Surrey Children's Emotional Wellbeing and Mental Health Services
Market Engagement Event - 15 October 2019

Key Themes emerging from the event:

- Recognition that Prevention and Early Intervention are not one and the same; distinct differences. Early Intervention definition should be that when somebody asks for help they get access to good quality help really quickly. Prevention is about not needing help in the first place.
- Requirement to define Early Intervention Services
- Mechanism for providers not formally under contract to contribute to service and system learning
- Strong support for a minimum 5 year term if not longer (7 years preferred)
- Strong support for outcomes based reporting/delivery
- Reliance on positive constructive relationships across the whole system to deliver a shared vision/ambition for children
- Audience welcomed proposal for independent system stewards to review delivery and maintain quality standards
- Neurodevelopmental service could be separate but must be holistic and retain strong links to Prevention, Early Intervention and CAMHS.
- Neurodevelopmental service is not just about diagnosis. It should be about identifying the right intervention to help with the circumstances the child/family/carers are having to deal with now.
- Digital offers are about more than early access; they should be seen as an option right across the pathway including specialist need treatments and step down.
- Conflicting views about whether anonymity is safe and whether digital services actually contribute to a child or young person's isolation
- The need to respect and understand the value of early intervention and its various offers.
- Model can only work as a result of strong, respectful, trusting and honest relationships across all providers and stakeholders.

One written question received post event:

Third Sector organisation

The majority of families only see a health visitor once after the birth of a baby. Some do not see a health visitor at all if they choose not to engage. As part of the preventative strategy, given the withdrawal of children's centres for Level 2 families, will this service address this gap in provision?

Procurement Questions from commissioners to attendees and the varied responses

What are views on the three service elements and whether these should be procured as a single contract or as separate lots?

Specialist online provider of mental health and neuro-developmental services:

- As a representative of the above organisation we would not be in a position to bid for the service as a Lead provider. If procured as separate Lots my organisation would have to be sub-contracted to each of the three elements as we offer services which cover pathways across the total Thrive model. Many other organisations will be in a similar position. It is not as simple as becoming a sub-contractor to a single Lot; there are many parts of the pathway we would be interested in becoming involved with. Sees a strong Lead provider model with sub-contracts beneath.

Third Sector organisations

- Commended commissioners for the ways in which Surrey is thinking about this Early Intervention approach which is very positive but Early Intervention and Prevention are two different things. Would strongly suggest separate Lots as there is a strong vibrant Voluntary Sector in Surrey; if it could pool resources as the third sector it would be possible to huge value to this contract. Stated would never be equal partners if not contracted directly; often at the back of the queue in the way that services are set up currently. There is currently much scrutiny on the contract and lots of demand. Now and in the future there will be issues to resolve and when one organisation is working alone to address these it can be very hard. When the system works together honestly and transparently the burden can be shared.

- In agreement with the above about multiple Lots; we are hearing a strong message about Early Intervention so a Lead Provider needs to be strong in that field.

- Separate Lots to make use of each organisation's specialist offering and get the most value for money.

Mental Health Trust

- Strongly disagrees with the model of Lots as sees this leading to fragmentation. Disagrees also with a Lead Provider model. Agrees with the way forward which has been shared but believes there are different routes to get there.

Unknown source

- A single contract is needed so that one contractual provider manages the providers to interact effectively. Without this there is no financial and legal incentive for the Lot providers to work together. Ask prime provider to specify a governance arrangement in the bid.

- Three very carefully commissioned contracts under three prime providers but coordinated by commissioners or one prime contractor overseeing all three elements but the drawback is the scope of knowledge needed to specify additional services accurately and really respect and understand the value of early intervention.

Does a five year contract with potential to extend sound workable to providers?

- Consensus view that should be 5 years minimum. Many attendees mooted 7 years plus 3 for a transformation programme of this size. It was relayed that there is lots of good practice nationally of contracts let for 10 years. Provided the contract contains provision for innovation, change, flexibility and progression this was agreed.

How can we encourage continuous development and flexibility throughout the range of services through the lifetime of the contract?

Third Sector organisations

- Irrespective of the circumstances, when somebody is in Crisis they always know what they want/need. In terms of innovation constantly ask the individual what it is they want and what they will benefit from. This will lead naturally to innovation if services capture what it is people require and then mirror these in the services on offer.

- Outcomes based commissioning; connected with this you will have peaks in the numbers coming through the system. Have outcomes connected to demographic knowledge. Agree with a phasing of the financial elements but a recognition is needed that if caseload is high this may not work appropriately. Will need to be a sophisticated refined response.

- Do not restrict specification; allow continuous review and reframing of services. If child/parent/carer needs are centre of provision this will drive direction.

- Broaden thoughts about enhancing Early Intervention across CAMHS in developing whole system approaches with schools and working closely with universal settings, families and communities. In this context create a more 'Early Intervention Distributive Model'.

Mental Health Trust

- Flexibility is required as there will need to be a change in financial flow over time. If the Early Intervention model takes hold and transformation occurs as expected we should then see a reduction in more complex needs. More money will need to flow into Early Intervention. That is an innovative model.

If there are separate lots, how can we ensure that the clinical service and the early intervention partners work together effectively?

Mental Health Trusts

- The question is not valid as even if let as one Lot there is still the question of how Early Intervention and CAMHS work together.

- To work it is dependent on the relationships being built across the system and having a common shared ambition.

School

- What does Early Intervention look like? I work for a school and what I categorise as Early Intervention may not be the same as that which other organisations/individuals perceive it to be. How does the system define the terms being used?

Third Sector organisations

- Moving to a Thrive approach and a common language; all partners in a single picture will really help the above.

- Agree with the reliance on positive constructive relationships and how they work together to achieve the ambition. Honest, transparent working as one system; suggestion of independent system stewards to keep a check on quality.

- It would help if there was recognition that Early Intervention and clinical services are not necessarily aiming to do different things. If a child receives counselling as part of Early Intervention at the start of their EWMH journey this will look very different to the counselling provided to a child who has had an issue for years and years. Variation of the same service.

- Disagreement to above comment as the service offering should be different as a consequence of stage in a child's EWMH experience. Early Intervention could be as simple as playing football with friends as opposed to counselling. There is a need to respect the value of each contribution.

- Partnership meetings, quality advisors, build into specification and reporting.

Unknown source

- Extremely harsh termination clauses related to relationships in the contract.

What are the challenges and opportunities of a "separate" Neurodevelopmental Diagnostic Assessment service in this model?

Third Sector organisations

- Great to see this moved away from CAMHS. People working in the neurodevelopmental world do not like being combined with CAMHS. Once obtained a diagnosis, so what? It's about managing parents expectations; a diagnosis is not the key to everything and, regardless of outcome, there is still a child requiring support. There must still be strong links to Prevention, Early Intervention and CAMHS.

- Could be separate but must be holistic. May be diagnostic but need to take into consideration the wider external and environmental circumstances in which a child for family finds themselves e.g. bed and breakfast. It is about identifying the right intervention to help with the circumstances having to deal with now.

- Agree with both of the above. The service should be about having effective system processes around the diagnostic offer and then identifying where the child best sits within the system response.

- ND assessment is a really important tool but not a "stand alone" service; must feed clearly into services able to give support and guidance so families are supported.

Unknown source

- Separate front door or separate service brings challenges about how the services and pathways work together but an opportunity for young people with potential diagnosis not to feel additionally labelled as having a mental health need.

Service Questions from commissioners to attendees and the varied responses

What type of support could be available within early intervention services? How should this support be accessed?

Online Counselling Services

- There are a wide range of things that can be available; everything from universal education, peer support to therapy. I feel strongly about how services can be accessed. Feedback is that children and young people value anonymity – they find online access easy and not intimidating. Not even having to say who you are is a massive draw. Our service ends up seeing and working with children who have never accessed services before. There I a need for more than a single point of access; you also need to ensure there is no wrong door.

- Again Prevention and Early Intervention are different. Prevention is education based. Working with colleagues in schools is a must and there is a need to think very carefully about this. Digital offers from an Early Intervention point of view are about more than early access; they should be seen as an option right across the pathway including specialist need. Value is not currently being drawn out of such services as it could be. It's treatments and step down too.

Third Sector organisations

- This relates to the previous conversation about definitions.

- Prevention should be a whole school approach. Need to consider how schools can change their culture to promote good mental health. Also wider with families. It a question of culture and not just about when people speak up and ask for help.

- I work with families with children of all ages but with a common denominator of one child under the age of 5. If we want prevention we need to work with families with children under 5. Neurological patterns are being established at this young age. Issues start to show once patterns are established. Otherwise we are just shifting EWMH provision to schools. There needs to be an early years' aspect of prevention in this model.

- There is a need to empower and encourage parents to access services; volunteers can support parents by attending GP appointments or filling out forms; all of this activity falls within Prevention to avoid a crisis later.

Mental Health Trust

- Digital solutions are appropriate for the workforce too. How to use digital solutions to work more smartly in the ways we communicate together; using algorithms to process information etc.

Unknown source

- Training in schools to see warning signs.
- Volunteer mentoring
- Training for peer support, teachers/school support
- Training for senior leaders in schools around anxiety
- Step down support
- Digital pathways/access and online support

- Support for transition points – pre-school to primary; primary to secondary; secondary to work or college; college to university;
- Support for exams
- Support for bereavement
- Support for parents
- Drop-ins and group support

How can we deliver the aspiration for more use of on-line/digital resources so that children, young people and parents can get advice/access self-help whenever they need it?

Third Sector organisations

- We should be asking children what they think about and want from a digital offer.
- Make sure GPs are aware of what online services are available for children and young people.
- Parents tell us frequently they have to repeatedly tell their story. This must stop and we need to progress information sharing across providers.
- Regarding the comment above it is all well and good to share information but then people need to look at it which does not always happen. It is less about passing people between services and more about sharing the information with all involved in care.
- Digital access is not for everyone; it should be about a choice. It does works extremely well for some. Children are digital natives who are au fait with it; we should take their advice.
- Explore what is already available rather than reinvent the wheel.
- Parents/teachers to have training to know what is available and how to use it.

Unknown source

- Utilise services children already use such as WhatsApp, Facebook subject to safeguards and confidentiality (GDPR)
- Work and collaborate with tech companies to get sign of their up and coming technology.
- Why is this an aspiration when young people have said they value/need face to face support? There is a danger that digital only, particularly anonymised, lead to young people facing problems with isolation rather than tapping into valuable community support. National statistics suggest that digital focus amongst young people actually contributes to poor mental health.
- Commissioners need to appreciate there is a lack of engagement in online solutions which can make them too easy. When face to face young people are engaged doing "work" because there is a motivation to have completed it if you are attending a group/therapist/teacher.

How can we embed the THRIVE principles in our work?

Mental Health Trust

- Make use of evidence based approaches; fine out what works and adopt it.

How can we provide better support for children and young people who are not in school?

Third Sector organisation

- We need to address help towards school refusers and get to the root of why children are not attending/refusing to go to school. This is about a systemic need to understand the cultural changes required to enable children to thrive.

Unknown source

- Organisation delivering services to be responsible for training around Thrive principles in the community and schools.

Should all support for mild to moderate mental health difficulties sit within Early Intervention (including support based around groups of schools)?

Unknown source

- No, some might need more specialist support.

- Question whether support for moderate mental health issues be termed “Early” Intervention. This language contributes to a culture that believes only major issues deserve support.

Questions from floor answered of and answered by commissioners

IUC Service Provider

I work for a 111 and GP OOH provider. One of our main challenges is 24 hour service delivery, 365 days a year and understanding integration with other services. We can get a 10 year old phone up with mental health problems or the parents/carers of such a child. Very little can do sometimes. Where do you see integration with emergency services and 111?

You are right to raise this. At the moment in Surrey we do not have a 24 hour children and young person's EWMH response. We want to put this in place. Currently it is about the interface with your part of the system and putting you in touch with people who can help. In other parts of the country services would know how to put you in touch with the correct people for support out of hours.

We currently have the provision of a mental health nurse out of hours. It would be helpful for us and the ambulance service, as outsiders to this system, to understand how you would commission that as a requirement for integration into our service?

We have discussed and thought about this. We have rightly talked a lot about Early Intervention this morning. The Crisis pathway is important too. We now have telephone advice for parents on a Saturday morning so that they know where to go for help on Monday. This can usually get them through a weekend. You are absolutely right and we are thinking about 111 as we are moving forward for integration.

Third Sector organisation

Will there be a specific IAPT element of provision?

This depends quite what is meant; IAPT is about talking therapies. We are saying these need to be available to a wider group of children through Early Intervention. I think this terms confuses the population and it is better to say talking therapies. Yes this is in scope but not with an IAPT label.

IAPT is valuable and a great resource for training the workforce. Both Mental Health Trust staff and staff in the Third Sector have been trained via IAPT. .

Third Sector organisation

I think I've got a sense today of the conundrum between innovation and creativity vs evidence based approaches. I appreciate there has to be a level of appropriate evidence for service provision. How are you going to bridge this potential lack and stay innovative?

May I clarify if you mean evidence base in delivery or that of a provider submitting a bid proposal i.e. to support the bidding entity?

Delivery.

This is a challenge for the system balancing the two whilst ensuring provision of safe and evidenced services. It should be possible to provide a balance and co-existence for both.

What is described in the transformation trajectory is about innovation and Early Intervention. I really like the idea of system stewards/possibly creating a system convener and establishing an action learning set for system leaders to come together to share expertise, practice and knowledge. Almost like a 'mirror' we hold up to ourselves to review and monitor and progress of the system. As we move forwards we are going to be looking at more innovation – schools and other partners as demand will require this. I am absolutely a fan of outcomes based commissioning; looking at more than outcomes and proxies but also impacts. There should be room for co-existence of innovation and evidence based methodologies.

Third Sector organisation

Will there be a Live Issues List so that organisations and individuals can contribute solutions even if not formally contracted? There will always be evolution in the market. How are you going to tap into that and draw upon it throughout the life of the contract?

We should be contributing to evidence and what works. In Surrey we should be trialing and promoting in addition to become an evidence builder.

Third Sector organisation

You outlined three service elements and budget. Do commissioners have a sense of how this budget will be split across the three?

We have more work to do on this. We are clear that we will specify a minimum level of funding for Early Intervention. Somebody mentioned that over time this level may raise and we need to make assessments about this. The challenge to us as commissioners is to set out that over time the balance of funding will shift.

Third Sector organisation

Is the system open to creative ideas regarding risk and gain share?

We are looking to you, the market, to give us some ideas for lotting etc. We have also heard today how providers who may not be in a formal contract for provision can contribute ideas. There are a variety of contract models to consider e.g. Lead/Prime provider, alliance contract, etc. Today demonstrates how it may be possible to have a holistic approach. The contract will offer tools and levers to enable a number of approaches. All NHS contract schedules can be adapted so it is possible to have conveners, a financial model with risk and gain share etc. The financial model will need to be sophisticated to shift funding across services. It is encouraging to hear you are aware of these challenges and not averse to working within these mechanisms.

We must not forget the power of relationships. Fundamentally this is the driver to providing successful provision for children and families. How as a system do we actively share learning, insights and practice as we progress through the contract, even if not a core provider. We must constantly hold up a mirror to ourselves. It may be possible to convene a learning forum in order to share learning and influence the broader national system.

Of note, a risk and gain share relies on excellent data so that everyone understands what is happening across the whole system. This is often a challenge.

Mental Health Trust

Can you confirm the age span for the contract vis a vis the Long Term Plan which states up to age 25.

Yes the NHS Long Term Plan does state service provision should span the ages of 0- 25yrs. This is about aligning services however. Similarly we need to review services up to the age of 5. The first 1000 days in a child's life if a crucial focus in Surrey. The services we are talking about today will align with the 0-5s and we are similarly doing the same at other end of the spectrum for young adults 18-25.