. We have now decided to go privately which is very costly, but at least my [child] is getting the help [my child] needs, from a provider who seems to care.
- Spent the whole time advising me what children with ASD do and not once spent time getting to know my [child]
- Very quick and felt rushed. Left information that I struggle to read and have had support from Portage to explain.
- Everything that was advised is already being implemented! [My child] eye contact HAS made a massive improvement as well as social interaction! I have been on the pyramid PECS course in July and if I had been spoken to then the therapist would have known this!
- Our [child] was seen by therapist who said that [my child] had an open bite so felt that therapy would not be appropriate.

Appendix D

Feel free to add any comments regarding feedback about your child or young person's progress from your therapist.

- My [child] made no progress really, [my child's] had private now for about 8 weeks and has made progress and is a lot happier with the therapist who [my child] trusts
- Took 8mths from assessment date till they saw us again.
- not very positive. never attended any annual reviews
- My [child] has speech problems it is still delayed. [My child] needs a review but this was a year ago [my child's] last appointment. The speech Salt was very lovely but discharged too quickly and I do think now we need to review. My [child's] siblings have speech delay and when they had therapy 5 years ago, at the same age as my [child] they had had a brilliant service. They were monitored at preschool, school and intervention set up and managed. At about age 5 they went to Upton road for specialist speech groups. The current speech service wouldn't know if my [child] would need that.
- The swallow salt discharged and to be honest [my child] had been so difficult/ confrontational in meetings that I'm happy to manage without her. Before this we had a very positive Salt relationship and clear guidance was given. I just continue following the advice of our original therapist.
- We received a discharge basic report, with common sense things on that I could have written
- [My child] initially had one to one and this was incredibly repetitive so he got bored, therapist felt he could not concentrate. Next was group sessions in small group again very repetitive and he got very bored, all parents who sat with me agreed the therapy was poor and the children would get more from being in their playgroup settings. Stated this to the therapist who smiled politely but nothing changed.
- The therapist calls me to discuss when she has seen my [child] but that is very seldom. There has been no program in place to improve [my child's] speech, the focus has solely been on the total communication approach and the use of symbols which, as parents, we have agreed is important but [my child] has such potential to speak much better and loves to talk that to have no focus on making speech sounds is incomplete and wrong.
- [My child's] now seen at school. I don't know when, what happens or for how long unless school tell me. When [my child] recently met [my child's] targets I then received a report in the post and [my child] was discharged with a new set of targets and 2 activities.
- None yet because it's taken so long to have [my child's] Therapy
- Extremely long waiting time, very poor communication
- My [child] was referred to speech therapy at 2 years. They saw [my child] once every two weeks and then once a month for about 2 months. It then changed to once every 3 -4months since then
- I have received two reports one after each visit to nursery! The total sum of visits my [child] will receive as [my child] has now been discharged!!!
- local NHS salt was not able to help as there was no money in pot
- SALT isn't just about the sounds it's also about the understanding. On two occasions that our [child] was under SALT service we were given lots of photocopy sheets and left to get on with it. Our first experience of SALT was through our surgery. Our therapist was excellent and gave us advice that we still follow today. We were disappointed when the service then moved away.

Appendix E

Feel free to add any comments regarding the therapy your child or young person receives or received.

Quite dissatisfied

- If my [child] wasn't at a specialist school now I'd be very dissatisfied. Just before the cut over [my child] had got to the stage where [my child] can engage in 1:1 therapy, [my child] had 6 sessions(weekly) in which [my child] made great progress and was really benefiting. After change-over [my child] didn't see anyone for 5 months (I had to kick up a fuss to get seen). There was no therapy, just an assessment and '[my child's] about to start school now so they'll do it.' I was given a couple of activities to do with [my child] (which I did anyway) and that's it.
- Therapy received was brilliant, informative and helpful for my [child]. I was taught how to help [my child] at home which I still do. My major problem is one to one time spent with NHS speech therapist is nowhere near enough. One hour every 3-4 months does not give therapist enough time at all to get to know the child's progress. Regular and consistent therapy for a child with significant speech and language is key. We have had to go PRIVATE to supplement what the NHS is doing. My [child] sees a private speech therapist once a week term time which has been very helpful.

Very dissatisfied

- The speech technician had no idea how to relate to my [child]
- Just because a child can talk does not mean that they don't really need SALT to be able to function in the world. Receiving a photocopy sheet about selective mutism is not much help.
- I am upset by the service and did lose sleep over it. I can't afford private but I have had children with speech problems in the past so I'm just using my own experience to manage the situation.
- 3 home visits consisting asking my child to point at items in book, & choose an activity from a picture.
- Stated before, no bespoke aspect to the service, my therapist also agreed this was not a possibility even though it was needed.
- It has been minimal.
- Not satisfied at all given [my child's] current level of need, [my child's] unrepaired cleft, [my child's] atypical oral anatomy, the weight of evidence which shows [my child's] conditions' propensity towards speech and language difficulties, and all the evidence which how's how important early intervention is for children with S&L difficulties. The social enterprise may be saving itself money in the short term, but it will doubtless cost the NHS more money in the longer term.
- Too little too late and too long in between
- I was told that my [child] would be getting 3 sessions but only got two. Change of therapist not told that this was happening. During assessment SALT telephone kept ringing.
- Everything advised to us is what we already do! We have made progress but not regarding verbal communication! We have received no therapy around speech and language outside of two visits to nursery! There is a comment about the therapist being involved to help with my child's care and therapy, however as my child starts reception in Sept they are no longer allowed to be involved in my child's therapy!
- Local SALT was overwork and not have any places left

Unsure

- I think it will be good when they actually start.

Appendix F

Please use this opportunity to tell us anything else about your experience with SALT?

- Not willing to help as [child] was 15 years old, autistic and said language and speech would not improve if they come out. Not helpful at all.
- We have not had our appointment yet. I was told it would be after school holidays so [my child] could be seen at school but it came through earlier in the holidays and we had to delay as we are away. It came through faultless quickly but I had already sourced a private assessment as I was told it would be a 4-month wait.
- Not fit for purpose.
- My [child] is still non-verbal and doesn't have any form of communication. We've had to re-re-refer in. Salt are the hardest professionals to get hold of with the least amount of help.
- I'm not sure how these therapist sleep at night, told me had I considered complex needs school Yet the private therapist has stated my [child] is not a complex needs child, [my child] will manage just fine if he has SALT, [my child's] EP agrees, as does [my child's] teacher.
  East Coast Seriously failing Norfolk children.
- I spent so much time emailing phoning and chasing them up they gave me so much false hope I just had to give up. I've gone private and it's the best thing I've done my [child] has made improvement and is happy to do [my child's] speech as we have found the right therapist. We are paying now but hoping to get a personal budget. East coast are a complete waste of time
- Haven't seen them enough to have a proper experience.
- Feeding specialist very helpful and supportive, communication complete opposite. Overall a truly disappointing, frustrating, concerning experience that has failed not only my children but many other vulnerable children in Norfolk. My children have very complex needs, medical, feeding, and social and communication. These needs aren't going to vanish and they need continuity and support from people with experience and qualifications that enable them to support their needs.
- The therapist couldn't give us any ideas on how to work on [my child's] speech at the time of the appointment (even though I quizzed her about it) and put [my child's] problems down to having ASD and said the ASD team should have been working with him. I was quite annoyed with this as I know other speech therapists can work on this and the problem was down to [my child's] speech articulation and not necessarily down to ASD.
- She did email us some pictures of speech sounds to practice and suggested we buy an Elklan book.
- In her report she named the speech problem [my child] has and discharged us.
  I really thought we would have had more help but she didn't seem qualified enough to know how to help.
- Whole process was very confusing and a very long wait, over 9 months to get a letter saying basically not support ASD children. To then query it, wait another few months, then get EHCP team involved and suddenly they want to come out to assess in school. But no ongoing therapy as ASD and can technically talk but as I said earlier talking is more than just the technical, if you cannot talk outside your home that has quite an impact on your ability to progress.
- not that impressed in our situation. It's never ever been explained why our child cannot speak
- Very, very disillusioned and frustrated that my [child] has been casted aside because [my child] can speak. It's [my child's] lack of understanding and social skills that are [my child's] problem but because these are unseen your service does not want to bother with [my child].
- Please change this back to what it was. This is a terrible service, and whilst I understand in theory the whole discharge straight away I think it just means too many children are being made vulnerable by repeated waiting times etc. or are more likely to be missed completely.
- Not happy they still haven't received iPad recommended

- It's non-existent. My [child] has only been seen for [my child's] EHCP assessment, the only info I received was that report. [My child] has been seen twice between Dec and July. [My child] is a non-verbal autistic child, who is making all the correct noises and no words. [My child] needs the additional help from speech and language. Once [my child] starts school in sept the only person [my child] will see is her Pead as then the therapist can no longer be involved in her care. Utterly shocked at the services available to autistic children in Norfolk. SALT was better before the change; before the change [my child] had seen two therapists within 8 weeks!
- Our experience was fantastic until EAST COAST took over SALT last year. Since the changeover no one answers phone calls, no one replies to messages... and all our children are still waiting for the therapy so crucially needed. It's completely disgusting the way parents/children have been left with no information.
- Hard to get service, but when you get it, it's very poor. They discharge you after 6 visits, you must wait for 3 months before putting on waiting list again, & there you can wait another 9 months before you see someone, effectively leaving my 4-year-old with no SALT for a year. Absolutely crazy system & they will end up paying for this cost cutting lunacy in the future. It makes me so angry they are messing with my Childs potential at being successful at school etc., because we are just being abandoned.
- I can only comment on my experience with my child. The school SENCO however has had horrendous issues getting further targets for children that have achieved the ones originally set by the salt. She has rung each week for the last three weeks of term requesting a call back to no avail. Totally and utterly inadequate from the service which is badly letting our children down. Not enough therapists to meet the demands of today's society!
- Poor communication throughout. We went private and in a space of weeks the improvement was astounding. Months waiting and then the service with the east coast and [my child's] speech and confidence got private sessions and then linking this well to other services things are far better. When I spoke to east coast staff they almost seemed embarrassed by the service they are having to offer. My child's therapist was a lovely person but had no skills to get down to my [child's] level, play and interact with [my child]. All very poor, sorry to be so negative.
- Not enough provision so uses a private speech and language therapist.
- I am very unhappy, I have 2 children and both our experience has been poor, I saw the same SALT and she didn't tell us anything that we couldn't have worked out ourselves, I dislike the fact that we must phone up for subsequent appointments and have nothing in-between.

- There is a drive to use PECs as opposed to voca which is not supported by research but they do not take parental preference or child preference into account and have threatened to withdraw services unless PECs are used I find this surprising and narrow in the current climate of holistic education and meeting individual needs
- we have found it much better there seem to be more therapists now especially for deaf children
- my child's development was greatly disadvantaged by the lack of SALT for 5 months at a critical stage of [my child's] life. [My child] was having good support and making progress before the changeover and then everything stopped. [My child] had just started saying a couple of recognisable words and was responding well to 1:1 therapy. When it all stopped I did what I could, researching myself and help from portage but [my child] needed therapy from a professional. I am so grateful that [my child] got into a specialist school last September. [My child] is now with professionals that can support [my child's] speech and language development and I don't need to rely on East Coast.
- Crazy system discharge with work then re refer to wait all over again
- No very happy with the service received. The school did more for my child when phonics was introduced.
- Over many years there has been minimal input from SALT. There seems an unwillingness to work 1:1 with a child over a period to develop their communication skills. Children are quickly discharged without their communication needs being addressed.

- I am concerned that the therapist does not have time to offer a 'gold' standard of therapy. She makes every effort and I am confident that she has the right clinical skills but there is a lack of time to offer therapist directed intervention and regular school visits.
- As I mentioned, my [child] is behind with [my child's] speech and this has been acknowledged and yet we have received NO therapy. I was told it will be YEARS before [my child] catches up and yet [my child] gets nothing. Honestly, what's the point of this organisation?
- It would be better for the salts to recommend reading material for the parents because the tidbits that they provide every 6 months are completely insufficient. To date the recommendations, they have made could have been written on a single A4 sheet and provided by a health visitor. Most of what we do with our child has been wholly intuitive.
- This was a very well organised service with good feedback about areas of need and treatment needed.
- I'm disappointed by the lack of communication we have had. Also, when they say they will ring they don't. I'm very disappointed because if I would have known about this special school my [child] could go to [my child] would have probably got a place from September but as I'm only now seeing a therapist I have only just been told about it [my child] had [my child's] assessment and scored very low. Also, all I keep getting told is they are short staffed and there's nothing they can do.
- dire
- Disappointing
- Myself, my [child's] pediatrician, health visitor and a family support worker have been contacting the service repeatedly over the past 18 months, to be told every time that [my child's] awaiting allocation.
- Poor service, lack of useful information given, signed off my [child] and told phone again in 3-months' time, still awaiting a follow up appointment.
  A total lack of interest in what is needed and what has already been provided by the parents, so advice not appropriate for where [my children's] needs were at the time.
- As I have said previous I feel very let down by the SALT team. It has taken many phone calls and emails just for my [child] to be seen. They have given me dates verbally for when they would see [my child] and then never come. When questioned they have said they don't have the time as they are to short staffed. The [child's] speech is very behind and the only reason [my child] is beginning to get better is because we had to pay for private help as the NHS salt team had let us down. They saw [my child] around November last year and done an assessment, stated [my child] was very behind and my [my child] has only just had [my child's] first session.
- Very limited service- assessment only so far within my [child's] nursery setting. We have had to seek treatment privately to meet my [child's] needs. Thankfully we have been able to pay for this but have had to make sacrifices to do so.
- I have had to fight to be seen it shouldn't be this way early intervention is so important.
- It's not been positive - unless we hadn't self-funded private since [my child] started school last September, [my child] would've nothing. Thankfully [my child's] about to start at an SRB in September but I feel that since ECCH have taken over he has been completely let down! If they spent more time offering support to those already on a waiting list instead of churning out 'drop in' sessions, then it might go somewhere to support those that need it.

- SALT sessions- Very good but not regular enough so impact limited. It is hard working with your child as a parent without regular guidelines from professionals. Regular interaction with professionals brings more success. What we have noticed is that after the NHS speech therapy sessions with my [child] became irregular, once every(3-4months), the accuracy of their reports about [my child's] progress declined because they don't see [my child] regular enough to get the true picture of how [my child] is progressing. My most shocking experience with SALT is that they cancelled an appointment to assess my [child] at home in August 2017 before [my child] starts school (Reception) in September. Their reason being that because [my child] has already been assessed at end of July by the Private Speech Therapist and they have got the report about [my child's] progress, it's not necessary to see [my child] again so they will instead see [my child] end of Sept in school. SHOCKING. I though NHS SALT oversaw my [child] and the Private Speech Therapist is supplementing, not the other way around. Thanks for opportunity for this survey. Might help the NHS do something about it.
- When telephoning staff not very helpful. Have waited in for SALT to telephone at given appointment time but no contact was made. On another occasion, I rearranged my plans to fit in a telephone appointment only to not get a phone call.
  When I finally met a SALT then discharged and told to contact again when my child has completed tasks. I have got no idea how to do this with my child as not shown. I am left confused, frustrated and feel what is the point of contacting SALT if I then must wait a year to hear from them!
- Not very helpful. Didn't get to know my child.

- It's a joke! Two visits within the nursery setting, only one I knew anything about and only because of my request for an EHCP. I was spoken to only after the first visit with my [child].
  No interaction after initial appointment, no discussions with me about the what
  Would help my [child] or what we already have in place, the fact I have done a two-day training course with PECS to help [my child] communicate.
  How they feel they can make a competent assessment of my [child's] needs and abilities within one setting for an hour observation each time 8-9 months apart and cannot see the progress [my child] has made or find out all the things we already have in place for [my child] astounds me.
  My [child] is nearly 5 and is nonverbal [my child] has ASD, but we have worked very hard in trying to help [my child] in all aspects [of my child's] social and communication issues. [My child's] eye contact has improved massively since [my child's] initial diagnosis, and [my child's] socialization with close friends and [my child's] brother have drastically improved to the point [my child] will hunt [my child's] brother out for a hug and kiss, and will sit and play with him regularly at home. This is something we never thought we would see.
  In all honesty with the shocking service and support provided you may as well shut the service down and provide money to each parent towards a private SALT therapist, at least that way their children will be provided with the help they deserve!
- When my non-verbal [child] was 2 they said there was not much they could do for [my child]. When they learnt we were with a private SALT they were very keen to discharge. Apparently, they will visit my still non-verbal [child's] school in September ([my child's] now in reception), observe [my child], inform staff about [my child's] needs, then discharge [my child] again! We've only referred ourselves again to try and prove they can't provide an adequate service and therefore try to access [my child's] personal budget for private SALT. As far as we're concerned there is no service, and we do things ourselves, and we do not rely on the public sector for anything.

- Local NHS salt was not a good experience due to lack of funding and being overworks, a child with more complex need put on a back burner to one that got more understanding. went private in the end and got better treatment and respect for the child and parent.

- When our [child] was first seen by SALT through our surgery it was excellent. We had personal sessions and group sessions. We were also advised to model sentences back which we still do today. The service then moved away from health to education. In infant school, [my child] was seen a couple of times with huge gaps between each session. Our [child] needs consistency and [my child's] school did not have the resources to concentrate exclusively on [my child]. They then decided to write [my child] off. At that time, we were unaware there was a physical problem. At this point I put in a complaint about the SALT. When he started Junior School, [my child] was seen again the new SALT service. {My child] was seen once for assessment where they decided it wouldn't be appropriate given [my child] had a physical issue. Again, they have written [my child] off. I feel strongly that SALT isn't just about the sound but also about the understanding. We still model our sentences back and get here to repeat them. Given our [child] has a learning disability [my child's] learning age is about 2 years behind [my child's] actual age so [my child's] school and we are trying to teach [my child] according to [my child's] learning age. Our experience with SALT hasn't been overly successful.
- I have found the service very slow with reports often not received until months after the assessment visit.
- Three sessions in about 3years, sessions to far apart, not been involved, not impressed with overall experience so far
- Didn't receive any confirmation that referral had been received. No indication how long to wait
- Good advice and support to start with Makaton, but then pretty much left to it. Feel we are falling down a gap. Would benefit from support now but must wait until [my child's] fallen back even further behind to get support again - some progress made, then left to it under new system. We need more SALTs.
- Therapist offered advice and pamphlets on sign language when it was obvious my child needed proper therapy and was advised to call again 4 months later if my child was still not communicating. Absolutely not good enough.
- My child has received speech and language therapy in the past. The last time was a good while ago and to be honest the service was very good.

Norfolk Health Overview and Scrutiny Committee
7 September 2017
Item no 7

Consultation on the future of Benjamin Court Healthcare Unit, Cromer

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

To receive consultation from North Norfolk Clinical Commissioning Group.

1. Introduction

1.1 Members of Norfolk Health Overview and Scrutiny Committee (NHOSC) received updates in the NHOSC Briefing throughout 2016-17 about the development of a supported care service in North Norfolk, rural Broadland and South Norfolk.

1.2 The Supported Care Programme aims to develop and implement an agreed system model for local integrated multidisciplinary community provision closer to home to reduce avoidable emergency attendances and admissions. It is about making adjustments to the way services are organised so that certain patients are reached before they reach crisis point. The programme aims to keep people at home and help to maintain independence as long as possible. It is part of an on-going process to establish local joined up community provision, connecting health and social care with the voluntary sector and wider community.

1.3 The Programme has three main strands:-

1. Establishment of the Supported Care Service
2. Focusing Norfolk Community Health and Care (NCHC) in patient care on 'sub-acute' patients with higher care needs
3. Exploration of alternative uses for existing in-patient units

1.3.1 Establishment of the Supported Care Service

The health and care components of the Supported Care Service were launched on Monday 31 July 2017 in the following areas:-

<u>North Norfolk</u>:
Mundesley, Cromer, North Walsham, Aldborough, Ludham, Stalham, Coltishall and Wroxham

<u>South Norfolk</u>:
Wymondham, Wicklewood, Hethersett, Morley, Ketteringham, Poringland, Mulbarton, Swardeston, Swainsthorpe, Framlingham Earl & Pigot, Stoke Holy Cross, Caister St Edmund, Howe, Dunston

The service will be rolled out to additional areas in North and South Norfolk in September and October 2017, as further staff are recruited and trained. During this period the Supported Care teams will work with other services to meet the needs of patients. The Supported Care teams across North and South Norfolk will consist of five Care Coordinators, four Nurses, four Occupational Therapists, two Physiotherapists, five Reablement Practitioners, and seventy Support Workers to provide an integrated and holistic approach to the needs of patients.

This first phase of the service provides immediate response, short term (up to seven days) wrap around reablement care with nursing and therapy oversight, to return patients to their previous levels of wellbeing and independence.

The service is expected to accept 30 new referrals a week in each CCG area when working at full capacity. Following a soft launch due to building capacity the service started receiving referrals from the first week; with the South Norfolk team taking five referrals and the North Norfolk team taking four referrals. Also referrals have been received from a variety of sources including GPs, Community Matron, Acute hospital, Community Nurse and Occupational Therapists. Interventions have included immediate response and reablement care, equipment provision, exercise plans and alternative strategies for undertaking tasks around the home.

The second phase of Supported Care will further develop the team to establish local joined up community provision. This will involve making connections between the Supported Care team and local voluntary and community sector organisations to support people in their own homes e.g. help to get out and about or encourage healthy lifestyles.

The key components of the integrated model are:-

- Voluntary sector
    - Carer Education and Coaching – the CCGs have undertaken engagement with voluntary sector organisations and have agreed to use an outcome focused procurement, where they make clear what outcomes they would like for patients and the voluntary sector organisations suggest the best way of achieving them using their expertise in the area.

    - Community Engagement and Development – making use of the Community Action Norfolk report detailing:
        - Health and care specific voluntary and wider community organisations across South Norfolk
        - How best to develop these assets
        - How best approach to managing the relationship between the voluntary sector and wider community organisations, the community and health and care professionals

- Reablement Care - Norfolk County Council recruiting 80 additional staff to work across North and South Norfolk to significantly increase capacity within the Norfolk First Support (NFS) service.

- Healthcare – Norfolk Community Health & Care NHS Trust (NCH&C) recruiting 10 Whole Time Equivalent (WTE) Nurses, Occupational Therapists and Physiotherapists to work across North and South Norfolk to provide nursing and therapy oversight including a rapid response review and a health and social needs assessment.

- Programme Management – North Norfolk Primary Care and Norfolk County Council recruiting Service Leads for North and South Norfolk to provide overall leadership, management and co-ordination across all the components of the Supported Care Service.

The CCG asked Healthwatch Norfolk to undertake a qualitative evaluation of the impact of the service on patient's perception of their health and social care support.

1.3.2 Focusing Norfolk Community Health and Care (NCHC) in-patient care on 'sub-acute' patients with higher care needs

Increased supportive care is expected to alter the demographic of inpatients within the intermediate care beds. Inpatients within these units are expected to come from both secondary care (step down) and direct admissions from GP's (step up). These patents will continue to be frail but to enable better flow through the hospital system, the plan is for patients to have access to these beds much earlier in their admission. A much broader range of therapeutic interventions will be available such as Nasogastric (NG) tubes and Intravenous (IV) therapy.

The plan is for admissions within both Kelling and North Walsham community hospitals to be aligned, to offer the largest flexible capacity and the best movement through the hospital system for patients. Therapy within these two units will be targeted to the patients as needed, to enable a more fluid system and help to prevent any ring fencing of beds.

1.3.3 Exploration of alternative uses for existing in-patient units

The consultation on alternative options for future use of Benjamin Court falls under this strand of the Programme. A public consultation was launched on 19 June 2017 and will run until 11th September. The consultation document is available on the North Norfolk CCG website
http://www.northnorfolkccg.nhs.uk/benjamincourtconsultation
(and at Appendix A to this report).

The CCG held a consultation drop-in event at Cromer Community Centre between 12.00 noon and 8.00pm on 29 August 2017 to give members of the public an opportunity to hear about the proposed plans, ask questions and make comments to the CCG.

Decisions about the future use of Benjamin Court will be made by the North Norfolk CCG Governing Body in public on 26 September 2017.

1.4 The consultation document includes six options for future use of Benjamin Court:-

Option 1 - Keep the service at Benjamin Court unchanged.
Option 2 – Palliative care provision
Option 3 – Discharge to assess – assessing the care needs for frail patients in the community
Option 4 – Intravenous therapy (IV) at Benjamin Court
Option 5 – Voluntary services
Option 6 – Outpatient services

The CCG set up a steering group to discuss the future use of Benjamin Court including representatives from Norfolk Community Health and Care NHS Trust (NCH&C), Norfolk & Norwich University Hospital (NNUH), clinicians working in the unit, GPs in Cromer and elsewhere in North Norfolk, Norfolk County Council, Cromer Town Council, Hospital Friends and members of Patient Participation Groups (PPGs) linked to local GP surgeries.

Benjamin Court Steering Group believe the most credible options for Benjamin Court to be:

- Up to 8 Palliative Care Beds
- 2 IV Therapy Beds/Chairs
- 6 Discharge to Assess Beds
- Additional voluntary/third sector provision
- Additional outpatient clinics

2. Purpose of today’s meeting

2.1 NHOSC Members were notified of the public consultation on the future use of Benjamin Court in the July NHOSC Briefing and on 20 July the committee agreed to receive the consultation at today’s meeting.

Representatives from the CCG have been invited to present the proposals, inform the joint committee about emerging themes in feedback from the public consultation to date, and to receive any comments that the joint committee may wish to make.

2.2 The public consultation document poses two questions in relation to the proposals for future use of Benjamin Court:-

- How would these proposed changes impact you?
- What else should the CCG consider in making this decision?

NHOSC may wish to consider making comments particularly in response to the second question.

3. Suggested approach

3.1 After the CCGs’ representatives have presented the consultation document, Members may wish to discuss the following areas:-

(a) Supported Care was launched on 31 July 2017. Has there been assessment of the early results of the new service?

(b) Great Yarmouth and Waveney (GY&W) CCG planned to introduce community based out of hospital teams and reduced its numbers of community hospital beds following an extensive ‘Shape of the System’ consultation in 2014. During the process it had to pause the introduction of the out of hospital teams due to financial constraints as demand for acute urgent and emergency care continued to rise. Are the CCGs confident that the Supported Care Service will continue to be rolled out in a timely way, and can they give assurance that enough intermediate care beds will remain available at Benjamin Court in the transitional period while Supported Care becomes established?

(c) What analysis has been done on the effect of the proposed changes in terms of transfers of patients from the acute hospital to care in a community setting?

(d) What analysis has been done in terms of future demand for services, including future need for NHS community beds?

(e) The consultation document lists a number of outpatient services which could be delivered at Benjamin Court. Is there buy-in from the acute hospital to making these happen at Benjamin Court, and would this have any implications for Cromer Hospital?

4. Action

4.1 The Committee is asked to:-

(a) Consider whether it wishes to make comments to North Norfolk CCG in response to the consultation.

(b) Consider whether it wishes to invite the CCG to report back to NHOSC on 26 October 2017 with analysis of all the feedback received in response to the consultation and the decisions taken by its Governing Body in light of that feedback.

IN TRAN communication for all	If you need this document in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Item 7 Appendix A

NHS
North Norfolk
Clinical Commissioning Group

A New and Vibrant Future for Benjamin Court Healthcare Unit -

A Resource for Everyone in

North Norfolk and rural Broadland

Public Consultation and Engagement

June 19th to September 11th 2017

Contents

NHS North Norfolk Clinical Commissioning Group (NN CCG) is a local membership organisation led by family doctors that is responsible for planning and paying for healthcare services. We do not provide healthcare like a GP Practice or hospital. Our role is to make sure the appropriate NHS care is in place for the people of North Norfolk, within the budget we have.

To find out more about NHS North Norfolk CCG go to www.northnorfolkccg.nhs.uk

The personal information you supply as part of your response to this consultation will be shared with a trusted third party. This individual third party will collate and analyse the data into a consultation report. Your feedback will remain anonymous and no personally identifiable information will be used in the consultation report. At the end of the consultation your personal information will be returned to NHS North Norfolk CCG who will securely store them in accordance with Records Management Code of Practice for Health and Social Care 2016.

What is the purpose of this document?

This document is published by NHS North Norfolk Clinical Commissioning Group (NN CCG) in conjunction with the Benjamin Court Steering Group. It offers detail on the proposed vision for the future use of Benjamin Court in Cromer and the development of a new Supported Care Service. It is the basis of the consultation process run by NN CCG to gather the views of local people between June and September 2017.

This document will set out:

- The CCG's overarching vision
- The case for change with supporting evidence
- A number of options considered by the CCG that were developed during extensive conversations with local people and clinicians
- The consultation process and how to have your say
- Opportunities for further public engagement and consultation in the future

What currently happens at Benjamin Court?

Currently Benjamin Court is an 18-bedded intermediate care unit. Intermediate care is defined as *'a range of services provided in the home or designated care setting to promote independence by providing enhanced services from the NHS and social services to prevent unnecessary hospital admissions and offer rehabilitation facilities to enable early discharge from hospital and to prevent premature admission to long term care.'*

The patients at Benjamin Court fall into three broad categories;

1. **Step-down** – patients who have either been within a ward in an acute hospital and are assessed as being medically stable but with on-going nursing needs and/or needing physiotherapy or occupational therapy input.
2. **Rehabilitation for the older person** – This is defined as the process by which patients are given the opportunity to improve physically and medically. This may not restore the patient to their previous physical baseline, but will allow them improved levels of independence. The amount of rehabilitation input for each patient is extremely variable. For some patients this will refer to sitting on the edge of the bed to help build up core stability, for others it will be mobilising around the ward or becoming more confident on the stairs.
3. **Direct GP admissions/step-up** – patients seen by the district nurse or GP and are assessed as having intermediate care needs and are admittedly direct to an intermediate care unit, often as opposed to secondary care.

In addition to the 18 intermediate care beds, there are a range of other outpatient and day care services although these are not intended for change and for this reason, do not fall within the remit of this consultation.

What is our vision for local services?

A new and vibrant future for Benjamin Court

We propose a health and community support hub comprising different types of beds and non-bed based NHS and voluntary sector services. A centre where people are given safe, high quality, person centred care, whatever the focus. This could include:

- ✓ supporting patients and their family and carers to have the most comfortable and dignified end of life care
- ✓ helping people achieve the best quality of life
- ✓ helping people to remain living independently
- ✓ an advice and support hub that brings together the best of our local healthcare and wellbeing organisations under one roof

To continue developing modern and forward-looking health and care in North Norfolk and rural Broadland

Admission into an inpatient bed is sometimes unavoidable and we will ensure that patients get the right care by the right team at the right time - that will never change; people who need to be in a hospital bed requiring care from our skilled nurses will get that bed and that care.

However, the evidence set out below demonstrates that many people who are currently in a community hospital bed could in fact be helped to live safely and independently at home – indeed people tell us they want to be cared for at home whenever possible.

Those who want to be at home, and who have been assessed as safe and medically fit should be at home. These patients will get the right support from the right staff, including NHS Registered Nurses and therapists. The CCG is also working with a project group which includes carers to design support and training to help the informal and family carers maintain their wellbeing and to help them continue in their caring role. Supported care will change the landscape for these patients and will help people remain at home, safe and independent.

Whilst our vision has good practice and patients' needs at the forefront, this is also about the best use of finite NHS resources. We can free up resources to introduce:

- specialist care to Benjamin Court in Cromer that does not exist now, such as palliative care beds so people can be assured of the best care when they need it most,
- specialist assessment beds that help people return home sooner, and
- Intravenous-therapy so people do not have to travel to Norwich.

What do we have now?

North Norfolk CCG currently commissions 73 beds across four units in North Norfolk predominantly for a population of approximately 172,000 people:

1. Kelling Hospital near Holt
2. North Walsham Memorial Hospital
3. Benjamin Court Unit (Cromer)
4. Cranmer House (Fakenham)

The units provide intermediate care beds, typically for patients being discharged from secondary care. All are run by Norfolk Community Health and Care NHS Trust (NCH&C).

In comparison to ten other CCGs in England most closely related to the demographics of North Norfolk, we have more intermediate care beds than most. The average of the other CCGs is 60 beds, however in many of these CCGs the beds are used specifically for additional purposes, for example specific palliative care beds or stroke rehabilitation.

Evidence from our neighbouring CCGs has also suggested we do not need so many beds with neither Norwich CCG, South Norfolk CCG nor West Norfolk CCG having as many beds in their area (the number of beds per CCG ranges from 24-45).

Why do things need to change?

One of the greatest challenges facing the health service today is the need to redesign services to meet the increasing needs of patients, improve the quality of care and achieve better value for money. Whilst feedback on the Intermediate Care Beds is broadly positive, they are an expensive resource with a single bed costing on average around £1,700 per week.

A key pillar of the NHS Five Year Forward View[1] is to focus on bolstering care with the community and finding alternatives to bed-based services. Whilst bed-based services will always be the best solution for some patients, it is equally true that for others this may not be the case.

To test this idea the CCG, in partnership with NCH&C, undertook eight clinically-led audits of the intermediate care beds in the four units across North Norfolk.

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[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

What did the clinical audits show?

The audits focused on answering the question:

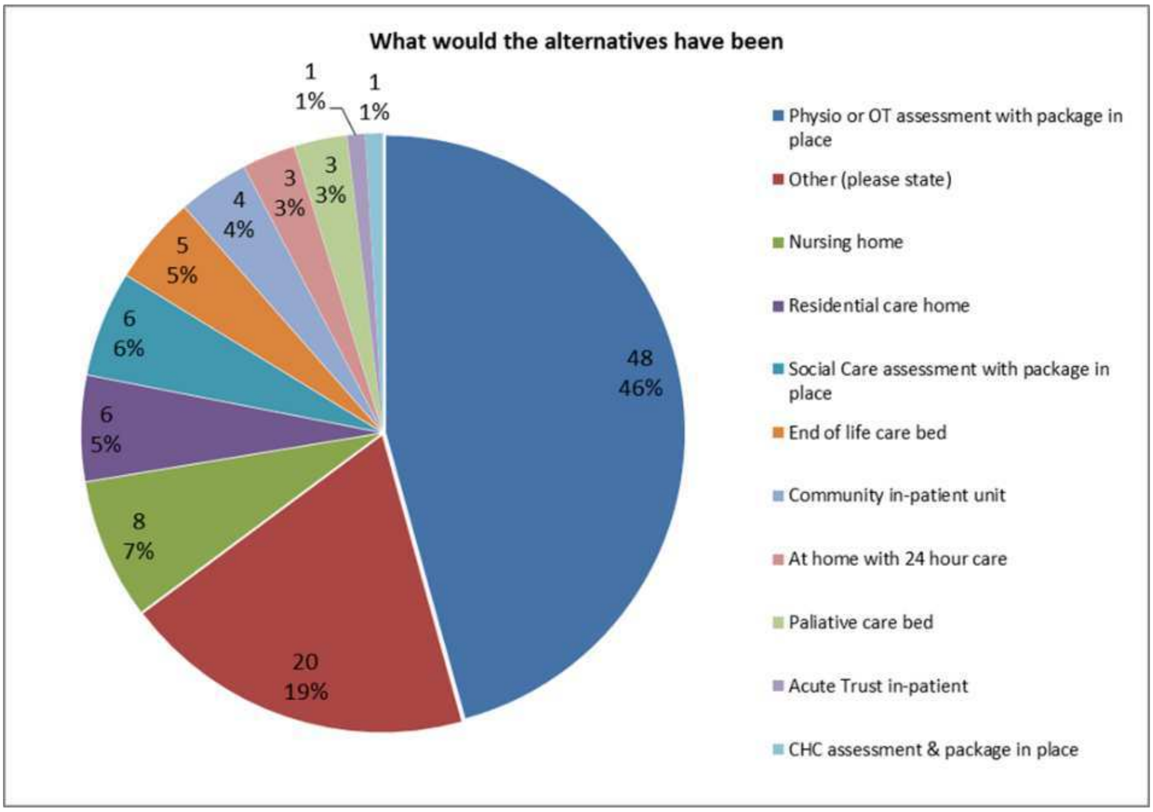
“What needs to be available in the community to enable people to be cared for at home, rather than being admitted to an inpatient unit?”

The Audit looked at

- The demographic of inpatients
- The reasons for the admission
- The referral source and route in to community inpatient units for all patients
- What alternatives are, or could be, available

On the days in question the audits showed that 82% of beds were occupied.

When looking at how to best meet the needs of the patients, the audit identified that the largest group of inpatients (46%- 48%) would have been able to go home with a Physiotherapy or Occupational Therapy assessment and care package in place if that was an option.



This evidence gave rise to the development and investment in the Supported Care model. This will enable the group of patients mentioned above to be cared for in their own home.

What is Supported Care?

The clinical audits have demonstrated that **additional** care is needed to prevent patients from being admitted to hospital or to be discharged to their own homes rather than an intermediate bed. That is why the CCG is investing around £1.5 million of **additional** resource to achieve this. This represents a significant increase in resources, equating to around 50 extra health, social care and voluntary sector staff in North Norfolk and rural Broadland. The collective name for this additional service is 'Supported Care'.

Supported Care is a new admission avoidance and supported discharge service – this means people only go to hospital if they need to, and get home again quickly if admitted. It is about making adjustments to the way services are organised so that we reach certain patients before they reach crisis point – helping them to stay independent and at home where they want to be. It is being launched on July 31st 2017 as part of an ongoing programme as the CCG develops and tests ideas and applies lessons learned.

The Supported Care service will bring together components from health, social care and the voluntary sector to deliver local joined up care closer to home delivered by a range of different health and care professionals. The service includes:

- Significant reablement care capacity
- Nursing and therapy assessment and oversight
- Informal carer education and coaching
- Community engagement and development

The CCG fully acknowledges that for some patients, an intermediate care bed provides the best solution to their needs. To that end, the intermediate care units in Kelling and North Walsham will continue to operate for rehabilitation, both step down rehabilitation (where patients are discharged from a hospital) and step up care (where patients are referred directly from a GP).

The investment in supported care does however give the health system an opportunity to change the use of the other intermediate care units - Cranmer House and Benjamin Court. In discussion with NCH&C, these units were deemed most suitable for change. Supported Care gives the CCG the opportunity to provide additional services to the community. Discussions are underway to transfer the beds currently commissioned by NN CCG at Cranmer House in Fakenham to NHS West Norfolk CCG who already commission beds there. It is expected that this will happen in August 2017. The Friends of Cranmer House have been involved with this process.

More information on Supported Care can be found in the leaflet "Supported Care in North Norfolk and Rural Broadland" which is available on the NN CCG website or from the CCG (details at the end of this document).

Supported Care – Patient's Journey

Millie is 89 years old. She lives on her own and loves her garden. Recently, whilst going outside she tripped and fell over the step from her kitchen door. Her neighbour heard her calling and phoned for an ambulance that took her to the Norfolk and Norwich hospital.

The team in the Emergency Department found that she had no broken bones but she did have a sprained her wrist and a bruised hip. Millie felt unsteady on her feet and was worried that she might fall again at home. A physiotherapist saw her in the Emergency Department and assessed her ability to walk independently. The physiotherapist felt that she was safe to walk but told Millie that she thought she could use some further physiotherapy to help improve both her confidence and mobility while she recovered from her injuries.

The physiotherapist explained that Millie could go home and the **supported care team** would come and visit her to help her get better and keep mobile whilst she got more confidence in the familiar surroundings of her home.

Millie was delighted that she was able to return to her own home and not have to stay in hospital. This way she could maintain her independence with **supported care** from the specialist healthcare staff she needed.

One week later, although still a little bruised, Millie is back to walking around as she was before she fell.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

What patient and stakeholder engagement has there been so far?

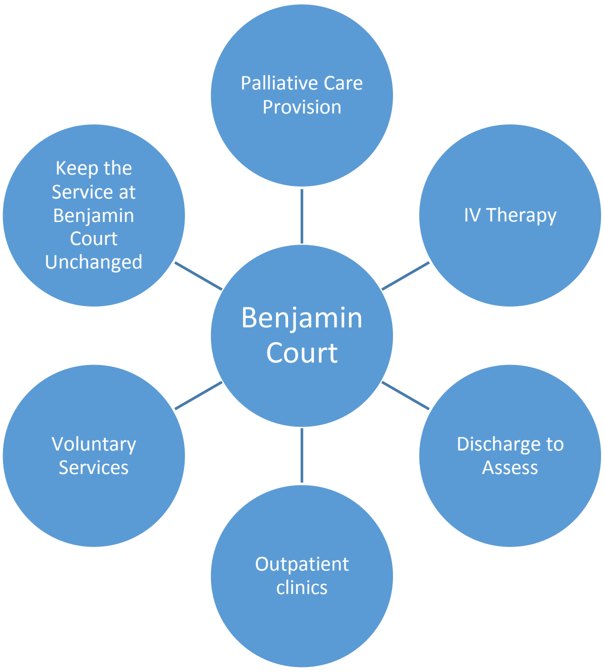
NN CCG has been working with its Community Engagement Panel (CEP), made up of local patient, carer and stakeholder representatives, since April 2016 on the development of Supported Care. A specially focused Project Group was also recruited from the CEP who have been giving more focused feedback on the development of the service. The CCG also hosts regular meetings of representatives from the local Hospital Friends groups to discuss ideas on how to ensure the units remain important local bases for health and care.

The CCG set up a specific steering group to discuss the use of Benjamin Court going forward. The steering group comprises of representatives from NCH&C, Norfolk & Norwich University Hospital (NNUH), clinicians working in the unit, GPs in Cromer and elsewhere in North Norfolk, Norfolk County Council, Cromer Town Council, Hospital Friends and members of Patient Participation Groups (PPGs) linked to local GP surgeries.

The steering group has met on four occasions. The first meeting was to provide some background to the work that was taking place and hear feedback. The second meeting was to explore some potential options for Benjamin Court going forward with the third meeting then being a discussion on the wider engagement which would take place. The fourth meeting took place on the 12th June 2017 allowing the CCG to put forward the more detailed options for the future use of the unit and finalise the details of the wider public engagement.

What are the options for the possible future of Benjamin Court Hospital?

This diagram summarises the options that have been explored. More detailed information for each option is given below.



Option 1 Keep the Service at Benjamin Court Unchanged

Summary of proposal

This option would mean that Benjamin Court continues to provide 18 beds for predominantly step down rehabilitation care. Whilst the service is well received from patients and there are no concerns over the quality of care being provided to patients, this would not address the fact that intermediate care is not the best solution for a number of patients. The CCG does not believe ‘standing still’ in this way is a good or viable option, especially in the context of the evidence from the audit mentioned above and far-reaching proposals outlined below.

On the days audited, occupancy in Benjamin Court beds ran between 83%-94%. Overall the 4 units accounting for the 79 intermediate care beds (including 6 commissioned by West Norfolk CCG at Cranmer House) run at approximately 91% occupancy. Supported care should enable, across all 4 units, 46%-48% of patients to go home.

The reduction in patient numbers would therefore make ‘standing still’ economically unviable at a time when precious NHS resources are under considerable pressure.

Advantages

- **No change** – There would be no disruption to the services at Benjamin Court and uncertainty for staff.

Disadvantages

- **Capacity in the wrong place** - The predicted occupancy at Benjamin Court will fall as more patients receive intermediate care at home, and this is not the best use for an expensive commodity.
- **Maintaining Skills** - Without a defined patient group, the available beds will still be used but will not be protected for specific pathways. This adds an element of clinical risk as the specialities will be varied and the nursing staff may not have the correct skills to care for the patients but more importantly patients may not be treated according to their specific needs.
- **Static service** - It would not be a service that was designed to meet the evolving needs of the community.
- **Recruitment** – finding staff to work in intermediate care in the North of Norfolk is difficult.
- **Not meeting other patient’s needs** – should the beds remain in use for the current group of patients, it would prevent other patients from being able to access services locally, e.g. palliative care.
- **Value for money** – the beds at Benjamin Court cost around £1,700 per week. With other possibilities available for the use of the unit, questions would be raised around the value for money of continuing to run the current service.

Option 2 Palliative Care Provision

Summary of proposal

Palliative care aims to ensure the best possible quality of life for individuals at end of life or with advanced illness and their families. Patients with advanced disease, whatever their diagnosis, deserve the best care that can be provided and evidence shows that for each medical speciality, having dedicated wards or units to care for patients, offers the most consistent high quality of care. Our proposal of providing a number of palliative care beds at Benjamin Court would enable multi-disciplinary teams that include consultants in palliative medicine, nurse specialists, and General Practitioners to assess, plan and deliver care that is specific to the needs of that patient and their relatives. For many patients it would mean avoiding admission to an acute hospital further from home if symptoms worsened and also offer support in a purpose-made environment for those who do not want to be (or cannot be) at home.

Evidence from palliative care staff who work in Norfolk shows that throughout the county there is a need for 49 in-patient palliative care beds. Currently there are only 18 at Priscilla Bacon Lodge (PBL) in Norwich. The care at home service has shown us there is a demand for extra provision - specifically an inpatient bed service.

There is a growing need for palliative care both in home settings and in community hospital settings, as the population ages. Proportionately people aged 85 or over receive less specialist palliative care than other age groups and importantly people with non-cancer diagnoses not only receive less specialist care, they also receive less generalist care than people with cancer (although they receive more social care).

Within the cohort of palliative care and end of life patients, there is a wide variation of age, even within North Norfolk. Young people who it was previously presumed would prefer to die at home have in fact identified that a hospice like setting, closer to home would offer more comfort and alleviate some of the fear around end of life. Montel et al (2009)[2] examined the factors that influence the choice of place of death in teenagers and young adults with cancer. Ninety percent of the families said they did not have a choice of the place of death, but would nevertheless have chosen the hospital where the death did in fact take place had they had a choice.

When it comes to numbers of community palliative care beds and provision to manage patients symptoms in their own home, there is wide variation both across the county, and among our other 10 comparative CCGs. Creating pathways for palliative patients would potentially increase the number of patients who could benefit by being referred to the service.

Advantages

- **Satisfy unmet demand** - There is a high demand for this service from the data given to us by our palliative care colleagues which is not currently being met in the most effective way – placing palliative care beds within the community would achieve this.
- **Local resource** - Benjamin Court would continue to serve the whole community and provide a local service for these patients.
- **More services available** - The unit would potentially form part of the palliative care directorate meaning that admissions into a palliative care bed at Benjamin

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[2] Montel, S. Laurence, V. Copel, L. Paquement, H. and Flahault C. (2009) Place of Death of Adolescents and Young Adults With Cancer: First Study in a French Population, Palliative and Supportive Care, 7, pp. 27-35.

Court would be managed by Pricilla Bacon Lodge (PBL). A co-ordinator at PBL would triage each referral, refer to a palliative care consultant where appropriate and admit patients directly from the community, enabling patients to avoid an admission into NNUH. Patients already within the NNUH that required 'fast tracking' home could also be stepped down into these beds, getting them at least one step closer to their preferred place of death.

- **Clinical improvement** - Pain and symptom control is one area that is central to palliative care and would be one of the core aims of the Enhanced Palliative Care beds at Benjamin Court (although palliative care is also a much wider concept). There is some evidence on differences in pain control depending on the setting. In a recent National Survey of Bereaved People in England, pain was reported as being relieved 'completely, all of the time' in a non-acute inpatient setting almost twice as often as in an acute inpatient bed and three times more likely than when patients were at home.
- **Better for patients** - Having a dedicated unit for Palliative care would mean that care would be targeted specifically at each patient, physically and emotionally. The patient would have access to specialist services that could treat and control not only pain but other symptoms synonymous with palliative patients. Additional this would include emotional and psychological support for patients and their relatives, creating a service around a patient and their specific needs. The ward at Benjamin Court lends itself to privacy and dignity for patients and their families by having individual rooms to care for patients during what can be a very difficult time.
- **Releases beds in secondary care** – providing palliative care beds within the community prevents patients from being admitted to secondary care, thus releasing beds for those patients who are acutely unwell.
- **Better for staff** - By having a specific patient group, nursing staff will be able to develop more focused skills needed for this more complex patient group. They will identify pathways for patients being discharged to a variety of settings. This would include discharging patients home which would have a positive impact on patients who wish to die in their usual place of residence and could allow, in the future, patients to be admitted to the unit directly ensuring the best patient journey. Many nurses say they find most rewarding. For patients at the end of their life, there is one chance as health care professionals to get it right, and achieve their priorities of care. Focusing the care provided at Benjamin Court would mean that nurses' confidence and competence in both enhanced Palliative care and end of life care would further develop.

Disadvantages

- **Time needed for service to fully develop** - There will be a transitional period where workforce skills may need enhanced development. For this reason the service will need to develop slowly in step changes before being 'fully functional.'

Palliative Care - Patient's Journey

Grace is 37 years old. She is married and has two children aged 6 and 8. Grace has a particularly aggressive form of breast cancer. She finished her second round of chemotherapy last week and has been suffering with nausea and vomiting since then. She has lost weight, become increasingly frail and fatigued and feels that she is no longer coping at home.

The care at home team have seen Grace this morning and feel that she now needs her symptoms controlled. They have spoken to the triage co-ordinator at Priscilla Bacon Lodge and a **palliative bed** close to her home in Cromer will be available later that afternoon. When Grace arrives with her husband to Benjamin Court later that day, she is met by the registered nurse who will be looking after her and is shown to her side room. The nurse takes a full set of observations, inserts a cannula so Grace can have **intravenous (IV) therapy** and takes a blood sample. The palliative care consultant comes to assess her. Grace's bloods show that she is dehydrated and this has had an effect on her kidney function. The consultant prescribes some IV fluids which should help her kidneys as well as some IV anti-sickness medication. She talks her through the benefits of a range of nutritional support and to start with they both agree to attempt small amounts of her new diet, as long as the anti-sickness medication works well.

Eight days later, Grace is taking anti-sickness tablets and her blood tests show her kidney function has improved. She is managing to eat several small meals each day with occasional snacks and feels a lot stronger. The care in Benjamin Court has enabled Grace to return home to her husband and children, with the support of the care at home team. She is given an outpatients appointment at Benjamin Court to see her palliative care consultant in two weeks' time to ensure her symptoms remain under control.

At the appointment, she is examined by the palliative care consultant and has her bloods taken. Grace says that she feels stronger physically, but she is struggling emotionally both with her prognosis and with how she can explain to her daughters what is going to happen. She is visibly distressed and explains that her husband is unable to discuss with her the practical implications of her deterioration. The consultant realises Grace has never accessed any psychological support due to the rapid detection and treatment of her disease. She is offered a referral to the psychological services within palliative care and also made aware of the volunteer counselling and drop in services offered in the **cancer support centre** at Benjamin Court. That evening, Grace discusses the counselling services at Benjamin Court with her husband and they agree to attend an appointment together.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

Option 3 Discharge to Assess (D2A) – Assessing care needs for frail patients in the community

Summary of proposal

This service enables medically fit patients to be given both the environment and therapies they need to get them to their best before an assessment of their longer term on-going care needs is made. These patients can be frail but with the potential to improve in strength and confidence. Assessing people when they have reached their optimum recovery means that they can plan the most appropriate care for their future needs.

Sometimes patients will be waiting for assessments for Continuing Healthcare (CHC) the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need".

Discharge to Assess (D2A) service enables patients to be discharged earlier from acute inpatient wards by co-ordinating care in alternative settings.

Important features of D2A include the trusted assessment between health and social care, in-house re-ablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process

D2A beds at Benjamin Court would support a timely discharge from hospital and would also support care closer to home whilst re-enablement takes place. By having some D2A beds at Benjamin Court, it would help maintain patients' independence where possible and reduce the requirements for long-term care packages. Work that was done before the D2A service started showed that approximately 4-6 patients per month would be appropriate for this pathway.

Many of the patients already on a D2A pathway are in nursing homes as this is where the beds were initially commissioned. This means they have far less access to therapy services and nursing staff, and therefore many patients are spending longer in a nursing home than they should.

Advantages

- **Better for patients** - By having D2A at Benjamin Court rather than in nursing homes, patients can have access to daily therapy support and there would be a greater focus on getting them to 'their best' prior to the assessment. This could not only speed up the time from admission to assessment but also increase the number of patients that are able to go back to their own home. Patients in the D2A beds at Benjamin Court would have more staffing cover than they currently receive in nursing homes.

- **Local primary care support** – There would be easy access to GP services on site.
- **Opportunities for staff** – Professional development opportunities for staff to progress into the re-ablement role.
- **Pleasant environment** – Benjamin Court has a pleasant environment with a large site and café for relatives to take patients out and explore to help with their rehabilitation.
- **Better chance of meeting patient's needs** – D2A beds provide a better chance of ultimately meeting the needs of a patient by assessing them in an environment best placed to assess their needs.

Disadvantages

- **Vulnerable group of patients** - Consideration would need to be given to whether the layout of the ward is suitable for complex needs.
- **Complex pathway** – D2A can be a complicated pathway and relies on the appropriate patients being targeted.

Discharge to Assess - Patient's Journey

James lives alone, but nearly four months ago he fell and broke his hip. He has been in hospital ever since. Before his fall, James was independent around his house; he could walk to the local shop to buy a few bits and pieces but his son, Anthony, and daughter in law, Sue, did James' main food shop for him. Sue also visited most days and helped him clean the house and maintain his garden.

James also suffers from COPD and whilst recovering in hospital during his four-month stay, he developed a chest infection. As a result and combined with the hip injury he has lost a lot of muscle tone meaning he cannot even stay balanced whilst sitting on the edge of a bed let alone walk independently.

On a ward round, James was told by his consultant that he was medically fit and that the team at the Norfolk and Norwich University Hospital were looking for the best way to discharge him. James told the consultant that he lived alone and whilst he wanted to go home, he didn't think that he could cope right now. The nurse in charge was also on the ward round and agreed with James. She said he could be assessed for a specific discharge where the focus would be on trying to improve his mobility, ideally to as good as it was before he came into hospital. From that point he would then be assessed for any additional care. Later that afternoon, he was assessed by one of the nurses and eligible for a **Discharge to Assess** bed at Benjamin Court.

Whilst James was in Benjamin Court, he was seen by a physiotherapist and a plan for his reablement was developed. Each day, the reablement nurse would go through his exercises and four weeks later was able to stand independently and walk a couple of steps. His hip movement remained constricted but it was continuing to improve. Anthony and Sue would visit most days and made the most of the facilities at Benjamin Court, taking him for tea in the café and exploring the grounds when the weather allowed. After seeing the occupational therapist a week later, he was taken back to his home, where he demonstrated that he could safely stand and walk from his lounge into his kitchen and make a cup of tea. After discussions with James, Anthony and Sue, it was decided that James could go home with additional support he needs. Five months after James' fall, he was finally able to go back to his home.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

Option 4 Intravenous Therapy at Benjamin Court

Summary of proposal

Intravenous (IV) therapy is when medicines or fluids are administered directly into a vein. Having IV services that can operate in the community, in people's homes or in community units, can be of significant benefit to both patients and the NHS. Throughout the UK there are a range of intravenous drugs that are administered outside of the acute hospital, these medications include (but are not limited to) blood and other blood products, antibiotics, iron, medication that slows down or prevents bone damage and antibodies that treat a wide variety of illnesses. They can prevent hospital admissions, facilitate early discharge, improve patient safety by reducing the risk of infection and improve choice by enabling patients to stay in their homes.

It requires a lots of different teams of health and care staff to work together and needs good communication between acute and community settings. Starting with a small service around palliative care, IV Therapy could over time expand to offer the range of therapies listed above that are not currently available in a community setting. The CCG is also working in partnership with the NNUH to ensure the best use of local facilities such as Cromer Hospital in the development of future IV services.

Advantages

- **Closer to home** - Patients needing a range of IV therapies can receive them closer to home. Receiving this therapy may go on to have an impact on the patients pathway and reduce the need for a hospital admission.
- **Life-changing service** - Patients who have long term IV therapy needs will travel less, and spend less time in treatment. This could reduce the impact the long term IV therapy has on their life and improve their quality of life.
- **High demand** - Based on the growth of community IV therapy services in the last few years, there is no doubt that this area of healthcare provision will continue to expand.
- **Avoid regular readmission –** clinicians have told us that IV therapy within Benjamin Court could prevent patients in Intermediate Care Bed from being readmitted to secondary care.

- **Impact on large group of patients –** IV therapy can be administrated reasonably quickly meaning a large number of patients can utilise a single bed per day and provide a greater impact for the North Norfolk population than the beds in their current guise could.

Disadvantages

- **Significant training and investment needed** - To ensure it is managed safely and effectively, there needs to be appropriate training and support. This will cost money to not only train staff but to backfill for this training gap.

Option 5 Voluntary Services

Summary of proposal

Big C is a Cancer charity based throughout Norfolk and Waveney giving local residents access to information and support in their local areas. The Big C have indicated they would like to offer a drop-in support and information centre within Benjamin Court. They have a number of centres throughout the region which provide valuable information and support for patients and their loved ones on all aspects of cancer and its impact on their lives. They would like to increase their presence in north Norfolk.

The Big C already has four support centres as well as online support for people who cannot make it into one of the centres. The Big C knows that there is demand for their services to further expand in this geographical area. The CCG would see this as an opportunity for other voluntary and community services to further complement this aspect of Benjamin Court as a hub for wider health and community support.

Advantages

- **Awareness** – Big C will help to raise awareness of the facility as it will be featured in their marketing and communications as well as people being signposted to their services within Benjamin Court.
- **Improved Patient Care –** Big C adds value to statutory provision for all those affected by cancer by offering five areas of care: information, advice (e.g. welfare advice), complementary therapies, talking therapies and access to exercise.
- **Support for Carers –** Big C services are inclusive of carers providing support and information for the family and friends of the person diagnosed with cancer.
- **More volunteer opportunities** – Having a presence at Benjamin Court may help the Big C attract additional volunteers to the service from the local area.
- **Opportunity to develop a community support hub** – Big C have extensive experience of working with other NHS and voluntary and community sector

providers. They have also delivered some services on behalf of the NHS so that they can be accessed by all (cancer and non-cancer patients) at the same centre. Having the Big C show an interest in working at Benjamin Court adds an opportunity to develop a wide-ranging community support hub, something that serves the whole community and might encourage other charitable organisations to follow suit.
- **Supporting Self-Management –** Big C's services help empower patients and carers in successful self-management for many areas of their care. This gives them more independence and is also in line with national and local priorities for care.

Note

- **Accommodation and resources** - Details about the space and configuration required have yet to be finalised. Consideration would need to be given about how a wider community hub can be funded, accommodated and managed.

Option 6 Outpatient Services

Summary of proposal

There are a variety of opportunities for developing additional community services at Benjamin Court such as outpatient clinics, many of which would currently involve going to an acute hospital. Many of these outpatient services are oversubscribed and the number of patients going into NNUH means waiting times are longer. Outpatient services could include:

Gynaecology clinic – to support women's and reproductive health.

Dermatology clinic – to support people manage conditions relating to skin.

ENT (Ear, Nose and Throat) clinic – to support people with conditions relating to the Ear, Nose and Throat.

Antenatal hubs – to support pregnant women and their families.

Palliative care clinic – to support people living with long term conditions with areas such as medicines and pain management.

Advantages

- **Investment in staff** - By developing a new service, additional skills would be needed by staff and that would lead to training and professional development opportunities.
- **Closer to home** - More access to services closer to home.

- **Complement Palliative Care** - the palliative care directorate see an outpatient clinic a natural extension of having inpatient beds.
- **Releases capacity in secondary care** – secondary care is under significant demand pressures and these outpatient clinics would release capacity for other patients in Norwich.

Disadvantages

- **Accommodation** - Appropriate space to house the consultation rooms and to offer an efficient functioning reception area to organise appointments. Also, enough space for a patient waiting area.
- **Information Technology (IT)** - There may be questions over how the IT systems for patient appointments within the acute trusts would work outside their hospitals.

Observation Beds for Ambulance Conveyances

The option to include observation beds at Benjamin Court as an alternative to taking people who have dialled 999 to A&E was considered but discounted as a viable alternative by the steering group. Patients would have been triaged to access an assessment from a GP, Emergency Nurse or Paramedic Practitioner where appropriate instead of being admitted to an acute hospital.

Whilst this option would have provided a service closer to home, and potentially helped ease pressure at A&E departments, there were concerns about both patient safety and the number of patients who would be suitable for this service.

The CCG will however continue to investigate ideas that help prevent patients being taken to A&E unnecessarily, and that help ease pressure on ambulances in North Norfolk.

Benjamin Court Steering Group’s Preferred Option

Many of the options above present excellent opportunities for the future of Benjamin Court and for the people of North Norfolk and rural Broadland; bringing new services to the community, helping more people to live well at home for as long as possible and putting finite NHS resources to better and more productive use.

Having considered the advantages and disadvantages of each of these options and fully explored them with relevant stakeholders, the stakeholders who made up the

Benjamin Court Steering Group believe the most credible options for Benjamin Court to be:

- Up to 8 Palliative Care Beds
- 2 IV Therapy Beds/Chairs
- 6 Discharge to Assess Beds
- Additional voluntary/third sector provision
- Additional outpatient clinics

The steering group is clear that it wants to keep Benjamin Court as a vibrant and focal point of the community and proposes an increase to the services it provides, whilst equally recognising the change needed to allow this to happen. The additional services being provided at Benjamin Court would require a similar number of nurses and health care assistants to that currently being provided and the CCG is therefore expecting minimal changes to staff numbers. Additional medical resource in the form of palliative care consultants and GP resource is being discussed. Additionally, these options would bring new opportunities for further training and development for doctors, nurses and support services.

The steering group understands and respects that there is a reluctance for change and that this is a valued and much-loved local resource. But it remains the view of the group that doing nothing is not a viable option. The preferred option presented above is better for people living in North Norfolk and rural Broadland, and delivers much more for Cromer and the surrounding area to more people.

Feeding Back and Next Steps

So what do you think?

We would like you take part in our consultation which is running between **June 19th and September 11th 2017**. We would like to know:

- ❖ How would these proposed changes impact you?
- ❖ What else should the CCG consider in making this decision?

How do I have my say?

Online: www.northnorfolkccg.nhs.uk/benjamincourtconsultation

Email: nnccg.contactus@nhs.net Please label your message with “Benjamin Court Consultation”

It would really help us if you could send your feedback by email or from our website but if you are not able to do so please use our freepost address overleaf.

Post: NHS North Norfolk CCG
FREEPOST RTKA-RUCU-BLHU
1 Mill Close
Aylsham
Norfolk
NR11 6LZ

Governing Body meeting in public:
September 26th 2017 ACT Centre, Aylsham NR11 6YA
Meeting papers will be available and meeting times confirmed one week in advance on the CCG website:
www.northnorfolkccg.nhs.uk/news-events/governing-body-meetings

Drop-in event: A drop-in event is planned for Cromer during the public consultation and engagement and will be advertised across North Norfolk and rural Broadland in the local media. Details will also be available on the CCG website.

Next steps

1. Period of public consultation and engagement **June 19th – September 11th 2017**
2. Consultation and engagement report compiled **September 11th – 18th 2017**
3. Benjamin Court Steering Group meeting to receive the consultation and engagement report in the **week starting September 11th**
4. Governing Body meeting in public **September 26th 2017**

Want to get involved going forward?

If feeding back on this document has given you a taste for getting involved in local healthcare commissioning why not consider one of the following options?

The Benjamin Court Steering Group will meet after the public consultation and engagement finishes to receive the results of the report. The consultation may raise awareness about the Friends of Cromer Hospital and Benjamin Court, and provide opportunities for recruiting more volunteers.

So why not?

Join your local Hospital Friends group at Cromer, Kelling, North Walsham or Cranmer House?

Join the North Norfolk CCG Community Engagement Panel (CEP) – more details from NHS North Norfolk CCG.

Join your GP Practice's Patient Participation Group (PPG) – more details from your local surgery.

Norfolk Health Overview and Scrutiny Committee
7 September 2017
Item no 8

Children's autism and sensory processing assessment / sensory integration therapy

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

A report from commissioners on access to autism services and sensory processing assessment / sensory integration therapy in central and west Norfolk.

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Children's autism and sensory processing assessment / therapy' to its forward work programme in February 2017, following concerns raised by a Member about waiting times for assessment and diagnosis and the availability of treatments.

1.2 NHOSC last looked at services for children with autism in October 2012, following up on a scrutiny review which had been completed October 2011. The initial concerns, which were brought to NHOSC's attention by Autism Anglia in 2011, had been about:-

- Lack of a funded diagnostic service for school age children
- Under-resourcing of the pre-school paediatric diagnostic services to meet the demand for assessments
- Variation in diagnostic methods across Norfolk
- Inability of the Child and Adolescent Mental Health Service to meet the needs of children with autism.

In 2012 progress had been made in relation to pathways for diagnosis of children. There was a more joined up approach between the NHS, education, parents and other services involved with the child to gain a fuller picture and make more accurate diagnosis within reasonable timescales. Post diagnosis support for families was expected to improve under the post diagnostic pathway.

1.3 2012-13 saw a major reorganisation of NHS commissioning with the formation of 5 Clinical Commissioning Groups (CCGs) in Norfolk, which took over commissioning responsibility for autism services from the 2 former Primary Care Trusts on 1 April 2013.

1.4 At the recommendation of NHOSC in October 2012 Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) continued to receive reports from Great Yarmouth and Waveney (GY&W) CCG and Norfolk and Suffolk Children's Services about the progress of children's autism services in its area. The last report was on 6 July 2017, when the Joint Committee received an update on progress made by Great Yarmouth and Waveney CCG working together with Children's Services in Norfolk and Suffolk County Councils to support children's needs. The report is available via the Norfolk County Council website (Great Yarmouth & Waveney Joint Health Scrutiny Committee, 6 July 2017, item 6, page 17):- http://norfolkcc.cmis.uk.com/norfolkcc/Meetings

The Joint Committee commended the considerable collective work that had been done in 2016-17 to improve the service and recommended:-

1. That Norfolk and Suffolk County Councils should encourage Ofsted, in their regular inspections of schools, to strengthen the focus on assessing how schools manage children with ASD.
2. That Norfolk and Suffolk County Councils and the Great Yarmouth and Waveney CCG should seek to provide more support to, and contact with, parents and carers of children with ASD, with more information and signposting of where and how they can get help.
3. That Norfolk and Suffolk County Councils and the GY&W CCG should continue to improve the feedback given to referrers, to ensure that children are placed on the correct assessment pathway at an early stage.
4. That Norfolk and Suffolk County Councils and the GY&W CCG should keep encouraging schools to play a greater part in identifying and supporting children with ASD, and recognising the link between academic success and children's emotional wellbeing.
5. That Norfolk and Suffolk County Councils should continue to share knowledge and good practice between each other.

The Joint Committee also asked to receive an information bulletin in February 2018 with updated data showing the numbers of children in Great Yarmouth and Waveney with Autistic Spectrum Disorders, data on time-to-assessment and time-to-treatment, and any data on the reasons why children haven't attended their appointments.

1.5 In October 2016 the Norfolk Autism Partnership Board (APB) consulted on a draft Norfolk All Age Autism Strategy 2016-2019 in response to the National Autism Strategy. The consultation documents are available on the Norfolk County Council Consultation Hub
https://norfolk.citizenspace.com/consultation/draft-autism-strategy/

The final strategy was to be launched in 2017. Part of the vision for the future set out in the consultation document was for an Autism Partnership Board to be set up that included autistic people and family representatives as well as statutory services.

1.6 NICE Clinical Guideline CG128 (Sept 2011) 'Autism spectrum disorder in under 19s: recognition, referral and diagnosis' recommends that consideration should be given to whether 'sensory sensitivities' assessment is needed when constructing a profile for each child or young person'.

In February 2015 Norfolk Public Health produced a report for the Norfolk commissioners on Sensory Integration Therapy Policy, which concluded that due to the lack of strong evidence and cost effectiveness sensory integration therapy should not be routinely funded. A copy of the Policy report is available on West Norfolk CCG's website:-
http://www.westnorfolkccg.nhs.uk/individual-funding-requests-nhs-treatment/clinical-policies

2. Purpose of today's meeting

2.1 As GY&W JHSC is already looking at children's autism services in its area, the information presented for **today's meeting focuses on the central and west Norfolk areas**. Norwich, North Norfolk, South Norfolk and West Norfolk CCGs hold a single contract with Norfolk Community Health and Care NHS Trust (NCH&C), which provides community services for children with autism. The CCGs have been asked to report to NHOSC with the following information:-

(a) A description of the current commissioned autism services (i.e. when did the current contract start and when does it finish; who commissioned it & the proportion of funding from each party); the commissioned capacity (i.e. how many children is it expected to see); who is the provider; description of the service and the type and numbers of staff involved; what is the geographic spread of the service and where are the location bases.

(b) Details of the sensory processing assessment provided and the sensory integration therapy service offered, or acknowledgement / explanation if such a service is not commissioned.

(c) Workload – what is the current workload; the trend; comparison between commissioned capacity and actual number of referrals for autism diagnosis / services

(d) Staffing – number and types of vacancies

(e) Waiting times – from referral to assessment; from assessment to start of therapy; numbers on the waiting list

(f) Key Performance Indicators (KPIs) – current performance against KPIs and trends in performance

(g) Complaints / user feedback – numbers of complaints; complaint themes; user satisfaction survey feedback

The CCGs' report is at **Appendix A** and representatives will be in attendance to answer Members' questions.

Great Yarmouth and Waveney CCG has recently taken the lead for Child Health and Maternity for all five of the Norfolk and Waveney CCGs, so the CCG representatives come from that area and will be able to answer questions for the whole county.

2.2 Representatives of the NHS provider of services for children with autism in central and west Norfolk, Norfolk Community Health and Care NHS Trust (NCH&C), have also been invited to attend to answer questions which may arise about the delivery of commissioned services in their area.

3. Suggested approach

3.1 After the CCGs' representatives have presented their report, Members may wish to discuss the following areas:-

(a) The commissioners' report (Appendix A) says that almost 300 cases are still awaiting to begin their assessment for autism and the service pathway's capacity can accommodate approximately 150 assessments at any one time, therefore many families are experiencing a wait of at least two years from acceptance for assessment to completion of the process. The CCGs have this issue under active consideration. Are there plans to increase capacity?

(b) The CCGs are currently reviewing the results of a positive behaviour programme that was trialled in 2016-17 to support families while their child is waiting for their diagnostic assessment to be completed. When is there likely to be a decision about whether such a service should be commissioned on an on-going basis?

(c) There are currently no performance indicators in place for the children's autism services and the CCGs are working to introduce more robust monitoring of the service through a weekly overview and more robust management of waiting times. When do the new monitoring arrangements start?

(d) Has there been continued progress in liaison between health, education and social care in the diagnosis and care and development of children with Autistic Spectrum Disorders?

(e) Are parents sufficiently and appropriately involved?

(f) What was the response to the draft Norfolk All Age Autism strategy in December 2016 and when will the strategy, including an appropriate Autism Partnership Board, be in place?

4. Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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Great Yarmouth and Waveney
North Norfolk, South Norfolk
Norwich, West Norfolk
Clinical Commissioning Groups

Briefing for Norfolk Health Overview and Scrutiny Committee

7 September 2017

Children's Autism and Sensory Processing Assessment / Therapy

1. Introduction

1.1 The Norfolk Health Overview and Scrutiny Committee (NHOSC) have requested a briefing on a number of key issues related to the provision of services for Autistic Spectrum Disorder (ASD) service for children across Norfolk and Waveney. This paper provides a response to each of the specific queries raised.

2. Background

2.1 The five Clinical Commissioning Groups across Norfolk and Waveney have recently agreed to collaborate with a single leadership team for children's, young peoples and maternity services. This work is being led by the Great Yarmouth and Waveney Clinical Commissioning Group across all five CCGs, and will ensure improved integrated working across all sectors for the benefit of the children that we all serve. It will have the added benefit for ensuring key priorities for services are agreed, with the delivery of integrated commissioning for health, education and social care, plus strong leadership. Whilst this is a work in progress, it will mean a much improved and joined up approach, which has been widely welcomed.

2.2 At the recommendation of Norfolk HOSC in October 2012, Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) continued to receive reports from Great Yarmouth and Waveney (GY&W) CCG and Norfolk and Suffolk Children's Services about the progress of children's autism services in its area. The last report was on 6 July 2017, when the Joint Committee received an update on progress made by Great Yarmouth and Waveney CCG working together with Children's Services in Norfolk and Suffolk County Councils to support children's needs. For this reason, the rest of this report relates to services for children and young people in Norwich, West Norfolk, North Norfolk and South Norfolk.

The next sections of this report address the specific queries raised by HOSC.

3. **Q: A description of the current commissioned autism services (i.e. when did the current contract start and when does it finish; who commissioned it and the proportion of funding from each party; the commissioned capacity (i.e. how many children is it expected to see); who is the provider; description of the service and the type and numbers of staff involved; what is the geographic spread of the service and where are the location bases?**

3.1 Current commissioned service

A new Norfolk ASD pathway for the assessment and diagnosis of autism for children and young people was commissioned in 2012. This was following the publication of new NICE guidance on recognition, referral and diagnosis of autism in children and young people (2011).

This new pathway was developed collaboratively by health, social care and education providers and commissioners. It was acknowledged that no single service can meet the needs of this group of children who have a diverse level of needs and presentations.

This Norfolk ASD pathway was updated in 2016 to a ‘pathway for referral assessment and support of possible autism in children and young people’. This was to take account of the major restructuring of services locally and publication of new NICE guidance on the management and support of children and young people on the autism spectrum (2013).

There are three current autism pathways for the recognition and diagnosis of autism in children and young people. These are:

- ASD Diagnostic Pathway: Age 1-5
- ASD Diagnostic Pathway: Age 6-18
- ASD Diagnostic Pathway: CAMHS for children with a mental health disorder.

All ASD three diagnostic pathways are commissioned by Norfolk CCGs. The contracts run to March 2019.

3.2 Proportion of funding from each commissioner

The ASD service is commissioned as part of a block contract with providers and we are now in the process of understanding the detail of that. This is a high priority for the commissioners so that we have a better understanding of the funding provided for the service and that it is being used to best effect.

3.3 Provider of the service

The pathways for children aged 1-18 are provided by Norfolk Community Health and Care (NCH&C), with support from other providers.

The CAMHS pathway is provided by Norfolk & Suffolk Foundation Trust (NSFT).

3.4 Geographic spread of the service

The service provided by NCHC is for children aged 1 to 18 years who are registered with a GP in Norwich CCG, West Norfolk CCG, North Norfolk CCG and South Norfolk CCG (with the exception of Thetford where services are commissioned from Suffolk Community Healthcare).

3.5 Staff delivering the service

The NCHC ASD diagnostic pathway is a multi-disciplinary pathway delivered by paediatricians, clinical psychologists, specialist nurses and family support workers, supported by speech and language therapy, psychology, therapy and teacher resource from other agencies and health/care providers such as East Coast Community Healthcare (ECCH), Norfolk County Council and Norfolk and Suffolk Foundation Trust (NSFT).

3.6 Description of the service

A referral is made into NCHC, the child will then be reviewed by a community paediatrician, clinical psychologist or nurse and this is aimed to be within the 18 week wait timeline.

If there is a likelihood of ASD the referral is then passed to the multi-disciplinary team who will gather and evaluate clinical information from referrer, parents, early years setting, school and any other relevant agencies.

Acceptance of referral for a full ASD assessment is based on this information. Children who do not reach the criteria for assessment for ASD will be referred on to alternative appropriate pathways / services such as mental health.

A diagnosis of ASD is made using holistic developmental assessments, with standardised tools and school observations.

Each child is seen by a minimum of two professionals in two different environments. All commissioned diagnostic assessments must be NICE compliant.

There is face to face feedback with the parent(s) or carer(s) about the outcome of the assessment. Each family is offered a post diagnosis appointment within six weeks to offer advice and information.

The CAMHS pathway is provided by Norfolk and Suffolk Foundation Trust (NSFT).

Autism is not a mental health diagnosis, although a significant number of children with autism also present with mental health needs. Mental health services are commissioned to provide targeted and specialist mental health support for the whole population, including those with additional or particular needs, like autism). The specifications for mental health services make it clear that reasonable adjustments need to be made to the standard treatment offer to accommodate the particular needs that autism can bring. Because some children with a complex or hard to assess set of symptoms are referred first to the main specialist mental health provider (NSFT), they complete diagnostic work for some cases.

3.7 Post Diagnostic Support

The Norfolk ASD Pathway identifies a range of services across health, education and social care that provide interventions as recommended by NICE guidance. It does not describe the wider range of services available from the voluntary sector because these are subject to change, depending on grants and local initiatives. However the local offer will have comprehensive information on local services available to help families.

3.8 Other health commissioned ASD specific services.

There are a range of other services commissioned to support ASD which include:

- ASD specific parent support programmes commissioned following diagnosis; groups for parents of school age children
- Early bird support for parents of pre-school children
- A holistic service to children with co-morbid learning disability and autism

4. Q: Details of the sensory processing assessment provided and the sensory integration therapy service offered, or service, or acknowledgement / explanation if such as service is not commissioned.

4.1 Sensory Processing

The ASD diagnostic assessment undertaken by NCH&C includes a generic assessment of children's sensory sensitivities.

Sensory Integration Therapy has been the subject of controversy. In 2014, the Norfolk Public Health department were asked to review sensory integration therapy (SIT) and present a serious of recommendations to inform the evidence base for SIT and future funding.

A report was produced for Norfolk Commissioners, Sensory Integrated Therapy Policy (February 2015). It concluded that there is no national guidance relating to the prescribing, deployment or monitoring of SIT. There is little robust scientific evidence to support the use of SIT. As a result of this lack of strong evidence and cost effectiveness, the recommendation was that SIT should not be routinely funded.

This position is kept under review in the light of any future national guidance.

5. Q: Workload – what is the current workload; the trend; comparison between commissioned capacity and actual number of referrals?

Demand for ASD assessments by NCHC has increased over the last five years since the establishment of the ASD Pathway. Reasons for this increase are as follows:

- Greater awareness by families and referrers of the condition of ASD
- Belief by parents in the value of a diagnosis as a means to leverage disability benefits as well as further educational and social care
- Parental expectations for post-diagnostic support have been increasing

NCHC's most recent figures from the years 2015-16 and 2016-17 show no significant change in the overall number of referrals to the pathway, leading NCHC to believe that demand has now plateaued and should not significantly increase further. Effective triage is in place; therefore of those referred over 80% are accepted for assessment.

Almost 300 cases are still waiting to begin their assessment (August 2017). The Pathway's capacity can accommodate approx. 150 assessments at any one time. Therefore many families are experiencing a wait of at least two years from acceptance for assessment to completion of the process.

6. Q: Staffing – number and types of vacancies

NCHC staffing resource for the pathway comprises:

Clinical Psychologist – Pre school	0.8 WTE
Clinical Psychologist –School age	1.0 WTE
Children's Nurse	0.6 WTE
Family Support Worker	1.0 WTE
Nursery Nurse	1.0 WTE
Path Way Administrator	0.88 WTE
Assistant Psychologist	0.5 WTE

There are no current staff vacancies. Input by speech and language therapy is provided by East Coast Community Health (ECCH). This is jointly commissioned by the CCGs and Norfolk County Council and managed by NCC.

7. Q: Waiting times – from referral to assessment; from assessment to start of therapy; numbers on the waiting list.

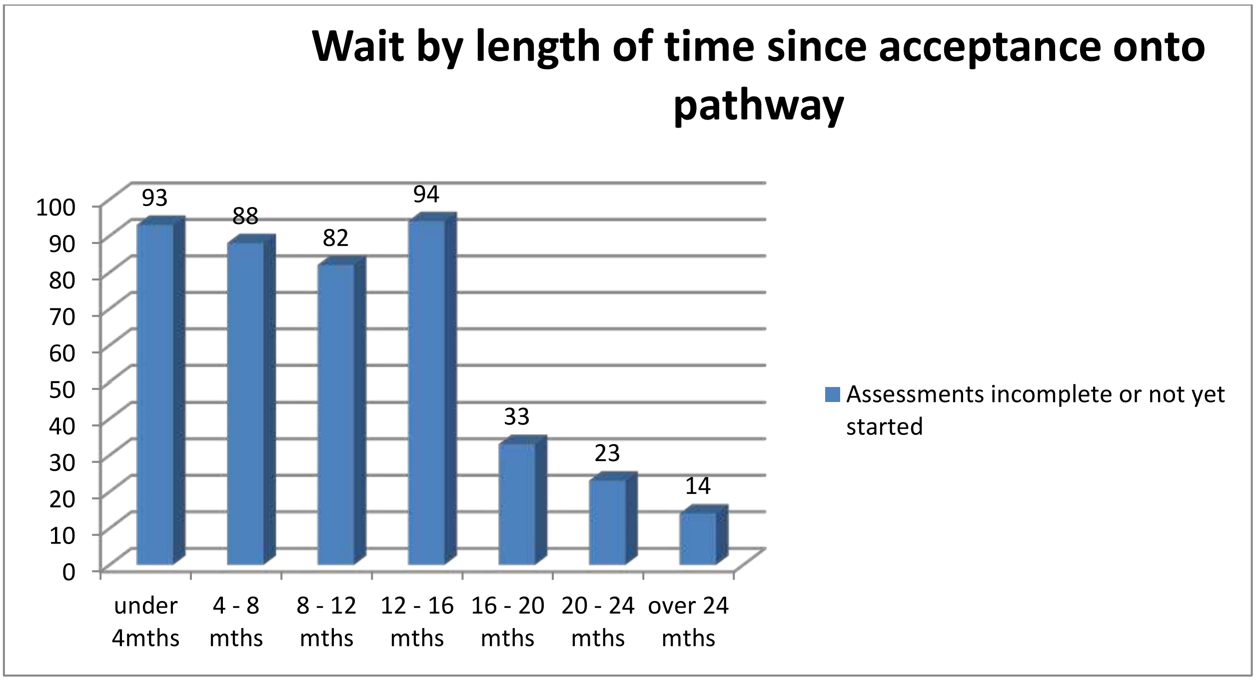
The current waiting times from first GP referral to a generic assessment by a paediatrician, nurse or clinical psychologist are aiming to meet the 18 weeks target within the next two to three months.

The length of time for assessment may be variable depending on the age of the child. The timescale for an ASD assessment to be completed is dependent on each patient, currently this can be a maximum of 24 months. The diagnosis of autism will have a lifetime impact so commissioners have focused on quality and timeliness of the service.

7.1 Numbers of children on the waiting list as of 8 August 2017:

	Referred in - awaiting discussion and decision by team to accept for full assessment	Accepted for full assessment – awaiting start of first assessment	Assessment started (= accepted onto pathway and first assessment underway)
Preschool - West 1- 4yrs	1	18	8
Preschool – Central 1 – 4yrs	1	20	35
School age – West 4 – 18yrs	19	186	53
School age – Central 4 – 18yrs	54	192	52
Total	**75**	**416**	**148**

This shows a total of 639 children that are awaiting discussion or assessment.



A significant number of those cases waiting more than eight months are waiting for their first or second assessment to complete their diagnosis. Of assessments currently in progress, approximately 90% are waiting for specialist ADOS or equivalent assessments to be completed. The issue of waiting times and availability of support to families is under active consideration by the CCGs.

A positive behaviour support programme was trialled in 2016-17, and well received by families. Since April 2017 there has been no programme of support available to families while their child is waiting for their diagnostic assessment to complete and this is currently under review by the CCGs.

8. Q: KPIs – current performance against key performance indicators (KPIs) and trends in performance

We are working as part of a new leadership arrangement with NHS Great Yarmouth and Waveney CCG as the lead for children and young people to put in place more robust monitoring of the service. We are introducing a weekly overview and regular management of waiting times.

We are aware that currently there are no performance indicators in place or analysis of trends in performance to enable us to monitor performance.

9. Q: Complaints / user feedback – numbers of complaints; complaint themes; user satisfaction survey feedback

There have been 53 complaints recorded since 2014 by NCH&C and North East London Commissioning support unit. We are planning to work on capturing complaints that may be directed through a number of different systems such as individual CCGS, Norfolk Children's Services, CAMHS or MPs.

Of those 53 complaints the themes include: length of wait (largest number), support for emotional/behavioural difficulties associated with autism (second largest number) and non-confirmation of independent assessments. There are rarely any complaints about the quality of the current service provided.

10. Conclusion

We recognise this is an area where services have not kept up with local need. The current service is NICE compliant. The CCGs are now working alongside NCHC to address this so that we have greater oversight, capacity and scrutiny.

We are actively looking at the options available to us to ensure that parents and families are better supported whilst they wait and that waiting lists are addressed and that the time to wait is far shorter.

Tracy McLean:	Head of Children Young People and Maternity Norfolk and Waveney
Alan Hunter:	Head of Service (Children) Norfolk Community Health and Care Trust (NCH&C)

Norfolk Health Overview and Scrutiny Committee
7 September 2017
Item no 9

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2017-18

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
26 Oct 2017	Ambulance Response and Turnaround Times in Norfolk – update on progress since 13 October 2016	
7 Dec 2017		
11 Jan 2018		
22 Feb 2018	*Continuing healthcare – an update on progress since Feb 2017.*	*Provisional*

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

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

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

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 D Harrison)

South Norfolk - Dr N Legg
(substitute Mr P Wilkinson)

Gt Yarmouth and Waveney - Mrs M Fairhead (substitute Mr A Grant)

West Norfolk - M Chenery of Horsbrugh (substitute Mrs S Young)

Norwich - Ms E Corlett (substitute Ms B Jones)

NHS Provider Trusts

Queen Elizabeth Hospital, King’s Lynn NHS Foundation Trust - Mrs S Young (substitute M Chenery of Horsbrugh)

Norfolk and Suffolk NHS Foundation Trust (mental health trust) - M Chenery of Horsbrugh (substitute Ms B Jones*)*

Norfolk and Norwich University Hospitals NHS Foundation Trust - Dr N Legg (substitute Mr D Harrison)

James Paget University Hospitals NHS Foundation Trust - Mrs L Hempsall (substitute Mrs M Fairhead)

Norfolk Community Health and Care NHS Trust - Mr D Harrison (substitute Mrs L Hempsall)

IN TRAN communication for all

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Norfolk Health Overview and Scrutiny Committee 7 September 2017

Glossary of Terms and Abbreviations

AAC	Augmentative And Alternative Communication
ADOS	Autism diagnosis observation schedule
AHP	Allied Health Professional
APB	Autism Partnership Board
ASD	Autistic Spectrum Disorders
ATT	Assisted Through Technology
CAMHS	Child and Adolescent Mental Health Service
CEP	Community Engagement Panel
CHC	Continuing Healthcare
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CYP	Children and young people
D2A	Discharge to assess
DASH	Disability, Additional and Specialist Healthcare
DFE	Department for Education
DNA	Did Not Attend
DRB	Deaf Resource Base
ECCA	East Coast Community Access (phoneline)
ECCH	East Coast Community Healthcare
EHC	Education Health and Care
EHCP	Education Health and Care Plan
EIT	Early Intervention Team
EKOS	East Kent Outcome System (speech and language therapy evaluation tool)
Elklan	A Speech and Language Therapy training provider, established in 1999
ENT	Ear, Nose And Throat
EP	Educational psychologist
EY	Early years
FVN	Family Voice Norfolk – a collective of parent carers from across Norfolk (from nearly 700 families as at August 2017). Funded through a direct Department for Education grant. Has worked in partnership with Norfolk County Council and NHS since 2006
GP	General Practitioner
GY&WCCG	Great Yarmouth And Waveney clinical commissioning group
GY&W JHSC	Great Yarmouth and Waveney Joint health Scrutiny Committee (which includes Members from Norfolk and Suffolk Health overview and Scrutiny Committees)
HCP	Health Care Professional / Practitioner

HOSC	Health Overview and Scrutiny Committee
HV	Health Visitor
IEP	Individual educational plan
IT	Information Technology
IV	Intravenous
KPI	Key Performance Indicator
KS	Key Stage (in education)
LA	Local Authority
LSA	Learning Support Assistant
Makaton	A language programme using signs and symbols to help people communicate
MER	Monitoring, evaluation and reporting
NCC	Norfolk County Council
NCCG	Norwich Clinical Commissioning Group
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NFS	Norfolk First Support
NG	Nasogastric
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICE	National Institute for Health and Care Excellence
NNCCG	North Norfolk Clinical Commissioning Group
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust
OT	Occupational Therapist / Therapy
Palliative care	The active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments (NICE, 2004)
PALS	Patient Advice and Liaison Service
PBL	Priscilla Bacon Lodge, Norwich – centre for specialist palliative care
PECS	Picture Exchange Communication System
PDA	Pathological Demand Avoidance
Portage	A home visiting service for preschool children with additional support needs and their families
PPG	Patient Participation Group
Q	Quarter of the financial year
RTT	Referral to treatment
SaLTA	Speech and Language Therapy Assistant
SEN	Special Educational Needs
SENCO	Special Educational Needs Coordinator

SEND	Special Educational Needs and Disabilities
SIT	Sensory Integration Therapy – aims to help children with sensory processing issues by exposing them to sensory stimulation in a structured, repetitive way
SLCN	Speech, language and communication needs
SLT / SALT / S&LT	Speech and language therapy
SMART	Specific, measurable, achievable, realistic, timely
SNCCG	South Norfolk clinical commissioning group
SRB	Specialist Resource Bases
TA	Teaching Assistant
TALC	Test of abstract language comprehension
TOMs	Therapy outcome measures
TUPE	Transfer of Undertakings (Protection of Employment)
VOCA	Voice Output Communication Aid
WNCCG	West Norfolk Clinical Commissioning Group
WTE	Whole time equivalent
Y	Year