HEALTH AND WELLBEING BOARD

Wednesday, 18th September, 2013

6.30 pm

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH AND WELLBEING BOARD

Wednesday, 18 September 2013 at 6.30 pm
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Ann Hunter**
Telephone: **01622 694703**

Tea/Coffee will be available 30 minutes before the meeting

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UNRESTRICTED ITEMS
(During these items the meeting is likely to be open to the public)

Item No	
1	Chairman's Welcome
2	Substitutes
3	Declarations of Interest by Members in Items on the Agenda for this Meeting
4	Minutes of the Meeting held on 17 July 2013 (Pages 1 - 8)
5	Kent Safeguarding Children Board - 2012/13 Annual Report (Pages 9 - 40)
6	2013/14 Health Monies- Verbal Update
7	The Integration Transformation Fund (Pages 41 - 48)
8	Long Term Conditions (Pages 49 - 58) Mapping the Future Report Dartford Gravesham and Swanley CCG Case Study

9 Update on the Assurance Framework for the Kent Health and Wellbeing Board (Pages 59 - 66)

10 Improving Health Outcomes for Children and Young People - Better Health Outcomes Pledge (Pages 67 - 80)

11 CCG- Level HWBs' Children's Sub Group (Pages 81 - 84)

12 Date of Next Meeting - 20 November 2013

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Tuesday, 10 September 2013

Please note that any background documents referred to in the accompanying papers may be inspected by arrangement with the officer responsible for preparing the relevant report.

HWB Membership

CCG Reps	Clinical Lead	Officer
Ashford CCG	*Dr Navin Kumta*	*Simon Perks*
Canterbury & Coastal CCG	*Dr Mark Jones*	*Simon Perks*
Dartford/Gravesham/ Swanley	*Dr Bhaskar Bora*	*Patricia Davies*
South Kent Coast	*Dr Darren Cocker*	*Hazel Carpenter*
Swale	*Dr Fiona Armstrong*	*Patricia Davies*
Thanet	*Dr Tony Martin*	*Hazel Carpenter*
West Kent	*Dr Bob Bowes*	*Ian Ayres*

District Councillor Reps

Cllr Andrew Bowles	Swale BC
Cllr John Cunningham	Tunbridge Wells BC
Cllr Paul Watkins	Dover DC

Healthwatch
Veronika Segall- Jones

NHS England

Michael Ridgwell or	*Felicity Cox*

KCC
Paul Carter
Andrew Ireland
Meradin Peachey
Graham Gibbens
Roger Gough
Jenny Whittle

Italics = statutory reps
CCG reps – each CCG has one vote

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Wednesday, 17 July 2013.

PRESENT: Mr R W Gough (Chairman), Dr B Bowes (Vice-Chairman), Dr F Armstrong, Mr I Ayres, Cllr Mrs S Chandler (Substitute for Cllr P Watkins), Cllr J Cunningham, Mr G K Gibbens, Mr A Ireland, Dr M Jones, Dr N Kumta, Dr T Martin, Ms M Peachey, Mrs J Whittle, Cllr K Pugh (Substitute for Mr A Bowles), Mr M Ridgwell and Ms D Stock (Substitute for Ms P Davies).

IN ATTENDANCE: Ms E Hanson (Policy Manager), Mr J Lampert (Commissioning Manager - FSC), Mr M Lemon (Strategic Business Adviser), Mr J Littlemore (Head of Housing and Community Safety - Maidstone Borough Council), Mr A Scott-Clark (Director of Public Health Improvement), Mr M Thomas-Sam (Strategic Policy Adviser - FSC), Mrs A Tidmarsh (Director of Older People and Physical Disability), Ms M Varshney (Consultant in Public Health) and Mrs A Hunter (Principal Democratic Services Officer).

UNRESTRICTED ITEMS

17. Chairman's Welcome
(Item 1)

(1) The chairman suggested moving the item on Befriending Services forward on the agenda and this was agreed.

(2) The chairman said that the consultants from Frontline, who were due to present the item on System Leadership- Integrated Commissioning, would not be able to attend as planned because of severe delays on the M25 motorway.

(3) The chairman said he had received a letter from the Kent and Medway CS about problems with Patient Transport Services. He said the Health Overview Scrutiny Committee was addressing the matter and that he would report any findings in due course.

(4) The chairman reported that a Keogh review of Medway Maritime Hospital had recently concluded. He suggested that the Health and Wellbeing Board received a report from the Quality Surveillance Group for Kent and Medway.

18. Substitutes
(Item 2)

19. Declarations of Interest by Members in Items on the Agenda for this Meeting
(Item 3)

There were no declarations of interest.

20. Minutes of the Meeting held on 29 May 2013

(Item 4)

RESOLVED that the minutes of the meeting of the Health and Wellbeing Board held on 29 May 2013 are correctly recorded and that they be signed by the chairman.

21. Befriending Services

(Item 15)

(1) Graham Gibbens (Cabinet Member for Adult Social Care and Public Health) and Emma Hanson (Head of Strategic Commissioning) said Kent had received a bronze award for its approach to reducing social isolation and loneliness and introduced the paper which set out a response to the research published by the Campaign to End Loneliness**.**

(2) The paper described the prevalence of social isolation within Kent and the impact it could have on an individual's physical and emotional health. It identified the approach taken by Adult Social Care to address social isolation through the development of a core offer of community based services including befriending.

(3) The paper also outlined the business case for investment in befriending services both in terms of improved outcomes for the individuals receiving the support and in financial terms for health and social care.

(5) RESOLVED that the report be noted.

22. Public Health Priorities (Presentation)

(Item 5)

(1) Meradin Peachey (Director of Public Health) gave a presentation called Transforming Public Health Outcomes. She set out: the PCT's expenditure in 2012/13 on public health issues that were now the responsibility of the County Council; an analysis of PCT expenditure on health lifestyle services; the context in which the public health business plan had been agreed and some activities and commitments that would contribute to the achievement of the Health and Wellbeing Strategy outcomes.

(2) In response to a question she said that total expenditure on public health in West Kent was lower than average and the spend in East Kent was average.

(3) RESOLVED:
- (a) That the presentation be noted;
- (b) That a more detailed report be considered at a future meeting.

23. Addressing Health Inequalities

(Item 6)

(1) Graham Gibbens (Cabinet Member for Adult Social Care and Public Health) Malti Varshney (Consultant in Public Health) and James Lampert (Commissioning Manager) introduced the report which identified the geographical areas where Clinical Commissioning Groups and other local

partners could focus their attention for effectively reducing health inequalities, by reducing disease and gender specific under- 75 mortality.

(2) Based on the model suggested by Professor Chris Bentley, the Kent Public Health department had developed a methodology to identify the number of lives that would need to be saved for an effective reduction in health inequalities and to identify where resources should be targeted.

(3) The paper set out the number of deaths that needed to be reduced in areas that have mortality rates within the top 20% of death rates for each clinical commissioning group area in order to achieve the average number of deaths across Kent and Medway.

(4) In response to questions Ms Varshney said that:

- She was as confident as she could be about the quality of the data in the report and would investigate any apparent discrepancies that were brought to her attention;

- The data presented in the report considered mortality rates and not deprivation data;

- It was hoped that this data and framework would be useful to inform decisions on the direction of travel, prompt discussion about variations between different parts of the county and help identify lessons to be learned.

(5) RESOLVED:

(a) That the data reported in this paper be noted;

(b) That CCGs, NHS England and local authorities be supported to develop action plans to address the number of premature deaths targeting the areas with top 20% death rate;

(c) That the local system in working together through the local Health and Wellbeing Boards be supported in this. Action planning at a local level to develop local 'Mind the Gap' would continue and bring together the District Council and CCG priorities to tackle health inequalities. This would be used as the mechanism to identify contributions from various parts of the system (CCGs, District Councils, KCC, Health Watch and the voluntary sector) and address the wider determinants of health, health promotion and preventing poor health.

24. Kent Framework for the Prevention and Management of Falls
(Item 7)

(1) Ms Peachey (Director of Public Health) introduced the briefing paper which provided background information to stimulate discussion around developing a 'framework' for falls prevention and management for Kent's population.

(2) A comprehensive picture across clinical commissioning group areas was presented at the meeting to provide a platform for further discussion and to

consider how this framework could contribute towards reducing A&E attendances, emergency admissions and need for residential care.

(3) A report by the Kent Joint Policy and Planning Board (Housing) which set out the ways in which the Kent local housing authorities and housing associations could assist with falls prevention was also considered.

(4) Malti Varshney (Consultant in Public Health), James Lampert (Commissioning Manager) and John Littlemore (Chairman of the Joint Policy and Planning Board (Housing) and Head of Housing and Community Services at Maidstone Borough Council) gave a presentation outlining the public health, social care and housing aspects of falls and falls prevention. Ms Varshney outlined the case for action, particularly as falls are on the increase in Kent, the population is ageing and there is a lack of co-ordination at both commissioning and provision levels. The four objectives for developing an integrated falls service published by the Department of Health were still relevant and the proposed framework concentrated on Objective 2 (responding to a first fracture) and Objective 3 (early intervention to restore independence) of the guidance. Mr Lampert set out the findings of the mapping and gapping exercise and gave some case study examples. Mr Littlemore outlined the role of housing professionals in preventing and managing falls.

(5) During discussion comments were made about: the cost of introducing the framework; the need to integrate the framework with other services especially as it needed to be a 24-hour service; the opportunity to involve the voluntary and community sector; and the need to learn lessons from West Kent. It was confirmed that support for developing business plans and adopting the framework would be available from the Public Health team.

(6) RESOLVED:

(a) That falls prevention and management services be seen as an important component of integrated services with specific outcomes for reducing the falls related burden of ill health across health and social care sector;

(b) That the implementation of the framework be led locally by commissioners represented at the local Integrated Commissioning Groups, reporting progress to the local Health and Wellbeing Boards;

(c) That progress on implementation be reviewed by the Health and Wellbeing Board in 6-9 months time.

25. Kent Framework for System Assurance
(Item 8)

(1) The Kent Health and Wellbeing Board (KHWB) had previously expressed a wish to develop an assurance framework across the Health and Social Care system.

(2) The report was introduced by Mark Lemon (Strategic Business Adviser) and proposed that indicators from the national outcomes frameworks for NHS, Public Health and Adult Social Care, the Kent Health and Wellbeing Strategy and KCC Key Performance Indicators were taken as the basis for the

development of an overview of the health and social care system across Kent. These indicators would form a relatively simple Assurance Dashboard for the KHWB to assess current service effectiveness.

(3) In addition the Board was asked to consider identifying indicators within the system that would alert the Board to potentially unsustainable pressures in the component sectors.

(4) During the discussion comments were made about the need to:

(a) Include indicators relating to children's health and wellbeing;

(b) Choose indicators that demonstrated progress towards the achievement of the outcomes set out in the Health and Wellbeing Strategy;

(c) Choose some qualitative indicators which would provide information about people's experiences of the services or interventions;

(d) Avoid the creation of artificial measurements or those that would create perverse incentives;

(e) Choose indicators that demonstrated what was happening at a local level; and

(f) Adopt a balanced scorecard approach to presenting the information.

(5) RESOLVED:

(a) That the contents of this paper be noted and the proposal for developing a Kent wide assurance framework be agreed in principle;

(b) That the development and ownership of the dash board for regular monitoring of the agreed indicators be approved;

(c) That the chairman writes to all members of the board summarising the discussion and inviting further feedback on the indicators to be included in the framework.

(d) That a further iteration of a Kent Framework for System Assurance be presented to the next meeting of the Health and Wellbeing Board.

26. Integrated Pioneer Programme Bid - Delivering the Vision
(Item 9)

(1) Anne Tidmarsh (Director of Older People and Physical Disability) introduced the paper, which included Kent's joint submission to the Department of Health's Integrated Pioneer Programme and proposed that work to deliver integrated care and support started immediately without the need to wait for the results of the bid in September. The paper also proposed the creation of a group to co-ordinate the work programme and asked how the HWB could embed this work into future health and wellbeing strategies.

(2) During discussion there was general agreement that as the integration of health and social care services would be designed to meet local needs it would be appropriate for the CCG level health and wellbeing boards to drive activity and report progress with the KHWB undertaking a strategic co-ordinating role.

(3) RESOLVED:

(a) That work to deliver the vision described in the Kent Integration Pioneer Bid submission be supported.

(b) That the governance arrangements be considered at a further meeting of the Health and Wellbeing Board and that Anne Tidmarsh, supported by Ian Ayres, prepare the report for this item.

27. Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline
(Item 10)

(1) Andrew Scott-Clark, Director of Public Health Improvement, introduced the report which sought approval of the timeline within which the Kent Joint Strategic Needs Assessment and the Kent Joint Health and Wellbeing Strategy would be produced in order to inform future health and care commissioning plans.

(2) RESOLVED:

(a) That the difference between Joint Strategic Needs Assessments and Health and Wellbeing Strategy be noted;

(b) That the proposed timeline for production of both the Kent JSNA and the Kent Health and Wellbeing Strategy be approved.

28. Working Arrangements Between Boards
(Item 11)

(1) Michael Thomas-Sam (Strategic Policy Adviser) introduced the report which set out proposals intended to clarify the relationship between boards including the Kent Safeguarding Children's Board, the Kent and Medway Safeguarding Vulnerable Adults' Board and the Kent Children and Young People's Joint Commissioning Board that have distinctive but complementary roles for promoting health and wellbeing and the safety of children and vulnerable adults in Kent.

(2) There was general agreement that the proposal was a practical way forward but that further development regarding Section 75 agreements should come as a result of other projects such as the pioneer work.

(3) RESOLVED:

(a) That the development of a working protocol as outlined in paragraph 5.5 of the report be endorsed;

(b) That a draft protocol be considered at the next meeting of the Health and Wellbeing Board on 18 September 2013;

(c) That it be a long-term objective of the Health and Wellbeing Board to take delegated responsibility for all Section 75 agreements but that this develops over time from integration projects such as Pioneer rather than being implemented in advance of them.

29. West Kent CCG - Mapping the Future (Verbal Update)
(Item 12)

(1) Dr Bowes gave a short presentation on developing a blueprint for a sustainable health care system for West Kent.

(2) He said all providers agreed that change was necessary and a series of workshops with patients, the voluntary sector providers and commissioners from health and social care had been held to consider how services might be delivered differently in the future. He said there was general agreement at the workshops that change was required and concluded by showing a map of provision in which providers had moved to a collaborative and non-competitive way to deliver re-configured services.

(3) RESOLVED:

(a) That the presentation be noted;

(b) That a further report be considered at a future meeting of the Health and Wellbeing Board.

30. System Leadership - Integrated Commissioning (Verbal Update)
(Item 13)

This agenda item was deferred to a future meeting as the consultants who were due to give a presentation were unable to attend.

31. Kent's Initial Stock-take of Progress against the Winterbourne View Concordat Commitment
(Item 14)

(1) Andrew Ireland (Director of FSC) introduced the report which gave an overview of the Winterbourne View Concordat, Kent's stock-take of progress against the commitments made in the Winterbourne View Concordat and actions to date. He said that this work was considered regularly by the Safeguarding Vulnerable Adults' Board and that Norman Lamb, Minister of State for Care and Support, had recently written to all health and wellbeing boards, stating his expectation that health and wellbeing boards would play a fundamental role in promoting and monitoring the work being undertaken in delivering the vision outlined in the Concordat and that the stock-take would provide a local assurance tool for health and wellbeing boards.

(2) RESOLVED:
(a) That Kent's initial stock-take of progress against the Winterbourne View Concordat Commitment be noted;

(b) That Kent's delivery of the programme to date be noted.

32. Date of Next Meeting 18 September 2013 at 6.30pm
(Item 16)

Kent Safeguarding Children Board

By: Maggie Blyth, Independent Chair of Kent Safeguarding Children Board

To: Kent Health and Wellbeing Board

Date: 18th September 2013

Subject: Kent Safeguarding Children Board – 2012/13 Annual Report

Summary: This attached annual report from the Independent Chair of Kent Safeguarding Children Board describes the progress made in improving the safeguarding services provided to Kent's children and young people over 2012/13, and outlines the challenges ahead over the next year.

Classification: Unrestricted

Recommendation: Board Members are asked to NOTE the progress and improvements made during 2012/13, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board

1. Introduction

(1) This report presents the 2012/13 Annual Report produced by the Independent Chair of Kent Safeguarding Children Board (KSCB). Current Government guidance captured in Working Together to Safeguard Children (2013) sets out the requirement introduced through The Apprenticeship, Skills, Children and Learning Act 2006 for Local Safeguarding Children Boards to produce and publish an annual report. This report provides a rigorous and transparent assessment of the effectiveness of local child protection arrangements and has been designed for circulation to all front line staff working with children across Kent.

(2) This report identifies progress across Kent in improving the child protection system and also identifies areas of vulnerabilities and what action is being taken to address challenges where they remain.

(3) The Annual Report includes lessons from management reviews, serious case reviews and child deaths within the reporting period.

(4) In Working Together 2013, (recently issued by the Department for Education), it is recommended that once the report is published it should be submitted to the Chief Executive (where one is in situ) and Leader of the Council, the local Police and Crime Commissioner and the Chair of

the Health and Wellbeing Board. This report has also been distributed to front line staff.

(5) KSCB is forceful in carrying out its scrutiny role in overseeing child protection arrangements in Kent and findings from its multi agency audits, Section 11 audits and all SCRs can be found on the KSCB website.

2. The 2012/13 Annual Report

(1) The report details the continued progress made by agencies to ensure that children in Kent are safe. Progress has continued this reporting year with caseloads and inappropriate referrals to Specialist Children's Services reducing. They remain below average compared to Kent's statistical neighbours.

(2) As the report indicates, the number of children with a Child Protection Plan (CPP) has risen slightly from 959 in March 2012 to 994 in March 2013. This is still below half the numbers of two years ago. KSCB is satisfied that the numbers have stabilised and are in line with those of our statistical neighbours. KSCB has noted that the numbers of children on CPP for a second or subsequent time remains high and that a focus must remain on ensuring that all agencies have a common understanding of thresholds for child protection intervention.

(3) Kent agencies have invested in a new early intervention strategy during 2012- 2013 which aims to provide swift support to children before a referral to Specialist Children's Services is required. Ofsted found this service to be working well. During the year KSCB has noted the improved use of the Common Assessment Framework (CAF) but identified continued barriers to its use across some sections of the health economy.

(4) Ofsted identified that interventions for children in need (CIN) across Kent were inconsistent which reinforces the need for KSCB scrutiny across the partnership about support given to this group of children.

(5) There has been significant progress over the last 12 months in how Kent is responding to the risks highlighted by the Children's Commissioner and more recently, the HO Select Committee, to children at risk of child sexual exploitation (CSE). KSCB has developed training for front line staff and a toolkit for assisting in identifying and assessing risk of CSE and publicity material has been distributed, drawing attention to the signs that may indicate that young people are at risk of CSE. KSCB has published a report on unaccompanied asylum seeking children called 'Staying in Kent'.

(6) To ensure that the spotlight is retained on those young people at risk of going missing, trafficking and CSE the focus of the KSCB conference in 2013 will be on these areas. During this reporting year 18 UASC went missing and did not return. KSCB is requiring statutory agencies to understand more clearly the trends relating to children missing in Kent to

ensure that the most vulnerable young people are supported at the right time.

(7) Specific challenges are highlighted around action taken to learn lessons from cases when things go wrong and where children are the subject of neglect, harm or abuse from their carers or other adults around them.

(8) KSCB is committed to publishing the findings from all SCRs and has placed the overview reports from two SCRs and one management review into the public domain during this reporting year. Although there were no new SCRs commissioned during the last year, there was one SCR that concluded. Other non SCR case reviews have been undertaken and the lessons from all of these cases have influenced the focus of KSCB's multi-agency learning and development strategy and training programme. KSCB obtains assurance from all Kent agencies that actions following these reviews are properly monitored and progress evidenced.

(9) During this reporting period KSCB has undertaken a number of multi agency audits to understand what is happening across different front line settings in protecting children. A Section 11 audit was undertaken with statutory agencies across Kent which asked each partner agency to provide evidence to the Board on how they are meeting the many aspects of their safeguarding responsibilities.. Where specific action has been required by certain agencies to improve their contributions, KSCB is closely monitoring this to ensure all agencies are discharging their safeguarding duties.

(10) The work of supporting Kent's 1831 Children in Care (including 190 unaccompanied asylum seeking children), as well as the 1194 looked after children placed by other local authorities in the county, continues to place massive pressures on public agencies responsible for supporting vulnerable children in Kent, including children's social services, schools, police, and health services. KSCB will continue to seek evidence that Kent agencies are adequately able to care for all children placed in the County and supports more rigorous risk assessments for children placed in Kent by other authorities.

(11) The Annual Report states that while dental and health checks for Children in Care have improved significantly there remain concerns about assessment and treatment of vulnerable groups of children with emotional wellbeing and mental health needs. Waiting times in the West of Kent have reduced significantly in recent weeks but KSCB will continue to require NHS representatives to report on progress in this area.

3. Conclusions

(1) Kent agencies have worked hard to ensure that the failings identified in 2010 by Ofsted have been addressed. Overall, the Independent Chair of KSCB is satisfied that progress has been made and that the child protection system in Kent has improved. However, challenges remain to ensure that there is a common understanding of thresholds in Kent; that

partnership agencies in Kent are suitably equipped to support the most vulnerable children and young people; and that those children identified as children in need are supported by all partner interventions.

(2) The revised Improvement Notice places specific expectations on KSCB. During 2013/14 KSCB is requiring all agencies in Kent to demonstrate improved outcomes for children in relation to safeguarding and will be reporting on this to the Improvement Board. Through its new Quality Assurance Framework intelligence will be shared across agencies and members of KSCB are expected to provide single agency reports on progress and participate in Executive walk-abouts of front line settings.

(3) Furthermore, there are specific challenges for Kent agencies in supporting those children and young people at risk of trafficking and sexual exploitation and understanding why certain groups of children, including some unaccompanied asylum seeking children, go missing.

4. Recommendation

(1) Board Members are asked to:

(a) NOTE the progress and improvements made during 2012/13, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board

5. Background Documents

None

6. Contact details

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Kent Safeguarding Children Board

KSCB Annual Report 2013

Safeguarding the children of Kent

FOREW0RD

"I would like to thank members of KSCB and its sub-groups for their continued energy, hard work and commitment to safeguarding children, both individually and collectively as we look forward to the next 12 months." *Maggie Blyth*

A FOREWORD FROM THE INDEPENDENT CHAIR
Maggie Blyth

The Kent Safeguarding Children Board (KSCB) is a partnership working to safeguard and promote the welfare of children in Kent.

This annual report describes the main achievements of the Board and partners during 2012/13 and outlines the priority areas on which the KSCB will focus in 2013/14.

Our aim has been to concentrate our attention on the safety of children who are most vulnerable and at risk of harm and ensure that positive outcomes for children remain a priority. During this year we focussed on necessary improvements to the child protection system looking at the numbers of children on child protection plans, reducing the numbers of re-referrals into Specialist Children's Services and concentrating on increasing the numbers and quality of different agencies' use of the Common Assessment Framework (CAF).

KSCB oversees a number of subgroups who deliver the workstreams of the Board.

These subgroups comprise:

Quality and Effectiveness
Learning and Development
Serious Case Reviews
Child Death Overview Panel
Health Safeguarding Group
Safeguarding in Education Advisory Group
Kent and Medway Trafficking Children and Sexual Exploitation Subgroup

The work of each of these subgroups and their achievements during 2012/13 are described in the body of this annual report.

A FOREWORD FROM THE INDEPENDENT CHAIR
Maggie Blyth

Kent Safeguarding Children Board

As in previous years we will focus our attention on selected areas to support continued improvement. KSCB will monitor these through the strategic priorities set out in its new plan for 2013/14; to improve outcomes for all vulnerable children in Kent and ensure that partnership arrangements for child protection are truly fit for purpose.

We will continue to hold all agencies to account through audit of cases, analysis of data and visiting front line settings to ensure children are protected and action is taken by staff working in health, social care, police, probation and education settings. We will also be extending our Section 11 audit (Children Act 2004; regarding arrangements for safeguarding and promoting the welfare of children) to include voluntary sector organisations in Kent.

OUR MAIN TASKS:

Develop policies and procedures to guide the day to day safeguarding practice in line with the revised statutory guidance 'Working Together' 2013.

Embed the quality assurance framework which will enable the KSCB to have a better overview about the quality of front line practice and the impact of those services in helping families to achieve positive outcomes and keep children safe.

Scrutinise front line practice by undertaking multi-agency audits and deep dives, exploring in depth the management information about the child protection system and asking children and families their views about how helpful they have found the services they have received.

Learn from reviews of individual cases, whether through Serious Case Reviews, other management reviews or from exploration of good practice.

Focus on the safeguarding needs of those children at risk of child sexual exploitation or trafficking.

Evidence improvements to outcomes for children in need across the partnership.

Ensure that child and adolescent mental health services are well co-ordinated and able to help children not just when their needs become severe, but also at an earlier stage when difficulties are emerging.

Data in this report is provisional, pending submission of statutory returns from KCC. This report is intended for all front line practitioners working with children in Kent. For fuller information on all multi agency audits, SCRs and S11 returns please see KSCB website.

CHAPTER 1

HOW SAFE ARE OUR CHILDREN & YOUNG PEOPLE IN KENT?

There are 322,700 children and young people (0-17 year olds) living in Kent, making up 22% of the population. It is impossible to offer a complete picture of the children whose safety is at risk in Kent because some abuse or neglect may be hidden, despite the best efforts of local services to identify, step in and support children who are being harmed. In Kent, trafficked children who arrive at British ports to be transported throughout the country are vulnerable because their traffickers work hard to keep them 'invisible'. In other cases, families themselves mask abuse or neglect and neighbours may turn a blind eye to a child's need for protection.

KSCB places a statutory responsibility on agencies in Kent to provide assurance that they are working hard to ensure that all children and young people in Kent stay safe and are adequately protected.

Many groups of children in Kent are vulnerable. They include children who are privately fostered, children missing from home and children missing from education; children who live in households where there is domestic violence, substance misuse and/or parents are mentally ill; children whose offending behaviour places them at risk of significant harm; children in custody who are at risk of significant harm; and children for whom the release of an offender places them at risk of harm.

This Annual Report of the work of KSCB starts by looking at the categories of children and young people in Kent who have been identified by the Local Authority and other agencies as in need of protection.

CHAPTER 1

HOW SAFE ARE OUR CHILDREN & YOUNG PEOPLE IN KENT?

Children with a Child Protection Plan

Children who have a Child Protection Plan (CPP) are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of one or more of these factors.

The CPP details the main areas of concern, what action will be taken to reduce those concerns, how the child will be kept safe, and how we will know when progress is being made.

During 2012/13 the numbers of children on CPPs have stabilised. After dropping significantly from 1,621 in March 2011 to 959 in March 2012, they currently sit at 994 in March 2013. KSCB requires regular analysis of this information to ensure that the figures reflect statistical neighbours. KSCB is satisfied that currently cases are reviewed with care and children provided with a range of interventions if they are no longer considered in need of protection.

Children in Care

Children in Care (CIC) are those looked after by the local authority. As at the 31st March 2013 there were 1,831 Children in Care in Kent, (included in this figure are 190 Unaccompanied Asylum Seeking Children (UASC)). Kent also has 1,194 CIC from other Local Authorities placed within its boundaries.

Only after exploring every possibility of protecting a child at home will the local authority seek a court decision to move a child away from his or her family. Such decisions, while incredibly difficult, are made when it is the best possible option to ensure the child's safety and wellbeing.

The number of CIC has remained reasonably static during the year. All of these children are subject to regular independent review to ensure their situations are being constantly evaluated.

In addition, during 2012/13 there were 143 UASC who arrived at Kent ports and for whom agencies in Kent provided a service.

The work of supporting Kent's 1,831 looked after children (including 190 unaccompanied asylum seeking children), as well as the 1,194 looked after children placed by other local authorities in the county, is placing massive pressures on public agencies responsible for supporting vulnerable children in Kent, including children's social services, schools, police and health services.

CHAPTER 1

Trafficked children and asylum seekers

Some of the most vulnerable children in Kent arrive in Dover each year seeking entry into the UK. Most turn up seeking asylum whilst others have been trafficked for exploitation. Where the UK Border Agency identifies unaccompanied children, they pass responsibility for these children to Kent County Council. There are significant child protection implications in how the local Immigration Team in Kent organises the processing arrangement for these children, and also for the police and the local authority in how they deal with or receive these highly vulnerable children.

KSCB remains concerned that this group of children must be seen as a high priority and during 2012 commissioned a follow up to the Children's Commissioner's report on children's experiences 'Staying in Kent'. KSCB has identified that some children and young people are going missing from care and are never found.

Between 1 April 2012 and 31 March 2013, 18 UASC (under 18 year olds) went missing and have not returned. KSCB has established a specialist group to understand why some children go missing and how this might be prevented.

Child Sexual Exploitation

KSCB has responded to the risks highlighted by the Children's Commissioner during 2012 to children at risk of Child Sexual Exploitation (CSE). KSCB has through its Trafficking Sub Group launched a new Toolkit for staff and has provided training on CSE to front line practitioners.

Funding from the government has allowed KSCB to develop some innovative training materials including a podcast for use with front line staff in understanding how to work with children at risk of CSE.

Achievements during 2012/13 have been

- Distributing the CSE Toolkit to front line staff working in all services with children across Kent
- Producing publicity material drawing attention to the signs that may indicate young people are at risk of CSE
- Independent Chair and Lead Member speaking at a national conference about the challenges facing local agencies in understanding the extent of CSE in any area
- Commissioning the report 'Staying in Kent'

Child and Adolescent Mental Health Services

KSCB has remained concerned during the year that many young people, particularly those resident in West Kent, have had to wait a very long time before being assessed or being given treatment through Child and Adolescent Mental Health Services (CAMHS). Some waiting lists are well over 20 weeks and this is unacceptable.

KSCB is seeking reassurance from the NHS that these waiting times are being reduced and has requested the partnership review the different referral pathways for children with a wide range of mental health or emotional wellbeing needs. Between August 2012 and March 2013 there has been improvements but this remains an area of concern for KSCB.

CHAPTER 1

HOW SAFE ARE OUR CHILDREN & YOUNG PEOPLE IN KENT?

Adolescents at Risk

The Youth Offending Teams across Kent have an average caseload of 430 of whom 40% are likely to be also supervised by Specialist Children's Services and the 16 plus Leaving Care Service. Those in custody / leaving custody will frequently have profound safeguarding needs which may have been unmet. During 2012/13 the downward trend in the numbers entering custody at either the remand or sentencing stages continued, with the average in the Secure Estate at any one time being approximately 25, the majority of whom will be young males aged 15+ years. KSCB is supportive of the requirements of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 which mean that all children and young people remanded to Youth Detention Accommodation have the status of a "child in care" and that as a result youth offending teams and Specialist Children's Services have joint responsibility for their welfare.

The downturn in the economy has had a marked effect on young school leavers looking for work, leading to a continuing increase in the numbers of young people not in education, employment or training in Kent, rising to 6.33% in November.

Children who are adopted

During 2012/13 105 children have been adopted in Kent, compared to 70 in the previous year. KSCB has been assured that the partnership between KCC and a voluntary organisation, CORAM, has worked well to help achieve this success. An Ofsted inspection of adoption services in March 2013 concluded that significant progress has been made in Kent in achieving positive outcomes for children awaiting adoption.

The Early Offer in Kent

Kent agencies have invested in a new early intervention strategy during 2012/13 which aims to provide swift support to children before a referral to Specialist Children's Services is required. Ofsted found this new service to be working well and KSCB has been assured that the early offer has helped keep the overall number of child protection referrals to Specialist Children's Services from some agencies steady.

Disabled Children

During 2012/13, KSCB introduced new guidance for professionals working with children with disabilities.

Following concerns that this group of children were not sufficiently prioritised, KSCB and the Children' Society hosted a conference in September 2012 for front line staff.

From January 2012 the Disabled Children's teams, including the Sensory team, have managed Child Protection investigations for disabled children, ensuring that their specialist knowledge of factors that impact disabled children are fully taken into account. Joint working and training between multi-agency partners continues to be undertaken to raise the awareness of all professionals of the particular vulnerabilities of disabled children and how they should be protected. National evidence shows that disabled children are three times as likely to suffer harm as a result of neglect or abuse.

CHAPTER 1

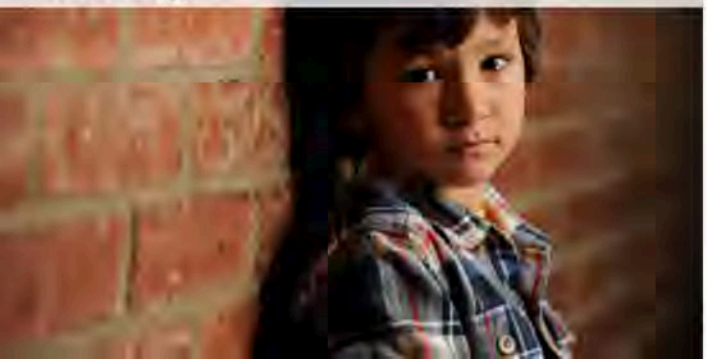
Children exposed to domestic abuse

Evidence from analyses of serious case reviews nationally in 2012 revealed that domestic abuse was present in almost three-quarters of families whose children died or sustained serious injury due to maltreatment.

Whenever a child is identified as being part of a household where there is a domestic abuse incident, the Central Referral Unit manages and shares that information between agencies so that appropriate support and further assessment can be provided".

The number of repeat incidents of domestic abuse where a child or young person was present has decreased recently; to 24.3% at the end of December 2012 from over 35% at the end of June 2011.

Agencies in Kent are funding a number of Independent Domestic Abuse Advisors and KSCB believes this may see the numbers of children identified at risk of domestic abuse increasing.



Who is responsible for protecting Kent's children and young people?

Everybody has a part to play in protecting children. Local communities can help by identifying what is happening in their areas. Safeguarding is everybody's business.

But ultimately when there remain serious concerns about harm to a child, a referral is made to Specialist Children's Services.

Most contacts and referrals into Specialist Children's Services come from all sorts of other professionals such as police officers, teachers, health visitors, midwives, nurses, GPs, mental health professionals or other specialist services. Specialist Children's Services, to make their decisions, need lots of information from the person making the referral. All professionals have a responsibility to ensure that accurate information is provided swiftly and shared promptly.

We are developing a common understanding of the levels of need in Kent – or what is sometimes known as agreement over 'thresholds'.

During 2012/13 KSCB has offered training to all staff in establishing a common understanding of levels of need in Kent.

On-going audits undertaken by KSCB suggest that much more inter agency collaboration could have taken place before some referrals were made to satisfy the referrer of the best course of action to take before a specialist intervention from Specialist Children's Services was considered essential.

Re-referrals into Specialist Childrens's Services are about 23% which, although a reduced number from the year before, suggests that there are still different views amongst professionals about what constitutes a child at risk.

During 2012, Kent Specialist Children's Services, Education, Police and different health professionals have worked closely to form Kent's first Central Referral Unit - where front line professionals are now working together to improve communication and joint working in how best to respond to children in need in the County.

Central Referral Unit

"The Central Referral Unit facilitates more consistent threshold application between agencies, reduces duplication, promotes more effective information sharing and thereby promotes more timely and targeted intervention for children and their families."
Mairead MacNeil,
Director, Specialist Children's Services

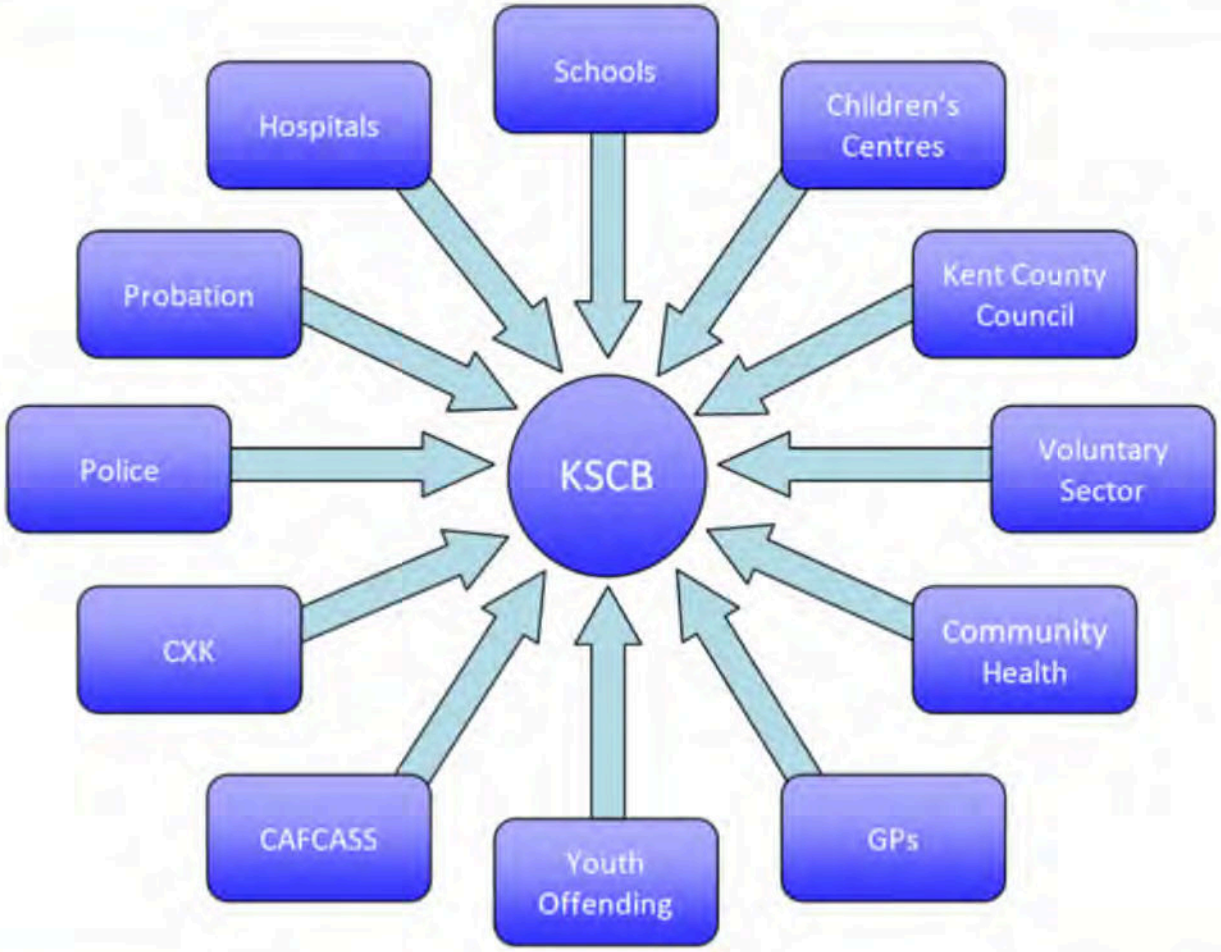
CHAPTER 2

WHAT IS THE KENT SAFEGUARDING CHILDREN BOARD?

The Kent Safeguarding Children Board

The KSCB is the partnership body responsible for coordinating and ensuring the effectiveness of Kent services in protecting and promoting the welfare of children and young people.

The Board is made up of senior representatives from all the main agencies and organisations in Kent concerned with protecting children.



What is the purpose of the KSCB?

The Kent Safeguarding Children Board provides a vital link in the chain between various organisational efforts, both statutory and voluntary, to protect children and young people in Kent. Our aim is to ensure that all these efforts work effectively in coordination so that children and their families experience a harmonious and 'joined up' service.

MAPPING THE MULTI AGENCY JOURNEY FOR CHILDREN

The KSCB is responsible for scrutinising the work of its partners to make certain that the services provided for children and young people in Kent are effective and actually make a difference. The effectiveness of KSCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

KSCB is responsible for raising awareness of child protection issues in Kent so that everybody in the community can play a role in making our county a safer place for children and young people to grow up. Our message is that protecting children from harm really is everyone's business.

CHAPTER 2

What are the main roles for the Kent Safeguarding Children Board?

The roles for the KSCB are set out in its constitution, which was updated in March 2013 and includes the following:

- Developing policies, standards, and procedures for safeguarding and promoting the welfare of children

- Monitoring and evaluating the effectiveness of what is done by agencies and organisations both collectively and individually, to protect children and young people

- Recommending areas and priorities for the commissioning of children's services

- Raising awareness of, and communicating, child protection issues to individuals and organisations

- Establishing and carrying out a review in cases where a child has died or has been seriously harmed in order to advise on lessons that can be learned (known as Serious Case Reviews)

- Ensuring the provision of single agency and multi-agency training on safeguarding to meet the need of local staff

See Chapter 3 for more information on KSCB's work in each of these areas.

Membership and structure of KSCB

Having explained the main priorities for safeguarding children in Kent, this section contains information about who is involved on the board and how it is organised.

KSCB has three tiers of activity:

1. Main Board

This is made up of representatives of the member agencies, as outlined in statutory government guidance. Board members must be sufficiently senior so as to ensure they are able to speak confidently and sign up to agreements on behalf of their agency and make sure that their agency abides by the policies, procedures and recommendations of KSCB.

A full list of KSCB's membership for 2012/13 is available in Appendix A.

2. The Executive Board

The Executive body is made up of chief officer representatives from the statutory member agencies. The Executive has strategic oversight of all Board activity and takes the lead on developing and driving the implementation of the Board's main activities and 'Business Plan'. It is also the body responsible for holding to account the work of sub-groups and their chairs.

3. Subgroups

The purpose of KSCB subgroups is to tackle the various areas of concern to the KSCB on a more targeted and thematic basis. The subgroups report to the Executive Board and are ultimately accountable to the main Kent Safeguarding Children Board.

A diagram of the structure of KSCB – including information on its subgroups - is available in Appendix B.

CHAPTER 2

KEY ROLES

Independent Chair

All Local Safeguarding Children Boards (LSCB) appoint an Independent Chair who can bring expertise and a clear guiding hand to the Board to make sure that the LSCB fulfils its roles effectively. The Independent Chair also frees up the Board members to participate on an equal footing, without any single agency having the added influence of chairing the Board.

Maggie Blyth was recruited to this position in April 2011 and during the last year was employed by KSCB for approximately 6 days a month. The Chair is subject to an annual appraisal to ensure the role is undertaken competently and that the post holder retains the confidence of the KSCB members. WT 2013 states that Independent Chairs should be accountable to the Chief Executive of a local authority and in Kent, the role is accountable to Andrew Ireland, the Corporate Director of Families and Social Care.

Director of Children's Services

The Families and Social Care Corporate Director in Kent is required to sit on the main Board of KSCB as this is a pivotal role in the provision of adult and children's social care within the Local Authority. This post is held by Andrew Ireland and he has a responsibility to make sure that the KSCB functions effectively and liaises closely with the Independent Chair who keeps him updated on progress.

Leader of Kent County Council

The ultimate responsibility for the effectiveness of the KSCB rests with the Leader of Kent County Council, Paul Carter. The Families and Social Care Corporate Director is answerable to the Leader, who forms the final link in this chain of accountability.

Lead Members

The Lead Member for Specialist Children's Services is the name given to the councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. In Kent, during 2012/13 Cabinet Member Jenny Whittle held this role. Councillor Whittle contributes to the KSCB as a 'participating observer'. This means that she takes part in the discussion, asks questions and seeks clarity, but is not part of the decision-making process.

Lay Members

KSCB has appointed two lay members – that is local residents – to support stronger public engagement in local child protection and safeguarding issues and contribute to an improved understanding of the LSCB's work in the wider community. In Kent, Roger Sykes and Mike Stevens play this role. From 2013 these roles will be advertised bi annually.

CHAPTER 2

KEY RELATIONSHIPS

Children and Young People's Joint Commissioning Board

The KSCB reports annually to this body on the matters facing children and young people at risk in Kent and we hold them to account to ensure they commission the services that are needed based on what we have highlighted as safeguarding priorities.

The Health and Wellbeing Board

The Health and Wellbeing Board (HWB) took on new responsibilities in April 2013. Clear lines of accountability have been developed with KSCB who will report annually to the HWB and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Kent.

Member Agencies' Management Boards

KSCB Board members are senior officers within their own agencies providing a direct link between KSCB and the various agencies' boards.

During 2012/13 Kent agencies have been subject to major public sector reform – particularly the NHS – and communication lines sometimes change. It's essential that the management boards of each statutory agency in Kent cement a close connection with the Safeguarding Children Board and invest in its work.

Clinical Commissioning Groups

During 2012/13 the arrangements in Kent for new GP commissioning were developed. There are now 8 Clinical Commissioning Groups (CCGs) across Kent and Medway and they will be important contributors to the KSCB in the coming year. Safeguarding responsibilities remain inherent to all CCGs but Medway CCG will host the NHS designated safeguarding team.

Police and Crime Commissioner

KSCB has welcomed the focus of the new Police and Crime Commissioner's (PCC) drive to support young people at risk and her commitment to protecting the most vulnerable children.

CHAPTER 2

FINANCIAL ARRANGEMENTS

During 2012/13 contributions from partners remained steady at £300,672. The variable income available to the Board this year was £264,050 which included residual funds of £674,879 brought forward from 2011/12.

With a total income of £1,275,154 and expenditure of £673,885 this ensured the overall costs of running KSCB were met as they could not have been covered solely by the contributing partners.

THE FULL FINANCIAL BREAKDOWN CAN BE FOUND AT APPENDIX C.

Working Together 2013

In April 2013 the government published new guidance for all agencies working to protect children. While this document was not in place for the period of this Annual Report, KSCB has worked hard during the year to enhance its scrutiny role in preparation for the new guidance. Particular emphasis has been placed on learning from work with children where partnership working has gone well in addition to a focus on system improvement where tragically children have suffered harm.

CHAPTER 3

The Child's Journey through the system in Kent

..... a summary

In February 2013 Ofsted published the results of its unannounced inspection of safeguarding arrangements in Kent.

Two years on from stating that services were failing children, the inspectors announced that all standards of child protection in Kent were 'adequate'.

They found no children at risk in the cases they observed.

Inspectors concluded that partnership work with children in need was still variable.

- The number of referrals to Specialist Children's Services has continued to fall during 2012/13. In March 2013 figures indicated 442 per 10,000 population (14,267) from 538.4 per 10,000 population at end of March 2012. KSCB has sought assurance from partner agencies that agencies continue to apply a common understanding of thresholds before contacting Specialist Children's Services with concerns over cases.

- The numbers of re-referrals continues to be higher than statistical neighbours at 22.8%. However, there has been a sustained downward trajectory during the year.

- The number of children with a child protection plan has risen slightly from 959 in March 2012 to 994 in March 2013 but has fallen to about half what the numbers were two years ago. KSCB is satisfied that the numbers have stabilised in line with statistical neighbours.

- The numbers of children on a child protection plan for the second or subsequent time is 19.5%. This remains high and a priority for KSCB to monitor during the coming year.

- Services for the 1,831 children in care have improved. Dental and health checks sit respectively at around 90% completion. For asylum seeking children in care 85% have had relevant health checks completed within the required timescales.

- There are an additional 1,194 children placed in Kent by other local authorities.

- S11 returns completed in December 2012 for agencies working with children across Kent found that all organisations were compliant with the requirements of this audit. To further test these self assessments KSCB has put in place a peer review procedure.

- KSCB audits undertaken through the year emphasise that the voices of children are well represented at child protection conferences and that the majority of parents taking part believe any review of their circumstances to have been a positive experience. There is evidence that improvements can be made to ensure all key agencies are represented at conferences.

- There have continued to be improvements in the timelines with which children are assessed and seen within set timeframes across all districts. All children are allocated a qualified social worker.

- Children with specialist mental health needs in West Kent continue to wait several weeks before being assessed for treatment. A target has been set to reduce this to no more than 4/5 weeks by June 2013.

CHAPTER 3

ACHIEVEMENTS 2012 / 2013

Increasing scrutiny, quality and effectiveness

What did we do? How well did we do it?

During 2012/13 the Quality and Effectiveness subgroup has been responsible for leading KSCB's work in this area, with the aim to drive the quality of service improvement and delivery of outcomes vigilantly, transparently and consistently across the partnership.

Key achievements included:

- The Quality and Effectiveness Framework has been accompanied by training for all agencies

- A dedicated performance analyst post commenced employment in January 2012

- A programme of multi agency audits has continued throughout Kent

Listening to the voice of children

What did we do? How well did we do it?

This year we have launched our new KSCB website and information about safeguarding and the work of the Board is now easily accessible. We have continued to listen to the views of children and young people about what they see as priorities for safeguarding.

The challenges ahead

Continuing the work to improve KSCB's approach to performance management and quality assurance in a way that strengthens the scrutiny and challenge role of KSCB is our main priority. This year has shown that data surrounding children at risk of sexual exploitation or trafficking is not sufficiently robust to indicate trends. We are putting this right.

The data also shows KSCB that concerted effort needs to remain in holding all partners to account in improving outcomes for children in need, to ensure they get the right help at the right time.

NB Detail on findings from all multi agency audits can be found on the KSCB website.

CHAPTER 3

Safeguarding Children in Education

Kent County Council's Education, Learning and Skills Directorate plays a crucial role in ensuring that the statutory duties placed on schools and local authorities (education functions) are carried out effectively.

Section 175 of the Education Act 2002 and related statutory guidance places specific responsibilities on schools to safeguard children and promote their welfare. It is the role of the local authority to provide support, training and challenge to schools (including academies) and early years settings.

The level of safeguarding activity carried out by the Education, Learning and Skills (ELS) Children's Safeguarding Team is reported to the KSCB's Quality and Effectiveness subgroup on an annual basis. This includes information on the number and nature of consultations with schools and settings, allegations against teaching staff and the volume of child protection training rolled out across the county.

Although Ofsted Inspections of schools no longer apply a limiting judgement to safeguarding arrangements this is still scrutinised as part of the school's Leadership and Management function.

Support and intervention for schools is provided when weaknesses are identified in inspection reports, but safeguarding in schools and early years settings is now rarely judged to be weak. The safety and welfare of children is a priority as a child who does not feel safe in school will not be motivated to learn. Work is ongoing to establish what additional data reporting to KSCB from Education is required to enhance the multi-agency perspective on how we are doing in terms of keeping children safe.

KSCB oversees an Education Sub Group (Chaired by the ELS Corporate Director) which has a number of representative Headteachers and Heads of Education Services involved in carrying out the work of the Board at a local level.

In the past year there has been good progress in reviewing and agreeing the ELS Policy Statement on safeguarding; completing the Education Section 11 audit; and procuring a secure e-mail system that allows schools to submit reports online prior to Child Protection Case Conferences as required as part of the Ofsted improvement plan.

CHAPTER 3

ACHIEVEMENTS 2012 / 2013

Report from Health Safeguarding Group

What did we do? How well did we do it?

During the year the Health Safeguarding Group (HSG) has reviewed critical safeguarding children areas including the work in health services on the common assessment framework, monitoring the progress of the new CAMHS provider, updates on serious case reviews and action plans and responding to the NHS reforms. 2012/13 has been a year of preparation for the implementation of NHS reforms, the most significant change in the NHS since its inception. The HSG has been seen as a stabilising factor during these rapid changes, a forum where health leaders for safeguarding children can continue to challenge and review the safeguarding issues for children who access health services. The HSG will continue to focus and respond to the NHS Safeguarding Accountability Framework.

Clinical Commissioning Groups (CCGs) have taken on the majority of the safeguarding responsibilities previously held by Primary Care Trusts (PCTs), along with the development of National Commissioning Board (now known as NHS England). During 2012/13, CCGs operated in 'shadow' form and needed training and development to ensure that they were ready for their statutory responsibilities. Sally Allum (now Director of Nursing, NHS England: Kent and Medway) will continue to chair the HSG during 2013/14 in partnership with CCG Chief Nursing Officers.

Common Assessment Framework

KSCB set a target to increase the total numbers of CAF by 15% during 2012/13. This has been achieved. The establishment of Early Intervention Teams in each district has been central to the increase in CAFs and building relationships across multi agency partners to increase confidence in the use of CAF. In March 2013 there were 2424 families in Kent supported with a Team around the Family (TAF) in place. Out of these cases, 61% were closed (1054 cases) with a positive outcome with just over 17% escalated to children's social care (301 cases).

Kent Community Health NHS Trust (KCHT) reported that an audit of how their staff applied thresholds showed that they used them appropriately. During 2012/13 KCHT completed 229 CAFs which meant that early and often intensive support was made available to children and families.

Kent is on target to achieve the growth in Health Visitor numbers set out in the Health Visitor Implementation Plan, which recommends that numbers are increased from 154 in 2011 to 342 in March 2015.

Case Study

A KCHT school nurse sought advice about a 5 year old boy who appeared to be neglected at home. Concerns were raised about domestic abuse towards the mother from a new partner, just released from prison. The School Nurse liaised with the Health Visitor and a referral was made to Specialist Children's Services when bruising was seen on the mother's face and she was identified as suffering from postnatal depression. The boy was not taken to see a GP despite worsening health problems.

Following a case conference where more information was shared between front line staff the boy and sibling were taken into foster care.

CHAPTER 3

ACHIEVEMENTS 2012 / 2013

Update on the Department for Education intervention in Kent and the Improvement Plan'.

During 2012/13 KSCB reported on its progress to the Kent Improvement Board.

KSCB is assured that all aspects of the second phase of Kent's Improvement Notice were achieved and that services for children in Kent have been steadily improving.

Strategic Priorities for 2013 / 14

The Kent Safeguarding Children Board has three priorities for the coming year, as agreed in its business plan endorsed by members in February 2013.

1) positive outcomes for all children and young people in Kent.

KSCB will continue work in 2013-14 to reduce the number of 'inappropriate' contacts and referrals to Specialist Children's Services. Guidance and policies have been issued to partner agencies and members across the KSCB, offering greater clarity on how to make use of the Common Assessment Framework.

We will know we have made a difference when thresholds for access to services for children in need are understood across all agencies and cases of 'inappropriate' contact and referrals, including re-referrals, are reduced. We will monitor this through a series of audits and through regular reporting of the Quality Assurance Framework.

2) holding partner agencies to account for their part in collectively improving safeguarding of all children in Kent.

We will know we have made a difference when our audits show that assessments are robust, responsive and facilitate multi-agency working.

We will expect to see robust plans for children involving effective risk management across the partnership at all levels of intervention.

3) demonstrating a robust safeguarding partnership that can effectively undertake the work of Kent's Improvement Board.

Enhancing the competence and confidence of professionals across the whole system of safeguarding children to accept responsibility for, and work with partners to manage risk is the single biggest challenge we face. The Common Assessment Framework (CAF) is designed to ensure professionals across the sector – be they teachers, GPs, police or health visitors – carry out precise and detailed assessments of risk in every child's case and work together with other agencies to help build as complete as possible a picture of a child's needs.

Part of this is working to ensure children's needs are met at the earliest opportunity and families get the support they need quickly.

We will know we have made a difference when strategic plans and priorities of partner agencies reflect targets relating to CAF and when children and families are receiving the support they need in the community when they are closed to Specialist Children's Services.

CHAPTER 3

Multi Agency Training

What did we do? How well did we do it?

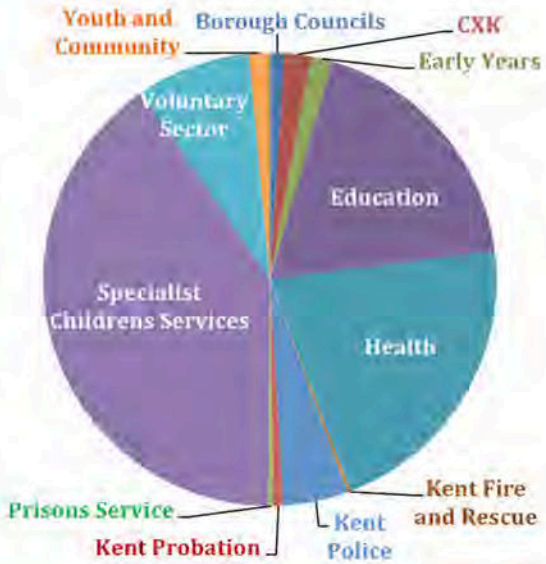
In November 2012 we held a Kent wide conference to which over 320 front line staff from different agencies attended. Speakers included the Children's Commissioner, Dr Maggie Atkinson, CEOP lead on missing children, Charlie Hedges and representatives from the DfE Safeguarding Unit (Jeanette Pugh).

We also organised a Safeguarding Summit in December 2012 for chief officers across Kent to understand the key challenges for the most vulnerable children in Kent.

The KSCB has a responsibility to ensure that appropriate child protection training is available to meet the multi-agency and Voluntary Sector training needs across Kent. It covers a variety of currently topical areas. We oversee training provided by single agencies to their own staff (monitored through the Section 11 audit); and multi-agency training offered through the Board and tailored to their specific needs. This also includes bespoke training offered to single agencies through the Board and tailored to their specific needs. KSCB's multi-agency basic awareness training delivered through the current KSCB College of Trainers (17 multi-agency and Voluntary Sector staff) continues to be an effective model of delivery.

The development of the 2012 -13 training programme was based on emergent themes from SCR's, operational good practice and Ofsted recommendations. Due to the developing nature of some of these themes, flexibility and evaluation of the training are important in order to produce a programme that is reflective of current topics. In total 100 courses were delivered in 2012-2013 with 2255 staff attending.

Training on the Eligibility and Threshold Criteria continued to be a priority for 2012-13 with 30 workshops delivered across the County to 1017 members of staff.



A new and developing learning programme this year has been the Immersive Learning sessions. Following the successful pilot of our first event, covering Child Abuse and Neglect, further courses are being developed and integrated into the 2013-14 training calendar.

Bespoke Training

The KSCB delivered 25 bespoke training sessions to a total of 355 staff working in Health, Childrens Services, District Councils, Kent County Council, Fostering Services and charities. The number of Voluntary Sector Staff receiving training is increasing, with 15 sessions delivered to 228 staff.

E-Learning

In 2012-13 a total of 1632 users registered to use the KSCB E-Learning training courses; this is an increase by over 300% compared to 505 users signing up in 2011-12.

CHAPTER 4

What happens when a child dies or is seriously harmed in Kent?

There are 2 processes for responding to a child death in Kent, depending on whether abuse or neglect is known or suspected to be a factor in the death:

The FIRST is called a Child Death Review Process.

Since 2008, Child Death Reviews have been a statutory requirement for Local Safeguarding Children Boards who are expected to review the circumstances of all children's deaths (up to the age of 18). In Kent the Child Death Overview Panel (CDOP) has oversight of the processes, ensuring that:

- reviews occur in a timely fashion;
- the information, support and investigation of each death is appropriate and compassionate;
- there is appropriate investigation or referral of any deaths where there are safeguarding or criminal issues;
- where issues or lessons emerge that have broader relevance, or public health implications, they are effectively disseminated;
- information is collated and reported to the Department for Education.

The SECOND is known as a Serious Case Review.

LSCBs are required to consider holding a Serious Case Review (SCR) when abuse or neglect is known or suspected to be a factor in a child's death and there are concerns about how professionals may have worked together.

The purpose of a SCR is to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; and
- as a consequence, improve multi-agency working when it comes to protecting children

KSCB takes seriously its responsibilities to ensure that lessons learned when children die or are seriously harmed are swiftly embedded and messages are used to support improvement across agencies.

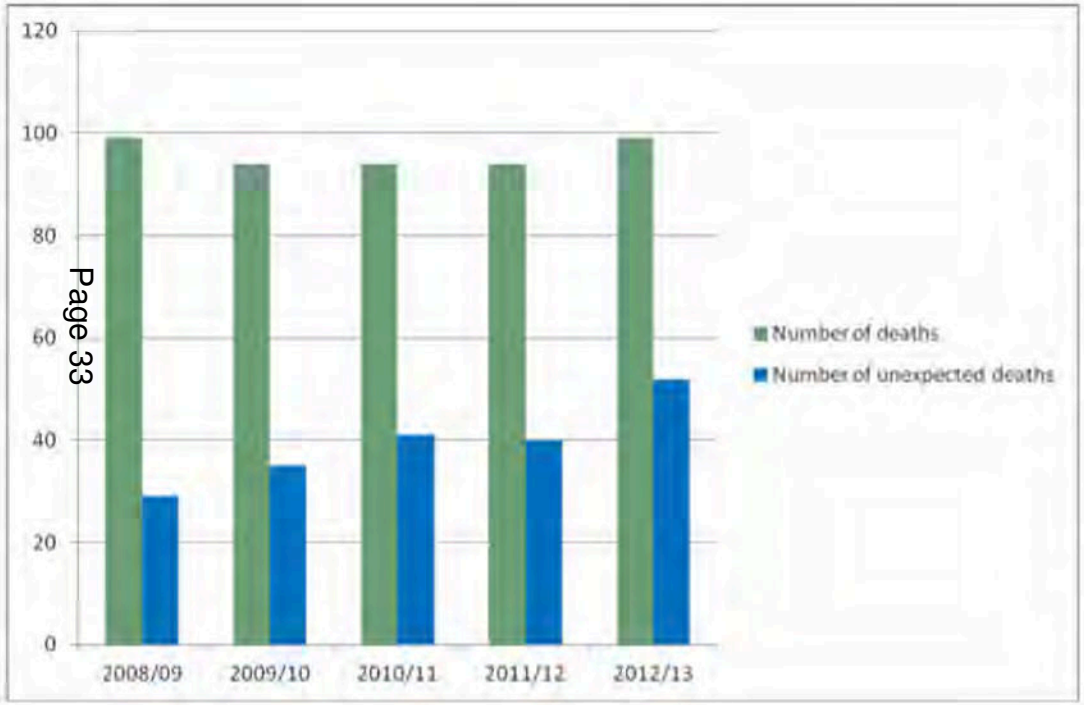
We are committed to publishing our Serious Case Reviews as part of our accountability to the wider community in Kent. During 2012/13 we published two SCRs and one management review.

CHAPTER 4

What happens when a child dies or is seriously harmed in Kent?

Child Deaths Reviews in Kent 12/13

The Child Death Overview Panel has a statutory responsibility to review the deaths of all children who are resident within KSCB's geographical area from birth up to the age of 18 years.



In 2012/13 there have been 99 deaths, of which 56 were unexpected. The number of deaths has remained fairly consistent over the previous five years. The increase in the number of unexpected deaths is believed to be as a result of more accurate recording of the circumstances of the death and a better understanding of the process as a result of ongoing training programmes which have been held throughout the period.

The definition of an unexpected death is the death of an infant or child (less than 18 years old) which:

- was not anticipated as a significant possibility, for example, 24 hours before the death; or
- where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

The number of child deaths equates to 28.9 deaths per 100,000 children under 18 living in Kent.

CHAPTER 4

What happens when a child dies or is seriously harmed in Kent?

Child Deaths Reviews in Kent 12/13

Although the number of child deaths has remained consistent over the past 5 years, due to increases in population, the death rate per 100,000 is falling, and Kent remains below the national average.

Child death rate per 100,000 child population			
Year	**Kent Rate**	**England rate**	**Difference between Kent and England (numbers)**
2008	37.1	44.1	-20
2009	37.6	42.7	-14
2010	26.6	40.6	-43
2011	28.6	39.0	-32
2012	28.9	37.3	-25
2008-2012	**31.7**	**40.7**	**-134**

The CDOP process also looks at whether there were any modifiable factors which may help prevent similar deaths in the future, and seeks to identify any lessons to be learnt from the death, or patterns of similar deaths in the area. In the current year 85 deaths were reviewed, of which 15 were deemed to have modifiable factors.

All deaths are grouped into one of 10 categories. These are:

1. Deliberately inflicted abuse or neglect
2. Suicide of Self Harm
3. Trauma, external factors
4. Malignancy
5. Acute medical or trauma condition
6. Chronic Medical condition
7. Chromosomal Genetic disorder
8. Neonatal
9. Infection
10. Sudden Unexpected death

The most common reason for the death of a child is in the neonatal category, which includes premature births and is in line with national trends. Following that category, children born with chromosomal genetic disorders form the second highest number of child deaths. Only on rare occasions is death caused by abuse, neglect, suicide or safety at home.

Achievements

Following the identification of issues in Kent relating to safe sleeping, our campaign has been expanded to work with midwives and health visitors to ensure that a consistent and thorough message is given to all parents to raise awareness of the risks associated with cot deaths.

The panel has also looked at the quality of bereavement support and work is currently underway to ensure that families are given the best possible support throughout the bereavement process.

CHAPTER 4

What happens when a child dies or is seriously harmed in Kent?

Serious Case Reviews published in Kent 12/13

During this year there were no Serious Case Reviews commissioned. There was one SCR that concluded, known as 'AMY' and this was published in December 2012. Lessons from Amy also have focussed on improving how front line staff identify signs indicating children are at risk of sexual abuse.

AMY'S STORY

Amy was a 10 year old girl who died at home. A SCR was instigated because there were concerns that agencies did not share crucial information about Amy's situation - the neglect and alleged abuse she suffered.

There were poor examples of shared working between Amy's school, Kent Police and Specialist Children's Services.

ANTONIO'S STORY

Antonio was taken to hospital with multiple injuries. He was just a few weeks old. Neither Antonio nor his parents were known to any statutory agencies in Kent. Antonio has recovered from his injuries.

The review of this case recognised the impressive speed and thoroughness of the response from all agencies after the discovery of Antonio's injuries. They worked together to manage a distressing and difficult situation. This management review was published in January 2013.

ASHLEY'S STORY

Ashley died from being shaken badly. His father was convicted of causing Grievous Bodily Harm (GBH) and sentenced in 2012.

Agencies did not share information they knew about the family and the SCR concluded that in light of the risks presented by Ashley's father, children should not have been left in his care. Staff are now aware of the need for ongoing risk assessments when a new partner comes into a family

During 2012/13 KSCB considered a number of cases that did not meet the threshold for a SCR but warranted an independent review to consider learning and how to encourage improved practice across front line settings.

CONCLUSION

What next for child protection in Kent?

Messages for Local Politicians

•You can be the eyes and ears of vulnerable children and families in your ward making sure their voices are heard by KSCB. For 2012/13 Councillor Jenny Whittle was lead member for children and families, making sure their voices are heard by KSCB

• When you scrutinise any plans for Kent, keep the protection of children at the front of your mind. Ask questions about how any plans will affect children and young people

Messages for Clinical Commissioning Groups

• New CCGs in the health service have a key role in scrutinising the governance and planning across a range of organisations

• You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children

Messages for The Police and Crime Commissioner

• Ensure that the voice of all child victims are taken notice of within the criminal justice system, particularly in relation to listening to evidence where children disclose abuse

• Monitor what police and probation staff do to share information regarding high risk MAPPA and MARAC cases and the risks that some adults present to children

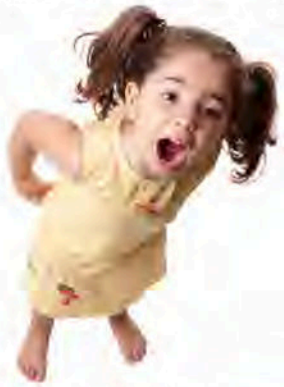
• Support the work of the independent domestic violence advisors in highlighting the maltreatment of children who witness domestic abuse

Messages for Chief Executives and Directors

•Ensure your workforce is able to contribute to the provision of KSCB safeguarding training and to attend training courses and learning events

• Your agency's contribution to the work of KSCB must be categorised as of the highest priority

• The KSCB needs to understand the impact of any organisational restructures on your capacity to safeguard children and young people in Kent



Messages for The Children's Workforce

• Ensure you are booked onto, and attend, all safeguarding courses and learning events required for your role

• Be familiar with, and use when necessary, KSCB's Thresholds Procedures to ensure an appropriate response to children and families

• Use your representative on KSCB to make sure the voices of children and young people and front line practitioners are heard

Messages for The Community

• You are in the best place to look out for children and young people and to raise the alarm if something is going wrong for them

• We all share responsibility for protecting children. If you are worried about a child, follow the steps on the KSCB website – www.kscb.org.uk

Messages for The Local Media

• Communicating the message that safeguarding is everyone's responsibility is crucial to the KSCB and you are ideally positioned to help do this

• The work of KSCB will be of great interest to your readers and listeners

• Your contribution to safeguarding children and young people in Kent

Messages for Children and Young People

Children and young people are at the heart of the child protection system. KSCB wants to ensure that children's voices are heard and during the year has consulted children about their views on how safe they feel. This has led to the development of a range of projects to properly review children's views of child protection arrangements in Kent.

APPENDIX A

MEMBERSHIP of KSCB

Maggie Blyth, *Independent Chair*

Maurice Reilly, *Director Kent Probation Trust*

Andrew Ireland, *Corporate Director Families & Social Care, KCC*

Angela Slaven, *Director of Service Improvement, KCC*

Nadeem Azim, *District Councils Representative ,CEO Dover*

Mark Gurrey, *AD Safeguarding & Quality Assurance, Specialist Children's Services, KCC*

Mairead MacNeill, *Director Specialist Children's Services, KCC*

Lorraine Goodsell, *Associate Director, Child Health & Maternity, KMCS*

Tim Smith, *Detective Superintendent Kent Police*

Mark Sheppard, *Director Kent Community Health NHS Trust*

Meradin Peachey, *Director of Public Health, KCC*

Mike Stevens, *Lay Member*

Nick Sherlock, *Head of Safeguarding Adult Services, KCC*

Patrick Leeson, *Corporate Director Education, Learning & Skills, KCC*

Roger Sykes, *Lay Member*

Sally Allum, *Director of Nursing & Quality, NHS Kent & Medway*

Sean Kearns, *Chief Executive, CXK (formerly Connexions)*

Stephen Bell, *Voluntary Sector Representative*

Steve Hunt, *Head of Service, CAFCASS*

Lesley Ellis, *Head Teacher (Secondary)*

Jay Pye, *Head Teacher (Primary)*

Jenny Whitte, *Cabinet Member*

MEMBERSHIP of KSCB EXECUTIVE

Maggie Blyth, *Independent Chair*

Maurice Reilly, *Director Kent Probation Trust*

Andrew Ireland, *Corporate Director Families & Social Care, KCC*

Mark Gurrey, *AD Safeguarding & Quality Assurance, Specialist Children's Services, KCC*

Mairead MacNeil, *Director Specialist Children's Services, KCC*

Sally Allum, *Director of Nursing & Quality, NHS Kent & Medway*

Sean Kearns, *Chief Executive, CXK (formerly Connexions)*

Jenny Whittle, *Cabinet Member*

Patrick Leeson, *Corporate Director Education, Learning & Skills, KCC*

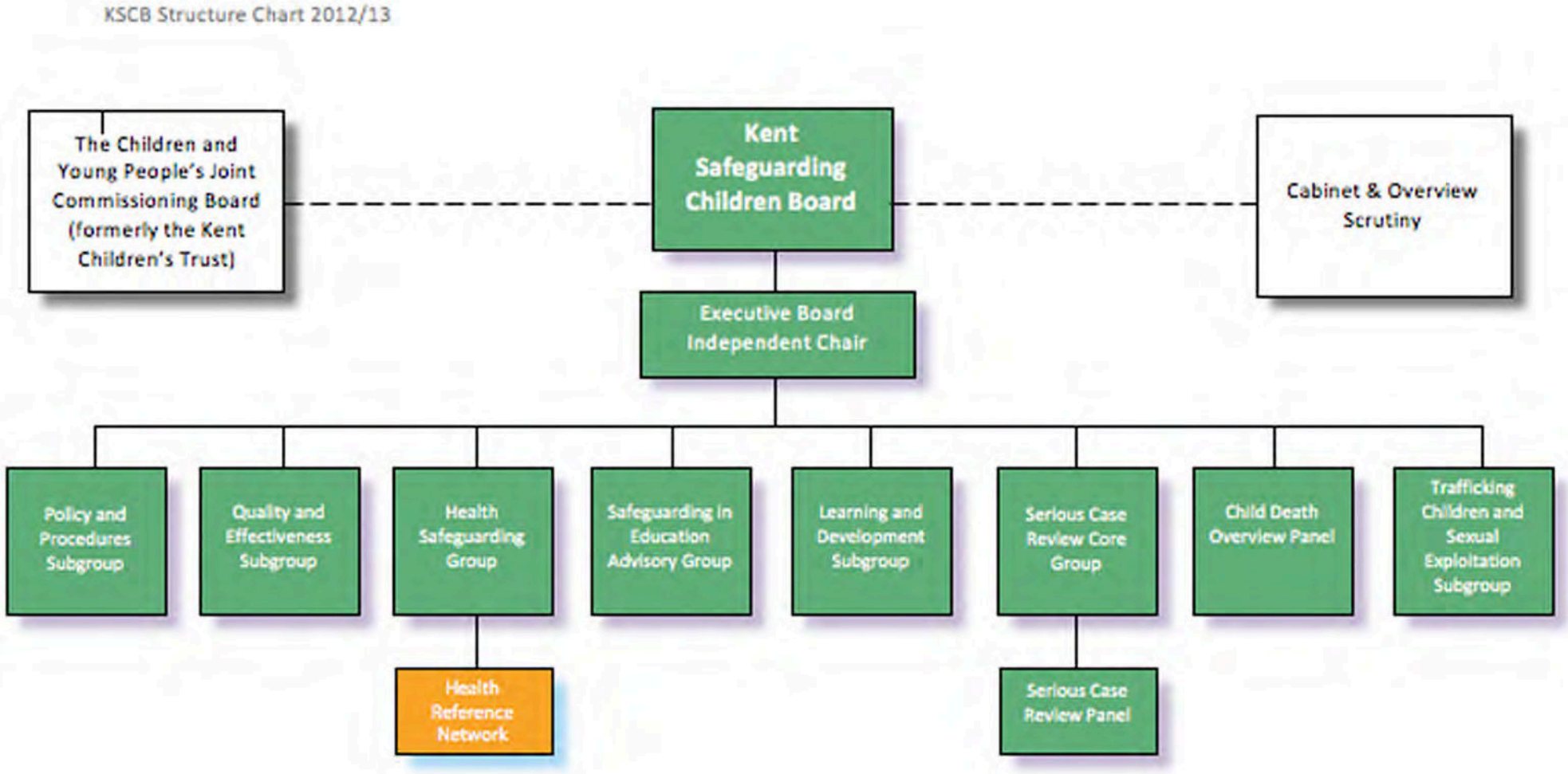
Che Choi Fung, *Senior Solicitor, KCC*

Mark Sheppard, *Director Kent Community Health NHS Trust*

Lorraine Goodsell, *Associate Director, Child Health & Maternity, KMCS*

Changed during the year: Tim Smith, *Detective Superintendent, Kent Police* replaced by Paul Brandon, *Assistant Chief Constable, Kent Police*

APPENDIX B


KSCB Structure Chart 2012/13
The Children and Young People's Joint Commissioning Board (formerly the Kent Children's Trust)
Kent Safeguarding Children Board
Cabinet & Overview Scrutiny
Executive Board Independent Chair
Policy and Procedures Subgroup
Quality and Effectiveness Subgroup
Health Safeguarding Group
Safeguarding in Education Advisory Group
Learning and Development Subgroup
Serious Case Review Core Group
Child Death Overview Panel
Trafficking Children and Sexual Exploitation Subgroup
Health Reference Network
Serious Case Review Panel

APPENDIX C

Budget Statement 2012/13

Expenditure	2012/13
Salaries	389,581
Travel	4,671
Staff training and development	1,744
ICT consumables, hardware, software, equipment	3,352
Direct staffing costs	**399,349**
Printing, publications and promotions	3,325
Room hire and refreshments – business meetings	1,785
Room hire and refreshments - SCR	239
KSCB web site & on-line procedure manual	9,342
Stationery	1,046
DCPP Grants	1,348
Independent Chair	46,714
Consultants	51,291
Audits (External Consultants)	8,659
Child Sexual Exploitation Project	5,050
Lay Members	146
Board support and development	**128,944**
Commissioning Case Reviews	66,619
Case reviews	**66,619**
E-learning, external trainers	18,075
Training College including trainer of trainer	3,745
Room hire and refreshments - Training	30,600
Annual Conference	8,592
CWDC - Implementing Munro & immersive learning	17,962
Learning and improvement	**78,974**
TOTAL EXPENDITURE	**673,885**

Income	2012/13
Income from contributing partners	**300,672**
under/over budget	**-373,213**
E-Learning Income	5,160
Non-attendance/Cancellation Income	20,731
Bespoke Training Income	9,662
Total Training Income	**35,553**
CWDC Grant	94,000
Child Death Grant	95,000
Training	35,000
Children's Improvement Board (National)	5,050
Strategic Health Authority	35,000
Total variable income	**264,050**
under/over budget	**-109,163**
Residual funds available	**674,879**
TOTAL INCOME	**1,275,154**
TOTAL EXPENDITURE	**673,885**
Residual funds to carry forward to next financial year	**601,268**

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From: Roger Gough, Cabinet Member for Education and Health Reform

Mark Lemon Strategic Business Advisor

To: Kent Health and Wellbeing Board

Subject: The Integration Transformation Fund

Classification: Unrestricted

Summary:

The £3.8bn Integration Transformation Fund (ITF) announced by the Government dramatically accelerates the timescale for achieving the integration of health and social care services. Government expectations are that a fully integrated system should be in place by 2018 based on actions identified to start in 2014-15 and begin significant delivery in 2015-16. The funding consists of a number of existing components as well as new allocations from CCG budgets.

Plans to spend the funding must be agreed by Health and Wellbeing Boards who must assume responsibility for monitoring the achievement of the targets required, agree contingency plans for re-allocating funding if targets are missed, and be satisfied that providers, especially acute hospital trusts, have been effectively engaged in the planning process.

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

1. Introduction

The Integration Transformation Fund was announced in the Comprehensive Spending Review It follows the NHS “Call to action” that identified a £30bn shortfall in NHS funding in 2020 unless action to manage demand is taken. This has also spawned the integrated care “Pioneer Programme”.

The funding is described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”

Funding will be awarded to local plans, based on a Health and Wellbeing Board footprint and with Boards as the leaders for implementation. Health and Wellbeing Boards will need to agree plans to spend the money to deliver agreed outcomes.

Plans will also need to take account of the implications for the acute sector of service transformation and set out arrangements for the redeployment of funding within the system if outcomes are not reached.

There will need to be some oversight and ministerial sign off of plans but it is intended that this be “light touch”.

The funding is a pooled budget, not a transfer, and local authorities and the NHS are equal partners. It is not necessarily confined to social care and other LA functions may be relevant. It is expected that the funding will be allocated under s256 arrangements.

A great deal of effort is already being devoted to furthering integration across Kent and there is a sound basis to build upon. The Integration Transformation Fund seriously increases the pace and the scale at which these developments need to deliver. The government expects “that each area moves to a wholly integrated approach to health and care by 2018” (Refreshing the Mandate to NHS England: 2014 – 2015 Consultation)

2. ITF Funding components

Half the ITF funding will come from existing commitments:

- £1.9bn of existing funding continued from 14/15 – this is money already allocated across the NHS and social care to support integration and including:

- £300m of CCG re-ablement funding

- £130m of CCG carers' break funding

- £900m existing transfer from health to social care plus £200m for the joint fund

- c. £350m in capital grants from government departments including £220m of Disabled Facilities Grant

Whilst it is not expected that these components will be diverted into funding other services the implication is that the plan associated with spending the ITF must show how each of these elements will contribute to the overall aim of achieving integrated services by 2018.

There is an additional element of £1.9bn from NHS allocations which includes funding to cover demographic pressures in adult social care and some costs associated with the Care Bill.

Of this £1bn has been designated as "at risk money". This will be paid dependent upon performance with particular reference to taking pressure off the acute sector and improving patient experience. If not paid, the funding will revert to the general NHS budget. The "at risk" funding will be split over the 15/16 financial year:

£0.5bn at start of 15/16 dependent upon performance in 14/15

£0.5bn at end of 15/16 dependent upon performance in 15/16

This £1.9bn contribution from core CCG budgets equates to £10m from an "average" CCG.

3. Conditions of the full ITF

The ITF will be a pooled budget that can be deployed locally on social care and health, subject to the following national conditions which will need to be demonstrated in the plans:

- joint agreement between local authorities and the NHS through the Health and Wellbeing Board.
- protection for social care services (not spending)
- as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health)
- ensure a joint approach to assessments and care planning
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached
- agreement on the consequential impact of changes in the acute sector.

4. Timetable

Money is for 1 year with no guarantee of repeat funding. There will be a general election and a further Comprehensive Spending Review in 2015. Funding is to establish practice that can be incorporated into allocation of base budgets in following years.

Further guidance and support will be issued in the Autumn to enable consideration within CCG commissioning plans for 14/15 with more events and engagement planned over the Autumn

However guidance states: “we think it is essential that CCGs and local authorities build momentum in 2014/15 using the additional £200m due to be transferred to local government from the NHS to support transformation. In effect there will need to be two-year plans for 2014/15 and 2015/16, which must be in place by March 2014. To this end we would encourage local discussions about the use of the fund to start now in preparation for more detailed planning in the Autumn and Winter”.

5. Key Messages

- This will only work if services are redesigned to move activity from the acute sector to the community and primary care.

- Successful implementation of plans may lead to significant hospital reconfiguration. Potential impact on providers (acute trusts) needs to be part of the planning process. Changes to service that are not properly planned could potentially destabilise providers. This led to emphasis being placed on involvement of providers with an urgent need to revisit how they engage with the commissioners and the Health and Wellbeing Board.

- This is urgent – get on with it. There are early wins to be had regarding winter pressures and in any event Boards need to start building momentum towards 14/15.

6. Outcome measures

Measures to determine progress and success have not yet been established. The general view is that any outcome measures should be taken from existing outcome frameworks and should not generate extra data collection for new indicators.

Some new measures may be necessary to demonstrate how issues such as better data sharing based on use of the NHS number have progressed

7. Timetable and Alignment with Local Government and NHS Planning Process

Plans for use of the pooled budgets should not be seen in isolation. They will need to be developed in the context of:

- local joint strategic plans
- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term strategic plans as part of the NHS Call to Action)
- the announcement of integration pioneer sites in October, and the forthcoming integration roadshows
- The outline timetable for developing the pooled budget plans in 2013/14 is broadly as follows:
- August to October: Initial local planning discussions and further work nationally to define conditions etc
- November/December NHS Planning Framework issued
- December to January: Completion of Plans
- March: Plans assured

8. National next steps

NHS England and the LGA and ADASS will work with DH, DCLG, CCGs and local authorities over the next few months on the following issues:

- Allocation of Funds
- Conditions, including definitions, metrics and application
- Risk-sharing arrangements
- Assurance arrangements for plans
- Analytical support e.g. shared financial planning tools and benchmarking data packs.

9. Other Issues

Analysis from Greater Manchester highlighted the scale of the issue. Their advice is that partners should agree how much money needs to move

across sectors in the system. Their calculation was that Greater Manchester needed to transfer £250m worth of activity from acute to community and primary care which translated into a potential 25% of hospital activity. There was concern whether existing systems such as HR and finance can cope with the required shift of resources and personnel around the system at this scale. Greater Manchester's experience also demonstrated the need for robust financial modelling and the need to "develop investable propositions".

10. Kent Workforce

Locally some discussions have already been held about how workforce planning needs to respond to the challenge posed by the integration agenda, including representatives from social care and KCHT. These discussions have led to the following summary for the Board:

The health and social care economy is reliant on the right staff and multi-professional teams being available at the right time, in the right place to deliver the right care and service. As we face the challenge of ensuring our services are sustainable for the future, meeting the need for improving outcomes and experience of patients whilst making best use of the public pound, a key factor in delivery will be workforce availability. This workforce stretches from carers through volunteers and on to registered health and social care professionals. How will HWBB commissioning partners be assured that the necessary workforce, with the right skills and competencies for future models of health and social care is being developed?

Health Education England (HEE) is the national NHS and social care body responsible for the education and development of the health workforce. The local presence of HEE is HE Kent Surrey Sussex who have a local partnership arrangements in Kent and Medway. The HEE work with their local membership of health providers and education institutes to ensure there are comprehensive workforce strategies and plans in place so that resources are appropriately focused. In order for providers to have detailed and deliverable workforce plans they need to have a clear strategic steer as to the future services to be commissioned. There is clearly a potential role for the HWBB partners to clearly describe the strategy for service change and development into the future in a way that enables HEKSS to respond.

The pioneer bid for integration provides an ideal and clear opportunity to test the new governance, roles and responsibilities with a focus on delivery. The HWBB should consider how it adequately describes the future service strategy in a way that the Local Partnership group, chaired by Marion Dinwoodie can consider how they provide assurance to the HWBB that plans are in place to implement the necessary changes in workforce that this may require. It is recommended that the Local partnership Board be asked to set out how local partners will develop the workforce to meet the requirements of the bid.

11. Issues for the Kent Health and Well Being Board

The Integration Transformation Fund raises a number of issues for the Health and Wellbeing Boards across Kent apart from the pace and scale of the changes required. The level of involvement in the planning process, oversight of effectiveness and responsibility to redeploy resources if plans are unsuccessful brings the Kent Board closer to being a joint-commissioning body and the group that manages risk within the wider system. The need to engage the acute trusts and others emphasises the importance of ongoing discussions about how to involve providers with the business of the Board.

In delivering the requirements of the Integration Transformation Fund it will be important that we bring all relevant resources to bear and there are a number of existing initiatives that can be deployed:

The Pioneer programme derived from the current bid could provide a focus for delivery of the plan

The local Health and Wellbeing Boards with their associated Integrated Commissioning Groups will be an essential element in developing plans.

12. Conclusions

The Board may wish to consider other ways the planning and delivery of the Integration Transformation Fund may be supported in Kent. In particular the Board will need to be assured that it can address the following questions.

What processes and mechanisms do we need to establish to deliver the ITF in Kent ?

Does the Pioneer Programme provide the vehicle for delivery ?

What will be the involvement and responsibility of local Health and Wellbeing Boards ?

How will providers, especially the hospital trusts, be engaged ?

Are local support systems including those for finance and Human Resources robust enough to deal with the scale of change within the system ?

How will the pooled funding be managed ?

Who will write the plan?

Recommendations:

The Health and Wellbeing Board is asked to:

(i) Acknowledge the timescales involved for the preparations of the Kent plan for the Integration Transformation Fund

(ii) Agree to establish the necessary processes and mechanisms to construct the plan and deliver the required activity across Kent.

13. Contact details

Report Author

Mark Lemon, Strategic Business Advisor, email: Mark.Lemon@kent.gov.uk

West Kent
Clinical Commissioning Group

Mapping the Future

Patient focused

Mapping the Future

Introduction

Attached is an Overview of the Mapping the Future programme being undertaken by NHS West Kent CCG. This document sets out a blueprint for how services might be organised in West Kent and is being shared with local people for feedback and comment. It is a description of the design principles to be used by the NHS and local partners when designing services to meet local need as set out in the JSNA and the priorities of the Health and Wellbeing Strategy.

The work has been undertaken because of a shared belief by all partners that without significant change the local health and social care systems will struggle to cope with the increasing pressures of an aging population and the cuts to funding that are likely in a time of Austerity.

Development of the blueprint has been by groups of clinicians and professionals working together with Patient and Public representatives to design the best way to organise services around individual patients.

The overwhelming view from these workshops has been the need for a new, more capable, more comprehensive out of hospital sector delivering health and social care. This will involve reshaping primary care, full integration of health and social care, working in partnership with the third sector, and traditional consultant led hospital services being delivered in the community.

To deliver this change will require new relationships between all partners based on co-operation and collaboration. It will also require comprehensive information sharing and a focus on the cost of providing care not the price of transition.

If the blueprint is supported it will be used to align the plans of all local NHS and partner organisations plans to deliver a common future.

As specific plans for implementation of Mapping the Future are developed, where they require significant service change, the NHS will discuss plans with HWB and HOSC and agree the appropriate processes for consultation.

NHS

MAPPING THE FUTURE

Overview

August 2013

What is Mapping the Future?

Mapping the Future is a project that will modernise health and care services for the 463,730 people who live across the boroughs of Tonbridge and Malling, Tunbridge Wells, Maidstone and most of the Sevenoaks district in west Kent.

Mapping the Future will produce a future picture of the modern, efficient health and care services that we will need to provide in order to meet the changing needs of people in west Kent.

Who is involved in Mapping the Future?

Mapping the Future is being coordinated by NHS West Kent Clinical Commissioning Group (CCG), the main organisation that plans and buys healthcare services for the area.

The other organisations that either pay for or provide services to people in west Kent are also involved in the project, including:

- Kent County Council's Social Services
- Maidstone and Tunbridge Wells NHS Trust
- Kent Community Health NHS Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Integrated Care 24 (IC24)
- Voluntary organisations
- GPs.

We want EVERYONE who has an interest in west Kent's health and care services, whether they are representing an organisation, or are a local resident, to let us have their views on this future picture.

Why is Mapping the Future needed?

Put simply, west Kent's health and care services need to change as there is a widening gap between what people in west Kent need and the funding available. Based on current trends, the demand for healthcare will increase by 20 per cent over the next five years but there will be no increase in funding. We have to find a way to give people the quality of care that they want and need, which is affordable.

NHS West Kent CCG has a budget of £471 million per year to spend on healthcare in the area. If we continue to deliver the services in the way we do now and meet new demands for care, we will have a funding gap of £62 million by 2018/19.

By being proactive and working together the NHS can start putting changes in place now, so that we can continue to provide you and your family with the health and care you need in the future.

What will Mapping the Future achieve?

At present different organisations and individual services make their own plans. This creates a disjointed and inconsistent service for people who need health and care services.

The Mapping the Future blueprint will help local health care providers develop more coherent plans, provide more joined-up services and reduce unnecessary spend.

Mapping the Future will:

- Lead to the creation of a five-year healthcare plan
- Provide the opportunity for local people to become involved in decisions about what should happen
- Enable commissioners and service providers – hospital trusts, community services, the mental health trust, ambulance services and social care providers – to plan more effectively
- Put patients at the heart of the process so that services are planned, commissioned and delivered in their very best interests
- Make it easier to coordinate care, especially for people with multiple health and/or social care needs
- Ensure resources are used wisely.

What has happened so far?

Between May and June 2013, four meetings took place for clinicians, health and care professionals, managers and patient representatives, to review the way health and care services are currently provided, from prevention through to recovery.

The sessions focused on the following areas:

- Falls and mobility
- Dementia and mental health
- Urgent and emergency care
- Respiratory diseases.

These topics were selected because they are areas where demands for care are increasing, but the topics themselves were not the main focus of the exercise. It was more about pulling out the common themes of how things are currently done and how they could be done in the future, to improve services.

People attending the sessions identified some of the current challenges to be overcome through the Mapping the Future project:

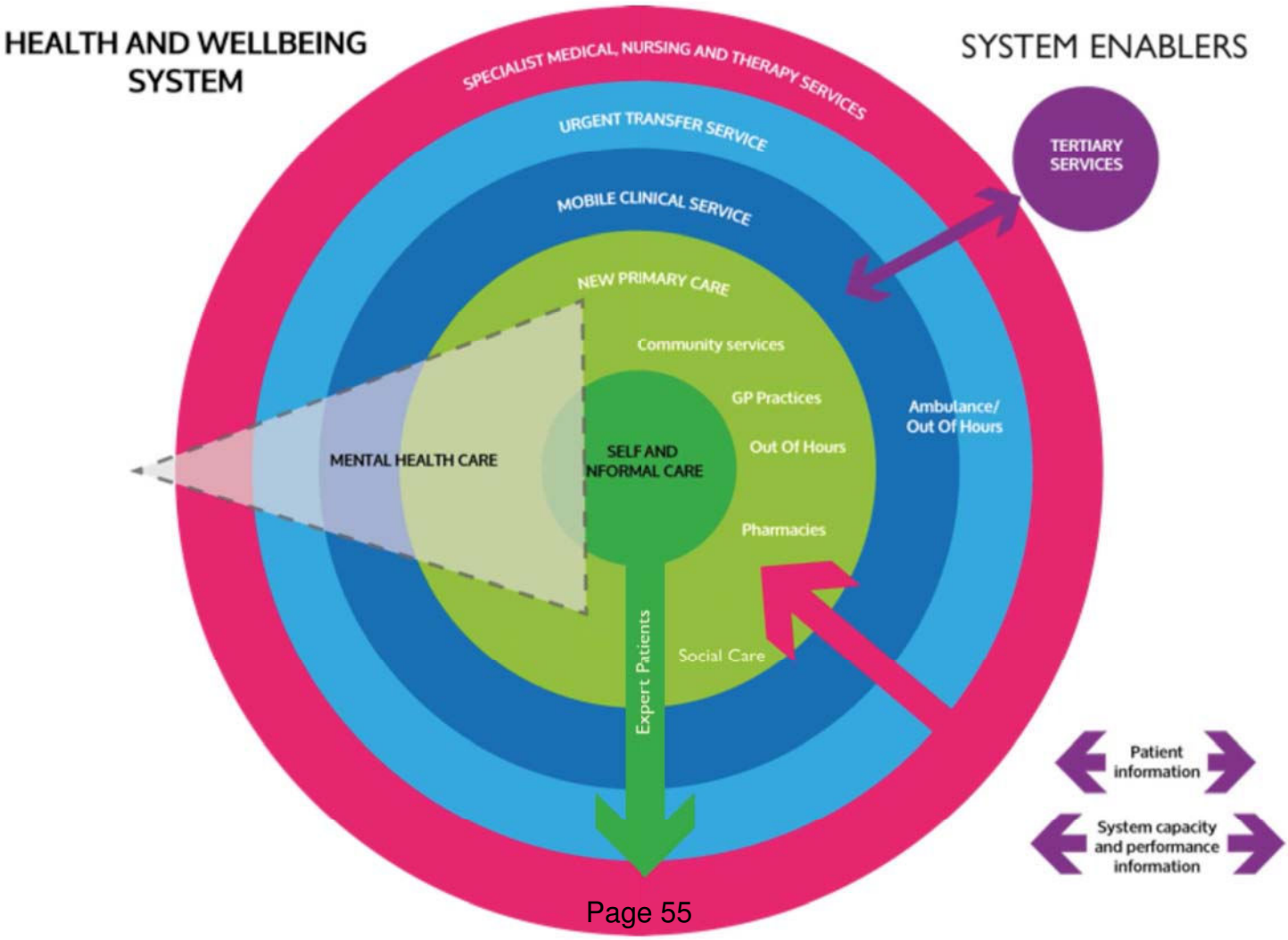
- Missed opportunities to tackle the causes of health problems
- Missed opportunities to tackle health problems early on
- Patient information doesn't 'flow' round the different systems
- Missed opportunities for involving voluntary and community organisations
- Services in the community are not geared to dealing with urgent care needs
- Opening times of services don't work together well and night and weekend access to services could be improved
- Providers of services don't know what other services are available, making it difficult to inform or steer people to the right place for help
- Professionals and the organisations they work in are concerned to protect their own interests but this can result in costly care that is not always best for the people that need care
- Lack of diagnostic services or consultant advice anywhere other than in hospital
- Not enough is done to learn from each other or share in identifying solutions
- The quality and performance of services delivered in the community is inconsistent
- Patients and carers aren't given enough information for them to be more actively involved in their care.

Participants heard the evidence about how other areas have tried different ways of organising health and care services. And they've used this information and their experience and judgement to describe what the future health and care system in west Kent might look like.

The information gathered from these sessions highlighted some common themes around the way health and care services should be delivered going forward in west Kent. A draft plan, known as a 'blueprint' was developed and then shared with everyone who had input to the four meetings.

This blueprint is now being refined in readiness for other health and care staff, voluntary and community organisations, patients and the public to comment on.

What does the 'blueprint' or plan look like?



At the heart of the blueprint are the people who need health and care. A health and wellbeing system ensures that all opportunities are taken to tackle important health risks such as tobacco, drugs and alcohol and enable people to choose healthy lifestyles. The majority of care is delivered by a new primary care system. This comprises pharmacists, GPs, community nurses, mental health and social care working together as a team, operating round the clock and working closely with specialist medical, nursing and therapy services in hospitals. More use is made of paramedics treating people at the point where they are ill. And mental health care is threaded through all of these aspects.

Health and wellbeing system

- All organisations involved in health and wellbeing will work together to tackle risks to health and to improve the health and wellbeing of local people.

Self and informal care

- Patients and carers will be supported to take responsibility for their health and care through education, peer support, and signposting so they know what services are available, including voluntary and community options
- People will be encouraged to make early decisions about how they prefer to be treated
- People will be supported to stay independent and at home for as long as possible.

New primary care

- GP practices, community services and social workers will be more joined-up and able to respond to patient needs round the clock
- Appointments or meetings with people will be provided face-to-face or over the phone and there will be longer opening times
- A consistent range of services will be available across west Kent and operating at weekends and nights
- Everyone will use the same patient record system
- GPs will have access to advice from hospital specialists so they can manage their patient's care without sending them to hospital unnecessarily
- Primary care teams will take a more proactive approach to tackling health risks and conditions early on, so they can help prevent people's health deteriorating

- Primary care teams will 'own' their patients' care. They will make sure patients receive specialist care if needed and help plan their return home as quickly as possible
- Professional teams will have advanced skills in diagnosis and treatment of patients with long-term conditions.

Mobile clinical service

- NHS 111 will provide valuable advice and help to patients and carers by phone and online as part of the health and care system
- Call handlers will be fully briefed on local services and have access to 'live' information
- Mobile clinical services that comprise paramedics and other health professionals, will provide care to the patient at the place where they become ill rather than bringing the patient to the services as a matter of course
- Mobile clinical services will have access to the same information as other health and care professionals (such as patient records) and there will be a clear system in place to transfer people back to the care of their primary care team.

Urgent transfer service

- The traditional ambulance service will continue to transfer patients with urgent care needs where necessary. They may provide a range of treatments and diagnostic tests to patients on the way, providing effective handover to specialist hospital services
- The same health and care protocols will be used across the system
- There will be access to the same information as other health and care professionals (e.g. patient records and awareness of what medicines people may need to take to hospital with them)
- The transfer service may take people to other care locations such as community hospitals or care homes as well as acute hospitals.

Consultant-led services / specialist doctors, nurses and therapists

- Hospital-based urgent and planned care will complement each other but will be managed separately to ensure they work as efficiently as possible
- Some consultant-led services will be concentrated in larger centres where there is evidence that this can improve quality and offer more cost-effective care

- There will be closer links with primary, community and mobile clinical services, with greater sharing of responsibilities, a culture in which there is clear accountability for care which stretches across organizational boundaries, supported by one single patient record system. People should experience more joined-up care as a result
- Information about patient needs and service activity will be constantly analysed to make sure resources are in the right place
- Hospital-based services will help people to make positive changes in their health behavior, e.g. around smoking or alcohol consumption
- There will be better linkages between the treatment of physical and mental health conditions
- Primary and specialist clinicians will work together to agree when it is appropriate to refer patients to specialist centres outside of west Kent and work to establish the same culture of shared care with clinicians in specialist centres.

What are the next steps?

The draft blueprint will be ready to share with the public in September 2013, and local people and organisations will be invited to submit their views through a dedicated Mapping the Future website and a range of engagement events.

Questions

We would welcome your response to the following questions. Responses can be submitted via our online questionnaire: http://www.surveymonkey.com/s/mappingthefuture

1. What are your comments on how we tackle west Kent's challenges of rising demand and limited resources for health and care?
2. If we all took responsibility for our own health what would we need to help us do that?
3. How can we make health and social care services more efficient (less wasteful)?
4. How can we ensure the person's experience of receiving services is more coordinated and joined-up?

From: Roger Gough, Cabinet Member for Education and Health Reform

Meradin Peachey, Kent Director of Public Health

To: Kent Health and Wellbeing Board

Subject: Kent Framework for System Assurance

Classification: Unrestricted

Summary:

The Kent Health and Wellbeing Board (KHWB) wishes to develop an assurance framework across the Health and Social care system. It is proposed that indicators relevant to the Kent Health and Wellbeing strategy are taken as the basis to develop an overview of the health and social care system across Kent. These indicators will form a relatively simple Assurance Dashboard for the KHWB to assess current service effectiveness. In addition indicators have been derived from the NHS England South Escalation Framework that can alert the Board to potentially unsustainable pressures in the component sectors. The Dashboard will also provide assurance on a regular basis if overall status of the indicators is progressing in the right direction.

Recommendation(s):

i) Note the contents of this paper and approve this proposal for developing Kent wide assurance framework.

iii) Approve the development and ownership of the dash board for regular monitoring of the agreed indicators.

1. Introduction

At its inaugural meeting in April 2013 the Kent Health and Wellbeing Board (KHWB) received information on how constituent parts of the health and social care system in Kent are performing against national requirements. The KHWB requested this information be available as a standing agenda item and be extended to include primary and community services, acute hospital services, public health and social care.

An initial proposal was considered at the last meeting of the Kent Health and Wellbeing Board and a number of amendments were discussed. The Board requested that a revised report be presented to its next meeting.

The original principles of the framework still apply:

Currently across the health and social care services a large amount of information is collected and it is important that the KHWB receives the most relevant and appropriate data selected from the myriad available in order to inform its business.

It is also important to ensure that the assurance reports to the KHWB contain data that is already available rather than generating new information and data collection

requirements. To be meaningful the data must also be reportable in time-frames relevant to the sitting of the Board rather than annual updating that is required for a number of indicators.

As well as demonstrating how the health and social care system is operating across the County the data supplied should inform the key responsibilities of the Board concerning the promotion of integration and the five outcomes contained in the Health and Wellbeing Strategy. It would also be useful to include indicators that demonstrate potential stress within constituent parts of the system that may require concerted action to alleviate and ensure service sustainability.

In addition the Board requested that the framework also reflected more clearly the outcomes that the Board has committed itself to through the Health and Wellbeing Strategy and that indictors for children's health are more closely related to medical outcomes.

2. Current indicators

Nationally there are three Outcomes Frameworks (for the NHS, Adult Social Care and Public Health) that assess performance and many of the indicators contained in the Frameworks are incorporated into the Kent Joint Health and Wellbeing Strategy. There is no corresponding national framework for children although some indicators in other frameworks are relevant..

Other indicator sets that can inform the Health and Wellbeing Board include the KCC Key Performance Indicators (KPI's) that are reported on a quarterly basis.

3. Kent wide Assurance Framework

The role of the Kent Health and Wellbeing Board is to provide a system overview and to:

- assess the needs of their local population through the joint strategic needs assessment process

- produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant

- promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

To assist the delivery of these functions the members of the Kent Health and Wellbeing Board wish to develop an assurance framework. It is proposed that the Board regularly receives quarterly or 6 monthly reports on a suite of indicators or dashboard as attached at Appendix 1.

The dashboard of indicators that is proposed is designed to incorporate a number of those relevant to the Kent Health and Wellbeing Strategy and KCC KPI's The system stress or sustainability indicators are derived from the NHS England South Escalation Framework which is designed to trigger corrective action across the health and social care system when services are struggling to meet demand.

Some of these overarching indicators such as Under 75 mortality rates for cardiovascular disease, respiratory disease and cancer are only reported on an annual basis. However, applying the analysis and methodology developed by Professor Chris Bentley compliments the report on *Addressing Health Inequalities in Kent*, reported to the board on 17th July 2013, which highlighted small geographical areas (Lower Super Output Areas) with the top 20% premature mortality due to cardiovascular, cancer and respiratory diseases. The high level indicators mentioned in the assurance framework related to premature mortality will have a sub set of detailed indicators which can be monitored on quarterly basis. For instance the indicator on under 75 mortality for all cardiovascular diseases will have a sub indicator of associated risk factors such as that of smoking cessation and uptake of NHS Health Checks in these areas. Similarly the indicator on Cancer can have a subset on uptake of cancer screening services and respiratory can have an indicator on smoking cessation. By monitoring these sub indicators the local health and wellbeing Board will be able to track progress of the named high level indicators.

4. Conclusions

Indicators across the Kent Health and Wellbeing Strategy and KCC KPIs can provide an overview of the status of the health and social care system. These indicators can form the basis for a relatively simple Assurance Dashboard that will inform the KHWB of current service effectiveness. In addition indicators derived from the NHS England South Escalation Framework can reveal whether the current service levels are sustainable in the longer term. The Dashboard should also demonstrate whether indicators are improving or deteriorating.

Use of the dashboard should enable the KHWB to:

- Have timely indication of areas of concern and improvement across the system with emphasis on those aspects that involve joint responsibility
- Identify potential areas of stress within the system that may be unsustainable without concerted action to address the issues highlighted.

Please see Appendix 1 for a sample dashboard

5. Recommendation(s)

The Health and Wellbeing Board is asked to:

i) Note the contents of this paper and approve this proposal for developing Kent wide assurance framework.

iii) Approve the development and ownership of the dash board for regular monitoring of the agreed indicators.

6. Contact details

Report Author

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Director Lead:

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Appendix 1

Proposed targets and indicators for the Kent Health and Wellbeing Board Assurance Framework

Joint health and Wellbeing Strategy Outcome targets and associated indicators

Outcome 1 Every child has the best start in life

Targets

Increasing breastfeeding initiation rates and continuance at 6-8 weeks, until they are at least 50% in all parts of Kent.

Improve MMR vaccination uptake and improve access to the vaccination, particularly for the most vulnerable groups. To attain 95% coverage levels

Reducing the number of pregnant women who smoke through their pregnancies by 50%

Associated indicators relevant to the H&WB Strategy

Unplanned hospitalisation for asthma, diabetes and epilepsy in children aged under 19s

CAMHS waiting times for assessment and treatment

SEN assessment timescales and out of county/independent school placements

Conception rates for young women aged under 18 years

Outcome 2 Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

Targets

Reducing the under-75 mortality rate from cancer (see report section 3)

Reducing the under-75 mortality rate from respiratory disease (see report section 3)

Reducing the numbers of hip fractures and falls for people aged 65 and over, where Kent is performing significantly worse than the England average

Reducing the rates of deaths attributable to smoking in all persons, targeting those who are vulnerable or most at risk (focussing on social gradient of smoking)

Reducing the under-75 mortality rate from respiratory disease (see report section 3)

Outcome 3 The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Targets

The proportion of older people (65 and over) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in re-ablement/rehabilitation services

Increasing the number of people using integrated personal budgets

Increasing the number of people using telecare and telehealth technology

Outcome 4 People with mental health issues are supported to "live well"

Targets

Reducing the number of suicides

Increasing the employment rate among people with a mental illness/those in contact with secondary mental health services

Associated indicators relevant to the H&WB Strategy

Rate of crisis response within 24 hours

Numbers of people receiving treatment for drug and alcohol misuse

Outcome 5 People with dementia are assessed and treated earlier

Targets

Improving the rates of diagnosis in Kent to at least 60% of expected levels

Increasing effectiveness of post diagnosis care in sustaining independence and improving quality of life for an increased number of people, including early intervention and crisis services in place, reduced care home placements and hospital admissions, an increased number of people supported by these new services

Associated indicator relevant to the H&WB Strategy

People waiting longer than 12 weeks to access memory services

System stress indicators derived from the NHS England South Escalation Framework

Acute Trusts

Bed Occupancy Rates

A&E 4 hr target

A&E admissions

Ambulance Service

Delays breaching 30 minute turnaround time

Social Care/Community Care

Delayed Transfers of Care

Infection control rates

Primary Care

GP attendances

Out of Hours activity/111 call volumes

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From: **Jenny Whittle, Cabinet Member for Specialist Children's Services**
Meradin Peachey, Director of Public Health

To: **Kent Health and Well Being Board**

Subject: **Improving Health Outcomes for Children and Young People – Better Health Outcomes Pledge**

Summary:

The consistently poor health outcomes for children in England have been highlighted in a letter sent by the Department of Health and the Local Government Association to Lead Members for Children and Chairs of Health and Well Being Boards. There is a call for all health and well being boards to demonstrate their commitment to improving opportunities for children and young people by giving them a better start in life.

Recommendation(s):

The Kent Health and Well Being Board is asked to consider and endorse the "Better health outcomes for children and young people pledge".

1. Background

1.1. In July 2013, a joint letter from the Department of Health, Local Government Association, Royal College of Paediatrics and Child Health and Public Health England was sent to all Lead Members for children and young people and the Chairs of the Heath and Well Being Boards. This highlighted the consistently poor health outcomes for children in England especially amongst those in vulnerable groups such as looked after children. It also noted considerable variations in child health across England with international comparisons showing clear areas for improvement in child health outcomes.

1.2. The signatories call for all health and well being boards to sign up to the "Better health outcomes for children and young people pledge" to demonstrate a commitment to giving children and young people a better start in life.

2. The Pledge

2.1. The pledge lists five ambitions for the Board:

1) Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.

2) Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.

3) Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.

4) Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.

5) There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

2.2. These ambitions are in direct alignment with Outcome 1 in the Kent Health and Wellbeing Strategy which aims to give every child the best start in life, with a particular focus on the integration of services for 0 – 11 year olds and improving the mental health of our children and young people. These ambitions aim to contribute to the following health outcomes:

- reduce child deaths
- prevent ill health for children and young people and improve their opportunities for better long-term health
- improve the mental health of our children and young people
- support and protect the most vulnerable
- provide better care for children and young people with long term conditions and disability

3. Conclusions

3.1. For the Kent Health and Well Being Board to achieve the ambitions of this pledge there is a need for the Board to undertake further commitments in its approach to supporting improvements in child health. These are identified in the recommendations below.

4. Recommendations

4.1. The Kent Health and Well Being Board is asked to consider and endorse the "Better health outcomes for children and young people pledge".

4.2. To ensure the success of Ambition 2, the Board should recognise the need to plan for:

- **Seamless pathways for children and young people aged 0-25. As an example - The new Children and Families Bill 2014 stipulates under Part 3 that there should be a single education, health and care plan (EHC) for SEN and disability.**
- **Integrated holistic multi-agency services that recognise the correlation between children's wellbeing and family and community systems. Whole family working and multi-agency support is crucial, particularly when it comes to vulnerable young parents, ADD and ASD, emotional health and wellbeing and early child development.**
- **Inclusive services that are accessible for all with clear transitional arrangement in places for young carers, parent carers, adult carers and disabled people of all ages.**

4.3. There is a required commitment to integrated planned commissioning and care for children and young people, as Ambition 4 states. The Board will need to ensure commitment from CCGs, KCC, Schools, District councils and Public Health in order that services for children and young people are fully integrated across health and social care pathways, at the same time.

4.4. For Ambition 5 to be realised, Kent Health and Well Being Board will need to have a robust governance framework and sub-architecture in order that operational accountability lines are clear and that assurances can be provided appropriately to the Board for progress against the measured outcomes for child health. This is particularly relevant for the integration of the "function" of the previous Local Children's Trust Board's into the Local Health and Well-being Board.

5. Background Documents

5.1. *Better Health Outcomes for Children and Young People: our pledge*, Department of Health, Local Government Association, Public Health England & Royal College of Paediatricians and Child Health, July 2013 (attached)

5.2. Letter to Lead Member of Children's Services and Chair of the Health and Well Being Board, July 2013 (attached)

6. Contact Details

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Better health outcomes for children and young people

Our pledge

> "The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood."
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

Department of Health | Local Government Association | RCPCH Royal College of Paediatrics and Child Health | Public Health England

20 July 2013

Dear Lead Member for Children's Services and Chair of the Health and Wellbeing Board,

Improving health outcomes for children and young people: Delivering and commissioning children and young people's public health services and invitation to sign the pledge

You will be as shocked as we are that childhood mortality in this country is among the worst in Europe. You will also want to know how poor many outcomes are for children and young people with long-term physical and mental conditions as well as those who are acutely sick. April 2013 marked the transfer of public health from the NHS to local authorities. Local authorities are now responsible for delivering and commissioning a range of children and young people's public health services for five to 19-year-olds, with responsibility for children under five following from 2015. This puts local authorities and health and wellbeing boards in a prime position to tackle the poor health outcomes experienced by children and young people.

We are writing jointly to you to share the resources available to assist councils with this increased responsibility and to invite you to sign up to the "Better health outcomes for children and young people pledge". The pledge is a part of the February 2013 system wide response to the Children and Young People's Health Outcomes Forum Report (2012).

Health and wellbeing boards are a crucial part of the new health landscape. Each board will want to ensure there is a proper focus on children within its priorities, that it has a thorough assessment of their needs through the Joint Strategic Needs Assessment, as well as from engagement with children and young people themselves. With a well-informed Joint Health and Wellbeing Strategy, services can be commissioned that will give children the best start in life. The resources outlined in Appendix A will help you to make this a reality.

We hope that signing up to the pledge will demonstrate a commitment to giving children the best start in life. We also hope it will start local conversations about how health and wellbeing boards, local authorities, health and wider partners can work together to improve health outcomes for children and young people, and tackle the unacceptable variation in the quality of care for children and young people across the country and reduce health inequalities. The Local Government Association (LGA), the Royal Colleges, the Department of Health and Public Health England are proud signatories of the pledge. We encourage you to work with partners and to engage with local children and young people to adapt the pledge to reflect local needs. A copy of the pledge is available at Appendix B.

Lead Members for Children's Services play a key role in these conversations and in ensuring that the health needs and wellbeing of all children and young people, including the most disadvantaged and vulnerable, and their families

and carers, are addressed. Lead Members will want to ensure they are working closely with their health and wellbeing boards in doing this.

We recognise that many local authorities are already doing important work to prioritise children's health outcomes through integration and partnership working. If all local areas were as good as the best, together we could improve children and young people's quality of life now, and their ability to live fulfilling lives as they move through childhood. We are inviting local authorities, health and wellbeing boards, health, schools and wider partners to share examples of good practice so that learning can be promoted nationally. If you would like to share what your local authority is doing or planning to do to improve health outcomes for children and young people email a short description to Samantha.Ramanah@local.gov.uk. All examples will be published on the LGA's website and Knowledge Hub for the National Learning Network for Health and Wellbeing Boards to share learning.

Not all change is an improvement, but there is no improvement without change. We ask you to make a commitment to using the information and resources attached to challenge the status quo and to signing the pledge. Bold and brave decisions will be needed if we are to give children, young people and families the services they deserve.

Dan Poulter MP,
Parliamentary Under Secretary of State for Health,
Department of Health

Cllr David Simmonds,
Chair of the Children and Young People Board,
Local Government Association

Christine Lenehan, Director, Council for Disabled Children and Co-Chair of the Children and Young People's Health Outcomes Forum

Professor Ian Lewis, Medical Director, Alder Hey Children's NHS Foundation Trust and Co-Chair of the Children and Young People's Health Outcomes Forum

Dr Hilary Cass,
President,
Royal College of Paediatrics and Child Health

Duncan Selbie
Chief Executive
Public Health England

Appendix A – Further resources

The Pledge can be accessed at:
www.gov.uk/government/publications/national-pledge-to-improve-children-s-health-and-reduce-child-deaths

Knowledge Hub for the National Learning Network for Health and Wellbeing Boards (HWBs)
The Knowledge Hub for HWBs is a free online platform, it shares information, resources, ideas and learning on Health and Wellbeing Boards. Members can ask for help from other members and participate in live question and answer sessions.
Join here:
https://knowledgehub.local.gov.uk/group/nationallearningnetworkforhealthandwellbeingboards
Email Samantha.Ramanah@local.gov.uk for help or further information

LGA dedicated children's health webpage
The LGA works with local authorities, including lead members for children's services to deliver better health and wellbeing outcomes for children and young people. Access the full range of support tools and latest information on children's health issues including safeguarding in the reformed NHS system, Health and Wellbeing Boards, local Healthwatch and public health issues.
www.local.gov.uk/childrens-health

The LGA has a dedicated webpage on health with tools and resources on public health, Healthwatch and health and wellbeing boards.
www.local.gov.uk/health

Child Protection Information Sharing project
The Children and Young People's Health Outcomes Forum welcomed the Department of Health's child protection – information sharing project, which Dan Poulter MP announced in December 2012. This will enhance national IT systems in emergency departments and other unscheduled health care settings to include information, fed securely from local authority systems, on the child protection status of individual children.

Local authorities are encouraged to express interest in the project now and to be ready to come on stream when it starts to roll out next year. More information can be found at:
www.gov.uk/government/news/child-protection-information-sharing-project

Child Health Profiles
Child Health Profiles provide a snapshot of child health and well-being for each local authority in England using key health indicators, which enable comparison locally, regionally and nationally. By using the profiles local organisations can work in partnership to plan and commission evidence-based services based on local need. The profiles allow local authorities to

compare the outcomes in their local population with others in order to identify and share best practice. Find your local profile at: www.chimat.org.uk/profiles

Atlas of Variation in Healthcare for Children and Young People
The Atlas of Variation provides information to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

Variations in healthcare exist for many legitimate reasons. Populations and individuals have distinct needs, and some of the variation observed is a reflection of the responsiveness of the service to meeting particular needs. However, the degree of variation demonstrated in the Child Health Atlas cannot be explained solely on that basis. Identifying and tackling variations in healthcare will improve both the quality and efficiency of the care provided, and deliver the best possible health outcomes for all children and young people.
www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults

Establishing Local Healthwatch: Engaging with Children and Young People
Local Healthwatch's duties extend to involving children and young people in their work. It includes the need to develop strategies for effectively involving children and young people, and particularly those who are most disadvantaged. This is covered in one of a series of briefings produced by the Local Government Association to assist local authorities and their partners in local communities and the NHS to support the commissioning, setting up and early development of local Healthwatch. http://tinyurl.com/kxartmk

Factsheets for School Governors and Health and Wellbeing Boards and Children, Young People and Families
The Children and Young People's Health Outcomes Forum has published a range of factsheets. Local authorities may find the factsheets for school governors and health and wellbeing boards and children, young people and families of particular interest.
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

Factsheet on School Nursing
In addition the Department of Health has published a school nurse factsheet for head teachers and governors. The factsheet sets out details of the model and vision for school nursing which will positively impact on standards in all schools and improve health and wellbeing of school aged children and young people. http://tinyurl.com/kwpqvo2

Department of Health | Local Government Association | RCPCH Royal College of Paediatrics and Child Health | Public Health England

Briefing on School Health Service
The Department of Health and Local Government Association have produced a briefing for Lead Members for Children's Services (LCMS) providing an overview of the School Health Service and sharing top tips to help LCMS think about how they can use the School Health services to deliver better health outcomes for 5-19 year olds.
www.gov.uk/government/publications/school-health-service-briefing-for-local-council-members

From transition to transformation in public health
The LGA and Department of Health has produced a set of online resource sheets. The purpose of this resource is to assist local authorities and public health to develop a local public health system that is designed to have the greatest potential for improving health, not just in councils but with all local partners. The focus is on transformation, showing how councils and public health are going beyond the practical steps of transition to develop a local vision public health, supported by new models for implementation.
http://tinyurl.com/kdk5w9t

National Child Measurement Programme: Briefing for elected members
These frequently asked questions for elected members have been jointly produced by the Local Government Association and Public Health England. They address a number of transitional issues relating to the transfer of responsibility for delivering the National Child Measurement Programme, which moved from PCTs to local government in April 2013.
http://tinyurl.com/n5etuj8

'Must Knows' for lead members for children's services
The 'Must knows' are a long-standing source of information and support for lead members for children's services (LMCS). The suite of information has been comprehensively revised for 2013 and focuses on the key issues facing lead members for children's services and the current and planned reforms impacting on children's services.
http://tinyurl.com/n3pdwt3

Teenage pregnancy resources for elected members and officers
The LGA has launched a number of resources on teenage pregnancy to help local authorities understand and address the key issues. The resources include: Relationships and sex education: a briefing for councillors and a briefing on local government's role in tackling teenage pregnancy.
http://tinyurl.com/l5ekp56

The council's role in tackling public health issues – resources for local authorities
The LGA has launched a number of resources on key public health issues including obesity, mental health, drugs and alcohol.
http://tinyurl.com/cod86q6

The 2012 report of the Children and Young People's Health Outcomes Forum
www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results

The system wide response to the Forum's Report
http://tinyurl.com/msaupsh

Statutory guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

Safeguarding children in the reformed NHS system
The Department for Education has published revised statutory guidance 'Working together to safeguard children' (2013)
http://tinyurl.com/brwtm77

NHS England has published an updated accountability and assurance framework for safeguarding vulnerable children and young people which sets out the responsibilities of each of the key players for safeguarding in the new NHS system. http://tinyurl.com/c57dca4

A guide for new councillors 2013/14
This Councillors' Guide, produced by the Local Government Association is designed to provide new councillors with all the information they need to know. It explores some of the key issues and challenges facing local government today and includes useful hints and tips from experienced councillors.
http://tinyurl.com/l95trlg

National Health Visitor Plan: progress to date and implementation 2013 onwards
The 'National Health Visitor Plan' is a joint DH, NHS England, Public Health England and Health Education England document. It sets out how these partner organisations will work with the health profession, families, local authorities and communities to achieve the government's health visiting commitment to increase the workforce by 4,200, transform the service by April 2015 and support its sustainability beyond 2015.

In 2011 the 'Health Visitor Implementation Plan 2011-15' set out action to revitalise the health visiting service, to help an expanded workforce to provide a new health visitor service model. We are now at the half-way point of a 4 year programme of recruitment and retention, professional development and improved commissioning linked to public health improvement.

'The National Health Visitor Plan: progress to date and implementation 2013' celebrates the successes of the programme so far and sets out how partner organisations within the new health landscape will work with the profession, families and communities in delivering the national commitment up to and beyond 2015. www.gov.uk/government/publications/health-visitor-vision

From: Michael Thomas-Sam, Strategic Business Adviser

To: Kent Health and Wellbeing Board – 18 September 2013

Subject: **CCG Level HWBs' Children's Sub-Group**

Classification: Unrestricted

Clinical Commissioning Group Level Health and Wellbeing Boards' Children's Sub-Group (Children's Operational Group)

Terms of Reference (Agreed by Joint Commissioning Board on 01.08.13)

Role of the Sub-group

The purpose of the Children's Operational Group is to ensure effective child and family centred local engagement by partners, promote collaboration between organisations with the aim of improving the wellbeing of all children through effective implementation of strategies, planning, joined-up commissioning and effective service delivery.

The Children's Operational Group will:

1. Report to the Clinical Commissioning Group Level Health and Wellbeing Board and the Children and Young People Joint Commissioning Board.

2. Drive and support joined-up service delivery and promote service integration and take forward projects on behalf of, or in collaboration with the Clinical Commissioning Group Level Health and Wellbeing Board.

3. Consider how resources can be pooled for a positive impact on the wellbeing of all children.

4. Debate and explore ideas to address current, emerging and future needs, problems and issues inhibiting effective delivery of integrated services and make recommendations to the Clinical Commissioning Group Level Health and Wellbeing Board and the Children and Young People Joint Commissioning Board and other bodies as appropriate.

5. Monitor and challenge service delivery where outcomes are poor.

6. Review lessons learned and use benchmarking information to improve services.

7. Ensure effective local engagement on children's issues, using existing mechanisms and where necessary linking up with appropriate bodies.

8. Advise (as part of the early warning system) the Clinical Commissioning Group Level Health and Wellbeing Board and the Children and Young People Joint Commissioning Board (other bodies as appropriate) on local service issues that may have adverse impact on the wellbeing of all children.

9. Report to the Clinical Commissioning Group Level Health and Wellbeing Board and the Children and Young People Joint Commissioning Board twice a year on its activities and any significant emerging issues.

Membership

The following is the suggested core membership. Additional members can be agreed by the Clinical Commissioning Group Level Health and Wellbeing Board.

It is suggested that the Chairperson should be an existing member of the Clinical Commissioning Group Level Health and Wellbeing Board. Alternatively, the Clinical Commissioning Group Level Health and Wellbeing Board would elect a member of the Children's Operational Group as the Chairperson.

The Chairperson is responsible for ensuring that the Children's Operational Group effectively fulfils its role in pursuit of the overarching aim.

Membership will include:

- Primary/Secondary Schools' representative
- District Councils' representative
- Housing representative
- Kent Police
- KCC Specialist Children's Services representative
- KCC Education Learning and Skills representative
- Youth Services representative
- Clinical Commissioning Group representative
- Voluntary Sector representatives[1]
- Other representatives as agreed by the Health and Wellbeing Board.

Meeting Arrangements and Frequency

Meetings will be held every two months.

Linked KCC Strategic Commissioning Officers will provide planning and information sharing support to the Children's Operational Group.

[1] At leas one voluntary sector representatives to sit on CCG level HWB - Ashford (1), C4G (1), DGS (3), SKC (2), Swale (1), Thanet (1) and West Kent (4).

KCC Community Engagement Officers will assist with the transition and continue to provide organisation, facilitation and support.

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