Child and Adolescent Mental Health Services

– a needs assessment for the Norfolk and Waveney Local Transformation Plan October 2017

This document is a local analysis of the current mental health needs of children and young people in Norfolk in order to inform the redesign of the Child and Adolescent Mental Health Services.

CONFIDENTIAL
Due to the small and potentially identifiable numbers within the service use

Intelligence and Analytics Team, Norfolk County Council

Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Norfolk County Council
Supported by INTELLIGENCE & ANALYTICS

Contents

Estimates for future need for services based on Five Year Forward View and Thrive model

The NHS requirements for performance and activity[1] suggests that NHS funder community services should be treating at least 35% of those aged 0 to 18 with a diagnosable mental health condition each year. The documentation estimates that about 10% of the population aged 0 to 17 have a diagnosable mental health condition, although they acknowledge that there is limited recent data available on the estimated prevalence. In the absence of recent data an estimate has been created by applying the 5-16 year old estimates as provided in the PHE fingertips tool[2] to 0-17 ONS 2014-based population projections[3].

Where areas are exceeding the 35% then the area should aim to increase the number of children aged 0 to 18 receiving treatment by 7% by 2020/21. For example, if an area was treating 38% of their estimated population with a diagnosable mental health condition in 2016/17 then they should be treating 45% of their population by 2020/21.

From the 2016/17 annual declaration[4] total referrals into NHS community services in 2016/17 was about 10,300. Of which about 4,550 were into Point 1 (about 390 were rejected) and about 5,740 were to NSFT (about 1,560 were rejected). In addition there were about 2,160 referrals for ADHD and 1,000 referrals for children with learning difficulties and mental health conditions.

We can apply these referral numbers to the NHS requirements for performance and activity to understand how the capacity of Norfolk and Waveney CAMHS might need to change over the next five years (Table 2). See Appendix F for the full tables for each CCG in Norfolk and Waveney.

Table 1 Expected referral numbers from 2016/17 applying NHS requirements for NHS Norfolk and Waveney

Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	57%	59%	61%	63%	64%
Number of additional CYP treated over 2016/17 position	-	436	879	1,329	1,786
Total referred	10,287 [4]	10,723	11,166	11,616	12,073
Total with condition aged 0 to 17	17,948[1 & 4]	18,154	18,360	18,566	18,772
Norfolk aged 0 to 17	168,228	169,771	171,314	172,857	174,400
Waveney aged 0 to 17	22,378	22,445	22,512	22,578	22,645
Total Norfolk and Waveney aged 0 to 17	190,606[3]	192,216	193,826	195,435	197,045

[1] https://www.england.nhs.uk/publication/joint-technical-definitions-for-performance-and-activity-20171-8-201819/
[2] https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data
[3] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandz2
[4] Norfolk County Council CAMHS data excluding ADHD and Starfish

We can further develop this using the The THRIVE [5] model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 2 THRIVE framework applied to estimated number of referrals across Norfolk and Waveney

Thrive State	Issue	NICE Guideline	Estimated Proportion	Estimated Number				
				2016/17	2017/18	2018/19	2019/20	2020/21
			100%	10,287 [4]	10,723	11,166	11,616	12,073
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	309	321	333	345	358
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	2,880	2,993	3,108	3,224	3,341
Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	720	748	777	806	835
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	206	214	222	230	239
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	514	535	555	576	597
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	103	107	111	115	119
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	617	641	666	691	716
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	411	428	444	461	477
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	103	107	111	115	119
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	206	214	222	230	239
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	617	641	666	691	716
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	206	214	222	230	239

[5] http://pbrcamhs.org/final-report/ and http://pbrcamhs.org/wp-content/uploads/2015/06/CAMHS-Payment-System-Project-Final-Report.pdf

Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	206	214	222	230	239
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	103	107	111	115	119
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	103	107	111	115	119
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	206	214	222	230	239
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	823	855	888	921	955
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	1,646	1,710	1,776	1,842	1,909
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	823	855	888	921	955

We can also use the older tiered approach[6] to understand potential size of each tier (Table 3 below)

Table 3 Estimated need for services at each tier

	2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Population aged 0 to 17	190,606[3]	192,216	193,826	195,435	197,045
Tier 1 – universal e.g. PATHS	28224	28462	28700	28939	29177
Tier 2 – community mental health	13174	13285	13396	13507	13619
Tier 3 specialist community	3497	3527	3556	3586	3615
Tier 4 – severe and/or complex	150	151	153	154	155

[6] Kurtz, Z. (1996) Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.

Currently Point 1 provide some Tier 2 targeted services, but only receive about 4,550 referrals out of an expected 12,360. NSFT who provide specialist Tier 3 services receive about 5,740 referrals compared to an expected number of about 3,280. However, about 1,560 were rejected as not being suitable. These might have been better off seen by Point 1.

Some of these young people would have been previously held in Connexions, youth service or social care. According to NSFT, referral trends highlight so-called 'inappropriate' referrals, where the need either does not fit the criteria for assessment in some services or, when assessments have been undertaken, no further work is deemed necessary. The proportion of accepted referrals (about 75%) to rejected referrals appears to be affected by:

- Referrers having poor knowledge of what resources and services are already available for children and young people.
- The lack of clarity and standardisation about specific and current referral pathways.
- The thresholds for accepting referrals in those services to which referrals are made.
- The lack of alternative provision.

Introduction

Mental health problems in children can affect their overall well-being in both the immediate and long term, with studies such as the *World Happiness Report 2017* finding that over half of children who have a mental health problem will suffer from mental ill-health as adults. The Happiness report explains how mental health problems such as depression can be more disabling than physical problems such as arthritis or asthma. It also acknowledges the challenges faced by children and young people in developing resilience and psychological wellbeing. Understanding children's mental health as an important part of their wellbeing, now and for the future, and examining the known links to other risk factors such as the mental health of the child's mother, primary and secondary school experience, bullying and family relationships, allows us to develop a local child and adolescent mental health service (CAMHS) that will meet our children's health needs.

"A Whole School and College Approach"
Public Health England (2015) have estimated that in an average class of 30 15-year olds:

- **Three** could have a mental disorder.
- **Ten** are likely to have witnessed their parents separate.
- **One** could have experienced the death of a parent.
- **Seven** are likely to have been bullied.
- **Six** may be self-harming.

Schools and colleges play a significant and valuable role in helping to promote children's and young people's emotional health and wellbeing. However, their contribution is just one element of a wider multi-agency approach, including strong links and recommendations required from the local Health Child Programme (HCP).

Within the national context, transforming children and young people's mental health and emotional wellbeing services has a current and high national profile that goes back to the launch of the Future in Mind 2015 report. This provides clear guidance for the next five years, with a specific focus on eating disorders, early intervention and crisis support. Norfolk and Waveney have received £1.9 million in the first year to transform CAMHS, including £0.5 million for eating disorders.

In 2016, Norfolk County Council began to work closely with the various NHS commissioning bodies to jointly re-design and modernise the entire mental health system for children and young people in Norfolk and Waveney. This fits with many local aspirations within the health economy, including the local Sustainability and Transformation Plan (STP) and the current development of the CAMHS service being implemented by the CCGs as part of their Local Transformation Plan (LTP). Example CAMHS projects have been included in Appendix A.

What is mental health?

Mental health comprises of two areas: mental illness or ill-health[7] and, mental or psychological well-being.

Mental ill-health measures consider whether a person has a higher likelihood of a clinical diagnosable illness, from anxiety or depression to conditions such as bi-polar or schizophrenia. These conditions can be defined by use of the international Classification of Disease (ICD10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In children, mental ill-health can emerge in different ways to adults, often resulting in behavioural and conduct problems, such as Attention Deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder (ODD). It can also appear as emotional problems such as depression or anxiety. Some of these conditions can also be symptoms of underlying problems, which can be caused by environmental factors such as parental conflict, or developmental factors such as Autistic Spectrum Disorders.

Mental well-being covers how people feel about their lives and whether their lives are worthwhile. It is described as a dynamic state and not just the absence of mental health problems. Good mental health allows "individuals to be able to develop their potential and work productively and creatively, forging strong and positive relationships with others around them, and contribute to their community" (Government Office for Science, 2008). Measures of children's well-being can include quarrelling with parents, talking to parents about things that matter, exposure to cyberbullying, happiness with family and friends, satisfaction with use of time and considering the things that one does are worthwhile[8].

Why is mental ill-health important?

Public Health England have shown the influence which a child's emotional health and wellbeing has upon their cognitive development, learning, physical health and their mental wellbeing in adulthood (Public Health England, 2014 & 2015). A number of disorders are persistent and will continue into adult life unless properly treated at an early stage. It is essential to have a positive mental wellbeing if children and young people are to flourish and lead rich and fulfilling lives. Children with mental health problems are more likely to have time off school, especially unauthorised absences, than those children without mental health problems. In addition, they are less likely to have a network of family and friends with whom they feel close too.

What is a 'Public Health Needs Assessment?'

To be able to accurately assess the health needs of a population in order to successfully re-design a service, agree priorities and allocate resources, the following information is recommended:

- Data collection, including population data (current and future population estimates and profiling) and disease/disorder profiling (prevalence and incidence).
- Identification of health priorities via perception of needs from health service users. This includes those of users, carers and families, and results of Healthwatch projects. Identification of CQC findings, national policy and guidance.
- Understanding of current resources, including CAMHS workforce (capacity, staff ratio clinical vs non-clinical) and finance data (e.g. spend per head) and assets. Plus, current service provision (access and activity) including referrals and waiting times.

[7] Also known as 'mental health problems' or 'mental disorders'.

[8] Adapted from Office for National Statistics (ONS), *Insights into children's mental health and well-being.* 2015.

- Recommended future models of care based on health conditions and determinant factors with the most significant size and impact, such as the Thrive framework.
- Clarification of aims of intervention, including action planning; monitoring (via CAMHS strategy outcome measures and Public Health outcomes) and evaluation strategy.
- Learning from the process of the health needs assessment and measuring its impact.

Population Estimates and Projections for Children and Young People

A CAMHS service needs to relate to the population it serves; it needs to be designed to work with different age groups and not aggregate everybody together. It should recognise that young people's mental health needs are different to younger children's or young adults. Understanding our population of children and young people within Norfolk and Waveney, both now and in the future, will help to tackle health inequalities and provide a CAMHS service that meets their mental health needs.

Transition from children's to adults' mental health services is an important aspect of CAMHS work and population figures are presented for 16-18 year olds to assist with service planning and integration. For groups not covered by health, social care and education legislation NICE 2016 guidelines[9] recommend planning for transition to adulthood from year 9 (age 13 or 14). For young people with education, health and care plans, transition planning must happen from year 9, as set out in the Children and Families Act 2014. For young people leaving care, this must happen from age 15-and-a-half years. For young people entering the service close to the point of transfer, planning should start at the same time as their mental health services. However, the point of transfer should not be based on a rigid age threshold.

Services and pathways which can straddle the transition period of 16-18 years, and provide services up to the age of 25, can help to overcome some of the barriers that many young adults find inaccessible or unresponsive to their specific needs; some will fall through the gaps between a CAMHS service and adult mental health services. With the prevalence of adolescence mental illness known to increase with age, particularly among young women, and 75% of lifetime mental illness starting before the age of 25, 19-24 year olds are a population that can present with more complex mental health needs and need effective early intervention to reduce life-course impairment.

The ONS 2004 Survey of the Mental Health of Children and Young People in Great Britain estimated differences in prevalence of mental health disorder between age ranges[10]. For both genders, prevalence of any mental health disorder was higher for children aged 11-16 (12%) than for 5-10 year olds (8%). The prevalence for children aged under 5 was estimated to be between 5% and 7.1%. Emotional and conduct disorders were estimated to be more prevalent in 11-16 year olds than younger children but hyperkinetic disorders were more frequently found in the younger cohort.

[9] NICE Guidelines NG43, 2016. *Transition from children's to adults; services for young people using health or social care services. Available at: https://pathways.nice.org.uk*

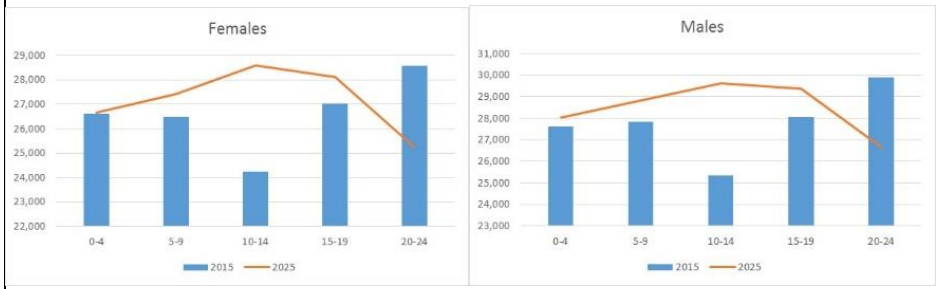
[10] The ONS 2004 survey is being updated with the 2016 survey of the mental health of children and young people, with results due to be published in 2018.

The 0-24 year old Population

In 2015, there were 271,698 children and young people aged between 0 and 24 years in Norfolk and Waveney. This group make up 27% of the total population within Norfolk and Waveney. Norwich district has the highest number of children and young people aged 0-24 years (47,758) and North Norfolk district the lowest number (22,857). South Norfolk CCG has the highest number of children and young people aged 0-24 years (65,710) and North Norfolk CCG the lowest (39,996). In total there are more males (138,769) than females (132,929) and this trend continues within each 5-year age band.

0-24 year old Population by District			
	2015	2025	Population Change (%)
Breckland	36,357	37,168	2.2%
Broadland	31,763	31,513	-0.8%
Great Yarmouth	27,692	27,179	-1.9%
King's Lynn and West Norfolk	39,584	40,614	2.5%
North Norfolk	22,857	22,961	0.5%
Norwich	47,758	50,434	5.3%
South Norfolk	34,827	38,614	9.8%
Waveney	30,860	30,116	-2.5%
Norfolk & Waveney	**271,698**	**278,600**	**2.5%**

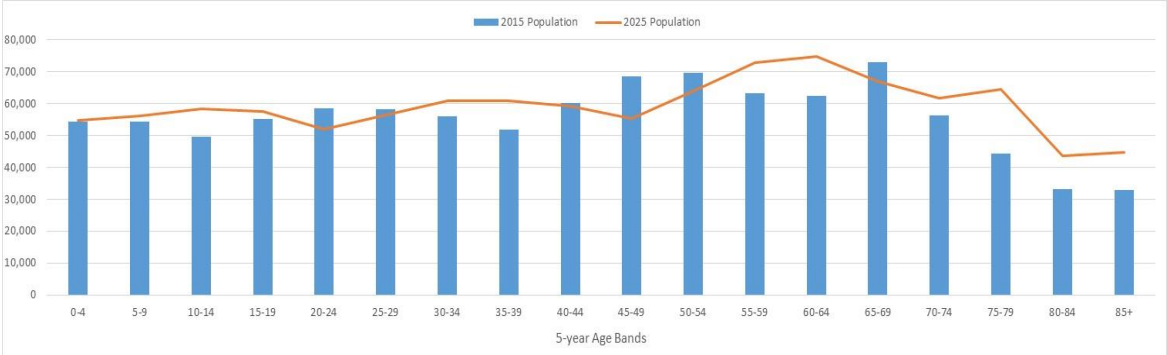
2015	Age Bands (5-years)					
	0-4	5-9	10-14	15-19	20-24	Total
Females	26,601	26,489	24,248	27,021	28,570	132,929
Males	27,609	27,857	25,359	28,047	29,897	138,769
Norfolk & Waveney	**54,210**	**54,346**	**49,607**	**55,068**	**58,467**	**271,698**

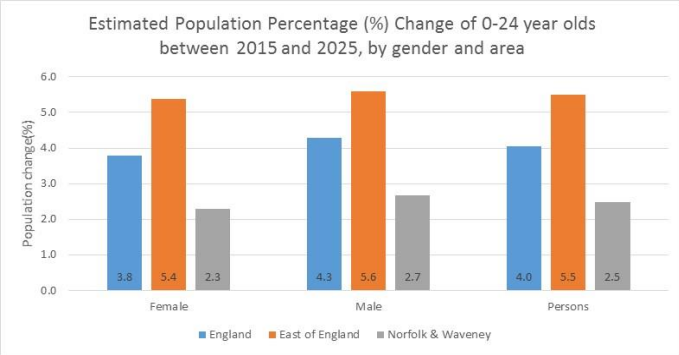


0-24 year old Population by Clinical Commissioning Group			
	2015	2025	Population Change (%)
Great Yarmouth and Waveney CCG	58,552	57,295	-2.2%
North Norfolk CCG	39,996	39,925	-0.2%
Norwich CCG	62,382	64,983	4.0%
South Norfolk CCG	65,710	70,166	6.4%
West Norfolk CCG	45,058	46,231	2.5%
Norfolk & Waveney	**271,698**	**278,600**	**2.5%**

Projected Population Changes

In 2025, the population of 0-24 year olds in Norfolk and Waveney is predicted to increase by 2.5%, East of England by 5.5% and England by 4.0%. This will bring the total in Norfolk and Waveney to 278,600 by 2025. The largest percentage increase in the number of children and young people will be in South Norfolk District and CCG (9.8% and 6.4% respectively). However, there are areas that are predicted to decrease in the number of children and young people aged between 0 and 24 years of age. This includes an expected small decline in Great Yarmouth (-1.9%) and Waveney (-2.5%) districts; -2.2% overall in Great Yarmouth and Waveney CCG. In addition, the number of children and young people is projected to decrease in some specific 5-year age bands but increase in others. These population changes by District, and CCG, by 5-year age bands can be found in Appendix A.





Source: Mid-2015 Resident Population Estimates, Office for National Statistics

The 0-17 year old Population

In 2015, there were 190,482 children and young people aged between 0 and 17 years[11] in Norfolk and Waveney. This group make up 19% of the total population within Norfolk and Waveney. King's Lynn and West Norfolk district has the highest number of children and young people aged 0 to 17 years (29,129), and North Norfolk district the lowest number (16,457). South Norfolk CCG has the highest number of children and young people aged 0 to 17 years (49,131) and North Norfolk CCG the lowest (29,405).

In 2025, the population of 0-17 year olds in Norfolk and Waveney is predicted to increase by 6.5%, East of England by 9.2% and England 7.6%. This will bring the total in Norfolk and Waveney to 204,507 by 2025. The largest percentage increase in the number of children and young people will be in South Norfolk district and CCG (14.3% and 10.9% respectively). There are not any Districts or CCGs that are predicted to decrease in the number of 0-17 year olds within their area.

0-17 year old Population by District

	2015	2025	Population change (%)
Breckland	26,513	28,385	6.6%
Broadland	23,553	24,319	3.1%
Great Yarmouth	19,685	20,300	3.0%
King's Lynn and West Norfolk	29,129	30,864	5.6%
North Norfolk	16,457	17,674	6.9%
Norwich	25,958	28,850	10.0%
South Norfolk	26,646	31,095	14.3%
Waveney	22,541	23,022	2.1%
Norfolk & Waveney	**190,482**	**204,507**	**6.9%**

0-17 year old Population by CCG

	2015	2025	Population Change (%)
Great Yarmouth and Waveney CCG	42,226	43,321	2.5%
North Norfolk CCG	29,405	30,941	5.0%
Norwich CCG	36,563	39,902	8.4%
South Norfolk CCG	49,131	55,137	10.9%
West Norfolk CCG	33,157	35,207	5.8%
Norfolk & Waveney	**190,482**	**204,507**	**6.9%**

[11] 17 years and 364 days.

The 16-18 year old Population

In 2015, there were 33,369 young people aged between 16 and 18 years in Norfolk and Waveney. This group make up 3.3% of the total population within Norfolk and Waveney. King's Lynn and West Norfolk district has the highest number of young people aged 16 to 18 years (4,918), and North Norfolk district the lowest number (3,100). South Norfolk CCG has the highest number of young people aged 16 to 18 years (8,660) and North Norfolk CCG the lowest (5,517).

In 2025, the population of 16-18 year olds in Norfolk and Waveney is predicted to increase by 4.6%, East of England by 8.7% and England 7.5%. This will bring the total in Norfolk and Waveney to 34,981 by 2025. The largest percentage increase in the number of young people will be in Norwich district and CCG (15.0% and 10.6% respectively). Both Broadland and Great Yarmouth districts are both predicted to see small declines in their numbers of 16-18 year olds, as is North Norfolk CCG.

16-18 year old Population by District

	2015	2025	Population change (%)
Breckland	4,584	4,745	3.4% ↑
Broadland	4,428	4,348	-1.8% ↓
Great Yarmouth	3,555	3,542	-0.4% ↓
King's Lynn and West Norfolk	4,918	5,083	3.2% ↑
North Norfolk	3,100	3,101	0.0% –
Norwich	4,092	4,817	15.0% ↑
South Norfolk	4,781	5,398	11.4% ↑
Waveney	3,911	3,948	0.9% ↑
Norfolk & Waveney	**33,369**	**34,981**	**4.6%** ↑

16-18 year old Population by CCG

	2015	2025	Population Change (%)
Great Yarmouth and Waveney CCG	7,466	7,490	0.3%
North Norfolk CCG	5,517	5,435	-1.5%
Norwich CCG	6,103	6,830	10.6%
South Norfolk CCG	8,660	9,391	7.8%
West Norfolk CCG	5,623	5,835	3.6%
Norfolk & Waveney	**33,369**	**34,981**	**4.6%**

The 19-24 year old Population

In 2015, there were 69,709 young adults aged between 19 and 24 years in Norfolk and Waveney. This group make up 7.0% of the total population within Norfolk and Waveney. Norwich district and CCG have a significantly higher number of young adults aged 19 to 24 years (20,179 and 23,508 respectively) and North Norfolk district and CCG have the lowest number (5,292 and 8,730 respectively).

In 2025, the population of 19-24 year olds in Norfolk and Waveney is predicted to decrease by 11.3%, East of England by 8.3% and England 7.2%. This will bring the total in Norfolk and Waveney down to 62,642 by 2025. The largest percentage decrease in the number of young people will be in North Norfolk district and CCG (-23.1% and -20.6% respectively). All of the districts and CCGs are predicted to see a decrease in their numbers of 19-24 year olds, with Norwich district and CCG expected to see the smallest reductions.

19-24 year old Population by District

	2015	2025	Population change (%)
Breckland	8,331	7,271	-14.6%
Broadland	6,767	5,777	-17.1%
Great Yarmouth	6,775	5,716	-18.5%
King's Lynn and West Norfolk	8,812	8,116	-8.6%
North Norfolk	5,292	4,298	-23.1%
Norwich	20,179	19,758	-2.1%
South Norfolk	6,586	5,867	-12.2%
Waveney	6,967	5,838	-19.3%
Norfolk & Waveney	**69,709**	**62,642**	**-11.3%**

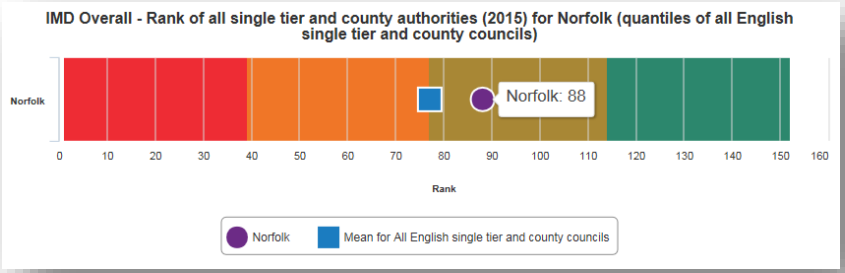
19-24 year old Population by CCG

	2015	2025	Population change (%)
Great Yarmouth and Waveney CCG	13,742	11,554	-18.9%
North Norfolk CCG	8,730	7,236	-20.6%
Norwich CCG	23,508	22,597	-4.0%
South Norfolk CCG	13,721	12,110	-13.3%
West Norfolk CCG	10,008	9,145	-9.4%
Norfolk & Waveney	**69,709**	**62,642**	**-11.3%**

Deprivation

General health, as well as mental health, are influenced by many socioeconomic factors, including income, housing employment and the wider environment. People from more deprived populations are more likely to live shorter lives, as well as live a greater proportion of their life in poor health. The index of multiple deprivation 2015 (IMD) combines seven different domains: income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment deprivation, and crime. When put together these seven domains provide a measure of deprivation. A rank of 1 indicates the highest level of deprivation.

Norfolk, as a county authority, has a deprivation ranking score of 88 out of 152 local authorities, as shown below[12]. The mean deprivation score for all single tier and county councils within England is 77 (out of 152). This means that Norfolk is less deprived than the mean (average) for single tier and county councils.



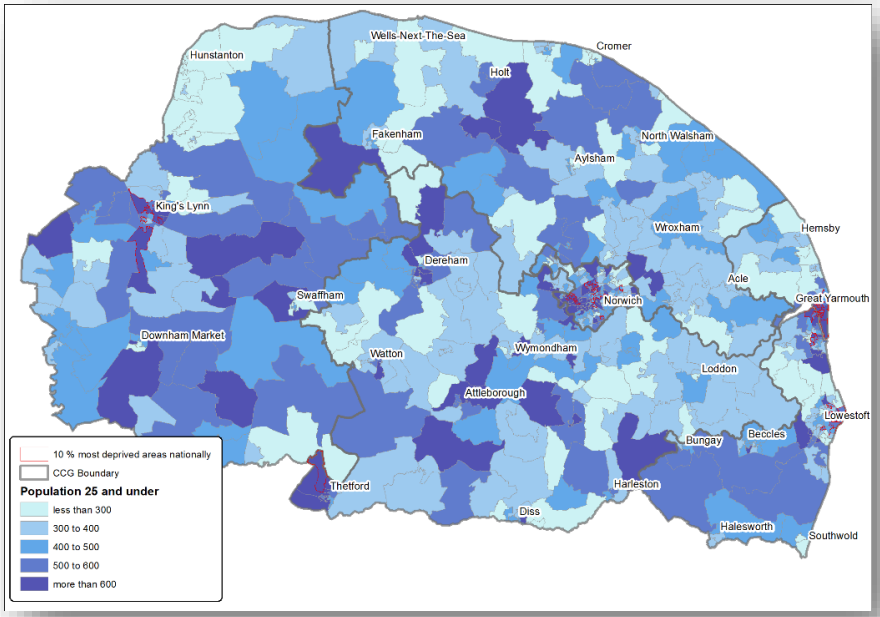
The Income Deprivation Affecting Children Index (IDACI) represents the proportion of children aged 0-15 years living in families that are income deprived. That is, families that are in receipt of income support, income based jobseeker's allowance or pension credit, or those not in receipt of these benefits but in receipt of Child Tax Credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs.

Norfolk has an IDACI 2015 score of 0.177. The average IDACI score for all single tier and county councils within England is 0.209; the mean for all English county local authorities is 0.145. This means that Norfolk is more deprived than the mean for county local authorities, but not as deprived as the mean for the single tier and county councils.

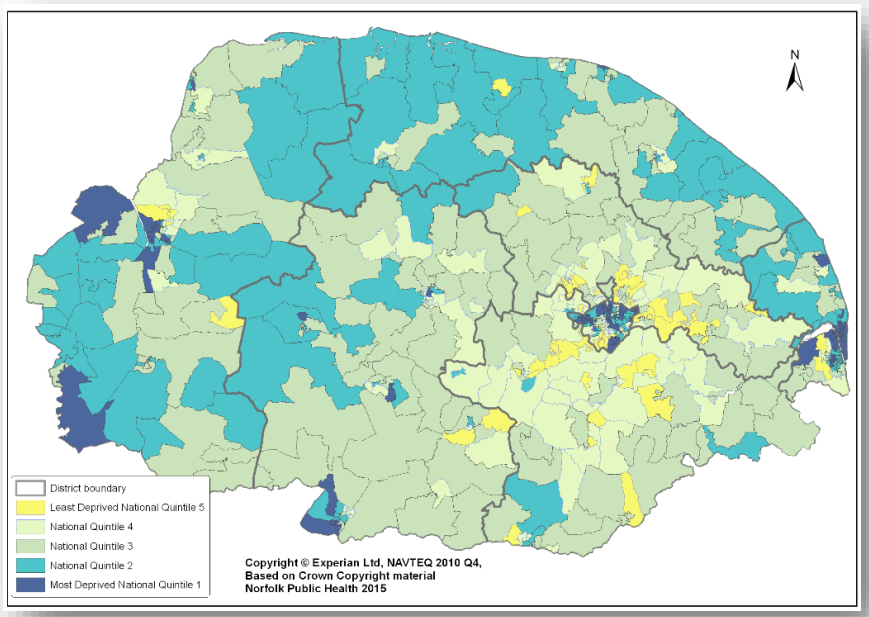
The percentage of children aged 16-18 years who were not in education, employment or training (NEET) in Norfolk in 2015 was 4.2%. This was slightly higher than the mean for all English county local authorities (3.8%).

[12] Source: http://lginform.local.gov.uk/reports/view/lga-research/lga-research-report-demographics-and-determinants-of-health-in-your-area

The maps below show the distribution of the 0-24 year old population across Norfolk and Waveney and the national deprivation quintiles. They highlight the CCG boundaries and the 10% most deprived areas nationally. The areas that are within the 10% most deprived nationally include pockets within Great Yarmouth, Lowestoft, Norwich, King's Lynn and Thetford.



Distribution of the Population aged 0 to 24 years by LSOA.



National Deprivation Quintiles by LSOA.

Meltzer *et al* (2003) found associations between the composition and socio-economic status of the family and mental health disorders in children. This national study found statistically significant associations between the following familial factors and increased risk of childhood emotional disorder:

- Living in a one parent household,
- Living with step-siblings,
- Mother having no educational qualifications,
- No parent working,
- Living in a flat or maisonette (as opposed to a detached property),
- Renting a property (as opposed to owning a property),
- Household income of less than £300 per week (in 2003)

Ethnicity

A helpful summary about ethnicity and the links to mental health disorder in children is provided by the Suffolk CAMHS Needs assessment 2016[13]:

"There is some evidence to suggest small differences in prevalence or incidence rates for mental disorder in children between ethnicities in the United Kingdom. The 2004 ONS report included small numbers of minority ethnic children in the sample and as such inferences of differences between those of white British ethnicity and other ethnicities are weak. However, there was some suggestion that children of Indian ethnicity had a lower rate of mental health disorder than other ethnicities (3%) and that hyperkinetic disorders were less frequent in all non-white British ethnicities. A systematic review of the evidence base for childhood mental health disorder and ethnicity found that, for common mental health disorders, Black African and Indian children may have a lower prevalence than other ethnicities.

For specific categories of common mental health disorder, while children of Indian ethnicity displayed a higher frequency of emotional disorders than the mean and a lower frequency of behavioural disorders, the converse was true for Black Caribbean and children of mixed white and Black Caribbean ethnicity (Goodman *et al,* 2008). The evidence base for ethnic differences in the prevalence of less common mental health disorders in children is small and Goodman *et al* for example, were not confident in making inferences without further research.

The systematic review by Goodman *et al* (2008) notes that utilisation of mental health services by children of Bangladeshi or Pakistani origin is significantly below the estimated prevalence for those groups, suggesting that there may well be particular unmet need for these ethnicities. The activity information provided by the NSFT for CAMHS in Suffolk does not distinguish between Indian, Pakistani and Bangladeshi ethnicity."

The population of Norfolk is not as ethnically diverse as the East of England and England, with 92.4% of its population being 'White British', 7.6% an 'Ethnic minority group' and 3.5% a 'Black and Minority Ethnic (BME) group'[14]. The Norfolk school population is much less ethnically diverse than the England population, with about 12% of the Norfolk school population made up of minority ethnic groups compared to almost 30% in England[15].

[13] Suffolk Child and Adolescent Mental Health Services Needs Assessment Refresh, April 2016. Available at: https://www.healthysuffolk.org.uk/uploads/20160519-CAMHS-Needs-Assessment-2016.pdf

[14] Census 2011. The total percentage does not equal 100% due to people classifying themselves into more than one ethnic minority group.

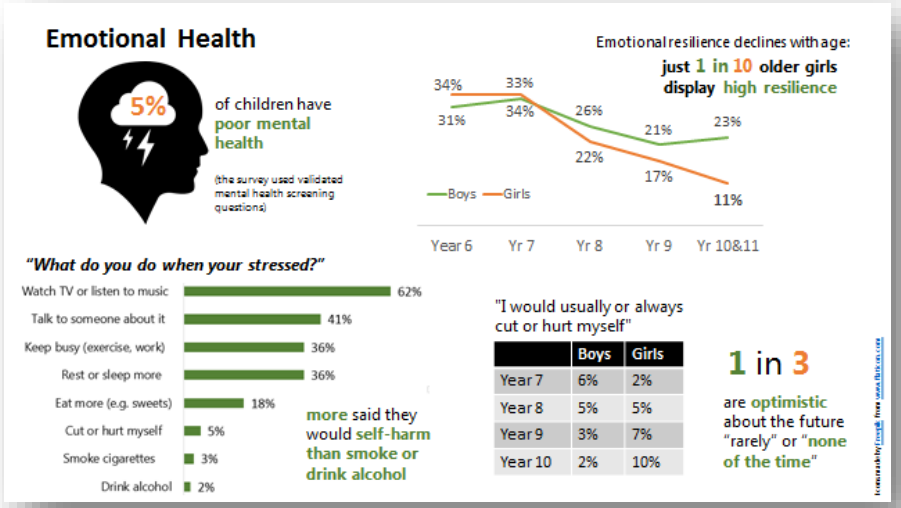
[15] Schools, Pupils and their Characteristics: January 2016 - Local Authority Tables SFR20 January 2016

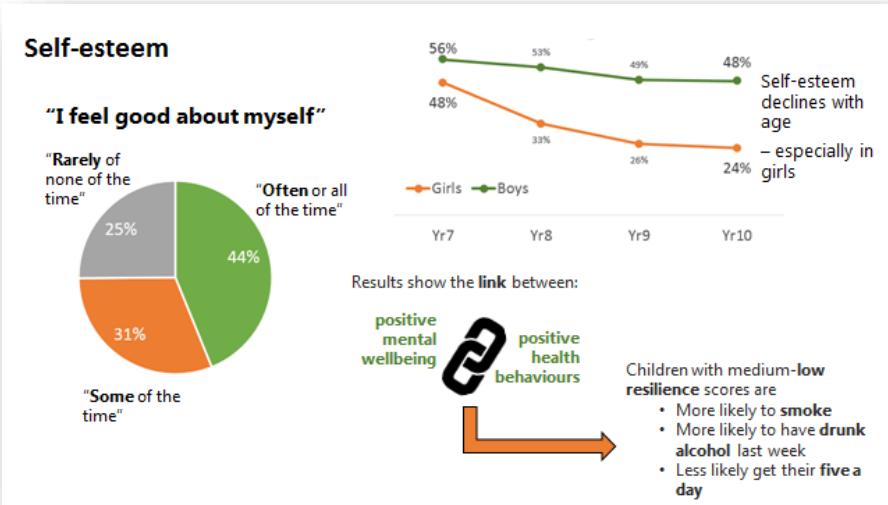
Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Children's Mental Health

School Health-Related Behaviour Survey 2015

The Child and Young People Health and Wellbeing survey carried out in Norfolk schools in 2015 found that 5% of secondary school pupils scored very low on the Warwick-Edinburgh Mental Wellbeing Scale, a validated mental health screening tool. This was similar to the national average. The survey indicated that emotional resilience and self-esteem declined as pupils got older and this was more marked for girls than boys, see 'Emotional Health' below. Also higher amongst girls is the prevalence of self-harm and this too increases with age. The survey will be repeated in October 2017. There is potential to gather the views of young people to help with the developmental of mental health services in Norfolk and Waveney.





Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Norfolk County Council
Supported by INTELLIGENCE & ANALYTICS

Best Practice of Mental Health and Emotional Wellbeing Activity in Norfolk Schools

A Children Services Council Members Group which reviewed access to support and interventions for children's emotional health and wellbeing asked the Education & Training Strategy Group in 2017 to take forward an evaluation of best practice in Norfolk of mental health and emotional wellbeing activity in schools. It was designed to be used to inform the re-design of existing CAMHS services. Across Norfolk there were 88 respondents to the survey, including 61 Primary and Infant schools, and 27 secondary and further education colleges. The key findings and recommendations were reported as follows:

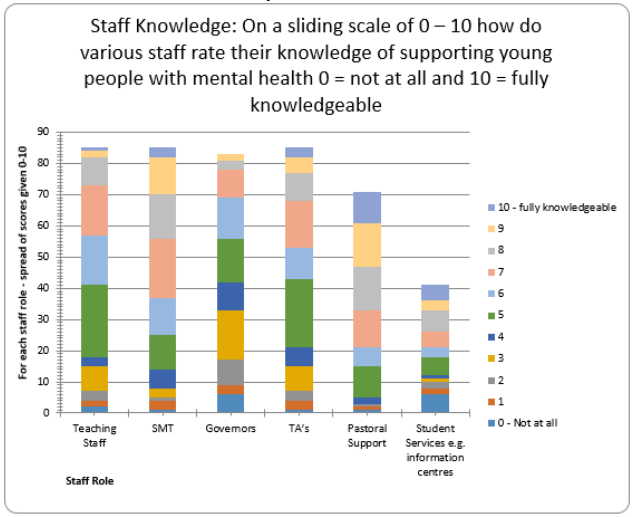
Key findings:

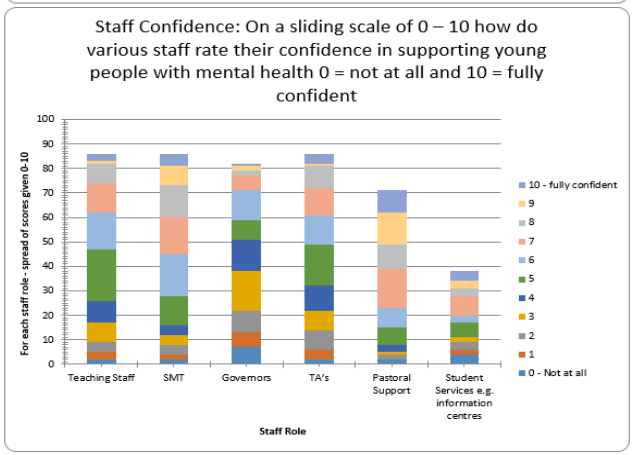
- Respondents offer a range of mental health support activities and interventions to learners
- The highest percentages are for individual interventions and counselling along with PSHE around mental health
- There is a lack of awareness of the full range of services and access routes
- Evidence of providers measuring the impact and quality of services and interactions is limited
- Groups/individuals requiring support are identified through a mixture of whole school approaches, individual screening or looking at learners with risk indicators (e.g. low attendance, pupil premium, SEND)
- 19.5% of respondents spent over £20,000 on mental health support in the last academic year
- Lack of funding and resources both for providers and mental health services is seen as a barrier
- Just over half of respondents have an identified strategic lead for mental health.
- Many respondents a need for more staff training and continuing professional development focussed on mental health issues
- Capacity of mental health services to meet demand - thresholds are felt to be too high, waiting times too long
- The need for a greater emphasis on family support and early intervention is identified
- A need for relevant information to be provided to the receiving provider at key transition points for learners

Recommendations:

- To support providers to commission high quality services and activities and monitor impact by creating a checklist of key questions
- To ensure that mental health and wellbeing is a key strategic priority by integrating mental health and wellbeing into the Education Inclusion Self-Assessment Framework
- All providers to have a nominated senior strategic leader and governor for mental health and wellbeing
- To map existing mental health training and to identify gaps
- Report findings to be fed into Social Mobility Opportunity Area activities

Areas for Further Improvement:





Mental Health Prevalence

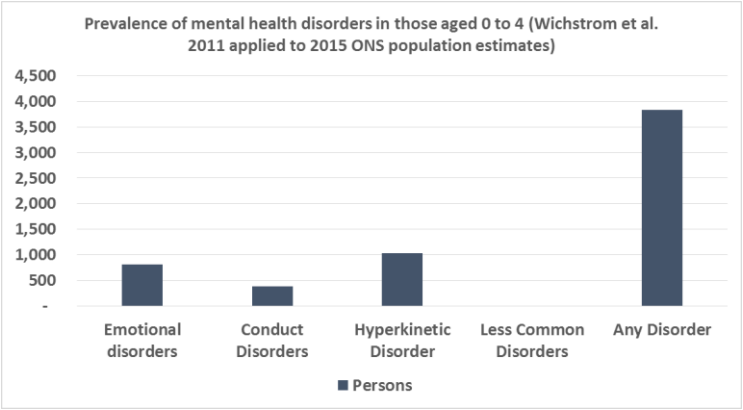
Across Great Britain, the statistics for children's mental health are alarming. 1 in 10 children and young people are experiencing mental health problems right now and/or emotional and behaviour problems (often the same children), according to the Mental Health Foundation in 2015. Half (50%) of lifetime mental illness has started by the age of 14 (Weare, K., 2015) and 75% by the age of 18. It has also been found that 1 in 7 children has less severe mental health problems that may not be diagnosed but will interfere with their development and learning. Understanding the prevalence of these mental health disorders allows support for the assessment of local need for services and interventions for this young age group.

Prevalence in 0-4 year olds

For children aged 0-4 the estimates of prevalence for common mental health conditions are taken from the research by Wichstrom *et al* (2011) and are reported as follows:

- ADHD 1.9%
- Oppositional Defiant Disorder 1.8%
- Conduct Disorder 0.7%
- Anxiety Disorder 1.5%
- Depressive Disorder 2.0%

- **Any psychiatric disorder 7.1% (3,836)**



The prevalence of any clinically diagnosable mental health condition within Norfolk and Waveney for 0-4 year olds equated to approximately 3,800 children in 2015.

Prevalence in 5-16 year olds

In Norfolk, the estimated prevalence of clinically diagnosable mental health disorders in children and young people aged between 5 and 16 years of age is around 9.4% (some estimates claim up to 10.2%). In 2015, the prevalence of mental health problems equated to approximately 11,900 children; by 2025, it is predicted to increase to 13,300 children. This will be an extra 1,400 children that will require mental health services. This increase does assume that the current prevalence estimates remain the same in the future population; it doesn't take into account that mental health prevalence may also be increasing. For example, if the prevalence of mental health conditions in children were to double from 9.4% to 18.8% by 2025, this would equate to 25,945 children with diagnosable mental health conditions.

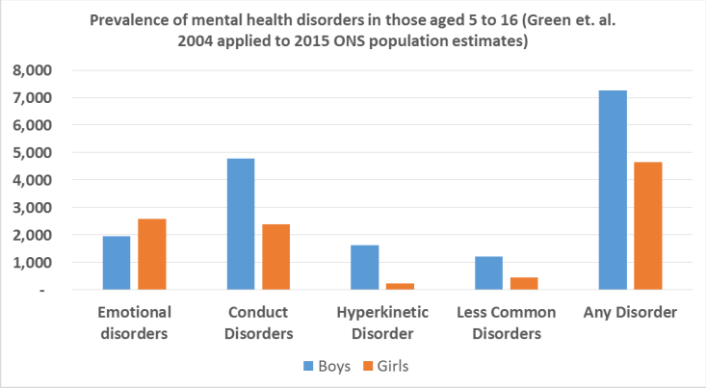
The prevalence of mental health problems in Norfolk's children is currently comparable to the England prevalence estimate of 9.3%, although slightly higher than the estimated prevalence for the East of England region (8.8%).

Gender

Studies have shown that boys are more likely to have a diagnosable mental health disorder than girls (11% versus 8% of girls), and although boys are more likely to have a conduct disorder (8% vs 4%), or a hyperkinetic disorder (3% versus 0.4%), they were slightly less likely than girls to have an emotional disorder (3% versus 4%). Certain differences extend into the older age ranges. For example the 2014 Adult Psychiatric Morbidity Survey[16] showed that there are young women aged 16 to 24 are more than twice as likely to experience a common mental health disorder compared to young men (26% vs. 9%). Further estimates for ages 16 to 24 are shown in the summary table within the 'Estimated Prevalence Summary' section.

In Norfolk and Waveney the estimates of prevalence of common mental health disorders in 5-16 year olds, and the differences between girls and boys, are as follows:

	Diagnosable Mental Health Condition		Emotional Disorder		Conduct Disorder		Hyperkinetic Disorder		Less Common Disorders	
Year	2015	2025	2015	2025	2015	2025	2015	2025	2015	2025
Boys	7,256	8,044	1,962	2,197	4,778	5,291	1,632	1,794	1,220	1,334
Girls	4,648	5,252	2,590	2,984	2,387	2,691	244	270	451	514
All	11,904	13,296	4,551	5,181	7,165	7,982	1,875	2,064	1,671	1,848



Emotional Disorders, low mood and anxiety

When children do not have their natural feelings of depression and anxiety dealt with in the proper fashion, they tend to have lower self-esteem and can struggle within many different situations, such as the school environment. Some will always have a difficult time coping with their emotions, whether their feelings are a product of nature or through nurture. If left untreated by a mental health professional, studies have shown that these children are likely to grow up with a lower self-worth, negative feelings, poor performance in school and can actively choose to be more unhealthy with their lifestyle decisions as adults; some will go on to repeat these behaviours with their own children.

Emotional resilience by children and young people in Norfolk has also been shown to decline with age, with just 1 in 10 older girls, compared to nearly 1 in 4 boys, being able to display high resilience. This was in response to a 2015 survey of Year 6 to Year 11 school children where they were asked resilience questions, such as 'what do you do when something goes wrong?', and responded with answers such as 'if I don't succeed I give up', 'if I don't succeed I ask for help' and 'if something goes wrong I learn from it for next time'. The children with a medium to low resilience score were more likely to smoke, have drunk alcohol and eat fewer than their five-a-day fruit and vegetables. These results suggest a connection between positive

[16] Available at: http://content.digital.nhs.uk/catalogue/PUB21748

emotional wellbeing and positive health behaviours. The emotional wellbeing results from young people in Norfolk are similar to those seen elsewhere (Norfolk County Council, 2016).

In Norfolk, the estimated prevalence of emotional disorders (e.g. anxiety and depression) in children and young people aged between 5 and 16 years of age is around 3.6% (ONS, 2005). In 2015, the prevalence of emotional disorders equated to approximately 4,550 children: by 2025, it is predicted to increase to 5,180 children (+630). This estimate does assume that the prevalence rate (3.6%) doesn't change over time, only that the population of 5-16 year olds will increase. The prevalence of emotional disorders in Norfolk is currently the same as the England prevalence, although slightly higher than the estimated prevalence for the East of England region (3.4%).

Social Anxiety Prevalence

Social anxiety disorder, previously known as 'social phobia', tends to start in childhood or adolescence, with adults that seek treatment having a median age of onset of early to mid-teens. Most people have developed the condition before they reach 20 years of age. Some individuals can pinpoint a moment in time when their condition started, such as moving school or being bullied or teased, whilst others will describe themselves as always being shy around other people. Once diagnosed with social anxiety disorder in adolescence it is possible to recover before reaching adulthood. However, the recovery without treatment is much harder in adulthood compared with other common mental health disorders. NICE recommend in their clinical guideline no.159, that any "treatment available for children and young people with social anxiety disorder, such as individual or group cognitive behaviour therapy (CBT), should consider involving the parents or carers to ensure the effective delivery of the intervention, particularly in young children".

An estimated 3% of 5-16 year olds have a clinically diagnosable anxiety disorder. In Norfolk and Waveney in 2015, this equated to nearly 4,100 children and young people. The prevalence of social anxiety (social phobia) is estimated to be about 0.3% of the 5-16 year old population; in 2015 this equated to about 400 children and young people.

Depression

Depression affects people, including children and young people, in many different ways. Symptoms can vary widely from lasting feelings of sadness or losing interest in things previously enjoyed, through to physical symptoms, such as tiredness, aches and pains, difficulty sleeping and loss of appetite. Using the Quality Outcomes Framework 2015/2016 (QOF), in adults aged 18years+ the prevalence is 8.3% (68,391). This is an increase of 7,425 compared to 2014/15.

An estimated 1% of 5-16 year olds have clinically diagnosable depression. In Norfolk and Waveney this equated to about 1,030 children and young people in 2015, with 760 having experienced a depressive episode and 270 experiencing other types of depressive episodes.

Estimates of depression for 16-24 year olds are thought to be higher, with about 2.3% of the 16-24 year old population having experienced a depressive episode. Females are four times more likely to be diagnosed with a depressive episode than males.

Conduct Disorders

Conduct disorders include defiance, aggression and anti-social behaviour and are the most common mental and behavioural problems in children and young people, having a significant impact on functioning and quality of life. These disorders can be divided into further sub-categories, such as socialised conduct disorder, un-socialised conduct disorder, conduct disorders confined to the family context and oppositional defiant disorder.

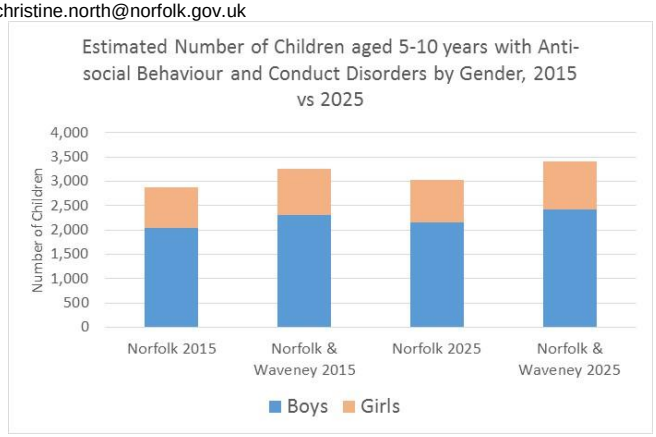
Depending on age, problem behaviours may include: persistent disobedience, angry outbursts and tantrums, physical aggression, fighting, destruction of property, stealing, lying and bullying. For about half of the children affected with conduct disorders, serious problems will persist into adolescence and beyond. Children with conduct disorders have much poorer outcomes which include an increased likelihood of drug dependency, lower educational attainment, entry into the youth justice system, imprisonment and a lower life expectancy. Some children with conduct disorders are also more likely than other children to have hearing, speech and muscle problems. It is thought that a wide range of risk factors, both genetic and environmental, may be linked to the early developmental of severe behavioural problems. A CAMHS service should recognise the importance of the influence of the family environment, including maltreatment and harsh, inconsistent or neglectful parenting. Understanding the prevalence of these conduct disorders is a useful measure to be able to plan psychotherapy services.

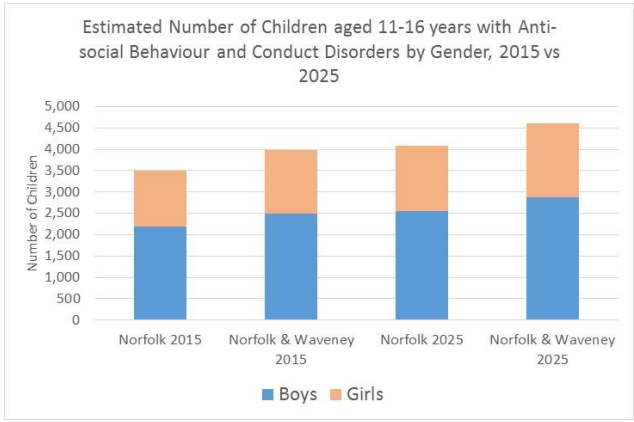
It's difficult to estimate the long-term costs of severe behavioural problems; quite often attempts have underestimated the true costs due to the complexity of the broad range of adverse outcomes that could be included and the difficulty of placing a monetary value on to these outcomes. Annual costs are thought to be around £5,000 per child with severe behavioural problems, including taking into account the extra costs falling on health, social care, education and from age 10 onwards, the criminal justice system. Estimates of overall lifetime costs per child are estimated to be about £85,000 for a child with moderate behaviour issues and up to £260,000 for a child with severe behaviour issues, taking into account costs relating to crime as the biggest single component (Parsonage, M *et al*. 2014).

It has been shown that anti-social behaviour and conduct disorder affects about 5.6% of children across Great Britain, particularly boys (ONS, 2005). In Norfolk and Waveney, the prevalence of anti-social behaviour and conduct disorders is estimated to be 5.7%, based on the age, sex and socio-economic status of children in this area; this is comparable to regional and national prevalence. In 2015, in Norfolk and Waveney the prevalence equated to approximately 7,200 children and young people aged 5-16 years and, by 2025, 8,000.

The prevalence of conduct disorders increases throughout childhood and these disorders are more common in boys than in girls. For example, 7% of boys and 3% of girls aged 5 to 10 years have conduct disorders; in children aged 11 to 16 years the proportion rises to 8% of boys and 5% of girls. The table below demonstrates the prevalence (%) of conduct disorders within the Norfolk and Waveney population:

	2015				**2025**			
	Boys		**Girls**		**Boys**		**Girls**	
	5-10 years	**11-16 years**	**5-10 years**	**11-16 years**	**5-10 years**	**11-16 years**	**5-10 years**	**11-16 years**
Prevalence:	7%	8%	3%	5%	7%	8%	3%	5%
Norfolk	2,042	2,191	829	1,304	2,147	2,550	874	1,537
Norfolk & Waveney	2,312	2,488	940	1,485	2,418	2,871	986	1,735





Conduct disorders commonly coexist with other mental health problems and up to 46% of boys and 36% of girls have at least 1 co-existing mental health problem; quite often this will be attention deficit hyperactivity disorder (ADHD). It has been found that ADHD is particularly prevalent and in some groups more than 40% of children and young people with a diagnosis of conduct disorders with also have a diagnosis of ADHD. Conduct disorders are the most common reason for a referral of young children to a CAMHS service and comprise of a considerable large proportion of the work of the health and social care system.

Attention Deficit Hyperactivity Disorder (ADHD) and Hyperkinetic Disorder

The definitions of ADHD and hyperkinetic disorder are based on unusually high levels of impulsivity, hyperactivity and inattention. A diagnosis is based on observations about how children behave: 'impulsivity' signifies premature and thoughtless actions; 'hyperactivity' a restless and shifting excess of movement; and 'inattention' is a disorganised style preventing sustained effort (NICE, 2013). It is very common for the core problems of ADHD in children to present together with other developmental impairments and/or mental health problems. There are many rather non-specific problems that are very common in ADHD and hyperkinetic disorders, and can even be, often incorrectly, used as grounds for the diagnosis. These include:

Common problems associated with ADHD and Hyperkinetic Disorders in children:	
Non-compliant behaviour	Motor tics
Sleep disturbance	Mood swings
Aggression	Unpopularity with peers
Temper tantrums	Clumsiness
Literacy and other learning problems	Immature language
Long duration of symptoms	Difficulties in more than one setting, such as home or school

ADHD is a common developmental disorder, with prevalence estimates ranging from between 3% and 5% for school age children across the UK, and approximately 1.9% for 0-4 year olds. There is a ratio of boys to girls of 4:1 for school age children. This equated to an estimated 3,700 to 6,200

children aged 5-16 in Norfolk and Waveney with ADHD in 2015. Prevalence estimates by CCG are shown below. ADHD pathway data is included within the 'ADHD service use' section.

ADHD Prevalence Estimates by CCG	ADHD in 5-16 year olds	
	Lower limit (3%)	Upper limit (5%)
NHS Great Yarmouth and Waveney	830	1,383
NHS North Norfolk	596	994
NHS Norwich	695	1,159
NHS South Norfolk	981	1,634
NHS West Norfolk	641	1,068
Norfolk and Waveney	**3,743**	**6,238**

The estimated number of people aged 16-24 with ADHD (with an ASRS score of 4 or more), based on applying the estimated prevalence[17] taken from the APMS Survey 2014, was 15,100 in Norfolk and Waveney in 2015. The prevalence of ADHD (with an ASRS score of 6) was 2,000 young people aged 16-24 in 2015. Prevalence for strictly applied ICD10 and DSM-V definitions of ADHD decline with age and it has been found through longitudinal studies that individuals diagnosed with ADHD as children by age 25 only 15% retained the full ADHD diagnosis. However, there are a large number of adults (65%) that are in ADHD partial remission, which indicates the persistence of some symptoms that are associated with clinical impairments and implies that ADHD in adults will be under identified if the same clinical criteria for children are applied to adults.

Hyperkinetic disorder is a less common disorder and describes a group of children and young people that form a severe sub-group of ADHD symptoms and criteria for diagnosis. Hyperkinetic disorder is further divided into hyperkinetic disorder with and without conduct disorder. Please note, oppositional defiant disorder and conduct disorders need to be differentiated from ADHD and have their own diagnoses in the ICD10 and DSM-V schemes. Oppositional and conduct disorder problems can be seen in some children with ADHD, but they are not essential features and should not be used as grounds for making the diagnosis of ADHD.

An estimated 1.5% of 5-16 year olds in Norfolk and Waveney have a clinically diagnosable hyperkinetic disorder, which is comparable to the regional and national figure. In 2015, in Norfolk and Waveney this equated to 1,900 children and young people and will increase to approximately 2,100 by 2025.

Autism Spectrum Disorder (ASD)

The term 'autism spectrum disorder (ASD)' is used to describe all diagnostic autism profiles of having a lifelong developmental disability, including Asperger syndrome and Pathological Demand Avoidance (PDA). Within the UK, there are an estimated 700,000 people of all ages on the autism spectrum (approximately 1.16% of the population), this equates to 1 person in 100 (Baird, G. *et al.* 2006). The prevalence of autism and related ASDs is substantially greater than previously recognised but it is unclear if this is because of better case identification, widened diagnostic criteria or an increase in incidence. Children with some form of ASD represent 1.16% of the child population and therefore, ASD services in health, education,

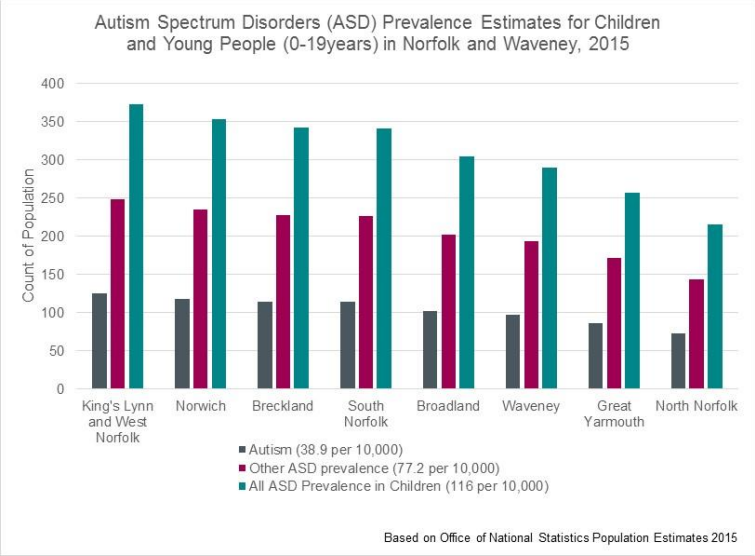
[17] Estimated ADHD prevalence (with an ASRS score of 4 or more) for males aged 16-24 is 15.2% and 14.1% for females. *Source: APMS survey 2014.*

and social care must recognise the needs of these children. For example, studies such as those by Brugha, T. *et al* (2012), have shown that local ASD case identification to be much lower for children of less educated parents. This should be a concern for service providers and any approach to screening and diagnosis should try to reduce this bias in less educated families.

In Norfolk, an estimated 10,266 people of all ages are on the autism spectrum. It can also be estimated that there are approximately 2,185 0-19 year olds on the autism spectrum in Norfolk, with King's Lynn and West Norfolk having the largest ASD population within the county. Further prevalence estimates by District, CCG, region, all ages and ASD sub-categories ('Autism' and 'Other ASD' conditions) can be seen in the tables below.

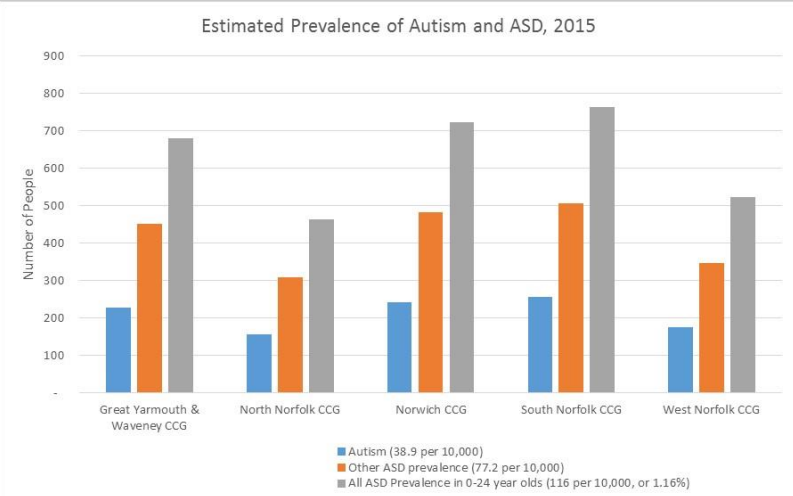
Estimated Prevalence for Autism Spectrum Disorders for 0-19 year olds, by District

				ASD Prevalence Estimates for 0-19 year olds only		
Area	Population (All Ages)	ASD Prevalence (1.16%, All Ages)	Population (0-19yrs)	Autism (38.9 per 10,000)	Other ASD prevalence (77.2 per 10,000)	All ASD Prevalence in Children (116 per 10,000)
Breckland	135,480	1,572	29,467	115	227	342
Broadland	126,628	1,469	26,195	102	202	304
Great Yarmouth	98,667	1,145	22,150	86	171	257
King's Lynn and West Norfolk	151,013	1,752	32,136	125	248	373
North Norfolk	103,308	1,198	18,586	72	143	216
Norwich	138,872	1,611	30,370	118	234	353
South Norfolk	131,010	1,520	29,327	114	226	340
Waveney	116,182	1,348	25,000	97	193	290
Norfolk	884,978	10,266	188,231	732	1,453	2,185
Norfolk & Waveney	1,001,160	11,613	213,231	829	1,646	2,476
East of England	6,076,451	70,486	1,436,987	5,590	11,094	16,683
England	54,786,327	635,521	13,005,727	50,592	100,404	150,996



Estimated Prevalence for 'All ASD' Children and Young People aged 0-24 years, by CCG (116 per 10,000, or 1.16%)

	5-year Age Bands					
CCG	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**0-24 year olds**
NHS Great Yarmouth & Waveney	138	139	129	142	132	680
NHS North Norfolk	89	95	95	103	82	464
NHS Norwich	132	124	103	130	234	724
NHS South Norfolk	157	163	150	160	133	763
NHS West Norfolk	113	110	99	104	98	523
Norfolk	**556**	**557**	**507**	**566**	**611**	**2,796**



Using the Learning Disability register held by Norfolk County Council, there are currently 601 children and young people aged between 0 and 25 years registered with Autism, Asperger's syndrome and ASD across Norfolk. The number of children and young people registered with Autism, Asperger's and ASD is a lot less than the estimated prevalence figures for 0-24 year olds (2,796). This could be because of a large undiagnosed population and/or due to low numbers of people registering with Norfolk County Council.

CCG	Total Registered with Autism, Asperger's and ASD
NHS Great Yarmouth & Waveney	96
NHS North Norfolk	96
NHS Norwich	115
NHS South Norfolk	140
NHS West Norfolk	154
Total	**601**

Eating Disorders

Eating disorders, the two most common being Anorexia Nervosa and Bulimia Nervosa, are estimated to have a prevalence of about 0.1% for males and 3% for females of the population of 5-24 year olds. In Norfolk and Waveney this equated to approximately 450 children and young people in 2015. Long-term eating disorders can cause severe physical and psychiatric consequences, with anorexia nervosa causing the highest mortality rate than any other mental health disorder. However, significant numbers of people will not ask for help and, as a consequence, prevalence estimates are likely to underestimate numbers within the general population.

- About 1 in 250 women and 1 in 2000 men will experience Anorexia Nervosa, with it usually developing in the mid-teens, although it can develop at any age.
- Bulimia is around two to three times more common than anorexia and usually develops in the teenage years. However, people don't seek help for it until their twenties as they are able to hide the signs and symptoms from family and friends.
- Binge eating affects about 5% of the adult population and involves dieting and binge eating, but does not include vomiting. It is not as harmful as bulimia but it is distressing and sufferers are more likely to become overweight.

Bipolar Disorder

In adults, bipolar disorder is fairly common, with 1 in every 100 adults being diagnosed with the condition at some point in their life. Bipolar disorder can occur at any age, although it quite often develops between the ages of 15 and 19 and rarely after 40. Men and women from all backgrounds are affected equally.

In Norfolk and Waveney, the prevalence of bipolar disorders is estimated to affect 3,540 16-24 year olds, with males and females affected equally. Norwich CCG is estimated to have the largest bipolar population (1,025) and North Norfolk CCG the smallest (482). Further information by gender and CCG is available in the 'Prevalence summary table for 16 to 24 year olds.

Generalised Anxiety Disorder (GAD) and/or Panic Disorder

In Norfolk and Waveney, the prevalence of GAD is estimated to affect a total of 7,468 children and young people. The majority of GAD is diagnosed in the later teenage years, with a higher number of young people expected to be affected by the disorder (6,556 16 to 24 year olds compared to 912 5-16 year olds). Twice as many girls as boys aged 16-24 years will be affected by GAD (4,550 versus 2,006). Norwich CCG is estimated to have the largest GAD population (1,927) and North Norfolk CCG the smallest (890). Further information by gender and CCG is available in the 'Prevalence summary table for 16 to 24 year olds.

Panic disorders are not as prevalent but demonstrate a similar pattern as GAD, with more 16-24 year old girls affected by this disorder than boys (1,112 versus 211).

Obsessive Compulsive Disorder (OCD)

In Norfolk and Waveney, the prevalence of OCD is estimated to affect a total 2,095 of children and young people aged 5-24 years, with a larger OCD population in the 16-24 year olds compared to the 5-16 year olds (1,847 versus 248). Nearly twice as many girls aged 16-24 years as boys are thought to be affected by OCD (1,213 versus 634). Further information by gender and CCG is available in the 'Prevalence summary table for 16 to 24 year olds.

Post-traumatic Stress Disorder (PTSD)

In Norfolk and Waveney, the prevalence of PTSD in the last month is thought to be much more common in those aged between 16 and 24 years than those aged 5-16 years (8,476 versus 210). In addition, three times more girls aged 16-24 years than boys are thought to be affected by PTSD in the last month (6,349 versus 1,917).

Psychosis

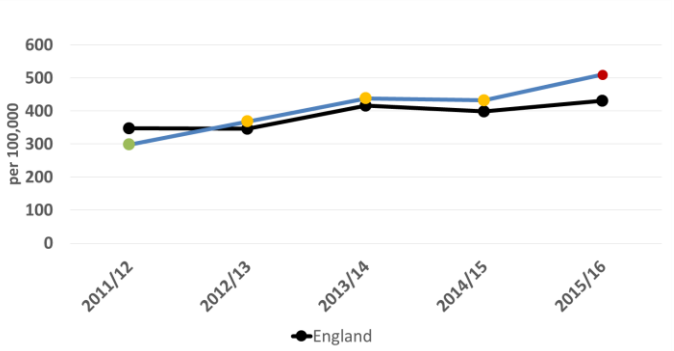
In Norfolk and Waveney, the prevalence of psychosis, or having a 'psychotic disorder in the past year', is estimated to affect 372 young people aged between 16-24 years. It is difficult to estimate the prevalence of a psychotic disorder in the past year for 5-16 year olds. Due to the larger 16-24 population within Norwich CCG, more young people in this CCG (109) are expected to have had a psychotic disorder in the last year than other CCGs in Norfolk and Waveney. Girls aged 16-24 years are more than 2.5 times more likely to have had a psychotic disorder in the past year than boys of the same age (266 versus 106).

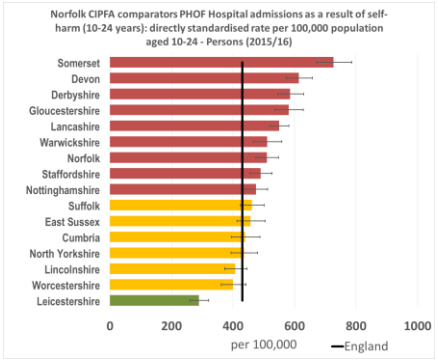
Self-harm

Hospital admissions for self-harm (usually cutting and self-poisoning) in children and young people have increased in recent years, with admissions for young women being much higher than admissions for young men. It reflects a key part of the mental health picture for young people, as the majority are aged between 11 and 25 years. Self-harming and substance abuse, such as alcohol mis-use, are known to be much more common in children and young people with mental health disorders – with ten per cent of 15-16 year olds having self-harmed. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment.

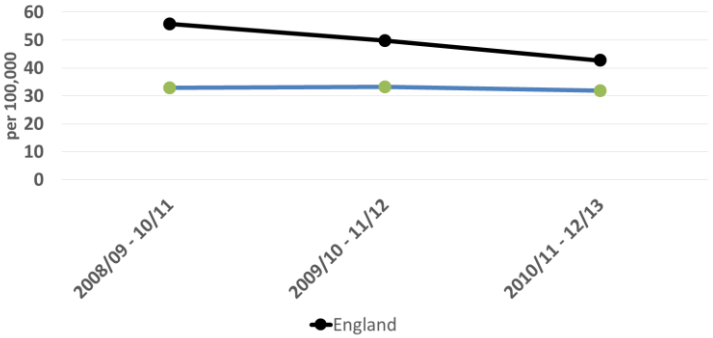
In Norfolk and Waveney, the estimated prevalence of 16-24 year olds that self-harm is around 9.7% for boys and 25.7% for girls. This equates to 5,112 boys and 13,003 girls self-harming across the CAMHS service area.

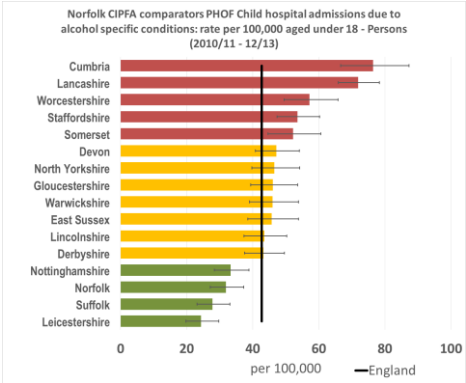
Services within secondary and the acute care setting need to ensure that children and young people do not feel stigmatised and are able to be assessed, treated and discharged quickly back to the community where recovery is ideally situated. The need for mental health support in acute hospitals for children and young people requires that hospital staff ensure this population are fully understood and not kept in overnight or for the weekend when this isn't necessary.





Hospital Admissions as a Result of Self Harm (10-24 years), 2015/2016





Child hospital admissions due to alcohol-specific conditions: rate per 100,000 aged under 18 - Persons (2010/11 - 12/13)

Suicide

Suicide by children and young people is rare. Between 2006 and 2015, there have been 9 suicides of young people aged under 18[18]. The average age of people who die by suicide in Norfolk is 49 years, with the age breakdown of suicide in Norfolk mirroring trends seen nationally[19]. National evidence has shown that in the week before death, 10% of young people will self-harm, 27% will express suicidal ideas and 43% will not have any contact with health care, social care services or justice agencies.

It is estimated that in 16-24 year olds, as many as 27,700 have had suicidal thoughts, equating to a prevalence of 19.3% in boys and 34.6% in girls in Norfolk and Waveney. Approximately 9,300 young people are estimated to have attempted suicide, with girls aged 16-24 years twice as likely to attempt suicide as boys (6,441 versus 2,837).

Known risk factors associated with suicide and self-harm by children and young people include isolation, economic adversity, alcohol and drug misuse, abuse and neglect, bullying, academic pressures (especially exam pressures), bereavement (including suicide in family or friends), physical health conditions, family problems and, recent self-harm (Rodway *et al,* 2016). These are risk factors that a CAMH service can help to address in order to reduce risk. Improved services for self-harm and mental health are crucial to suicide prevention and the wide range of risk factors emphasises the roles of schools, primary care, social services and the youth justice system.

Within Norfolk, the Child Death Overview Panel and Norfolk Safeguarding Children Board are responsible for monitoring the trends in mortality for children and young people. A 'Child Suicide Thematic Review' was carried out by the Norfolk Child Suicide Review Group and can be obtained on request from Norfolk County Council.

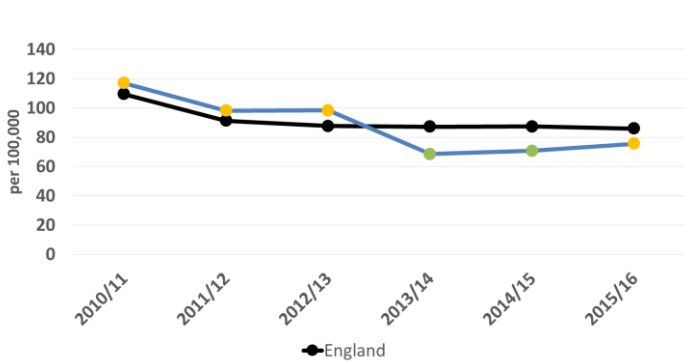
[18] In 2016, the National Statistics definition of suicide has been modified to include deaths from intentional self-harm in 10- to 14-year-old children in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 and over.

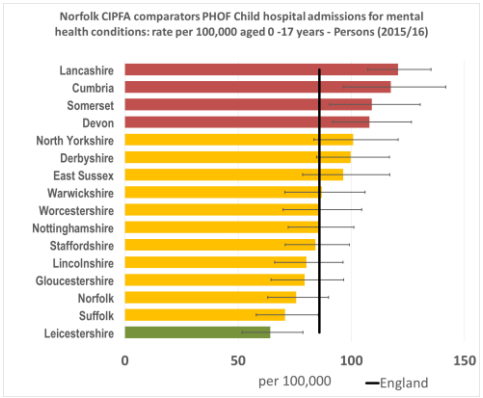
[19] ONS (2014) Suicides in the United Kingdom: 2014 registrations. Office for National Statistics.

Hospital admissions for mental health conditions

Each year in Norfolk just over 100 children are admitted to hospital for conditions relating to mental health (113 in 2014/15). The trend is largely due to changes in the number of regular planned admissions between 2012/13 and 2013/14 – suggesting a change in the pathway for these children rather than a specific trend in prevalence of conditions. Emergency admissions have remained stable over the period (around 80 each year). The most common cause of emergency hospital admissions relating to mental health are eating disorders (33 in 2014/15, 91% female) followed by alcohol-related admissions (12 admissions), anxiety disorders (7 admissions) and depressive episodes (6 admissions).

The crisis pathway for children and young people aged 0-18 years needing emergency CAMH services in Norfolk and Waveney can be found in appendix B.





Child hospital admissions for mental health conditions: rate per 100,000 aged 0 -17 years

Prevalence Summary Table for 5-16 year olds

The prevalence estimates for those aged 5 to 16 for 2015 are based on national survey data from 2004 and the ONS 2014 CCG resident population projections. They should be treated with caution due to the amount of time since the survey was first conducted but remain the most reliable prevalence estimates currently available. New prevalence estimates are expected in 2018.

	NHS Great Yarmouth and Waveney		NHS North Norfolk		NHS Norwich CCG		NHS South Norfolk		NHS West Norfolk		Norfolk and Waveney	
	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16
2015 Population	14,028	13,638	10,152	9,729	11,896	11,285	16,859	15,827	10,930	10,423	63,865	60,902
Emotional disorders	433	584	315	419	360	467	520	678	334	443	1,962	2,590
Anxiety Disorders	398	516	290	370	332	415	478	599	308	392	1,805	2,292

	NHS Great Yarmouth and Waveney		NHS North Norfolk		NHS Norwich CCG		NHS South Norfolk		NHS West Norfolk		Norfolk and Waveney	
	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16
Separation Anxiety	49	75	36	53	42	64	59	87	39	58	225	337
Specific Phobia	112	109	81	78	95	89	135	126	87	83	511	486
Social Phobia (Social anxiety)	42	47	31	34	34	37	50	55	32	36	188	209
Panic	14	34	10	24	11	26	17	39	10	25	62	148
Agrophobia	14	27	10	20	11	21	17	31	10	20	62	119
Post Traumatic Stress Disorder (PTSD)	7	41	5	29	5	32	8	47	5	31	31	179
Obsessive Compulsive Disorder (OCD)	28	27	20	19	23	23	33	32	21	21	126	122
Generalised Anxiety Disorder (GAD)	76	129	56	93	62	101	92	149	58	97	344	568
Other Anxiety	105	149	76	107	88	120	126	173	81	113	476	663
Depression	83	149	61	107	67	116	100	173	63	112	375	657
- Depressive Episode	62	108	46	78	50	84	75	126	47	82	280	478
- Other Depressive Episode	21	41	15	29	16	32	25	47	16	31	93	179
Conduct Disorders	1,051	537	762	385	886	434	1,262	623	817	408	4,778	2,387
Oppositional Defiant Disorder	562	280	406	199	481	235	676	325	440	215	2,565	1,254
Unsocialised Conduct Disorder	147	75	107	54	123	60	177	87	114	57	668	331
Socialised Conduct Disorder	222	128	163	93	181	98	266	149	170	96	1,002	563
Other Conduct Disorder	112	61	81	44	96	47	135	71	88	46	513	268
Hyperkinetic Disorder	358	55	259	39	305	45	430	63	280	42	1,632	244
Less Common Disorders	267	102	193	73	229	81	321	118	209	77	1,220	451

	NHS Great Yarmouth and Waveney		NHS North Norfolk		NHS Norwich CCG		NHS South Norfolk		NHS West Norfolk		Norfolk and Waveney	
	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16	Male 5-16	Female 5-16
Autistic Spectrum Disorder (ASD)	205	41	147	29	177	32	246	47	161	31	935	179
Tic Disorder	-	7	-	5	-	6	-	8	-	5	-	31
Eating Disorder	77	21	56	15	65	17	93	24	60	16	350	92
Mutism	7	34	5	24	5	27	8	39	5	26	31	150
Any Mental Health Disorder	1,596	1,046	1,158	750	1,344	843	1,918	1,215	1,240	795	7,256	4,648

Prevalence Summary Table for 16-24 year olds

Expected prevalence for those aged 16 to 24, based on the ONS 2015 population projections and APMS Prevalence Estimates:

	NHS Great Yarmouth and Waveney		NHS North Norfolk		NHS Norwich CCG		NHS South Norfolk		NHS West Norfolk		Norfolk and Waveney	
	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24
2015 Population	11,023	10,274	7,252	6,826	14,519	15,281	11,683	10,626	8,318	7,550	52,794	50,557
ADHD (ASRS score 4 or more)	1,675	1,449	1,102	962	2,207	2,155	1,776	1,498	1,264	1,065	8,025	7,128
ADHD (ASRS score all 6)	214	192	141	128	282	286	227	199	161	141	1,024	947
Bipolar Disorder (7+several same time and causing problems; MDQ)	345	383	227	255	454	570	366	397	260	282	1,652	1,886
Common Mental Disorder	1,003	2,671	660	1,775	1,321	3,973	1,063	2,763	757	1,963	4,804	13,145
Generalised Anxiety Disorder (GAD)	419	925	276	614	552	1,375	444	956	316	679	2,006	4,550
Depressive Episode	99	390	65	259	131	581	105	404	75	287	475	1,921
Phobias	143	555	94	369	189	825	152	574	108	408	686	2,730

	NHS Great Yarmouth and Waveney		NHS North Norfolk		NHS Norwich CCG		NHS South Norfolk		NHS West Norfolk		Norfolk and Waveney	
	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24	Male 16-24	Female 16-24
Obsessive Compulsive Disorder (OCD)	132	247	87	164	174	367	140	255	100	181	634	1,213
Panic Disorder	44	226	29	150	58	336	47	234	33	166	211	1,112
Common Mental Disorders – not otherwise specified (CMD-NOS)	617	1,161	406	771	813	1,727	654	1,201	466	853	2,956	5,713
Antisocial Personality Disorder	706	341	465	227	930	507	748	353	533	251	3,382	1,678
Any Personality Disorder	2,027	2,730	1,334	1,813	2,670	4,060	2,148	2,823	1,530	2,006	9,708	13,432
PTSD in last month	400	1,290	263	857	527	1,919	424	1,334	302	948	1,917	6,349
Psychotic Disorder in past year	22	54	15	36	29	80	23	56	17	40	106	266
Suicide thoughts ever	2,130	3,552	1,402	2,360	2,806	5,283	2,258	3,673	1,608	2,610	10,204	17,477
Suicide attempts ever	592	1,309	390	870	780	1,947	628	1,354	447	962	2,837	6,441
Self-harm	1,067	2,642	702	1,755	1,406	3,930	1,131	2,733	805	1,942	5,112	13,003
Any drug lifetime use	4,719	3,219	3,104	2,139	6,215	4,788	5,001	3,329	3,561	2,365	22,601	15,840

Many existing CAMHS services are targeted, at least partially, for the needs of vulnerable and complex groups of children. Children and young people with complex factors, contextual problems and education/employment/training (EET) difficulties[20] have an impact on resources, clinical practice, service planning and outcomes of a CAMH service. As a consequence, a new CAMH service should make arrangements for an assessment within 7 days of becoming known to the service. Examples of these vulnerable and complex groups include the following, those in **bold** have been described in more detail:

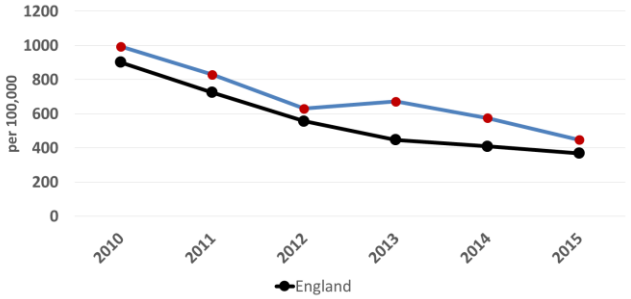
- **Young offenders and those in contact with the Youth Justice System**
- **Looked after children, including identification of care leavers, adoption, early years trauma e.g. broken attachments**
- **Learning difficulties, special educational needs (SEN), including Down's Syndrome**
- **Young carer status**
- **Refugees and asylum seekers**
- Experience of war, torture or trafficking
- Exposure to terrorism
- Traveller children and young people
- Long term physical health Issues e.g. chronic fatigue, diabetes, asthma
- Neurological issues e.g. Tics or Tourette's, cerebral palsy, epilepsy
- **'Child in need' as deemed by social service input**
- **Experience of abuse or neglect, sexual violence, discrimination**
- Current protection plan status
- School Exclusions
- **Parental mental and physical health issues, including substance abuse and long-term conditions (parent and/or sibling)**
- **Living in financial difficulty, including free school meals, parental employment, debt, housing and fuel poverty**
- Living in conditions where services are not available or easily accessed
- **Stressful life events, including bereavement, bullying (e.g. cyber)**
- **Suicide, including ideation, attempts and experience**
- Gender beliefs

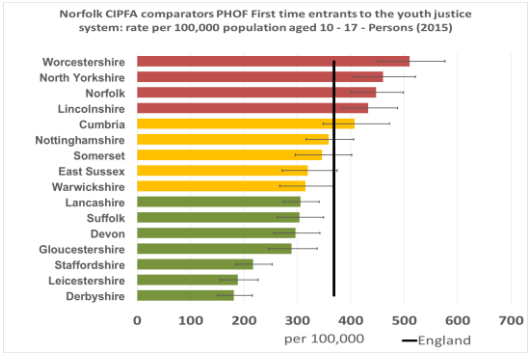
[20] Definitions of these complex factors, contextual factors and EET difficulties can be found in Appendix D.

Young Offenders and the Youth Justice System

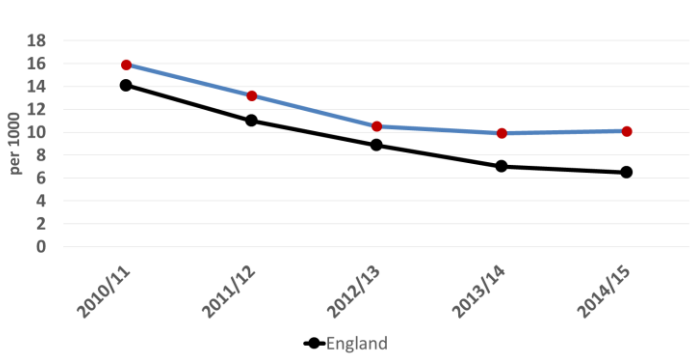
Norfolk has significantly higher proportion of children aged 10 to 17 entering the youth justice system for the first time compared to the England average and its CIPFA (Chartered Institute of Finance and Accountancy[21]) comparator group. This has the impact of raising the proportion of 10 to 17 year olds ever entering the youth justice system and suggests another group of young people who may be experiencing or bordering on emotional wellbeing concerns that are manifesting in criminal behaviour.

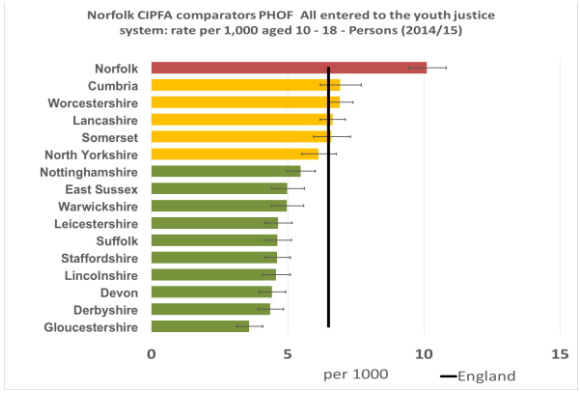
In Norfolk, there were 325 first time entrants to the youth justice system in 2015, compared to 424 (-99) in 2014. There were a total of 838 children recorded as being in the youth justice system in 2015, compared to 830 in 2014.





First time entrants to the youth justice system: rate per 100,000 population aged 10 - 17





All entered to the youth justice system: rate per 1,000 aged 10 - 18

[21] CIPFA nearest neighbour' is a comparative analysis between a local authorities *nearest neighbours* based on their distance apart. Available at: http://www.cipfastats.net/resources/nearestneighbours/.

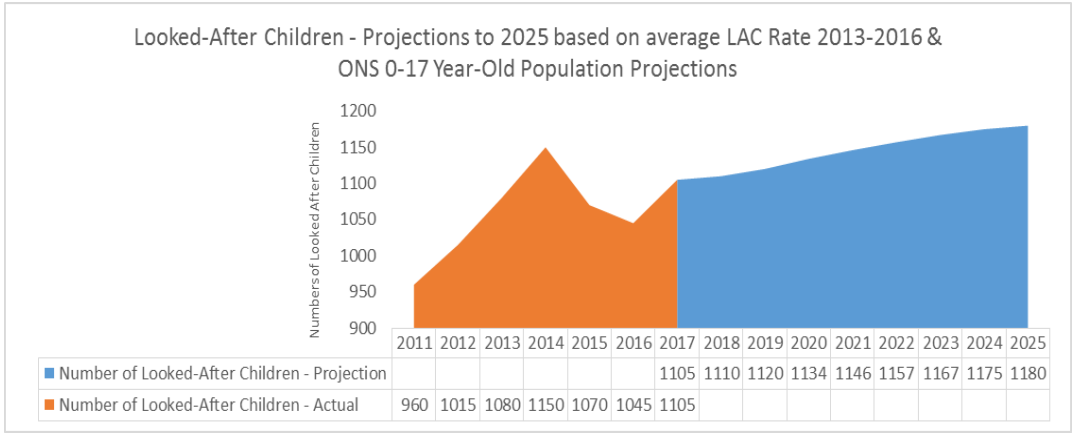
Looked after Children

It is important to monitor the mental health of looked after children, as without an indicator covering this vulnerable group, there would be an even greater increase in rates of undiagnosed mental health problems, placement breakdown, alcohol and substance misuse, convictions and care leavers not in education, employment or training. This group are more likely to encounter emotional wellbeing issues which if not checked, or treated, can escalate into more severe mental health problems as they age. In addition, under Section 10 of the Children's Act 2004, local authorities have a duty to co-operate to promote wellbeing among children and young people.

The average difficulties score for all looked after children in Norfolk aged 5-16 who have been in care for at least 12 months as of 31st March 2016, was 14.6[22]. This is above the national average of 14.0 but comparable to the East of England average of 14.5. Ofsted have shown that this is a focus of their activity in Norfolk and include those young people leaving care.

The rate of looked after children in Norfolk is 62.2 per 10,000 population (0-18 years). This is higher than the regional rate 48.7 per 10,000 and national rate of 60.3 per 10,000. This places Norfolk children and young people more at risk of suffering from emotional wellbeing concerns that in turn can lead to mental health issues.

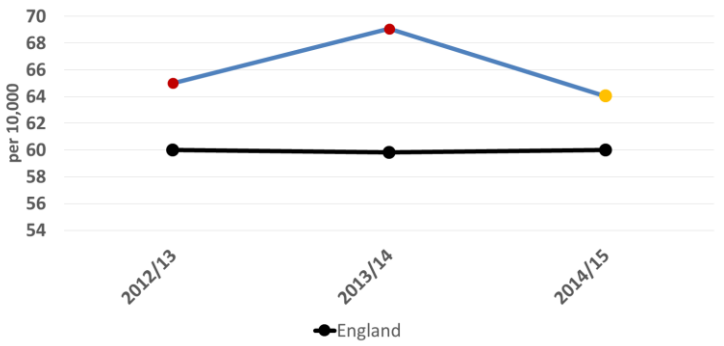
As of April 2017, there were 1,090 looked after children in Norfolk. Over 1,700 vulnerable families have been supported by Norfolk Family Focus.

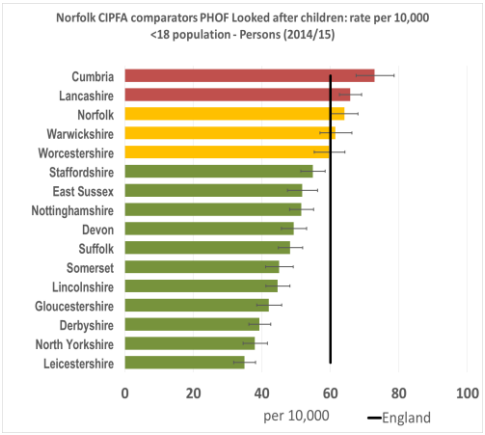


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Number of Looked-After Children - Projection							1105	1110	1120	1134	1146	1157	1167	1175	1180
Number of Looked-After Children - Actual	960	1015	1080	1150	1070	1045	1105								

Source: *Intelligence and Analytics, Norfolk County Council, June 2017*

[22] Fingertips tool. Available at: www.fingertips.phe.org.uk





Looked after children rate per 10,000 <18 population

Learning Disabilities and Special Educational Needs (SEN)

A learning disability is a lifelong condition that affects someone's learning, communication and understanding. It is likely that someone with learning difficulties will require support with some aspects of their life, including planning, learning new skills and socialising. But, there isn't just one type of learning disability, there are many and with various causes, some of which are not very well understood. For example, learning disabilities such as Down's syndrome or Fragile X syndrome, occur before birth and have genetic causes. Others occur after birth but before adulthood and can include infection (such as bacterial meningitis), brain injury, and lack of oxygen at birth or premature birth. The effects of a learning disability on the individual can also range from mild to severe to profound (very severe), with many likely to experience physical and mental health problems.

In the United Kingdom, there is an estimate of between 700,000 to 1.5 million people living with a learning disability. Using the QOF 2015/2016 register for Norfolk and Waveney a total of 6,268 people with learning disabilities (all ages) were registered with GP practices, from a total GP practice population of 1,029,714. This is equal to a prevalence of 0.61% across Norfolk and Waveney (up 0.02% from 2014/2015). The prevalence of learning disabilities for England is 0.5%.

The QOF register doesn't distinguish between learning disabilities that are mild, moderate or severe. So, someone who can communicate easily and effectively, and can look after themselves, will be on the same register as someone unable to communicate at all and who needs full time care. Within Norfolk, one of the big issues that has been identified is the increased complexity of care needs, especially for those people with learning disabilities. NHS North Norfolk CCG has had the highest prevalence of people registered with learning disabilities for the last two years (0.70% in 2014/2015 and 0.74% in 2015/2016), with NHS West Norfolk CCG the lowest prevalence in the same time period (0.50% in 2014/2015 and 0.52% in 2015/2016).

Prevalence of Learning Disabilities in Norfolk and Waveney using the QOF Register 2015/2016.

CCG	Prevalence of Learning Disabilities (%), all ages	Number of LD on Register	Registered GP Population
NHS North Norfolk	0.74%	1,266	171,330
NHS Norwich	0.68%	1,469	217,292
NHS Great Yarmouth and Waveney	0.57%	1,341	237,175
NHS South Norfolk	0.56%	1,295	231,373
NHS West Norfolk	0.52%	897	172,544
Norfolk & Waveney	**0.61%**	**6,269**	**1,029,714**

Using the SEND report 2017 data[23] in Norfolk 15.5% of school pupils have a statement or EHC plan[24] or are receiving SEN support[25] (previously 'School Action' and 'School Action Plus'). This compares to an average of 14.4% across all English regions and a CIPFA nearest neighbours average of 13.8%. A total of 9,711 children in primary schools were recorded as having a SEN, 6,183 in secondary schools and 1,291 in Special schools.

Across England, '*Moderate Learning Difficulty'* is the most common primary type of need overall. 22.7% of pupils with SEN have this primary type of need. In Norfolk, 21.6% of pupils with SEN have this primary type of need.

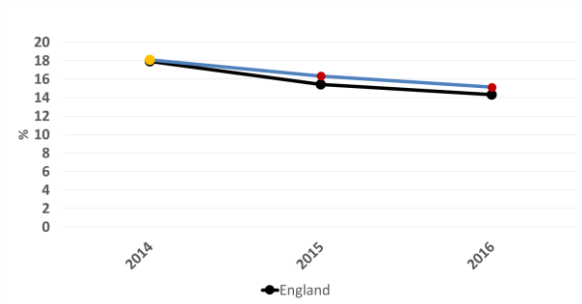
The distribution across Norfolk by primary type of SEN need and school type is shown in figures c), d), and e) below. For most the primary type of SEN need in Norfolk schools is in line with the England average. However, there are slight differences. A higher proportion of children in Norfolk primary and secondary schools have a 'social, emotional and mental health' SEN primary need, a higher number of children in special schools have 'speech, language and communication' needs, and a higher number of children in secondary school have a 'specific learning disability' such as dyslexia.

Combining the total SEN data for all types of schools and comparing it to the trends within England is also presented in figures f and g below.

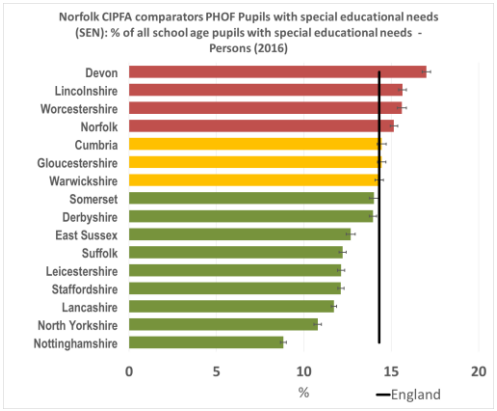
[23] Metric 2212, Department for Education, Special Educational Needs in England, January 2017.

[24] A statement/education, health and care (EHC) plan is when a pupil has a statement of SEN or and EHC plan when a local authority issued one following a formal assessment. This document sets out the child's needs and the extra help they should receive.

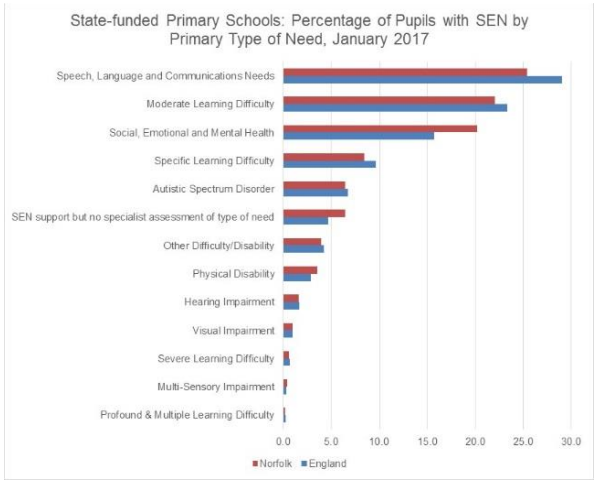
[25] SEN support is defined as extra or different help that is given from that provided as part of the school's usual curriculum. The class teacher and SEN Coordinator (SENCO) may receive advice or support from outside specialists. This category has replaced the 'School Action' and 'School Action Plus' categories.


20
18
16
14
12
% 10
8
6
4
2
0
2014
2015
2016
England

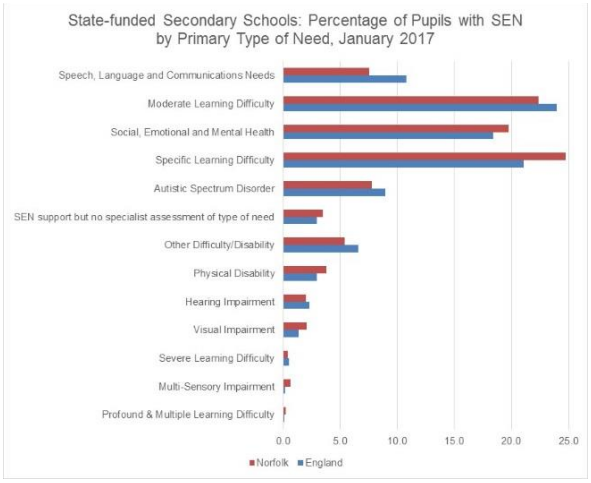
a.


Norfolk CIPFA comparators PHOF Pupils with special educational needs (SEN): % of all school age pupils with special educational needs - Persons (2016)
Devon
Lincolnshire
Worcestershire
Norfolk
Cumbria
Gloucestershire
Warwickshire
Somerset
Derbyshire
East Sussex
Suffolk
Leicestershire
Staffordshire
Lancashire
North Yorkshire
Nottinghamshire
0
5
10
15
20
%
England

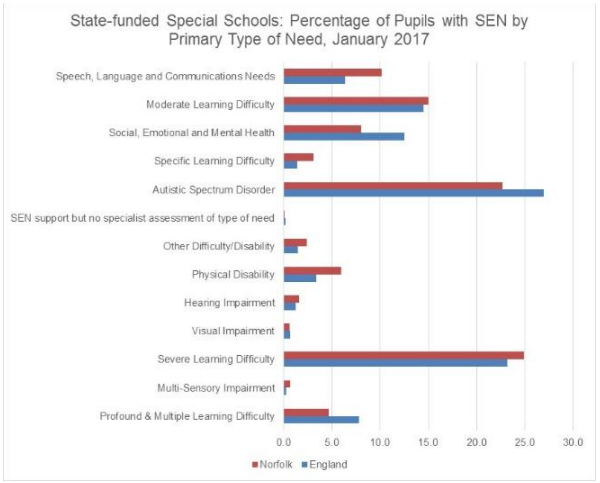
b.


State-funded Primary Schools: Percentage of Pupils with SEN by Primary Type of Need, January 2017
Speech, Language and Communications Needs
Moderate Learning Difficulty
Social, Emotional and Mental Health
Specific Learning Difficulty
Autistic Spectrum Disorder
SEN support but no specialist assessment of type of need
Other Difficulty/Disability
Physical Disability
Hearing Impairment
Visual Impairment
Severe Learning Difficulty
Multi-Sensory Impairment
Profound & Multiple Learning Difficulty
0.0
5.0
10.0
15.0
20.0
25.0
30.0
Norfolk
England

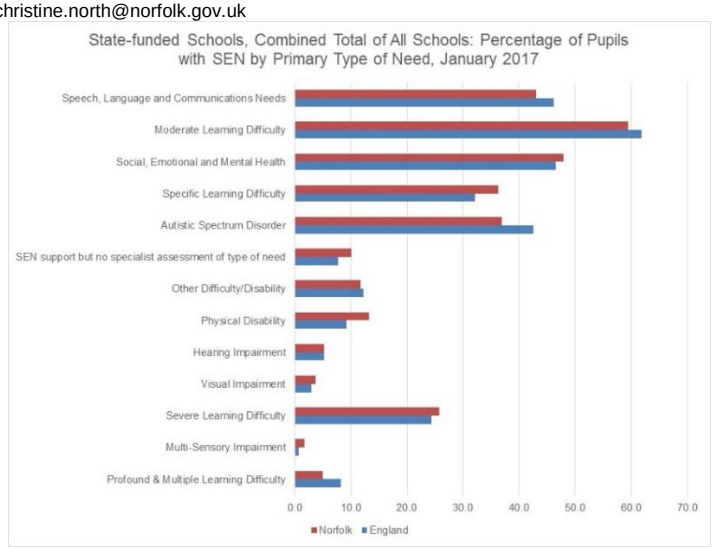
c.


State-funded Secondary Schools: Percentage of Pupils with SEN by Primary Type of Need, January 2017
Speech, Language and Communications Needs
Moderate Learning Difficulty
Social, Emotional and Mental Health
Specific Learning Difficulty
Autistic Spectrum Disorder
SEN support but no specialist assessment of type of need
Other Difficulty/Disability
Physical Disability
Hearing Impairment
Visual Impairment
Severe Learning Difficulty
Multi-Sensory Impairment
Profound & Multiple Learning Difficulty
0.0
5.0
10.0
15.0
20.0
25.0
Norfolk
England

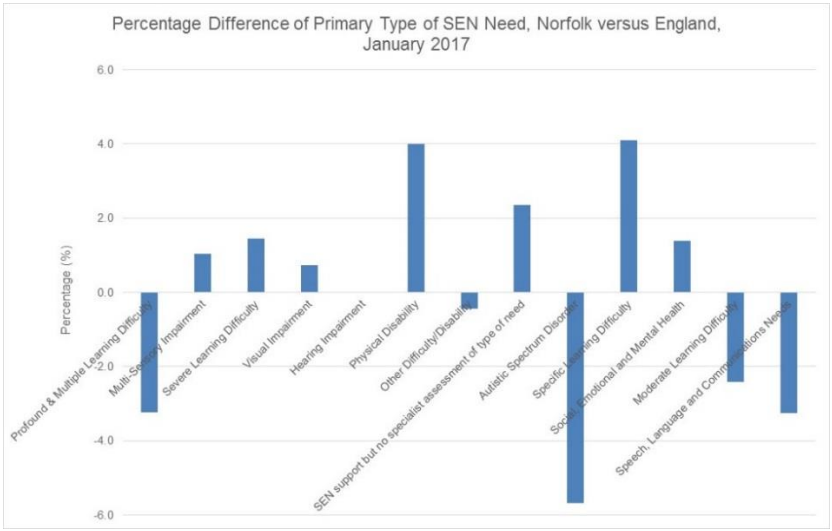
d.


State-funded Special Schools: Percentage of Pupils with SEN by Primary Type of Need, January 2017
Speech, Language and Communications Needs
Moderate Learning Difficulty
Social, Emotional and Mental Health
Specific Learning Difficulty
Autistic Spectrum Disorder
SEN support but no specialist assessment of type of need
Other Difficulty/Disability
Physical Disability
Hearing Impairment
Visual Impairment
Severe Learning Difficulty
Multi-Sensory Impairment
Profound & Multiple Learning Difficulty
0.0
5.0
10.0
15.0
20.0
25.0
30.0
Norfolk
England

e.



f.



g.

Figures a) and b) % of all school age pupils with SEN in Norfolk; c), d) and e) the primary type of SEN need by school, based on January 2017 data. Figures f) and g) demonstrate the combined total of SEN pupils by primary type of need, as well as the percentage difference between Norfolk and England (more than 0 is more than the England average, less than 0 is less than the England average).

It should be noted the SEND data can be used to assess how well SEN arrangements are working locally when compared to delivery across local areas. The data only tells one part of the story and success will vary for individual children and young people. SEND is currently education-focused but plans are being made to link data from within the Department of Health's Children and Young People's Health Services Data Set to the Department of Education's National Pupil Database. There is now an increased emphasis on supporting children and young people with SEND to make a positive transition into adulthood (up to 25 years), with good adult health, independent living and participating in society. This will happen if the young person is known to the service before they become 18 years of age. Further data is available by the number of SEN children and young people in education, employment or training at 17, those that are persistently absent from 15% or more school sessions, as well as for the number of adults with learning difficulties in settled accommodation.

Children with special educational needs aged 0-24 have been successfully supported in Norfolk via the dedicated schools grant fund and the 'high needs block' investment. This is one element of the SEN strategy to manage the forecast high demand for specialist placements and the increase in high needs in the school population (Norfolk County Council, 2017).

Down's Syndrome

The estimated prevalence rate for Down's syndrome is thought to be between 5.9 per 10,000 for the general population (Mantry, D. *et al*. 2008) and 6.6 per 10,000 live births (Health and Social Care Information Centre, 2015). In Norfolk, this equates to an estimated population of between 160 and

179 people with Down's syndrome for 0-24 years olds (119 and 113 for 0-18 year olds) during 2015. With the expected population growth by 2025, it is predicted to raise to between 164 and 184 for 0-24 year olds and, between 127 and 143 for 0-18 year olds.

Using the Learning Disability register[26] held by Norfolk County Council, there are currently 77 children and young people aged between 0 and 25 years registered with Downs Syndrome across Norfolk. The following table represents these register children and young people by CCG:

CCG	Total Number Registered with Downs Syndrome
NHS Great Yarmouth and Waveney	6
NHS North Norfolk	16
NHS Norwich	23
NHS South Norfolk	17
NHS West Norfolk	15
Total (exc. Waveney)	**77**

Supporting disabled children and their families so that they can access the information and services they need, to live the life they choose, will help to increase resilience and improve the future potential of that child. Increasing access to early and tailored support will help a child transition to adulthood and move into work.

Young Carers

Large numbers of children and young people up to the age of 18 years are involved in some kind of care for members of their families, often a parent but sometimes a sibling or other family member who has a long term illness or disability, learning disability, mental health problem or misuses alcohol and/or drugs. Having caring responsibilities isn't necessarily linked to lower well-being but it has been found that depending on the types and levels of care, there may be aspects of caring that are harmful to the child's health and well-being, social activity, education and employment opportunities. For example, if someone is missing school as a consequence of their caring responsibility, this has been related to their education attainment and health and well-being. Around one in 20 young carers miss school because of the amount of support they have to provide at home (Children's Society, 2013) so it becomes important to understand the impact of their caring responsibility. A child or young person's caring responsibilities should not become excessive or inappropriate as they can become isolated from other children and find it difficult to balance their own needs with those of the person they are caring for.

In Norfolk, the 2011 Census reported 5,712 carers between the ages of 0 and 24 providing unpaid care, 1,752 aged under 15. The Norwich district has the highest numbers of young carers followed by King's Lynn and West Norfolk, and then Breckland. The 2011 Census is regarded as an underestimate of the number of children and young people with unpaid caring responsibilities, with other survey's suggesting the actual number to be

[26] The data held on the register is updated annually, with 17 year olds asked if they would like to remain on the register; not all 17 year olds wish to stay on the register. Upon reaching the age of 25 years, individuals are automatically removed from the register. The register only contains details of Norfolk residents and not Waveney residents.

closer to 12,000 but, this may be an overestimate. Indications show that there are more female young carers than males, with the highest percentage in the 10 to 14 year old age group (JSNA, 2017).

Refugees and asylum seekers

Evidence by the University of Bristol (2015) as shown that approximately a third of the refugee and asylum seeking young people may have mental health concerns, especially with regards to having anxieties about the past rights and entitlements to education, housing and leaving care services, as well as their asylum claims and its impact on their future. With the moving UK political boundaries and an uncertain future within the European Union (EU), this is a vulnerable group of children and young people that we need to be aware of. In 2016 Norfolk was aware of 5 unaccompanied asylum seeking children being looked after, compared to 450 within the East of England and 4,210 within England (Source: SSDA 903).

'Child in need/concern' as deemed by social service input

There were 521 children aged 4 to 16 who were looked after continuously for 12 months at 31st March 2014 for whom a strengths and difficulties questionnaire (SDQ) should have been received. An SDQ was returned for 93% of these children. Of their results 39% were of eligible children were considered 'of concern', with an average SDQ score of 14.6. A score of under 14 is considered normal, a score of 14-16 is a borderline cause for concern and, 17 or over is a cause for concern.

This group of children and young people aged between 5 and 16 years are in care for at least 12 months and have a SDQ score that indicates a cause for concern (17 or over) and are affected by poor emotional wellbeing. In Norfolk the percentage of children where there is a cause for concern was 42.1% in 2015/2016. This was higher than the East of England (41.2%) and England (37.8%) figure.

Experience of abuse or neglect, sexual violence, discrimination

Children and young people who experience a range of adverse childhood experiences, such as living with abuse or neglect, witnessing violence or substance abuse at home or experience sexual exploitation or discrimination, alongside any pre-existing mental health needs, are particularly at risk of developing mental health problems. However, children and young people may not always view themselves as victims of sexual abuse. Conditions such as post-traumatic stress disorder (PTSD) can occur as a result of abuse or neglect.

In Norfolk and Waveney, there are an estimated 210 children aged 5-16 years suffering with PTSD, and a further 8,400 16-24 year olds.

Parental mental health issues

Large numbers of children grow up with a parent who has a mental health problem. Many of these parents will have a mild or short-lived problem, but some parents have a severe and enduring mental illness. Research has shown that some children of parents with a severe and enduring mental illness experience greater levels of emotional, psychological and behavioural problems than children and young people in the rest of the population. This may be because the genes that some of them inherit make them more vulnerable to mental ill health, but it could also be because of their situation and the environment in which they are growing up e.g. they are more likely to live in deprived areas. Children may become carers for their parents and lose out socially and educationally.

Research by CHIMAT and the National Child and Maternal Health Network Mental Health in Pregnancy Needs Assessment (2016) estimated the need for perinatal mental health services. They identified risk factors associated with stillbirth (foetal death occurring after 24 weeks of gestation) including a history of mental health problems, smoking, maternal obesity, pre-existing diabetes and pregnancy related conditions such as foetal growth restriction and antepartum haemorrhage. In Norfolk and Waveney, there are on average 10,500 births, with a stillbirth rate of 3.9 per 1,000 births each year. The stillbirth rate is similar to the England and East of England rate. This equates to the following need for perinatal mental health services in Norfolk and Waveney:

Stressful life events

Bereavement

Nelson's Journey is a Norfolk-based charity that supports children and young people aged 0 – 17 years that have experienced the death of a significant person in their life. Their aim is to improve the emotional well-being of the children in a variety of ways including therapeutic residential weekends, activity days, Nelson's Journey Clubs and therapeutic 1:1 work; as well as guidance and education to parents, carers and professionals. In 2016, 788 referrals were made to Nelson's Journey, 139 more than in 2015. If the 2017 referrals continue on their current trajectory, Nelson's Journey will exceed the number of children that accessed their services in 2016.

Service users feedback	
"She does not feel so isolated alone and does not question 'why me?' or feel that she is alone"	"Confidence has improved, anger management has improved, generally less anxious, more able to discuss his loss"
"We have been able to celebrate my father's / their grandad's life and talk to each other more"	"He has learnt how to deal with his emotions by talking instead of hiding it, he talks more about losing his nannie"
"It has helped us so much, I learnt as a mum not to hide my tears / feelings etc. I learnt that it was making my son worse by doing this, we can both talk openly now about the death of our loved one"	'It's nice to be around people with the same experiences. Making friends who understand each other. Talking to people and helping each other out.'

"With my son's language and understanding problem, I found it so hard to help him understand everything. Nelson's Journey helped this situation so much. He doesn't have massive outbursts anymore, he talks more openly, he says why he's crying instead of hiding it"	"We both find it more easy to talk about Harry's mum"

Living in financial difficulty

There are many factors that contribute to children in poverty suffering from mental health problems. For many, mental health problems develop and are heightened by exposure to a variety of different issues. These can include debt, poor housing and inadequate access to services. A survey by The Debt Trap reported that 47% of parents were in arrears and that their financial situation caused their children emotional distress, with frequent feelings of stress and anxiety. 19% reported that the financial difficulties also contributed to the children having mood swings. Mental health problems can be a difficult for families already struggling to maintain the everyday costs of supporting their children.

Free school meals

Within Norfolk in early 2016, there were 65,127 pupils within a state-funded nursery and primary school aged between 5 and 15 years. Of this population, 8,577 (13.8%) were known to be eligible for and claiming free school meals. This is lower than the England proportion (15.2%) but higher than the East of England (11.9%). There were a further 45,480 children and young people registered within state-funded secondary schools, of which 4,873 (12.2%) were known to be eligible for and claiming free school meals. This follows the same trends as the nursery and primary school free school meals and is lower than the England proportion but higher than the East of England.

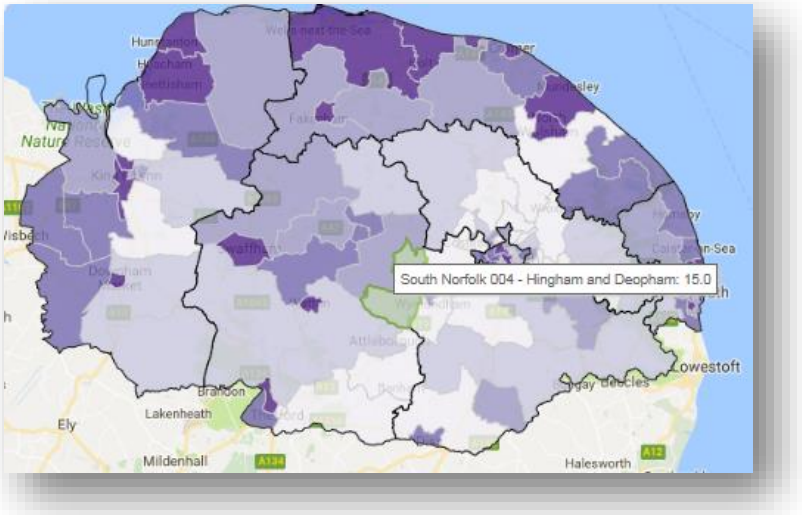
Pupils eligible for free school meals based on School Performance Tables	Number of Pupils on roll	Number of pupils known to be eligible for and claiming free school meals	Percentage known to be eligible for and claiming free school meals (%)		East of England %	England %
State-Funded Nursery And Primary Schools	65,127	8,577	13.8		11.9	15.2
State-Funded Secondary Schools	45,480	4,873	12.2		10.3	14.1
Special Schools	1,246	390	36.6		31.1	37.7
Pupil Referral Units And Alternative Provision Academies And Free Schools	383	133	34.7		34.3	41.8

Households in Poverty

A household is deemed to be in poverty if the household's income lies below 60% of the UK median income, where income is defined as net weekly equivalised income. Applying an equivalisation scale adjusts the household income values to take account of the number and composition of people in the household. Therefore, it represents the income level of every individual in the household. The proportion of households in Norfolk estimated to

be in poverty before housing costs[27] (BHC) is 17.7% and after housing costs[28] (AHC) 19.4%. England and Wales had an average of 15.6% of households estimated to be in poverty BHC and 18.9% AHC.

Households in Poverty in Norfolk before and after housing costs (%), by MSOA, 2013-2014



Source: Office of National Statistics, April 2017

Fuel Poverty

Fuel poverty itself is detrimental to health, especially mental health, through the financial stress that it causes to households. The Marmot 2011 Review Team found that mental health is negatively affected by fuel poverty and cold housing for any age group. In children and young people, "more than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing". Children living in bad housing conditions, including cold homes, are more likely to suffer with anxiety and depression and experience long-term ill health and disability.

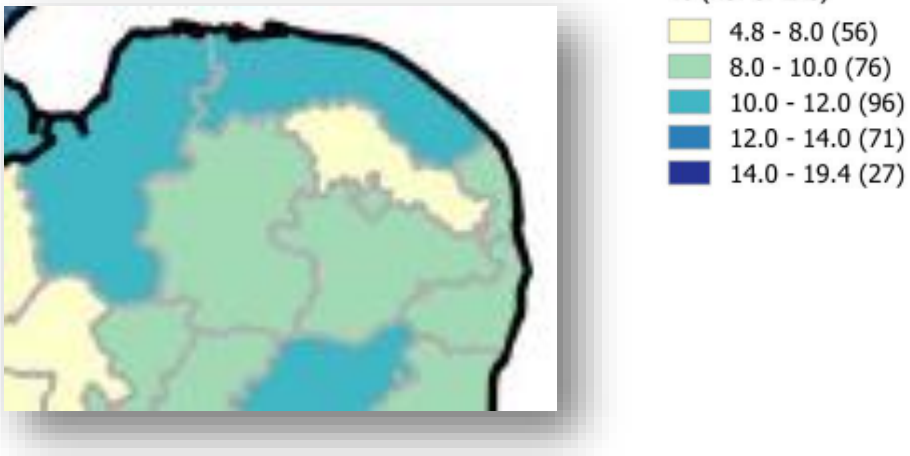
In Norfolk and Waveney during 2015, there were 41,308 households estimated to be fuel poor. North Norfolk and King's Lynn and West districts have the highest proportion of fuel poor households (11.3% and 10.1% respectively), and Broadland having the least (6.6%). It is not possible to

[27] £272 per week corresponds to 60% of UK median before housing costs equivalised net income (£453 per week). Therefore, a household with a weekly income of less than £272 (BHC) is classed as a household in poverty.

[28] £232 per week that corresponds to 60% of UK median after housing costs equivalised net income (£386 per week). Therefore, a household with a weekly income of less than £232 (AHC) is classed as a household in poverty.

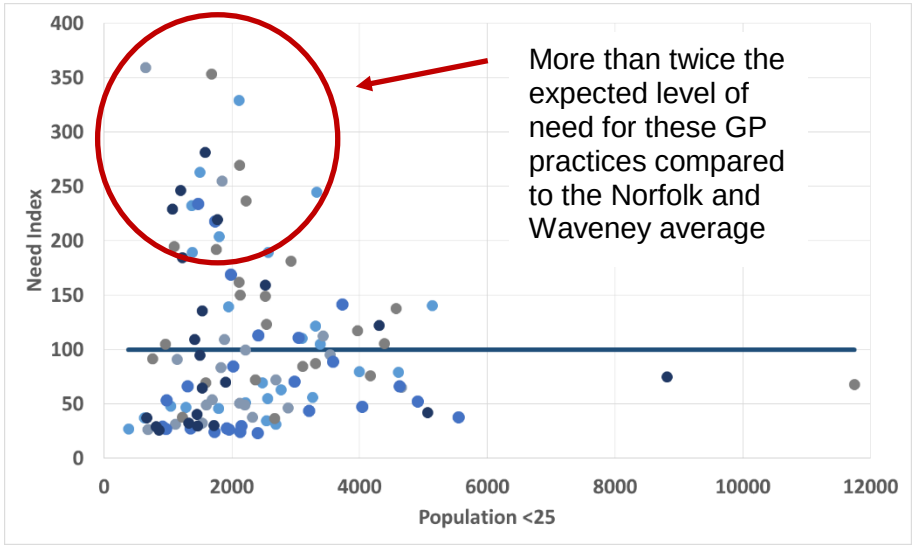
accurately calculate the number of fuel poor households that have children and young people but using the map, the 'Distribution of the population aged 0-24years', the geographical areas with the largest number of 0-24 year olds can be seen e.g., larger urban areas such as King's Lynn, and pockets within the rural areas of Norfolk such as those near Holt.

Proportion of Fuel Poor Households (%) by Local Authority, 2015

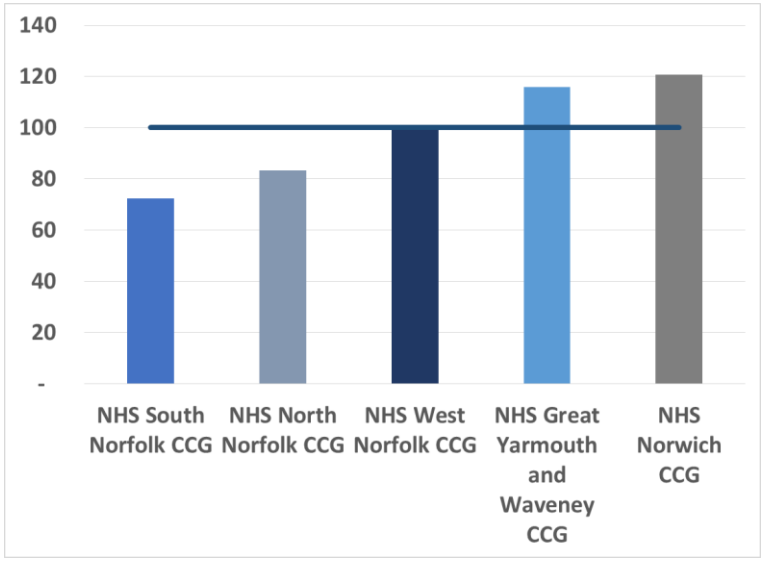


Estimating Relative Need for Children and Young People's Mental Health Services

The *Person Based Resource Allocation for Mental Health Model* provided by NHS England[29] is a useful starting point to estimate the relative need for children and young people's mental health services across NHS Norfolk and Waveney. It includes variables related to GP practice level variables (e.g. unpaid care, ESA IB/SDA etc.), person-level condition severity and care markers (e.g. detention under mental health act, contacts with services), person-level psychiatric diagnostic markers, service user characteristics (e.g. settled accommodation, unemployed). Using these it is possible to create a Need Index for each practice and each CCG. There are some practices where the level of need is twice that of the Norfolk and Waveney average (xx) NHS Norwich CCG and NHS Great Yarmouth and Waveney CCG have more need than the other CCGs in the system.



Need Index for practices in NHS Norfolk and Waveney



Need Index for CCGs in NHS Norfolk and Waveney

The level of need in a practice can be compared to service use. For example, there is variation across the Norfolk and Waveney system in the referrals to the wellbeing service run by NSFT and referrals into secondary care mental health services (see the funnel plots below). In addition, there is a moderate association between referrals to the wellbeing service and referrals into secondary care mental health services (see the scatter graph below, as the use of wellbeing services rise so does use of secondary care mental health services). Assuming that the level of need for secondary care services is proportional to the level of need for wellbeing services then once in the wellbeing service a person from one practice is as likely to access the secondary care mental health service as a person from another practice.

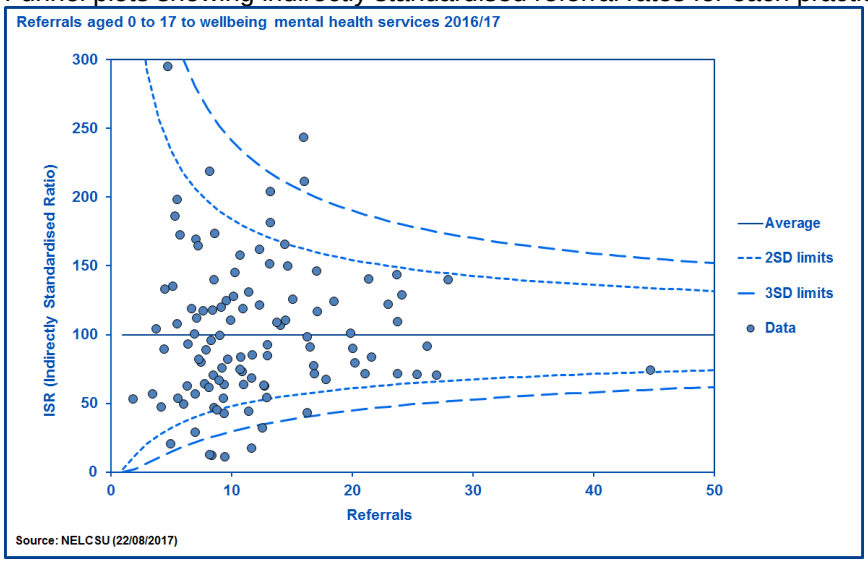
[29] NHS England CCG allocations. Available at: https://www.england.nhs.uk/2016/04/allocations-tech-guide-16-17/

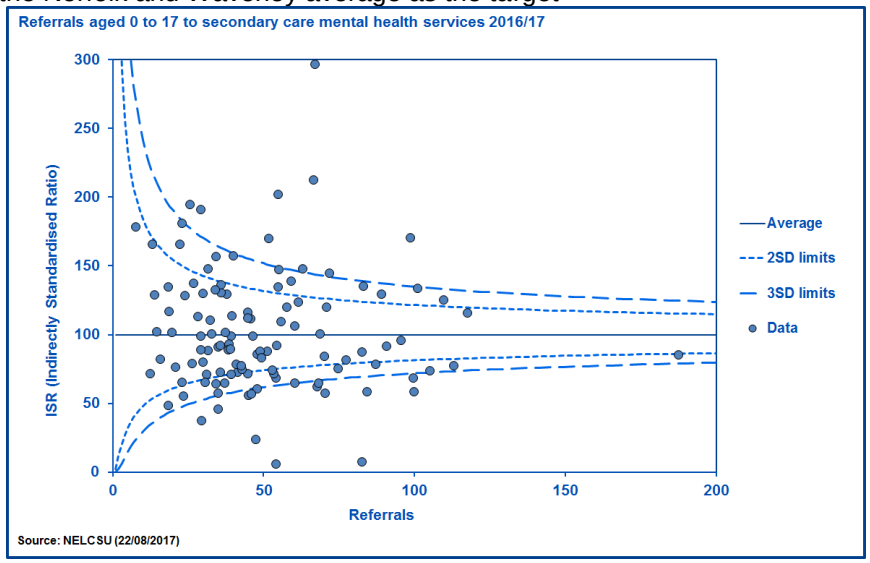
However, if we compare the practice need index with use of the wellbeing service it appears that those people from practices with the highest level of need do not necessarily access the wellbeing service (see the scatter graph below, as the need index increases the access to the wellbeing service stays relatively flat).

This could be due to the need index not reflecting the true need in the population or that those with need are not accessing the service. However, a similar pattern is seen when plotting the referrals to the wellbeing service against deprivation (IDACI and IMD). This suggests that those practices with the most need are not necessarily accessing mental health services.

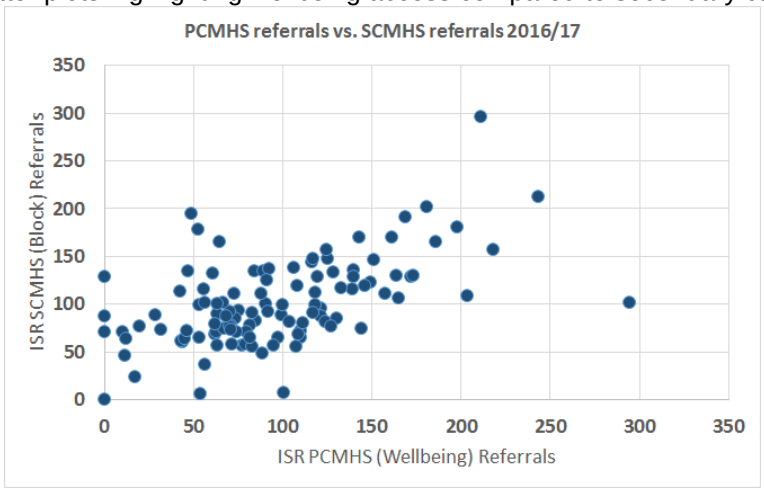
We can further understand if this is the case by using self-harm and other mental health admissions for those aged 0-24 as a proxy indicator for need for mental health services. Again it appears that those practices with most need are not necessarily accessing services. This might be a process issue in that some people presenting as emergency admissions are not then referred to the NSFT but maybe to point 1

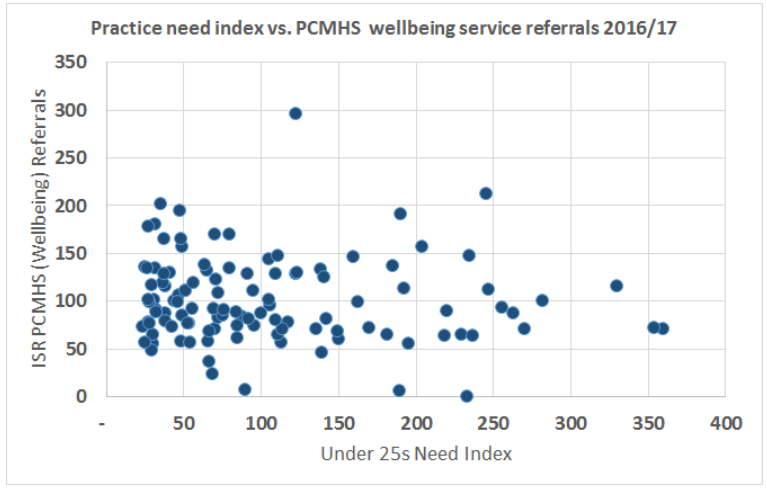
Funnel plots showing indirectly standardised referral rates for each practice using the Norfolk and Waveney average as the target



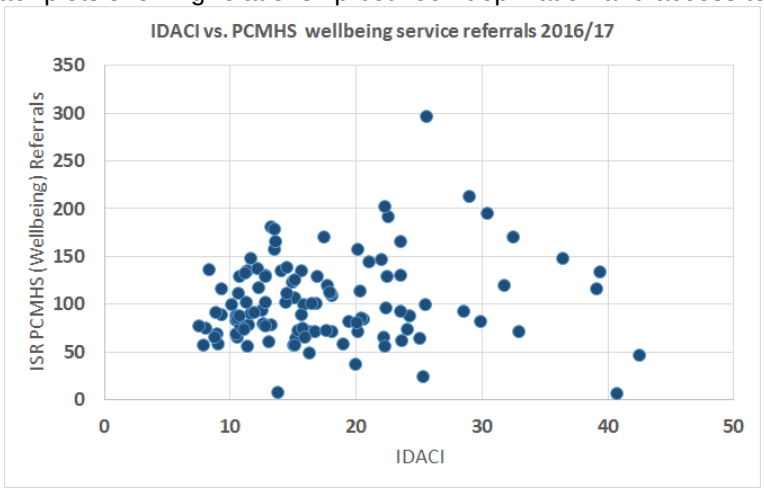


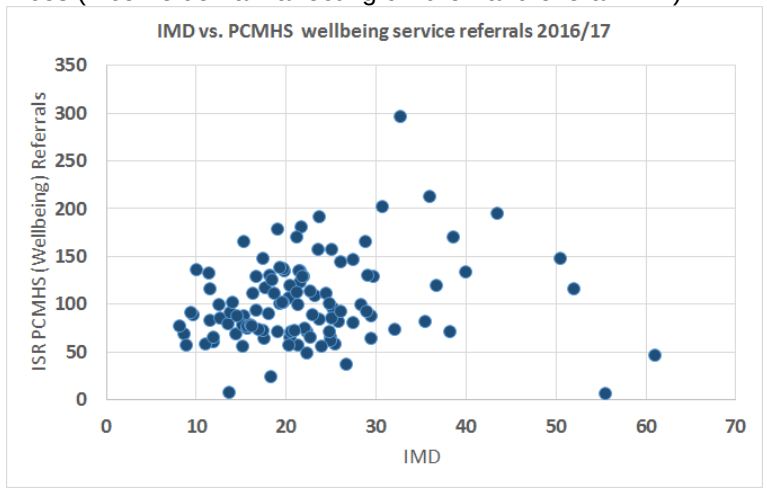
Scatter plots highlighting wellbeing access compared to secondary care access and practice need vs. access for mental health services



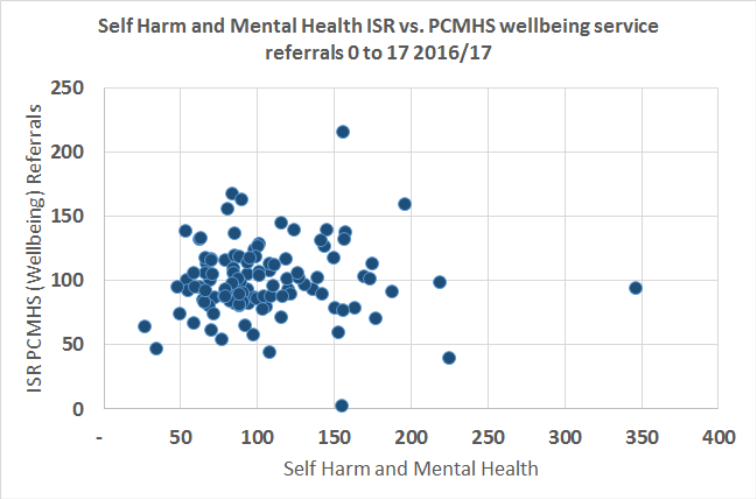


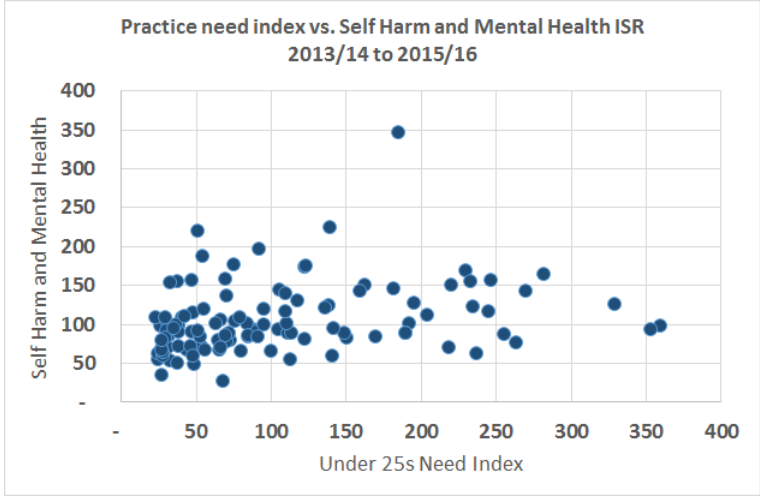
Scatter plots showing relationship between deprivation and access to mental health services (Income domain affecting children and overall IMD)





Standardised self-harm and other related mental health admissions for those aged under 25 vs. wellbeing service referrals





Another approach to estimate the relative need for a service is to use the historical *'tiered'* CAMHS model. Estimated numbers in each tier of the CAMHS model by CCG for 2016 are shown in the infographic below.

Historically child and adolescent mental health services (CAMHS) cover all types of provision and intervention ranging from mental health promotion and primary prevention to specialist care. Services are often separated into 4 tiers. Whilst some services may have structural and /or functional tiers, others may combine some tiers.

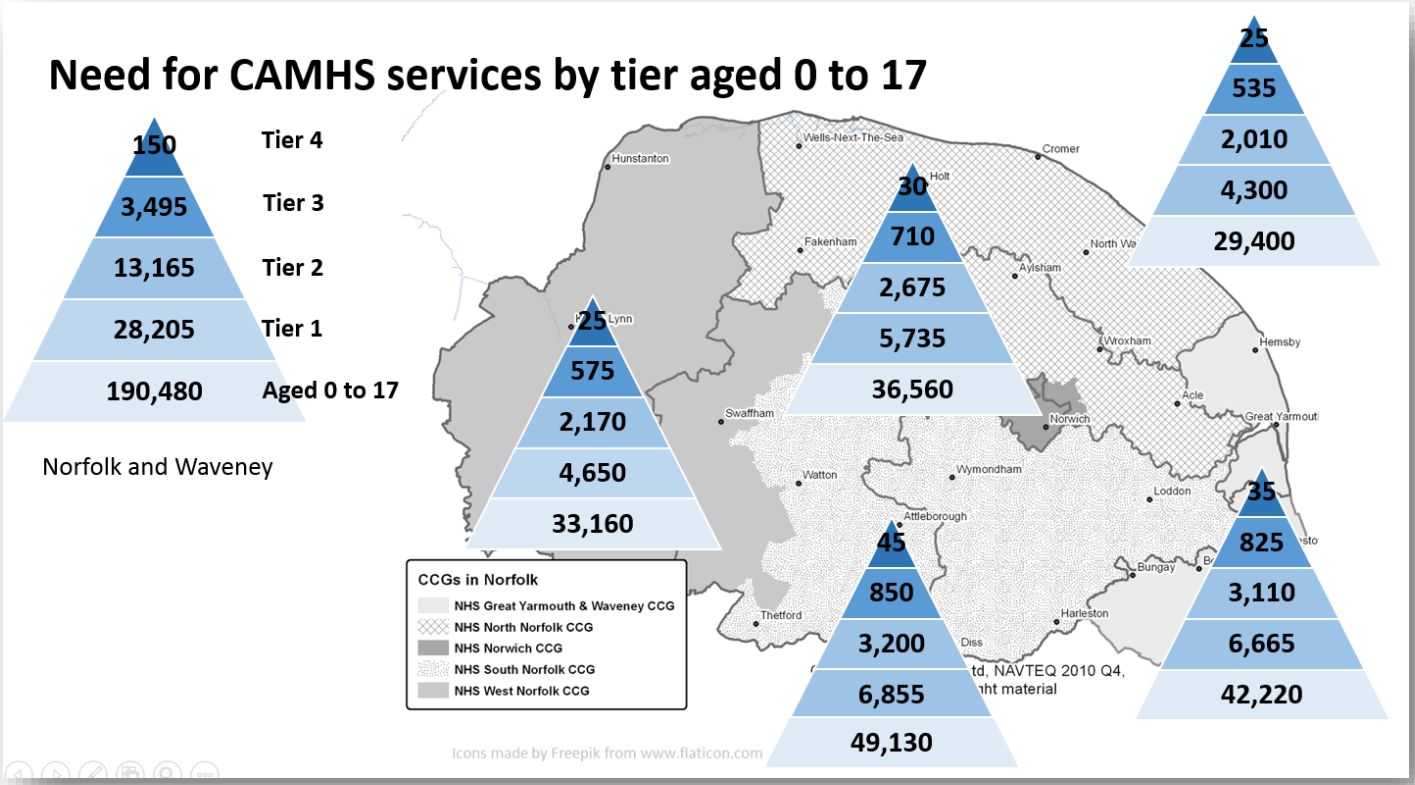
Tier 1 CAMHS is provided by professionals whose main role and training is not in mental health. These include GPs, health visitors, school nurses, social services, voluntary agencies, teachers, residential social workers and juvenile justice workers.

Tier 2 CAMHS is provided by specialist trained mental health professionals. They work primarily on their own but may provide specialist input to multiagency teams. Their role involves helping young people that have not responded to Tier 1 interventions and they usually provide consultation and training to Tier 1 professionals. Roles include clinical child psychologists, paediatricians (especially community), educational psychologists, child psychiatrists and community child psychiatric nurses/ nurse specialists

Tier 3 CAMHS is aimed at young people with more complex mental health problems than those seen at Tier 2. Many of the professionals working at Tier 2 will work in this area, however the service is provided by a multidisciplinary team. Roles include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists and art, music and drama therapists

Tier 4 services are aimed at children and adolescents with severe and/or complex problems. These specialised services may be offered in residential, day patient or out-patient settings. The service requires a combination or intensity of interventions that cannot be provided by Tier 3 CAMHS. These services include adolescent in-patient units, secure forensic adolescent units, eating disorder units, specialist teams for sexual abuse and specialist teams for neuro-psychiatric problems. (York, A. et al, 2006; Kurtz, Z., 1996)

Wolpert et al[30] argue that this model was very useful at its time of development in 1995 (NHS Advisory Service, 1995) for helping differentiate between the forms of support that might be available to children and young people, but that now they feel that the THRIVE model offers a more helpful conceptualisation to address the challenge and opportunities of the current CAMHS situation.



[30] Available at: http://www.annafreud.org/media/4817/thrive-elaborated-2nd-edition.pdf

The THRIVE Model

The THRIVE framework below conceptualises five needs-based groupings for young people with mental health issues and their families. The graphic on the left describes the input that is offered for each group; that on the right describes the state of being of people in that group – using language informed by consultation with young people and parents with experience of service use.

Each of the five groupings is distinct in terms of the:

- Needs and/or choices of the individuals within each group
- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group.

The THRIVE model has been aligned with the development of a payment system that attempts to capture a more complete picture of the work done by clinicians, and therefore cost, in order to inform the development of a system by which payment, such as for children and young people mental health services, is determined according to need[31].

[31] http://pbrcamhs.org/final-report/ and http://pbrcamhs.org/wp-content/uploads/2015/06/CAMHS-Payment-System-Project-Final-Report.pdf

The table below summarises the process of choosing a needs based grouping[32]. This work helpfully gives estimates of the proportions of children and young people who are likely to fall into each needs based grouping if the child or young person. For example, the algorithm suggests that about 28% of referrals would be a one-off contact requiring "signposting and guidance for self-management" in the "Getting Advice" Thrive state. However, an important finding from the payment system work was that algorithm assignment did not fit neatly with actual resource use. This is consistent with findings in the development and analysis of other algorithm-based classifications[30]. Despite this the needs based grouping approach provides an initial estimate to start thinking about the potential volumes likely to be seen in each grouping.

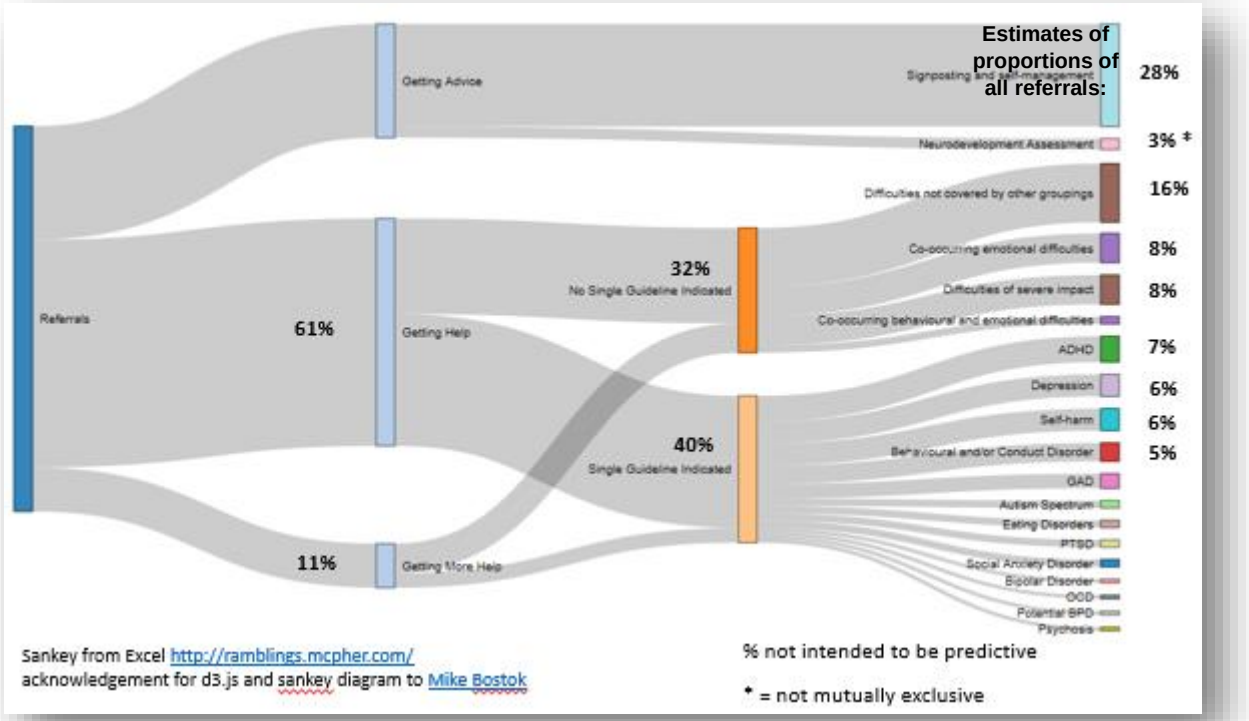
Based on an estimated total number of referrals for 2016/17 of about 10,300 (need to check this) then following the needs based grouping in the Thrive model, the potential resource use across the Norfolk and Waveney system is shown in the table below. This is also provided for the CCGs in appendixes.

Thrive State	Issue	NICE Guideline	Estimated Proportion	Estimated Number	
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	309	
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	2,880	Mutually Exclusive
Single Guideline Indicated					
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	720	
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	206	
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	514	
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	103	
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	617	
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	411	
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	103	
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	206	
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	617	
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	206	
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	206	
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	103	

[32] http://pbrcamhs.org/wp-content/uploads/2015/06/A-Guide-to-Choosing-Needs-Based-Groupings-in-CAMHS-to-Inform-Payment-Systems-v1.pdf

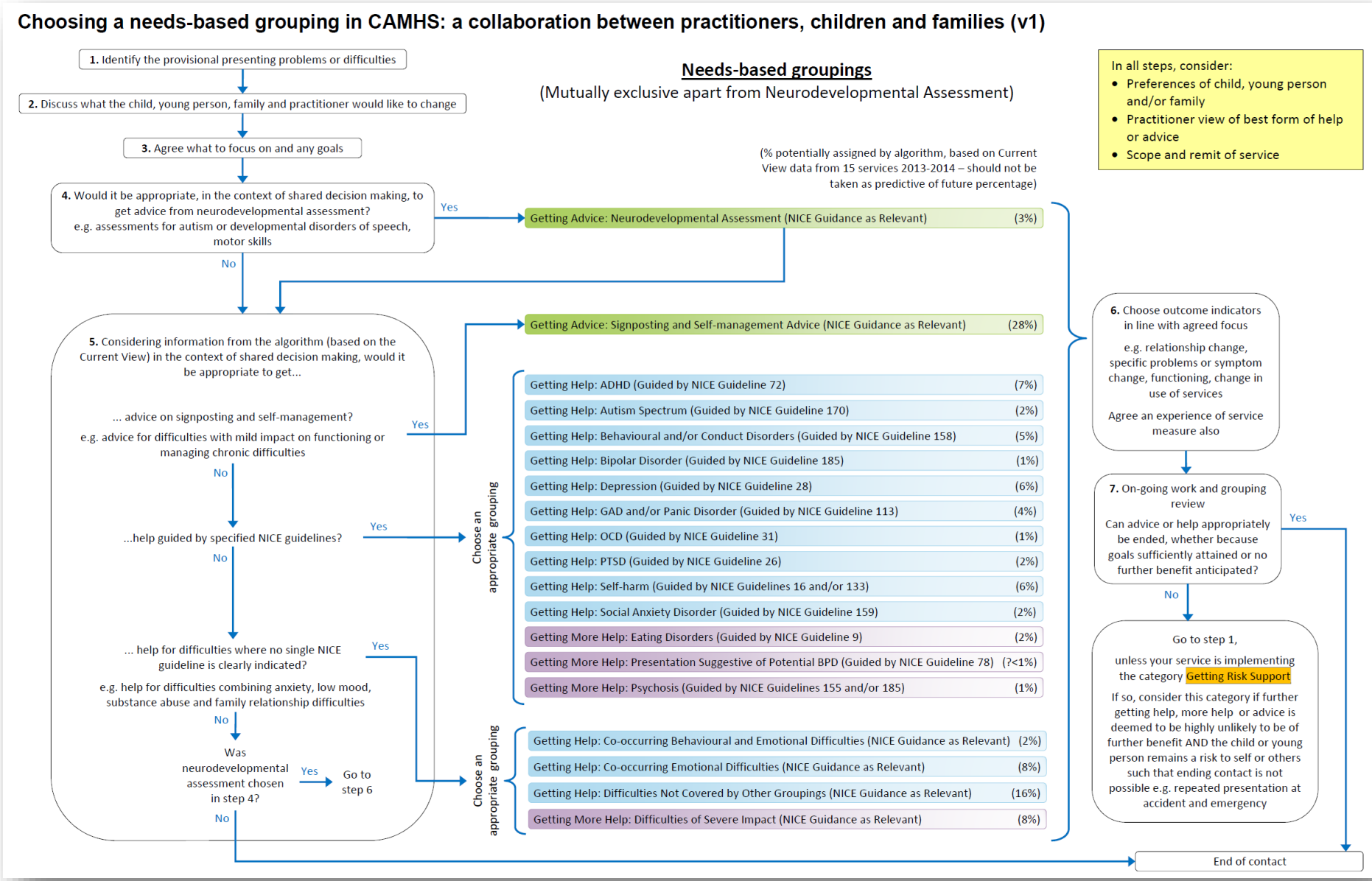
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	103
No Single Guideline Indicated				
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	206
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	823
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	1,646
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	823

The THRIVE model of proportions as allocated to different states from referral:



Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Choosing a needs-based grouping in CAMHS: a collaboration between practitioners, children and families (v1)



The Existing CAMH Service

Child and adolescent mental health services in Norfolk are currently commissioned by Norfolk County Council and the 5 Clinical Commissioning Groups (CCGs) within Norfolk and Waveney[33]. The joint strategic planning and commissioning of CAMHS is led in Norfolk by the CAMHS Strategic Partnership and the CAMHS Joint Commissioning Group. Both of these groups are accountable to Norfolk's Mental Health and Learning Disability Network. The CAMH service consists of a Targeted Tier 2 CAMHS service and a Specialist Tier 3 service, both have a perinatal and infant mental health service (PIMHS) element. Services are provided by a mix of NHS and non-NHS organisations, local authority services and voluntary organisations, as well as being covered geographically by two Children's Services and Public Health Departments and two Youth Offending Teams. The CAMHS service, along with the CAMHS 2015-2017 strategy, work to meet the mental health needs of children and young people in Norfolk and to deliver the aims of the Government's Mental Health Strategy 2011, *No Health Without Mental Health*.

The term 'CAMHS' can be used in a couple of ways; firstly, as a broad concept that covers a network of services and agencies that work with the mental health care of children and young people, including health, education, social services or other non-statutory organisations and, secondly, as a term specifically relating to the 'Specialist CAMHS services'. This covers the services operating under the universal, targeted and specialist services and settings (previously known as tier 1, tier 2 and tier 3 & 4 services). In general, the numbers of children requiring treatment reduce as the intensity of the service increases. However, it should be noted that the resource required to care for each service user increases with the intensity of the treatment and with the movement through the levels of service available. In addition, there is often some overlap between targeted and specialist provision, with specialist teams providing targeted interventions to groups known to be at high risk of developing mental health conditions and problems.

The Norfolk and Suffolk NHS Foundation CAMHS offer assessment and treatment when children and young people have emotional, behavioural or mental difficulties. The CAMHS service has developed inclusive services for 0-25 year olds removing previous transitions and barriers to service at 18 years. They are also part of the CYP IAPT programme. This has allowed the embedding of adolescent mental health services models within a local pathway. There has also been progress of innovative integrated services within Social care and education with the development of Outreach services, mainstream school PIMHS services and a range of other approaches that meet the need of young populations that traditionally find it hard to access CAMHS.

Universal services and provision (Tier 1)

These are accessible by all children and young people. They are delivered in settings such as children's centres, schools and primary care by teachers, early year's workers, GPs, school nurses, health visitors and many other professionals. The mental health role of universal services is to promote positive mental health and well-being and to help identify, refer on and support those children who may require input from targeted or specialist services.

Targeted services and provision (Tier 2)

These are for children and young people who may be considered to have specific identified mental health needs and/or to be vulnerable, where some low intensity monitoring/interventions may be required. Service settings include universal settings, but the provision is aimed at identified groups, not

[33] 1.NHS Great Yarmouth and Waveney CCG 2.NHS North Norfolk CCG 3.NHS Norwich CCG 4.NHS South Norfolk CCG 5.NHS West Norfolk CCG

the whole population. Services such as youth offending teams, primary mental health workers, educational psychologists and school and voluntary/third sector providers counselling (including social care and education).

The Targeted Tier 2 CAMHS Service is predominantly provided by 'Point 1', a consortium consisting of Ormiston families, Mancroft Advice Project, and Norfolk and Suffolk Foundation NHS Trust. It is commissioned by Norfolk County Council on behalf of the County Council and the 5 CCGs. Point 1 works with 0-17 year olds with mild to moderate mental health issues that would benefit from effective, early, time limited interventions from a targeted CAMH service. The service also works with parents/carers, and staff who work in universal and non-specialist mental health settings. The aims of the service are:

- To improve the emotional wellbeing and mental health outcomes of the 0-17 year old population of Norfolk by providing evidence informed targeted mental health interventions and pathways of care.
- To provide equitable access to the interventions and pathways for the whole 0-17 year old population of Norfolk, including those children and young people with additional or particular needs.
- To develop the mental health competence and capacity of staff in universal settings by providing effective consultation, joint assessment and joint case work
- To work in partnership to deliver improved, streamlined and more integrated interventions and pathways for children and young people.

Point 1 is commissioned to provide a minimum volume of activity for the population per year. Activities include:

- Talking therapy sessions – 1:1 and group
- Structured psychosocial sessions – 1:1 and group
- Consultation sessions – group and individual
- Parenting courses – delivery of the Incredible Years, Strengthening Families and Triple P programmes to families in Norfolk
- Parent Infant Mental Health provision
- Co-ordination of a 'Clearing House' function for the Norfolk CAMHS system – named by Point 1 as the Single Area Meeting (SAM)

Specialist services and provision (Tier 3 and 4)

These are for children and young people with identified complex and/or high levels of need or mental health problems. Settings include specialist clinics and out of county provision, with staff including talking therapists, child and adolescent psychiatrists and other practitioners with specialist mental health training.

The specialist Tier 3 CAMHS is provided by Norfolk Suffolk Foundation NHS Trust and is commissioned via 3 separate contracts with West Norfolk CCG, Gt Yarmouth & Waveney CCG and with North, Norwich and South CCGs (known as Central Norfolk). The Tier 4 inpatient CAMHS unit is commissioned by NHS England.

The Tier 2 service provides a county-wide targeted mental health service for children and young people with mild to moderate mental health needs, while the Tier 3 service provides a county wide specialist mental health service for children and young people with moderate to severe mental health needs.

Referrals into both Tier 2 & Tier 3 services are via self-referral, agency-referral, health, parent or school.

In addition, Norfolk & Waveney offer the following services:

Starfish Service: Supports children aged between 5-18 years who have a significant learning disability and young people with complex developmental needs.

Starfish Plus: Supports children aged between 5-18 years who have a significant learning disability and additional severe mental health difficulties, and young people with complex developmental needs, in challenging often crisis situations.

ADHD Pathway (x2): Provides specialist assessment and support for young people with behaviour disorders.

LD CAMHS Team (Waveney): Supports children and young people with a learning disability and additional mental health difficulties.

6 Airey close: Targeted, structured, skilled intervention and support for learning disabled young people with long-term and enduring challenging behaviours and/or mental health conditions, offering assessment and treatment beds.

Provider delivered out-of-hours crisis cover, via its all age Crisis Teams and the back-up of an on call CAMHS psychiatrist (for telephone advice only)[34].

Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT)

The CYP IAPT programme is a service transformation programme that began in 2011. It has a target to work with CAMH services to cover 60% of the 0-19 population. There is a further commitment to roll out the programme to 100% coverage of the population. Its main aim is to improve existing CAMHS services working in the community, working in partnership with the NHS, local authority and voluntary sector providers. The CYP IAPT programme seeks to improve services through training staff in evidence based therapies, integrating regular frequent outcome monitoring, ensuring easy access and use of technologies and active participation by young people and families in the design and delivery of services.

[34] Extract taken from '*Benchmarking Children and Young People's Mental health Services in the East of England – East of England Community CAMHS Mapping Project 2016',* Associate Development Solutions, January 2016.

Benchmarking – a comparison with other areas and Mental Health Trusts

Information from national datasets are an important factor when commissioning a local service. Capturing the base data and national data from a variety of systems used by service providers allows a standardised extract to be utilised as a benchmark to compare our local service data. They are robust, comprehensive, nationally consistent, and allow comparable person-based information. From January 2016, the Mental Health Services Data Set (MHSDS) includes patient level, output based secondary use information not only for adults but also for people in children's and young people's mental health services, including CAMHS, for the first time. Learning disabilities and autism services have been included since September 2014. The MHSDS not only covers services provided in hospitals, but also services in outpatient clinics and in the community, where the majority of people in contact with these services are treated. Due to the immaturity of this dataset and the new measures that are included, the data are currently labelled as 'experimental statistics'. This will continue until the characteristics of the data flow are fully understood. However, they are an invaluable tool that can be used to look at the basic measures that cover a wider set of services.

England

Between 1st April 2016 and 31st March 2017 there were 2,638,067 people in contact with mental health, learning disabilities and autism services across England. Of these, 606,846 were aged 18 years or less, 1,365,992 were aged between 19 and 64 years and, 664,354 were aged 65 years or more. During 2016/2017 of the people in contact with these services 101,873 had an inpatient spell. Of these, 4,512 were aged 18 years of less, 77,715 were aged 19 and 64 years and, 19,643 were aged 65 years or more.

Between 1st January 2017 and the end of March 2017, there were 1,227,312 people in contact with mental health, learning disabilities and autism services. The majority of these people (1,039,471; 85%) were in adult mental health services. However, there were 134,852 (11%) people in contact with children and young people's mental health services and 77,955 (6%) in learning disabilities and autism services (NHS Digital, June 2017).

There were 3,840 people with learning disabilities and/or autistic spectrum disorders in hospital at the end of March 2017, of which 160 were 0-18 years and 1,795 were in a secure setting. Of those people with learning disabilities and/or autistic spectrum disorders in hospital at the end of March 2017, 1,290 (34 per cent) had been in hospital for over 2 years. Of those people with learning disabilities and/or autistic spectrum disorders in hospital at the end of March, 2,860 (74 per cent) were subject to the Mental Health Act.

Norfolk

In Norfolk and Waveney, between 1st January and 31st March 2017 there were 14,680 people in contact with mental health, learning disabilities and autism services. The majority of these people (11,875; 80.9%) were in adult mental health services. There were 2,530 (17.2%) people in contact with children and young people's mental health services, which is higher than the England proportion of 11%. There were also 420 (2.9%) in learning disabilities and autism services, which is lower than the England proportion.

Of the 14,680 people in contact with services 2,850 were aged 18 years of less (approximately 19.4% of the total people in contact with the services).This proportion of service users by age is similar to England (20.1%).

There were 55 people with learning disabilities and/or autistic spectrum disorders in hospital in Norfolk and Waveney at the end of March 2017. Their ages are unknown.

People in Contact with Mental Health Services between 1st January 2017 and 31st March 2017.

Organisation	People in contact with services at the end of RP (MHS01)	People in contact with mental health services aged 0 to 18 at the end of RP (MH01a)	People in contact with mental health services aged 19 to 64 at the end of RP (MH01b)	People in contact with mental health services aged 65 and over at the end of RP (MH01c)	People in contact with adult mental health services at the end of RP (AMH01)	People in contact with children and young people mental health services at the end of RP (CYP01)	People in contact with LDA services at the end of RP (LDA01)
NHS North Norfolk CCG	2,105	430	925	735	1,725	390	20
NHS Norwich CCG	3,500	510	2,350	610	3,020	465	40
NHS South Norfolk CCG	2,640	520	1,390	715	2,165	480	40
NHS West Norfolk	1,650	435	810	405	1,240	420	-
NHS Great Yarmouth and Waveney CCG	4,785	955	2,570	945	3,725	775	340
Norfolk and Suffolk NHS Foundation Trust (NSFT)	22,570	4,715	12,035	5,195	17,040	3,990	720
Norfolk and Waveney	14,680	2,850	8,045	2,060	11,875	2,530	420
England	1,227,312	247,183	607,889	311,591	1,039,471	134,852	77,955

Source: MHSDS Monthly Data March 2017. Available at: http://www.digital.nhs.uk/catalogue/PUB30000. Due to rounding, the number may not add up to the totals.

Benchmarking Peer Group

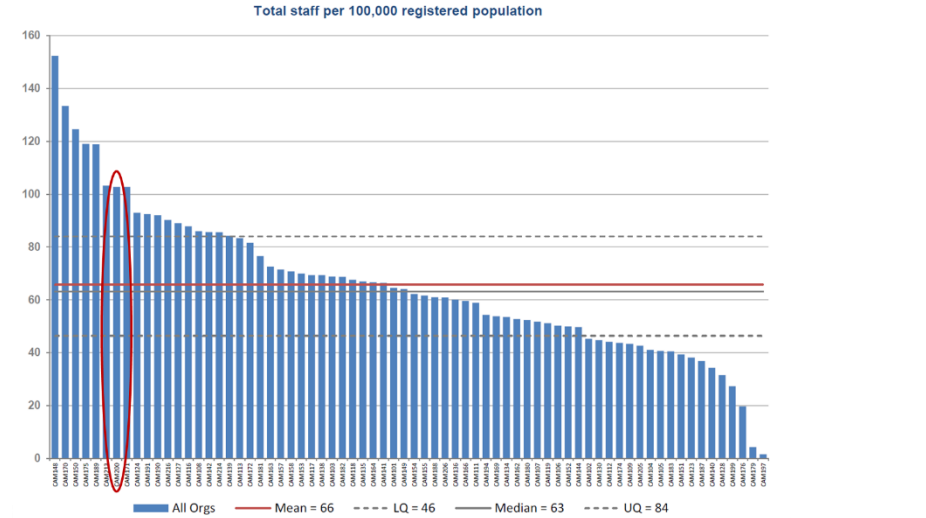
It is useful to have an understanding of mental health trusts that are similar to the Norfolk and Suffolk Foundation trust (NSFT) and serve a similar population. Having comparable organisations and areas allows a better understanding of NSFT and CAMHS services and if they are doing better, or worse, or similar to their peers. Based on the number of beds available to patients (more than 355), NSFT is comparable in size to 11 other NHS trusts, including Avon and Wiltshire Mental Health Partnership and Kent and Medway NHS and Social Care Partnership Trust, see Appendix B for further details.

"CIPFA nearest neighbour" is a comparative analysis between a local authorities' *nearest neighbours* based on their distance apart and other indicators, including population, percentage of households, mortality ratio and various other factors. Our comparable 15 CIPFA neighbours include Worcestershire, East Sussex, Somerset and Lincolnshire, see Appendix B for further details. This information can be used to explore CAMHS services provided in these areas for transfer of knowledge and services into Norfolk and Waveney.

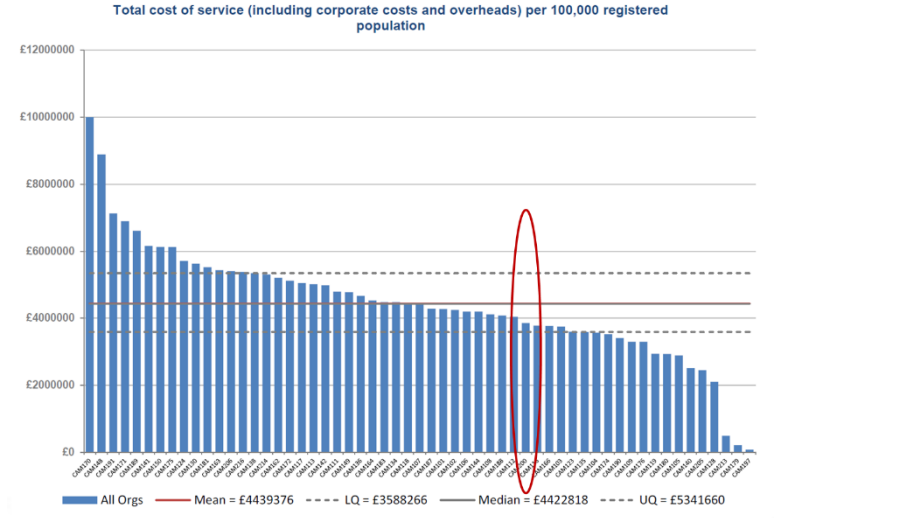
Workforce

The CAMHS NHS Benchmarking Report 2016[35] provides information regarding total staff per 100,000 registered population and costs of service per 100,000 (figures a and b below). This data indicates that the NSFT CAMHS service has about 104 whole time equivalent staff per 100,000 registered population, which is higher the median (66 per 100,000 population) and outside the upper quartile range of 84 per 100,000 when being compared to other mental health trusts. Most trusts within this dataset reported a further increase in staffing building compared to the previous year. However, the NSFT CAMHS service cost in 2015/2016 about £3.9 million per 100,000 registered population, which is lower than the average of £4.5m per 100,000 population (including corporate costs and overheads). The median cost per contact across England during 2015/16 was £240. Given the number of contacts per 100,000 of about 19,500 in NSFT, the cost per contact in NSFT is about £196. This is a low cost per contact when compared to the average of £240 and just outside of the lower quartile of £197.

Variation for cost per contact is dependent not only on overall costs but also the frequency of contacts and overall number of contacts. Variation may be due to different types of contacts being delivered, and different durations for contacts.



a. Staff per 100,000 registered population



b. Cost of service per 100,000 registered population

The data below shows the performance of Norfolk and Suffolk NHS Foundation Trust (NSFT) within the STP against a selection of workforce metrics. The data covers the period to the end of FY15/16.

[35] Kindly provided by NSFT. NSFT are represented as code CAM200 and circled in red.

		Sickness Absence Rate (%)				Leavers (Total Trust)				Leavers (Nurses)				Leavers (Doctors)		
Provider	**Sector**	**FY 13/14**	**FY 14/15**	**FY 15/16**		**FY 13/14**	**FY 14/15**	**FY 15/16**		**FY 13/14**	**FY 14/15**	**FY 15/16**		**FY 13/14**	**FY 14/15**	**FY 15/16**
Norfolk & Suffolk NHS Foundation Trust (NSFT)	Mental Health >355 beds	5.6	5.1	4.8		13.8	10.7	13.4		17.7	15.9	10.2		14.8	12.0	13.3
Norfolk & Waveney		4.4	4.1	4.4		8.6	8.9	10.9		9.3	9.9	9.8		8.9	10.5	12.1

Source: Electronic Staff Record Data Warehouse (ESR), FY13/14 to FY15/16. Key: Short-term issues identified >1 SD above mean; 0.67 SD – 1 above mean.

CAMHS Referrals, Waiting Times and Did Not Attends (DNAs) for Tiers 1 to 3 Community Services

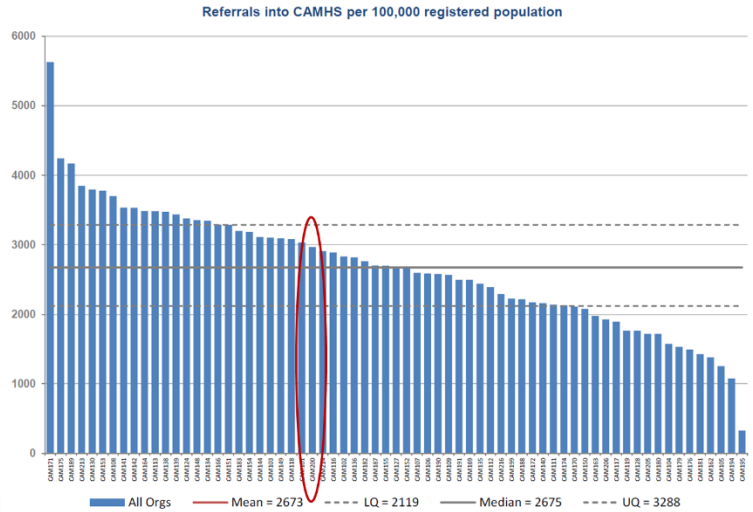
The CAMHS 2016 NHS Benchmarking Report shows that across the country referral rates for CAMHS have shown a sustained increase since 2012, although this year's figures have dropped slightly compared to 2014/15. The number of referrals accepted mirrors changes in referral rate, with on average 72% of referrals received accepted for assessment. This is the lowest level seen in recent years, and may indicate a rise in thresholds for CAMHS. Around 70% of young people assessed by CAMHS subsequently start treatment within the team. Therefore, on average only around half of young people initially referred will be assessed by CAMHS and start treatment. At the same time, recent years have seen a gradual increase in re-referrals, i.e. young people being referred back into CAMHS following a previous discharge from the service.

Compared to other trusts the referrals into NSFT are approximately 2,990 per 100,000 population (figure a below). This is slightly above the median of 2,673 per 100,000 per registered population (0-18 years). However, the number of referrals accepted is below the upper quartile (approximately 1,000 per 100,000; figure b below) indicating that there may be issues with service capacity, patients are not meeting the eligibility thresholds or that the referrals are not appropriate.

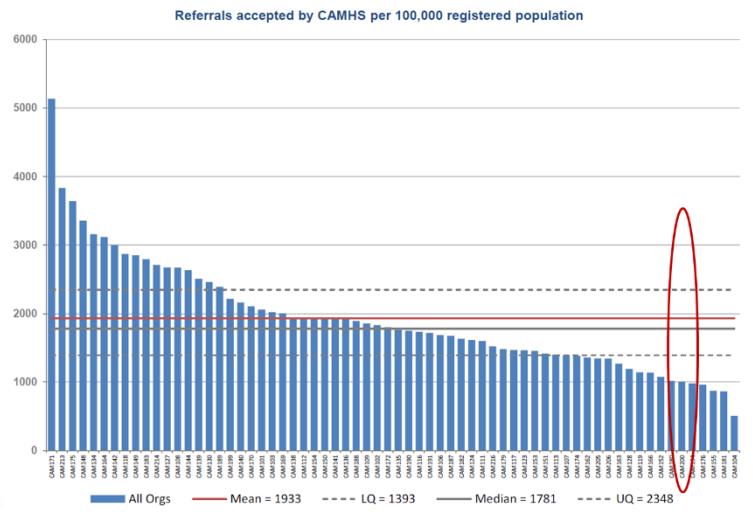
The average waiting time from referral to first appointment for NSFT is similar to the median for all trusts, with a wait of seven weeks for first assessment appointment (figure c below). The lowest 25% percent of trusts achieve a waiting time of five weeks. The average waiting time from referral to second appointment is also similar to the median for all trusts (11 weeks; figure d below) and can be used as a proxy for RTT (referral to treatment).

The CAMHS conversion rate measures the number of young people who had a first (assessment) appointment who subsequently had a second appointment, and are therefore assumed to be accepted onto the CAMHS caseload. The conversion rate for NSFT is relatively low (approximately 59%; figure e below) which is below the lower quartile. This may indicate that signposting, guidance and self-management is all that is required, or referrals are inappropriate, or higher thresholds for treatment when resources are limited. The patients on the case load are about average (approximately 1,800 per 100,000; figure f below) but total contacts and face-to-face contacts are above average (approximately 19,500 and 18,000 per 100,000 population respectively; figures g and h below). This might indicate that the level of support for children and young people is high and that the service is delivering for those children and young people that it is able to see. This is further supported by the low number of DNAs in total

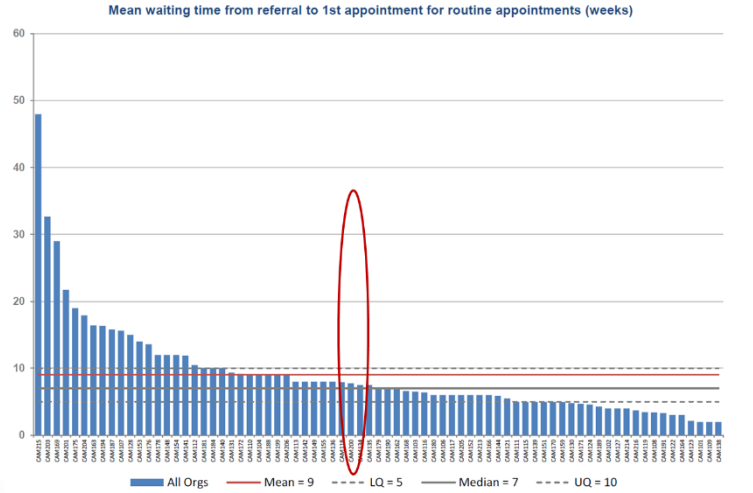
(about 7%; figure I below), the percentage cancelled by the patient (about 5%; figure j below) and the low number of formal complaints relating to the Tiers 1-3 CAMH services (approximately 2 per 10,000 population; figures k and l below).



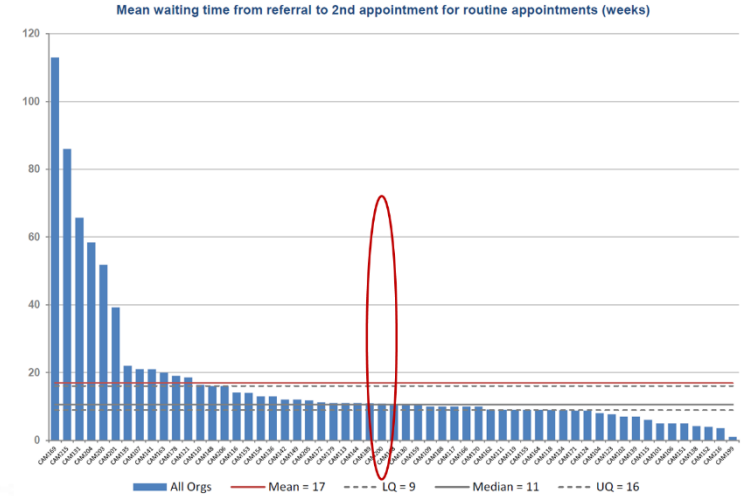
a. Referrals to CAMHS for trusts in England 2015/16 NHS Benchmarking



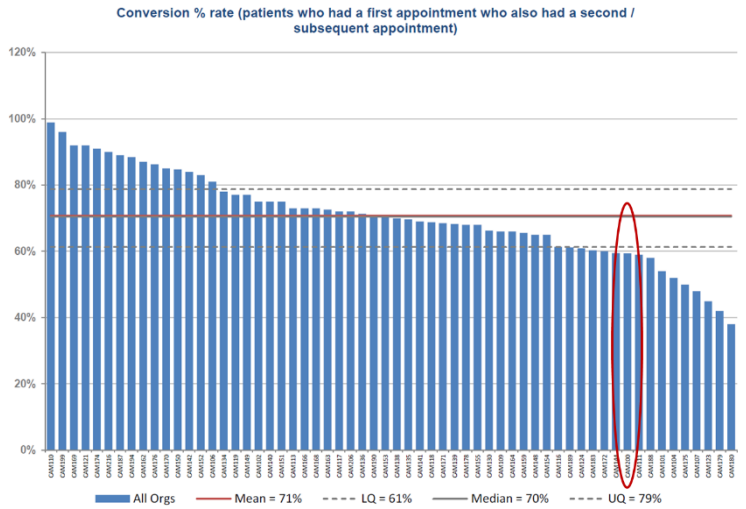
b. Referrals accepted by CAMHS for trusts in England 2015/16 NHS Benchmarking



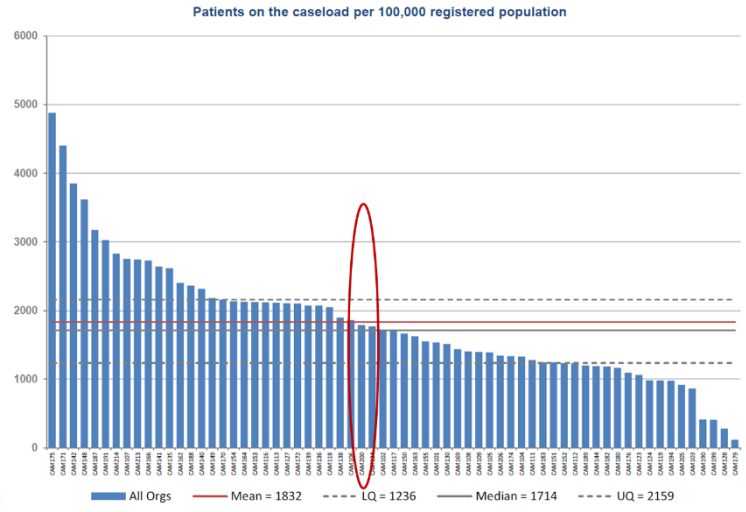
c. Average waiting time from referral to first appointment



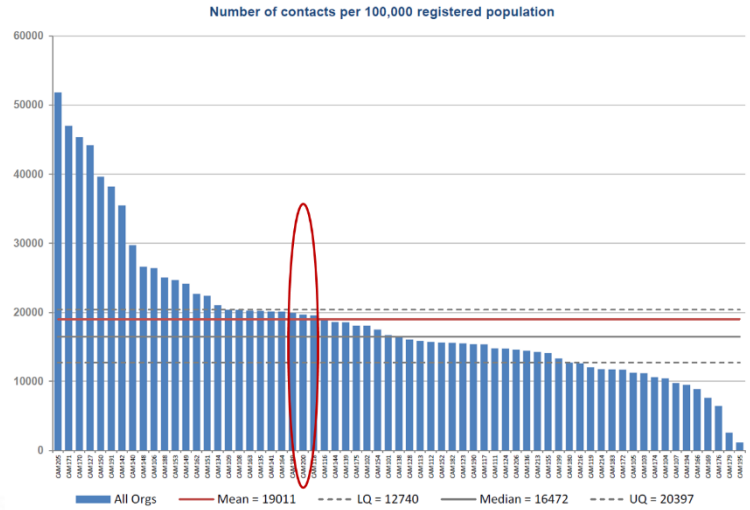
d. Average waiting time from referral to second appointment



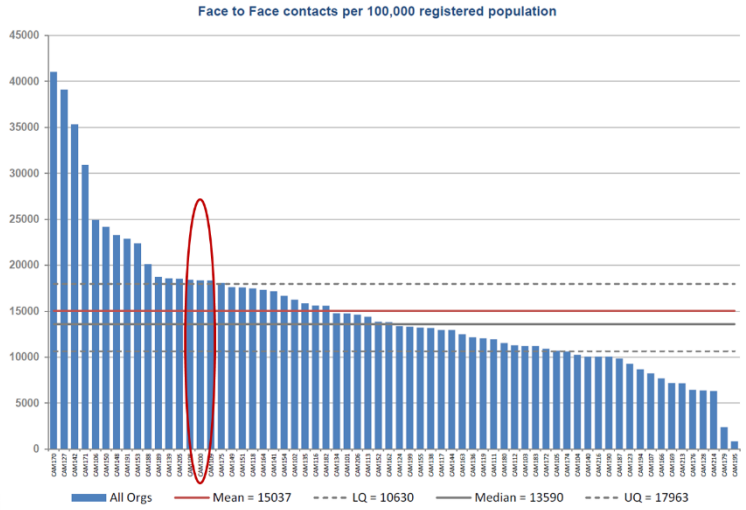
e. Conversion rate



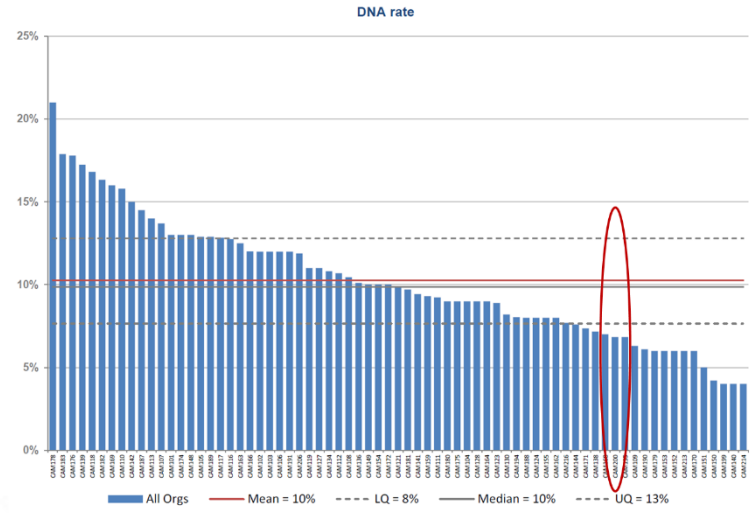
f. Caseload



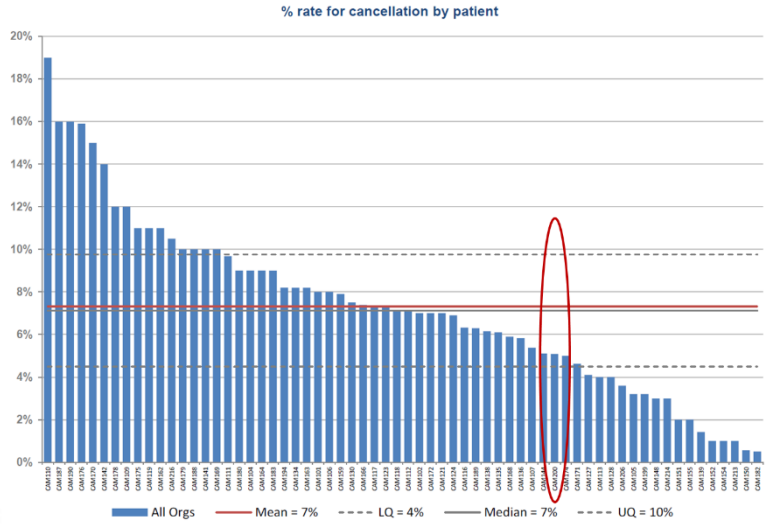
g. Number of contacts



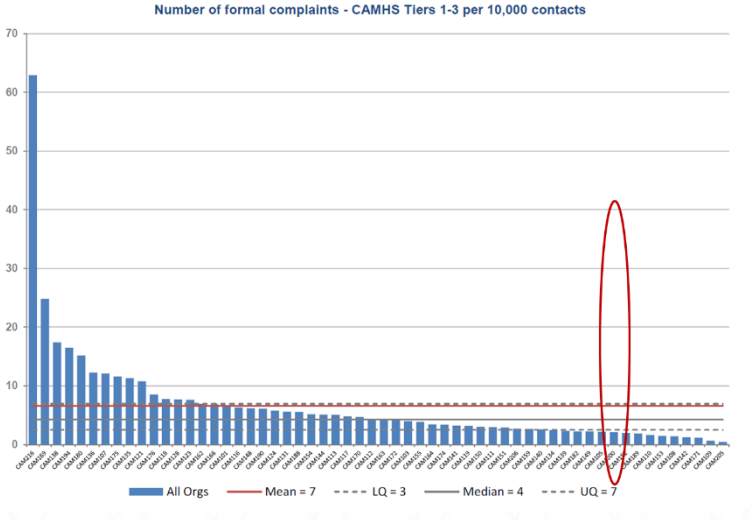
h. Face to Face contacts



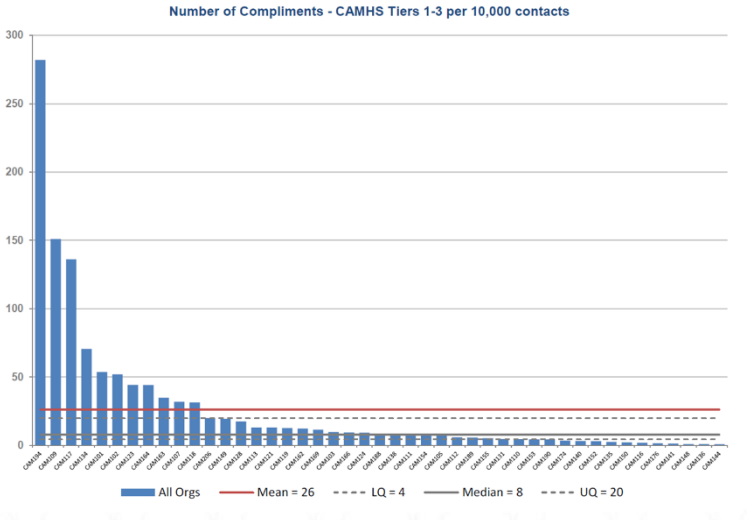
i. DNA rate



j. % cancelled by the patient



k. Number of formal complaints per 10,000 contacts



l. Number of compliments

Nationally, of all community referrals received, 72% are assessed face to face and 70% of those assessed will enter treatment with CAMHS. Across England 1,743 young people are on CAMHS caseloads per 100,000 population (aged 0-18+ years). The community activity equates to 19,010 community CAMHS contacts delivered per 100,000 population (aged 0-18+ years). National referral trends suggest that approximately half of referrals to CAMHS do not result in a service being offered, following either a paper triage or face-to-face assessment.

All data for Norfolk and Waveney CCGs referrals and waiting times were received from NEL CSU in March 2017.

Referrals in Norfolk and Waveney CCGs

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02	2017 03	Grand Total
CAMHS Referrals	**527**	**554**	**524**	**542**	**447**	**578**	**559**	**633**					**3898**

CAMHS / Youth Referrals 2016/17, YTD, (Norfolk excl. GY&W)

All Patients

Service Line	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	Grand Total
CAMHS / Youth	438	481	428	469	399	522	478	561	3776
Children & Family	17	13	13	13	6	11	11	3	87
Youth	1	6	4	3	6	2	3	10	35
Grand Total	**456**	**500**	**445**	**485**	**411**	**535**	**492**	**574**	**3898**

Patients under 18 years

2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02	2017 03
318	353	295	360	243	384	344	407	358	336	337	429

Waiting Times (Patients seen within 8 weeks)

The national average wait from referral to start of treatment in the community is 8 weeks[36]. In Norfolk and Waveney, 86.5% of patients were seen within 8 weeks between April 2016 and January 2017. The national average cost of a year of care on a CAMHS community caseload is £2,518.

[36] NHS Benchmarking Network. *Benchmarking Mental Health 2016 - Summary*. Available at: http://www.nhsbenchmarking.nhs.uk/projects/network-projects.php#10

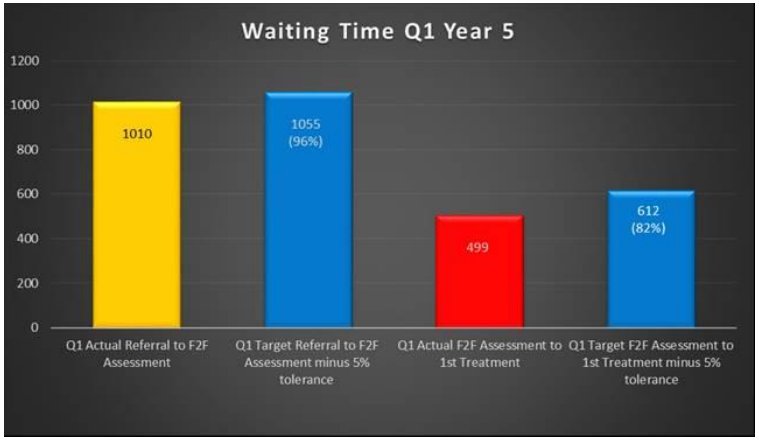
Norfolk & Waveney CCGs Waiting Times

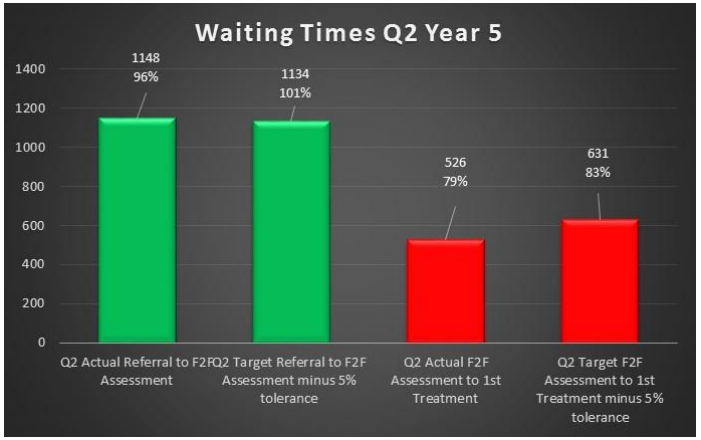
Target	Key	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
80%	Actual	200	212	204	184	168	151	147	181	113	147			1707
	Denom	237	255	242	203	196	192	170	194	121	163			1973
	%	84.4%	83.1%	84.3%	90.6%	85.7%	78.6%	86.5%	93.3%	93.4%	90.2%			86.5%

Point 1 (Tier 2) – a Targeted service

Point 1 is a county wide targeted service that began in October 2012. It is provided by a consortium consisting of Ormiston Children and Families Trust (lead provider), Mancroft Advice Project and Norfolk and Suffolk Foundation NHS Trust (NSFT). Along with the Specialist service (Tier 3), the Targeted service is one of the largest commissioned CAMH services. It works to 6 KPIs, of which one is a waiting time indicator. The KPI is a two-part indicator and, firstly, requires that the child or young person waits no more than 28 days between their referral and a face-to-face assessment. Secondly, it is monitored that the child or young person does not wait more than 28 days between that assessment and their first treatment session. Variance does occur within the KPI depending on the quarter of the year and how it relates to the school year. It will also fluctuate depending on whether CCGS have been able to award any extra funding to reduce waiting lists (usually via NHS England awards).

Point 1 – Waiting Times

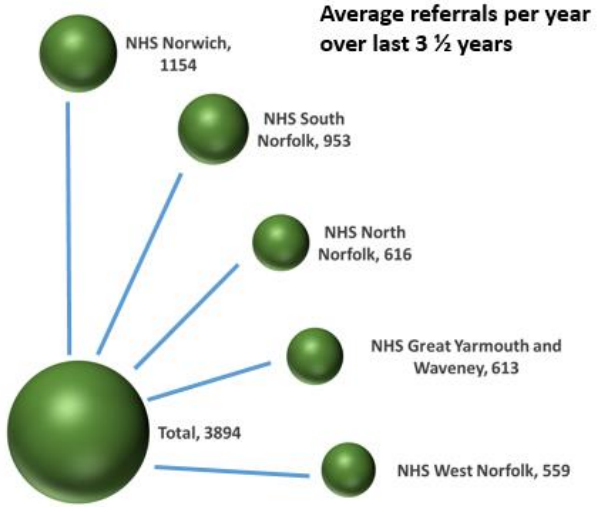




Point 1 assessed 1,055 new clients in Q3 of 2016/2017 (period ending December 2016). 96% of those assessed were face-to-face within 4 weeks of their initial referral. This gave a RAG (Red/Amber/Green) rating of AMBER for the time period. Of the 612 clients who were provided with their first treatment session, 82% had this session within 4 weeks of their initial face-to-face assessment. This gave a RAG rating of RED for the time period.

There has been an increase in demand and referrals to Point 1, as the graph below shows, with an average of 350 per month over the last financial year. The current provider reports that the waiting times target is a problem when children and young people, or their parents, aren't able to accept the appointments offered within the specified 28 days' time period.

Point 1 Service Demand.



Presenting issues (more than one is possible):

- Emotional disorder ~ 94%
- Self-harm ~ 10%
- Infant bond issues ~ 7%
- Eating disorder ~ 4%
- Hyperkinetic disorder ~ 4%
- Habit disorder ~ 2%

Average Number of Treatment Contacts per patient

The assumption is that the data relates to the average number of intervention sessions per client, and not the average length of time the service work with the clients.

As an early intervention service working with mild-moderate mental health needs, Point 1's work is time limited. The average number of direct intervention/contacts per client is 5. As mentioned before, this estimate disregards the additional time and effort put into initially screening the patients, liaising with the family/carers and any other agencies that may be supporting the patients, as well as the time to deliver the consultation and advice to family/carers and partner organisations.

The Specialist Service (Tier 3)

As set out in the Revision to the Operating Framework for the NHS in England 2010/11, performance management of the 18 weeks waiting times target by the Department of Health has now ceased. However, 'referral to treatment' data continues to be published and monitored. Standards and quality should be maintained pending the development of more outcomes-focused measures. The current locally agreed Norfolk waiting time standard for NSFT is 8 weeks for 'referral to treatment' – a standard that is far more ambitious than many areas in England. The local standard is that 80% of CAMHS patients should be seen within 8 weeks of their referral being received by NSFT.

The table below shows a breakdown of month by month performance against the local standard (covering the period of April 2016-March 2017). NSFT's performance has during this year improved from a position of non-compliance to one in which the standard is being consistently met. The mean average waiting time for England is 17 weeks (NHS Benchmarking 2016). Where there are 'breaches' of the waiting time standard, exception reports are submitted to the lead commissioner. The main reason cited for the months where breaches occurred were team capacity issues.

Both the numbers of referrals and the number of active service users continue to increase significantly year on year. In 2015/2016, NSFT's active service users at year end increased by 10% from the previous year from 1,338 to 1,478. Increased numbers in active service equates to an increase in caseload the following year.

Performance against 8 week target, (not including GYW)

The target is for 80% of referrals to be seen within 8 weeks.

Key	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	**2016/2017**
Actual	112	126	100	80	91	107	117	155	90	130	126	145	**1379**
Denominator	141	159	129	91	108	145	136	163	97	146	134	161	**1610**
%	79.4%	79.2%	77.5%	87.9%	84.3%	73.8%	86.0%	95.1%	92.8%	89.0%	94.0%	90.1%	**85.7%**

The NHS Benchmarking Mental Health summary[1] confirms a stabilising of demand levels and provision arrangements nationally. However, referral and activity levels are much higher than in previous years and the CAMHS workforce has had to grow in response to this change. Waiting times for community CAMHS now have a mean average of 17 weeks from referral to treatment. The longest waiters for each CAMHS provider is about 26 weeks on average.

Inpatient services across the country show a significant variation depending on sub-specialty bed type. Length of stay has increased in the last year which has the following impact of increasing unit costs, with the average cost of a CAMHS admission being £61k. Low bed occupancy in Tier 4 CAMHS units remains an issue, as does the level of incidents reported.

Average Treatment Contacts per patient discharged in 2016/17, YTD

	Average Number of Treatment contacts per Patient
North Norfolk CCG	6.82
Norwich CCG	7.61
South Norfolk CCG	6.11
West Norfolk CCG	6.87
Great Yarmouth & Waveney CCG	Data unavailable
Norfolk (exc. Great Yarmouth)	**6.89**

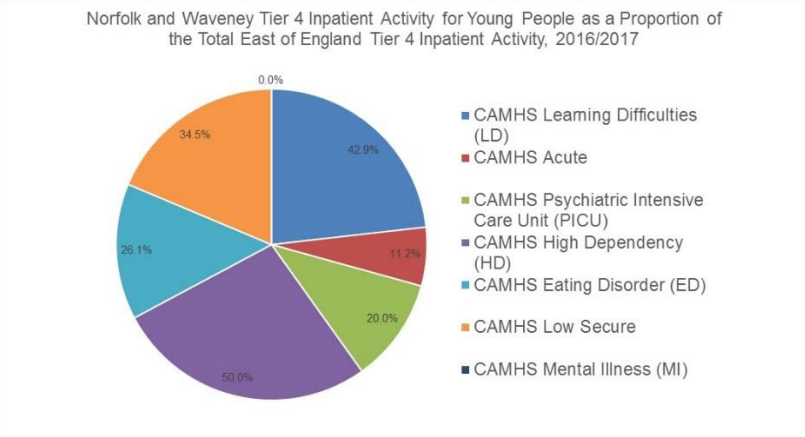
There is an assumption made with the above table that the data relates to the average number of intervention sessions per patient, rather than the average length of time the service works with patients. Therefore, the average number of direct intervention/treatment sessions per client is about 7 (6.89). This estimate disregards the additional time and effort put into initially screening the patients, liaising with the family/carers and any other agencies that may be supporting the patients, as well as the time to deliver the consultation and advice to family/carers and partner organisations.

Tier 4 Inpatient Units Activity

In 2016/2017, Tier 4 inpatient unit activity for young people across the five CCGS of Norfolk and Waveney accounted for 15.5% all of the Tier 4 inpatient activity in the East of England region (107/691 inpatients). Without previous years' data it is not possible to state if this is higher or lower activity than expected for Norfolk and Waveney CCGs. The graph below shows the type of Tier 4 inpatient activity as a proportion of the total Tier 4 inpatient activity within the East of England. Due to very small numbers in some categories for both the numerator and denominator, the data has been supressed to maintain confidentiality. For example, the CAMHS High Dependency (HD) had very small numbers on inpatients and, as a proportion (50.0%), this trend in activity should be interpreted with caution.

The biggest numbers of inpatients were seen in the 'CAMHS Acute', 'CAMHS Eating Disorder', and 'CAMHS Low Secure'. The other categories each saw less than 6 inpatients in 2016/2017. Norfolk and Waveney 'CAMHS Acute' activity accounted for 11.2% of the total CAMHS Acute activity within the East of England, 'CAMHS Eating Disorder' activity accounted for 26.1% of the total CAMHS Eating Disorder activity within the East of England and, 'CAMHS Low Secure' activity accounted for 34.5% of the total CAMHS Low Secure activity within the East of England.

Tier 4 Inpatient Activity In Norfolk and Waveney, 2016/2017



Number of patients	Learning Difficulties	Acute	Psychiatric Intensive Care Unit	High Dependency	Eating Disorder	Low Secure	Mental Illness
Norfolk & Waveney	<6	57	<6	<6	30	10	<6
East of England	<6	507	30	<6	115	29	<6

Source: NHS England Specialised Mental Health Commissioning, May 2017.

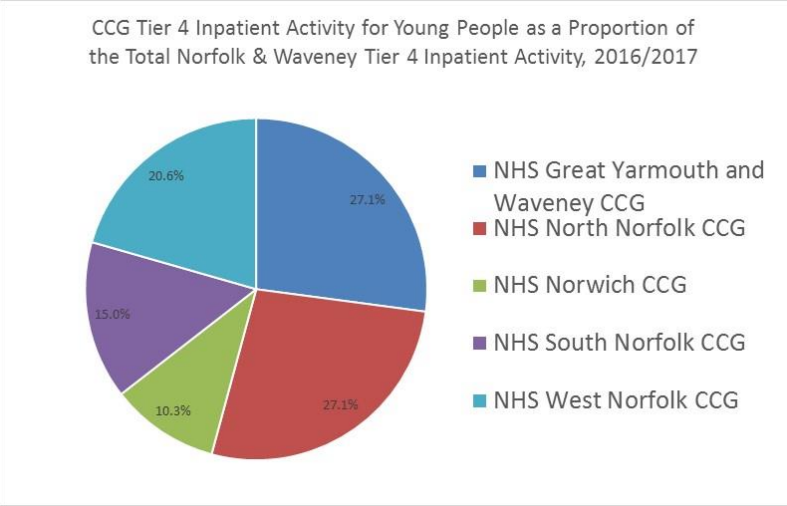
The figure below examines the Tier 4 inpatient activity by each of the 5 CCGs within Norfolk and Waveney by comparing their activity as a proportion of all Tier 4 activity within Norfolk and Waveney. Both Great Yarmouth and Waveney CCG and North Norfolk CCG each represent 27.1% of Tier 4 inpatient activity within Norfolk and Waveney, both having 29 Tier 4 inpatients. This means that NHS Norfolk and NHS Great Yarmouth account for more than half of the total Tier 4 service activity within Norfolk and Waveney.

The largest proportion, at 62.1% (18), of Great Yarmouth and Waveney CCG's inpatients were for 'CAMHS Acute' services, whereas 58.6% (17) of North Norfolk CCG's inpatients were for 'CAMHS Eating Disorders'. Norwich CCG only had 11 Tier 4 inpatients in 2016/2017, which seems low for a population of approximately 62,000 0-24 year olds.

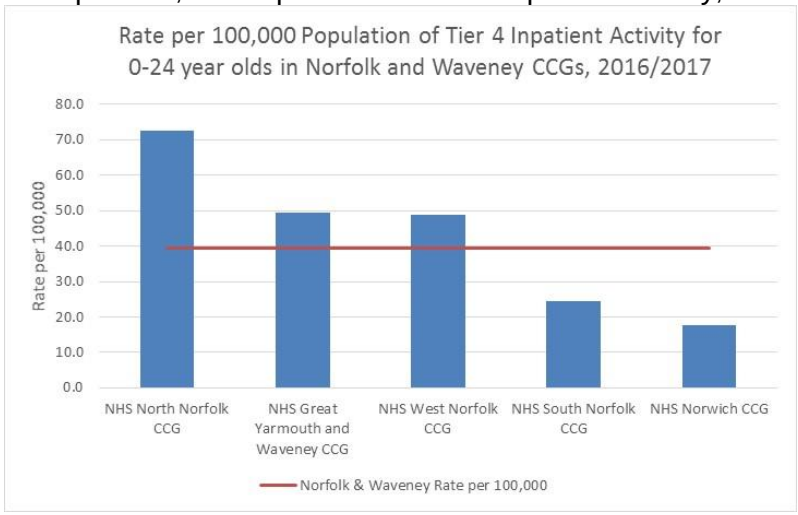
The crude rate of Tier 4 inpatient activity per 100,000 population of 0-24 year olds is shown in the graph below, in blue. North Norfolk CCG had the highest rate per 100,000 of Tier 4 inpatient activity at 72.5 per 100,000, followed by Great Yarmouth and Waveney CCG at 49.5 per 100,000. The Norfolk and Waveney rate was 39.4 per 100,000.

The average distance to Tier 4 services in Norfolk and Waveney was 55 miles, with a range of 0 to 175 miles.

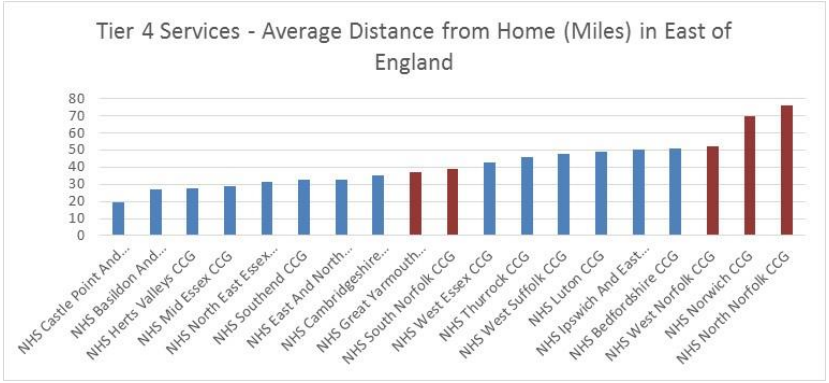
Tier 4 Inpatient Activity by CCG in Norfolk and Waveney, 2016/2017



Rate per 100,000 Population of Tier 4 Inpatient Activity, 2016/2017



Average Distance to Tier 4 services



CAMHS Finances and Resources

Norfolk and Waveney CAMHS provider spends between £6.19m and £6.27m per 100,000 of the population aged 0-18 years. This is comparable to North Essex and Luton. However, Hertfordshire budget for just £3.5m per 100,000 0-18 year olds. It is worth noting that Norfolk and Waveney have the lowest spend per clinical FTE within the East of England region (£61k) and one of the most favourable spend per referrals (£1,509) and per accepts (£1,733), even though it started with the highest relative budget of any area.

The full sum of £1.9 million received for transforming CAMHS services was invested in 2016/2017 and is now a recurrent commitment in provider contracts (2017-19). Additionally in 2016/2017 the CCGs invested £168k of additional recurrent core CAMHS funding for increased specialist CAMHS capacity in the Thetford area and upwards of £350k non-recurrent funding to reduce waiting times in core CAMHS.

	Hertfordshire	North Essex	Norfolk and Waveney	South Essex	Bedfordshire	Luton
Budget	**£9,632,178**	**£13,851,552**	**£12,566,805**	**£8,130,149**	**£4,739,600**	**£3,532,001**
2014 (forecast) Population (0-18)	275,065	221,444	200,310	177,063	100,080	57,026
Spend per 100,000 CYP Population	**£3.50 M**	**£6.26 M**	**£6.27 M**	**£4.59 M**	**£4.74 M**	**£6.19 M**
Total Number of Clinical Staff (FTE)	101	111	205	95	61	
Spend per Clinical FTE	**£95,020**	**£124,363**	**£61,406**	**£85,491**	**£77,305**	
Number of Referrals (All)	6,225	4,750	8,327	3,150	3,032	1,178
Spend per Referral	**£1,547.34**	**£2,916.12**	**£1,509.16**	**£2,581.00**	**£1,563.19**	**£2,998.30**
Number of Accepted Referrals	4,234	3,571	7,252	2,625	2,175	959
Spend per Accepted Referral	**£2,274.96**	**£3,878.90**	**£1,732.87**	**£3,097.20**	**£2,179.13**	**£3,683.00**
Number of Face to Face Appointments Offered	43,470	30,592		19,385	22,352	7,501
Spend per F2F appointment Offered	**£221.58**	**£452.78**		**£419.40**	**£212.04**	**£470.87**
Number of Discharges	5,871	3,836		1,808	2,319	1,106
Spend per Discharge	**£1,640.64**	**£3,610.94**		**£4,496.76**	**£2,043.81**	**£3,193.49**

Source: *Benchmarking Children and Young People's Mental health Services in the East of England – East of England Community CAMHS Mapping Project 2016,* Associate Development Solutions (ADS), January 2016.

Staffing

CAMHS services require a mix of clinical staff and admin staff and will naturally have a number of vacancies. This data is available by headcount and the full time equivalent (FTE). The staffing ratios, split between clinical and admin staff, in Norfolk and Waveney across Tier 2 services are 15% and

for Tier 3 services 3%[37]. ADS anticipate that the clinical to admin staff ratio should be in the region of an 80:20 split and it would appear that any service with an extremely low level of admin support, such as that seen in Norfolk and Waveney Tier 3 services, may be using expensive clinical staff to cover administrative tasks that could otherwise be delegated to admin support.

In addition, when combining the staffing data for Tier 2 and Tier 3 (FTE), Norfolk and Waveney, who have the 3rd largest population of children and young people in the East of England, report the highest staffing levels (219 FTE). Cambridge and Peterborough have the lowest (46 FTE). Although, Norfolk and Waveney have about 102 FTE members of staff per 100,000 population 0-18 year olds and Cambridge and Peterborough only have 25 FTE per 100,000 population. It is thought that this difference does create service provision inequalities within the East of England region. It might be beneficial to understand the approach used by Cambridge and Peterborough CAMHS provision and the level of expertise within their team to see if any models of care can be replicated in Norfolk and Waveney.

One of the benefits of having the highest ratio of clinicians to population aged 0-18 year olds means that the Norfolk and Waveney CAMHS service report the shortest waiting times in the East of England region, in particular for its Tier 3 service with people waiting on average 30 days for assessment and treatment/intervention.

Data wasn't available for face-to-face appointments versus clinical full-time equivalent for Norfolk and Waveney.

[37] Tier 4 service staffing data was not available.

Speciality Community Services Children and Young People

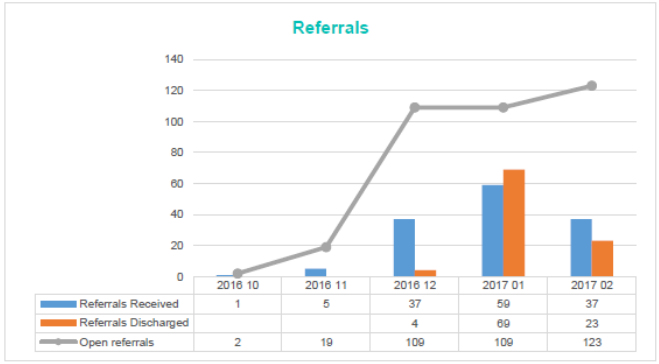
All referrals and waiting time data have been taken from NEL Commissioning Support Unit's '*NCH&C Service Activity Report – Children's Services by CCG'*, February 2017. The data shows the number of referrals of children and young people waiting for first contact for all services. 15 months of rolling data is included. Data for Great Yarmouth and Waveney CCG was not available.

The number of referrals received are a good proxy measure of the need and demand of patients within the local health system. Although it should be noted that they only represent the tip of the iceberg and we would not expect the number of referrals to be comparable to the estimated prevalence figures for Norfolk.

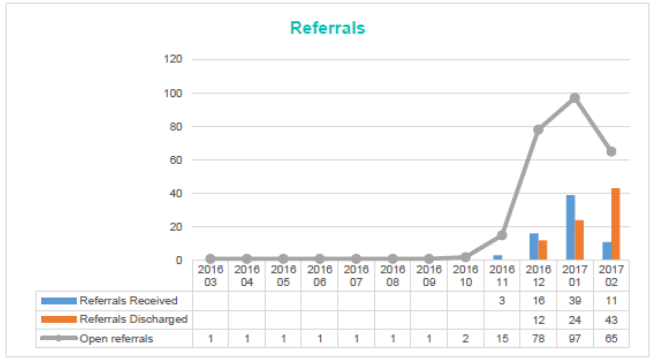
Attention Deficit Hyperactivity Disorder (ADHD)

ADHD prevalence is estimated to be between 3% and 5% for children aged between 0 and 16 years. The service in Norfolk and Waveney provides specialist assessment and support for young people with behaviour disorders.

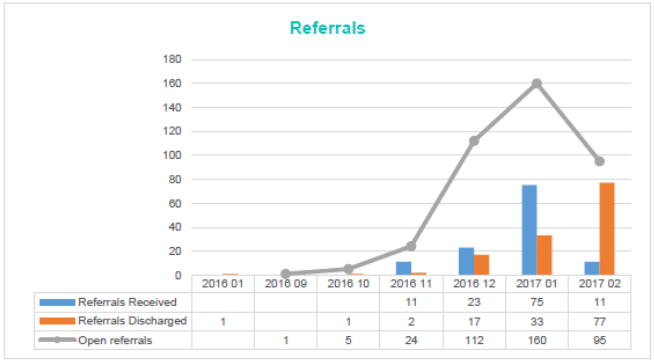
ADHD Pathway - Referrals Received



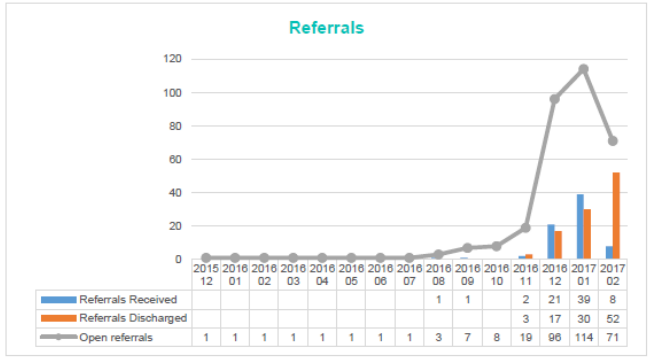
West Norfolk CCG



North Norfolk CCG



Norwich CCG



South Norfolk CCG

ADHD Pathway - Waiting Times (total number waiting)

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02
West Norfolk CCG	1	1	1	1	8	13	25	33	53	45	36
North Norfolk CCG						4	12	24	22	22	10
Norwich CCG				4	6	10	27	39	39	42	23
South Norfolk CCG	1	1	2	5	6	10	18	30	34	30	15
Great Yarmouth & Waveney CCG	Data unavailable										

ADHD Pathway - Average Waiting Time

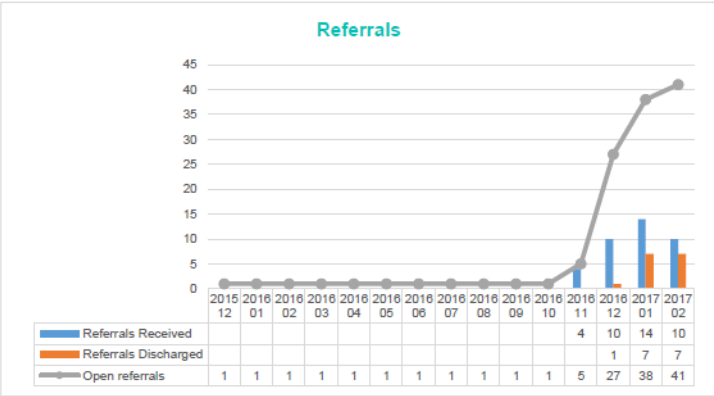
The average number of weeks waiting was calculated between September 2016 and February 2017. This was a 6-month period that was available for all 4 CCG's.

	Average No. of Weeks Wait (Sept 2016 – Feb 2017)
West Norfolk CCG	7.3
North Norfolk CCG	7.1
Norwich CCG	9.2
South Norfolk CCG	9.7
Great Yarmouth & Waveney CCG	Data unavailable

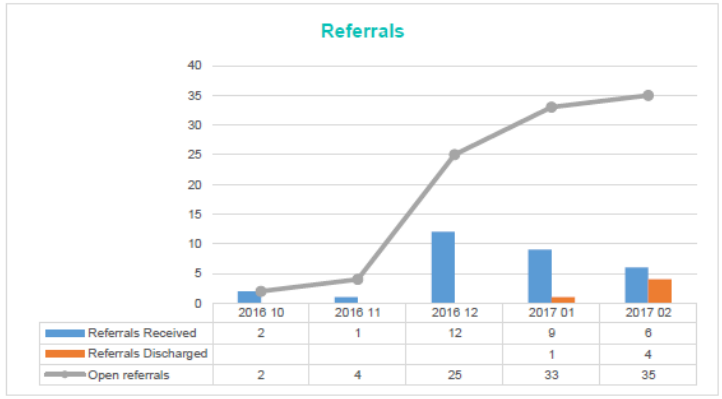
Autism Spectrum Disorder (ASD)

Children with some form of ASD represent 1.16% of the child population and therefore, ASD services in health, education, and social care must recognise the needs of these children.

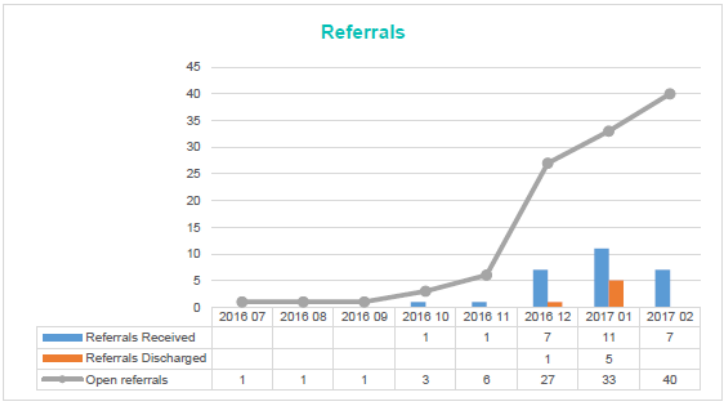
ASD Pathway - Referrals Received



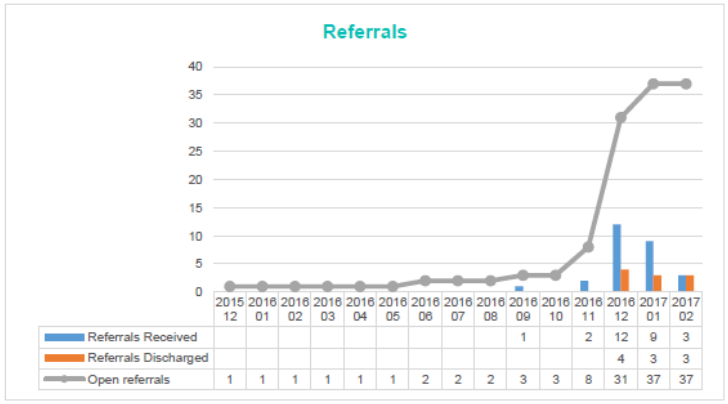
West Norfolk CCG



North Norfolk CCG



Norwich CCG



South Norfolk CCG

ASD Pathway - Waiting Times (total number waiting)

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02
West Norfolk CCG		2	3	3	3	3	4	9	17	16	24
North Norfolk CCG							2	5	17	23	22
Norwich CCG			1	1	1	1	5	8	14	20	21
South Norfolk CCG				1	1	2	2	4	16	23	23
Great Yarmouth & Waveney CCG	Data unavailable										

ASD Pathway - Average Waiting Time

The average number of weeks waiting was calculated between October 2016 and February 2017. This was a 5-month period that was available for all 4 CCG's.

	Average No. of Weeks Wait (Oct 2016 – Feb 2017)
West Norfolk CCG	10.8
North Norfolk CCG	4.8
Norwich CCG	7.7
South Norfolk CCG	8.2
Great Yarmouth & Waveney CCG	Data unavailable

ASD Further Information and Recommendations

The NICE Clinical guideline CG128[38] describes how approximately 70% of people with autism also meet diagnostic criteria for at least one other, often unrecognised, psychiatric disorder that is further impairing someone's psychosocial ability to function. Plus, intellectual disability, e.g. an IQ of below 70, occurs in nearly 50% if young people with autism. Health services need to identify and diagnose autism in children and young people and understand that these individuals can have coexisting conditions, such as intellectual disability, that means they are less likely to be diagnosed with autism. Services that are tailored to meet the demands of this ASD population will help to reduce inequalities in healthcare and service provision.

Coordination between health agencies and other key services, such as education, social care and the voluntary sector is also important. A new service should aim to work in partnership with the child or young person with autism and their family/carers.

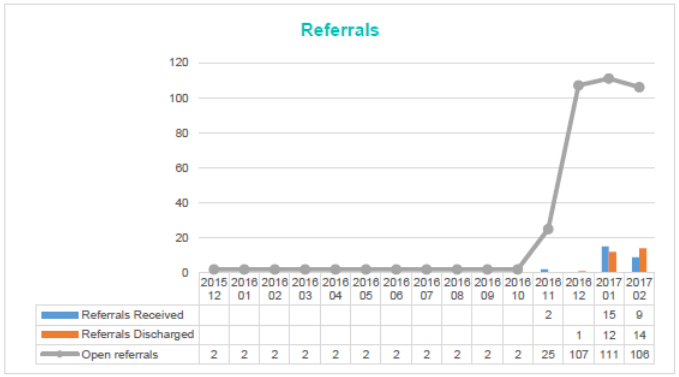
Further recommendations can be found at: https://www.nice.org.uk/guidance/cg128/chapter/Key-priorities-for-implementation. Sections within this clinical guideline are being partially updated, including 'referring children and young people to the autism team' and 'autism diagnostic for children and young people'. They are due for release late 2017.

[38] NICE Clinical Guideline [CG128], *Autism Spectrum Disorder in under 19s: recognition, referral and diagnosis,* September 2011. Available at: https://www.nice.org.uk/guidance/cg128

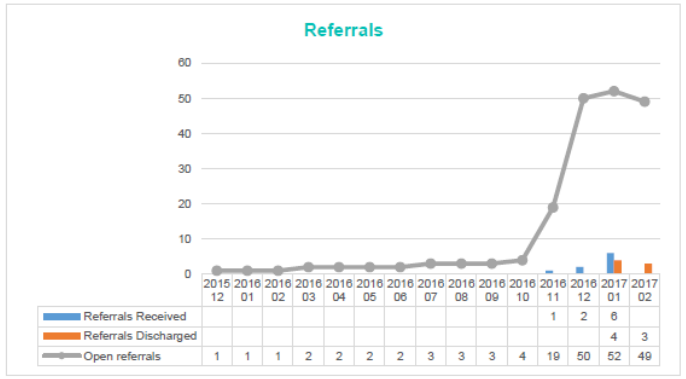
Starfish

This service supports children aged between 5-18 years who have a significant learning disability and young people with complex developmental needs.

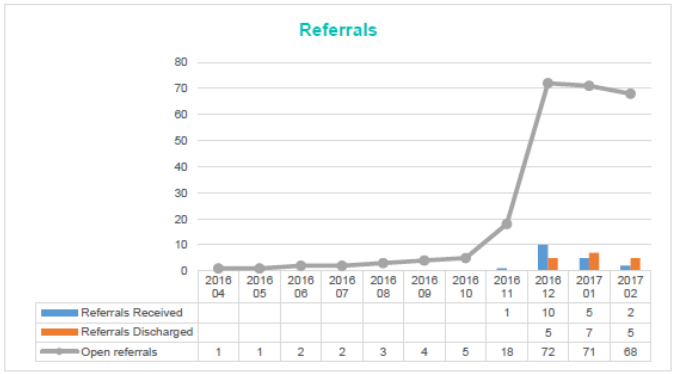
Starfish - Referrals Received



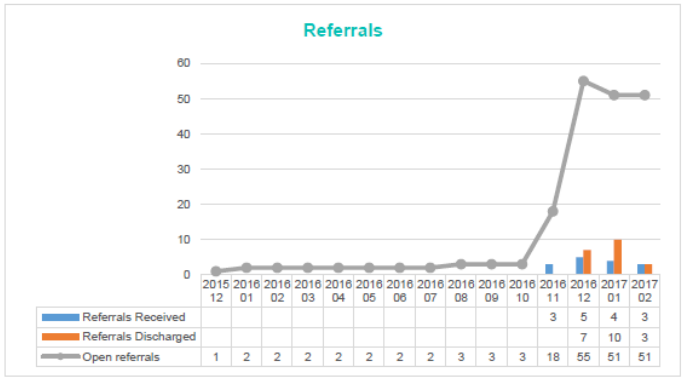
West Norfolk CCG



North Norfolk CCG



Norwich CCG



South Norfolk CCG

Starfish - Waiting Times

The number of people waiting, by month.

	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 02
West Norfolk CCG	1	1	1	2	3	5	8	17	17	20	22
North Norfolk CCG					1	1	2	6	8	10	9
Norwich CCG			1	1	3	5	5	11	18	13	11
South Norfolk CCG						2	3	9	12	10	9
Great Yarmouth & Waveney CCG	Data unavailable										

Starfish - Average Waiting Time

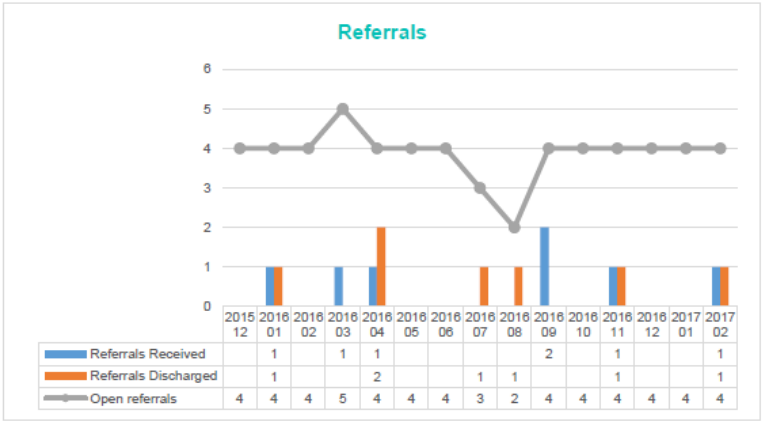
The average number of weeks waiting was calculated between September 2016 and February 2017. This was a 6-month period that was available for all 4 CCG's.

	Average No. of Weeks Wait (Sept 2016 – Feb 2017)
West Norfolk CCG	12.0
North Norfolk CCG	7.0
Norwich CCG	8.9
South Norfolk CCG	6.3
Great Yarmouth & Waveney CCG	Data unavailable

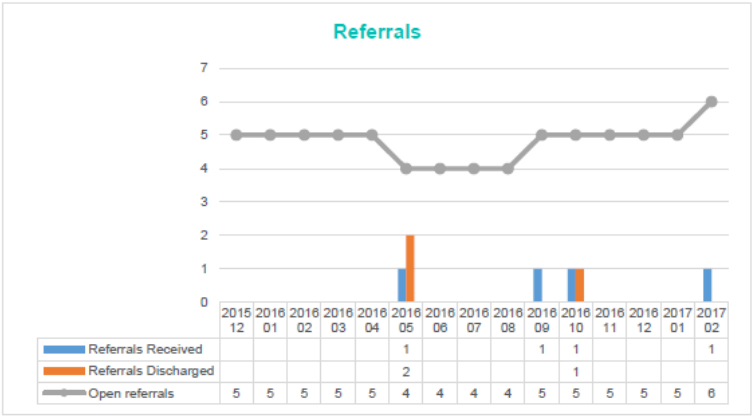
Starfish Plus

This service supports children aged between 5-18 years who have a significant learning disability and additional severe mental health difficulties, and young people with complex developmental needs, in challenging often crisis situations.

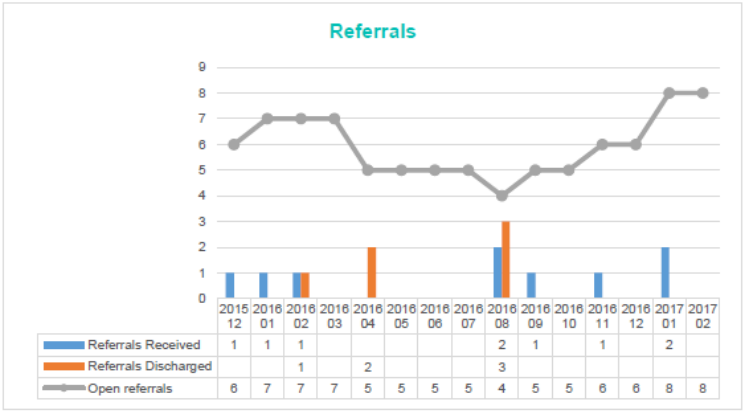
Starfish Plus - Referrals



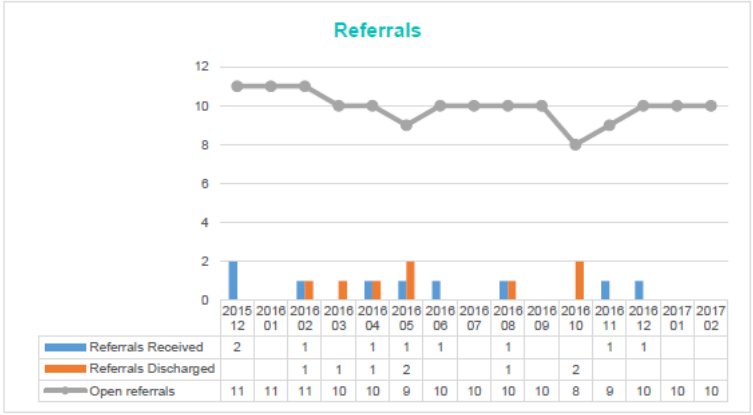
West Norfolk CCG



North Norfolk CCG



Norwich CCG



South Norfolk CCG

Starfish Plus - Waiting Times

Waiting times for Starfish Plus were unavailable.

Care Quality Commission (CQC) Inspection Results 2016

The CQC described their judgement of the quality of care provided by Norfolk and Suffolk NHS Foundation Trust within their Quality Report published in October 2016[39]. The overall rating for services at this provider are based on a combination of what they find at inspection, what people tell them, use of their Intelligent Monitoring data and local information from the provider and other organisations. There is a four-point scale available: outstanding, good, requires improvement or inadequate. Overall, NSFT were rated as 'requiring improvement', However, CQC rated the wards for children and adolescents with mental health problems, based at 5 Airey Close, as 'good' overall. 5 Airey Close is NSFT's only inpatient ward for children and young people, providing seven beds in total.

NSFT – CAMH wards CQC inspection, July 2016

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall findings and areas for improvement:

- There was use of **physical restraint**, but this was time limited and practice in place to de-escalate situations.
- **Ligature points** seen, but risks mitigated by staff as much as possible.
- **Vacant shifts** had not been filled with bank or agency staff, meaning staff had to work with below usual staffing numbers.
- **Lack of inpatient beds** for young people in crisis, so on occasions young people were admitted to a hospital a long way from home (but a new build is planned).

The CQC's quality report for 'Community mental health services for people with learning disabilities or autism' was awarded 'requires improvement'. NSFT provide community mental health services for children, young people and adults with learning disabilities and autism through a variety of community based teams. Services for children with LD's are commissioned differently in Norfolk and Suffolk. In Norfolk, these services are provided primarily through the Learning Disability Service (CAMHS) Waveney. In Suffolk a smaller CAMHS team is commissioned. Additional community services for children are provided at the Child Family and Young Person Service Great Yarmouth & Waveney. An ageless autism diagnostic service is provided in Suffolk.

NSFT - Community mental health services for people with learning disabilities or autism CQC inspection, July 2016

Overall rating for the service	Requires improvement
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Overall findings and areas for improvement:

- Patients had **long waits** for allocation of a care coordinator or to specialist services e.g. SLT and psychology. However, target times from referral to assessment and referral to treatment were set and being met in CAMHS Learning Disability service. Urgent referrals were seen quickly.
- **Leaflets** were only in English and not widely available to community CAMHS teams.
- **Leadership** and governance was disjointed and staff morale low.

[39] Care Quality Commission. *Norfolk and Suffolk NHS Foundation Trust: Quality Report.* October 2016. Available at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAF8329.pdf

The CQC's quality report for 'Specialist community mental health services for children and young people' was awarded 'requires improvement'. NSFT provide mental health services to children and young people for the first time, who require longer term services and who have complex needs. They also provide Specialist community mental health services for children and young people throughout Norfolk and Suffolk. There are variations for services depending on the commissioning arrangements for the local area. In Norfolk:

• In Central Norfolk, there are two locations. Mary Chapman House has a community eating disorders service. A second location is at 80 St Steven's road where there is an early intervention team; youth assessment and duty team, and youth treatment teams.

• In West Norfolk, there is Thurlow House which has an early intervention team and a community eating disorders service.

In Suffolk, the trusts operational model was based on integrated delivery teams (IDTs). These teams are responsible for coordinated delivery of community mental health services. They provide support for people of all ages with mental health difficulties within the designated locality. This includes early intervention and support for children, adolescents and young people. The IDTs operate on a Monday to Friday basis (9am – 5pm), although they link in with other services, such as the access and assessment teams to provide a 24 hour assessment and intervention service. The trust has five IDTs, Bury North, Bury South, Central, Ipswich, and Coastal.

NSFT - Specialist community mental health services for children and young people CQC inspection, July 2016

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Overall findings and areas for improvement:

- **Waiting times** from referral to assessment and treatment need to be kept to a minimum.
- **Staff caseloads** must be manageable.
- **Waiting times for a care-coordinator** must not be excessive.
- **Staff mandatory training** needs to be up-to-date.
- **Clinical supervision** must be regular and annual appraisals are required.
- All patients require a completed **core assessment and risk assessment** following face-to-face appointment.
- **Work with young people** to formulate care plans and goals.
- **Monitor patient's physical health.**
- Provide **support to staff** after an incident.
- Offer **flexibility in appointments** for patients.

Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Norfolk County Council
Supported by INTELLIGENCE & ANALYTICS

Voice / Stakeholder Experience and Service User Views

Service user experience - voice

- Much better *information* and emotional wellbeing support in schools
- Fast, non-stigmatising access to support in schools – evidence based and consistent
- One stop shops where mental health is one of a range of services provided, including 'virtual' one stop shops that provide outreach across the county
- Services to be open when young people actually want to access them i.e. outside of school and college hours
- Self-referral
- Peer workers that help you navigate your way to the right person to help
- Access to activities which reduce isolation
- Alternatives to hospital such as outreach, youth focussed crisis team, crisis houses
- Psycho-social support – help that doesn't pathologise, medicalise or label a range of emotional responses/distress
- To be protected from abuse and harm

Better access to *information* and advice about services.
More capacity.
Shorter waiting times.
Mental Health training.

- What are the experiences of people (incl carers or population groups) of using the services?
- Consider all categories of service user experience:
  - Access and waiting
  - Safe, high quality, coordinated care
  - Building closer relationships
  - Better Information, more choice
  - Clean, friendly and comfortable place to be
- What are the views of non-service users?
- What do service users, carers or population groups think would improve services?
- What are the opinions of professionals on services in terms of met and unmet need?
- What do professionals think would improve services?

Healthwatch Norfolk

There are three relevant reports by Healthwatch Norfolk that are applicable to the CAMHS service within Norfolk and Waveney. They are all available on the Healthwatch Norfolk website at http://www.healthwatchnorfolk.co.uk/

1. Young persons' perspectives and experiences of specialist tier 4 in-patient mental health services in Norfolk, January 2014.

This report covers the views and experiences of professionals who are dealing with the referral process in and around Tier 4 mental health services for young people aged 14-18 in Norfolk. It also covers the core strengths and weaknesses of the processes, as well as understanding of the current picture of referrals into Tier 4 mental health services for this client group.

Accessing Tier 4 services

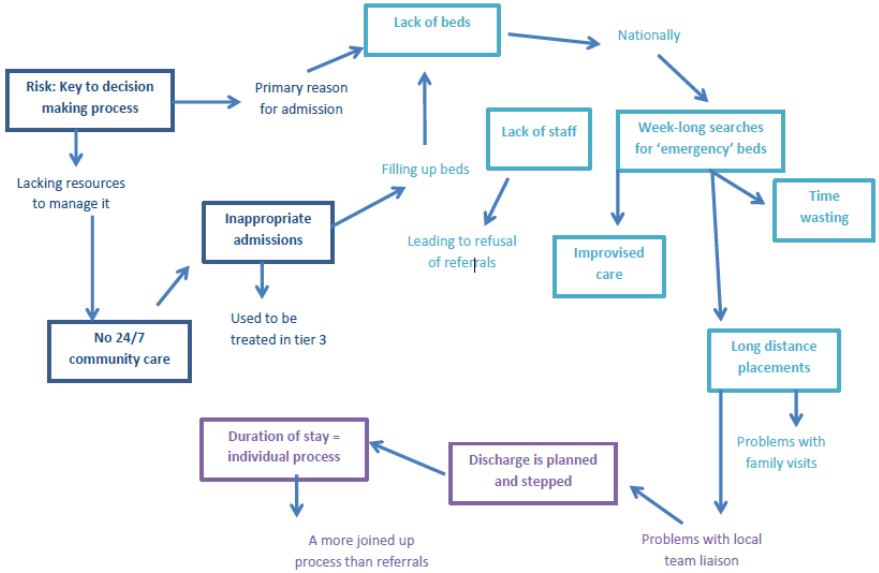
Key points:

- Lack of beds for young people on a national level
- Increasingly common to have to wait a week or more for an emergency admission
- Large proportion of clinicians time spent searching for potential placements
- Service users left in limbo whilst waiting for admission
- Clinicians needing to improvise whilst waiting for a bed to become available

Experiencing and transitioning from Tier 4 services

Key points :

- Service users describe a lack of information provided to them about the unit
- Service users describe feeling socially isolated on the unit
- Once admitted to treatment, duration of stay is individualised according to progress
- Long distance placements can impact on smooth discharge process



Flowchart of the development of core themes from interviews regarding – decision making, ease of access and the process out of tier 4.

2. Health and wellbeing needs of children, young people and families in Norfolk, July 2015.

This report captures the work by Healthwatch Norfolk to engage with over 3,700 children and young people and parents to better understand their attitudes to health and wellbeing and their experiences of local health and social care services. They worked in partnership with schools, children's centre, youth provision and other voluntary organisations to conduct a range of surveys, focus group-type discussions and other engagement.

Recommendations for commissioners and providers of services for children and young people:	*Who*
Give higher priority to children and young people's health and wellbeing concerns in strategic planning and reporting in the NHS.	HWN/CCGs/ NHS England/ Providers
Review provision of information and communication tailored for different age groups including information on service levels/provision (e.g. health visiting).	CCGs/ NHS England/NCC/ Providers
Improve communication between professionals and children and young people.	National training bodies/ NHS England/ Healthwatch England
Commit to multi-agency working to promote engagement and co-production with children and young people at the centre.	NCC/CCGs/NHS England/Provider organisations

3. Understanding health and wellbeing needs of looked after children, young people and adoptive families, July 2015

This report focusses on work with, and on behalf of, children, young people and families who are classed as 'looked after' or who have spent time in the care system (before being adopted or returning to their birth families). This is a group for whom health and wellbeing remains consistently low. The scope of the report was to understand how effectively the needs of looked after and adopted children, young people, foster carers and adoptive parents, are met by services in Norfolk.

Recommendations arising from engagement with looked after young people:	*Who for*
Senior leaders in children's services and the NHS ensure that processes are in place to actively listen to and involve children and young people.	NCC (including Children's Services and Public Health)/CCGs
Medical professionals (of universal services) should receive appropriate training and/or guidance to allow them to better understand the needs of children and young people in care.	National training bodies/NCC/CCGs
That specialist services for young people, particularly mental health services are more accessible, and that commissioners and providers give active consideration to delivering services in less clinical environments.	CCGs/NSFT
Children and young people are given more and better information about how services might help them, how long they may need to wait to access a service and what the follow on steps might be.	NSFT/GPs/CCGs
Leaders from all relevant statutory services explore co-ordinated or joint consultation and data gathering activities which will inform Norfolk's Joint Strategic Needs Assessment (JSNA).	NCC/CCGs/NHS England/Public Health England/provider organisations
Leaders from all relevant statutory services explore joint engagement and involvement activities which will widen participation and deepen understanding while reducing the *number* of consultation exercises.	NCC/CCGs/NHS England/ provider organisations
Healthwatch Norfolk will continue work to widen our engagement with and understanding of the needs of children and young people in care and those who have recently left care. This work will include: - Working with partner organsiations. - Work with specialist agencies to understand more about the experiences and needs of care leavers who are in the criminal justice system. - Alignment with other elements of our 2015-2017 work programme, particularly Child and Adolescence Mental Health Services (CAMHS) related work and work relating to service users.	HWN/UEA/MAP (teams carrying out Healthwatch-commissioned research)

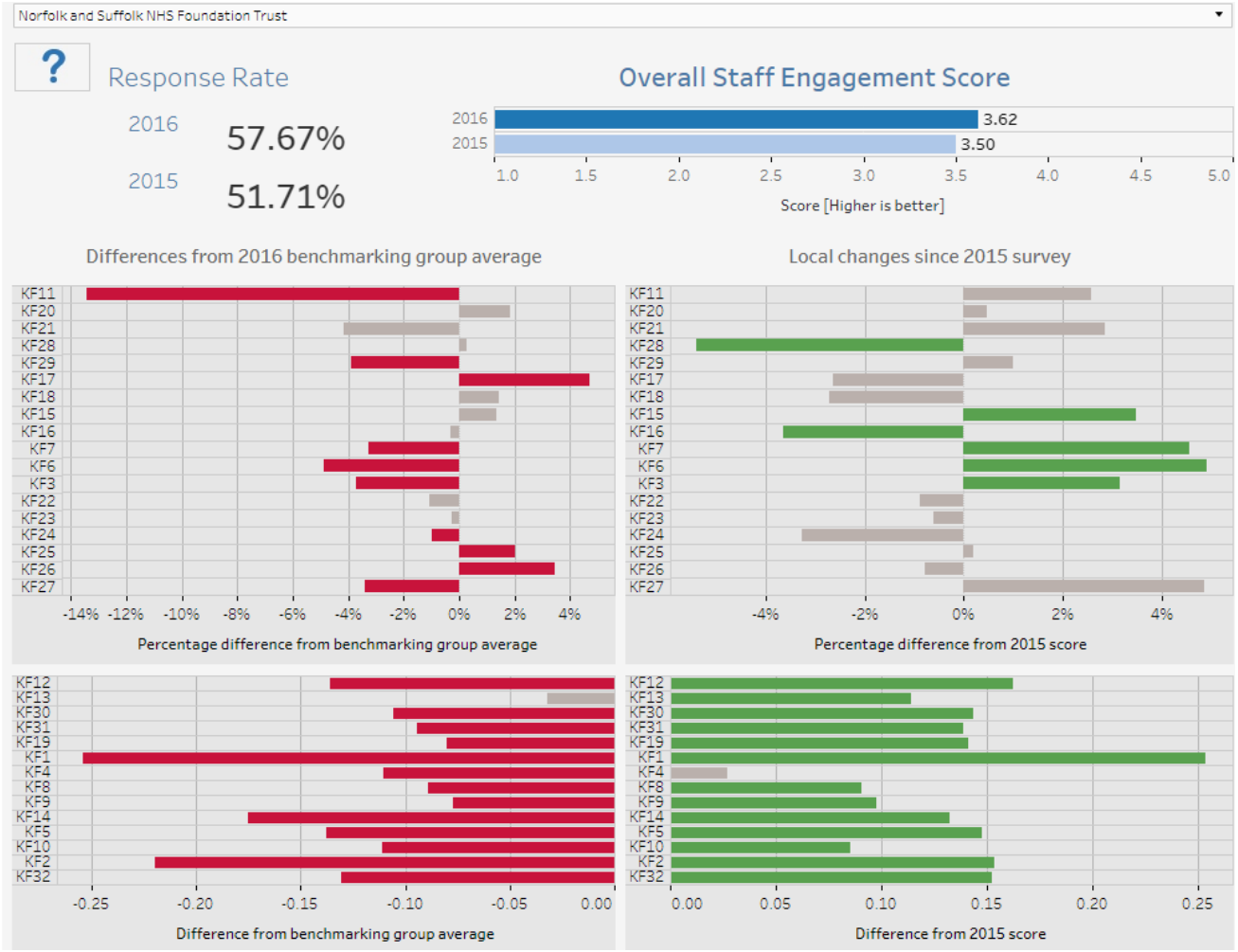
Recommendations arising from engagement with adoptive families:	*Who for*
That NCC reviews its preparation for adoptive parents and includes specific training on team parenting and examples of play therapy sessions and other techniques tailored to the likely needs of their adopted child. Continuing professional development for social workers and other professionals should be matched with an ongoing programme of support for adoptive families.	NCC
That NCC adopts an evidence-led approach to post adoption support and shares information about what works and what does not. This should include meaningful opportunities for professionals to share what they do and learn from each other to inform service improvement.	NCC
Norfolk Adoption Services (NAS) and CAMHS providers should establish more robust and regular opportunities to learn from each other's practice and explore the opportunities for more integrated provision which better addresses the needs of adoptive families.	NAS/NSFT/NHS England
NAS and CAMHS should look at practical forms of integration to deliver a more joined up and effective service to meet the needs of adoptive families.	NAS/CAMHS (commissioners and providers)
That adoptive parents are actively involved in service design and throughout relevant commissioning processes.	NCC/CCGs/NHS England
Healthwatch Norfolk should make representation through Healthwatch England and other national channels that the training for GPs/school staff/health visitors should include guidance on understanding the needs of adoptive families.	HWN/NHS England/ Healthwatch England/DfE

Recommendations arising from engagement with Foster carers of children with complex needs:	*Who for*
Leaders of Children's services should ensure that foster carers' views and insights are given due weight in a review of Health assessments, LAC reviews and strengths and difficulties questionnaires (SDQs) to ensure that processes are better aligned and give more prominence to the voice of children and young people with disabilities.	NCC
NCC explores ways of improving the respite care offered to foster carers.	NCC
Healthwatch Norfolk ensures that the needs of looked after children are appropriately reflected in its ongoing work in relation to CAMHS in Norfolk.	HWN/UEA/MAP (teams carrying out Healthwatch-commissioned research)

Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

NSFT Staff Survey

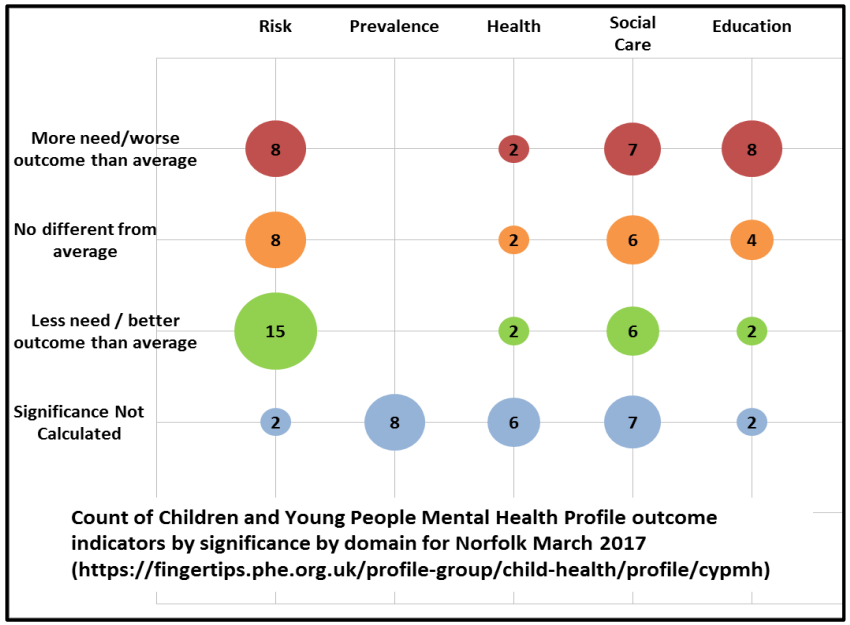
57.7% NSFT staff completed the 2016 NHS Staff Survey, this was up 6% from 2015. The results have been benchmarked against the results for 2015 and can be seen in the diagram below. A summary of the top and bottom ranking scores can be found in Appendix E.



Proposed Outcome Measures

In order to be able to successfully monitor the impact of the re-design of the Norfolk and Waveney CAMHS service, the following Public Health indicators are examples of a vast array of outcome measures that can be used. They will give commissioners of the CAMHS service the ability to monitor and evaluate the effectiveness of any changes made to the existing service.

Current health needs outcome summary and associated Public Health Indicators, March 2017.



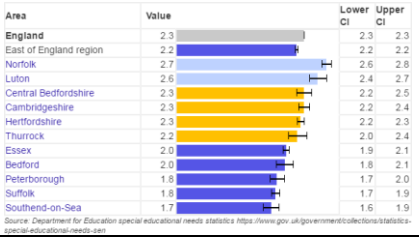
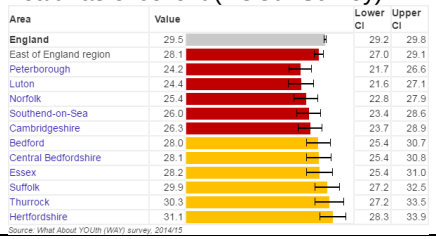
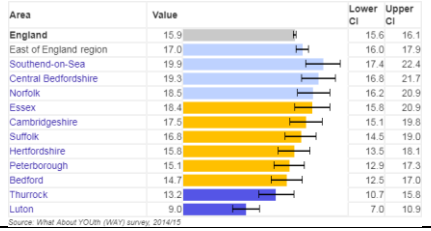
More need / poorer outcomes	Risk	Prevalence	Health	Social Care	Education
1	15 yr olds % who were bullied recently		Admissions for unintentional and deliberate injuries	All entered to the youth justice system	Exclusion due to persistent disruptive behaviour
2	% children aged <15 who provide unpaid care		Self-harm admissions (10-24 years)	Children leaving care	Primary school fixed period exclusions
3	15 year olds: % reporting low life satisfaction			First time entrants to the youth justice system	Pupils with a SEN statement
4	Marital breakup: % of adults			Health assessments for LAC	behavioural, emotional and social support needs
5	Parents in alcohol treatment			LAC in secure units, children's homes and hostels	% of school pupils with Learning Disability
6	Parents in drug treatment			in need: Rate of new cases identified during the year, per 10,000	% of all school age pupils with special educational needs
7	15 yr olds: % currently smoking			Repeat CP cases	Pupils with speech, language or communication needs
8	Mean wellbeing (WEMWBS) score age 15				% of school pupils with social, emotional and mental health needs

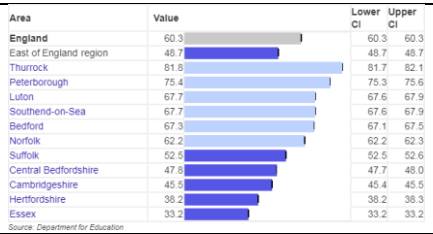
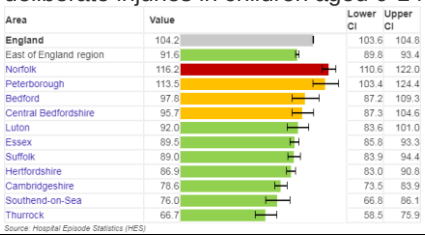
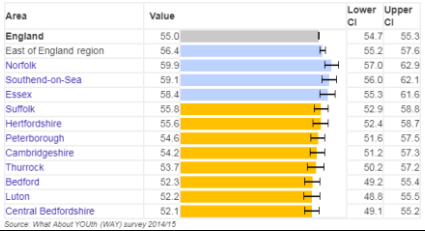
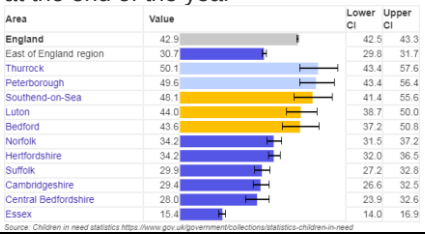
The 2015-17 CAMHS Strategy and Project Initiation Document (PID) specified the following priority outcomes for CAMHS:

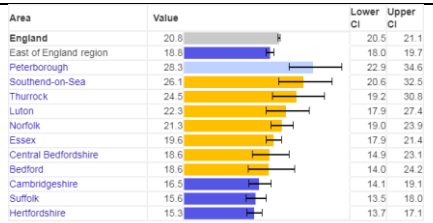
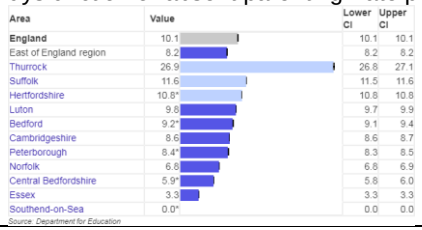
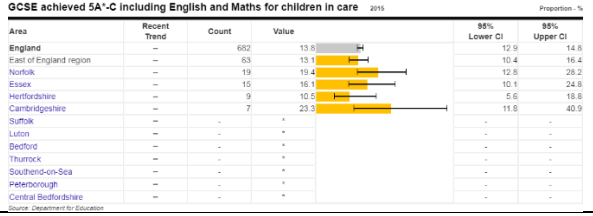
1) More people will have good mental health
2) More people with mental health problems will recover
3) More people with mental health problems will have good physical health
4) More people will have a positive experience of care and support
5) Fewer people will suffer avoidable harm
6) Fewer people will experience stigma and discrimination
7) More infants, children and young people will be able to remain at home for the long term with their parents/carers in safe, stable and nurturing circumstances
8) More vulnerable parents/carers who receive targeted and/or specialist support will be confident in their parenting abilities
9) More people will be able to make and maintain positive, supportive relationships

10) More people will be able to be engaged with and achieving in education, training and employment

There are many Public Health-related indicators and data to support the proposed priority outcome measures within the CAMHS strategy. Examples include:

CAMHS Priority Outcomes	Examples of Possible Public Health-related Indicators:	Examples of Current Available Public Health Data:
1. More people will have good mental health	1. School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs 2. Number of hospital admissions for mental health conditions	School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs, 2016. 
2. More people with mental health problems will recover	1. The number of hospital admissions for self-harm by repeat attenders 2. Percentage of children and young people reporting general health as excellent (YOUth Survey)	Percentage of children and young people reporting general health as excellent (YOUth Survey) 
3. More people with mental health problems will have good physical health	1. Percentage of people with mental health problems reporting physical health as good via local survey/data collection 2. Percentage of 15 year olds with 3 or more risky lifestyle behaviours	Percentage of 15 year olds with 3 or more risky lifestyle behaviours 
4. More people will have a positive experience of care and support	1. Number of children in care in Norfolk and Waveney (<18 years). 2. Feedback of experience in care and support from children & young people via local survey/data collection	Looked after children: rate per 10,000 <18 population

		
5. Fewer people will suffer avoidable harm	1. Number of hospital admissions caused by unintentional and deliberate injuries in children (0-4; 0-14 years) and young people (0-24 years). 2. Number of hospital admissions as a result of self-harm (10-14year olds, 15-19 year olds, 20-24 year olds, 10-24 year olds)	Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years 
6. Fewer people will experience stigma and discrimination	1. The number of excluded and vulnerable young people in Norfolk. 2. Percentage who were bullied in the past couple of months, as well as percentage who had bullied others in the past couple of months.	Percentage of 15 year olds who were bullied in the past couple of months 
7. More infants, children and young people will be able to remain at home for the long term with their parents/carers in safe, stable and nurturing circumstances	1. Child protection cases: rate of children who were the subject of a child protection plan at the end of the year (31 March) 2. New child protection cases: rate of children who became the subject of a child protection plan during the year, per 10,000 aged <18 years.	Rate of children who were the subject of a child protection plan at the end of the year 
8. More vulnerable parents/carers who receive targeted and/or specialist support will be confident in their parenting abilities	1. Young people providing unpaid care (0-15 years and 16-24years). 2. Teenage mothers – rate of conceptions	Rate of conceptions per 1,000 females aged 15-17

		 Source: Office for National Statistics (ONS)
9. More people will be able to make and maintain positive, supportive relationships	1. Children in need due to family stress or dysfunction or absent parenting. 2. Children started to be looked after due to family stress or dysfunction or absent parenting.	Children started to be looked after due to family stress or dysfunction or absent parenting: rate per 10,000 <18 population  Source: Department for Education
10. More people will be able to be engaged with and achieving in education, training and employment.	1. Number of children achieving 5 GCSEs, grades A*-C inc. English and Maths for children in care. 2. Number of CAMHS referrals from schools and colleges. Plus, persistent absentees (secondary and primary school).	Percentage of children in care who achieved 5 or more GCSEs at grades A*-C including English and mathematics  Source: Department for Education

Conclusions, Service Gaps and Recommendations

There is no doubt that mental health disorders in our children and young people in Norfolk and Waveney are prevalent and surprisingly common. It is difficult to know if our younger generation are truly anxious, depressed and more stressed than previous generations but, however, we are now much better at recognising and treating these disorders. The importance of early intervention is reflected in many of the national and local strategies that were used to support this mental health needs assessment and, as a consequence, identifying children and young people at an early stage should be a key aim and outcome of any CAMHS service.

Service gaps

This CAMHS health needs assessment has identified the following as gaps within the current commissioning arrangements:

- Referrers to the CAMHS service seem to have a poor knowledge of what resources and services are already available for children and young people.
- There is a lack of clarity and standardisation about specific and current referral pathways for Tier 2 and 3 services, with large number of referrals rejected as not being suitable. This indicates that the pathway is not very clear to those referring and those using the services.
- Referrers are not fully aware of the thresholds for accepting referrals in those CAMHS services to which referrals are made and there are users who need a higher level of input than Tier 2 but do not reach the threshold for a Tier 3 referral. Consequently, referrals are being rejected as patients do not meet the threshold for Tier 3 services.
- There is a lack of alternative provision if a referral is not accepted.
- There are few services locally for addressing self-harm and the prevention of drug addiction (rather than treatment of an existing addiction).
- Consistency of data received and recorded within the referrals to the CAMHS service. As a minimum, all referrals throughout the system should endeavour to include GP practice code to enable tracking, benchmarking and matching with other local health-based datasets.

Recommendations

1. Strengthen universal services to reflect the increasing volumes and complexity of low level emotional, behavioural and mental health needs within the general population. This should include early recognition of emotional and mental health issues, developmental of parenting skills and whole family resilience, building capacity within the universal workforce, as well as mental health and wellbeing promotion for the whole population.
2. Increase resilience in children by embedding evidence-based school-based mental health and wellbeing approaches in all primary, secondary and special schools across Norfolk and Waveney. This should include increased early prevention within Tier 1 work, such as further strengthening the School Nursing and Health Visiting work via the Healthy Child Programme. A key focus should be the promotion of health and wellbeing, building resilience and self-esteem. Children aged 0-4 years and young carers will also need the same level of service provision.
3. Increase awareness of CAMHS services, especially for universal and targeted service provision and, ensure access to these services is clear and easy for referrals, for example develop a single point of referral. A directory of services should be made available in different formats accessible via different channels, which could then be used to develop a pathway for child and adolescent mental health in the longer term. Make use of any existing information and guidance channels if not already used.
4. Develop a clear pathway across all services and providers to ensure any gaps where children may fall between services are identified and reduced. Publish this pathway so people understand what happens next.

5. Ensure a smooth transition into adult services for all 16-18 year olds, including continuity of care between children's and adult's mental health services to allow continuous and uninterrupted service provision. This should include improved communication between service providers, the public and other professionals, such as those within the education setting. Plus, clarity around thresholds and eligibility criteria.
6. Co-design services so that service users are empowered to find their own solutions to their difficulties. For example, the Sussex Recovery Colleges[40], whereby individuals are *'students not patients'* and can be involved in service design and delivery on everything from understanding depression to sea swimming for recovery.
7. Use a range of evidence-based interventions within the new re-designed service, including co-production and peer supported recovery techniques.
8. Include family/next-of-kin throughout the decision making process (where appropriate), rather than just child only services.
9. More provision of family and group based mental health and wellbeing services, both for short and long-term interventions.
10. Keep patients safe, within a caring CAMH service, protected at all times from avoidable harm.
11. Safe practice can be achieved by adopting a rigorous learning culture, including staff training and use of evidence-based practice incorporated into routine care (University of Manchester, 2016). This will ensure that the workforce has the knowledge and skills to meet the emotional and mental health needs of children and young people across all tiers of service.
12. Improve local data collection to understand the prevalence of mental health issues and self-harm in children and young people in Norfolk and Waveney.

Suicide and Self-harm Recommendations[41]

Acute Care	1. Crisis teams are unlikely to be a safe setting for patients at high risk or who live alone. The use of crisis teams should be kept under regular review	
	2. Services should ensure that patients are followed up within 2-3 days of hospital discharge and that care plans are in place.	
Alcohol and drug misuse	1. Specialist alcohol and drug services should be available, with the ability to manage clinical risk, working closely with mental health services, with agreed arrangements for "dual diagnosis" patients.	
Restricting suicide methods	1. Opiate analgesics should be subject to safer prescribing in primary care and accident and emergency departments, i.e. reduced use, short-term supplies.	
New groups at risk	1. Mental health services should be aware of the changing nature of patients at risk of suicide, i.e. economic problems, recent immigration, isolation and be able to work with services with specialist expertise in these areas.	
Self-harm	1. Liaison psychiatry teams offering 24 hour specialist psychosocial assessment and follow-up should be available, with specific arrangements for people under mental health care.	
Avoidable deaths	<u>Key recommendations for safer care in mental health services:</u> 1. Safer wards — Removal of ligature points — Reduced absconding — Skilled in-patient observation	<u>Key elements of safer care in the wider health system:</u> 1. Psychosocial assessment of self-harm patients 2. Safer prescribing of opiates and antidepressants 3. Diagnosis and treatment of mental health problems especially depression in primary care

[40] More information about the Sussex Recovery College programme is available from sussex.recoverycollege@nhs.net
[41] Source: University of Manchester. *National Confidential Inquiry into Suicide and Homicide by People with Mental Health Illness: Annual report and 20-year review*. Manchester, 2016.

	2. Care planning and early follow-up on discharge from hospital to community 3. No 'out of area' admissions for acutely ill patients 4. 24 hour crisis resolution/home treatment teams 5. Community outreach teams to support patients who may lose contact with conventional services 6. Specialised services for alcohol and drug misuse and "dual diagnosis" 7. Multidisciplinary review of patient suicides, with input from family 8. Implementing NICE guidance on depression and self-harm 9. Personalised risk management, without routine checklists 10. Low turnover of non-medical staff	4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

Physical Disability Services Recommendations:

The role of a disability service provider should be seen as 'a facilitator', enabling disabled people to access and remain in education, work and their home, to achieve an "equal society in which all disabled people have the same opportunities as everyone else" (Scope, 2017).

Tier 4 Recommendations[42]

a) For in-patient units to update their website, with **easy to access information** on policies and things to expect whilst on the unit. A virtual (website) tour and introduction to staff would also help prepare young people for admission.
b) Upon admission to an in-patient unit, for young people to be given a 'treatment folder' in which **clear information about unit boundaries and procedures is documented**. This folder could also contain copies of individual care plans, goal setting etc.
c) CAMHS is a specialist setting and requires staff with the **relevant specialist skills and training**, not just in mental health, but also in working with young people. Local training in Tiers 1-4 of CAMHS for all professions, delivered by specialist trainers should be considered.
d) To address the 'clunky' referral process, we suggest that there should be a **frequently updated list of units** of who are currently accepting emergency admissions.
e) We also suggest the **streamlining of the referral process**, with a centralised form, to avoid multiple forms needing to be completed for multiple units.
f) The lack of 24/7 community care is, according to our participants, linked with emergency admissions which might not always be appropriate. We suggest a **review of the current capacity of community services**, and if warranted, a strengthening of community resources.
g) We suggest that services **explore ways of enabling service users** to continue to engage and stay connected with family and friends via the use of technology, whilst managing any safeguarding or risk-related issues.
h) The décor of a unit contributes to how service users relate to their experience there. We suggest **service users are consulted about ways to enhance the 'feel' of the unit** they are on.

[42] Based on the Healthwatch 2014 report "Young persons' perspectives and experiences of specialist tier 4 in-patient mental health services in Norfolk

The “Best Practice of Mental Health and Emotional Wellbeing Activity in Norfolk Schools 2017 Report” recommended the following improvements to CAMHS services:

- To support providers to commission high quality services and activities and monitor impact by creating a checklist of key questions
- To ensure that mental health and wellbeing is a key strategic priority by integrating mental health and wellbeing into the Education Inclusion Self-Assessment Framework
- All providers to have a nominated senior strategic leader and governor for mental health and wellbeing
- To map existing mental health training and to identify gaps
- Report findings to be fed into Social Mobility Opportunity Area activities

Bibliography

Baird, Gillian and et al. “Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP).” *The Lancet* 368 (2006): 210-15.

Brugha, T. et al. *Estimating the prevalence of autism spectrum conditions in adults: extending the 2007 Adult Psychiatric Morbidity Survey.* Leeds: The NHS Information Centre, Community and Mental Health Team, 2012.

CHIMAT. “Mental Health in Pregnancy, the postnatal period and babies and toddlers: needs assessment report.” 2016. Available at: http://www.chimat.org.uk/resource/view.aspx?RID=266077 .

Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London: Department of Health, 2011. www.gov.uk.

GBD 2015 Mortality and Causes of Death Collaborators. “Global, regional, and national life expectancy, all-cause mortality, and cause-specific mortality for 249 causes of death, 1980–2015: a systematic analysis for the Global Burden of Disease Study 2015.” *The Lancet* (2017): 388: 1459-544.

Goodman, A, V Patel and D Leon. “Child Mental Health Difference Amongth Ethnic Groups in Britain: A Systematic Review.” *Biomedcentral - Public Health* (2008): 8(258).

Green, H, et al. *Mental Health of Children and Young People in Great Britain 2004*. Norwich, 2005.

Green, J. et al. “Promoting the social and emotional health of primary school aged children: reviewing the evidence base for school based interventions.” *Int. Journal of Mental Health Promotion* (2005): 7 (3) 30-36.

Health and Social Care Information Centre. “Incidence of Down's Syndrome.” 2015. *https://indicators.hscic.gov.uk/webview/.*

Helliwell, J. Layard, R. Sachs, J. “World Happiness Report 2017.” 2017. *www.worldhappiness.report.*

Joint Strategic Needs Assessment (JSNA). *Norfolk JSNA Briefing Document: Young Carers and Young Adult Carers*. Norwich: Norfolk Insight, 2017. Available at: http://www.norfolkinsight.org.uk/jsna/childhood-health-wellbeing/vulnerable-groups/young-carers.

Kurtz, Z. *Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people*. London: Mental Health Foundation, 1996.

Langford, R. et al. *The WHO health promoting school framework for improving the health and well-being of students and their academic achievement*. Cochrane Database of Systematic Reviews 4 CD008958, 2014.

Mantry, D. et al. “The prevalence and incidence of mental ill-health in adults with Down syndrome.” *Journal of Intellectual Disability Research* (2008): 52 (2), 141-155.

Marmot Review Team. *The health impacts of cold homes and fuel poverty*. London: Friends of the Earth and The Marmot Review Team, 2011. Available at: https://www.foe.co.uk/sites/default/files/downloads/cold_homes_health.pdf.

Meltzer, H, et al. *Persistence, onset, risk factors and outcomes of childhood mental disorders*. London: Office National Statistics, 2003. Available at: http://ww.dawba.com/abstracts/B-CAMHS99+3_followup_report.pdf.

National Centre for Social Research and University of Leicester. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: The NHS Information Centre for Health and Social Care, 2009. Available at: http://content.digital.nhs.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf.

National Institute for Health and Clinical Excellence (NICE). *Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults. National Clinical Practice Guideline No.72*. London: The British Psychological Society and The Royal College of Psychiatrists, 2009. Available at: https://www.nice.org.uk/guidance/cg72/evidence/full-guideline-241963165.

NHS Benchmarking Network. *Raising Standards Through Sharing Excellence: CAMHS Benchmarking Project 2016*. NHS Benchmarking Network: www.nhsbenchmarking.nhs.uk, 2016.

NHS Digital. *Mental Health Services Monthly Statistics: Final March 2017*. June 2017. www.digital.nhs.uk.

NHS England. "Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing." 2015. Available at: www.gov.uk.

NHS Health Advisory Service. *Together we stand: Thematic review of the commissioning role and management of child and adolescent mental health services*. London: The Stationary Office, 1995.

NICE. *Social and emotional wellbeing in primary education*. London: National Institute for Health and Care Excellence, 2008.

—. *Social and emotional wellbeing in secondary education*. London: National Institute for Health and Care Excellence, 2009.

—. "Social anxiety disorder: recognition, assessment and treatment." May 2013. *www.nice.org.uk.*

Norfolk County Council. *Dedicated Schools Grant (DSG) Report January 2017*. Norwich: Children's Services Committee, 2017. Available at: http://norfolkcc.cmis.uk.com.

Office for National Statistics. "Insights into Children's Mental Health and Well-being." 2015. *www.ons.gov.uk.*

—. "Survey of the mental health of children and young people in Great Britain 2004." 2005. *NHS Digital: www.content.digital.nhs.uk.*

Parsonage, M. et al. *Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention*. London: Centre for Mental Health, 2014.

Public Health England. "Improving Young People's Health and Wellbeing: A Framework for Public Health." 2014. *www.gov.uk.*

—. "Promoting children and young people's emotional health and wellbeing: A whole school and college approach." 2015. *www.gov.uk.*

Public Health Norfolk County Council. *Norfolk's Health Related Behaviour Survey of Children and Young People*. Norwich: www.norfolk.gov.uk, 2016.

Rodway, C, et al. "Suicide in children and young people in England: a consecutive case series." *Lancet Psychiatry* (2016): 751-9.

Scope. "Everyday Equality: Scopes's strategy 2017-2022." 2017. Available at: www.scope.org.uk.

The Children's Society. "Hidden from view: The experiences of young carers in England." 2013. Available at: https://www.childrenssociety.org.uk/sites/default/files/tcs/report_hidden-from-view_young-carers_final.pdf.

—. "The debt trap: Exposing the impact of problem debt on children." 2014. Available at: https://www.childrenssociety.org.uk/sites/default/files/debt_trap_report_may_2014.pdf.

The Government Office for Science. *Foresight Mental Capital and Wellbeing Project*. London: Government Office for Science, 2008.

University of Bristol. *Children and Young People's Views on Being in Care: A Literature Review*. Bristol: Hadley Centre for Adoption and Foster Care Studies: Coram Voice, 2015.

University of Manchester. *National Confidential Inquiry into Suicide and Homicide by People with Mental Health Illness: Annual report and 20-year review*. Manchester, 2016.

Weare, K. *What works in promoting social and emotional well-being and responding to mental health problems in schools? Advice for schools and framework document*. Southampton: National Children's Bureau, 2015.

Wichstrom, L, et al. "Prevalence of psychiatric disorders in pre-schoolers." *The Journal of Child Psychology and Psychiatry* (2011): 695-705. Available at: http://onlinelibrary.wiley.com/doi/10.1111/jcpp.2012.53.issue-6/issuetoc.

Wolpert, M and et al. *THRIVE Elaborated. Second Edition*. London: CAMHS Press, 2015.

York, A. *Building and sustaining specialist child and adolescent mental health services. Council Report CR137*. London: Royal College of Psychiatrists, 2006.

https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016

https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2015

Appendix A

Evidence of What Works - Example CAMHs projects

1. **'Edge of care'** project for 0-2yrs attachment – cohort of 50 – rate of 3 not going into care. Birmingham City Council.
2. **Compass Approach** – DfE 'outreach' in care (Warwick University) NIAP connected > place 18months.
3. **Whole school approach** to the promotion of emotional health and wellbeing (primary and secondary school). Examples included in the NICE guidance (2008 and 2009) and WHO guidance (2014).
4. **Parenting Programmes.** Examples include behavioural training programmes emphasising improvements in the parent-child relationship. If well implemented, these programmes can be very effective in improving child behaviour (Parsonage, M. 2014).
5. Focus on **early help/preventative services**, such as Signs of Safety/Norfolk Family Focus.
6. Where appropriate, interventions should evaluate the mother's mental health alongside the child and young person's, and offer health and wellbeing services in conjunction with the child.

Population Projections 2015 to 2025

Population Change (%) by District and 5-year Age Bands

	0-4	5-9	10-14	15-19	20-24	Total Pop Change (%)
Breckland	-1.4	2.8	17.1	2.3	-14.4	**2.2%**
Broadland	2.3	2.4	6.6	-4.1	-15.2	**-0.8%**
Great Yarmouth	-2.6	-1.1	10.5	-2.7	-16.0	**-1.9%**
King's Lynn and West Norfolk	-4.1	4.0	15.3	4.6	-10.6	**2.5%**
North Norfolk	0.9	4.6	13.7	-3.2	-20.2	**0.5%**
Norwich	3.7	2.7	20.2	17.4	-6.5	**5.3%**
South Norfolk	9.9	10.1	21.5	10.5	-14.3	**9.8%**
Waveney	-3.2	-0.6	9.4	-2.0	-20.7	**-2.5%**
Norfolk & Waveney	0.9	3.4	14.8	4.2	-12.6	**2.5%**

Population Change (%) by CCG and 5-year Age Bands

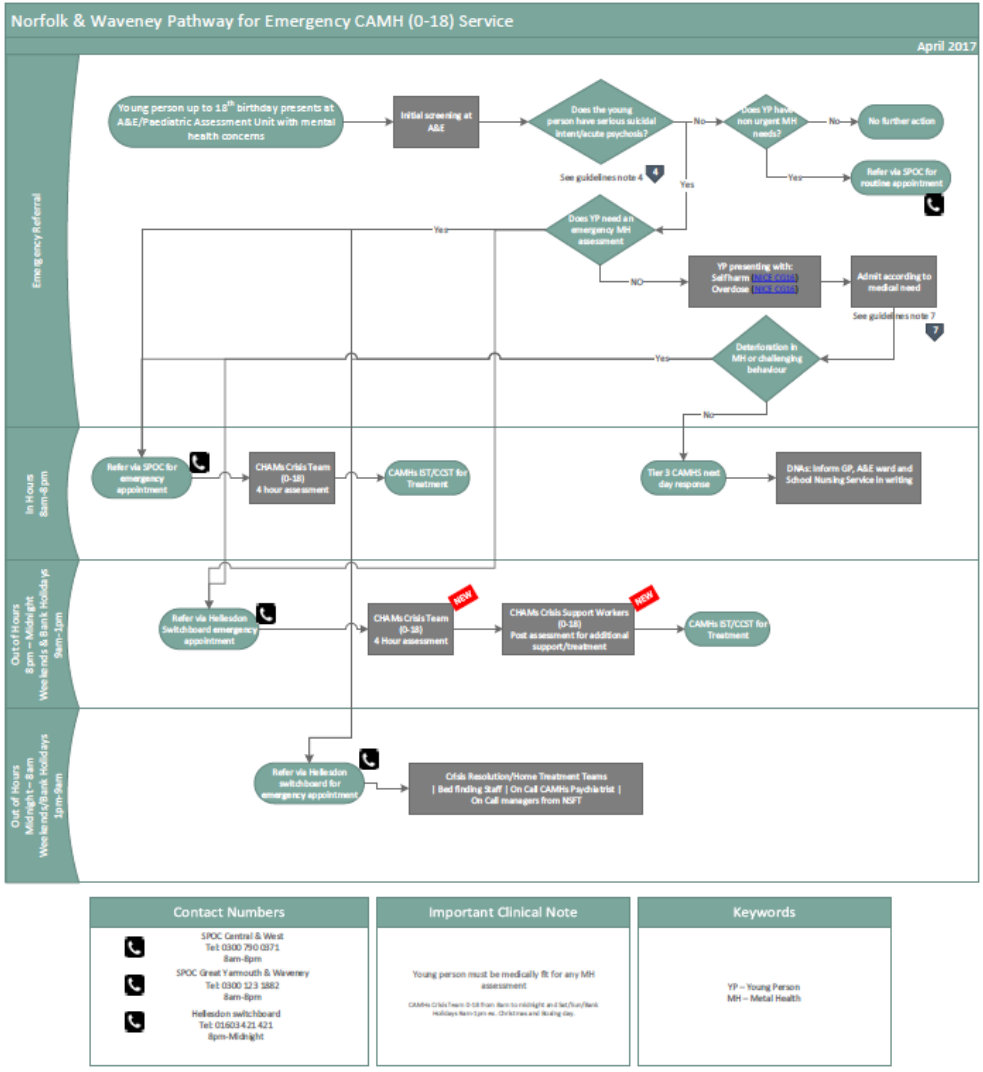
	0-4	5-9	10-14	15-19	20-24	Total Pop Change (%)
Great Yarmouth and Waveney CCG	-2.9	-0.8	9.9	-2.3	-18.3	**-2.2**
North Norfolk CCG	0.5	4.0	10.2	-3.5	-18.0	**-0.2**
Norwich CCG	4.0	2.3	16.5	12.1	-7.7	**4.0**
South Norfolk CCG	4.8	6.8	19.6	6.9	-14.3	**6.4**
West Norfolk CCG	-3.8	4.0	15.5	4.4	-11.0	**2.5**
Norfolk & Waveney	**0.9**	**3.4**	**14.8**	**4.2**	**-12.6**	**2.5**

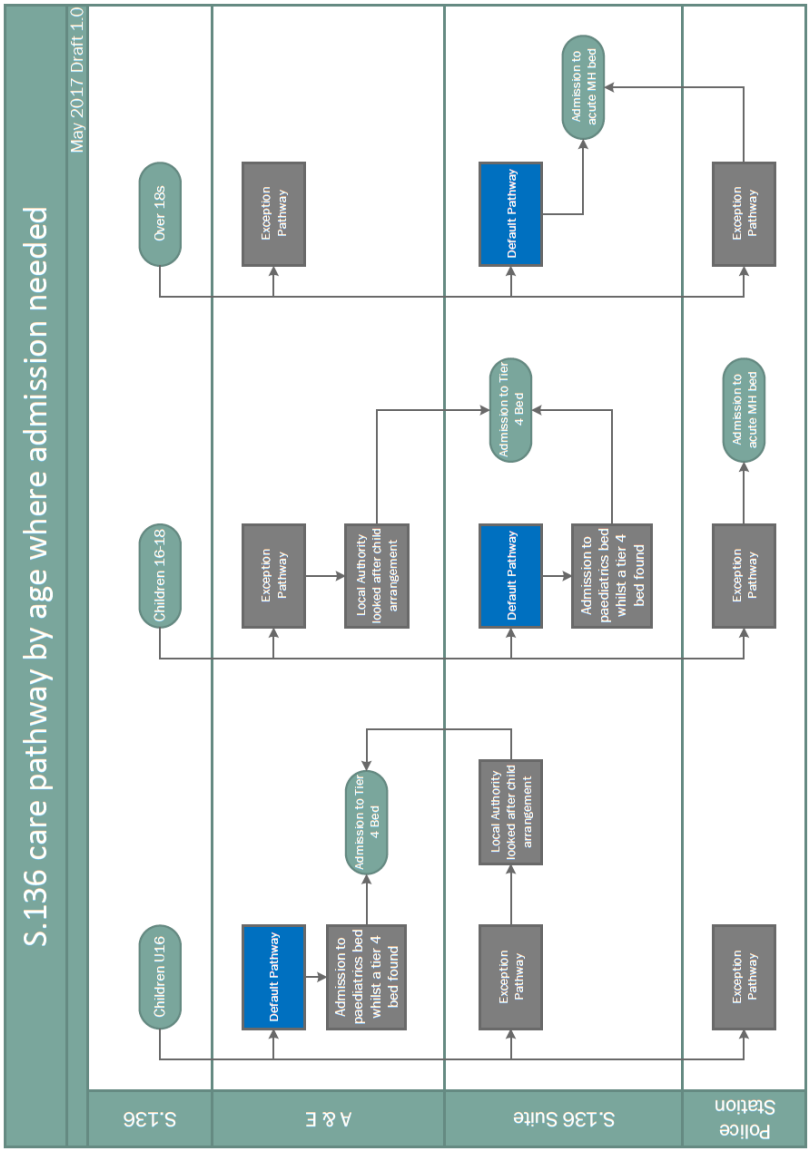
Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

Norfolk County Council
Supported by INTELLIGENCE & ANALYTICS

Appendix B

Norfolk & Waveney Pathway for the Emergency CAMH (0-18 years) Service.





Our Benchmarking Mental Health Trust Peer Group 2016

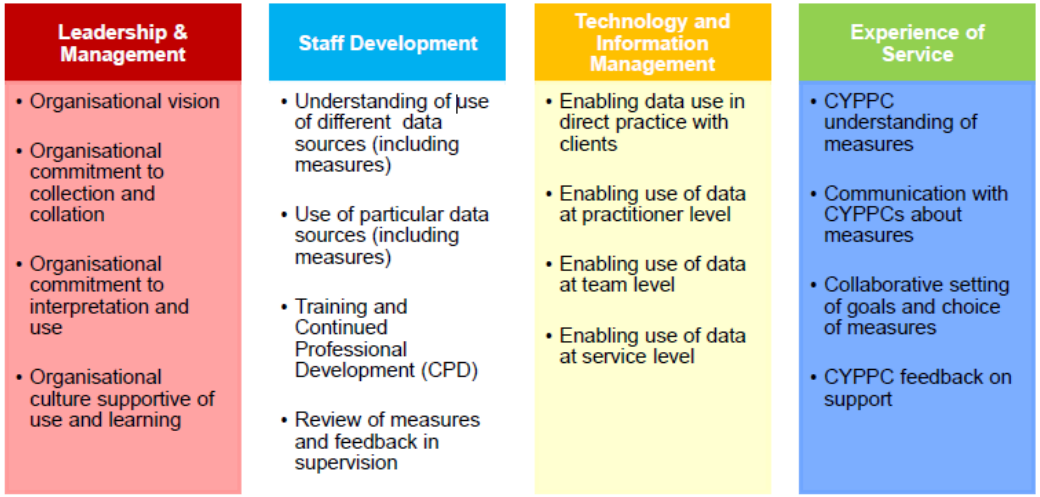
Mental Health <355 beds	Black Country Partnership NHS Foundation Trust Cornwall Partnership NHS Foundation Trust Derbyshire Healthcare NHS Foundation Trust Devon Partnership NHS Trust Dudley and Walsall Mental Health Partnership NHS Trust North Essex Partnership NHS Foundation Trust Rotherham Doncaster and South Humber NHS Foundation Trust South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Mental Health >355 beds	Avon and Wiltshire Mental Health Partnership NHS Trust Barnet, Enfield and Haringey Mental Health NHS Trust Birmingham and Solihull Mental Health NHS Foundation Trust Kent and Medway NHS and Social Care Partnership Trust Leeds and York Partnership NHS Foundation Trust Mersey Care NHS Trust **Norfolk and Suffolk NHS Foundation Trust (NSFT)** Northumberland, Tyne and Wear NHS Foundation Trust Nottinghamshire Healthcare NHS Foundation Trust Sussex Partnership NHS Foundation Trust Tees, Esk and Wear Valleys NHS Foundation Trust West London Mental Health NHS Trust

Norfolk's CIPFA Comparable Neighbours

Suffolk
Lincolnshire
Somerset
Derbyshire
Worcestershire
Cumbria
Gloucestershire
Nottinghamshire
Warwickshire
Staffordshire
North Yorkshire
Devon
Leicestershire
Lancashire
East Sussex

Appendix C

Best practices in data collection for CYP MH&WB services (CORC Best Practice Framework, available at: www.corc.uk.net).



All providers of NHS funded mental health care must flow data to the Mental Health Services Data Set (MHSDS). This includes services co-funded with the local authority (LA) or voluntary sector organisations. Data quality and completeness are important as the MHSDS will increasingly be used to inform service design, improvement and accountability. Transformation funds can be used to improve local ICT systems, of which NHS Digital can provide support.

Appendix D

Definitions of mental health problem descriptions:

DEFINITIONS OF PROBLEM DESCRIPTIONS
These definitions are for general guidance purposes only and should be considered within an age-appropriate context and with reference to cultural norms where appropriate. The examples given are not exhaustive.
1. Anxious away from care givers (Separation anxiety)
Excessive and inappropriate anxiety on separation from primary care giver(s); nightmares about separation and physical (somatic) symptoms are common. May manifest as school refusal.
2. Anxious in social situations (Social anxiety/phobia)
Strong fear of social and performance related situations e.g. starting conversations, joining in with games, completing homework, taking tests or answering question in class. Anxiety may be present in situations with same-age peers and/or adults and is likely to be expressed by avoidance of such situations.
3. General anxiety (generalised anxiety)
Recurring fears and worries on a wide variety of topics (e.g. school work, family, natural disasters). These worries are difficult to control or dismiss and signs may include restlessness, irritability, tiredness, disrupted sleep and concentration problems.
4. Compelled to do or think things (OCD)
Recurrent involuntary or uncontrollable thoughts or images (obsessions) and/or uncontrollable urges to perform certain behaviours (e.g. checking, counting, hand-washing).
5. Panics (Panic Disorder)
Frequent episodes of extreme fear and discomfort which occur unexpectedly and when no known feared stimulus is present, often accompanied by shortness of breath and fast heartbeat. Not restricted to just one situation or set of circumstances; commonly characterised by anticipatory fear of panicking.
6. Avoids going out (Agoraphobia)
Avoids or becomes frightened in open spaces or public places; may have a 'safe zone', usually including (but not restricted to) their home, which they will be reluctant to leave. Panic is a common feature of this problem.
7. Avoids specific things (Specific phobia)
Extreme and inappropriate fear in response to specific objects or situations. Common fears include animals (e.g. spiders), natural environment (e.g. heights), blood/injection/injury and situational fears (e.g. aeroplanes).
8. Repetitive problematic behaviours (Habit problems)
CYP shows repetitive patterns of behaviour of which they appear unaware and/or unable to control (e.g. severe nail-biting, Trichotillomania (hair pulling), skin picking).
9. Depression/low mood (Depression)
Low or sad mood (either reported or observed). May report being less active, and having less energy. May also find it hard to concentrate and not enjoy the things they used to do. Changes to appetite and sleeping pattern are common.
10. Self-harm (Self injury or self-harm)
CYP deliberately attempts to (or reports wanting to) hurt themselves (e.g. by cutting, biting, hitting and burning). Also includes attempted or threatened suicide and/or suicidal ideation.

DEFINITIONS OF PROBLEM DESCRIPTIONS
11. Extremes of mood (Bipolar disorder)
CYP has (either reported or observed) difficulties affecting feelings and behaviour characterised by major mood changes.
12. Delusional beliefs and hallucinations (Psychosis)
CYP has (either reported or observed) paranoid thoughts, delusions and/or confused thinking.
13. Drug and alcohol difficulties (Substance abuse)
CYP is addicted to and/or using drugs/alcohol in a harmful manner.
14. Difficulties sitting still or concentrating (ADHD/Hyperactivity)
Difficulties with attention and/or hyperactivity, impulsive behaviour is also common. May move around a lot, fidget, be easily distracted or have trouble waiting their turn.
15. Behavioural difficulties (CD or ODD)
Repeated and persistent challenging or out of control behaviour, may include behaviour that is violent, aggressive and harmful to others. Typical behaviours may include excessive fighting, bullying, cruelty to people or animals, stealing, truancy, tantrums, disobedience and fire-setting.
16. Poses risk to others
Threatened or actual violence towards others, including inappropriate sexualised behaviour.
17. Carer management of CYP behaviour (e.g. management of child)
Parents are unable to manage/cope with aspects of the CYP's behaviour (e.g. sleep (in infants), toilet training (in toddlers), tantrums (in middle childhood), challenging behaviour (in adolescence)).
18. Doesn't go to the toilet in time (Elimination problems)
Unable to reach the toilet in time or goes to the toilet in inappropriate places (either on purpose or accidentally). This includes defecation (encopresis), urination (enuresis) and smearing. PLEASE NOTE: In order to be classified as an elimination problem, the CYP must be at least 4 (defecation) or 5 (urination) years old (or equivalent developmental level).
19. Disturbed by traumatic event (PTSD)
Extreme and prolonged distress following witnessing or experiencing a traumatic event (e.g. rape, assault, death, serious accident, natural disaster). This may be expressed through disrupted sleep, nightmares, repetitive play in which the event is re-enacted (fully or in part), avoidance of stimuli associated with or refusal to talk about the event.
20. Eating issues (Anorexia/Bulimia)
Preoccupation with body image and weight accompanied by disturbed eating behaviours (e.g. food restriction, purging, bingeing, over-exercising).
21. Family relationship difficulties
Problems within the family (e.g. arguments, high conflict between family members, high expressed emotion, inappropriate levels of involvement, adjustment difficulties).
22. Problems in attachment to parent/carer (Attachment problems)
Difficulty forming or maintaining relationships with primary care giver(s) which has implications for relationships with key people in their life going forward.

DEFINITIONS OF PROBLEM DESCRIPTIONS
23. Peer relationship difficulties
Problems relating to peers (e.g. difficulties integrating into available peer groups, difficulties forming or maintaining friendships, conflicts in relationships). May also include problematic or inappropriate romantic or sexual relationships.
24. Persistent difficulties managing relationships with others (includes emerging personality disorder)
On-going difficulties relating to others usually linked with aggression, self-harm or difficulties with expressing and/or regulating emotion.
25. Does not speak (selective mutism)
Is able to speak and understand language but chooses not to do so in one or more contexts (e.g. school, at the homes of certain relatives).
26. Gender discomfort Issues (GID)
Extreme discomfort associated with anatomical gender. Repeated insistence that they are (or want to be) the opposite gender.
27. Unexplained physical symptoms
Regular reporting of physical symptoms that have no known biological cause and are suspected to be psychological in nature (e.g. unexplained pain, stomach and headaches, hypochondriasis).
28. Unexplained developmental difficulties
CYP presenting with failure to meet developmental milestones. These are of as yet unknown cause and could be of physical and/or psychological origin (e.g. feeding, sleeping, movement or language problems). Include Pica and suspected Pervasive Developmental Disorder.
29. Self-care issues (includes medical care management, obesity)
Difficulties in managing diet (e.g. over-eating), medical care regime (e.g. insulin regime) or personal care (e.g. hygiene issues).
30. Adjustment to health issues
CYP experiencing emotional and/or behavioural difficulties following diagnosis of health condition in self or significant other. This may also include on-going adjustment difficulties.

Adapted from: "Current View Tool – Completion Guide". 2013. CAMHS Press: London. Available at: https://www.ucl.ac.uk/ebpu/docs/publication_files/current_view

Definitions of Complexity Factors:

The complexity factors chosen are through expert consultation as being likely to be some of the more relevant indicators of resource use. It does include factors that may fall outside of the mental health problem or diagnosis, but that may need to be considered when thinking about the amount of resource required to achieve a positive outcome.

DEFINITIONS OF COMPLEXITY FACTORS
These definitions are for general guidance purposes only and should be considered within an age-appropriate context and with reference to cultural norms where appropriate. The examples given are not exhaustive.
1. Looked after CYP
Include CYP who are under section 20, special guardianship or kinship care, or subject to a care order (either temporary or long term).
2. Young carer status
CYP is responsible for the care of a family member. This may be due to a parent or sibling being incapacitated through physical or psychological disorder/disability and/or substance abuse. Common responsibilities include physical and personal care of family member, managing budgets and medication, interpreting and providing emotional support.
3. Learning disability
CYP must have diagnosis of a moderate, severe or profound learning disability. Do not include CYP with a specific learning difficulty (e.g. Dyslexia) without a comorbid learning disability.
4. Serious physical health issues (Including Chronic Fatigue)
CYP has a physical illness, disease, injury or impairment that requires continuing input and treatment from a healthcare provider (e.g. diabetes, epilepsy, tuberous sclerosis, autoimmune disorders).
5. Pervasive Developmental Disorders (Autism/Asperger's)
Developmental disorders that affect cognitive and social functioning and often include difficulties with social interaction, communication and flexibility of thought (e.g. Autistic Spectrum Disorders, Rett's Disorder).
6. Neurological issues (e.g. tics or Tourette's)
Neurological disorders that manifest physically (e.g. Tic disorder, Tourette's). Include Cerebral Palsy and speech and language disorders.
7. Current protection plan
CYP is subject to a current child protection plan.
8. Deemed "child in need" of social service input
CYP has been identified by professionals as needing local authority services to achieve or maintain a reasonable standard of health or development and/or to prevent significant or further harm to health or development. This includes CYP who are classed as disabled. Include CYP who are deemed in need of local authority input but are currently below threshold for acceptance of the referral.

DEFINITIONS OF COMPLEXITY FACTORS
9. Refugee or Asylum Seeker
CYP has been forced to leave their country to escape war, persecution or natural disaster.
10. Experience of war, torture or trafficking
CYP has witnessed or experienced war, torture or trafficking.
11. Experience of abuse or neglect
CYP has witnessed or experienced physical, emotional, sexual abuse or neglect. Include witnessing of domestic violence.
12. Parental health issues
At least one primary care giver is currently suffering from a diagnosable mental health problem(s), moderate, severe or profound learning disability, significant substance abuse and/or significant physical health issues (e.g. parent/carer in a wheelchair).
13. Contact with Youth Justice System
Current or repeated contact with a Youth Offending Team.
14. Living in financial difficulty
Family is deemed to be in considerable debt or under financial stress requiring local authority assistance to meet basic needs (e.g. CYP is in receipt of free school meals).

Additional Guidance:

Complexity factors should be rated based on the clinician's best judgement as to whether they are objectively present. That is, based on the factual information you have. They should be rated only if currently present, with the following exceptions:

- Refugee/Asylum seeker, Experience of war torture or trafficking and Experience of abuse or neglect should be rated if they occurred at any point in the CYP's life
- Contact with the Youth Justice System should be rated if repeated.

Definitions of Contextual Problems:

Contextual problems are issues present in the assessment that are external to the child or young person (CYP) and additional to the problems and complexity factors already rated. They are rated for impact in four areas: home, school/work/training, community and service engagement.

DEFINITIONS OF CONTEXTUAL PROBLEMS
These definitions are for general guidance purposes only and should be considered within an age-appropriate context and with reference to cultural norms where appropriate. The examples given are not exhaustive.
1. Home
Problems in the home environment that are external to the CYP and could affect their psychological wellbeing. This may include crowded housing, homelessness, lack of social support network.
2. School, Work or Training
Problems in the school, work or training environment that are external to the CYP and could affect their psychological wellbeing (e.g. difficulties in communications between home and school, multiple changes of teacher, breakdown in relations between teacher(s) and CYP/family).
3. Community
Problems in the community that are external to the CYP and could affect their psychological wellbeing. This may include street violence, gang intimidation, racial discrimination and difficulties with neighbours.
4. Service Engagement
Difficulties regulating the appropriate level of service engagement. This may include history of multiple or fractured contact with services, difficulties locating care records, difficulties accessing the service and problems engaging the CYP and their family appropriately, need for interpreter.

Additional Guidance

Contextual problems should only be considered within an impact rating if they are currently present. That is, they should not be considered if they were only present in the past.

Definitions of education, employment or training (EET) difficulties (attendance and attainment difficulties):

EET difficulties involves considering whether the CYP has any **current** difficulties in attendance and/or attainment in school, training or employment.

DEFINITIONS OF ATTENDANCE AND ATTAINMENT DIFFICULTIES	
These definitions are for general guidance purposes only and should be considered within an age-appropriate context and with reference to cultural norms where appropriate. They should also be considered with specific reference to the CYP you're working with (e.g. if the CYP has a learning disability, attendance and attainment should be considered in relation to peers of the same developmental rather than chronological age). The examples given are not exhaustive.	
Attendance difficulties	
None	No problems noted. As rough guidance, around 1-2 days absence from school per month should be considered as within normal limits.
Mild	Some definite problems. The CYP may be attending part-time or missing several lessons (includes truanting, school refusal or suspension for any cause). As a rough guidance, 1 day of absence per week might be considered here.
Moderate	Marked problems. The CYP may be attending infrequently, or is at high risk of exclusion or dismissal. As a rough guidance, the CYP may be absent 2 days per week.
Severe	CYP is out of school the majority of the time (for reasons of truancy, exclusion or refusal) or may be in a Pupil Referral Unit, excluded or not in Education, Employment or Training.

Attainment difficulties	
None	No problems noted. The CYP will be attaining at the optimum age-appropriate level moderated by that expected for their known abilities.
Mild	Some problems. For example, if the CYP is in school they may be well below the year level in at least one subject, or have problems with work rate or timekeeping if in employment or training.
Moderate	Significant problems. If at school they may fail key exams, or be below the year group in all subjects. If in employment, they may have received formal warnings about their performance and/or behaviour.
Severe	CYP has dropped out of education, employment or training.

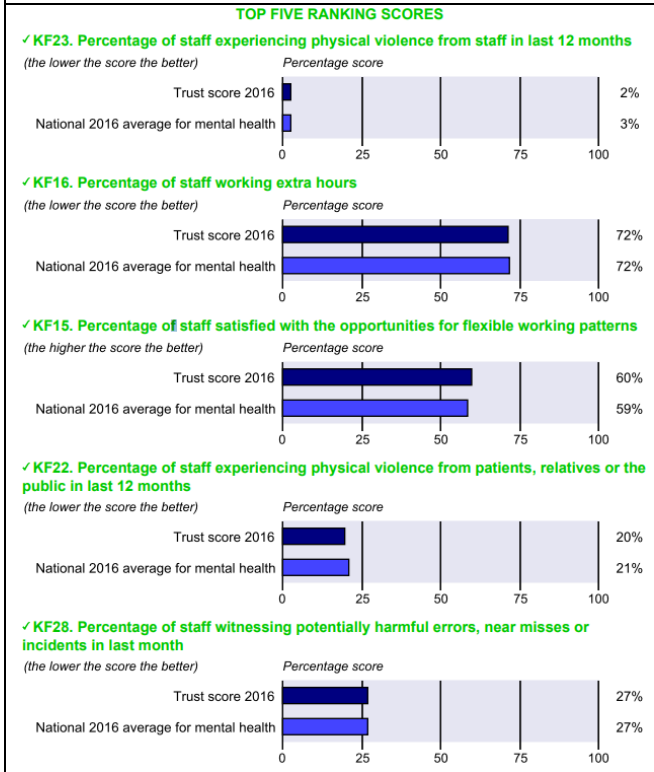
Intelligence and Analytics. October 2017.
christine.north@norfolk.gov.uk

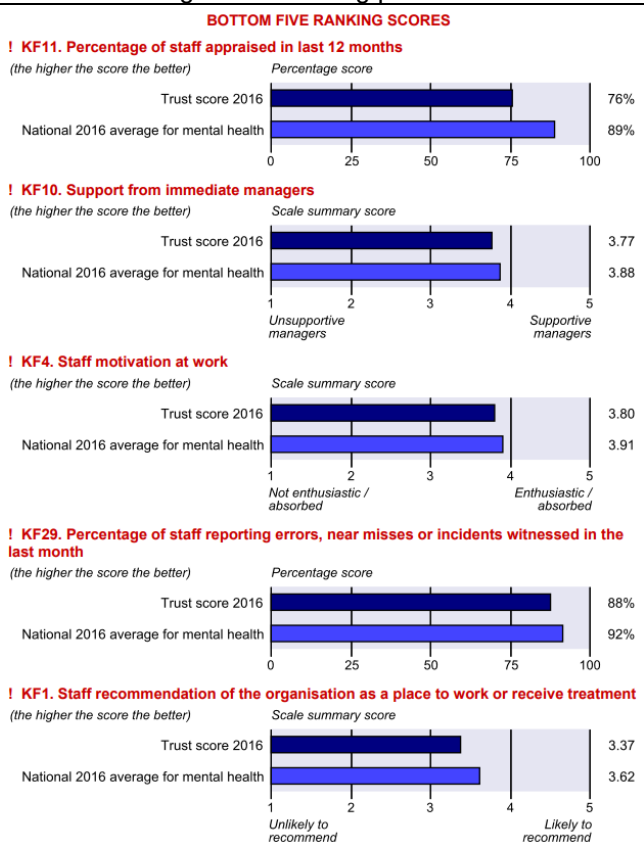
Norfolk County Council
Supported by INTELLIGENCE & ANALYTICS

Appendix E

Summary of NHS Staff survey key findings details for Norfolk and Suffolk NHS Foundation Trust, 2016

Top Ranking Scores for which NSFT compares most favourably with other mental/learning disability trusts in England.	Bottom Ranking Scores for which NSFT compares least favourably with other mental health/learning disability trusts in England. It is suggested that these areas might be a starting point for local action.





Appendix F

Estimated activity numbers by CCG

NHS Great Yarmouth and Waveney CCG

Table 4 Expected referral numbers from 2016/17 applying NHS requirements for NHS Great Yarmouth and Waveney

NHS Great Yarmouth and Waveney CCG	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	70%	72%	74%	76%	77%
Number of additional CYP treated over 2016/17 position	-	76	153	230	308
Total referred	2,646	2,722	2,799	2,876	2,954
Total with condition aged 0 to 17	3,757	3,772	3,786	3,801	3,815
Total aged 0 to 17	41,949	42,084	42,220	42,355	42,491

We can further develop this using the The THRIVE model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 5 THRIVE framework applied to estimated number of referrals across NHS Great Yarmouth and Waveney

Thrive State	**Issue**	**NICE Guideline**	**Estimated Proportion**	**Estimated Number NHS Great Yarmouth and Waveney CCG**				
				2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
		Referred	100%	2,646	2,722	2,799	2,876	2,954
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	79	82	84	86	89
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	741	762	784	805	827
Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	185	191	196	201	207
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	53	54	56	58	59
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	132	136	140	144	148

Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	26	27	28	29	30
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	159	163	168	173	177
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	106	109	112	115	118
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	26	27	28	29	30
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	53	54	56	58	59
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	159	163	168	173	177
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	53	54	56	58	59
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	53	54	56	58	59
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	26	27	28	29	30
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	26	27	28	29	30
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	53	54	56	58	59
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	212	218	224	230	236
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	423	436	448	460	473
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	212	218	224	230	236

We can also use the older tiered approach to understand potential size of each tier (Table 3)

Table 6 Estimated need for services at each tier for NHS Great Yarmouth and Waveney CCG

NHS Great Yarmouth and Waveney CCG	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Population 0 to 17	41,949	42,084	42,220	42,355	42,491
Tier 1 – universal e.g. PATHS	6212	6232	6252	6272	6292
Tier 2 – community mental health	2899	2909	2918	2927	2937
Tier 3 specialist community	770	772	775	777	780
Tier 4 – severe and/or complex	33	33	33	33	33

NHS North Norfolk CCG

Table 7 Expected referral numbers from 2016/17 applying NHS requirements for NHS Great Yarmouth and Waveney

NHS North Norfolk CCG	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	56%	58%	60%	62%	63%
Number of additional CYP treated over 2016/17 position	-	57	114	172	230
Total referred	1,493	1,550	1,607	1,665	1,723
Total with condition aged 0 to 17	2,649	2,667	2,684	2,702	2,720
Total aged 0 to 17	29,256	29,439	29,621	29,804	29,987

We can further develop this using the The THRIVE model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 8 THRIVE framework applied to estimated number of referrals across NHS Great Yarmouth and Waveney

Thrive State	**Issue**	**NICE Guideline**	**Estimated Proportion**	**Estimated Number NHS North Norfolk CCG**				
				2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
		Referred	100%	1,493	1,550	1,607	1,665	1,723
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	45	46	48	50	52
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	418	434	450	466	483

Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	105	108	112	117	121
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	30	31	32	33	34
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	75	77	80	83	86
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	15	15	16	17	17
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	90	93	96	100	103
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	60	62	64	67	69
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	15	15	16	17	17
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	30	31	32	33	34
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	90	93	96	100	103
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	30	31	32	33	34
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	30	31	32	33	34
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	15	15	16	17	17
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	15	15	16	17	17
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	30	31	32	33	34

Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	119	124	129	133	138
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	239	248	257	266	276
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	119	124	129	133	138

We can also use the older tiered approach to understand potential size of each tier (Table 3)

Table 9 Estimated need for services at each tier for NHS North Norfolk CCG

NHS North Norfolk CCG	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Population 0 to 17	29,256	29,439	29,621	29,804	29,987
Tier 1 – universal e.g. PATHS	4332	4359	4386	4413	4440
Tier 2 – community mental health	2022	2035	2047	2060	2073
Tier 3 specialist community	537	540	544	547	550
Tier 4 – severe and/or complex	23	23	23	23	24

NHS Norwich CCG

Table 10 Expected referral numbers from 2016/17 applying NHS requirements for NHS Great Yarmouth and Waveney

NHS Norwich CCG	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	73%	75%	77%	78%	80%
Number of additional CYP treated over 2016/17 position	-	88	178	269	362
Total referred	2,381	2,469	2,559	2,650	2,743
Total with condition aged 0 to 17	3,251	3,293	3,334	3,376	3,418
Total aged 0 to 17	36,871	37,261	37,652	38,042	38,433

We can further develop this using the The THRIVE model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 11 THRIVE framework applied to estimated number of referrals across NHS Great Yarmouth and Waveney

Thrive State	Issue	NICE Guideline	Estimated Proportion	Estimated Number NHS Norwich CCG				
				2016/17	2017/18	2018/19	2019/20	2020/21
			100%	2,381	2,469	2,559	2,650	2,743
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	71	74	77	79	82
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	667	691	716	742	768
Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	167	173	179	185	192
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	48	49	51	53	55
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	119	123	128	132	137
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	24	25	26	26	27
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	143	148	154	159	165
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	95	99	102	106	110
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	24	25	26	26	27
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	48	49	51	53	55
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	143	148	154	159	165
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	48	49	51	53	55
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	48	49	51	53	55

Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	24	25	26	26	27
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	24	25	26	26	27
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	48	49	51	53	55
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	190	198	205	212	219
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	381	395	409	424	439
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	190	198	205	212	219

We can also use the older tiered approach to understand potential size of each tier (Table 3)

Table 12 Estimated need for services at each tier for NHS Norwich CCG

NHS Norwich CCG	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Population 0 to 17	36,871	37,261	37,652	38,042	38,433
Tier 1 – universal e.g. PATHS	5460	5517	5575	5633	5691
Tier 2 – community mental health	2548	2575	2602	2629	2656
Tier 3 specialist community	677	684	691	698	705
Tier 4 – severe and/or complex	29	29	30	30	30

NHS South Norfolk CCG

Table 13 Expected referral numbers from 2016/17 applying NHS requirements for NHS Great Yarmouth and Waveney

NHS South Norfolk CCG	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	49%	51%	53%	55%	56%
Number of additional CYP treated over 2016/17 position	-	107	215	326	449

Total referred	2,200	2,307	2,415	2,526	2,649
Total with condition aged 0 to 17	4,455	4,511	4,568	4,624	4,697
Total aged 0 to 17	49,589	50,216	50,842	51,469	52,096

We can further develop this using the The THRIVE model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 14 THRIVE framework applied to estimated number of referrals across NHS Great Yarmouth and Waveney

Thrive State	Issue	NICE Guideline	Estimated Proportion	Estimated Number NHS South Norfolk CCG				
				2016/17	2017/18	2018/19	2019/20	2020/21
		Referred	100%	2,200	2,307	2,415	2,526	2,649
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	66	69	72	76	79
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	616	646	676	707	742
Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	154	161	169	177	185
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	44	46	48	51	53
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	110	115	121	126	132
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	22	23	24	25	26
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	132	138	145	152	159
Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	88	92	97	101	106
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	22	23	24	25	26
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	44	46	48	51	53

Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	132	138	145	152	159
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	44	46	48	51	53
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	44	46	48	51	53
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	22	23	24	25	26
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	22	23	24	25	26
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	44	46	48	51	53
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	176	185	193	202	212
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	352	369	386	404	424
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	176	185	193	202	212

We can also use the older tiered approach to understand potential size of each tier (Table 3)

Table 15 Estimated need for services at each tier for NHS South Norfolk CCG

NHS South Norfolk CCG	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Population 0 to 17	49,589	50,216	50,842	51,469	52,096
Tier 1 – universal e.g. PATHS	7343	7436	7528	7621	7714
Tier 2 – community mental health	3427	3471	3514	3557	3601
Tier 3 specialist community	910	921	933	944	956
Tier 4 – severe and/or complex	39	40	40	41	41

NHS West Norfolk CCG

Table 16 Expected referral numbers from 2016/17 applying NHS requirements for NHS Great Yarmouth and Waveney

NHS West Norfolk CCG	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	53%	55%	57%	59%	60%
Number of additional CYP treated over 2016/17 position	-	66	134	202	271
Total referred	1,567	1,633	1,701	1,769	1,838
Total with condition aged 0 to 17	2,933	2,960	2,987	3,014	3,041
Total aged 0 to 17	32,941	33,216	33,490	33,765	34,040

We can further develop this using the The THRIVE model to understand what the demands on the various services might look like by different condition if the referrals into the system meet the NHS requirements (Table 2)

Table 17 THRIVE framework applied to estimated number of referrals across NHS Great Yarmouth and Waveney

Thrive State	**Issue**	**NICE Guideline**	**Estimated Proportion**	**Estimated Number NHS West Norfolk CCG**				
				2016/17	**2017/18**	**2018/19**	**2019/20**	**2020/21**
		Referred	100%	1,567	1,633	1,701	1,769	1,838
Getting Advice	Neurodevelopment Assessment	NICE guidance as relevant	3%	47	49	51	53	55
Getting Advice	Signposting and self-management advice	NICE guidance as relevant	28%	439	457	476	495	515
Single Guideline Indicated								
Getting Help	ADHD	https://www.nice.org.uk/guidance/cg72	7%	110	114	119	124	129
Getting Help	Autism Spectrum	https://www.nice.org.uk/guidance/cg170	2%	31	33	34	35	37
Getting Help	Behavioural and/or Conduct Disorder	https://www.nice.org.uk/guidance/cg158	5%	78	82	85	88	92
Getting Help	Bipolar Disorder	https://www.nice.org.uk/guidance/cg185	1%	16	16	17	18	18
Getting Help	Depression	https://www.nice.org.uk/guidance/cg28	6%	94	98	102	106	110

Getting Help	GAD	https://www.nice.org.uk/guidance/cg113	4%	63	65	68	71	74
Getting Help	OCD	https://www.nice.org.uk/guidance/cg31	1%	16	16	17	18	18
Getting Help	PTSD	https://www.nice.org.uk/guidance/cg26	2%	31	33	34	35	37
Getting Help	Self-harm	https://www.nice.org.uk/guidance/cg16 or https://www.nice.org.uk/guidance/cg133	6%	94	98	102	106	110
Getting Help	Social Anxiety Disorder	https://www.nice.org.uk/guidance/cg159	2%	31	33	34	35	37
Getting More Help	Eating Disorders	https://www.nice.org.uk/guidance/cg9	2%	31	33	34	35	37
Getting More Help	Presentation suggestion of potential BPD	https://www.nice.org.uk/guidance/cg78	1%	16	16	17	18	18
Getting More Help	Psychosis	https://www.nice.org.uk/guidance/cg155 and/or https://www.nice.org.uk/guidance/cg185	1%	16	16	17	18	18
No Single Guideline Indicated								
Getting Help	Co-occurring behavioural and emotional difficulties	NICE guidance as relevant	2%	31	33	34	35	37
Getting Help	Co-occurring emotional difficulties	NICE guidance as relevant	8%	125	131	136	141	147
Getting Help	Difficulties not covered by other groupings	NICE guidance as relevant	16%	251	261	272	283	294
Getting More Help	Difficulties of severe impact	NICE guidance as relevant	8%	125	131	136	141	147

We can also use the older tiered approach to understand potential size of each tier (Table 3)

Table 18 Estimated need for services at each tier for NHS West Norfolk CCG

NHS West Norfolk CCG	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**

Population 0 to 17	32,941	33,216	33,490	33,765	34,040
Tier 1 – universal e.g. PATHS	4878	4918	4959	5000	5040
Tier 2 – community mental health	2277	2296	2315	2334	2353
Tier 3 specialist community	604	609	614	620	625
Tier 4 – severe and/or complex	26	26	26	27	27