Transforming mental health services for children and young people in Norfolk & Waveney

RETHINK PARTNERS

Feedback report to the Norfolk & Waveney system
January 2019

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However, this vision is not well understood by partners across the system, and it has not been translated into a clear route map that all organisations own setting out how it will be delivered.

There is an exciting debate underway locally about the potential to further integrate wider children's services and mental health. It will be important to consider this emerging direction as new revised arrangements for CYP mental health are designed and implemented.

2 Norfolk and Waveney is a large and complex health and care system. This adds to the challenge of ensuring that there is an integrated, equitable and comprehensive response to meeting the emotional and mental health needs of children and young people.

Meeting this challenge requires partners to have mature, strong and trusting relationships. We found that there is some way to go before these are in place: we observed considerable tension between organisations, a lack of joined-up thinking and a reluctance to surface and address difficult or contentious issues.

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3 Leadership of mental health services for children and young people is fragmented across the system, and individuals frequently lack a clear mandate from their partners.

Clinical leadership in planning and commissioning services is limited. We found a lack of clarity over how the views of professionals are sought, and considerable frustration at a perceived inability to influence service delivery.

4 The existing governance and decision making arrangements for children and young people's mental health are complex, bureaucratic and fragmented.

It is unclear where decisions get made, there is duplication across the different groups and there is a lack of accountability.

5 Resources to support the planning and commissioning of mental health services for children and young people are fragmented across the system.

Leadership of this agenda is also fragmented: at present no one individual has the explicit role or mandate to bring together the full range of skills required to commission effectively or to act as the focus point for this service area.

6 There is a focus on achieving high levels of performance against a small number of national metrics, which tends to mask significant pressures and challenges in existing services and risks distracting attention from local service improvement.

The types and breadth of data currently collected is inconsistent and fragmented and, as a result, so there is no single system narrative that clearly sets out how services are performing.

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7 Norfolk and Waveney have a rich and distributed network of 3rd sector organisations supporting the emotional well-being and mental health of children and young people, and providing invaluable support to parents, families, and carers.

There is an opportunity to expand and generate more value and impact from this sector through creating a clearer approach and process for involvement; to move beyond commissioned service or grant funding relationships into a true partnership model with the sector and leading organisations within it.

This approach would also bridge into true community action / community led approaches to emotional resilience and supporting those with mental health conditions.

8 There are a number of common threads in this report which centre on how individuals and organisations operate when coming together to collaborate effectively.

Whilst progress will be made by implementing specific changes, there is a need to pay attention to the softer, more human side of system interactions, including consideration of behaviours, expectations and leadership capability. Developing the conditions in which collaboration becomes the norm will be vital; this is the glue which will hold the system together.

Investment in these areas will strengthen the current transformation programme, as well as leaving a legacy for future work.

9 Currently services are delivered through a traditional tiered approach from different providers with different referral processes and access criteria. This results in a confused and fragmented system which bounces children and young people between tiers and allows others to fall between services.

The existing services are under pressure and long waits have developed in parts of the system. This, and the lack of integration, prevents young people from being able to step up and down and this lack of throughput adds to the capacity constraints.

10 The current approach to contracting is siloed and fragmented resulting in inconsistent system responses to service challenges.

The current approach to contracts is historical and transactional which acts as a barrier to collaboration and service transformation.

11 At present there is no clear picture of the total investment the system makes in mental health services for children and young people. Financial contributions are largely driven by history, rather than as the result of a clear strategy, and decisions about future levels of investment are largely taken within organisational silos.

There is no whole system medium term investment plan, and there is considerable distrust within the system about how - and whether - recent funding increases received as part of the LTP have been spent.

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12 At the heart of the local vision for CYPMH services is an integrated delivery model. National NHS policy supports this view, including combining tier 2 and tier 3 services into a single model.

The current Tier 2 contract expires at the end of September 2019. This is not co-terminus with the contract end date for tier 3 services, posing an immediate challenge for further integration. There is also now insufficient time to plan and deliver a move to an integrated model.

In addition, an ambitious plan for integrated children's services is now emerging. The system needs to create a short window to enable decisions about CYPMH to be taken in the context of this broader ambition.

13 The existing workforce feels highly pressurised and in parts undervalued. This is exacerbated by recruitment difficulties to some key specialist posts.

There is no system wide workforce strategy or associated development plan to support service transformation.

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14 There is a strong track record of research relating to children and young people's mental health in Norfolk, often nationally recognized. However, the adoption and spread of innovations and research within the local system is patchy.

Looking ahead towards an integrated model there is a real opportunity to capitalize and nurture this capability – both within clinical services and more broadly across an integrated system. Consciously considering how to nurture and systematize innovation in the new system and models will be a key element of creating sustainable, responsive services over the longer term.

15 *"You know when you're swinging on a chair? That moment where you're not sure if it's about to fall? That's how I feel, all day, every day"* - focus group participant.

Children and young people in Norfolk and Waveney are overwhelmingly contemplating emotional and mental health issues in their daily lives.
They appear resilient on the face of it, but they have a perception that they need to 'deal' with issues themselves – in order to avoid burdening friends and family.

There is a dearth of opportunities for young people to discuss emotional wellbeing and to build resilience and skills and there is little knowledge on how to access support.

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16 Referrers, young people and their families are confused and frustrated by the existing neurodevelopmental and learning disability service offer.

The is no single service across the system with considerable variation between the pathways currently commissioned. The focus is mainly on diagnostics with little or no pre and post diagnostic support.

17 In response to these findings, our key recommendations are:

<u>System working</u>

Refresh system arrangements to strengthen collaboration and support delivery, including: strategy, partnership working, leadership, governance, creation of a single integrated commissioning team, a system approach to performance, increased partnership working with the 3rd sector and an organisational development programme for the system to underpin delivery.

<u>Future service model</u>

Key elements of the proposed future service model include: an integrated tier 2/3 service operational by October 2020, a single point of access for all CYPMH contacts, and a confirmed 0-25 service model.

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Commercial

Disaggregate and separately identify tier 3 and other relevant services within the NSFT block contract and develop an outcomes based approach to commissioning.
In parallel, complete work to confirm current and future funding for CYPMH.
Extend current tier 2 contracts to the end of September 2020 to enable time to plan and deliver the proposed integrated service.

Delivering the future

Develop a workforce strategy to underpin system transformation plans.

Embed innovation and research as core capabilities in the integrated system for CYPMH.

Develop a new approach to insight and engagement to support wider co-production.

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In this report, we have set out our main findings and conclusions based on the work we have done with colleagues from across the system. We have developed and tested recommendations which will, we believe, move the system on. However, we recognise that, taken together, our recommendations represent a formidable agenda.

In order to successfully implement the step change that is required, we think there are four key issues that need to be addressed:

- System 'reset'
- Development of a comprehensive implementation plan
- Cascade and communication of this report
- Resources to deliver

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Context

What we did – method and approach

We were commissioned by partners from across Norfolk and Waveney to review the system-wide approach to transforming mental health services for children and young people (CYP).

Our work encompassed planning, commissioning and provision as well as interfaces with other relevant services, and we have also looked at the experiences of the wider community including children and young people themselves, schools and the 3rd sector.

The catalyst for our work was a shared view that there are significant opportunities to improve the current arrangements, and that existing transformation efforts have been too slow.

As part of our work we conducted interviews and ran focus groups with staff, stakeholders and children and young people, attended a number of key meetings across the system and reviewed a wide range of existing documents and data. The majority of our fieldwork took place between September and November 2018.

Our approach throughout our work has been to take a whole system view, guided by a focus on meeting the needs of children, young people and their families. In our conversations, we have encouraged a stronger focus on prevention, early intervention and building resilience, whilst recognising that there are unwell children that require excellent specialist services.

During our work, we have embedded ourselves within the local system, working in partnership with a wide range of people to identify strengths, weakness and - above all - practical approaches to improvement.

Norfolk & Waveney – a snapshot

The context within which services are planned and delivered is a complex one, spanning five separate Clinical Commissioning Groups (CCGs), two County Councils and a range of other partners, such as NHS England (commissioner of tier 4 – inpatient – services).

There are approximately 190,400 children and young people aged 0-17, and 271,700 aged 0-25. By 2025, this is expected to grow to 204,500 and 278,600 respectively.

At present, the five CCGs spend approximately £19m on mental health services for children aged between 0 and 17, and a further £16.2m on young people aged 18-25. Norfolk County Council (NCC) invests a further £38m in relevant services, spanning the whole 0-25 aged range. Comparable data for Suffolk was not available.

The main provider of tier 2 services is Point 1, a consortium of Ormiston families, Mancroft Advice Project and NSFT.

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This contract is held by NCC and is for approximately £1.9m.

Tier 3 services are provided by NSFT and are embedded within a block contract which spans all mental health services. This contract is which is managed by South Norfolk CCG, and the approximate value of these services is £13m.

In addition, tier 4 (largely inpatient beds) are commissioning by NHS England, and there are also a number of smaller providers (such as Starfish) providing services to some or all parts of the patch.

The main mental health provider across Norfolk and Waveney – NSFT – was inspected by the Care Quality Commission in May 2018 and again in September. Overall, the Trust was rated in both reviews as being 'inadequate', although aspects of children's mental health services were rated more positively, including child and adolescent wards which were judged to be outstanding.

Alongside our work, there is a major review of adult mental health services, which is due to report in December 2018. This review is being conducted by Boston Consulting Group (BCG); we have worked closely with BCG to ensure the two reviews are aligned.

<u>What we found – insight</u>

In all our work, we seek out and listen carefully to the views of the people who know most about how things are at present – children and young people, clinicians / professionals working in the system, and wider stakeholders.

We found that children and young people were happy to be given a platform to talk freely about emotions and mental wellbeing without fear of being judged. Broadly, we found that children and young people in Norfolk and Waveney are contemplating emotional and mental health issues in their daily lives. Although they appear to be incredibly resilient on the face of it, there is a clear tendency to try to "deal" with issues themselves – in order to avoid burdening friends and family. We also found that at present there is a dearth of opportunities for young people to discuss emotional wellbeing and to build emotional literacy and skills, and that there is a lack of awareness of services beyond school and college.

Clinicians and professionals that are delivering services painted a picture that can be summed up in one word – frustration. GPs told us they are exasperated by siloed services, not knowing which service provided what and seeing referrals bounce around the system. Other professional's working in children's services spoke of a lack of integration and inadequate support to universal services. And staff delivering mental health services expressed disappointment at the slow pace of change and the difficulty they experience in getting ideas for improvement accepted and acted on.

Wider stakeholders, especially those in the 3rd sector, told us that they find the current system very hard to engage with, are not clear who is accountable and do not understand how decisions get made.

System working

Vision and strategy

There is a strong vision for the future of mental health services for children and young people that breaks down traditional tiers, focuses on prevention and resilience and is driven by outcomes.

However, this vision is not well understood by partners across the system, and it has not been translated into a clear route map that all organisations own setting out how it will be delivered.

There is an exciting debate underway locally about the potential to further integrate wider children's services and mental health. It will be important to consider this emerging direction as new revised arrangements for CYP mental health are designed and implemented.

There is a compelling vision for the future of mental health services for children and young people in Norfolk and Waveney. This is a strong starting point for working together in future.

This vision commits the system to moving away from the current tiered approach to service delivery, and to embrace the thrive model which takes a much more child centred approach. The vision sets out a series of principles that the system will follow, and describes services as being clustered in four main areas:

- Universal
- Core community mental health (including bringing together tier 2 and 3 services)
- Neuro-developmental pathways
- Inpatient

In each area, the key elements of future services are clearly described.

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System working

However, in our work we have found that this vision is not widely owned and there is not a pan-system delivery or implementation plan that all partners buy into.

It is also notable that the system's strategy - which we would normally expect to play a key role in bridging from the vison to implementation – expired in 2017, and has not been updated or refreshed.

One reason for the lack of progress in implementing the vision seems to have been the emergence during this period of the Local Transformation Plan (LTP). This process, which has been nationally mandated by the NHS, has been a significant distraction for the system, causing a narrowing of the focus on to a small number of issues rather than the job of transformation core CYP mental health services.

<u>Integration with wider children's services</u>

In our discussions, a recurrent theme was the need to think more deeply about how CYP mental health services might in future be more integrated with wider children's services – a model of 'horizontal' integration.

The underpinning rationale for this is twofold. Firstly, there is a consensus that in any future model of care there needs to have a much stronger focus on universal services and (as far as possible) meeting children's needs in that setting, rather than 'pulling' up into specialist services. Secondly, and more pragmatically, there is increasing recognition that there is a high degree of overlap between those children and families that are in receipt of mental health services and those that are known to and involved with other children's services, such as looked after children. This also extends to thinking about the links between CYPMH and other important aspects of the statuary environment, such as safeguarding arrangements

We discussed the potential for a more horizontally integrated system with the STP executive. This was welcomed as a direction of travel, and the Director of Children's Services of Norfolk County Council has agreed to begin development of this vision, setting out in more detail what the model might look like, which services could be further integrated and what the next steps might be.

System working

Whilst this vision of horizontal integration is beyond the scope of this phase of our work, it offers an exciting future for the sector. As a result, in developing our recommendations – which are principally focused on improving the way the system plans and delivers core CYP mental health services – we have been mindful of this wider strategic direction and sought to 'future proof' the proposed new arrangements we set out in this report.

Recommendations

Rapidly update the vision and ensure it is formally signed off by relevant Boards/Committees, and ensure that it is well communicated to the wider system

Develop a revised strategy that builds out from the refreshed CYP mental health services vision, and together with a detailed implementation plan

Secure a clear mandate from relevant Boards/Committees to fully develop the emerging vision of more integrated children's services

Future proof new system models so that they are responsive to the emerging integrated children's services vision

System working

Partnership working

Norfolk and Waveney is a large and complex health and care system. This adds to the challenge of ensuring that there is an integrated, equitable and comprehensive response to meeting the emotional and mental health needs of children and young people.

Meeting this challenge requires partners to have mature, strong and trusting relationships. We found that there is some way to go before these are in place: we observed considerable tension between organisations, a lack of joined-up thinking and a reluctance to surface and address difficult or contentious issues.

Overview

Accountability for ensuring that the mental health needs of children and young people are met is spread across many organisations. No one individual or organisation has sole responsibility.

For this reason, having strong partnership arrangements in place is vital to successfully meeting the needs of children and young people.

In Norfolk and Waveney, we found that at the most senior level progress has been made in developing a collaborative, whole system approach. The STP is well established, has clear governance arrangements in place, an effective executive and a number of shared workstreams, and is now part of a national programme to accelerate development towards becoming an integrated care system (ICS).

We did note, however, that there is no explicit workstream within the STP focusing on children and young people, the result of which is that many of the issues relating to these services do not have a high profile.

However, we found that this very senior commitment to partnership working has yet to cascade down within the constituent organisations. The relationships between partners that have a role in planning and delivering CYPMH services are often strained.

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System working

There are several wider, external factors that contribute to this pattern. This includes the five CCGs' plans to move to a single accountable officer and - over time – one commissioning team. As well as creating uncertainty for many individuals, this is a difficult environment in which to promote long term, outward looking partnership behaviors.

A further factor that makes the development of strong partnership working difficult is the financial pressure facing the whole system. This pressure risks driving organisations back into silos and taking decisions that either are, or are perceived to be, in their own rather than the wider system's interests. Early on in our work we encountered what appeared to be an example of this: several partners expressed considerable disquiet over the County Council's consultation on closing a number of Children's Centres; they questioned whether this had been adequately discussed with partners prior to launch, and feared that, if the proposals were implemented, there could be a number of unforeseen consequences on other services.

Commissioner relationships

Although there are several CYPMH groups that bring partners from across the system together, there is little sense that this is one team with a common, unified purpose.

One source of strain within the system appears to be the recent changes agreed by the STP to the NHS leadership of the wider Children's agenda (and with it CYPMH).

This change has not been welcomed by some members of the wider team, who feel that accountability is now confused, that some CCGs have been marginalised and that their own roles have been diminished.

Commissioner - provider relationships

Relationships between commissioners and providers in the system are very poor, particularly at a middle management level. We heard numerous commissioners describe providers as lacking transparency, being unwilling to change and behaving defensively. Simultaneously, we heard providers describe commissioners as unrealistic, unresponsive and lacking a clear plan.

More widely, we observed a confusion about whether commissioners and providers should be working collaboratively together or not. This is reflected in the current groups that plan CYPMH services: some of these are very clearly commissioner only, whilst others are mixed provider and commissioner groups, even though the topics being discussed were very similar.

System working

Partnership with Suffolk

One of the complexities of the Norfolk and Waveney system is that it spans two county council areas. As a result the Waveney sub-system faces in two directions when it comes to strategic planning: to the Norfolk & Waveney system as it's 'home' STP, and – as a result of being part of Suffolk County Council (SCC) - to the Suffolk and NE Essex STP.

As a consequence, Suffolk County Council are an important partner in planning and delivering CYPMH services across the Norfolk and Waveney STP footprint.

At present, SCC are included in the membership of many of the system's planning groups. This is resource intensive for SCC and we observed that, partly as a consequence of the complex planning architecture (which is set out in more detail below), it has been very difficult for Suffolk to fully engage.

In our view, the current arrangements do not work for children and young people. They do not enable sufficient focus on the services actually being provided, resulting in inconsistent pathways (and on occasion confusion) for people living in Waveney and along the Norfolk/Suffolk border.

Recognising and managing this complexity will require pragmatism as the future arrangements are developed. For example, whilst it is clearly desirable to have consistent models across the whole footprint, this must be balanced by ensuring there is adequate flexibility to accommodate some differences in the way services are organised and in professional practice across the two areas, where there is a good rationale for this.

The key to getting this right, in our view, will be ensuring that SCC are fully involved in the revised governance arrangements set out in this report, as well as in the detailed development of new service models. In this way, it will be possible to ensure that there is as much consistency as possible across the footprint and, where there are justifiable differences, ensuring that these are well understood and effectively communicated.

Recommendations

Formally link the existing CYP Partnership Board to the STP, and make it the key forum for developing and overseeing the STP's Children's work programme

In implementing the revised arrangements for governance and decision making, ensure Suffolk County Council are fully involved, including in the development of new service models

System working

Leadership

Leadership of mental health services for children and young people is fragmented across the system, and individuals frequently lack a clear mandate from their partners.

Clinical leadership in planning and commissioning services is limited. We found a lack of clarity over how the views of professionals are sought, and considerable frustration at a perceived inability to influence service delivery.

Overview

One of the key factors that determines the effectiveness of complex partnership arrangements is the presence (or absence) of consistent, authoritative strategic leadership.

Without it, the shared vision is often lost, progress towards common goals is slow and uneven and individuals often revert to organisational silos.

The role is a complex one requiring a particular set of skills. Among other things, leadership in a partnership context requires the ability to:

- continually reiterate and reinforce the shared vision
- lead through consensus and respect rather than through organisational position
- identify and secure resources from across the system.

Current position

Although there is a consensus among senior leaders on both the importance of CYPMH services and many aspects of the broad vision, in our view leadership of the type outlined above is not yet in place.

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System working

Great Yarmouth and Waveney CCG has taken a lead across the five Norfolk CCGs for Children's Services, but what this means for who does what in CYPMH services has not been fully articulated or defined. One consequence of this is that there is not yet a single individual that is widely accepted across the whole system as the strategic leader for CYPMH services.

In our view this is a significant gap and is one of the main factors contributing to the slow progress in implementing the system's vision for CYPMH services. We have observed a leadership pattern which is highly fragmented, with several individuals leading different aspects (such as contract management, developing the LTP), but no one individual taking responsibility for the whole.

Future position

In our work, we have been considering who at the most senior level may be best placed to fill this gap and take on the key system role of strategic leader for CYPMH. In our view, this role could in future rest with the NCC Director of Children's Services. This is for two main reasons:

- the DCS is accountable for the wider range of Children's Services that are vital to implementing the vision of shifting the focus towards promoting resilience and wellbeing
- the current post holder has the skills and appetite required for the role

System mandate

As the leaders of partnerships lack organisational authority, it is important that any individual that is asked to take on such a role has a clear and explicit mandate that all partners have signed up to.

This mandate is largely missing in the system at present, and this lack of clarity over roles and remits may be contributing to some of the behaviours we have observed in our work, such as the focus on organisational silos and concerns over status and sovereignty and, on occasion mistrust between key partners.

Clinical and Professional Leadership

In our work, we met with a number of senior clinicians and other professionals. We were struck by both the clear and passionate views that many people hold on what needs to change or how improvements to services could be made, but also by a pervading sense of frustration that they did not know how to get involved in or influence 'the process'.

In part, this is a consequence of the complicated planning architecture that is in place at present (details in a separate section of this report). This makes it difficult for even the most committed clinical or professional leader to work out where they might get involved, a problem that is compounded by the lack of a clear forum where the views of clinical and professional leaders from across the system can be sought and responded to.

System working

There are a number of steps that the system could take to strengthen and systematise the involvement of clinical and professional leaders. Two areas that we have discussed in our work – and which attract considerable support – are:

- In designing revised governance arrangements, consider creating a clear forum through which professional and clinical leaders can contribute their views
- Establishing a senior clinical/professional role to strengthen links with the wider constituencies and support the transformation programme.

Recommendations

Develop a role description for the system leader of Children's services, and formally sign this off at the STP Executive

Alongside the above, nominate the current DCS to take on the role of system leader for CYPMH services, and sign this off at the STP Executive

Establish an appropriate forum for seeking and responding to the views of clinical and professional leaders

Establish role description(s) for Clinical/Professional lead(s) for CYPMH Services, and recruit to the role(s)

System working

Governance and decision making

The existing governance and decision making arrangements for children and young people's mental health are complex, bureaucratic and fragmented.

It is unclear where decisions get made, there is duplication across the different groups and there is a lack of accountability.

Overview

Decision making in a partnership context is inevitably complex. A balance needs to be struck between ensuring decision making is clear and streamlined whilst recognising the sovereignty of individual partners. This is not an easy balance to get right.

Similarly, there is a trade off between ensuring that every organisation and stakeholder is directly represented on key groups so that their voice is heard, whilst keeping the number of people involved small enough to be effective.

Current position

As part of our work we have mapped out the key groups that have a role in planning and commissioning CYPMH services, and have discussed how well this architecture operates with people from across the system. We have also attended and observed a number of the main meetings.

We have found a near universal view (which we share) that the current pattern of governance is not fit for purpose and needs significant reform. The existing architecture has grown over time, with new groups being added as issues have arisen and is, as a result, confusing and extremely cluttered.

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System working

The main concerns we have identified are:

- It is not clear where decisions about priorities, investment or services are made
- The boundaries of authority of each group are not defined
- Because there are multiple groups with overlapping remits, there is considerable duplication - but there are also gaps
- There is a lack of accountability in the system, both for individuals and for groups
- Strategic and operational issues are often blurred
- Although there are a plethora of groups, some stakeholders feel that they are excluded from key decisions
- There is confusion about which groups need to be 'commissioner only' and which should include service providers

Future position

In our view, the way in which governance and decision making is organised needs radical change. There are three main elements to the changes we are proposing:

- Stand down a number of existing groups
- Establish a single, core CYPMH Board to act as the principal decision making group for the system
- Embed/locate this Board within a wider network of stakeholders, including children, young people and their families, clinicians and professionals and wider children's services

Standing down existing groups

There is considerable support from across the system for standing down a number of the existing meetings and groups. In our view, the following groups should be discontinued, with some of their functions going into the revised structure outlined in the following section:

- CAMHS Redesign Steering Group
- CAMHS Strategic Partnership
- CAMHS Joint Commissioning Group
- CYP IAPT Partnership

Establishing a core CYPMH Board

Standing down the above groups will create the space to carefully design and implement a new decision making architecture. In our view, the cornerstone of the new arrangement needs to be a single, senior level cross system Board that focuses entirely on CYPMH.

System working

We think this new Board, which needs to be the 'centre of gravity' for all aspects of CYPMH, should:

- Have direct, senior level representation from each main partner
- Be a mixed commissioner/provider forum (adopting, where necessary, a Part A (commissioner only) - Part B (commissioners and providers) format
- Be responsible for service strategy/transformation as well as business as usual
- Act as the executive group for Section 75 agreements
- Have delegated authority to sign off the LTP
- Be accountable for the the financial 'envelope' for CYPMH services
- Be directly accountable to both the Joint Strategic Commissioning Committee and the Children's Services Committee

We envisage this core group acting as if it were the 'Board for CYPMH services', and should as a result have the following membership:

- Chair
- Director/assistant director level representation from each of the five CCGs, NCC and SCC
- A CCG Director of Finance, to both take the the lead for the system on CYPMH and to link into the wider finance network
- A CCG Director of Nursing (or equivalent) to take the lead on CYPMH quality and to link into relevant quality networks
- The senior contract/performance lead for CYPMH services
- Senior representation from each of the main providers of CYPMH services
- A senior representative from public health
- Once appointed, the Clinical Lead for CYPMH services
- Chair/Vice Chair of relevant CYP/family networks
- Chair/Vice Chair of Norfolk CYP Partnership Board

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System working

We envisage the core functions of this Board will include:

- Receive and consider information and data on the current and future mental health needs of CYP and families
- Receive regular insight reports on the views and preferences of CYP and families
- Develop and agree strategic plans for the transformation of CYPMH service and, critically, determine priorities for development
- Collectively agree system commissioning intentions and the annual work plan
- Develop and agree outcome measures and KPIs for relevant services
- Assess the performance of existing contracts, and take action to promote improvement where required*
- Take responsibility for the overall financial envelope for CYPMH services
- If required, develop recommendations to go to CCG Boards/Committee on potential changes to the financial envelope, significant service change or changes to key agreement such as Section 75
- Sign off, on behalf of Boards/Committees, key returns such as updates to the Local Transformation Plan
- Liaison with NHSE on tier 4 services

*Likely to be matters for 'Part A' (commissioner only)

To be effective, this Board needs to have a clear and explicit mandate from each of the partners in the system. We suggest that this should be via a formal framework of delegation that is signed off by each relevant Board/Committee.

In this way, the Board will be empowered to take decisions on behalf of the whole system, the potential right of veto of an individual organisation is reduced and ambiguity over where decisions are taken is removed.

In our view, as a minimum the framework of delegation needs to authorise the Board to:

- take financial and investment decisions, including shifting the pattern of expenditure, within the agreed financial envelope
- Sign off on behalf of the partners all key CYPMH plans and returns, such as the LTP
- Make recommendations on significant service changes or changes to the financial envelopes

We recognise that this core group will have a formidable agenda. It will need to meet at least monthly, and to be effective it will require:

- A senior, independent chair
- A clear annual work plan
- A strong support team

System working

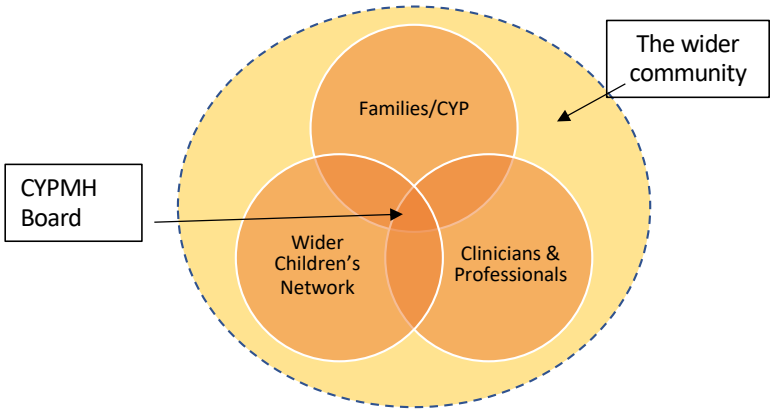
Embedding the core group within a wider network

The Board outlined above needs to be kept small enough so that it can be effective, take decisions and act as the 'brain' for CYPMH. However, it cannot act in isolation: clear links with a range of other services and networks need to be developed.

The approach that we have discussed with stakeholders as part of our work (and which has attracted considerable support) is to locate the core CYPMH group at the centre of three main, overlapping networks:

- Children, young people and families
- Wider children's services
- Clinical and professional groups.

This is set out below:



The strength of this model is flexibility – there is a clear core Board that has overall responsibility, but it has strong links to (and is embedded within) each of the main wider constituencies. A further advantage of this model is that it enables task and finish groups to be established, especially in areas where two or more circles overlap. For example, if work were to be conducted by the children's network to seek the views of CYP, a time limited group could be established with the CYP/families network to determine the key issues and methodology for mental health.

As outlined above, the Board needs to meet monthly in order to maintain pace and fulfil its responsibilities. We suggest that the three wider networks that it sits within meet quarterly.

The networks' core function is to provide a clear channel through which each stakeholder group can influence the development of CYPMH services. They will also act as a source of expert advice on CYPMH; sometimes this will be reactive, being used as a sounding board for proposals, while on other occasions it will be proactive, shaping and leading aspects of the CYPMH agenda.

There are some existing meetings/fora that fulfil aspects of the three groups' role. For example, both the existing Children's Integrated Commissioning Group and the Norfolk CYP Partnership Board fulfil aspects of the role of the wider children's network.

Recommendations

Stand down the following groups:
- CAMHS Redesign Steering Group
- CAMHS Strategic Partnership
- CAMHS Joint Commissioning Group
- CYP IAPT Partnership

Establish the core CYPMH Board, ensuring it includes appropriate clinical and professional representation

Develop a framework of delegation for the core CYPMH Board which clearly sets out the boundaries of the Partnership Group's authority, and ensure this is signed off by relevant Boards/Committees

Establish the following wider CYPMH networks:
- CYP and families
- Clinical and Professional
- Wider Children's Network

RETHINK PARTNERS

System working

Integrated commissioning team

Resources to support the planning and commissioning of mental health services for children and young people are fragmented across the system.

Leadership of this agenda is also fragmented: at present no one individual has the explicit role or mandate to bring together the full range of skills required to commission effectively or to act as the focus point for this service area.

Current position

To plan and commission a complex set of services such as CYPMH, a wide range of skills are required. These include:

- Quality
- Business intelligence
- Finance
- Strategy
- Clinical/professional/subject matter expertise
- Contracting
- Programme/project management

In our work, we were struck by the fact that although many of these skills exist in the Norfolk & Waveney system, they are widely distributed across a number of organisations. There is no single team tasked with planning and commissioning CYPMH services.

RETHINK PARTNERS

System working

For example, the integrated commissioning team is hosted by Norfolk County Council, but the main contract (with NSFT) is managed by South Norfolk CCG. Business Intelligence (which is a vital function) is provided externally by the CSU. Redesign capacity exists in several small pockets, including in the County Council's central children's team.

A further weakness in the current arrangements is that only a small number of individuals have a primary focus on CYP mental health; many of the people working in the functions outlined above are spread across a number of service areas, diluting the expertise that is available.

One consequence of commissioning skills and expertise being fragmented across the system is that where overall leadership of the team comes from is unclear. This has a number of disadvantages, including making it extremely difficult for stakeholders to know who to approach to discuss issues or raise concerns.

In our view, in future the Norfolk and Waveney system needs to address these issues by forming a single, integrated team that focuses on CYP mental health. This team should bring together skills that currently rest in CCGs, the County Council and the CSU, and the team should be responsible for all aspects of planning, commissioning and contracting for mental health services for CYP.

This team should encompass all of the functions outlined above, and (if practical) should be co-located.

In addition, this integrated team needs leadership. A senior role is required to lead the integrated team, have an overview of all the issues and to be a clear point of contact for all stakeholders.

Finally, one aspect we would encourage the system to think about is seconding individuals between provider and commissioner organisations. This would help to foster the 'one system' approach that all partners are signed up to, as well as reducing duplication and making best use of scarce skills.

RETHINK PARTNERS

Recommendations

Establish a single, integrated NHS/NCC CYPMH commissioning team, ensuring it encompasses all of the key functions and (if practical) co-locate the team.

Remove duplication in the system by ensuring there is a single, consolidated function that spans providers and commissioners for all key areas (e.g. business intelligence)

Ensure that there is a single senior leader for the integrated CYPMH team accountable to the children's service system leader

Enable and encourage secondments between commissioning and provider organisations for key functions such as business intelligence

System working

System approach to performance

There is a focus on achieving high levels of performance against a small number of national metrics, which tends to mask significant pressures and challenges in existing services and risks distracting attention from local service improvement.

The types and breadth of data currently collected is inconsistent and fragmented and, as a result, there is no single system narrative that clearly sets out how services are performing.

At present, a range of data is collected across the system on how well mental health services for children and young people are performing. The national metrics, taken in isolation, would suggest a system that is performing well, for example:

- 55% achievement against a national access target of 35% (best in the region)
- NSFT Referral to Treatment (RTT) standard is currently 12 weeks, compared to national RTT of 18 weeks
- Within NSFT, 98.6% of under 18s are treated within the 12 week standard
- Early Intervention in Psychosis (EIP) – first treatment within 14 days is 68.2%, against a target of 53%
- 100% of urgent referrals to the eating disorders service receive treatment within 1 week

However, the existing data is masking many of the true system challenges that we have outlined in this report. We have heard from both commissioners and providers that there are significant hidden waits across services, that key services are lacking in capacity, that there are recruitment difficulties and that throughput is a significant problem. Despite these challenges, we have also heard that there is a drive to further improve on the narrow national metrics without any formal process to consider the impact of such decisions.

RETHINK PARTNERS

System working

An example of this is the Referral to Assessment (RTA) target of 95% of children to be assessed within 28 days that is currently within the NSFT contract – not only is this target not being met, it appears to have frontloaded resources at the expense of service delivery and is causing waiting times to increase further along the pathway. Similarly, clinical leaders and commissioners have raised concerns with us over a proposal to increase access rates to 65%, even though there is little or no evidence base behind it.

In our view, parts of the system have become distracted with demonstrating excellent performance against a narrow range of metrics. This may be to the detriment of local creativity and improving outcomes for children and young people with mental health needs.

As we outlined above, currently there is no single forum that is accountable for mental health services for CYPMH. As a result, no single body holds the complete narrative, and and no part of the system is aware of the whole picture. In short, there is no 'single version of the truth', and there is no comprehensive, balanced report that enables leaders across Norfolk and Waveney to gauge the true performance of these services.

Recommendations

Develop a single dashboard for mental health services for children and young people that links performance, quality, finance and insight. Specifically, this dashboard must include profiled and total waiting list management to give transparency to waits along the complete pathway.

Develop a concise report that give senior leaders and Boards a clear picture of the overall performance of CYP mental health services

System working

Community capacity

Norfolk and Waveney have a rich and distributed network of 3rd sector organisations supporting the emotional well-being and mental health of children and young people, and providing invaluable support to parents, families, and carers.

There is an opportunity to expand and generate more value and impact from this sector through creating a clearer approach and process for involvement; to move beyond commissioned service or grant funding relationships into a true partnership model with the sector and leading organisations within it.

This approach would also bridge into true community action / community led approaches to emotional resilience and supporting those with mental health conditions.

Current position

Norfolk and Waveney have a rich and distributed network of 3rd sector organisations supporting the emotional well-being and mental health of children and young people, and providing invaluable support to parents, families and carers. This includes:

- Organisations specifically concerned with CYPMH
- Organisations supporting children and young people more broadly but including emotional well-being support
- Organisations concerned with specific conditions – either mental health or conditions which are connected with mental health issues such as ASD, ADD, ADHD
- Organisations supporting families or carers – including young carers
- Organisations providing support for professionals e.g. in schools
- At the outer tier organisations providing activities or input for children and young people (e.g. music, sport) but where there are known benefits to mental health.

Existing engagement and relationships with the sector are good in parts, but there is an opportunity to strengthen the model and do more.

RETHINK PARTNERS

System working

Tier 2 service provision for example includes a partnership between 2 local 3rd sector organisations and NSFT. Whilst there have been some challenges with this contract on both sides, there has been good learning for both commissioners and the 3rd sector providers about the differences and adjustments that this type of commissioning relationship entails.

More broadly funding arrangements tend to follow the more traditional grant funding model. NCC has made some progress with the sector in recent years but NHS arrangements continue to be fragmented and short term, and it is often unclear to the sector how to engage or who has responsibility.

3rd sector organisations do attend and participate in various parts of the current system governance architecture, but their specific role is often unclear.

We saw some evidence of true grass roots activity as part of our insight work with schools; there is more that could be achieved with a more targeted approach to communities building on transferable models from elsewhere e.g. Dementia Friends / Dementia Action Alliances, Mental health first aid training etc.

<u>Future position</u>

We have found a strong willingness and appetite from the sector to engage as mature partners with statutory bodies across a range of issues; not just in pursuit of funding. For some of the larger organisations locally this is already in place; there is a challenge to statutory bodies about how a more inclusive approach could be achieved that allows smaller, less-resourced organisations also to be involved.

There are some good local leaders in this sector who are stepping up to provide useful contributions and challenge in the system. Whilst not universally true, 3rd sector organisations often have a stronger connection to the people and communities they serve; this can be a useful network for statutory bodies to tap into particularly when seeking to co-produce work / services.

In addition to the more generic system characteristics that create the conditions for good collaboration, there are some specific elements in place in systems where there are strong and functional statutory / 3rd sector relationships. These include:

- A framework or agreement for partnership activity - jointly developed and produced - with shared aims, mutual expectations and accountabilities set out between the sectors; and that the framework is actively discussed and adhered to within the system.

System working

- Longer term funding agreements – usually 3 years – with oversight and monitoring proportionate to the size of the delivery organisation and the funding agreement / service. So not one size fits all.
- Integrated funding model between health and social care; single process, shared priorities, single application, single monitoring.
- Often a single representative body / single infrastructure organisation to provide an effective conduit between statutory bodies and the wider sector. This is not an intrusive or exclusive body that stands between organisations, but does give statutory partners a mechanism for discussion and input on issues that effect the sector as a whole.

In its most local form, the 3rd sector drifts beyond organisations and into community action / social movement territory and true grass roots self–organised activities. This includes faith groups, community groups and local citizens passionate and motivated by a cause or an issue – or just wanting to make their local community a better place. This is tricky territory for statutory organisations to navigate and galvanise, is often under the radar, and by its very nature will be unregulated. However, this is also fertile territory for truly local capacity building, engagement, campaigning and support for those living with mental health conditions or experiencing emotional distress. It is also a place where stigma can be confronted.

Recommendations

Develop an integrated third sector funding model between health and social care for children and young people to achieve:
- 3 year funding contracts
- single application and oversight process

Secure involvement of the third sector throughout revised system governance and within a co-production model; create the right conditions in which a range of 3rd sector organisations can participate.

Jointly develop a programme to stimulate grass roots community action on mental health and emotional resilience.

Develop a partnership strategy with the sector setting expectations and accountability for joint working

RETHINK PARTNERS

System working

System development

There are a number of common threads in this report which centre on how individuals and organisations operate when coming together to collaborate effectively.

Whilst progress will be made by implementing specific changes, there is a need to pay attention to the softer, more human side of system interactions, including consideration of behaviours, expectations and leadership capability. Developing the conditions in which collaboration becomes the norm will be vital; this is the glue which will hold the system together.

Investment in these areas will strengthen the current transformation programme, as well as leaving a legacy for future work.

Overview

There is increasingly good evidence from both the NHS and other public sector bodies –such as the Leadership Centre, the NHS Leadership Academy, and the Staff College – about the conditions needed for effective collaborative working to thrive and to drive service transformation. Much of this work is drawn from and grounded in the lived experience of systems working together to tackle some of their most complex issues.

Aligning ambition and delivery with a purposeful organisational development programme can make the real difference between successful, impactful transformation that sustains and a more transactional, short-lived set of changes.

There is some good local emerging work in Norfolk already nudging towards this need. A local programme of "systemic conversations" between leaders on CYPMH has already started to develop local capability. This is a strong start from which to build out and include others.

Alongside a wider, more inclusive system development programme there are some specific changes proposed within the report which need some specific organisational development support. These include changes to the commissioning arrangements, leadership capability building, and bringing the new governance model to life.

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Recommendations

Design and implement an organisational development programme for the children's system in support of collaborative working to underpin the other changes proposed in this report.

In addition to a wider OD programme for the children's system, include a specific focus on:

- OD for the newly formed integrated commissioning team
- The new governance model
- CYPMH leaders including clinical, professional, managerial and 3rd sector leaders

Future service model

Currently services are delivered through a traditional tiered approach from different providers with different referral processes and access criteria. This results in a confused and fragmented system which bounces children and young people between tiers and allows others to fall between services.

The existing services are under pressure and long waits have developed in parts of the system. This and the lack of integration prevents young people from being able to step up and down and this lack of throughput adds to the capacity constraints.

Overview

The current service model is commissioned and delivered through a traditional tiered approach. Tier 2 or targeted services are delivered through the Point 1 contract and tier 3 services are delivered as part of the overarching block contract with NSFT. There are major demand and capacity pressures within the system with both service tiers pressurised. Providers are struggling with throughput as children and young people cannot be stepped up or down between services. Professionals within tier 2 describe holding more complex cases than their contract specifies due to the limited ability to 'step up'. Conversely professionals in tier 3 describe that they are having to hold on to cases because they are unable to 'step down'.

Both tiers have described to us that the system has in effect created a 'tier 2.5'. Whilst this may be appropriate it is not explicitly commissioned nor is it detailed in any existing pathway. It is likely to be a response to a siloed service offer which results in children and young people not always being supported in the best place and at the right time to meet their needs.

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Future service model

This lack of integration across pathways is also coupled with separate referral processes and access criteria between providers. Referral routes are not transparent nor streamlined. This opacity promotes a system where children and young people often 'bounce' around the system and can fall between service gaps or fail to be eligible for any existing commissioned service.

The Way Forward

As previously outlined, a strong vision for children and young people's mental health and emotional wellbeing across Norfolk and Waveney already exists. The vision clearly articulates the case for change and the principles and key elements of a future service model. In our view, this vision is still relevant and fit for purpose. Based on our conversations there seems to be a high degree of alignment with the direction set out in the vision and, as such, it could be the ideal springboard for system transformation.

It is essential that the system takes a phased approach to ensure successful and sustainable service transformation. The scope of services to be included needs to be agreed at the outset. We recommend that the system clarifies the age range to be considered as in scope, the services and the referral pathways to be included.

Age Range

We have been impressed by the work the system has completed looking to change the age range for core services to 0 – 25. The system is recognised as being at the leading edge of such thinking including by national colleagues.

However this shift in policy needs to be clearly and explicitly agreed by the system, together with a clear view about which pathways/ services are exceptions and which will have a more restrictive age range or are all age.

Immediate examples of this are Early Intervention in Psychosis, Neurodevelopmental Disorders and Eating Disorders.

Where there is consensus that a pathway should not be 0 – 25 it will be vital for the system to clarify where the responsibility and accountability for this service area lies. In addition there are considerable implications in moving towards a 0 – 25 service across all tiers, including workforce impact, activity impact and additional demand, data monitoring and IM&T issues, contractual issues and the potential impact on other service areas. All of these will need careful consideration as part of the decision making process.

Future service model

Single Front Door

The existing vision for Norfolk and Waveney children and young people's mental health and emotional wellbeing includes the principles of 'no wrong door' into services, no gaps to stop young people falling between services and system ownership of the person in need. The vision is clear that a core element of the future service should be easy access via a single phone number, website with an initial screening/assessment for all those with mental health needs – in other words, a single front door.

The existing transformation programme has already considered the development of a single point of contact (SPOC) and a draft service specification has been developed. The system has shown its commitment to this and a working group has been established to plan the service model and develop an implementation plan.

In our view, developing and implementing the single front door is a priority, and one that needs to be brought into the new governance structures outlined above (and not a stand alone workstream).

We think it is important that the working group considers how to;

- achieve a consistent and standardised approach to screening
- streamline the referral process and improve access to services
- ensure there is appropriate alignment with other routes into children's services, such as the MASH and the Children Advice and Duty Service
- ensure rapid screening by a mental health professional, reduce admin processes and hand offs within the referral pathway
- link with Early Help services.

We acknowledge that establishing a successful SPOC is challenging. There are the immediate challenges of developing an effective operating model within a complex provider landscape but also the SPOC can only be as effective as the services that surround it.

As a result, in our view it would be sensible to take a phased approach to implementation aligned to other priority workstreams. Phasing should be considered for access and acceptability criteria, response times and prioritisation and operating hours.

Future service model

Integrating Tiers 2 and 3

A particular challenge in large and complex transformation programmes is knowing where to start. There are always competing priorities, but it is not possible to progress everything at the same time. Based on our conversations, our view is that the system should initially focus its transformation efforts on tiers two and three. This is because they are 'core' CYPMH services, there is a large degree of consensus over what needs to change and the imminent expiry of contracts makes this an urgent issue.

In our view, the system needs to collapse the current tiered model and develop a single service offer through integrated pathways. Integration should ensure that the most appropriate professional is available as quickly as possible to support the needs of a child or young person.

The needs of children and young people can and will change over time and interventions should be flexible and adaptable to respond to these changes. An integrated service should support minimal hand offs, minimise gateways between services and support children and young people to move freely between services as needed.

An integrated service will improve collaboration between professionals and agencies. Benefits should include better support to families and carers when complex needs extend beyond the child or young person and easier and more equitable access for children and young people to receive the least intrusive and intensive level of support to meet their needs.

Tier 4

There is currently a separate process, led by NHS England, seeking to redesign tier 4 services. Given the likely wider geographical footprint of this work, the Norfolk and Waveney system will need to engage with this programme but is unlikely to lead it.

Recommendations

Ensure relevant Boards/Committees sign off an age range of 0 – 25 for core services, with clearly specified exceptions.

Clarify the age range for services that are an exception to 0-25 (such as EIP, ED and NDD), and agree where accountability lies

Ensure partner organisations agree that core CYP MH services (tiers 2 and 3) are the initial priority for the transformation programme

Engage with the Tier 4 redesign programme being led by NHS England as part of the New Models of Care Programme

Design the operating model for a SPOC as a system priority

Formalise the governance of the SPOC working group, ensuring it reports to the CYPMH Board

Develop a phased implementation plan aligned to other workstreams (e.g. demand and capacity reviews)

Establish a time limited task and finish group to redesign pathways and remove the artificial separation between tiers 2 and 3, ensuring that this group has strong input from children and young people as well as clinicians/professionals

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Contracting

The current approach to contracting is siloed and fragmented resulting in inconsistent system responses to service challenges.

The current approach to contracts is historical and transactional which acts as a barrier to collaboration and service transformation.

Current position

The current approach to contracting is fragmented and disconnected. There are disconnects of contract management within a single contract (for example the separation of quality and performance monitoring for NSFT) and disconnects between contracting approaches - particularly the differences between the Point 1 contract and the NSFT contract for tier 3.

The existing tier 2 and tier 3 providers are managed under different contracts with different contract management arrangements and lead agencies. This has resulted in a siloed approach to contracting. It has also resulted in an inconsistent approach to contracting. The Point 1 contract for example is monitored through an extensive list of performance indicators whilst the CYP mental health element of the NSFT contract has a very limited set of key performance indicators.

A further consequence of these differential arrangements is an inconsistent system response to service challenges such as waiting times.

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The tier 3 contract with NSFT is part of an overall block contract set on an historical basis and simply rolled forward. At no stage has the contract been 'reset' to align with revised policy, national changes to CYP mental health reporting, the introduction of Local Transformation Plans or service redesign.

The point 1 contract was reviewed at the time the contract was extended but adjustments were incremental rather than transformational and did not address service pressures in a whole system way.

The commissioners and providers we spoke to almost all recognised the importance of moving towards outcome based contracting. However, we also found that this approach is not yet fully understood or embedded. The point 1 contract routinely reports on outcome measures and the NSFT contract includes the development of outcomes in its service development and improvement plan. However, these are not yet used to inform standards for monitoring, development of improvement trajectories.

Future position

In our view the existing contracts act as barriers to change. They are historical rather than forward looking and are transactional rather than developmental. There is also a perception that they are used as a 'wall' to protect commissioners from potential cost pressure or redistribution of resource decisions.

The counter side is that we found providers to be unwilling to share information that they are not contractually obligated to provide for fear of contractual penalties or reputation damage.

We believe that if the system is to progress, the way in which contracts for mental health services for children and young people needs to change. Specifically, we think that the NSFT contract needs to be disaggregated from the main block contract so that there can be a specific focus on children's services, and integrated contract management – encompassing all aspects of performance, quality and finance – needs to be introduced. Finally, we think it is vital that the same contract team are involved in all the reviews so that interdependencies between contracts are understood, and interface issues addressed.

As transformation plans crystallise there will be contractual implications not just for CYP mental health but also for other contracts with universal services and adult services. It will therefore be important to consider the impact on other service areas when changing the CYPMH contracting landscape.

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Recommendations

Disaggregate the overall NSFT block contract and move to a separate contract for CYPMH, with work commencing as part of the SDIP in Q1 with a shadow separate schedule in place for Q3 and Q4.

Undertake a demand and capacity review by the end of Q2 latest

Establish separate and dedicated contract monitoring for all CYP mental health services, encompassing performance, quality and finance

Ensure consistency of representation from commissioners at all CYP mental health contract meetings to allow interdependencies and interface issues to be addressed

Where contracts include existing outcome measures, in 2019/20 jointly develop improvement trajectories

Including a clear timeline in the NSFT contract (SDIP) to develop and roll out the existing work on outcome measures (POD)

Over time, develop and move to a system wide set of outcomes informed by national and local developments

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Finance

At present there is no clear picture of the total investment the system makes in mental health services for children and young people. Financial contributions are largely driven by history, rather than as the result of a clear strategy, and decisions about future levels of investment are largely taken within organisational silos.

There is no whole system medium term investment plan, and there is considerable distrust within the system about how - and whether - recent funding increases received as part of the LTP have been spent.

<u>Current position</u>

Having clarity and transparency over current levels of investment in services, together with a clear and shared forward financial plan, are essential features of effective planning and commissioning.

At present, neither of these elements is in place for CYP mental health services in the Norfolk and Waveney system. Although there is good cross-system work underway to try and clarify the existing pattern of expenditure by organisation (and by age band), there is currently no clear overview of the total 'envelope' that is spent on services and therefore available for investment.

There are several reasons for this:

- Current investment levels largely reflect historic patterns which, in the case of CCGs, were inherited from predecessor organisations and have not been refreshed
- The existing NSFT contract is a single block that does not separate investment by service line
- Services span a number of different age ranges, making the total CYP picture difficult to assemble

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It is also striking that at present each organisation takes decisions about the level of investment it makes in mental health services for CYP in isolation – it is not part of a wider system discussion. This inevitably results in differences in investment levels, as well as causing tensions between partners.

In addition to operating largely in silos when it comes to financial planning, at present almost all organisations take a short term (single year) approach to financial planning. This compromising the system's ability to develop and implement strategic plans – all of which need to be backed up by a sound multi-year financial framework if they are to be credible.

LTP Investment

The national LTP programme has resulted in additional investment across the country, including in Norfolk and Waveney.

Whilst this is welcome, we observed that it has also caused tensions locally. In particular, there is a clear perception that not all of the additional funds that were allocated for CYP mental health services were actually released, with some organisations holding funding back to offset wider financial pressures. There is a lack of transparency over this issue, causing considerable mistrust and some resentment across the system.

Section 75

Section 75 agreements are particularly useful where a number of partners need to come together to jointly plan and fund services – such as mental health services for children and young people.

Given this, we were surprised to note that the current scope and value of the Section 75 is very small £2.1m.

The existing scope is limited to the Point One contract (tier 2) as well as funding a small number of posts.

Approach to savings

Almost all of the organisations in Norfolk and Waveney are under considerable financial pressure and as a result need to produce detailed plans showing how savings will be achieved.

In our work, we observed that at present plans for future savings tend to be developed within individual organisations, and do not appear to be fully discussed or shared with partners before they are finalised.

An example of this came early on in our work, when the County Council began a major consultation which included proposals to close a large number of children's centres. We heard from a number of organisations that (in their view) they had not been fully involved in developing these proposals and, in several cases, had significant concerns about the possible knock on impact of the proposals on other services.

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Future position

In our view, determining and agreeing the current level of investment in mental health services for CYP is a priority for the system. Without this clear baseline, is will be very difficult to make meaningful progress in developing a clear strategic plan, ensuring funding is focused on the right areas or in deciding between competing priorities.

With this foundation in place, we think the next step needs to be for the system to – together – develop a multi-year investment plan for CYP mental health services. We suggest that this should cover at least three years, but could extend to five. The five CCGs are about to receive notification of their allocations for the period 2019/20 to 2025/26, so there is a clear opportunity to adopt such an approach.

Partners from across the system should also agree a clear process for making changes to the level of investment in CYP mental health services. This will be important to promote financial transparency across the system.

Over time, we would expect the value of the Section 75 to grow significantly, with virtually all relevant services included within it. This will reinforce the 'one system' approach to planning and providing mental health services for CYP.

Recommendations

Establish the existing level of investment in mental health services for CYP, by organisation [aligned with age]

Develop and sign off a transparent multi-year investment strategy, and codify the process for future variation

Over time, expand the scope of the Section 75 agreement (or similar) to cover all relevant services and teams

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Sourcing integrated provision

At the heart of the local vision for CYPMH services is an integrated delivery model. National NHS policy supports this view, including combining tier 2 and tier 3 services into a single model.

The current Tier 2 contract expires at the end of September 2019. This is not co-terminus with the contract end date for tier 3 services, posing an immediate challenge for further integration. There is also now insufficient time to plan and deliver a move to an integrated model.

In addition, an ambitious plan for integrated children's services is now emerging. The system needs to create a short window to enable decisions about CYPMH to be taken in the context of this broader ambition.

<u>Overview</u>

At the core of the local vision for CYPMH services for Norfolk and Waveney is an integrated delivery model. National NHS policy supports this approach, including combining tier 2 and tier 3 services into a single model to enable the right conditions for early intervention, continuity of care and a much more person-centred approach to care delivery.

This integrated service then forms the centrepiece of an end to end approach to emotional well-being and mental health services for children and young people. Over time strong connections into universal services can be developed to enable prevention, resilience building and local support to be developed; whilst also reaching up into tier 4 to ensure the most unwell children receive good quality care as locally as possible. The current vision endorses the THRIVE model to care planning and delivery which has been successfully developed elsewhere; delivery of this approach requires a single tier 2/3 model.

Whilst there are a range of models and processes through which an integrated solution can be developed, in our view the optimal approach will simplify and consolidate local provision. Reducing the number of interfaces between providers will, we believe, have real benefits for children and young people as well as for staff. This includes improvements in outcomes, continuity of care,

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data sharing and is also likely to enable efficiencies to be released. It also supports the desired strategic shift towards early intervention and prevention; a single / integrated provider managing within an agreed financial envelope over time will have the right motivation and incentives to invest in this approach and reduce demand for higher end, more expensive services. Return on investment in early intervention is generally not realised until years 3 to 5 of a contracting cycle; sustained shift in outcomes at a population level will take even longer.

A single tier 2 / tier 3 service

With current tier 2 contracts expiring at the end of September 2019 there is now insufficient time to plan and deliver an integrated delivery model – regardless of the chosen procurement / sourcing creation route. In our view we believe commissioners should extend the current tier 2 contract until September 2020.

Whilst the current NSFT contract cycle ends in April 2020, custom and practice in the NHS has generally been to roll over the large acute mental health contracts.

Our experience is that 15 months is not sufficient time to fully plan a new model of care and deliver a change of this scale. At the back end of any process, most providers will require a 6 month mobilization period before starting a new contract, meaning the true time available is only about 9 months.

At the front end further clarity and detail is required on the proposed process, scope of services, financial envelope and disaggregation of services from current contracts.

The process itself may take a number of paths and time spent on different stages will vary; but in general terms most programmes of this type will require a 12 month delivery window.

The outline timeline to developing a single tier 2/3 service is therefore:

- Jan to Mar 2019: strategy, scope, sourcing options appraisal and planning
- Apr 2019: decision about sourcing option and approach
- May 2019 to Mar 2020: sourcing process leading to contract award
- Apr 2020 to Sept 2020: service mobilization
- Oct 2020: new integrated service commences

Tier 2 context

There have been a number of issues and concerns regarding tier 2 services in recent months, including a mismatch between demand and capacity leading to long (and initially undisclosed) waiting times. Recovery and support plans are now in place through stronger commissioning arrangements and waiting times are reducing.

Commercial

Whilst this has caused concern and attracted attention in the wider system, it is clear that:

- children and young people receiving the service continue to achieve good outcomes
- the providers are continuing to treat more people than they are contracted to see

The current oversight and support arrangements have given greater visibility to profiled waiting times for assessment and treatment.

In extending the current contract an open discussion and agreement needs to take place at a senior level between commissioners and providers about capacity, demand, funding and affordability to establish the right conditions for the service to thrive during the proposed extension period.

Tier 3 context

The most recent CQC report (published in November 2018) concluded that specialist community mental health services for CYP are inadequate, which is a deterioration from the CQC's previous rating.

We found strong support in our discussions with stakeholders throughout the system for sustaining the current services, but potentially in new, more integrated arrnagements.

This was driven by three factors. Firstly, a recognition of both the likely benefits of an integrated tier 2 / 3 model. Secondly, a concern that the distraction of recovery for adult services could adversely impact on CYPMH. And, thirdly, a perception that CYPMH does not receive an equal level of internal support and leadership attention as other NSFT services. This last factor is not unique to NSFT but is often the culture in specialist mental health trusts in which adult services often dominate the agenda.

Disaggregation of tier 3 CYPMH from the overall NSFT contract has a number of strategic interdependencies that need to be considered including:

- Sustainability of adult services on a stand alone basis
- Cross subsidy / all age services within NSFT
- Consultation and co-ordination with Suffolk commissioners and their strategy

Creating breathing space for longer term integration

As outlined above, a wider vision for more ambitious integrated children's services in Norfolk and Waveney is emerging; the scope of this is under discussion but yet to be agreed and thinking is still at an early stage.

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Nationally, whilst the NHS is advocating a move towards Integrated Care Systems (ICS), and there are national exemplars of new models of care and new integrated contracting and service delivery models, there remain a number of unanswered questions about legal form and best practice commissioning models to support integration. It is expected that some of these issues will be clarified in the first half of 2019 as the NHS 10 year plan is published.

Locally, the Norfolk and Waveney STP is on a fast track route towards becoming a next wave ICS and the strategic commitment to integration is clear. However, the detailed operating model(s) to underpin this ambition are not yet articulated.

There is therefore an expectation that there will be greater clarity on the local appetite for wider children's integration during the first part of 2019. There remain a number of flexibilities and options within local authority powers that are also potentially pertinent to creating a more integrated delivery model.

Whilst there is a need to maintain momentum and focus on moving towards an integrated CYPMH service, in our view it would be helpful to progress the strategy, scope and planning for a wider children's model in parallel with planning and delivering the CYPMH programme. This is both in order to future proof CYPMH services for the longer term and to enable consideration of whether the CYPMH process can be flexed or extended to deliver a wider service scope within existing agreed timescales.

Equally, it is vital that the system does not lose focus or momentum on CYPMH integration and transformation in pursuit of a more ambitious – but lengthier – children's integration option.

<u>Future delivery options and paths towards this future</u>

Whilst the emerging ambition for a much more integrated approach to children's services is compelling and exciting, the ultimate end state / delivery vehicle and the path to achieve this end is not straightforward. This is explored more fully in appendix 5.

Commercial

Key factors to consider include:

- Scope of services: minimum service scope tier 2 / 3
- Fit with longer term strategy
- Desired level of integration
- Options for end state form: single provider or a looser integrated partnership model with variants between these 2 extremes
- Range of options for process
- Legal and regulatory context
- Local context: strength of case for change and extent of transformation needed, risk appetite, political conditions, clinical leadership and workforce engagement.

<u>Key conditions</u>

We would advocate that any new model is underpinned by a long term contract; 10 years (7 + 3) is generally the longest contract NHS regulators will currently approve.

Whilst supporting a shift in investment and workforce towards an early intervention and resilience building model, we would also advocate for a strong clinical focus on specialist CYPMH; there will always be children and young people who have serious mental health conditions and who require specialist treatment. This needs to be underpinned sustainably (financially, contractually) in any future model.

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Recommendations

Extend the current tier 2 contracts by 12 months to end September 2020 through:

- Senior level discussion between commissioners and the current provider to confirm the benefits and conditions needed to agree the extension – by the end of December 2018
- Formal approval through relevant NCC / CCG governance processes – by the end of January 2019

Plan and deliver the sourcing process for an integrated tier 2 / 3 service to commence September 2020, encompassing:

- Task and finish group to establish sourcing options – Jan to Mar 2019
- Decision on forward pathway and resources to support delivery - April 2019 governance
- Delivery of above from April 2019 onwards (detailed programme and milestones dependent on selected sourcing model).
- Integrated service mobilisation period – April to September 2020
- Integrated service commencement underpinned by appropriate integrated contracting model: October 2020

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Delivering the future

Workforce

The existing workforce feels highly pressurised and in parts undervalued. This is exacerbated by recruitment difficulties to some key specialist posts.

There is no system wide workforce strategy or associated development plan to support service transformation.

Current position

Future in Mind, which was published in 2015 recognised the importance of developing the workforce and set out the following:

The national vision is for everyone who works with children, young people and their families to be;

- ambitious for every child and young person to achieve goals that are meaningful and achievable for them
- excellent in their practice and able to deliver the best evidenced care
- committed to partnership and integrated working with children, young people, families and their fellow professionals
- respected and valued as professionals.

In our work, we found that professionals within targeted and specialised CYPMH services feel increasingly pressurised with rising workloads and increases in the range of responsibilities to be delivered. We also found that some staff are feeling undervalued as a consequence of contractual actions taken due to the system's demand and capacity issues.

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Delivering the future

We were also told that there are long-standing difficulties in recruiting to specialised posts. As Norfolk tends to be a somewhat closed system there is movement between agencies rather than bringing in additional capacity and capability from outside the system. Examples we heard about include therapists moving between NSFT and Point 1 and business intelligence expertise moving from NSFT to NCC. Recruitment is further challenged due to the way in which some national programmes are constructed.

Future position – developing the whole workforce

Successfully implementing transformation will require the system to change the way that the workforce behaves and in some cases what it does. A system wide approach to workforce planning will be necessary and the development of a clear workforce strategy is essential to support this.

We think that this should be established as a key component of the system redesign process and undertaken in an holistic, rather than on a service by service or discipline by discipline, basis. This approach should help minimise the "all fishing in the same pond" challenge and reduce the risk of the same groups of staff moving into the same type of post elsewhere in the system.

In developing the strategy the system should consider:

- skills and gaps analysis
- succession planning
- recruitment and retention plans
- process reviews to understand duplication, gaps, hand-offs etc
- support, training and development of workforce e.g. building in-system training solutions rather than exporting cohorts of staff to out of area based programmes with costly back fill or pauses to service delivery.
- Better use of technology
- Opportunities for agile working

In addition, we think the system can improve the way in which staff are engaged, ensuring that they have a voice and can contribute to service improvement. Experience suggests that the frontline workforce know the children's and young peoples community best and are as a result best placed to know where things can be done differently.

Delivering the future

We suggest the establishment of a staff forum that links into the governance arrangements outlined above and which operates system wide to encourage new ideas and creativity, helps support the change management process and ensures that all staff have the opportunity to get real time information about the redesign from system leaders.

In our work we have been struck by the genuine commitment within the system to move towards an early intervention and prevention focus at the front end of the new service model. To make this successful, all parts of the system need to own the principle that mental health and emotional wellbeing is everybody's business and not the sole remit of dedicated mental health services. This requires a consistent support programme to build resilience and confidence in general services for children and young people.

Such a support programme should include building knowledge and confidence with a wide range of professionals. Professional should be able to identify early signs of mental health issues presenting in young people, how they might be able to support them and also have a better understanding of the role of specialised and targeted services and when and how to refer.

Recommendations

Develop a system wide CYPMH workforce development strategy

Build local training and development solutions rather than relying on national programmes

Build sustainable staff involvement fora for the system, and link these into the revised governance arrangements

Develop support programmes for universal services and primary care to build capacity and capability for early intervention and prevention

Delivering the future

Innovation

There is a strong track record of research relating to children and young people's mental health in Norfolk, often nationally recognized. However, the adoption and spread of innovations and research within the local system is patchy.

Looking ahead towards an integrated model there is a real opportunity to capitalise and nurture this capability – both within clinical services and more broadly across an integrated system. Consciously considering how to nurture and systematize innovation in the new system and models will be a key element of creating sustainable, responsive services over the longer term.

<u>Current position</u>

In recent years clinicians and professionals in the local system have actively participated in and initiated research and wider service innovation activity motivated by a desire to improve services and outcomes for children and young people. As a result, Norfolk and Waveney is often a go to destination for national teams seeking out best practice and wanting to learn.

However, we have found that whilst some stand out work has taken place, there is very little evidence of scale and spread of these models across and within the local system. The over arching causes are linked back to issues covered elsewhere in this report – fragmentation and complexity. However, specific barriers include:

- Funding
- Risk aversion
- A lack of a systematised process for moving research and innovation into the mainstream

This is a missed opportunity for the current system. But looking ahead the need to develop a conscious capability to experiment with models, evaluate, learn, fail, replicate – an innovation process connected to but beyond research – will become even more vital to sustainability.

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Delivering the future

The need to square the mismatch between demand and capacity is a key driver for innovation – driven not just by funding, but also workforce availability. Other drivers include:

- Digital transformation: understanding and exploring how best to deploy digital approaches and capabilities to achieve improved outcomes – as part of an embedded approach and not in isolation
- An empowered approach to care and recovery: increasingly using the assets and capabilities of a person and their informal care network to support and sustain improved outcomes
- Prevention and early intervention: shifting services into a genuine early intervention and prevention model has arguably not been properly embraced and tested anywhere. Learning how to do this well and demonstrating the hypothesis that this is a desirable approach will need local prototyping
- Integrated system approach: the opportunity and conditions for emotional well-being and more acute mental health needs to benefit from a joined up whole system approach will be created in Norfolk and Waveney. Understanding how to exploit this to best effect will benefit from research capability and an integrated approach.

<u>Future position – developing a system approach to research and innovation</u>

As the system moves towards a more integrated service delivery model – initially between tiers 2 and 3 but ultimately with stronger connections into universal services, other children's services, education and developing community capability – there will be a need to evaluate the impact of this shift in approach and to learn how to do this well.

At the formal end is the need to continue to nurture and develop a strong clinical research focus for CYPMH. This is helpful for local services, improves outcomes for children and young people, stimulates a broader learning culture, keeps a positive profile for the system externally, and is motivating and attractive to the workforce.

Building on this there is an opportunity to embed this research capability and combine it with innovation models from other sectors to develop a model which supports prototyping, dynamic development, evaluation and adoption to consciously experiment with new service models in action. In combination, key elements of this would include:

- Adopting agile approaches from the technology sector
- User-centred service design

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Delivering the future

- The best transformation approaches from the NHS
- Research disciplines from the NHS and academia
- Evaluation and impact
- Effective citizen and patient co-production

There is a real opportunity to combine these approaches and assets into a single approach, and deploy them to support collaborative innovation to develop integrated services. For example, in and around a school, within a community, in a particular service area, in a specific location.

Across both of these approaches – research and collaborative innovation – there is a need to build a clear process for evaluation, adoption and spread. This process should be clearly articulated in its own right AND embedded in other processes within the system; this would include:

- Financial planning
- Workforce planning
- Commissioning and service planning
- Provider service development
- Education and training

Not all innovation and research requires investment to achieve scale; sometimes we just need to make it happen.

Recommendations

Secure an embedded research and innovation capability within the new integrated CYPMH service building on existing strong foundations – and connected to a clear process for local adoption and spread.

Develop a system model for prototyping, testing, evaluating, scaling and spreading new service models that encourages collaborative innovation; use this to prototype new operating models and services to demonstrate effectiveness prior to wider roll out. Draw in assets and capabilities from across the system – including co-production with citizens and service users – to deliver the model

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Delivering the future

Insight

"You know when you're swinging on a chair? That moment where you're not sure if it's about to fall? That's how I feel, all day, every day" - focus group participant

Children and young people in Norfolk and Waveney are overwhelmingly contemplating emotional and mental health issues in their daily lives.

They appear resilient on the face of it, but they have a perception that they need to 'deal' with issues themselves – in order to avoid burdening friends and family.

There is a dearth of opportunities for young people to discuss emotional wellbeing and to build resilience and skills and there is little knowledge on how to access support

<u>Overview</u>

In our work we spoke to a range of people in order to build on existing service user, families, and professional insight on experiences of the current services. We talked to staff involved in commissioning and delivering the services and held a number of focus groups with professionals, children and young people.

We wanted to get people talking about the broader system of support for children and young people and their emotional wellbeing and not specifically about mental health services. We chose this approach because there is already a good level of insight into the views of children and young people that are already accessing mental health services.

The key question which drove our enquiries was: 'What happens before children and young people access mental health services?' We wanted to explore:

- what happens in this space?
- what sort of things keep young people emotionally safe and robust?
- who organises activities?
- were activities formally organised or were they more organic?
- were there any similarities or trends across age groups, geography and other demographics?
- what works well and what doesn't?

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Delivering the future

Findings

Our detailed findings and conclusions are set out in the Annex to this report.

Overall, however, we found that children and young people in Norfolk and Waveney are thinking about, and are concerned by, emotional and mental health issues in their daily lives. We also noticed that whilst on the surface children and young people seem to be extremely resilient and appeared to have developed coping strategies, there was a general perception that they needed to 'deal' with any issues or challenges themselves, without external support. In general, this tendency to internalise seemed to be driven by a concern to avoid "burdening" friends and family.

We also found that there are very limited opportunities for children and young people to discuss emotional wellbeing and to build emotional literacy and skills. We explored whether children and young people knew about services and support that are available beyond their school or college, and found that knowledge of what is available – and how it might be accessed - was limited.

In our discussions with professional staff who need to access support from mental health services – such as GPs, nurses and teachers – we found widespread frustration and confusion. This included concern over a lack of clarity of service offers, referral criteria and pathways.

Professionals reported that they feel they are constrained by resources and hampered by a complex system that bounces children around, often risking a deterioration in the mental health of young people before they get the right support.

We found that there is a significant appetite from citizens and professionals to influence commissioning decisions about mental health services for children and young people, but there is at present no consistent and inclusive co-production model that they can participate in.

Delivering the future

Recommendations

Develop a co-production insight model that has therapeutic space, is skills building and motivational

Signposting – map services to create a decision tree which enables visibility of services and more opportunities to self-help outside of formal referral processes

Develop a Single Point of Access digital referral service - for all tiers, using technology to:

- place people at the correct referral junction
- provide clarity on their referral journey and real time updates on their waiting times
- suggest other interventions whilst people are waiting for appointments
- enables self-referral; non-professional referral, clinician and professional referrals

Rethinking parenting support:

- Investigate opportunity to develop a parenting development offer.
- This would require mapping current provision in Norfolk and Waveney against that in other territories and against the provision currently being delivered to foster carers.
- Potential offer would look at training and skills development; peer support models; whole family approaches and opportunities

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Interfaces

Neurodevelopmental Disorders and Learning Disabilities

Referrers, young people and their families are confused and frustrated by the existing service offer.

The is no single service across the system with considerable variation between the pathways currently commissioned. The focus is mainly on diagnostics with little or no pre and post diagnostic support.

Overview

The most recent needs assessment identifies an estimated 2,476 0 – 19 year olds on the autistic spectrum across Norfolk and Waveney (2015). Demand for neurodevelopmental services has increased over recent years leading to capacity pressures and increased waiting times.

Currently services for children and young people in Great Yarmouth and Waveney are provided by James Paget University Hospital and for the rest of Norfolk services by Norfolk Community Health and Care NHS Trust.

The contracts with both providers do not include separate Neurodevelopmental Disorders (NDD) specifications, but services are detailed within the community paediatrics specification. Similarly there are no identified budgets for NDD as these are incorporated into various service lines within wider block contracts. NSFT provides support for eligible young people including running joint clinics across the patch. There are also specialist learning disability(LD) services for children with combined LD and mental health needs.

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Interfaces

System challenges

Current pathways are confused and are not transparent to referrers, young people or their families. There is widespread frustration at the lack of information and support and at the long waiting times currently being experienced. These have been clearly articulated in the recently published Healthwatch report: Access to health and social care services for families with autism (October 18).

There is no single offer across Norfolk and Waveney and we observed variation and inequitable provision both within and between providers. For example, JPUH provides an assessment and diagnostic service to children and young people with possible ASD/ADHD but follow up services are only available for those with ADHD. The ADHD service in west Norfolk only covers children up to the age of 12 whereas services for children in Norwich, north and south Norfolk are available for those aged up to 18. Most services are primarily diagnostic with little pre and post diagnostic support available for young people with ASD.

There are also cross border complexities within the system. Children and young people who live within Great Yarmouth and Waveney but who attend a school in another area are referred to the paediatric service where the school is located.

Similarly, children and young people registered with a Thetford GP are excluded from the NCHC contract and receive their service from the Suffolk community provider

NDD pathways are complex and have many interfaces both within and across services. They do not readily sit within the remit of any single agency as education, social care and health all have responsibilities.

Way forward

In our view, the system needs to review and improve NDD pathways and consider in much more depth the need for pre and post diagnostic support. Whilst there is not an obvious single forum that might lead such a review, the best placed existing group is the multi-agency Autism Partnership Board.

Interfaces

We also heard that the need for such a review has previously been recommended by the system neurodevelopmental workshop held at the end of July 2018. The workshop made a series of recommendations and concluded that a review should be all age and independent.

In our view, it would also be logical and appropriate to include a review of LD/LDD as a sub set of the NDD work acknowledging the crossovers and touch points between these services.

Recommendations

Establish an all age review of NDD, led by and reporting into the Autism Partnership Board

As part of the NDD review, include within scope a focus on CYP with a learning disability and with combined mental health issues and learning disabilities

Ensure that Phase 1 of the review focuses on mapping the diagnostic pathway.

Implementation

Delivery

In this report, we have set out our main findings and conclusions based on the work we have done with colleagues from across the system. We have developed and tested recommendations which will, we believe, move the system on. However, we recognise that, taken together, our recommendations represent a formidable agenda.

In order to successfully implement the step change that is required, we think there are four key issues that need to be addressed:

- System 'reset'
- Road map
- Cascade and communication
- Resources

<u>System reset</u>

Virtually everybody we have spoken to in our work has agreed that 'the system', as currently constructed, does not work. Those trying to access help and support often find it a confusing, bureaucratic and slow process. Existing service providers are deeply frustrated with commissioners, and vice versa.

There is though a broad consensus over what things could and should look like in future, and there is a clear appetite to (and much enthusiasm for) change. As a result, we hope that our work and this report can act as a catalyst for a system 'reset', in which every partner is willing to commit to leaving the past behind, move out of organisational silos and throw their energy behind implementing a new 'one system' approach to transforming the mental health of children and young people.

<u>Roadmap</u>

To begin this journey of transformation, it will be essential to have a clear roadmap. In time this will be underpinned by a more detailed implementation plan co-produced by the system and aligned to delivery governance. But the following sets out key phases and activities as the beginning of a framework for action – and to underline the need for pace and momentum to achieve the desired transformation by October 2020.

The road map highlights key activities over the first 12 month period. And whilst there is a need to begin urgently now the work to bring tier 2 and 3 services together in the medium term by October 2020 there is also much that can be done to transform the system and services in the short term.

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Implementation

Area for action	Jan to Mar 2019 Planning	Apr to Jun 2019 Delivery	Jul to Sep 2019 Delivery	Oct to Dec 2019 Delivery
System working	• Share report • Implement new CYPMH Board & leadership model • Develop implementation plan & secure resources • Vision for integrated children's services developed • Agree system performance / outcomes and dashboard • Engage third sector in new partnership approach	• Implement further governance changes • New integrated commissioning team established • Wider engagement on children's vision • Begin strategy refresh • Develop third sector partnership strategy • Design system development programme	• Third sector commissioning framework for 2020/21 commences • On-going OD	• On-going OD • Review effectiveness of new arrangements
Integrated services	• System mandate for 0-25 age range for core services • Mobilise task and finish group to redesign integrated tier 2/3 pathways • Progress single front door plans	• Finalise model and timescales for single front door	• Conclude strategy refresh • Phase 1 single front door operational	

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Implementation

Area for action	Jan to Mar 2019 Planning	Apr to Jun 2019	Jul to Sep 2019	Oct to Dec 2019
Commercial	• Confirm contract extension for existing tier 2 services (to Sept. 2020) • Scope and process for tier 2/3 sourcing • Agree changes to contracting process • Implement contracting measures for 19/20 • Confirm baseline expenditure on CYPMH	• Commence tier 2/3 sourcing process • Complete demand and capacity review • New contract monitoring process commence • Confirm multi-year investment plan, linked to strategy	• Develop action plan in response to demand and capacity review • Complete disaggregation of tier 3 from current contracts • Complete 0-25 scope	
Delivering the future	• Baseline workforce plans • Share insight with the system • Consider longer term co-production / insight models	• Workforce strategy developed linked to wider strategy refresh • Commence work on new co-production / insight model • Convene working group for innovation and research	• Workforce strategy completed • Test new co-production / insight model • Plan for first service innovation prototype	• Implementation of workforce strategy begins • Launch first service innovation prototype

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Implementation

Cascade and Communication

In addition to the reset and the roadmap, it will be vital that all partners agree to take on responsibility for cascading the key findings in our report, the recommendations that we are asking the system to sign up to and the practical next steps in implementation.

In a complex transformation such as this, which involves many partners and numerous stakeholders, it is impossible to over-emphasise the importance of ongoing communication. The direction of travel will need continual reinforcement, as will highlighting early wins and benefits.

Resources

Developing and delivering the forward programme outlined in this report and the system ambition will not happen without dedicated resources.

We have already highlighted some specific resource changes or requirements in the report such as the system leader for children and creating an integrated commissioning team. Ultimately this transformation will become mainstream business as usual. But - particularly in the planning phase and early delivery phase outlined in the road map – where activities are front loaded to instil momentum and pace – there is a need for additional and dedicated resource.

Most importantly, all parts of the system need to step up and commit to providing resources to support the transformation programme. This includes freeing up people to participate in and lead workstreams, senior leadership capacity to engage and sponsor, and financial contributions towards additional / specialist capacity. A number of system organisations are already contributing to STP funding and this may be one source of collaborative funds.

There are some specific, time-limited roles that we also believe will help generate energy and sustain a forward programme:

- An independent chair for the core CYPMH Board for at least it's first year of operation.
- An experienced programme director to drive forward and co-ordinate the transformation programme for the system
- A senior leader for new integrated commissioning team – possibly transitional

Some specialist capacity for specific tasks:

- Health economics: to inform strategy and longer term financial plan
- Organisational development

It is important to note that not all this capacity is additional– our recommendations should free-up capacity within the current system that can be redeployed to the programme.

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Appendices

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Appendix 1 - Scope

Scope

- At the outset of our work, we agreed with our Task & Finish group to retain a degree of flexibility in our scope, so that we could focus on the key priorities as they emerged. We therefore initially agreed a broad scope, encompassing all aspects of the planning, commissioning and provision of mental health services for children and young people.
- At our first Task & Finish Group, we developed this thinking a little further, and agreed that our core scope should be on:
    - All current tier 2/3 Services
    - CYP crisis pathways
    - Tier 1/universal services, where focus is on building resilience
    - Transition to AMH
- We also recognised that there were a number of key 'touchpoints' with other series which, whilst not core to our review, we would consider. This broad approach is set out on the following slide.

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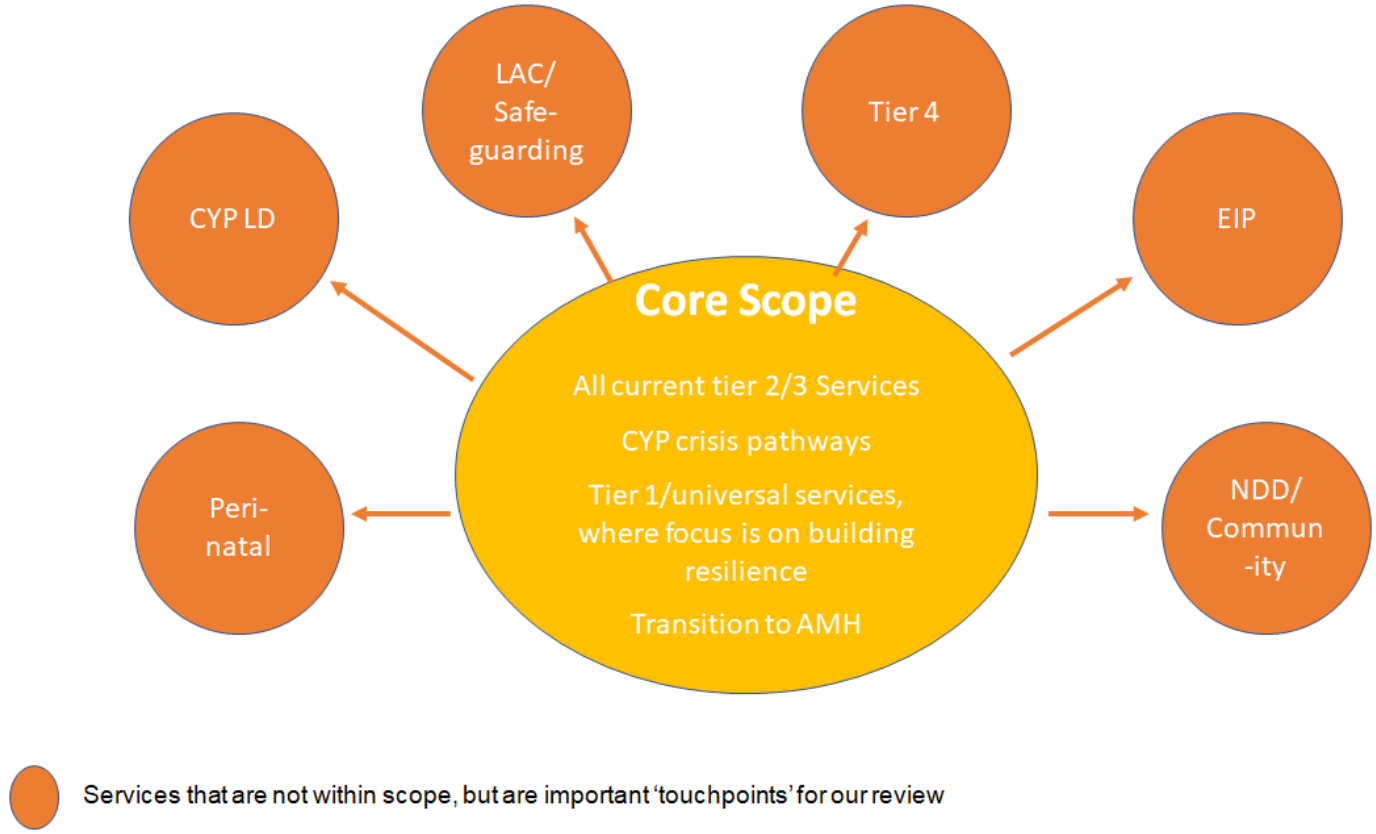
Scope



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Scope

- Following discussions at the first Task and Finish group about our initial scope, we agreed to look in more detail at two key interfaces or touchpoints – neurodevelopmental disorders (NDD) and learning difficulties (LD).
- At our second Task and Finish Group, we finalised this approach, and agreed that for both NDD and LD we would carry out a limited reach review of the diagnostic pathway and underpinning commissioning arrangements, including:
  - Contract review re joint triage
  - Interviews with small number of key stakeholders
  - Interface with all age autism strategy at NCC
  - Recommendations
- At each subsequent Task and Finish Group we discussed progress and reviewed our proposed next steps, including agreeing how we would report back our findings, conclusions and recommendations to the system.

RETHINK PARTNERS

Appendix 2 - Recommendations

Vision and Strategy

- Rapidly update the vision and ensure it is formally signed off by relevant Boards/Committees, and ensure that it is well communicated to the wider system
- Develop a revised strategy that builds out from the refreshed CYP mental health services vision, and together with a detailed implementation plan
- Secure a clear mandate from relevant Boards/Committees to fully develop the emerging vision of more integrated children's services
- Future proof new system models so that they are responsive to the emerging integrated children's services vision

Partnership Working

- Formally link the existing CYP Partnership Board to the STP, and make it the key forum for developing and overseeing the STP's Children's work programme

RETHINK PARTNERS

- In implementing the revised arrangements for governance and decision making, ensure Suffolk County Council are fully involved, including in the development of new service models

Leadership

- Develop a role description for the system leader of Children's services, and formally sign this off at the STP Executive
- Alongside the above, nominate the current DCS to take on the role of system leader for CYPMH services, and sign this off at the STP Executive
- Establish an appropriate forum for seeking and responding to the views of clinical and professional leaders
- Establish role description(s) for Clinical/Professional lead(s) for CYPMH Services, and recruit to the role(s)

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Governance and Decision Making

- Stand down the following groups:
  - CAMHS Redesign Steering Group
  - CAMHS Strategic Partnership
  - CAMHS Joint Commissioning Group
  - CYP IAPT Partnership

- Establish the core CYPMH Board, ensuring it includes appropriate clinical and professional representation

- Develop a framework of delegation for the core CYPMH Board which clearly sets out the boundaries of the Partnership Group's authority, and ensure this is signed off by relevant Boards/Committees

- Establish the following wider CYPMH networks:
  - CYP and families
  - Clinical and Professional
  - Wider Children's Network

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Integrated Commissioning Team

- Establish a single, integrated NHS/NCC CYPMH commissioning team, ensuring it encompasses all of the key functions and (if practical) co-locate the team.
- Remove duplication in the system by ensuring there is a single, consolidated function that spans providers and commissioners for all key areas (e.g. business intelligence)
- Ensure that there is a single senior leader for the integrated CYPMH team accountable to the children's service system leader
- Enable and encourage secondments between commissioning and provider organisations for key functions such as business intelligence

System Approach to Performance

- Develop a single dashboard for mental health services for children and young people that links performance, quality, finance and insight. Specifically, this dashboard must include profiled and total waiting list management to give transparency to waits along the complete pathway.

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- Develop a concise report that give senior leaders and Boards a clear picture of the overall performance of CYP mental health services

Community Capacity

- Develop an integrated third sector funding model between health and social care for children and young people to achieve:
  - 3 year funding contracts
  - single application and oversight process
- Secure involvement of the third sector throughout revised system governance and within a co-production model; create the right conditions in which a range of 3rd sector organisations can participate.
- Jointly develop a programme to stimulate grass roots community action on mental health and emotional resilience.
- Develop a partnership strategy with the sector setting expectations and accountability for joint working

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System Development

- Design and implement an organisational development programme for the children's system in support of collaborative working to underpin the other changes proposed in this report.

- In addition to a wider OD programme for the children's system, include a specific focus on:
    - OD for the newly formed integrated commissioning team
    - The new governance model
    - CYPMH leaders including clinical, professional, managerial and 3rd sector leaders

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Future Service Model

- Ensure relevant Boards/Committees sign off an age range of 0 – 25 for core services, with clearly specified exceptions.
- Clarify the age range for services that are an exception to 0-25 (such as EIP, ED and NDD), and agree where accountability lies
- Ensure partner organisations agree that core CYPMH services (tiers 2 and 3) are the initial priority for the transformation programme
- Engage with the Tier 4 redesign programme being led by NHS England as part of the New Models of Care Programme
- Design the operating model for a SPOC as a system priority
- Formalise the governance of the SPOC working group, ensuring it reports to the CYPMH Board
- Develop a phased implementation plan aligned to other workstreams (e.g. demand and capacity reviews)

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Future Service Model (continued)

- Establish a time limited task and finish group to redesign pathways and remove the artificial separation between tiers 2 and 3, ensuring that this group has strong input from children and young people as well as clinicians/professionals

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Contracting

- Disaggregate the overall NSFT block and move to a separate contract for CYPMH, with work commencing as part of the SDIP in Q1 with a shadow separate schedule in place for Q3 and Q4.
- Undertake a demand and capacity review by the end of Q2 latest
- Establish separate and dedicated contract monitoring for all CYP mental health services, encompassing performance, quality and finance
- Ensure consistency of representation from commissioners at all CYP mental health contract meetings to allow interdependencies and interface issues to be addressed
- Where contracts include existing outcome measures, in 2019/20 jointly develop improvement trajectories including a clear timeline in the NSFT contract (SDIP) to develop and roll out the existing work on outcome measures (POD)
- Over time, develop and move to a system wide set of outcomes informed by national and local developments

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Finance

- Establish the existing level of investment in mental health services for CYP, by organisation [aligned with age]
- Develop and sign off a transparent multi-year investment strategy, and codify the process for future variation
- Over time, expand the scope of the Section 75 agreement (or similar) to cover all relevant services and teams

Sourcing Integrated Provision

- Extend the current tier 2 contracts by 12 months to end September 2020 through:
  - Senior level discussion between commissioners and the current provider to confirm the benefits and conditions needed to agree the extension – by the end of December 2018
  - Formal approval through relevant NCC / CCG governance processes – by the end of January 2019

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- Plan and deliver the sourcing process for an integrated tier 2 / 3 service to commence September 2020, encompassing:
    - Task and finish group to establish sourcing options – Jan to Mar 2019
    - Decision on forward pathway and resources to support delivery - April 2019 governance
    - Delivery of above from April 2019 onwards (detailed programme and milestones dependent on selected sourcing model).
    - Integrated service mobilization period – April to September 2020
    - Integrated service commencement underpinned by appropriate integrated contracting model: October 2020

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Workforce

- Develop a system wide CYP mental health workforce development strategy
- Build local training and development solutions rather than relying on national programmes
- Build sustainable staff involvement fora for the system, and link these into the revised governance arrangements
- Develop support programmes for universal services and primary care to build capacity and capability for early intervention and prevention

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Innovation

- Secure an embedded research and innovation capability within the new integrated CYPMH service building on existing strong foundations – and connected to a clear process for local adoption and spread.

- Develop a system model for prototyping, testing, evaluating, scaling and spreading new service models that encourages collaborative innovation; use this to prototype new operating models and services to demonstrate effectiveness prior to wider roll out. Draw in assets and capabilities from across the system – including co-production with citizens and service users – to deliver the model

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Insight

- Develop a co-production insight model that has therapeutic space, is skills building an motivational

- Signposting – map services to create a decision tree which enables visibility of services and more opportunities to self-help outside of formal referral processes

- Develop a Single Point of Access digital referral service - for all tiers, using technology to:

    - place people at the correct referral junction
    - provide clarity on their referral journey and real time updates on their waiting times
    - suggest other interventions whilst people are waiting for appointments
    - enables self-referral; non-professional referral, clinician and professional referrals

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Insight (continued)

- Rethinking parenting support:
    - Investigate opportunity to develop a parenting development offer.
    - This would require mapping current provision in Norfolk and Waveney against that in other territories and against the provision currently being delivered to foster carers.
    - Potential offer would look at training and skills development; peer support models; whole family approaches and opportunities to co-deliver with schools

Neurodevelopmental Disorders and Learning Disabilities

- Establish an all age review of NDD, led by and reporting into the Autism Partnership Board
- As part of the NDD review, include within scope a focus on CYP with a learning disability and with combined mental health issues and learning disabilities
- Ensure that Phase 1 of the review focuses on mapping the diagnostic pathway.

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Appendix 3 - Call to Action

Purpose

Our review recommends that the Norfolk and Waveney system makes some significant changes to the way in which it plans, commissions and provides mental health services for children and young people.

The following slides briefly set out why, in our view, the system must commit to driving this change a priority. They cover:

- The evidence – selected facts
- What we found
- The stories we heard

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The evidence – selected facts

- One in eight 5-19 year olds has at least one mental health disorder
- Half of all mental health conditions first occur by the age of 14, three quarters by 24
- 6% of the mental health budget is invested in services for children and young people
- Teenagers who have a common mental disorder are more than two and half times more likely to have a CMD at age 36
- Young people with a conduct disorder are 20 times more likely to end up in prison, and four times more likely to become dependent on drugs
- Anorexia kills more than any other mental health condition
- Maternal depression results in a fivefold increase in risk of mental health disorder in the child
- 60% of looked after children have mental health disorders
- 10-13% of 15 & 16 year olds have self harmed

"too many children and young people have a poor experience of care and some are simply unable to access timely and appropriate support " (CQC 2017)

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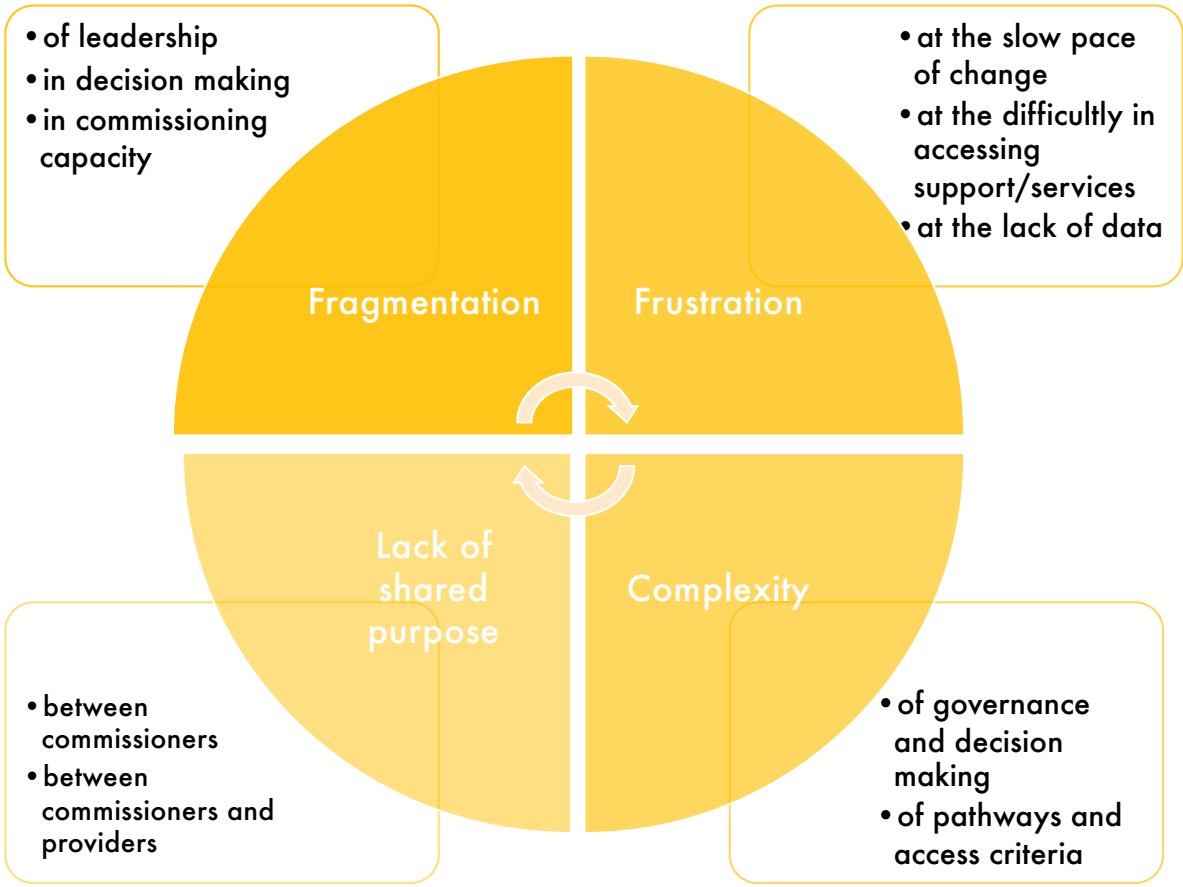
What we found



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The stories we heard

You have to almost know what the diagnosis is, in order to refer

I have alone time. I might hurt myself

I shut myself off for hours on end. I have a hard time opening up about stuff

If I'm at home I'll go see my dog. If I'm at school, I'll hold it in and punch the wall in my room. I've asked for a punch bag for Christmas

I force myself to kinda black out on my bed. I might eventually speak to my mum

We know our kids. We know what's a wobble, and what's going to become a long-term issue. Get that referral process right

If it's my problem I should probably deal with it myself

I am often facilitating between the student and their parents. Then you get to crisis point and the family concedes their child is in crisis, then they don't meet service criteria

White text – children & young people
Black text - professionals

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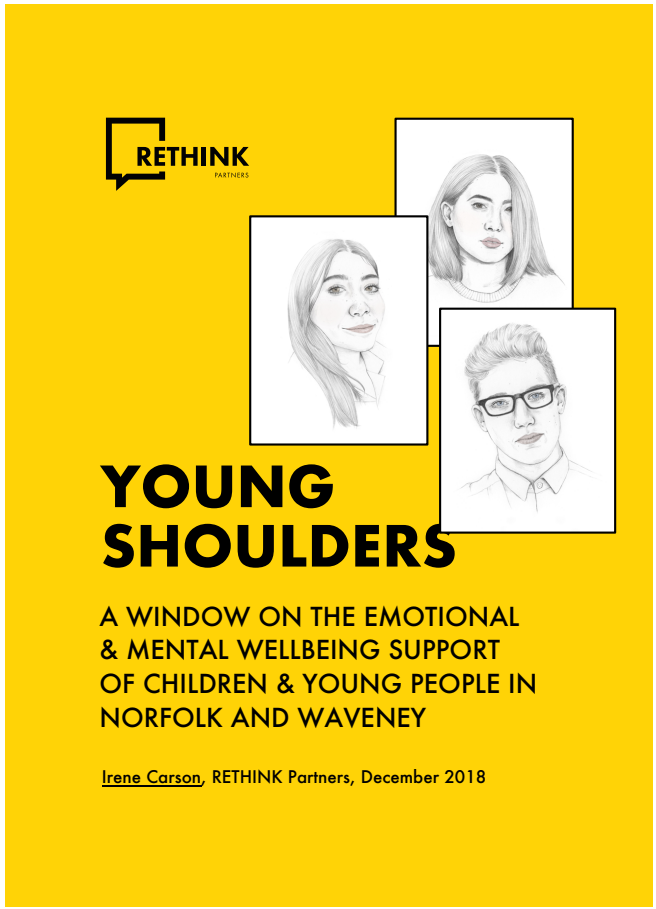
Appendix 4 – Young Shoulders

A WINDOW ON THE EMOTIONAL & MENTAL WELLBEING SUPPORT OF

CHILDREN & YOUNG PEOPLE IN NORFOLK AND WAVENEY

In autumn 2018, RETHINK Partners were asked by the NHS Clinical Commissioning Groups and Norfolk County Council to review and help progress their approach to transformation of mental health services for children and young people in Norfolk and Waveney. This included looking at aspects of the Local Transformation Plan and wider ambitions for these services including commissioning arrangements, leadership and governance, service models, performance, the provider landscape, and the many interfaces these services have with other parts of the system to truly provide a joined-up service for children, young people and families.

The report is available opposite (double click to open)



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YOUNG SHOULDERS

A WINDOW ON THE SUPPORT FOR EMOTIONAL AND MENTAL WELLBEING FOR CHILDREN & YOUNG PEOPLE IN NORFOLK & WAVENEY

Children and young people in Norfolk and Waveney are **overwhelmingly contemplating emotional** and mental health issues in their **daily lives**

Variation: it's a complex picture of influencing factors on the **emotional wellbeing** of children and young people - there is **no such thing** as **a universal experience**

Young people appear **resilient**, but this is dominated by a high propensity to **"deal" with issues themselves** – in order to avoid "burdening" friends and family

First line of defence is to **internalise** and **deal with issues themselves**, with family; friends; school and college coming second

School plays a crucial role as a **trusted source of support.** It is often the **last chance of hope** in a fragmented system

There is a **lack of awareness** of services beyond school and college

Schools and medical professionals are **constrained by resources** and hampered by a **complex system** that bounces children around

Professionals are working against a **backdrop of confusion** over service offers, referral criteria and pathways

There is a huge appetite from **citizens and professionals** to **influence commissioning decisions** but no consistent and inclusive co-production model

There's a dearth of **opportunities** for young people **to discuss emotional wellbeing** & **build emotional literacy and skills**

Schools are commissioning a **patchwork of support** based on their local connections to compensate for **gaps in statutory Camhs** and **wellbeing provision**

Appendix 5 – Sourcing integrated provision

Sourcing integrated provision

The review has identified and recommended integrating tier 2 and tier 3 CAMHS provision, as a first step towards creating a more integrated emotional well-being and mental health service offer for children and young people. Further, discussions have begun about creating a wider vision and road map towards a fuller integrated offer for children more widely under the leadership of the Children's Strategic Partnership Board and the STP.

This annex sets out at a high level:

- Key considerations for considering how to move this plan forward and agree a sourcing model
- High level options for sourcing the tier 2/3 service in the short term as a building block for further possible integration

The term sourcing includes a range of processes including procurement and structural change.

<u>Key factors influencing the forward path</u>

Having agreed to proceed with a process to integrate tier 2 and tier 3 CAMHS services, the following issues need to be taken into consideration when deciding what an appropriate forward path to creating an integrated service would be:

- Legal / procurement compliance issues: are the services subject to open competition regulations? If so what would be the potential mitigations for not using a procurement route? Are the benefits greater than the risks? And what are the risk appetites of key partner organisations?
- Regulatory issues: will the chosen route / end state option provide the necessary regulatory framework for the services to be able to operate lawfully and compliantly?
- Workforce: retaining and motivating the current workforce through any change process is a key consideration; they are the key asset of the service and must be fully involved and ideally supportive both of the process and the longer term vision. Also ensuring that any end state vehicle is compatible with maintaining staff benefits; in particular access to NHS pensions.

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- Level of disruption v maintaining the status quo: how satisfied are commissioners with the quality and delivery of the current services? Is a major shake-up required or is there a softer approach that will realise the benefits of integration without risking huge disruption?
- Cost: the direct and indirect costs of any formal process should be considered – alongside the costs of not acting.
- Provider performance: linked to the point about disruption above, but more broadly what is the track record of incumbent providers and is there a desire for a change of provider.
- Strategic fit: how does the chosen process fit with current plan to integrate tier 2 and tier 3 CAMHS? And to what extent is it compatible with further integration with other parts of children's services in the medium term (either able to add in other services at key points in the current process, or able to add in other services at a future point to an integrated tier 2 / 3 service.
- Market appetite: to what extent is there likely to be interest in providing services from new market entrants?
- Public perception and reputational risk: this is always a consideration, but in the current context for health and care – and in particular mental health services – in Norfolk and Waveney the public perception of proposals should be carefully considered. Regardless of the agreed way forward an active process of co-production, engagement and media management wrapped around the core process.

<u>Narrowing down the options</u>

Whilst all of the above considerations are important, fundamentally the interplay between the following core issues will drive discussions about the forward journey and end state:

- Strategy: the clear desire for better integrated services
- Function / Scope: tier 2 and tier 3 CAMHS; possible for other services to follow; strong links to universal and tier 4
- End state form: will require CQC and a strong clinical model; but also include social and emotional well-being values and approaches

This is only a starting point; more detail and specifics will need to be worked up rapidly in the early stages of a forward process.

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Sourcing Options

Option	Description	Benefits	Risks
Market process / procurement	Using a market process to procure a defined set of services; various options about process	Well-defined process, legally compliant, will require clarity of thought and intent by commissioners at a detailed level. Could introduce new capabilities into the system	Potential loss of control of outcome and process, difficult to pause, expensive, disruptive to staff and –potentially – service users during a contract mobilization period. Less opportunity for further future integration of services
Integrated approach e.g. alliance contract, lead provider contract	Awarding a contract across a number of providers to bind them to work together to deliver to a shared service specification and set of outcomes; can be combined with a market process or awarded with due process; or elements contested.	Opportunity to draw on a range of organizational strengths; can combine existing providers with new organisations; less disruptive for staff and users if working with incumbents; less costly than a market process – but resources required to do this well are significant.	Mixed track record of success in the NHS – deeply dependent on good relationships, trust, effective leadership and strong and clear commissioning. Some flexibility for future integrations of other children's services potentially.
Creation of a new provider entity	Drawing existing services out of current providers and placing them into a new legal entity (possibly with shared ownership).	A clean sheet and a fresh start for all; opportunity to consciously shape culture, operating model, governance etc from the outset	Regulatory barriers in the NHS for formation of a new entity; need to be CQC credible from day one; risk of old habits transferring with services; expensive process. Could transfer services over time into the entity.

Sourcing Options

Option	Description	Benefits	Risks
Transfer services into an existing provider entity	Drawing existing services out of current providers and placing them into an existing legal entity (either with other services or dedicated to this purpose).	A simpler way of integrating services into a single provider vehicle; avoids additional legal / regulatory costs of set up. Services could benefit from organizational track record / established leadership team. Could enable further integration of services over time.	Subject to challenge from the market (mitigations available through due process – but not entirely risk free). Disruptive to staff (strong engagement process required). Does a suitable entity exist?
Hosted by local authority using flexibilities	Drawing existing services out of current providers and placing them into local authority control – either alongside other children's services or into some form of arms length body.	Established organization with strong focus on children's services. Opportunity for greater integration with all aspects of children's services, including public health. A simpler way of integrating services into a single vehicle; reduced additional legal / regulatory costs of set up.	May be resisted by the NHS at various levels; complexity around accountability mechanisms to drive quality and performance; lack of clinical culture / operating model; CQC status
Integrated Care System	The NHS / STP is on this path currently; there is not clarity currently on the underlying legal entity – legislative change is pending linked to the NHS 10 year plan.	Likely to be the preferred model and approach to integration by the NHS, therefore supported and encouraged in all senses. Likely to be compatible with delivering a broader vision for integration.	Forward path and underlying entity questions remain unclear. Dependence on legislation is high risk currently. And whilst increasing numbers of systems are on this path, N&W would be a likely first mover

Appendix 6 – who we've seen

Appendix 6 – who we've seen

We would like to thank everybody who gave up time to support us with this review. Particular thanks go to Kelly Penton, Jonathan Stanley, Kalu Kalu and Karen Waters for all their help and support.

Adrian Leddy
Adrian Marr
Ali Jennings
Alison Bailey
Amy Eagle
Andrea Bell
Andrew Bruce
Andy Douglas
Anita Bagge
Anna Sims
Anne-Louise Schofield
Antek Lejk
Andy Goff
Ardyn Ross
Bill Belton
Bindy Price
Chris Butwright
Claire Jones
Clive Rennie
Dan Mobbs
Danny Sweatman
David Ashcroft
David Wright
Denise Clarke
Dr Dawn Allen
Dr Jon Wilson
Dr Nishi Puri
Dr Sarah Maxwell
Dr Sarah Steel
Dr Suzie Fiske
Dr Tim Clarke
Ed Lambert
Ed Maxfield
Emma Chapman
Emma Rush
Faye Hewitt
Fiona Springall
Frank Simms
Jacqui Starling
James Savill
James Wilson
Jane Hackett
Jess Barnard
Jo Smithson
John Webster
Jonathan Stanley
Julia Fairbrother
Justine Goodwin
Kalu Kalu
Karin Bryant
Karryn Dixon
Karla Oakley
Kathryn Garnham
Katy Blakely
Kay Vetesse
Karen Waters
Kelly Penton
Kevin Vaughan
Kim Goodby
Lorna Hughes
Lorraine Rollo
Lucy Parsons
Lucy Weavers
Maria Richardson
Mark Gower
Mark Osborne
Mark Scrogie
Mary-Anne Morris
Mel Blanch
Melanie Craig
Michelle Bibby
Michelle Ward
Neelam Subba
Nic Yeates
Nikki Bramford
Nikki Rider
Oliver Cruikshank
Pallavi Devupalli
Paul Webb
Paula Mellor
Penny Ayling
Philippa Gregory
Rebecca Hulme
Rob Mack
Robin Konieczny
Sally Hughes
Samantha Mason
Sara Blake
Sara Nurse
Sarah Flindall
Sarah Hardy
Sian Larrington
Sophia Elsegood
Stef Rice
Stephanie Gallop
Stuart Bennett
Stuart Brunton-Douglas
Sue Cook
Sue Hobbs
Sue McNeilly
Teresa Miles
Tim Eyres
Tony Palframan
Tracy McLean
Tracey Walton
Tracy Williams
Wendy Gair
Wendy Thomson
Zandrea Stewart

Young people from Aylsham High East Coast College Ormiston Victory Academy, YAB Wayland Academy, Thetford

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