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HEALTH AND CARE PARTNERSHIP

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NHS

Surrey Children's Emotional Wellbeing & Mental Health Services for Children & Young People

Market Engagement Event 28th January 2020

FEEDBACK

Single Point of Access – Key Points of Clarity Provided

- A Single Point of Access (SPA) will triage all requests for support received as related to emotional wellbeing and mental health services delivered under the scope of the contract.
- The SPA will be jointly delivered by staff working within the provision of Early Intervention support and services covered by this contract and those delivering specialist/clinical CAMHS.
- Young people, parents and carers will be encouraged to make their own requests for support (where they feel confident to do so).
- The SPA will include ‘navigation and coordination’ staff to signpost to other local organisations/facilities or evidence-based online resources where appropriate.

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Questions about Single Point of Access

- What challenges and opportunities does the proposed service model present?
- What more should be considered within the service proposal?
- How will the SPA support access to self-help and services outside of the scope of the Emotional Wellbeing and Mental Health Services Contract, for example, physical activity, social opportunities and community support?
- How would the organisations involved in delivering Early Intervention and Clinical CAMHS work together to ensure there is an appropriate response to all requests for support?
- We know that children can be referred to multiple agencies and sometimes they may be referred to the wrong service but wait for an assessment or to be directed to a different source of help. The ambition is to develop integrated initial response whereby we are able to determine which service is best placed to meet that child's needs. This will provide a swifter service and prevent multiple assessments. How could you help the partnership to realise this ambition?

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Feedback about Single Point of Access

Operation

- Integration of the SPA and C-SPA very well received though some perception that linking with Social Services may make families fearful of seeking support for their children. This will need combatting.
- Concerns over the “bigness” of SCC and how this may impact SPA success once integrated.
- A SPA can prove to be more accessible and personal if based in a local area. Experience reported of a SPA network established by locality, creating mini SPAs, which worked well. Staffing resilience not considered an issue.
- It would be advantageous if the SPA could offer assessment for some children alongside triage.
- Detail the expectation of the SPA to facilitate a prompt response for those children who need to be seen quickly; how will this be achieved?

Experience

- The SPA is currently considered a threshold in itself and should not be.
- Once you are “referred in” you are a “condition”. Conversation with the SPA should be about what the child enjoys and what their strengths are rather than the condition.
- Important to build trust in the role of the SPA and its workforce.
- Make the process easy for children needing support; offer a multi disciplinary experience.
- Important to have a “navigator” or assigned individual aligned to a child during the EI/referral process until effectively supported by an appropriate support solution.
- Include social prescribing in the support offers.
- Analyse where referrals are originating.
- SPA could maintain web site detailing all services and an explanation of what is on offer from each.
- All services available via the SPA should be branded NHS first and foremost to avoid confusion.

Early Intervention - Key Points of Clarity Provided

- Focus will be on supporting children and young people with emerging and mild to moderate mental health difficulties, e.g. anxiety, low mood and behavioural issues such as anger
- The Service will enable a faster response to children and young people referred to the EWMH Single Point of Access where a counselling or similar intervention may be appropriate.
- Development of an online resource of 'approved' information to support children and young people's emotional wellbeing and mental health.
- The Emotional Wellbeing and Mental Health Single Point of Access should fully integrate the Early Intervention offer and ensure that consideration of, signposting and access to Early Intervention services is a fundamental part of triaging function with integration of appropriate expertise and staff to resource and deliver this.
- The triaging function will change and develop over the lifetime of the contract as steps are taken to work more closely/integrate with the Surrey County Council Children's Single Point of Access (C-SPA).
- The Primary Mental Health Service will provide the key link between health and education, working in partnership with the range of Early Intervention Services provided across the contract but funded within the financial envelope of the Clinical CAMHS element.
- Examples of EIS interventions or therapeutic approaches may be mentoring, counselling (online or webchat) and supporting schools to enable children and young people to build resilience (including online resources).

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Questions about Early Intervention

- What challenges and opportunities does the proposed service model present?
- What more should be considered within the service proposal?
- Prevention and Early Intervention are key to providing early support to children and young people, their families and carers, de-escalating crisis and/or need and enabling people to cope better and implement self-help strategies. What interdependencies will the EWMH service have with other key providers/services and how might these be enabled and developed?
- How will the provider(s) ensure that the Early Intervention is dynamic and able to respond to new and emerging need?
- How can the Personalisation agenda and access to Personal Health Budgets be incorporated into the contract over time?

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Feedback about Early Intervention

Operation

- Agreement that a focus on EI is the right thing to do but there needs to be a clear definition of the remit of Early Intervention.
- The service should not make children fit what is on offer; it should be about using a navigator to support finding the appropriate service/s for the child.
- Support prior to formal referral should be the preferred option; focus on facilitating not referring.
- Present a single NHS service brand across all support elements.
- Have fun whilst talking to someone e.g. Havens, Café, Youth Club
- Implement a simple and personal approach to confidentiality and consent.
- Ensure funding is correct as full benefit will not be realised for a few years and there will likely be a need to "double run".
- Clearly define the role of EI as part of the neurodevelopmental pathway.
- More EI may lead to greater demand which is a risk in a block contract.
- Maintain flexibility as the contract term is long; use social prescribing and non-contractual wide ranging social community provision.

Language

- Term Early Intervention appears less "adequate" of a service; needs to be understood within the cyclical THRIVE model
- Alter name to "Request for Support" or "Request for advice".
- EI name is wrong as support is also about step-down.
- Term "intervention" not liked though the word prevention is.
- Use the term "self support" not "self referral".
- Service should be for all as anybody needing additional support will be identified through triage.
- Lack of clarity/understanding about the difference between Community Early intervention and Mental Health Early Intervention.
- Focus on de-stigmatisation to allow "secret" to emerge

Schools

- Perception that seeking out a school "counsellor" is a big step; an in-between role is required e.g. PMHW.
- Schools and the community have a level of responsibility they need to understand and accept. Freya did not need to see 30 people.
- Educate schools - consider joint EI roadshow as one NHS EWMH service offer
- What are schools doing about a shift in culture? Now that one size does not fit all, is it acceptable to allow different school models to develop?
- Working with parents is key to success

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Neurodevelopmental Assessment Service - Key Points of Clarity Provided

- A diagnostic service does not have to be delivered by a traditional, specialist mental health provider and needs to be clearly separated out from Clinical CAMHS with its own pathway.
- The model needs to be part of a wider system change that is clear on what should happen before a referral is made for a diagnostic assessment. There is an expectation of a pathway that shows what is required of other partners, primarily schools and services that support schools, for example specialist teachers and educational psychologists.
- Any child with potential ASD/ADHD or a diagnosis should have access to support for any mental health difficulties as part of the Early Intervention Service or Clinical CAMHS, as would any other child or young person.
- Oversight of prescribed medication for ADHD will be provided as part of the neurodevelopmental assessment service, bearing in mind shared care protocols in place with GPs.
- Support the cultural change that shows effective help for most children and young people with ASD/ADHD comes from good practice within schools and giving parents and carers strategies for responding to children with additional needs.

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Questions about Neurodevelopmental Assessment Service

- What challenges and opportunities does the proposed service model present?
- What more should be considered within the service proposal?
- What role is there for support and guidance within this service, for parents as well as young people? This may be during the wait for assessment or after diagnosis
- With a separate pathway which may lead to a diagnosis of ASD/ADHD, how can you ensure that children and young people with potential/diagnosed ASD/ADHD get access to the right type of support if they have a co-morbid mental health difficulty?
- What are your views on ways of developing a pathway that ensures that parents/carers, schools and GPs are clear on what should happen before a request is made for a diagnosis for ASD/ADHD?

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Feedback about Neurodevelopmental Assessment Service

Operation

- Dedicated SPA staff could enable a better response for these children and their families/carers.
- Some clinical intervention is required early to signpost correctly.
- A need to clarify what is in and out of scope, what constitutes pre and post diagnosis support, Surrey expenditure on SEND.
- Move on from an assessment/diagnostic service to also focus on a SEND type of pathway being clear about what the offer is for families with a lifelong diagnosis.
- Have a clear support offer if criteria for diagnosis is not forthcoming.
- Make clear this doesn't exclude access to other services on offer; similarly for LD children
- A desire for the service reach out and support parents.
- Neurodevelopmental services must not be perceived as a "bolt on" to mental health provision; some surprise this is an element at all as considered to have greater synergy with community provision.
- Requirement for pathway to be NICE compliant with an MDT approach.
- Concerns about sufficient staff for this service

Language

- Remove "assessment" from title of element as infers no service pathway thereafter; replace with the word "support".
- It is ADHD that requires a diagnostic service as this condition requires medication
- Definition required to distinguish between LD, ADHD and ASD; IQ threshold.

Schools

- Challenged to be autism friendly across the system rather than expecting an EHCP.
- Alter the dynamic of schools driving the need for assessment in order to access support.
- Link to the SEND agenda and approaches.

Clinical CAMHS - Key Points of Clarity Provided

In spite of focused investment into the early intervention elements of the new service, there will always be children that require Clinical CAMHS and sometimes crisis support.

The following range of services will need to be delivered, as under the current contract, but commissioners wish to see innovation (including use of digital) to get the best possible support from available financial envelope:

- Community Eating Disorder Service
- Community CAMHS (including the Mindful Service)
- Sexual Trauma and Recovery Support (STARS)
- Care and Leaving Care Service (including support for Unaccompanied Asylum Seeking Children)
- Current Crisis-related Services in CAMHS (including clinical input into HOPE and Extended HOPE)
- Service for 16-25 year olds who find it difficult to engage with CAMHS

Services OUT of scope of new contract, as referred to in current contract:

- Children and young people Learning Disability Service
- Parent and Infant Mental Health Service

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Questions about Clinical CAMHS

- What challenges and opportunities does the proposed service model present?
- What more should be considered within the service proposal?
- Is there enough clarity on the full range of services that need to be delivered within this element of the Emotional Wellbeing and Mental Health Services contract?
- How might you ensure that the available financial envelope is able to provide timely support for children and young people with moderate to severe mental health needs?
- How can the needs of vulnerable groups be met through the delivery of robust clinical services?
- No mention of relapse and recovery support

Feedback about Clinical CAMHS

Experience

- Integration is required between EI and CAMHs but this may come with an element of stigma. It will be easier to combat stigma if children and families understand what the pathway looks like and know what to expect.
- Reduce fear by making the process of seeking support and the route to be followed transparent.
- Provide choices at intervals along the service pathway to allow children and young people to maintain control for themselves. Owning choices about recovery is part of reclaiming oneself.
- Educate parents to understand there is not always a “cure”; support is about finding the resolution that works for the child.
- Educate the system to understand there is not always a “cure”; a change of mind set is required towards ongoing support and signposting.
- Alter the perception that access to help is only available when a child becomes ill enough to “merit” it.

Operation

- Make setting and environment appropriate; even if severely ill, waiting rooms and surroundings can be less medical and less frightening.
- Dip in and out, step up and step down, within CAMHS and EI as required. For some children and young people mental health is a chronic condition for which it should be possible to obtain the appropriate level of support seamlessly.
- Alleviate the existing system dependency on CAMHS.
- There is currently a lack of detail about integration back into society/the community with wellbeing support. This may be an area where digital solutions are explored.

Feedback about General Observations

Operation

- Integration is paramount to understand ones position in the system.
- Options available at each stage should be transparent.
- Clinically led early contact to enable informed choices about tailored options.
- Acknowledgement of receipt of request for help e.g. “handshake in a week”
- Four strands of service may be too compartmentalised; currently appears as though they are not interconnected.
- Assurance required that service contract design/governance structure is designed to maximise effective partnership working.
- Current lack of clarity that commissioners are seeking a Lead Provider
- Importance of access to local provision appropriate to the presenting need of children in a geography.
- No mention currently in specification of gender identity issues, forensic and youth justice support or substance misuse services and how these inter-relate.
- Description required as to how services can be accessed by children in the independent school sector or not in school at all
- Procuring in one Lot provides confidence the service will not become disparate but is a consolidated whole offer
- Clarity on thresholds and pathways required.
- Outcome expectation will need to change over the lifespan of the contract.
- Positive experience previously witnessed of Provider Integrated Care Partnership (ICP) arrangements between Community, Mental Health, GP Foundation, Voluntary Sector and Acute providers.

Experience

- Children can often self-manage if given the opportunity and tools to do so.
- Importance of personalisation, caring and being able to tailor to an individual
- Aspiration for 0-25 provision by 2024.
- How are children with vulnerabilities managed on waiting list?

Digital Offer

- Children are more likely to use a digital resource than to self-refer for voice support. Self referral must include online chat options etc.
- Commissioners and service providers are assuming children and young people want to have a conversation in the first instance.
- Digital solutions can allow funding to be used more efficiently across human resources.
- Online resources should complement face to face services and align with young people's wants and needs

Wider System Opportunities

- Excitement about joint working.
- Alignment with Adult MH vital.
- Consider community hubs for entire families
- Spark new initiatives that turn off the demand for CAMHS.
- Change of culture to support children so that CAMHS is only required for a minority.
- KPIs will be key to ensuring innovation can be delivered in partnership.
- Eradicate postcode lottery.
- Eliminate duplication of services and different language/ terminology for the same offer across Surrey. This is where the value of the SPA truly lies.
- An open book accounting model will change relationship dynamics in the system.
- Offer LAC and “leaving care” screening service to prevent later breakdown.
- Trust prior assessments across the system.
- Maximise inter-relationships in the wider setting of Early Help, SEND and First 1000 Days.
- Clarify the mental health offer for 3-5 year olds which is a current gap in provision

Open Questions to the Panel and responses – 1 of 2

PROVIDER QUESTION: Is a Neurodevelopmental Assessment Service the right way to be headed as the system is trying to move away from needing a diagnosis? If we are developing a diagnostic service are we subliminally suggesting that parents need a diagnosis to obtain help?

COMMISSIONER RESPONSE: Granted this name is suggestive; the service element may be called something different when the tender is released. Parents report that currently without diagnosis they do not obtain the support they need. Some children and young people also report needing a diagnosis to understand why it is they feel different. We know that nationally requests for diagnosis have rocketed since 2014. A conversation is needed with schools, GPs and parents to offer help without a diagnosis but a diagnostic service is required and this must be a clear pathway that is as efficient as possible. You will get help from other parts of system if you do not have a diagnosis but parents and schools need to know how to provide support. We need to encourage all schools across Surrey to sign up to the Autism Education Standards. We need to establish a good baseline in schools and then introduce techniques for individual schools to utilise. We have had similar conversation about not perpetuating a clinical model that infers diagnosis is a golden ticket.

PROVIDER OBSERVATION: There is a national shortage of psychiatrists so the pool of individuals who can deliver Neurodevelopmental diagnosis is very small nationally and will exacerbate waiting lists.

COMMISSIONER QUESTION: Are there any suggestions on what this service element should be called so that the offer is framed in a way that manages people's expectation?

PROVIDER RESPONSE: The name should put the support offer at the front and centre with emphasis about supporting families first.

VOLUNTARY SECTOR/PROVIDER QUESTION: where does support for families lie in the Neurodevelopmental Assessment Service? Does the funding include support for families pre and post diagnosis?

COMMISSIONER RESPONSE: The funding sits within the Early Intervention element of service. Children and families should be able to access support without a diagnosis.

VOLUNTARY SECTOR/PROVIDER QUESTION: Once in receipt of a diagnosis are you then supported by the EI service or post diagnosis within this service?

COMMISSIONER RESPONSE: As mentioned above the funding sits within the Early Intervention element of service. Children and families should be able to access support without a diagnosis.

PROVIDER QUESTION: Prevention also includes a child or young person coming back into services after a crisis to prevent re-admittance. This aspect of care seems to be missing from this specification?

COMMISSIONER RESPONSE: Although the four elements of service are described separately all should work in partnership and staff should understand how to operate across the service. Organisations bidding for the service will need to set out and propose those pathways.

Open Questions to the Panel and responses – 2 of 2

PROVIDER QUESTION: £2.4 million has been earmarked for EI. How much of this is for digital interventions? Are you interested in being more specific about the age at which EI is initiated as well as how early in the presentation?

COMMISSIONER RESPONSE: This service does not cover Early Years as offers within the Children's Community Contract provide for those children.

PROVIDER QUESTION– I mean a Primary school age specific offer?

COMMISSIONER QUESTION: We had a conversation on our table about more services being on offer for primary school children and we do want to intervene and help earlier therefore should we specify what it is we expect for early years?

PROVIDER RESPONSE: The most beneficial way to support good mental health is to foster age 0-5 attachments. How do we support children in the age range 3-5 years? With some attachment support services could really help here.

COMMISSIONER RESPONSE: This contract is for children aged 6 and above. As a children's system we are focused on the First 1000 days of a child's life, Early Help and SEND services. This age range of children is supported within those services, in family connections and in social connections. When we see school age children they often have siblings so EI will be about knowing where a child sits within the family unit and where they are receiving wrap around support. Some children may be missing out on mental health intervention but that may be as a result of housing or family issues. Children below the age of 6 are seen as comprehensively supported by the Community Health and Early Help service offers. Provision under this contract must be aware of this.

VOLUNTARY SECTOR/PROVIDER QUESTION: Regarding the ring fenced budget for EI. I am a Voluntary Sector provider currently involved with Surrey & Borders Partnership NHS Foundation Trust. Our offer sits at approximately £1.4 million now. If we want to improve the system are we being ambitious enough?

COMMISSIONER RESPONSE 1: We had this exact same conversation on another table. Whilst it is a fairly bold figure it is not huge in the scheme of the whole contract. We would wish it to be different but we must work with what we currently have and focus on how quickly we can move from what we have to what we want. The contract will need to cover the cost of the staff already working in the system. Today we cannot accommodate more but commissioners want to look for every opportunity to increase this funding. We are stating that £2.4 million is the minimum spend. Sadly we cannot change the position from which we are starting.

COMMISSIONER RESPONSE 2. We are looking for innovation. How would a provider add value to shift resources from one part of the system to an earlier part of the system? This is what we are looking for from a provider along with ideas about how to shift demand. We recognise this is something for the whole system to address.

COMMISSIONER RESPONSE 3: We have also had lots of conversations about how the VCFS and its workforce can contribute. Often people have much they can bring. In Surrey the VCFS makes extensive use of volunteers and we will be looking at this to see what more we can obtain for Surrey's children.