in good health
The Norfolk and Waveney Health and Care Partnership

July 2019

An Emerging Mental Health Service Model for Children & Young People in Norfolk & Waveney

There is a shared view across Norfolk & Waveney that there are significant opportunities to improve mental health and wellbeing services for children, young people and young adults. The current system is:

- Too fragmented, complicated, and difficult to access;
- Too focused on diagnosis and ill-health, with not enough focus on early prevention;
- Not consistent across Norfolk & Waveney;

RETHINK Partners were commissioned in 2018/2019 to help diagnose problems, identify workable solutions, and provide extra capacity to start transformation. Staff across the system have since built new relationships and worked collaboratively, and system leaders have made the following commitments:

01 **We are listening to children, young people, families and professionals and are transforming children's mental health services, to improve access and focus on getting support to children earlier.**

02 **We are working together to ensure there are the right services for children and young people aged 0-25, moving away from a focus on illness and diagnosis towards young people's health and emotional well-being.**

03 **All of those working across children's services in Norfolk and Waveney are united in creating the best mental health services.**

04 **We appreciate the fantastic staff working across mental health services and we want to ensure that the right systems are in place to support them to do their job.**

We want to create a system based on the THRIVE framework, a nationally recognised best practice approach cited in the Government's recent Green Paper*.

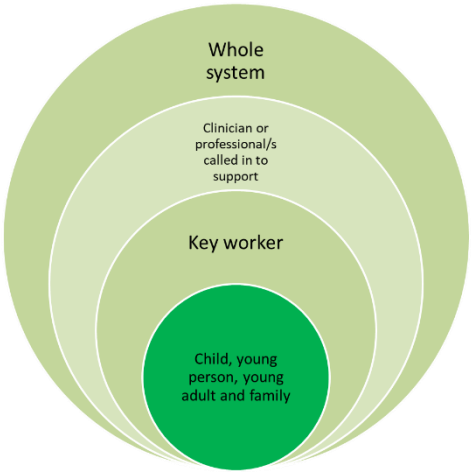
- Instead of a tiered system that creates gaps and exacerbates waiting times, a THRIVE-based system conceptualises the needs of individual children, young people and young adults into five needs-based groupings.
- All 0—25 year olds are considered to be *'in'* the THRIVE framework. The majority will be 'Thriving'. Of those who need help, most will have needs met through 'Getting Advice'.

* The THRIVE framework was developed by a collaboration of authors from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. National i-THRIVE Community of Practice sites are responsible for over 62% of the population of children and young people in England: www.implementingthrive.org/implementation-sites/i-thrive-community-of-practice/

The THRIVE Framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and families. It uses common language that everyone understands, and is needs-led as defined by children, young people and families, alongside professionals through shared decision making *(THRIVE Framework for System Change 2019).*

Needs are not based on severity, diagnosis or health care pathways. Decisions are taken following collaborative goal-orientated discussions around what might be done to alleviate or improve a problem or difficulty, ranging from advice, to support, to specific interventions delivered by the most appropriate agency or group of agencies.

The THRIVE Framework provides the platform for improved outcomes for children, young people and families when implemented across social care, mental health and education.



In order to improve outcomes for children, young people and young adults, the system needs to change how it currently delivers services. Instead of moving the child or young person around the system, we aim to move the system around the child.

There is an opportunity to reshape how statutory and early intervention services work together to reduce inefficiencies, increase the contact time spent supporting children, young people and young adults, improve access and choice of services, improve transitions, and develop new and improved ways of working between partners.

THRIVE's philosophy emphasises serving the needs of individuals and their communities, taking an asset-based approach (building on strengths), and operating as a single service (delivered by a core partnership of providers).

A new operating model needs more than just a new structure. It must be built on a key set of principles and integrated systems that system partners are required to work to:

- **0—25 yrs:** any child, young person or young adult up to their 26th birthday will be served by this model.
- **A focus on Thriving & Early Intervention:** investing in early prevention and aiming to return those with difficulties to a Thriving state.
- **Working as a single system**, with a single IT/ case management system, operational processes, and performance and quality framework, and shared assessments across providers.
- **Clear access routes** for children, young people, young adults and professionals.
- **Community based:** serving local communities and building community capacity.
- **Relationship focused:** reducing 'hand offs' and reducing the amount of times children and young people need to tell their story.
- **Multi-agency, multi-disciplinary teams** that provide support to families, professionals, and universal settings (especially schools).
- **Goal-Focused Episodic Interventions:** involving children, young people and young adults in setting goals and making choices.
- **Shared Decision Making** between practitioners and the children, young people and families they serve.

How might it work?

Access Service

A single phone number for comprehensive advice and signposting to help, available for extended hours. Face to face drop in or appointments via Community Base teams or One Stop Shops (see below). A digital offer that provides advice, guidance and self referral. This could include a text chat service, alongside a website that facilitates online self-help tools and advice, interventions via video, and an online booking and appointment system.

Community Bases

Community Bases are the heart of the new model: multi-agency multi-disciplinary teams based in local communities who serve as a resource for the area. Teams could consist of Mental Health, Early Help, Social Work, Third Sector or other practitioners who go out to serve the community in different settings according to need and build positive relationships with (and offer support to) local communities and agencies. However, community bases could also be physical locations for drop in advice and support, or assessment and treatment.

Key Worker

Whether a school staff member, youth worker, family worker or mental health practitioner, children and young people will be able to keep working with one or two people who journey with them to get the help they need. This key worker will be able to draw in support from the multi-agency team according to need.

One Stop Shops

A smaller number of drop in and treatment bases that focus on the needs of 14—25 year olds, based in four or five locations depending on need.

Specialist Support

There will still be specialist teams or services to serve those who need them. These county-wide teams will be drawn in to help children, young people and young adults wherever they are.

Initial contact will be facilitated by the '**Advice Service'**, a single phone number, face to face drop-in network or online service available across extended hours for children, young people, families and professionals to use as often as required. It will be widely advertised, targeting intended users.

Each contact will be handled by suitably experienced staff, who will be able to draw on other professionals across mental health and social care. A first conversation might promote self-help and provide advice, but would prioritise and facilitate getting the right support at the right time. The Access Service will have appropriate links with Community Bases and One Stop Shops, but also with other agencies and referral systems. A single IT / case management system, alongside clinical oversight and robust procedures, will ensure that those presenting with risk or safeguarding concerns are quickly identified and responded to.

Face to face contact will be delivered via **Community Bases** (situated throughout Norfolk & Waveney according to an agreed footprint), alongside a smaller number of alternative **One Stop Shops** aimed at 14 – 25 yr olds (potential sites could include Norwich, Kings Lynn, Thetford, Great Yarmouth and Cromer).

Community Bases may develop drop in facilities offering extended support, depending on local need, but One Stop Shops will be set up to offer this level of support and advice for those who prefer it. Both types of facility will facilitate bookings for consultation or treatment (once assessed).

A multi-agency multi-disciplinary team will work together in each Community Base to manage local needs and demand by providing advice, a single agency response, multi-agency assessment and/or interventions as appropriate. There is a need to develop services to move beyond traditional 'diagnosable conditions' to address 'distress', an increasing presentation in children, young people and young adults. A multi-agency approach to meet holistic needs will therefore be a core practice for each of the Community Bases and One Stop Shops, with the introduction of clear social recovery interventions.

Indeed, the system as a whole must be fluid and flexible to meet the needs of individual communities and the children, young people and families within them. Each Base will host a mix of statutory and non-statutory agencies, co-located and working together; the specific mix of staff and skills in each Base will be determined according to local demography and need. However, an alliance agreement binding service providers together will ensure that resource is moved as demand and need changes.

There will still be a need for specialist services that operate county-wide, and each Community Base will be able to "pull in" advice or interventions from others within the alliance to provide specialist input, ranging from psychiatric advice and consultation, to social recovery-orientated interventions. Each intervention will be informed by the best available research evidence and NICE guidance, as well as drawing on the specialist skills and knowledge of local practitioners. As far as practicable, assessments and interventions will be delivered within Community Bases or One Stop Shops, offering advice or direct interventions at the point of assessment to address shared goals.

Work is currently underway to map the different geographical footprints used by health, social care and districts to compare local referral data and 'need' indicators so that, in accordance with available estates, we might establish where Community Bases would be best located.

Shared Assessments

The new service will need to develop a shared approach to Mental Health Assessments*,* taking into consideration traditional mental health diagnostic and social recovery-based models of understanding mental distress and emotional difficulties. A shared recovery-orientated approach will need to be adopted across the system to provide this shared language.

This approach to assessment will need to be proportionate and timely. Where there is a need, core multi-agency assessments should be common practice to reduce duplication and clients telling their story more than once. By removing the 'referral on' approach, we will end the current duplication of assessment within the system and ensure the service maximises time spent delivering direct work.

Goal Focused

When someone asks for help, the initial conversation should ascertain what needs to change for them to 'feel better' or 'feel safe'. Potential goals are discussed at the earliest opportunity to help identify which of the available intervention/s are best suited to the individual, and most likely to help him/her to reach their goals.

The model we're adopting recognises that clients often present with a range of problems that do not neatly fit into traditional diagnostic categories, particularly in the early stages of developing mental health problems. We will adopt a goals-focused approach to best match the goals of clients and their families with available interventions (rather than diagnoses). These goals would be identified collaboratively with service users to guide the focus of the advice, or the interventions offered.

Progress against achieving these shared goals will be routinely tracked to ensure that the focus remains clear to both the client and the provider of the intervention. Should the agreed goals not be achieved, a review would be triggered to reassess what meaningfully could be done, and by whom.

Interventions

A range of core interventions have been identified that would support the THRIVE principles offered across the age range. Service users will have a clear understanding of the interventions available to them, including access to self-help tools. They will be offered a choice-led approach which takes into consideration ambivalence and anonymity. When making a choice regarding next steps, service users will not only be fully informed about the options available, but also what is required by them so that necessary changes are made to improve their mental health.

They will be free to repeatedly ask for help and at each event can consider why previous advice or interventions have not been fully successful. **The overall model will encourage episodic care and gaining support from the network around the young person or family.**

A guiding principle of the model is to reduce the 'hand off' of referrals between agencies and avoid any 'falling between gaps in service'. It is therefore a key axiom of this model that **every child and young person is viewed as already being within the THRIVE framework.** This principle of 'not referring on' or handing over to other agencies unnecessarily also ensures that the person with whom the young person or family has a therapeutic alliance or trusting relationship would remain involved as much as possible.

Once a service user is 'allocated', the guiding principle will be that **the 'receiving' worker will retain responsibility for the client** whilst in the 4 quadrants of THRIVE (Getting Advice, Getting Help, Getting More Help and Getting Risk Support). Staff from different provider organisations operating out of each Community Base will operate as a single team. Ongoing multi-agency training with local and meta-level management and clinical supervision will ensure that the service works to a common set of principles and practice. As a 'team' they will be able to draw on each other's skills and expertise to support the community they serve.

Workers will be able to access support from other professionals for their caseload through locally organised supervision and support structures, and will be able to 'pull in' more help or risk support as required. This could take the form of consultation, group case discussion, or advice and guidance for alternative strategies. The service user will remain with the original case holder until s/he returns to 'Thriving'.

What difference will it make?

For Children, Young People, Young Adults & Families

- If I'm 0—25 yrs old, this service is for me.
- No matter who I turn to for help, I'll be able to get the help I need.
- No matter where I live in Norfolk & Waveney, I'll be able to get help nearby if I need it.
- I can call a dedicated number, use a website / app, or meet someone face to face.
- We'll focus on possibilities and strengths, setting goals and making choices.
- I won't need to repeat my story too many times. I'll be able to keep working with someone for as long as I need to.

For Mental Health Practitioners

- Everyone in the system takes responsibility: no 'referrals on'. Support will be 'drawn in' for any worker continuing key relationships as a 'team around the professional' from wherever in the system is required.
- If I'm not in a specialist service, I will be in a multi-agency multi-disciplinary team co-located in a Community Base, One Stop Shop, or universal setting. I'll use community resources to resolve difficulties if possible, drawing in specialists as required.
- We will work as a whole system, with a single performance and quality framework, and a shared IT system for case management and reporting.
- Commissioning and decision making will take place through a single governance body.

For other professionals and key workers

- I will be able to get to know my local CYPMHS Team and work together in my locality to meet the needs of children, young people and young adults. Important information will be shared between us. Our aim will be to increase early intervention, build resilient communities, and help every child to thrive.
- I can call a dedicated number, access a digital platform, or liaise with my local CYPMHS Team for advice, guidance and support. It will be easier and quicker for children, young people and young adults to get the help they need.
- If I have a working relationship with a child, young person or young adult experiencing particular needs, I will receive support and input to continue that relationship.

Typical Case Study Examples	*What happens now*	*What will happen in the new service model*
6 year old presenting with anxiety, school refusal and potential attachment difficulties.	The family will turn to school for help, or school will flag up an issue. The school's referral to Early Help will likely be rejected, and the presentation is not severe enough for Tier 3 help. Tier 2 provision (Point 1) may take on the case, but the waiting list is up to 12 months, and there'll be no involvement with the parent when intervention begins.	The team from the local Community Base will already have established relationship with the school. The school or the parent will be able to call a single phone number for help and advice, or the school may call in a team member, or seek advice during a regular check in. The team may have an embedded Mental Health Practitioner in the school. The family will be involved and addressed as a whole; family workers may be called in. The school will be supported to gain contextual understanding of the issues presented from a mental health perspective, and other agency colleagues will be worked with collaboratively to decide on the best course of action to support the child and family.
14 yr old presenting with self-harming behaviours	There is currently no specific service or place to refer for help to address issues surrounding self harm. The individual may seek help from Chat Health, or search the internet for whatever advice they can find.	The individual or their family will be able to access help via a single phone number, face to face drop in or appointment, or an online offer that provides or signposts relevant information. Teams from Community Bases will be able to meet with individuals, and also their parents for advice and support in contextualising the behaviour and providing guidance in managing self harming behaviours. Specialists can be drawn in if there's need, and risk support will be available from multiple agencies if required.
21 yr old presenting with repeated self harm and significant distress.	Significant history of trauma, looked after child. Presents with complex PTSD and Borderline personality disorder features and disorganised attachment. Bounces around the system between services, acute, crisis, social care and mental health. Struggles to engage. Eventually "case managed" within the youth service for "treatment" but cannot engage. Seen for crisis appointments repeatedly. Offered psychological interventions but with little impact.	"AMBIT" style working supports the relationship with the LAAC worker who forms a joint understanding of the person using mentalisation, which contains and supports the young adult. Interventions supported in being delivered by the youth team. Later feels ready and is realistic about the need to engage in therapy. This specialist therapy is then offered via the youth team. A year later, the young adult undertakes a future course of therapy which builds on the earlier intervention, and (together with the social care team and the GP) feels supported and contained by this, no longer feeling the need to repeatedly seek help beyond existing relationships.

Further considerations

Looked After Children
Existing targeted service delivery for looked after children and young people is not working effectively. We need an enhanced, flexible mental health offer that can respond quickly and intensively, and can work with a number of children and young people who may not have a diagnosable condition, but who are nonetheless experiencing significant distress and/or displaying behaviours that challenge those supporting them.

Timescales and onset of need for looked after children is different to other cohorts of children and young people. Within the CAMHS system there is an acknowledgement that they often get caught up in complex processes and require more time to support and manage, which ultimately impacts on the wider offer for children and young people.

The new service model will therefore introduce an 'integrated' service offer for looked after and adopted children with social work and mental health staff working as one team. This team will be able to provide a continual therapeutic approach, clinical supervision for social care staff, and interventions that are jointly assessed and mobilised by Social Work and Mental Health practitioners.

Crisis
A major part of the Thrive framework is 'Getting Risk Support'. It is recognised that many young people present with complex difficulties for which no simple health-based intervention exists. In part this is because the young person has emotional needs which preclude them from engaging in steps to modify or better manage their distress or behaviour.

Nevertheless, such young people cause a significant degree of concern within their families and communities. They require ongoing support and often have specific requirements, such as access to 24 hour support and advice. In addition, numerous professionals who come into contact with such individuals also require support, containment and advice. As a group, they often need to reach a shared understanding regarding the risks posed and the steps needed in order to minimise or manage them.

It is therefore proposed that the outworking of 'Getting Risk Support' should manifest a more sophisticated approach to multi-agency working. This will involve a range of agencies, including crisis and liaison workers, youth workers, social recovery support and coaching. Ultimately it will result in the provision of better crisis facilities, including 24 hours digital and telephone support, and crisis houses and drop in facilities where issues can be discussed repeatedly (rather than making assumptions about treatment).

Such an approach should seek to identify the causes of distress in a multi-disciplinary manner and address the underlying needs where possible. This method of working will require ongoing robust supervision of the individuals involved across agencies. Taking a systemic approach to the majority of such presentations to services should allow individuals to begin to take steps towards recovery, supported by their communities. Such interventions should also seek to nudge or encourage young people to meaningfully engage with the treatment choices available, including specialist health or social care interventions.

Key Assumptions

This new model presents an exciting opportunity to not only address the problems many of us have identified, but also to deliver nationally recognised best practice services. However, it is reliant on some key assumptions:

- Sufficient capacity & resource,
- Sufficient and supported workforce,
- 'Managing out' the current waiting list,
- Rapid access to help for those who need it.

It also demands a significant culture change, and a very different set of behaviours from everyone in the system. Implementation will be complex. However, there is a high level of ownership of this vision across the system, and a strong acceptance of the need for change. We've also established very strong foundations of joint working between Children's Services, commissioners, and providers in the last six months of Transformation work that we can build on.

What's next?

Having laid the foundations of systemic collaboration, and having established a clear understanding of what children, young people, families and clinicians want the new service model to be, we now need to answer detailed questions about how it will work in practice. We may need to change things gradually, and there will be a continuous process of learning and adapting, but we're aiming to launch the new service in October 2020.

RETHINK Partners were commissioned to provide a diagnostic report in the first phase of transformation (August – December 2018), and to provide additional programme capacity during the second mobilisation phase (January - June 2019). During this latter period, colleagues from NSFT, NCC, CCGs and third sector partners worked to mobilise the report's recommendations. We have now entered the third phase of transformation, focused on implementation.

One key recommendation was to establish a single governance body (the Alliance Board) with delegated financial responsibility, and a newly integrated commissioning team. This piece of work is a crucial foundation on which the rest of the transformation depends. We're on track to achieve this by October 2019, so our initial focus in the next quarter is on:

1. **Supporting these changes to governance and process,** with consideration for sourcing and legal issues as we develop an Alliance agreement to deliver services.

2. **Articulating the detail of a new Service Model and performance management framework**, with consideration for workforce and the requirements of our digital offer.

Workstreams are currently clustered in these two areas (cf Appendix 1), each overseen by a programme manager who supports workstream leads, convenes monthly delivery group meetings, and reports monthly to Exec Sponsors and the STP. Once the Alliance Board is established, the transformation plan will be reviewed, and additional workstreams, such as Innovation and Research, Insight, and Third Sector engagement will be continued from October 2019.

To achieve our October 2020 deadline, we need continued input and co-production from children, young people, young adults, families, and staff across the system. Following a Service Design workshop in September 2019 we will work with these stakeholders to test our assumptions, demonstrate how this model can work in practice, and use whatever we learn to shape the service.

Appendix 1: Current Overview of Workstreams

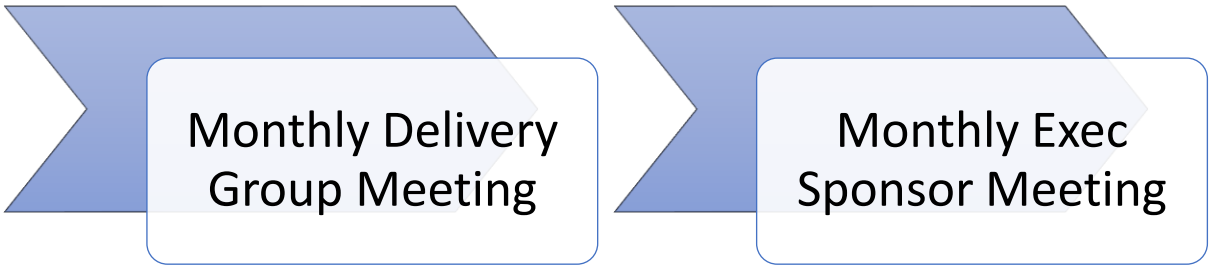
Service Design & Change Cluster

Workstream	Objective
SDC 1: Service Design	To further refine the service model and prepare a clear plan for test and learn for sign of by the Alliance Board.
SDC 2: Outcomes & Reporting	To produce a single outcomes & reporting framework for all CYPMH providers for sign off by the Alliance Board.
SDC3: Workforce	To finalise the workforce framework, drawing on results of test and learn phase*
SDC4: Digital	To scope the future CYPMH Digital offer and single provider platform, and prepare a costed options appraisal.
Enabler: Demand & Capacity Model	*Refine tool to estimate key gaps, agree mitigation plans, and test assumptions during test and learn phase.*

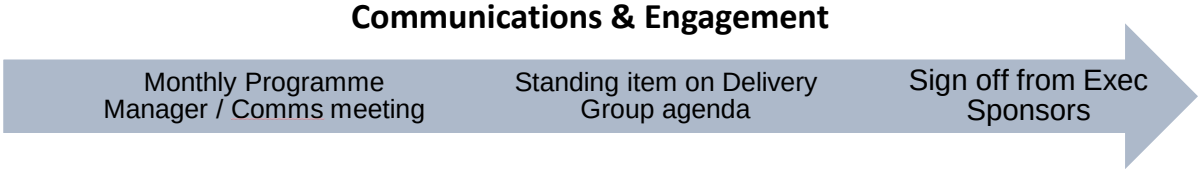
Governance & Process Cluster

Workstream	Objective
GP1: Alliance Board	To mobilise and service the new CYPMH Alliance Board.
GP2: Alliance agreement	To develop the Heads of Terms of the Alliance.
GP3: Section 75	To prepare the new S75 (with legal input), for sign off by CCGs/NCC
GP4: Sourcing & Legal	To establish the milestones, process and legal input to enable the system to implement the Alliance model.

Reporting Infrastructure



Communications & Engagement



Additional Phase 3b Workstreams

Topic	Objective
Insight	Prototype and then refine the insight model
Innovation and research	Implement the agreed framework to focus I&R on service improvement priorities
Financial and performance reporting	Agree and roll out approach to integrated quality, financial and performance reporting
Estates	Determine the estates requirements of the new service model, and identify costed options
3rd sector	Implement agreed framework to develop capacity