# AGENDA

# HEALTH AND WELLBEING BOARD

**Wednesday, 19th November, 2014, at 6.30 pm** Ask for: **Ann Hunter**

**Darent Room, Sessions House, County Hall, Maidstone** Telephone **01622 694703**

*Refreshments will be available 15 minutes before the start of the meeting*

**Membership**

Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Dr B Bowes (Vice-Chairman), Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Mr G K Gibbens, Mr E Howard-Jones, Mr S Inett, Mr A Ireland, Dr M Jones, Dr E Lunt, Dr N Kumta, Dr T Martin, Mr P J Oakford, Mr S Perks, Dr R Stewart, Cllr P Watkins and Cllr L Weatherly

## UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

3 Declarations of Interest by Members in Items on the Agenda for this Meeting

In accordance with the Members' Code of Conduct, members of the board are requested to declare any interests at the start of the meeting. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

4 Minutes of the Meeting held on 17 September 2014 (Pages 5 - 8)

To consider and approve the minutes as a correct record

5 Update on the Joint Health and Social Care Self-Assessment Framework for 2013/14 (Pages 9 - 50)

To receive a report which provides a position statement on progress made on delivering the outcomes in the Joint Health and Social Care Self-Assessment Framework for 2013/14; progress made to date; a comparison of national results and a proposed process for sign off for the 2014/15 Joint Health and Social Care Self-Assessment Framework.

6 Kent Safeguarding Children Board - 2013/14 Annual Report (Pages 51 - 86)

To note the progress and improvements made during 2013/14, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board

7 Care Act 2014 - A New Legal Framework for Adult Social Care (Pages 87 - 92)

To discuss a report setting out the main changes of the Care Act 2014 that have implications for the constituent members of the Health and Wellbeing Board and impact the future development of the Joint Strategic Needs Assessment and implementation of the Kent Joint Health and Wellbeing Strategy

8 Kent Integration Pioneer Programme Update (Pages 93 - 104)

To note the report and progress to date within Kent’s Pioneer programme and support the approach for developing work streams in evaluation, Europe and the innovation lab

9 Systems Resilience (Pages 105 - 106)

To note the report and discuss what steps the Board needs to take to seek assurance that the appropriate steps are being taken to minimise the risks these challenges pose to the sustainability of local health and care services

10 Minutes of Local Health and Wellbeing Boards (Pages 107 - 150)

To note the minutes of the local health and wellbeing boards

11 a) Minutes of the Children's Health and Wellbeing Board b) Emotional Health and Wellbeing Strategy (Pages 151 - 180)

To note the minutes of the Children’s Health and Wellbeing

Board and the Emotional Health and Wellbeing Strategy

12 Promoting and Delivering the Kent Joint Health and Wellbeing Strategy - Progress reports from local Health and Wellbeing Boards (Pages 181 - 220)

To note the reports of the local health and wellbeing boards

13 Date of Next Meeting - 28 January 2015

## 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, 11 November 2014**

This page is intentionally left blank

**KENT COUNTY COUNCIL**

# HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 17 September 2014.

PRESENT: Mr R W Gough (Chairman), Dr F Armstrong, Mr I Ayres, Mr A Bowles, Ms H Carpenter, Mr P B Carter, CBE, Mr A Scott-Clark, Dr D Cocker, Ms P Davies, Ms C Greener, Mr S Inett, Mr A Ireland, Dr E Lunt, Dr T Martin, Mr P J Oakford, Mr C P Smith and Dr R Stewart

IN ATTENDANCE: Ms J Frazer (Programme Manager Health and Social Care Integration), Mr M Lemon (Strategic Business Adviser) and Mrs A Hunter (Principal Democratic Services Officer)

**UNRESTRICTED ITEMS**

**98. Chairman's Welcome**
*(Item 1)*

(1) The Chairman confirmed that he had written to local health and wellbeing boards encouraging them to consider how they might engage with the Kent Fire and Rescue Service, particularly in relation to falls prevention and the identification of dementia, as agreed at the last meeting of Kent Health and Wellbeing Board on 16 July 2014.

(2) He also said he had written, as agreed, to the local health and wellbeing boards asking them to ensure that the Kent Health and Wellbeing Strategy was reflected in any public engagement activities arranged by partner organisations and to report progress to the KHWB in November 2014.

(3) Mr Gough said that the actions identified in minute 89(4) would be followed through alongside the resolutions at minute 89(5).

(4) Mr Gough said that the Children's Health and Wellbeing Board had commissioned an Emotional Wellbeing Strategy for 0-25 year-olds and that a period of public engagement was underway on the strategy and the development of a supporting delivery plan. He suggested that this work be presented and discussed in more depth at the next meeting of the KHWB on 19 November with a view to recognising it as a supporting document beneath the Kent Health and Wellbeing Strategy.

**99. Apologies and Substitutes**
*(Item 2)*

Apologies for absence were received from Dr B Bowes, Mr G Gibbens, Mr E Howard-Jones, Dr M Jones, Dr Kumta, Mr S Perks and Cllr P Watkins. Mr C Smith and Ms C Greener attended as substitutes for Mr Gibbens and Mr E Howard-Jones respectively.

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

There were no declarations of interest.

**101. Minutes of the Meeting held on 16 July 2014**
*(Item 4)*

Resolved that the minutes of the Kent Health and Wellbeing Board held on 16 July 2014 are correctly recorded and that they be signed by the Chairman.

**102. BCF - Updates**
*(Item 5)*

(1) The Chairman thanked those involved in the submission to the Better Care Fund for their hard work in bringing it together.

(2) Jo Frazer (Programme Manager, Health and Social Care Integration) thanked the staff from the Clinical Commissioning Groups and the Better Care Fund team for their input. She introduced the report which outlined: the steps taken following the assurance process; changes to the policy underpinning the BCF that lead to the re-introduction of pay for performance; and summarised the changes required to the templates. She also said Kent's BCF submission, which had been circulated to all members of the HWB, was very likely to be approved subject to conditions relating to delivery and governance arrangements.

(3) In response to questions she confirmed that approximately £30m of the £101m BCF for Kent would be performance related pay and that payments for performance would be released quarterly at the Kent level.

(4) Chris Greener introduced a report prepared by Paul Hyde (Finance Director Kent and Medway) which considered the financial risk and governance arrangements for the sophisticated pooled budget arrangements required by the BCF.

(5) During discussion it was confirmed that S75 agreements would be between individual CCGs and KCC and that it was planned to use a generic template with an annex relating to each CCG. Comments were made that the changes to the BCF nationally made it less useful than anticipated and that the timescale for submission had not allowed for extensive public and patient engagement. There was also general agreement that: integration should be driven at a local and health economy level, in particular through structures that included provider engagement; the Board should have oversight of progress through the appropriate metrics; and the Pioneer programme was the vehicle to bring agencies together at the local level to drive integration and to lobby for legislative and policy changes at national level.

(6) Resolved that:

(a) The BCF plan be agreed and endorsed for submission to NHS England with a 3.5% target for emergency admissions across Kent;

(b) The CFO Finance Group be asked to consider how the on-going finance and performance requirements of the BCF might be met and reported to the Health and Wellbeing Board;

(c) The underlying principles to support the pay for performance element of the fund be noted;

(d) The clear commitment to closer integration across health and social care through the Kent Pioneer Programme be endorsed;

(e) The Area Team leads a group with CCG chief finance officers and senior leads identified by the KCC Corporate Director of Finance and Procurement to discuss and recommend pooled fund arrangements and provide a standard S75 agreement with local CCG annexes to support and deliver the Kent BCF plan and that this group be supported by the relevant experts in local government and National Support.

**103. Quality and the Health and Wellbeing Board**
*(Item 6)*

(1) Steve Inett (Healthwatch) introduced the report and gave a short presentation to support a discussion about how the HWB could be best apprised of key strategic quality issues and ensure that the commissioning plans of its constituent organisations reflected the needs of the population.

(2) During discussion, the members of the HWB said it was: important to avoid duplicating the work of other monitoring and regulatory bodies; that information should be high level to enable strong links with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, provide structured feedback to strategic commissioners and facilitate consideration of structural issues, such as workforce and service configuration, that cut across all organisations.

(3) Resolved that:
(a) A small group meets to consider the nature of a quality overview report to the Health and Wellbeing Board;

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

**104. Pharmaceutical Needs Assessment**
*(Item 7)*

(1) Andrew Scott-Clark (Interim Director of Public Health) introduced the report which included the draft form of the Kent Pharmaceutical Needs Assessment (PNA) proposed for consultation.

(2) In response to questions about the ability of the PNA to respond to future residential and other developments, he confirmed that the legislation allowed

for the publication of regular amendments. He also confirmed that Equality Impact Assessments would be completed and the needs of hard to reach groups would be included in the final PNA.

(3) Resolved:

(a) That the development of a draft Pharmaceutical Needs assessment be noted;

(b) That the key findings and recommendations to be formally consulted on be noted as follows:

(i) Overall there is good pharmaceutical service provision in the majority of Kent.
(ii) Where the area is rural, there are enough dispensing practices to provide basic pharmaceutical services to the rural population.
(iii) The proposed major housing developments across Kent, the main ones being Chilmington Green near Ashford and Ebbsfleet Garden City, means that these areas will need to be reviewed on a regular basis to identify any increase in pharmaceutical need.
(iv) The proposed Paramount leisure site plans in North Kent to be reviewed regularly to identify whether visitors and staff will have increased health needs including pharmaceutical.
(v) The current provision of "standard 40 hour" pharmacies to be maintained especially in rural villages and areas such as Romney Marsh.
(vi) The current provision of "100 hour" pharmacies to be maintained

(c) That proceeding to statutory consultation on the Pharmaceutical Needs Assessment with the key stakeholders and any other identified interested parties as per regulation and according to KCC's policy be endorsed.

**105. Healthwatch Annual Report 2014**
*(Item 8)*

(1) Steve Inett, Chief Executive Officer introduced the report, which included the Healthwatch annual report for 2014, and gave a short presentation outlining the role of Healthwatch, the activities underway to fulfil its role as the voice of the public and the projects planned for the future.

(2) In response to a question, he said that Healthwatch was keen to be involved with the children's health and wellbeing boards.

(3) Resolved that the Healthwatch Annual Report 2014 be noted.

**106. Date of Next Meeting - 19 November 2014**
*(Item 9)*

**To:** Kent Health and Wellbeing Board


**To be presented by:** Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Penny Southern, Director of Learning Disability and Mental Health


**When:** 19th November 2014


**Subject:** An update on the Joint Health and Social Care Self-Assessment Framework (JHSCSAF) for 2013/14.

This includes a look at how well Kent compares with the rest of the country and what we are doing about where we have not done so well.

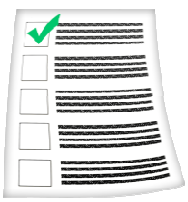

We will also look at the Kent Action Plan for carrying out the Winterbourne View Joint Improvement Programme.

---


**Summary:**
At the Kent Health and Wellbeing Board meeting on 20th November 2013 the Board agreed to support the submission and publication of the 2013 Kent Joint Health and Social Care Self-Assessment Framework (JHSCSAF).

This paper tells you about where we are at the moment and what we are doing to make any improvements including;

- progress made to date
- a comparison of national results
- and a process for sign off for the 2014/15 Joint Health and Social Care Self-Assessment Framework.

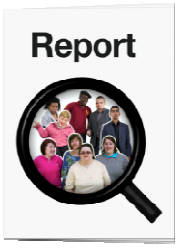



There is also an update on the Kent Action Plan for carrying out the Winterbourne View Joint Improvement Programme.


There are 2 reports with this paper:

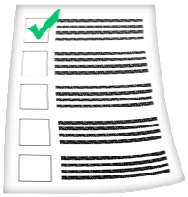
1. an easy read report which will be presented at the meeting of the Health and Wellbeing Board.

2. a more detailed report with further information.




These are the recommendations (what we will look at carefully) from the reports

1. To comment on the 2013/14 national comparison Action Plan including the progress made in the red indicators of the RAG rating.



2. To comment on the way in which Kent is approaching the 2014/15 JHSCSAF.

3. To comment on the Kent Action Plan for Winterbourne View.


4. To agree the process for sign-off of the Joint Health and Social Care Self-Assessment Framework 2014 so that Kent's Joint Health and Social Care Self-Assessment Framework is submitted in January 2015.

# Joint Health and Social Care Self-Assessment Framework and update on Winterbourne

## Health & Wellbeing Board

### 19th November 2014



---

Tina Walker: Co-Chair, Kent Learning Disability Partnership Board
Daniel Hewitt, Co-Chair of the Good Health Group
Penny Southern: Director of Learning Disability and Mental Health, KCC
Sue Gratton: Associate Partner, KMCS
Malti Varshney: Consultant Public Health, KCC
David Holman, Head of Mental Health Commissioning, West Kent CCG

# What is the Framework?

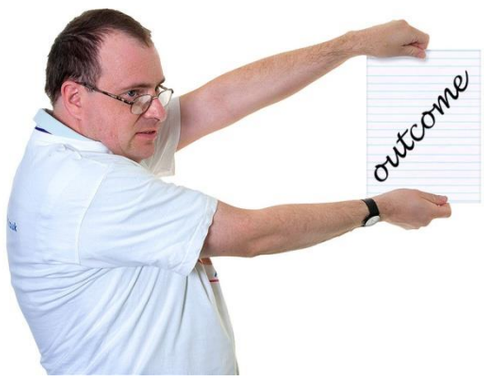
- It is a way to check that Health and Social Care in Kent are making sure things are getting better for people with a learning disability and to see what needs to be improved


- It will keep a record of how health and social care are providing services together in Kent


- Learning Disability Partnership Board, Clinical Commissioning Groups, Health & Wellbeing Boards and Local Authority are involved in doing this

# What will the Health & Wellbeing Board need to do?


- They need to hold Kent to account for completing and publishing the outcome and quality of Joint Health and Social Care Self Assessment Framework




- They need to ensure that the outcomes inform Health and Wellbeing Strategy and Joint Service Needs Assessment for people with a Learning Disability living in Kent


- They need to ask for evidence that shows improvements

# Outcome of the Self-Assessment Framework


The government has agreed to keep the Self Assessment Framework and continue to monitor services nationally

We have achieved an amber or green rating in all but 3 of the areas of the framework in 2013/14.

We had 3 red ratings in contract compliance assurance, health screening and health action plans

# How do we compare nationally?

# Facts and figures

Majority Rating Highlighted Yellow

| Measure | Total Responses | GREEN | % | AMBER | % | RED | % | KENT Rating | (For Printing purposes) | Below National Average? |
|---|---|---|---|---|---|---|---|---|---|---|
| A1 | 148 | 52 | 35.14% | 78 | 52.70% | 18 | 12.16% | | AMBER | NO |
| A2 | 148 | 41 | 27.70% | 72 | 48.65% | 35 | 23.65% | | RED | YES |
| A3 | 149 | 14 | 9.40% | 100 | 67.11% | 35 | 23.49% | | AMBER | NO |
| A4 | 144 | 24 | 16.67% | 54 | 37.50% | 66 | 45.83% | | | |
| A5 | 148 | 36 | 24.32% | 76 | 51.35% | 36 | 24.32% | | RED | YES |
| A6 | 146 | 32 | 21.92% | 71 | 48.63% | 43 | 29.45% | | AMBER | NO |
| A7 | 148 | 86 | 58.11% | 56 | 37.84% | 6 | 4.05% | | AMBER | YES |
| A8 | 147 | 16 | 10.88% | 122 | 82.99% | 9 | 6.12% | | AMBER | NO |
| A9 | 146 | 20 | 13.70% | 89 | 60.96% | 37 | 25.34% | | AMBER | NO |
| B1 | 150 | 30 | 20.00% | 59 | 39.33% | 61 | 40.67% | | AMBER | NO |
| B2 | 150 | 45 | 30.00% | 69 | 46.00% | 36 | 24.00% | | RED | YES |
| B3 | 140 | 56 | 40.00% | 77 | 55.00% | 7 | 5.00% | | AMBER | NO |
| B4 | 150 | 73 | 48.67% | 76 | 50.67% | 1 | 0.67% | | AMBER | NO |
| B5 | 151 | 23 | 15.23% | 103 | 68.21% | 25 | 16.56% | | AMBER | NO |
| B6 | 150 | 52 | 34.67% | 94 | 62.67% | 4 | 2.67% | | AMBER | NO |
| B7 | 150 | 64 | 42.67% | 72 | 48.00% | 14 | 9.33% | | GREEN | NO |
| B8 | 150 | 65 | 43.33% | 81 | 54.00% | 4 | 2.67% | | GREEN | NO |
| B9 | 149 | 61 | 40.94% | 83 | 55.70% | 5 | 3.36% | | AMBER | NO |
| C1 | 149 | 89 | 59.73% | 59 | 39.60% | 1 | 0.67% | | GREEN | NO |
| C2 | 147 | 51 | 34.69% | 94 | 63.95% | 2 | 1.36% | | AMBER | NO |
| C3 | 148 | 81 | 54.73% | 67 | 45.27% | 0 | 0.00% | | AMBER | YES |
| C4 | 147 | 89 | 60.54% | 58 | 39.46% | 0 | 0.00% | | GREEN | NO |
| C5 | 150 | 54 | 36.00% | 82 | 54.67% | 14 | 9.33% | | GREEN | NO |
| C6 | 149 | 39 | 26.17% | 89 | 59.73% | 21 | 14.09% | | AMBER | NO |
| C7 | 148 | 39 | 26.35% | 98 | 66.22% | 11 | 7.43% | | GREEN | NO |
| C8 | 148 | 51 | 34.46% | 97 | 65.54% | 0 | 0.00% | | AMBER | NO |
| C9 | 147 | 60 | 40.82% | 82 | 55.78% | 5 | 3.40% | | AMBER | NO |
| Total | 3997 | 1343 | 33.60% | 2158 | 53.99% | 496 | 12.41% | Overall | AMBER | NO |

# Kent Learning Disability Partnership Board Monitors Progress


**<u>Staying Healthy</u>** (A1-A9)**– this work is being monitored by the Good Health Group**

- NHS Health Checks
- Cervical, breast and bowel screening
- Learning Disability Liaison function in acute settings

**<u>Keeping Safe</u>** (B1-B9)**– this is being monitored by the Winterbourne Steering Group & Divisional Management Teams**

- Quality in Care
- Contract compliance assurance
- Kent Local Action Plan for Winterbourne View

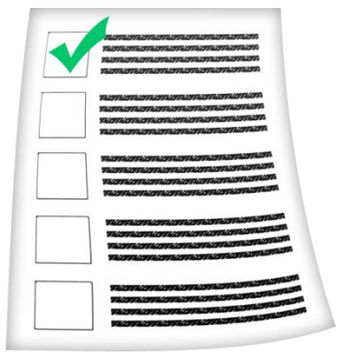

**<u>Living Well</u>** (C1-C9)**– this is being led by the Kent Learning Disability District Partnership Groups**

- Community Inclusion
- District Partnership Groups' Action Plans

# What we have done since receiving our results
# Some headlines….


**Staying Healthy – monitored by the Good Health Group**

- Public Health have held regular meetings with Kent and Medway Commissioning Support, the Clinical Commissioning Groups, Public Health England and NHS England to look at how we can get more people with learning disabilities to have screening and health checks. This includes plans for GP training and NHS England are writing to GP practices asking them for some more information on why they believe that women with a learning disability are not taking up screening opportunities.



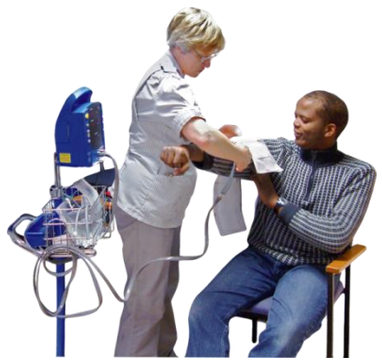
- The Good Health Group have been working on a cancer screening questionnaire. The questionnaire was sent out to Support Workers to discuss with adults with a learning disability. The responses are being looked at now.

# What we have done since receiving our results
# Some headlines….

## Staying Healthy


- The Needs Assessment identified where we need to look at gaps in health improvement services

- Developing projects to undertake health improvement initiatives



- Aim is to develop health improvement services that tackle problems early on.


- The draft Sensory Strategy has been developed.

# What we have done since receiving our results
# Some headlines….

**Keeping Safe – Winterbourne Steering Group & the Divisional Management Team for Learning Disability and Mental Health**

- Commissioning staff are visiting all providers of learning disability services and plan to do this annually

- Commissioning staff are planning a way forward for looking at the Quality in Care framework

- Work is going on across social services to make sure that our performance with the Mental Capacity Act and Depravation of Liberty Safeguards meets new legal requirements

# What we have done since receiving our results
# Some headlines….


**Keeping Safe**

- Commissioners have launched the KCC Accommodation Strategy. The aim of the strategy is to work with partner organisations and agencies to develop and make available a wide range of housing and accommodation for people with learning disabilities, reducing the dependency on residential care and offering more choice and the appropriate accommodation.

- A programme of transformation is underway to reshape the learning disability residential market, improve the range of short break facilities available to people with a learning disability and their carers; further development of the Supporting Independence Service and Shared Lives Service.


# Winterbourne Update

77 clients, based in a range of secure and non-secure hospitals, have been assessed to see if they can move into the community


The assessments said:

- 41 clients are appropriately placed in hospital
- 36 clients need to move into the community

Of the 36 clients that need to move into the community:

- 12 clients have moved into the community
- 12 clients have plans in place to move by the end of the year
- 8 clients are waiting for the right placement to be found
- 4 clients need forensic outreach support to move but this is not currently available

# Winterbourne update other news

- The Joint Strategic Plan - CCGs and local authorities will set out a Joint Strategic Plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. The **Plan** for Kent is in development and a draft has been shared with Working Group members

- Kent and Medway Partnership Trust and Kent Community Health Trust are getting new staff to work in a new enhanced community service from January 2015

- We have told NHS England that there is not enough forensic outreach support for people with learning disabilities. This could stop us moving people from secure hospitals into the community

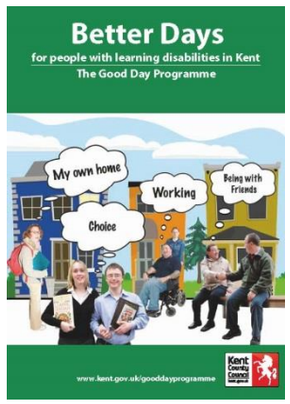
# What we have done since receiving our results

## Some headlines….


**Living Well - this is being led by the Kent Learning Disability District Partnership Groups**

- The Kent Valuing People Partnership have made a plan for checking access to arts and culture in Kent. This will be done in January 2015 with the findings available in the Spring.

- District Partnership Group Action Plans have focussed on work that has made community facilities more accessible to adults with a learning disability.




- The Good Day Programme supports people in all parts of Kent to find local services and activities to suit their needs. The programme has increased the range of opportunities available in various locations – one particular example is Folkestone Sports Centre.

# Learning Disability Integrated Commissioning

## The Case for Change – What we are doing


- We are looking at how we commission Health and Social Care Services for adults with a Learning Disability
- We want to have an integrated approach with all partners
- We are looking at different models to deliver integrated commissioning
- A report is going to the CCGs in December 2014 to decide what model is best for the future

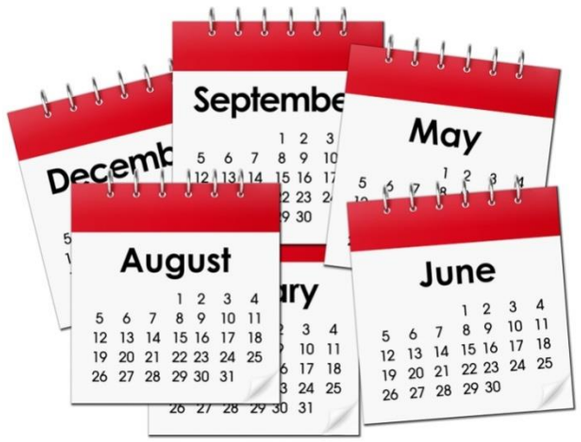
# Learning Disability Integrated Commissioning

## The Case for Change – Why are we doing this?


- So that we buy good Health and Social Care services for people with learning disabilities that are a good quality and value for money


- To make sure each area has the same approach to buying services


- To have a Kent-wide performance Framework




# Timeframe for the Joint Health and Social Care Learning Disability Self-Assessment Framework 2014/15




| Date | What is happening |
|---|---|
| **End January 2015** | Local Authorities and CCG Leads to complete the framework.<br><br>This must be approved by:<br>• Learning Disability Partnership Board<br>• The Kent Health & Wellbeing Board (H&WBB) |
| **February 2015** | Regional improvement work.<br>The following agencies to lead on putting together regional action plans: NHS England, Association of Directors of Adult Social Services |
| **End March 2015** | There will be a presentation to the Health & Wellbeing Board– leading to local action plan |
| **End March 2015** | Review questions and launch the 2014/15 SAF |


# Recommendations



The Health and Wellbeing Board is asked:

- To comment on the 2013/14 national comparison including the progress made in the red indicators of the RAG rating.
- To comment on the way in which Kent is approaching the 2014/15 JHSCSAF.
- To comment on the Kent Action Plan for Winterbourne View.
- To agree the process for sign-off of the Joint Health and Social Care Self-Assessment Framework 2014 so that Kent's Joint Health and Social Care Self-Assessment Framework is submitted in January 2015.

**To:** Kent Health and Wellbeing Board

**By:** Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

**Date:** 19 November 2014

**Subject:** An Update on the Joint Health and Social Care Self-Assessment Framework (JHSCSAF) for 2013/14 including a national comparison and progress to date. This includes the Kent Action Plan for the local implementation of Winterbourne View Joint Improvement Programme

**Classification:** Unrestricted

**Summary:**
At the meeting of the Kent Health and Wellbeing Board on 20th November 2013 the Board agreed to support the submission and publication of the 2013 Kent Joint Health and Social Care Self-Assessment Framework (JHSCSAF). This paper provides a position statement on progress made on delivering the outcomes in the Joint Health and Social Care Self-Assessment Framework for 2013/14; progress made to date; a comparison of national results and a process for sign off for the 2014/15 Joint Health and Social Care Self-Assessment Framework.

This includes an update on the Kent Action Plan for the local implementation of Winterbourne View Joint Improvement Programme.



## 1 Introduction

The Joint Health and Social Care Self-Assessment Framework is a single delivery and monitoring tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, the Department of Health and the Association of Directors of Adult Social Services on the following:

- *Key priorities in the:*
  - Winterbourne View Final Report Annex B (WBV)
  - Adult Social Care Outcomes Framework 2013-14 (ASCOF)
  - Public Health Outcomes Framework 2013-16 (PHOF)

- National Health Service Outcomes Framework 2013-14(NHSOF)

- *Key levers for the improvement of health and social care services for people with learning disabilities*
  - Equality Delivery System
  - Safeguarding Adults at Risk requirements
  - Health & Wellbeing Boards
  - Consultation and co-production with people with learning disability and family carers
  - Progress report on Six Lives and the provision of public services for people with learning disabilities.

The Joint Health and Social Care Self-Assessment Framework ensures a targeted approach to improving health equalities and achieving equal and fulfilling citizenship, helping commissioners and local people assess how well people with a learning disability are supported to STAY HEALTHY, KEEPING SAFE and LIVING WELL.



## 2. Uses of the framework

The findings from the JHSCSAF are used both locally and nationally.

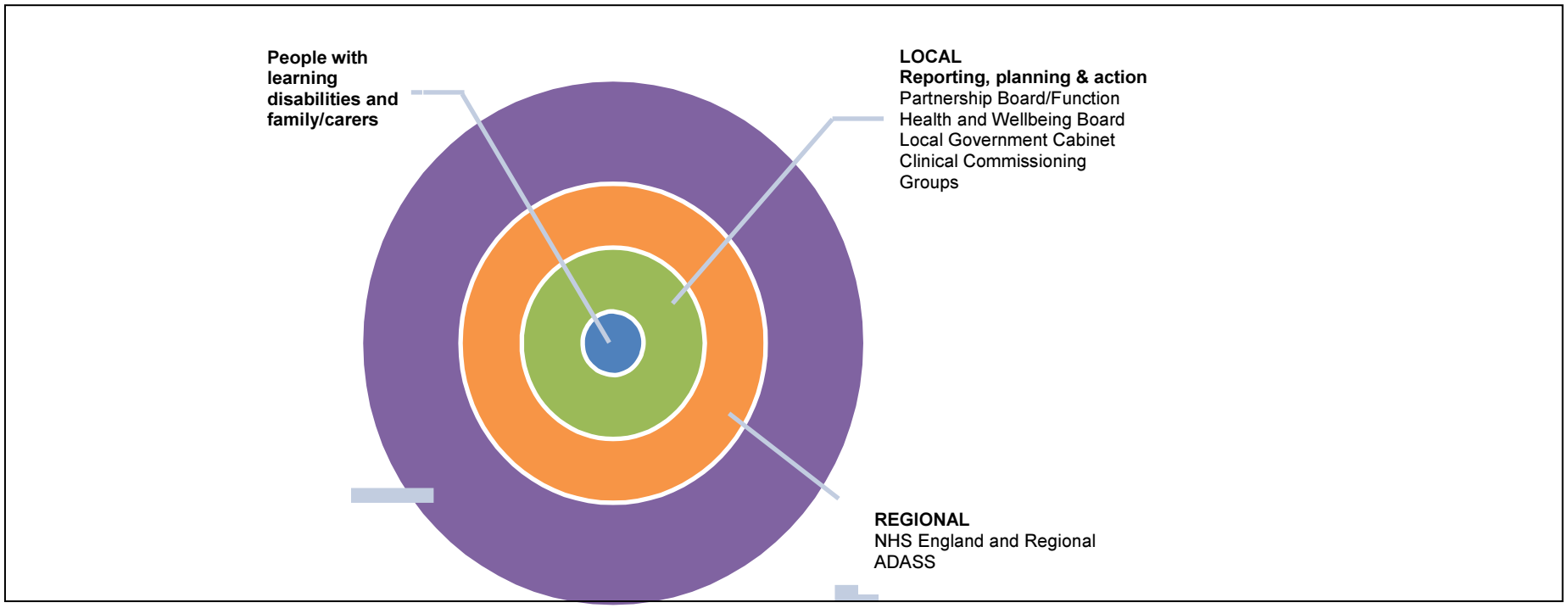
Nationally, it is issued to report publicly and to Ministers on the progress in providing services in every part of the country to meet the aspirations of *Healthcare for All* and of *Transforming care: A National Response to Winterbourne View*. Locally, it is used to inform:

- Joint Strategic Needs Assessments
- Health and Wellbeing Strategies
- Commissioning intentions/strategy
- Winterbourne View Kent Local Action Plan
- Learning Disability Partnership Board work programmes

The organisational arrangements of the JHSCSAF retain at their heart the principles of engaging with people with a learning disability, their families and carers, and of strengthening their voice. The governance arrangements set out below are designed to support this.

## 3. Governance structure

The governance structure is designed to facilitate local, regional and national arrangements for reporting, planning and action. The Local Authorities and Clinical Commissioning Groups, through their Health and Wellbeing Boards, provide the local leadership. The geographical arrangements for the JHSCSAF are based on Local Authority/ Health and Wellbeing Board Boundaries.



## 4. National Comparison

The Kent submission was sent to NHS England and ADASS in January 2014. Feedback was made available about how well we did in comparison to the 154 other submissions in June.

**Majority Rating Highlighted Yellow**

| Measure | Total Responses | GREEN | % | AMBER | % | RED | % | KENT Rating | (For Printing purposes) | Below National Average? |
|---|---|---|---|---|---|---|---|---|---|---|
| A1 | 148 | 52 | 35.14% | 78 | 52.70% | 18 | 12.16% | | AMBER | NO |
| A2 | 148 | 41 | 27.70% | 72 | 48.65% | 35 | 23.65% | | RED | YES |
| A3 | 149 | 14 | 9.40% | 100 | 67.11% | 35 | 23.49% | | AMBER | NO |
| A4 | 144 | 24 | 16.67% | 54 | 37.50% | 66 | 45.83% | | | |
| A5 | 148 | 36 | 24.32% | 76 | 51.35% | 36 | 24.32% | | RED | YES |
| A6 | 146 | 32 | 21.92% | 71 | 48.63% | 43 | 29.45% | | AMBER | NO |
| A7 | 148 | 86 | 58.11% | 56 | 37.84% | 6 | 4.05% | | AMBER | YES |
| A8 | 147 | 16 | 10.88% | 122 | 82.99% | 9 | 6.12% | | AMBER | NO |
| A9 | 146 | 20 | 13.70% | 89 | 60.96% | 37 | 25.34% | | AMBER | NO |
| B1 | 150 | 30 | 20.00% | 59 | 39.33% | 61 | 40.67% | | AMBER | NO |
| B2 | 150 | 45 | 30.00% | 69 | 46.00% | 36 | 24.00% | | RED | YES |
| B3 | 140 | 56 | 40.00% | 77 | 55.00% | 7 | 5.00% | | AMBER | NO |
| B4 | 150 | 73 | 48.67% | 76 | 50.67% | 1 | 0.67% | | AMBER | NO |
| B5 | 151 | 23 | 15.23% | 103 | 68.21% | 25 | 16.56% | | AMBER | NO |
| B6 | 150 | 52 | 34.67% | 94 | 62.67% | 4 | 2.67% | | AMBER | NO |
| B7 | 150 | 64 | 42.67% | 72 | 48.00% | 14 | 9.33% | | GREEN | NO |
| B8 | 150 | 65 | 43.33% | 81 | 54.00% | 4 | 2.67% | | GREEN | NO |
| B9 | 149 | 61 | 40.94% | 83 | 55.70% | 5 | 3.36% | | AMBER | NO |
| C1 | 149 | 89 | 59.73% | 59 | 39.60% | 1 | 0.67% | | GREEN | NO |
| C2 | 147 | 51 | 34.69% | 94 | 63.95% | 2 | 1.36% | | AMBER | NO |
| C3 | 148 | 81 | 54.73% | 67 | 45.27% | 0 | 0.00% | | AMBER | YES |
| C4 | 147 | 89 | 60.54% | 58 | 39.46% | 0 | 0.00% | | GREEN | NO |
| C5 | 150 | 54 | 36.00% | 82 | 54.67% | 14 | 9.33% | | GREEN | NO |
| C6 | 149 | 39 | 26.17% | 89 | 59.73% | 21 | 14.09% | | AMBER | NO |
| C7 | 148 | 39 | 26.35% | 98 | 66.22% | 11 | 7.43% | | GREEN | NO |
| C8 | 148 | 51 | 34.46% | 97 | 65.54% | 0 | 0.00% | | AMBER | NO |
| C9 | 147 | 60 | 40.82% | 82 | 55.78% | 5 | 3.40% | | AMBER | NO |
| Total | 3997 | 1343 | 33.60% | 2158 | 53.99% | 496 | 12.41% | Overall | AMBER | NO |

**Note:** A full description of all the indicators is provided in the appendix
All measures in **section A** (A1-A9) are **Staying Healthy**
Measures in **section B** (B1-B) are **Keeping Safe**
Measures in **section C** (C1-C9) are **Living Well**

## 5 What we are doing to improve outcomes

### 5.1 Staying Healthy (Section A of the JHSCSAF)

Public Health, South East Commissioning Support Unit, the local team of NHS England KCC and Public Health England are working together to identify issues relating to low uptake of Learning Disability health checks and of national screening programmes with the aim of increasing uptake. To date, the following actions have been identified and pursued: sharing information between organisations in order to ensure that people with a learning disability are identified; developing training for GPs to ensure that they understand the barriers for people with learning disabilities to use LD health checks and that the GP is provided with tools to overcome this; developing an audit of screening practice in GP surgeries for people with learning disabilities with colleagues from Public Health England.

The Needs Assessment has been refreshed this year and has identified where we need to address gaps in health improvement services. As a result a number of projects have been developed to undertake health improvement initiatives. The aim of this work is to develop population level systemic interventions to reduce health inequalities.



### 5.2 Keeping Safe (Section B of the JHSCSAF)

Commissioners are undertaking a schedule of introductory visits and full monitoring reviews for all commissioned services to ensure that all providers are complying with the terms of their contracts. Depending on the size and type of service, this will involve: in person introductory visits for new service providers at the service; in person full monitoring reviews at the service; a virtual review in terms of a self-assessment for the service. These will be carried out on an annual basis.

A Red, Amber Green (RAG) rating tool has been produced to include a quality assessment of learning disability residential services and if the service meets future requirements. The RAG rating of all learning disability residential services has been carried out with the outcome informing both the Accommodation Strategy and the reshaping of the residential market through the Transformation Programme.

KCC commissioned the Institute of Public Care (IPC) to lead on the development of a Quality in Care (QiC) framework. The framework will:

- Develop a shared vision of Quality in Care across its partner organisations.
- Develop an overarching QiC framework outlining the principles to which the partner organisations adhere; Roles and responsibilities of the partner organisations in contributing to the QiC framework. High level reporting mechanisms and a

series of overarching Key Performance Indicators by which partners can monitor services over time.

Community Learning Disability Teams and health partners will pilot the new framework and testing of the model, including defining roles and responsibilities within health and social care teams and providers of commissioned services.

### 5.2.1 The case for change

We are looking at how we commission Health & Social Care Services for people with a Learning Disability with an aim of an integrated approach to commissioning with all partners. This includes looking at different models to deliver integrated commissioning. A report is going to the Clinical Commissioning Groups in December 2014 to decide what model is best for the future.

The outcomes of this work will ensure that we jointly commission Health & Social Care services for people with learning disabilities that are a good quality and value for money. This will be monitored through a performance framework which will report regularly to the Learning Disability Management Team.



### 5.2.2 The Kent Action Plan for Winterbourne View

A total of 77 clients, placed in a range of secure and non-secure hospitals, have been assessed to see if they can move into the community. The results of the assessments were that:

- 41 clients were appropriately placed in hospital
- 36 clients need to move into the community


Of the 36 clients that need to move into the community

- 12 clients have moved into the community
- 12 clients have plans in place to move by the end of the year
- 8 clients are waiting for the right placement to be found
- 4 clients need forensic outreach support to move but this is not currently ava

In order to provide greater capacity to support clients who need to move into the community and to prevent people having to be admitted to hospital, Kent and Medway Partnership Trust (KMPT) and Kent Community Health Trust (KCHT) will have new staff to

work in a new enhanced community care pathway from January 2015. However, further support is needed for forensic clients in the community before they can be discharged. We have told NHS England that there is not enough forensic outreach support for people who urgently need it.

### 5.3 Living Well (Section C of the JHSCSAF)

The Kent Valuing People Partnership have developed an audit plan for arts and culture accessibility which they will start to work on in 2015. The anticipated outcomes of this work include: sharing findings of the audit with venues to provide them with information and best practice examples; promote the museums and galleries who make provision for people with a learning disability; promote the showing of autism friendly films in cinemas.

The Good Day Programme supports people in all parts of Kent to find local services and activities that suit their needs. During its life, the programme has increased the range of opportunities available in various locations but one particular example is Folkestone Sports Centre.



## 6. How we are monitoring what we are doing

All the work on the Joint Health and Social Care Self-Assessment Framework is being monitored by the Kent Learning Disability Partnership Board. Each of the three areas of the JHSCSAF are monitored separately: the Good Health Group monitors Section A (Staying Healthy), the Winterbourne Steering Group and the Safegaurding Divisional Management Team monitor Section B(Keeping Safe) and the District Partnership Groups monitor Section C (Living Well). The Kent Learning Disability Partnership Board looks at progress across the whole document.

## 7. Timeframe for submitting the 2014/15 JHSCSAF

Association of Directors of Adult Social Services (ADASS) and NHS England confirmed in September that the Joint Health and Social Care Self-Assessment Framework will continue for the coming year. The following timescale and activity have been published and highlight the activity for the year ahead for the 2014/15 JHSCSAF.

| Date | Action |
|---|---|
| **End January 2015** | Local Authorities and CCG Leads to complete initial submission of 2014/15 JHSCSAF.<br><br>This must be approved by the Learning Disability Partnership Board and signed off by the Health and Wellbeing Board |
| **February 2015** | Regional improvement work.<br>NHS England and ADASS leads for regional work. Leading to regional action plans/sector led improvement |
| **End March 2015** | Presentation to Health and Wellbeing Boards – leading to a local action plan. |
| **End March 2015** | Review questions and launch 2014/15 JHSCSAF |



## 7 Recommendations

1. To comment on the 2013/14 national comparison Action Plan including the progress made in the red indicators of the RAG rating.
2. To comment on the way in which Kent is approaching the 2014/15 JHSCSAF.
3. To comment on the Kent Action Plan for Winterbourne View.
4. To agree the process for sign-off of the Joint Health and Social Care Self-Assessment Framework 2014 so that Kent's Joint Health and Social Care Self-Assessment Framework is submitted in January 2015.

Penny Southern
Director of Learning Disability and Mental Health
Families and Social Care
Kent County Council
0300 333 6161 penny.southern@kent.gov.uk

Sue Gratton
Associate Partner – South East Commissioning Support Unit
07766 902 479
suegratton@nhs.net

# Appendix

## Joint Health & Social Care Self-Assessment Framework

## Explanation of measures & red, amber, green (RAG ) ratings

**Staying Healthy**: A1-A9

| Measure | Guidance Notes |
|---|---|
| **A1**<br><br>**Current Rating:**<br><br>**Amber** | There is concern that many people with learning disability are unknown to services and do not subsequently get access to the healthcare that they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disability. Using available prevalence data will allow some indicative benchmarking around whether numbers of people on registers are likely to be accurate. All people with learning disability are not being identified via the QOF and therefore local data needs to be scrutinised and systems put in place within primary care to ensure that all people are put onto the QOF register irrespective of if they are known to social services, or not.<br><br>**Red**: The numbers of people on Learning Disability (LD) and Downs Syndrome Registers reflect the requirements outlined in QOF<br>**Amber**: Learning Disability and Down Syndrome Registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity)<br>**Green**: Learning Disability and Down Syndrome Registers reflect prevalence data. Data stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.) |
| **A2**<br><br>**Current Rating:**<br><br>**Red** | Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability.<br><br>**Red:** Evidence that people with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease Epilepsy but NO COMPARATIVE DATA of the population that do not have a learning disability<br>**Amber:** Comparative data in some of the health areas listed in the descriptor at LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP level<br>**Green:** Comparative data in all of the health areas listed in the descriptor at each of the following levels; LOCAL AREA TEAM CLINICAL COMMISSIONING GROUP,INDIVIDUAL GP PRACTICE |

| | |
|---|---|
| **A3**<br><br>**Current Rating:**<br><br>**Amber** | Whilst many practices sign up to the LD DES there is significant variability in the numbers of annual health checks that are actually completed. Underlying health conditions continue to be missed leading to poor health, sometimes death and long term costly interventions. Annual health checks have been shown to effectively reduce health inequality and improve health outcomes. Therefore a population wide 'roll out' at a local level is an essential action required to secure long term and consistent improvement in the health of this vulnerable group.<br><br>**Red:** Registers not validated since set up. 25% of people with learning disability on the GP DES Register had an annual health check.<br>**Amber**: Registers Validated within past 12 months. 50% of people with learning disability GP DES Register had an annual health check.<br>**Green**: Validated on a minimum of an annual basis and process in place for all people aged 18 or over to be put on register.80% of people with learning disability GP DES Register had an annual health check. |
| **A4**<br><br>**Current Rating:**<br><br>**Nil return** | The LD DES guidance puts the onus on GPs to generate meaningful health action plans at the time of the annual health check to address health priorities. Integrated annual health checks and health action plans will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which can support reduction inappropriate secondary care referrals. It also provides the person with a learning disability (and their Carer, if appropriate) with a clear understanding of what needs to happen over the next 12 months.<br><br>**Red:** No evidence that the Annual Health Check and Health Action Plans are integrated.<br>**Amber:** GP Annual health check data indicates that a Health Action plan has been completed, directly as a result of an AHC, in the current year for 70% of patients.<br>**Green:** GP Health Action Plan (HAP) contains specific health improvement targets identified during the AHC for 50% of patients (to be captured through AHC template |
| **A5**<br><br>**Current Rating:**<br><br>**Red** | Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability.<br><br>**Red:** Unable to produce data for people with a learning disabilities in each and every screening group a, b & c.<br>**Amber:** Numbers of completed health screening for eligible people who have a learning disability; AND Some comparative data but |

| | |
|---|---|
| | not for every screening group requested.<br>**Green:** Numbers of completed health screening for eligible people who have a learning disability in every screening group; AND comparative data of screening rates in the non LD population for every screening group; AND Scrutinised exception reporting and evidence of reasonably adjusted services |
| **A6**<br><br>**Current Rating:**<br><br>**Amber** | Healthcare providers frequently state that having no prior warning of somebody's learning disability and specific needs resulting from their disability, prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be made trackable as identified within primary and secondary care. By including LD status in your referral you will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will lead to a potential reduction in DNA's, length of stay and inappropriate repeat attendances.<br><br>**Red:** There is no LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals<br>**Amber:** There is evidence of a LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed<br>**Green**: Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the ld identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed |
| **A7**<br><br>**Current Rating:**<br><br>**Amber** | In Healthcare for All (recommendation 10) the value of advocacy, including learning disability liaison is clearly described, as well as a clear call for Trust Boards to publicly report that they have effective systems to deliver reasonably adjusted health services. Many Trusts have appointed learning disability liaison nurses though there is more than one way in which the learning disability liaison function can be delivered. This indicator seeks to explore the full extent of the learning disability liaison function in acute settings within the localities in England. Of particular importance is whether providers and commissioners are gathering and using HES data to inform decisions on where the greatest need for an LD function may be given trends and evidenced need.<br><br>**Red:** No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site<br>**Amber**: Designated learning disability liaison function or equivalent process in place and details of the provider sites covered has been submitted. Providers are not yet using known activity data to effectively employ LD liaison function against demand.<br>**Green:** Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes |

| | |
|---|---|
| **A8**<br><br>**Current Rating:**<br><br>**Amber** | Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator will capture examples of where this is happening well in the wider primary care community. In order for reasonable adjustments to occur routinely services need a way to both record patients' learning disability status and describe the required reasonable adjustments. This measure is about universal services **NOT** those services specifically commissioned for people with a learning disability.<br><br>**Red:** People with learning disability accessing/using these services are not flagged or identified. There are no examples of reasonable adjusted care<br>**Amber:** Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements.<br>**Green:** All people with learning disability accessing/using service are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement |
| **A9**<br><br>**Current Rating:**<br><br>**Amber** | Evidence suggests 7% of the prison population - and greater number in the criminal justice system, have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform Provision, regarding: what is available including prevention, development required and ensuring health services are accessible.<br><br>**Red:** There is no systematic collection of data about the numbers of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability<br>**Amber**: An assessment process has been agreed to identify people with LD in all offender health services e.g. learning disability screening questionnaire.<br>Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system.<br>**Green**: Local Commissioners have good data about the numbers /prevalence of people with a learning disability in the CJS. Local commissioners have are working with regional, specialist prison health commissioners. Good information on health needs of people with LD in local prisons /wider criminal justice system and a clear plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check, or are scheduled to have one within 6 months (either as part of custodial sentence or following release, as part of GP health check cycle). They are offered a Health Action Plan. |

**Section B: Keeping Safe**

| Measure | Guidance Notes |
|---|---|
| **B1**<br><br>**Current Rating:**<br><br>**Amber** | Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way.<br><br>**Red**: Less than 90% of all care packages including personal budgets reviewed at least annually<br>**Amber**: Evidence of at least 90% of all care packages including personal budgets reviewed at least annually<br>**Green:** Evidence of 100% of all care packages including personal budgets reviewed at least annually |
| **B2**<br><br>**Current Rating:**<br><br>**Red** | This measure asks localities to demonstrate how thorough their contracting processes are. This is important as contract monitoring is one of the first methods of scrutiny and assurance.<br><br>**Red:** Less than 90% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance<br>**Amber:** Evidence of at least 90% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health & social care.<br>**Green:** Evidence of 100% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health & social care |
| **B3**<br><br>**Current Rating:**<br><br>**Amber** | Following the publication of Healthcare for All in 2008 (Sir Jonathan Michael) the CQC developed a number of essential standards for healthcare providers to meet in order to assure a minimum standard of care, to be offered to people with learning disability. Subsequently MONITOR (the independent regulator of Foundation Trusts) adopted the same standards into their compliance framework. As these are minimal quality standards it would be expected that all FTs should be meeting these. This indicator not only seeks confirmation that this is the case but expects commissioners to demonstrate the evidence gathered from providers to confirm this and the evidence that where trusts strive to achieve foundation status, commissioners support the attainment of monitor standards.<br><br>**Red:** Commissioners do not assure themselves of the ongoing compliance, via monitor returns and EDS, for each foundation trust |

| | |
|---|---|
| | OR<br>For non-foundation trusts, commissioners are not aware of the trusts position in working towards monitor & EDS standards and foundation trust status<br>**Amber:** Commissioners review monitor & EDS returns of foundation trust providers. Evidence that commissioners are aware of and working with non- foundation trusts in their progress towards monitor level & EDS compliance.<br>**Green**: Commissioners review monitor returns and & EDS review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non- foundation trusts in their progress towards monitor level & EDS compliance. |
| **B4**<br><br>**Current Rating:**<br><br>**Amber** | Governance, safety, quality and monitoring.<br>Learning from Winterbourne View Review and good commissioning practice have identified failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safety and safeguarding for people with learning disability in all provided services and support.<br><br>**Red:** No Board Assurance and Learning points not identified. Action plan(s) either not in place, or not yet discussed with partners<br>**Amber:** Regular Board Reporting and key points and lessons learned are included in action plans. Evidence that Learning Disability Partnership Board(s) and/or health sub group(s) involved in reviewing progress. The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service have assured their board that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services.<br>**Green:** Evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well- Being Boards and Clinical Commissioning Executive Boards. The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the learning disability agenda |
| **B5**<br><br>**Current Rating:** | This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training.<br><br>**Red:** No evidence of commissioning and provider practice that demonstrates involvement of people with learning disability and families in the recruitment and training of staff |

| | |
|---|---|
| **Amber** | **Amber:** LD specific services: evidence of 90% of services involving people with learning disability and families in recruitment/ training and monitoring of staff. Some evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services.<br>**Green**: LD specific services: evidence of 100% of services involving people with learning disability and families in recruitment/ training and monitoring of staff including advocates. Strong evidence of commissioners specifically raising the need for LD awareness training and reasonable adjustment within universal services in line with consultation by people with a learning disability and family carers. Strong evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services AND of universal service providers sharing good practice and experience. |
| **B6**<br><br>**Current Rating:**<br><br>**Amber** | Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the confidential enquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this.<br><br>**Red:** No evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce<br>**Amber:** LD Specific Provision: Some evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce. No clear evidence of this approach in relevant universal services<br>**Green**: Clear evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce. Evidence of this approach in relevant universal services |
| **B7**<br><br>**Current Rating:**<br><br>**Green** | This measure is about how effectively your locality assesses and addresses the needs and support requirements of people with learning disabilities through local authority strategies with clear reference to current and future demand.<br><br>**Red:** Not all strategies are up to date and there are not Equality Impact Assessments in place for every strategy.<br>**Amber:** Up to date Commissioning Strategies and Equality Impact Assessments are in place.<br>**Green:** Evidence of Commissioning Strategies and associated Equality Impact Assessments being presented to people who use services and their families and clear plans in place for the development of Care, Support and Housing for people with learning disabilities based on evidence of current and future demand. |
| **B8** | This standard requires evidence of a learning organisation that integrates, learning from complaints, incidents, patient, carer and staff |

| | |
|---|---|
| **Current Rating:**<br><br>**Green** | feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities.<br>Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements.<br><br>**Red:** No evidence of commissioning practice that demonstrates changed practice as a result of complaints and whistleblowing<br>**Amber:** Evidence that 50 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate.<br>**Green:** Evidence that 90 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate. |
| **B9**<br><br>**Current Rating:**<br><br>**Amber** | Mental Capacity Act (MCA). MENCAP's report Death by Indifference: 74 Deaths and Counting, highlighted the inconsistent application of the MCA 2005. This standard requires evidence that the five principles of the MCA are understood and consistently embedded within and across organisations to ensure safe, equal and high quality healthcare people with learning disability. Organisations are asked to demonstrate that there is evidence of routine monitoring across the whole organisation of implementation of MCA principles.<br><br>**Red:** There is no evidence that organisations routinely check implementation of MCA guidance relating to decision making, capacity, and restrictions<br>**Amber:** There is limited evidence that the implementation of MCA guidance relating to decision making, capacity, and restrictions is checked within contract monitoring and commissioning.<br>**Green**: All appropriate providers have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice where necessary. |

**Section C: Living Well**

| Measure | Guidance |
|---|---|
| **C1**<br><br>**Current Rating:**<br><br>**Green** | This measure looks for the evidence that formal arrangements are in pace that foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented.<br><br>**Red:** There is no evidence of integrated governance structures such as Section 75 or 37 agreements. There are no joint commissioning functions in place.<br>**Amber:** Commissioners can provide evidence of integrated governance structures. Monitoring is undertaken jointly and key partners are involved at Partnership Board level. Joint commissioning functions are in place.<br>**Green:** There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements. |
| **C2**<br><br>**Current Rating:**<br><br>**Amber** | This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.<br><br>**Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places.<br>**Amber:** Local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places.<br>**Green:** Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places and evidence that such schemes are communicated effectively. |
| **C3** | This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. |

| | |
|---|---|
| **Current Rating:** **Amber** | **Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals.<br>**Amber:** Few examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals.<br>**Green:** Numerous examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively. |
| **C4**<br><br>**Current Rating:**<br><br>**Green** | This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability.<br><br>**Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups etc.<br>**Amber:** Local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups etc.<br>**Green:** Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups, designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated effectively. |
| **C5**<br><br>**Current Rating:**<br><br>**Green** | This measure is about the importance of occupation and the equity that needs to be shown for people with a learning disability. Evidence of initiatives, data of the actual local picture are important.<br><br>**Red:** No data and commissioning intentions in place<br>**Amber:** Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months AND Employment activity of people with learning disability is linked to data<br>**Green:** Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months. Employment activity of people with learning disability is linked to commissioning intent for future services. Commissioning is clearly linked to proportionate local need. |
| **C6** | Delivering effective transitions for young people is recognized as a way of addressing the difficulties confronted by young people with learning difficulties and their families at transition. Previous research has demonstrated that information is a key need at this |

| | |
|---|---|
| **Current Rating:**<br><br>**Amber** | time. Information relates to co-production of local services driven by parent and user involvement as well as having a sound knowledge base of future need to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health services needed to support young people approaching adulthood - and their families. This measure touches upon the national Single Education, Health and Care Plan for people with learning disability. This policy is one of your key ways of evidencing success in this area.<br><br>**Red:** No evidence of a Single Education, Health and Care Plan for people with learning disability. Little or no evidence of transition planning or structures to support effective transitions in health & social care<br>**Amber:** Evidence of at least 50% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014.<br>There is evidence of effective plans, strategy, service pathways and multi- agency involvement across Health and Social Care<br>**Green:** Evidence of 85% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014. There is evidence of well- established and monitored strategy, service pathways and multi-agency involvement across Health and Social Care. There is evidence of very clear transition services or functions that have joint health & social care scrutiny and ownership. |
| **C7**<br><br>**Current Rating:**<br><br>**Green** | Community inclusion and Citizenship are core to the need for people with a learning disability to be equal members of our community. This measure asks you to evidence that you have asked what inclusion and citizenship means to your local population, evidence that you are responding to such consultation and evidence that people actually feel part of the local community.<br><br>**Red:** No reference to indicators of social exclusion, hate& mate crime, natural support or isolation of people with learning disability in Joint Strategic Needs Assessments or Public Health data. No clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability<br>**Amber:** Some evidence of data and findings of social exclusion, hate & mate crime, natural support or isolation of people with learning disability in Joint Strategic Needs Assessment. Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, including the support of friendship development and maintenance<br>**Green:** Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, linked to data and Joint Strategic Needs Assessments. Commissioning intentions and processes are aligned across both health & social care, supported by joint commissioning arrangements. Clear evidence of strong consultation with local communities in developing what it means to be a citizen |
| **C8** | People with learning disability and family carer involvement in service planning and decision making including personal budgets This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding |

| | |
|---|---|
| **Current Rating:**<br><br>**Amber** | this in practice.<br><br>**Red:** There is no evidence that people with learning disability and families have been involved in co- production of service planning and decision making.<br>**Amber:** Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice.<br>Inconsistent or no evidence of co-production in universal services<br>**Green:** Clear evidence of co-production in universal services that the commissioners use this to inform commissioning practice |
| **C9**<br><br>**Current Rating:**<br><br>**Amber** | Family Carers – Consultation on the JHSCSAF raised a strong call for family carers to be given a place to specifically contribute about their needs in the measures. This measure asks for evidence that family carers are involved not only in service design and commissioning, but in wider strategies as not all people with learning disabilities and family carers are known to or use services but need a voice in the shaping of the community.<br><br>**Red:** Commissioners do not have clear information on the numbers of registered carers in the locality. There is little evidence of formal arrangements to allow carer voice to shape commissioning intentions and provider delivery<br>**Amber:** Commissioners have clear information on the numbers of registered carers in the locality including the number of carers offered and in receipt of a carers assessment. There is clear evidence of a carers strategy and that this has been consulted upon. There is clear evidence that providers of LD services involve family carers in service development.<br>**Green**: Commissioners are using needs assessment information relating to carers to shape services and provide a range of support. There is clear evidence of a carers strategy that has been co-produced with family carers and that this has been consulted upon. There is clear evidence that providers of LD services involve family carers in service development. There is clear evidence that such involvement has led to service improvement. |

This page is intentionally left blank

Kent Safeguarding Children Board

By: Gill Rigg, Independent Chair of Kent Safeguarding Children Board

To: Kent Health and Wellbeing Board

Date: 19 November 2014

Subject: Kent Safeguarding Children Board – 2013/14 Annual Report

**Summary:** This attached annual report from Kent Safeguarding Children Board describes the progress made in improving the safeguarding services provided to Kent's children and young people over 2013/14, and outlines the challenges ahead over the next year.

**Classification:** Unrestricted

**Recommendation:** Health and Wellbeing Board members are asked to NOTE the progress and improvements made during 2013/14, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board.

## 1. Introduction

(1) This report presents the 2013/14 Annual Report produced by the Independent Chair of Kent Safeguarding Children Board (KSCB) and endorsed by members of that Board. 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 and managers 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, (issued by the Department for Education), 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.

(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.

(6) In March 2014, Gill Rigg was appointed the new Independent Chair of KSCB, taking over from Maggie Blyth.

## 2. The 2013/14 Annual Report

(1) The report details the ongoing activities undertaken by agencies to ensure that children in Kent are as safe as possible.

(2) As the report indicates, the number of children with a Child Protection Plan (CPP) has risen slightly from 1025 in March 2013 to 1177 in March 2014. KSCB will continue to monitor this to see if this continues to be in line with those of our statistical neighbours, and is the appropriate plan for individual children. KSCB will make sure that the focus remains on ensuring that all agencies have a common understanding of thresholds for child protection intervention.

(3) During the year 2013-14, KSCB has noted the improved use of the Common Assessment Framework (CAF) with an increase of 53% on last year. What is extremely positive is the number of Team Around the Family (TAF) closed with the outcomes recorded as 'achieved' has increased by 121%.

(4) Ofsted previously identified that interventions for children in need (CIN) across Kent were inconsistent which reinforced the need for KSCB scrutiny across the partnership about support given to this group of children. This will continue to be a focus with the number of children who have been on a Child In Need Plan for more than 6 months and more than 12 months having risen over the last year.

(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 Home Office Select Committee, to children at risk of child sexual exploitation (CSE). KSCB has continued to develop 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.

(6) To ensure that the spotlight is retained on those young people at risk of going missing and CSE, more detailed multi-agency work is being undertaken to ensure greater accuracy on the reporting and recording of missing incidents as well as putting in place tighter arrangements for offering 'return interviews' to those young people who go missing. This will provide partners with a greater understanding of what happens to young people when they go missing and provide intelligence that can be used to implement more preventative measures. KSCB is also 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) KSCB is committed to publishing the findings from all Case Reviews. There were no new Serious Case Reviews (SCR) commissioned during the last year. Other reviews have been undertaken and the lessons from all of these and from other National SCRs 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.

(8) Specific challenges are highlighted around action taken to learn lessons from cases when things go wrong and where children are the subject of sexual abuse. These areas feature within the 2014/15 Strategic Priorities and specific work has been commissioned by

the Case Review and Quality and Effectiveness Sub Groups to look into this area in more depth.

(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. The follow up to the Section 11 audit was undertaken with statutory agencies across Kent providing evidence to the Board on how they are meeting the many aspects of their action plans following their original submissions. 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 significant pressures on public agencies responsible for supporting vulnerable children in Kent, including Specialist Children's 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 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) The DfE Improvement Notice was lifted on 11th December 2013. 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, there can be no complacency and 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 placed specific expectations on KSCB during 2013/14. All agencies in Kent were required to demonstrate improved outcomes for children in relation to safeguarding and will be reporting on this to the Improvement Board. Through its Quality Assurance Framework, the Independent Chair believes that KSCB has evidenced its capability to take on the role of the Improvement Board, through the reviewing of members' progress reports. This was supported by findings from the Executive Group member '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 sexual exploitation and having a greater understanding of the picture of children who go missing.

## 4. Recommendations

(1) Health and Wellbeing Board Members are asked to:

(a) NOTE the progress and improvements made during 2013/14, as detailed in the Annual Report from the Independent Chair of Kent Safeguarding Children Board.

## 5. Background Documents

None.

## 6. Contact details

Gill Rigg
Independent Chair
Kent Safeguarding Children Board
01622 694859

Kent Safeguarding Children Board

# Annual Report 2013/14

www.kscb.org.uk

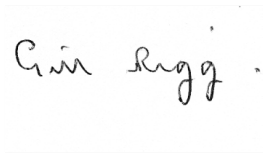
## Foreword by Independent Chair - Gill Rigg

As the recently appointed Independent Chair of Kent Safeguarding Children Board (KSCB), I am delighted to introduce the annual report of the Board to inform you of what the Board has done from April 2013 to March 2014. The report identifies the significant progress that has been made to improve the safeguarding of the children and young people who live in Kent and who number over 322,000. I hope that you find this report helpful and interesting. I took up the role of the Independent Chair in March 2014, and feel very privileged to be your Chair.

It is of note during the year, that the Improvement Notice to Kent County Council, from the Department for Education was lifted, and the LSCB was seen as being competent to oversee the ongoing safeguarding agenda. This is, in no small measure, down to the commitment, dedication, and hard work of the very many partners who make up the membership of the Board, and was a significant step forward.

As ever in safeguarding activities, it has been a busy and challenging year. April 2013 saw the introduction of Working Together 2013, and we particularly welcomed the freedom to move away from a prescribed way of undertaking Serious Case Reviews to a more learning culture. We also saw the piloting, and then the introduction of the new Ofsted framework of inspections, and the new approach of Ofsted reviewing the work of the Boards.

The work of the Board, its Executive and the sub groups continues to drive the safeguarding agenda forward, and I am immensely grateful to you all who work so hard to keep children and young people safe in Kent.



Gill Rigg
Independent Chair, KSCB

# Introduction

All of the work of the Kent Safeguarding Children Board is aimed at making Kent as safe a place as possible for children and young people to grow up in as we can. This report summarises the Board's structure, activity and progress during 2013/14, with a focus on what has been undertaken as required by the Department of Education to lift the Improvement Notice.

There are just over 322,000 children and young people 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 and step in to support children who are being harmed.

In Kent, trafficked children who arrive in 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.

That is why the Department for Education 'Working Together' guidance (2013) emphasises the shared responsibility we all have in keeping children safe.

# Role of the Board

### What is Kent Safeguarding Children Board (KSCB) and what does it do?

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.

KSCB provides a vital link in the chain between various organisational activities, both statutory and voluntary, to protect children and young people in Kent. Our aim is to ensure that these activities work effectively in the provision of a joined up service.

KSCB is responsible for scrutinising and challenging the work of its partners to ensure that services provided to children and young people are effective and make a difference.

We are also responsible for raising awareness of child protection issues in Kent so that everybody in the community can play a role in making Kent a safer place for children and young people.

Our message is – **Protecting Children From Harm is Everyone's Business**

# Government Guidance

**Working Together 2013** outlines the statutory objectives and functions of LSCBs as:

An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are:

**Section 14 of the Children Act 2004** sets out the objectives of LSCBs, which are:

A) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

B) to ensure the effectiveness of what is done by each such person or body for those purposes.

**Regulation 5 (1) of the Local Safeguarding Children Boards Regulations 2006:**

a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

1. the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
2. training of persons who work with children or in services affecting the safety and welfare of children;
3. recruitment and supervision of persons who work with children;
4. investigation of allegations concerning persons who work with children;
5. safety and welfare of children who are privately fostered;
6. cooperation with neighbouring children's services authorities and their Board partners;

b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

d) participating in the planning of services for children in the area of the authority; and

e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) relates to the LSCB Serious Case Reviews function and **Regulation 6** relates to the LSCB Child Death functions.

**Regulation 5 (3)** provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

In order to fulfil its statutory function under Regulation 5 an LSCB should use multi-agency data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in Section 11 of the Children Act 2004;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

A structure chart, including the links to the Health and Wellbeing Board and Children and Young Persons' Joint Commissioning Board and list of Board members can be found at **Appendices A and B.**

A summary of agency attendance at Board and Sub Group meetings is published on the KSCB website **– www.kscb.org.uk**

# 2013 to 2014 – What did we do?

The main focus of KSCB and Partner activity throughout 2013/14 was to ensure that in its follow up Inspections, Ofsted witnessed evidence of practice improvements and better outcomes for children and young people and have confidence to lift the Improvement Notice issued in 2011. As is explained later in this Report, this was achieved in December 2013.

Since July 2013, the KSCB has aligned itself to Improvement Board meetings and agenda, in order to ensure a holistic oversight and scrutiny of all areas of the Council's performance. KSCB is now in a position of considerable strength, with robust partnership arrangements.

## Evidence of Improvement

The establishment of robust governance arrangements which has supported the efficient execution of board business including the effective running of streamlined sub groups that have become the hub of LSCB activity. Evidence of improvement is supported by the following:

- Chairing of each sub group by Executive Member of Board, ensuring senior management/chief officer oversight of all key work streams
- Regular and consistent attendance at Board, Executive and Sub Group meetings (over 90%) by senior managers from across the partnership
- A memorandum of understanding with the Children and Young Persons Joint Commissioning Board and Health and Wellbeing Board regarding respective reporting on system improvement.
- A re-structure of the Board support functions to focus on programme management and performance reporting against the KSCB Business Plan.
- The establishment of a Health Safeguarding Sub Group to ensure that the new Clinical Commissioning Groups, NHS Local Area Team (LAT) and all health providers working across Kent are able to demonstrate how they discharge safeguarding duties. This group is chaired by the LAT Director of Nursing.
- The establishment of an Education Advisory Group to ensure that the education sector is fully represented across KSCB. This group is chaired by the Corporate Director for Education Learning and Skills.

All key building blocks of QA activity report regularly to the Executive and full Board allowing meaningful challenge and scrutiny of partnership activity. Evidence of improvement is supported by the following:

- Quarterly reporting to the Board from individual agencies with exception reporting where challenges remain in relation to safeguarding improvement i.e. Child and Adolescent Mental Health Services (CAMHS), Common Assessment Framework (CAF), Children in Need) CiN) activity, repeat Child Protection Plans (CPPs) and re-referrals;
- The development of a comprehensive multi-agency data set providing regular information and analysis;
- The completion of an annual multi-agency audit plan, including deep dives of multi-agency activity, reported through the Quality Assurance Framework with a particular focus on threshold application and work with children in need;
- The establishment of Executive/Board walkabouts to front line settings

The development of a learning and improvement framework which outlines the KSCB approach to Serious Case Reviews (SCR) and Management Reviews of cases where children and young people have been the subject of significant harm. Evidence of improvement is supported by:

- The commissioning of regular reviews where the criteria for a SCR is not met but significant learning is considered important to support system improvement;
- The development of KSCB's immersive learning suite to ensure dissemination of learning to front line practitioners following relevant SCRs/Management Reviews.
- The absence of any newly commissioned SCR in a 12 month period.

There has also been a focus from KSCB in responding to local challenges for the child protection system in Kent as part of its integrated support to system improvement. This has led to specific pieces of work in relation to tackling risks associated with Child Sexual Exploitation (CSE) and Trafficking and in supporting those children placed in residential care. Evidence of improvement in relation to local needs is supported by:

- The successful completion of the workplan of the Trafficking and CSE Sub Group;
- The establishment of a new focus on children going missing.

## Department for Education Improvement Plan:

In response to the Ofsted Inspection of KCC's arrangement for the protection of children, published in January 2013, which rated the arrangements as 'adequate', one of the key outstanding actions was to manage the transition towards the Kent Safeguarding Children Board taking on the role of the Improvement Board for driving further improvements in Kent. In order to do this, KSCB were required to provide evidence on a number of key areas:

1. KSCB must in particular ensure that services to children in need provided by the Council and all relevant parties are timely and effective, driven by accurate and timely assessments and clear and effective and outcome focused plans. KSCB must seek quarterly reports on this work from June 2013 onwards which should then be presented to and scrutinised by the Improvement Board.

2. Both the Improvement Board and KSCB must seek regular reports on developments in the Children and Adolescent Mental Health Services service across the County. These reports must not only identify work being done to reduce waiting times for assessment (down to an average of not greater than 6 weeks) and increased treatment timetables, they must also identify impact of the treatment on children and young people, emerging identification of therapeutic themes and proposed future service developments.

3. KSCB must demonstrate to the Improvement Board an **increasing effectiveness in its role especially in relation to performance challenge and scrutiny across the partnership**. The Improvement Board Chair and the KSCB Chair must work together to effectively plan the handover of future challenge and scrutiny from the Improvement Board and the KSCB. The plan must be presented to the Improvement Board for scrutiny.

4. KSCB must ensure it is compliant with the terms set out in Working Together 2013.

5. Ensure that multi-agency audits are undertaken by the LSCB and reported to the Improvement Board outlining the key lessons to be learnt and improvements to be made.

Evidence was provided to the Independent Chair of the Improvement Board and subsequently to the Government Minister and on 11th December 2013, Kent received formal notification of the lifting of the Improvement Notice.

## KSCB Strategic Priorities 2013/14:

1. Positive outcomes for all children and young people in Kent;

- We know we will have made a difference when we can evidence a multi-agency understanding of the Thresholds for accessing services for children resulting in a reduction in the number of 'inappropriate' contacts and referrals to Specialist Children's Services.

*KSCB have reviewed the Threshold Criteria and have continued to deliver specific multi-agency Threshold Workshops. Thresholds have been integrated into all other training sessions, including Early Help and Common Assessment Training provided by KSCB, and also by designated staff in single agency training. This will continue to be a focus in the KSCB Strategic Priorities and Business Plan for 2014/15.*

*Multi-agency referrals into the Central Duty Team have risen from 14,301 in 2012/13 to 19,751 in 2013/14. This is reflected in the increase of Children in Need and Children under Child Protection Plans (see below).*

2. Holding partner agencies to account for their part in improving safeguarding of all children in Kent;

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

***There has been a noticeable improvement in the findings from both single and multi-agency audits. There are however, some continuing themes that need to be continually monitored, e..g. record keeping, using the voice of the child to influence outcomes and greater case supervision. KSCB will ensure that these remain at the forefront of its priorities for 2014/15.***

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

- We will know we have made a difference when the Chair of the Improvement Board is confident that KSCB is in a position to take over the role of the Improvement Board.

*The evidence of success in this area is demonstrated by the withdrawal of the Improvement Notice.*

**Aisha Paulose – Named GP**

Understanding the importance of Safeguarding children has improved and progressed a great deal over the last 3 years. The training of GPs and GP trainees has been heavily supported by KSCB and active plans are in place to continue this training and development. During such training, multiple links and contacts have been made within agencies helping to further the links when delivering and making training plans for the future across Kent. This has a significant and positive knock on effect and front line working GPs feel more linked with other agencies and are keen to improve practice.
KSCB have worked in a consistent and enthusiastic manner with the clinical designated leads for child safeguarding.

# How safe are Children and Young People in Kent?

Whist we can never ensure that no child is hurt, all our efforts are to try to minimise any risk to children. The following show some of the figures for children helped and supported in Kent. The figures included below are provisional snapshot figures taken at the end of each performance monitoring year (March 31st).

## Children in Care (CiC):

CiC are those looked after by the Local Authority. A decision to take a child away from his or her home without the parents' agreement is an extremely difficult one and can only be taken following a court decision. It is only taken after every possibility of protecting the child at home has been explored and where the decision really is the best option of ensuring the child's safety and wellbeing. There are, however, other cases where some children are in voluntary care. The key governing Board for the local Kent Children in Care is the Corporate Parenting Panel This has the responsibly for ensuring that their safety and wellbeing is promoted. In December 2013, following evidence provided in the Children in Care Action Plan, the Ofsted Improvement Notice was lifted. Specialist Children's Services (SCS) are continuing in their efforts to ensure that having achieved 'satisfactory', the aspiration was to provide 'good' services. In order to do this, they will focus on supervision, participation, child focussed practice and good quality care plans. Performance against this areas will continue to be monitored by the Corporate Parenting Panel

The year on year figures show very little change with **1842** CiC in Kent at the end of March 2014, **11** more than at the same time as last year.

## Unaccompanied Asylum Seeking Children (UASC):

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. Support for these young people is delivered by the UASC Service, but in a complex operational environment.

The issue of asylum seekers receives high profile media and political attention prompting frequent legislative changes that affect Kent's protection arrangements for these children. In the last year, there were **229** UASC. This is an increase from **190** in 2013.

This continues to be a serious concern as these children are especially vulnerable to exploitation. The KSCB's Trafficking and Child Sexual Exploitation Sub Group will closely monitor progress across agencies in tackling this problem. This key priority will continue into 2014/15.

## Children in Care placed in Kent by Other Local Authorities:

As of the end of March 2014, there were over **1,200** children placed in Kent by other local authorities, with two thirds of them placed by London councils. This high number of other local authority Children in Care placed in Kent has been consistent for many years. This places massive pressures on public agencies responsible for supporting vulnerable children in Kent, including SCS, Schools, Police, and Health Services.

Following the recent high profile conviction of those involved in sexual exploitation networks across the Country, all councils must make sure they can properly safeguard teenagers placed in residential children's homes, particularly those placed many miles from home, which increases their vulnerability. These are young people at particular risk of being sexually exploited by criminal networks and gangs and it is extremely difficult for other local authorities, as the corporate parents, to properly safeguard these young people when they are placed so many miles away.

With Kent placing **212** of its CiC out of County (snapshot as at 31st March 2014), KSCB will also want assurance from local agencies that Kent children placed out of the County are appropriately safeguarded.

## Children with a Child Protection Plan (CPP):

Children who have a CPP are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of these factors.

Evidence nationally shows that children who grow up in families where there is domestic violence, mental illness and/or parental substance misuse are most likely to be at risk of serious harm. There continue to be low levels of children with plans relating to sexual abuse both nationally and in Kent.

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.

At year end, 2013/14, the number of children on CPPs was **1,177**. This compares to **1,025** at the last year end. This is an increase of **152**. KSCB is provided with regular analysis of this information to ensure that the figures reflect statistical neighbours. We are satisfied that currently, cases are effectively reviewed and children are being provided with a range of appropriate multi-agency interventions in support of their needs.

## Children in Need (CiN):

Children in Need is an area that all partner agencies are continuing to work closely to address the issues of 'drift' identified in the Improvement Notice. At year end, 2013/14, there were **3,162** CiN cases that had been open for 12 months or more, this compares to **3,061** the previous year, an increase in **101** cases. For CiN cases open for 6 months or more (not reaching 12 months) the figures were **4,110** for 2013/14 against **3,786** for 2012/13, an increase of **324**.

Significant work is being undertaken to examine CiN cases, both by Specialist Children's Services, through in depth on-line quality assurance audits, and by KSCB's Quality and Effectiveness Sub Group by way of multi-agency audits. Early indications show that where there is strong supportive supervision of CiN cases, there is little 'drift' and the CiN plan is more likely to be effective and obtain positive outcomes for the child or young person.

This will continue to be a priority for KSCB to monitor throughout 2014/15.

## Early Help:

A significant amount of multi-agency effort has been put in to the offer of Early Help. There has been an increase in the number of Common Assessment undertaken over the last two years with last year showing an increase of **53.5%** on the previous year (**3,754** CAFs completed).

With numbers on the increase, the emphasis has moved to the outcomes of the Team Around the Family (TAF), actions. The number of TAFs closed with their outcomes recorded as achieved in 2013/14 was **1,554**, compared to **702** the previous year, an increase of **121.4%**.

The number of Team Around the Family closed with their outcomes recorded as requiring single agency support in 2013/14 was **904**, compared to **352** the previous year, an increase of **156.6%**.

The impact of Early Help and the outcomes of TAFs will continue to feature as a priority and the longer term effect on referrals to Specialist Children's Services will be monitored.

## Report on the Voice of the Child

We on the Board very much recognise the importance of hearing the voice of children and young people in Kent and have been seeking different ways of ensuring that their voice is heard and influences the Board priorities and work that is undertaken.

A young person, currently in care in Kent, jointly opened our Annual Conference with our Independent Chair, and spoke to the conference on issues that were relevant and important to all young people in Kent.

The Board actively supports Kent Youth County Council (KYCC) through their identified campaigns. For the third year running the campaign which has received the most votes has been on anti-bullying, with a particular emphasis on cyber-bullying. As part of this, the KYCC have developed an anti-bullying policy for schools to support them in addressing the issues of cyber-bullying. Representatives from KYCC were invited to launch this policy at the annual conference in November. The group also showed a video clip that they had written, filmed and produced to show the effects of bullying.

In addition KYCC run a safeguarding interest group, which is working on a project to reduce the stigma attached to mental health issues. This project is currently underway with the results expected over the next few months.

The Board also invited another group of young people, the Young Health Champions, who work within schools as part of Kent Integrated Adolescent Support Services (KIASS) to present their work at the Conference. Liaisons with these young people will continue to support the identification of health issues which are key for young people.

The Board are keen to understand issues which are pertinent to young people and have engaged with a Young Evaluators Group from the Dartford and Gravesham area to develop a survey which will be rolled out to children and young people later this year. This group have ensured that the context and wording of the survey is appropriate and 'young people friendly'.

Work has begun in Gravesend with a particular group of schools who have concerns around young people becoming involved in exploitative relationships. This is a peer led programme which will encourage vulnerable young people to discuss issues around positive relationships and where to turn to for help if they have any concerns. Once this project has been piloted in Gravesend it will be available to all schools across the County.

### Kerry Sildatke - Joint Chair of the KSCB Annual Conference 2013

*My name is Kerry Sildatke and I am 17 years old. I have been in care since the age of four, in both foster and residential placements. During this time I have attended both special needs and mainstream schools so will be speaking from both personal and professional experience.*

*Professionally my journey started at the age of 11 as a peer mentor for children with special needs in a mainstream school. When I then transferred to a special needs school, due to my autism, I began peer mentoring there, and am now a Heart Mentor meaning I help new students settle in. Through this I spent a year as an online mentor for Beat Bullying with a special interest in mental health, however have had to give this up due to other commitments.*

*I am currently a part of Kent Youth County Council, where I chair the Safeguarding and anti-bullying group both of which work closely with KSCB.*

# Views of Practitioners

## Practitioners Survey

The KSCB Practitioners Survey was developed by the Business unit in 2013 to gain an understanding of the issues that practitioners were facing whilst working with children and their families in Kent. The survey also gave practitioners the opportunity to feedback to the board regarding training gaps and their knowledge of designated safeguarding roles within their organisations.

The Survey was launched in February 2014 and was distributed across a wide range of agencies across all sectors. The survey was live for a month and closed in March 2014. A total of 740 respondents completed the survey from across the county, from a wide range of agencies including many from the voluntary community sector. The data was evaluated and grouped into district data so that the findings from the survey could be shared with Team Managers on District levels to inform practice and ensure local training needs could be met.

Some of the main findings from the survey were as follows:

### Thresholds:

- 33% of practitioners were not aware of the Kent and Medway Thresholds and Tiers of Intervention

**Knowledge of specialist staff:**

- 56% of practitioners did not know the role of the Designated Nurse
- 36% of practitioners did not know the role of a Local Authority Designated Officer (LADO)

### Multi-agency working:

27% of practitioners did not feel that they have a good working relationship with other agencies / organisations in their area. The main reasons that were suggested were:

- Poor information sharing between agencies, lack of consistency around information sharing between agencies (20%)
- Lack of understanding of other agencies/organisations in the area and their remit (17%)
- Lack of understanding of who the key contacts are in relation to safeguarding (14%)
- Lack of multi- agency networking opportunities (11%)

### Multi-Agency Training:

- 19% of practitioners said that they had not had any child protection or safeguarding training in the last three years
- 23% of practitioners said that they were unable to access training easily; the practitioners said that the main barriers were:
    - The cost of training (34%)
    - They were unaware of the training that was available (15%)
    - They were unsure of how to access/book onto the training (14%)

### Next Steps:

KSCB, together with partners, are using this information inform the targeting of staff awareness-raising workshops, marketing of key safeguarding messages, passing on information on the roles and responsibilities of designated professionals and details of the comprehensive KSCB multi-agency training programme that is available.

# Views of Board Members

**Mike Stevens – Lay Member**

As a Lay Member of the Board I have the privileged position of being able to have an overview of the Boards activities without being committed to any particular statutory or voluntary body. There is no doubt in my mind that 'safeguarding' has played and is playing an increasing role during the last twelve months in the day to day running and management of those bodies. Evidence of personnel working more closely together, sharing advice, expertise and confidence has grown and is to be welcomed. More however needs to be done as further co-operation and understanding between agencies is secured. Priority areas have been identified and inter agency work is taking place to deal with these issues.

Safeguarding within Kent has a firm foundation on which it is growing in both depth and strength.

**Julie Pearce - East Kent Hospital University Foundation Trust (EKHUFT)**

EKHUFT are confident that there has been an improvement in safeguarding children by having robust safeguarding processes in place with effective feedback mechanisms in order to ensure quality and improved outcome for children and their families.

**Roger Sykes – Lay Member**

The vast spread of safeguarding issues and the geographical and population size of Kent combine to ensure that there will always be significant challenges to safeguarding in the county. Since I became a lay member of KSCB in April 2011, I have seen definite progress in many areas, particularly within Specialist Children's Services, but nevertheless much remains to be achieved among which I would highlight the following –

- The board needs to be more effective in ensuring that appropriate members attend board and subgroup meetings;
- Minutes of all meetings need to be sufficiently detailed to demonstrate that agencies were appropriately challenged regarding processes and outcomes;
- The voices of the children do not adequately permeate the processes that the board and its member agencies design and operate;
- In common with the rest of the country, the provision and availability of mental health services for Kent children are poor.

Views from more Board members can be found throughout this Report

# Reports from each Sub Group – activity and outcomes

## The Quality and Effectiveness Sub Group

The Quality and Effectiveness (QE) Sub Group's main function is to co-ordinate quality assurance and evaluate the effectiveness of what is done by KSCB partner agencies, individually and collectively, to safeguard and promote the welfare of children. It has oversight of multi-agency and single-agency audits, Section 11 audits and analysis of performance data about safeguarding from the key statutory agencies in Kent.

QE has been working hard this year to improve KSCB's approach to performance management, along with its role of professional scrutiny and challenge, by implementing a local Quality Assurance Framework alongside adopting principles from the South East Regional Framework.

The QE examine quarterly performance indicators supplied by a range of partners in order to satisfy KSCB that the arrangements in place to safeguard and promote the welfare of children are good. A wealth of information is available to the QE and the focus this year has been on partners contributing to the analysis of these statistical measures, commenting on whether outcomes have improved. We are in an improved position but the sub group still has a lot more work to do to ensure valuable contributions are available at these meetings.

## KSCB Audits:

The QE carry out an annual programme of multi-agency audits and in 2013/14 these were:

### Application of the Inter-Agency Threshold Criteria:

Professionals make assessments on levels of need for children and families utilising an agreed document, the "Kent and Medway Inter-Agency Threshold for Children in Need". Regular auditing of partners' understanding and use of these levels is essential in assuring the KSCB that children's welfare is being considered and safeguarding practice is of high-quality. This audit highlighted the importance of good quality information included at the referral stage and of the need to share information appropriately and promptly. In addition more work is required among partners to utilise help as early as possible in order to negate the need to escalate cases to statutory interventions.

### Section 11 Self Assessments:

Following a full round of assessments collected in 2012/13, KSCB piloted a newly revised tool with the seven new Clinical Commissioning Groups in Kent and with the Sussex Partnership responsible for Child and Adolescent Mental Health Services. Prisons in Kent were also requested to submit a shorter self assessment tailored to their level of responsibility. Moving forward, KSCB are looking at ways the oversight of these self assessments can be improved, ensuring partners adherence to this statutory function are fully met.

### 'Child in Need' Deep Dive Reviews:

A new way of auditing was piloted this year focussing on involving practitioners and their managers in an in-depth discussion regarding one of their cases. Eight of these were undertaken across the County with extremely positive feedback and outcomes. Practice clearly showed a strong link between one or two professionals providing consistent and relevant support and improved outcomes for the child or young person. QE is continuing to monitor practice surrounding Child in Need as an ongoing priority, as part of KSCB's focus on early intervention and prevention.

The QE has a planned audit programme for the forthcoming year which will focus on KSCB strategic priorities, some areas to be covered are: children on Child Protection Plans; practice regarding children affected by repeat incidents of Domestic Abuse; Section 11 self assessments.

## 2013/14 Performance Summary:

The number of Common Assessment Frameworks completed for families in Kent has improved over the year from 75.7 completed per 10,000 children in March '13 to 116.3 in March '14. This increase is positive and QE is now focussing on the quality of these assessments by following up monthly auditing.

Referrals made into Specialist Children's Services (SCS) have increased over the year from March '13 at 442 per 10,000 children to 611.8 in March '14, a significant workload increase. This is in part down to improved recording processes implemented over the year, but also a reflection of additional workflow. The percentage of children and young people being re-referred into SCS has also increased over the period, standing at 26.6% in March '14 compared to 22.8% in March '13.

These increases are also reflected in Child in Need numbers and some of the Child Protection figures, depicted in the table below:

| Performance Measure | March 2013 | March 2014 | Target / Benchmark March 2014 |
|---|---|---|---|
| Number of Children in Need per 10,000 population under 18 (snapshot) | 287.3 | 330.1 | 323.8 |
| Number of Section 47 enquiries per 10,000 population under 18 (rolling 12 months) | 109.6 | 130.8 | 103.6 |
| Number of children with a Child Protection Plan per 10,000 population under 18 (snapshot) | 30.8 | 36.5 | 34.9 |
| Percentage of Child Protection plans lasting 2 years or more at the point of de-registration (year to date) | 8.0% | 4.9% | 6.0% |
| Percentage of children becoming subject to a Child Protection Plan for a 2nd or subsequent time within 24 months (year to date) | 10.8% | 8.0% | 7.5% |

These rises are teamed with the potential added pressures of average caseloads rising (22.6 in March '14 from 18.4 in March '13 for non Child in Care teams) and agency staff in case holding posts sitting at 18.8% in March '14 from 15.0% in March '13. KSCB will monitor this closely through the QE to ensure performance and practice does not deteriorate.

Health, Police and Education data into the QE has changed over the period, due in part to the changes in NHS and Kent County Council structures and Police identifying performance indicators that better reflect safeguarding practice, thus making comparisons from last year impractical. All partners are committed to providing high quality performance information and are valuable members of the QE.

## Upcoming Challenges:

KSCB are working hard to update existing policies relating to Missing Children and are committed to overcoming barriers presented by this potentially very vulnerable group. Children missing from their home or placement could be at risk of: sexual exploitation; missing education; engagement in criminal behaviour and be more exposed to other risk-taking behaviours. Following National guidance, KSCB aims to provide a unified multi-agency approach where the needs of these children and young people are met more appropriately and effectively.

QE aims to continue to improve its effectiveness, in order to ensure the Board receives relevant and timely information that enables children in Kent to get the right help at the right time.

# Child Death Overview Panel (CDOP)

This panel has the responsibility for reviewing all deaths of children in Kent. The panel is chaired by Kent's Director of Public Health and its work is supported by two Designated Doctors for Unexpected Death; a Child Death Coordinator, partner representatives (including the Police and Social Care) and LSCB Officers. This mandatory panel works in close partnership in order to monitor trends in child death nationally and locally, analyse data relating to specific child deaths, identify modifiable factors and to promote any learning from them. Whilst there are a host of other factors that are also considered as part of this work, environmental effects and parenting issues are key and these are subject to careful deliberation in each case.

The primary aim of the CDOP is to reduce the number of preventable child deaths through systematic multi-disciplinary review, education of professionals and the general public and to make recommendations for legislation and public policy changes. These recommendations are based on panel reviews and circumstances surrounding individual causes of child death. The data is used to identify trends that require systematic solutions. In order to improve the way in which partners collect and respond to the necessary information KSCB and Health colleagues are progressing the development of a bespoke CDOP database that will provide an enhanced level of efficiency and reporting to this important process.

## Key findings and learning from child death reviews

During the period 1 April 2013 – 31 March 2014 the Kent CDOP reviewed 74 child deaths. It should be noted that there are still sudden deaths that occurred during this period that are outstanding for review due to coroner inquests or outcomes of enquiries still pending. Data relating to these reviews will be carried forward for inclusion in the 2014-2015 CDOP Annual Report. The gender and presence of modifiable factors are identified at Table 1 and the age of the child at Table 2.

| | **Number of child deaths with modifiable factors** | **Number of child deaths with no modifiable factors** |
|---|---|---|
| Male | **16** | **27** |
| Female | **5** | **26** |
| TOTAL | **21** | **53** |

*Table 1: Child Deaths in Kent 2013-14*

| **Age** | **Number of child deaths with modifiable factors** |
|---|---|
| < 5 | 15 |
| 6 - 9 | 0 |
| 10-14 years | **<5** |
| 15-17 years | **<5** |
| TOTAL | **21** |

*Table 2: Ages of children whose deaths featured modifiable factors*

The data confirms that the highest proportion of child deaths in Kent during this period relate to those children who are under 1 year old. Cases with modifiable factors are further considered in the context of ten separate categories at Table 3 with the likely cause of death confirmed in Table 4.

| Category | Definition | Number |
|---|---|---|
| 1 | Deliberately inflicted injury, abuse or neglect | **0** |
| 2 | Suicide or deliberate self-inflicted harm | **<5** |
| 3 | Trauma and other external factors | **6** |
| 4 | Malignancy | **0** |
| 5 | Acute medical or surgical condition | **<5** |
| 6 | Chronic medical condition | **<5** |
| 7 | Chromosomal, genetic and congenital anomalies | **0** |
| 8 | Perinatal/neonatal event | **<5** |
| 9 | Infection | **<5** |
| 10 | Sudden unexpected, unexplained death | **8** |
| | TOTAL | **21** |

*Table 3: Categories of Cases with Modifiable Factors*

The cause of death is defined at Table 4, which information confirms that sudden unexpected death in infancy/ neonatal death accounts for over 50% of child deaths in Kent.

| Cause of death | Numbers |
|---|---|
| Neonatal Death | <5 |
| Known life limiting illness | <5 |
| Sudden unexpected death in infancy | 9 |
| Road traffic accident/collision | <5 |
| Drowning | <5 |
| Other non-intentional injury/accident/trauma | <5 |
| Substance miss use | <5 |
| TOTAL | 21 |

*Table 4: Causes of Death where Modifiable Factors were Present*

Full information relating to child deaths in Kent is regularly considered by the CDOP panel and is used to bring about improvements in local working processes and practice whenever appropriate and to inform KSCB's learning and development. As a result of emerging information from the CDOP during the period in question new Self Harm training was developed at Level 2 and 3. Further, the regular analysis of national statistical data in respect of child death 'trends' has highlighted some new areas of concern and KSCB has taken preventative action by making new baby safety information available to parents on its website in respect of the dangers of nappy sacks, hair straighteners, baby bath seats and baby slings: (http://kscb.org.uk/kscb_resources_and_library/baby_safety.aspx).

The Panel has also identified issues relating to co-sleeping and the need to provide enhanced bereavement support to parents. Joint partnership work has resulted in active preparation and development of material for these two local initiatives.

## Serious Case Review Sub Group

The Serious Case Review Sub Group has fully embraced the guidance from Chapter 4 of Working Together 2013. The Group has developed a Case Review framework, identifying the criteria for undertaking the various types of reviews, (see below).

| Review Type | Criteria |
|---|---|
| Serious Case Reviews | Regulation 5 (2) of the Local Safeguarding Children Boards Regulations 2006 defines a Serious Case Review as one where:<br>abuse or neglect of a child is known or suspected; and either<br>(i) the child has died; or<br>(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child<br>In addition, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. This includes cases where a child died by suspected suicide. |
| Critical Incident / Serious Incident Reviews | Criteria for an SCR not met, however, it is felt by agencies, that due to the circumstances, an alternative multi-agency review should be undertaken (the decision will be that of the SCR Sub Group based upon the information recorded and submitted on the 'Referral Form for Consideration of a Case Review) |
| Best Practice Reviews | There cannot be any tight criteria for this type of review.<br>Where an agency feels that there are examples of good multi-agency practice demonstrated in a particular case which would provide good learning opportunities and positive outcomes for children, the case should be submitted to the SCR Sub Group for consideration of a good practice review. |

The Group has also introduced a Case Review Notification Process where, in line with the above criteria, agencies can notify the Group of cases they feel warrant a case review. The Group are then presented with the outline circumstances of the case and make a decision as to whether a case review is required. This process has an audit trail in order to record not only the decision but also the rationale.

In 2013-14, the Group received 12 notifications from which no Serious Case Reviews were recommended or undertaken, 7 management reviews were undertaken and in the other 5, the outcomes were not to review as the issues presented were themes that were already being addressed through findings from other recent or ongoing reviews.

The decision on the type or style of review undertaken is taken by the Chair of the Sub Group and takes into account the nature of the case and the agencies involved. The outcome will be proportionate to the case presented.

The key themes from the findings of the case reviews are signed off by the Sub Group and, in line with the KSCB's Learning and Improvement Framework, are shared with the Learning and Development and Quality and Effectiveness Sub Groups. They are also circulated to Board members and cascaded to operational staff. The findings assist in informing the development of the KSCB Training Programme and themed multi-agency audits to check if practice is changing as a result of the training. Findings from Case Reviews have been used to inform the KSCB Strategic Priorities and multi-agency audit programme and are published on the KSCB website.

# Learning and Development Sub Group

KSCB has a responsibility to develop policies and procedures in relation to: "… training of persons who work with children or in services affecting the safety and welfare of children … to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children". (*Working Together, 2013*)

## What We Did

With oversight from the Learning and Development Sub Group, a comprehensive multi-agency training programme was developed and delivered by KSCB during 2013/14. Issues from local and national Serious Case Reviews (SCRs) and other case reviews were analysed, considered and incorporated to ensure that the content of the training programme related to emerging issues of concern, as well as to core safeguarding learning, that all practitioners working with children and their families need to understand.

| | | | |
|---|---|---|---|
| Number of E-Learning sessions offered | 18 | No of attendees | 2,037 |
| Number of Face-to-Face sessions offered | 87 | No of attendees | 1,765 |
| Number of Bespoke sessions delivered | 74 | No of attendees | 1,664 |
| KSCB Annual Conference | | No of attendees | 266 |
| **Total number of training sessions offered** | **179** | **Total attendees** | **5,732** |

Although safeguarding children is everyone's business, it can be difficult to reach all professionals in the county who require training. In order to meet the needs of our diverse workforce across all Districts, the training programme for 2013/14 was differentiated to incorporate:

## E-learning

KSCB's suite of 14 modules can be used as stand-alone learning or as a pre-learning tool to maximise the effectiveness of face-to-face training so that learners acquire a good understanding of the subject matter. All courses are certificated and evaluated. In 2013/14, 2,037 practitioners successfully completed this learning and new topics that support and relate to existing learning are being identified.

## Face-to-Face Training

KSCB has an established 'College of Trainers' comprising a range of multi-agency practitioners who have successfully completed the KSCB 'Train the Trainer' Course. Sixteen new trainers were recruited in 2013/14 to support the delivery of face-to-face training. 87 training sessions covering 18 topics were delivered to 1,765 practitioners from 36 different agencies in this period, including voluntary sector partners and foster carers.

In addition, KSCB delivers 'bespoke' single agency training to organisations at their own premises on request. In this way, all stakeholders are encouraged to develop the safeguarding knowledge of their staff. During the period in question, KSCB delivered 74 safeguarding training sessions to 54 individual organisations.

## Immersive Learning

MAX Immersive Learning is a computer-based training simulation that is unique to KSCB in which participants interact with each other to discuss and deal with emerging issues in an evolving scenario. This innovative training gives delegates the opportunity to collectively decide the most appropriate course of action in relation to a safeguarding scenario and to understand the priorities and decision-making processes of partner agencies.

In 2013/14, 8 training sessions took place, enabling practitioners to explore the subjects of Child Abuse and Neglect, and Child Sexual Exploitation and Online Safety in some depth. Additionally KSCB worked in partnership with NHS England to develop and deliver a bespoke Safeguarding session for members of Kent's Clinical Commissioning Groups. Feedback from these courses has been extremely positive and new topics are currently under development.

## Additional Learning Opportunities

KSCB further enhanced the learning and development of local practitioners by:

- hosting 7 Area Workshops on Domestic Abuse and Learning from SCRs
- offering formal and informal learning opportunities at KSCB's Annual Conference
- developing the content of KSCB's website so that Practitioners can use it to access safeguarding information and advice.

A summary of KSCB learning and development activity and overall attendance figures from 2013/14 appears at Appendix C

## What was our impact?

All KSCB training is evaluated by participants and an evaluation summary produced for both KSCB and the Trainer. Evaluation forms have been revised to determine not only the quality of the training but also the level of learning of those concerned before and after the session and any additional training required.

Although at an early stage of development, this amalgamated information has already helped us to adjust the content of courses and to target specific audiences. Information shared by participants during training in respect of additional support required is shared with relevant agencies.

KSCB also commissioned Christ Church Canterbury University to research how best its new immersive learning can be evaluated. The resulting report was presented to the Learning and Development Sub Group In February and recommendations will now be implemented.

**Angela Slaven – Director of Service Improvement Education and Young People's Services**

The Youth Offending Teams across Kent during 2013/14 continued to prioritise the ambition of reducing the number of young people entering the criminal justice system and the downward trend supports this effort. This has been achieved through strong collaborative work with the Kent Police with the establishment of restorative justice practice at the heart of interventions with young people.

### What will we do next?

With a constantly evolving children's workforce in one of the largest Local Authority in the UK, KSCB will be further developing its training programme and working with partners to collaboratively deliver effective learning to all practitioners working with children, young people and their families. We aim to:

- Ensure that the KSCB Strategic Priorities and learning from the KSCB Case Reviews and multi-agency audits undertaken inform the future training programme content
- Increase the number of bespoke training sessions delivered by engaging new organisations
- Develop the range of face-to-face training topics in partnership with statutory and voluntary stakeholders
- Increase the skills and knowledge of KSCB's College of Trainers
- Extend our immersive learning offer
- Further diversify the means by which training is delivered, using technology to best effect
- Explore more opportunities to work collaboratively with partners
- Further develop collaboration with Early Help colleagues
- Develop our evaluation methods to inform the Training Cycle.

## Trafficking and Child Sexual Exploitation Sub Group

## Trafficking

Concerns for children and young people who are trafficked into the UK are high on our agenda. Because of additional vulnerabilities within Kent around our ports and international rail stations, we commissioned an independent review of our procedures to help us to identify areas of good practice and also to look for ways of improving our protection of unaccompanied asylum seeking young people who arrive at our border. As a result of this report we have made changes to our assessment procedures and are working with multi agency partners, including police, social care and UK Border Force to improve the service that we offer. We are also expanding our work and support for EU young people who can travel in and out of the country with fewer restrictions, but may lead to increased vulnerability.

During the year we recorded 229 as at 31st March 2014 UASC who entered the UK and needed our support.

We have an ongoing awareness-raising training programme for frontline staff around the issues of Trafficking.

## Child Sexual Exploitation (CSE)

Following the well-publicised cases from other local authorities, Kent has taken the learning from these reports to inform its own response to CSE. Kent commissioned Barnardos to explore CSE in Kent and develop an informed approach to address specific issues within Kent. As a result of this, a risk assessment toolkit and CSE awareness training programme has been developed, for frontline staff across Kent to support them in identifying the signs of CSE and what to do when it is suspected.

So far 350 practitioners have received this training, with regular ongoing events being offered. Kent Police are working towards producing a CSE profile for Kent.

**Tim Smith - Kent Police.**

Safeguarding children is the responsibility of all Police officers. Particular responsibility falls to the Kent Police Public Protection Unit (PPU). The PPU manages the safeguarding of children on a number of levels. The multi-agency Central Referral Unit (CRU) coordinates the response to initial safeguarding referrals and notifications. Combined Safeguarding Teams on each police Division are responsible for joint working to protect children and investigate abuse.

PPU resources are available 24 hours a day and provide advice and guidance on child protection issues to other staff. PPU has developed improved practices for Child Sexual Exploitation (CSE) investigations, missing children and in particular information sharing regarding children involved in domestic abuse.

The coordination of the response to missing children between police, children's services, other agencies and voluntary partners remains a challenge for the Board in 2014/15. Police are in a position to share information on a daily basis but the management of that information and response by other key partners, particularly regarding the return interviews of missing children and the associated intelligence capture, is an area for development in 2014/15.

## Missing Children

In response to the Ofsted Thematic Report, 2013, and the Department for Education Statutory Guidance, 2014, Kent has set up a dedicated Missing Children Task and Finish Group to undertake a comprehensive review on the reporting, recording and response to children and young people who go missing in Kent. Following a comprehensive self assessment using the recommendations from the earlier mentioned reports, multi-agency work is underway to address those areas identified as falling short of expectations as well as ensuring best practice is implemented. This work links to that being undertaken on Child Sexual Exploitation. Kent has signed up to The Children Society Runaways Charter and changes to policy and procedures are being planned and implemented for 2014/15, together with awareness raising for staff to ensure links to other areas of concern are identified and appropriate support is offered to all children and young people who go missing from home or care. This work will also provide us with a greater understanding of the countywide picture of children who go missing.

**Patricia Denney – Assistant Director, Safeguarding Unit, Specialist Children's Services**

Following an Ofsted Inspection in 2010, Kent Safeguarding Services were graded as inadequate and an Improvement Notice was put in place. In 2013, Ofsted undertook two inspections looking specifically at Safeguarding and Looked after children. These inspections evidenced an improvement journey for children and their families that meant they were better protected and outcomes were vastly improved.

Action plans from the Ofsted inspections were developed. A number of actions have been completed and others remain part of ongoing work. Kent Specialist Children's Services continue on an improvement journey which will be further tested at the fourth improvement review due to be undertaken in June/July 2014. There is regular reporting to the Children Services Improvement Panel, Corporate Parenting Panel and the Kent Safeguarding Children Board.

## Kent and Medway Domestic Abuse Strategy Group (KMDASG)

To increase practitioner knowledge KSCB, together with the KMDASG, has developed and delivered multi-agency domestic abuse training for practitioners to improve their knowledge and understanding of the impact that domestic abuse can have on children and young people, and the way that they respond to and work with children who have been in households where there has been Domestic Abuse.

Multi-Agency Risk Assessment Conference (MARAC) provides a formal process, hosted by Kent Police, where confidential information can be shared appropriately to aid in the prevention, detection and reduction of crime, including the protection of vulnerable people; this includes victims of domestic abuse. Their reports are regularly presented to the KSCB Quality and Effectiveness Sub group and Domestic Abuse will continue to feature in the KSCB priorities. As part of its quality assurance role, KSCB will be undertaking audits on service involvement with families where there are repeat DV incidents and where children are present.

The KSCB Business Unit is represented on both the operational and strategic Domestic Abuse groups.

**Karen Proctor - Kent Community Health NHS Trust (KCHT)**

We have continued to work closely with our partners in Kent Social Care services, to ensure that our staff, who work predominantly with children and their families, understand the multi-agency thresholds that have been developed to help them identify and manage safeguarding and child protection concerns.

The continued application of the Common Assessment Framework, by KCHT practitioners, ensures the timely assessment of children and families' needs, which may impact upon their health/wellbeing and, where required, early and intensive support being arranged to address their specific needs.

The Children in Care Nursing Service has continued to maintain the uptake of statutory review health assessments within the required timescale at 93%. Links with the Family Nurse Partnership, to identify children in care who are pregnant, has been established. Support and advice is given to the young and pregnant individuals which will facilitate the giving and receiving of information to enable the individual young and pregnant individual to make informed decisions and positive lifestyle choices.

**Nick Sherlock – Adult Safeguarding**

All staff within Social Care, Health and Wellbeing recognise the need to focus on the welfare of any children involved when carrying out assessments.

## KSCB Finance Report

In line with the requirements of Working Together 2013, this report outlines the KSCB financial contributions from partners and its expenditure. Working Together states:

> "*All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies."*

A breakdown of the 2013/14 finances and the projected expenditure for 2014/15 is attached at Appendix D.

During 2013/14, contributions from partners reduced to £250k from £300k in 2012/13. The variable income (grants, training and residual funds) totalled £865k, making the total income £1,111,000, a reduction of £174k on last year. With a total income of £1,111,000 and expenditure of £425k, this ensures that the overall costs of running KSCB were met as they could not have been covered solely by contributing partners.

With regard to the reserve, this has been raised with Board and Executive Group members and a programme was agreed on how this reserve is to be reduced. It is projected that, through an anticipation of a gradual reduction in Partner contributions and reduction in grants, the Board should have a break even working budget, (with a small reserve to cover the costs of any future Serious Case Review (s) ) within three years.

**Sally Allum - NHS England**

NHS England is committed to partnership working to safeguard children, young people and adults at risk of abuse at all levels. We have worked closely with our CCG colleagues in providing professional leadership and expertise including the responsibility of named professionals for safeguarding children. We have and will continue to lead with partner agencies on the implementation of national policies to prevent child sexual exploitation, female genital mutilation, sexual violence and domestic abuse.

Our strong engagement with partner agencies has supported partnership working in priority areas such as children and young people's mental health. We have taken a collaborative working approach to sustain improvements and share learning from serious case reviews. We continue to actively work to improve and deliver training for GPs in order that they really understand what safeguarding means and how and when to raise a concern.

# What next? - Strategic Priorities 2014/15

## Priority 1

**Co-ordinate, monitor and challenge the effectiveness of local arrangements for the quality and appropriateness of early help and preventative services.**

To address this priority detailed actions will focus on:

- Ensuring there is an embedded awareness and understanding of the Kent threshold document
- Continuing to develop safeguarding policies and procedures in line with Working Together 2013
- Ensuring effective early help is provided at the CAF/TAF stage of support
- Undertaking consistent and holistic assessments
- How early help and early intervention features in mental health support for young people
- Effective participation of all partners
- Ensuring that the voice of children and their families are listened to, and influence practice and services

## Priority 2

**Ensure multi-agency and joined up working which protects and supports children with specific vulnerabilities, including the provision of timely and appropriate services.**

To address this priority detailed actions will focus on the following groups of vulnerable young people, although this is not an exhaustive list:

- Missing young people
- CSE young people
- Those being trafficked
- Those affected by gangs
- Those affected by 'on line' safety and those at risk of on line threats
- Those with emotional health vulnerability, at all levels
- Children with disabilities, including those with autism
- Victims of sexual abuse
- Victims/perpetrators of domestic abuse
- Those bullying or being bullied

## Priority 3

**Develop a family focused approach in relation to substance misuse, mental health problems and domestic abuse.**

This will be developed into an action plan to focus on:

- The impact on children and young people and what happens next as a result
- The impact of working between adults and children's services
- The knowledge of staff of these specialist areas

## Priority 4

**Provide evidenced assurance to the KSCB through robust monitoring, scrutiny and challenge, that multi-agency safeguarding practices are improving and there is ongoing learning and development for staff.**

To address this priority detailed actions will focus on:

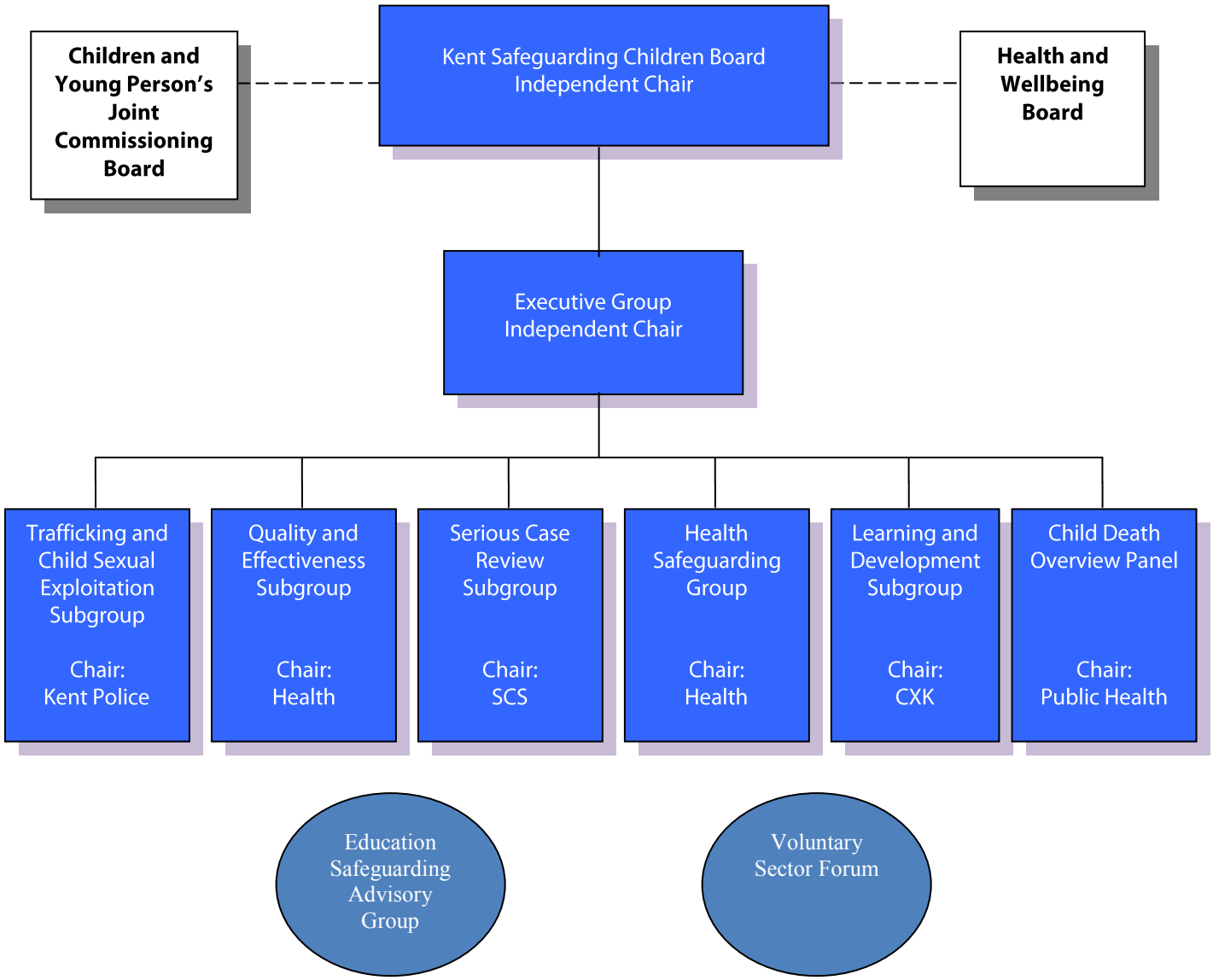
- Implementation of the Quality Assurance Framework
- Implementation of the Case Review processes
- Implementing a robust multi-agency audit programme
- Lessons learnt from case reviews and audits
- Learning from CDOP reviews
- Implementation of the Learning and Improvement Framework
- Response to Ofsted Review Framework
- Reporting from each KSCB Sub Group
- Feedback to staff

## Key threads that run through all priorities:

- Voice of the Child
- Multi-agency partnership working (including the voluntary and community sectors)
- Lessons are identified and learned from case reviews and multi-agency audits undertaken and the monitoring of the implementation of recommendations (Learning and Improvement Framework
- Knowledge and understanding of the children's workforce

The KSCB Business Plan for 2014/15 outlines key activity that will be undertaken to address these priorities. This Business Plan can be found on the KSCB website **www.kscb.org.uk**

# Structure of Kent Safeguarding Children Board (2013/14)




This Chart reflect the Board structure and links from 2013/14.

**Appendix B**

# Kent Safeguarding Children Board Membership (2013/14)

| Member | Role | Agency |
|---|---|---|
| **Maggie Blyth/Gill Rigg** | **Independent Chair** | **KSCB** |
| Aisha Paulose | Named GP for Safeguarding Children | NHS England |
| Andrew Ireland | Corporate Director | Families and Social Care, KCC |
| Meradin Peachy | Director of Public Health | KCC |
| Angela Slaven | Director of Service Improvement | Education and Young People's Services, KCC |
| Bethan Haskins | Chief Nurse – NHS Ashford CCG and NHS Canterbury & Coastal CCG | Clinical Commissioning Groups |
| Jay Pye | Executive Headteacher | Loose Schools Federation |
| Jenny Whittle | Cabinet Member | Specialist Children's Services, KCC |
| Julie Pearce | Chief Nurse & Director of Quality and Operations | East Kent Hospitals University Foundation Trust |
| Karen Proctor | Director of Nursing and Quality | Kent Community Health Trust |
| Mairead MacNeil | Director for Specialist Children's Services | Specialist Children's Services, KCC |
| Mike Stevens | Lay Member | KSCB |
| Nadeem Aziz | Chief Executive | Dover District Council |
| Nick Sherlock | Head of Adult Safeguarding | KCC |
| Mark Gurrey / Mark Wheeler / Patricia Denney | Assistant Director of Safeguarding and Quality Assurance | Specialist Children's Services, KCC |
| Patrick Leeson | Corporate Director | Education and Young People's Services, KCC |
| Roger Sykes | Lay Member | KSCB |
| Sally Allum | Director of Nursing and Quality | NHS England |
| Sean Kearns | Chief Executive | CXK Limited |
| Stephen Bell | Director of Business Improvement | CXK Limited |
| Steve Hunt | Head of Service | CAFCASS Kent |
| Tim Smith | Detective Superintendent | Public Protection Unit, Kent Police |
| Tina Hughes | Acting Director North Kent LDU | National Probation Service |

**Appendix C**

# KSCB Learning and Development activity from 2013/14

| Training | Number of sessions/ modules | Topic |
|---|---|---|
| **E-Learning (Level 2)** | 18 | • Awareness of Child Abuse and Neglect (Introduction)<br>• Awareness of Child Abuse and Neglect (Foundation)<br>• Awareness of Child Abuse and Neglect (Core)<br>• Awareness of Child Abuse and Neglect (Police)<br>• Basic Awareness of Domestic Abuse Including the Impact on Children and Young People<br>• Child Development<br>• Cultural Awareness in Safeguarding<br>• Hidden Harm<br>• Parental Mental Health<br>• Safer Recruiting<br>• Safeguarding Children from Abuse by Sexual Exploitation<br>• Safeguarding Children with Disabilities<br>• Safeguarding Children - Refresher Training<br>• Teenage Pregnancy |
| **Face-to-Face Level 2 (9 Topics)** | 45 | • Child Protection Basic Awareness<br>• Safeguarding Children with Disabilities<br>• Attachment Theory – Introduction<br>• Safeguarding Sexually Active Young People<br>• E-safety – Basic Awareness<br>• Understanding Thresholds and the Referral Process<br>• Child Trafficking<br>• Child Sexual Exploitation<br>• Self-Harm - Introduction |
| **Face-to-Face Level 3 (9 Topics)** | 42 | • Drug User Screening Tool (DUST)<br>• Participating in Child Protection Conferences, a New Approach<br>• Safeguarding in Cases of Physical and Emotional Neglect<br>• Child Protection for Designated Staff<br>• Child Protection for Line Managers<br>• Parental Mental Health and the Impact on Children and Young People<br>• Self-Harm – Intermediate<br>• Engaging with Hostile and Resistant Families<br>• Fabricated and Induced illness<br>• Transition from Early years to Adolescence |
| **Immersive Learning (Level 3)** | 9 | • Child Abuse and Neglect<br>• Child Sexual Exploitation and Online Safety<br>• Safeguarding - CCGs |
| **Area Workshops** | 3 | • Domestic Abuse & the Impact on Children & Young People |
| **Area Workshops** | 4 | • Learning from Serious Case Reviews |
| **KSCB Annual Conference** | 1 | • "Young People - Transition, Engagement and Resilience" Attended by 280 multi-agency partners |
| **KSCB Website** | Information on a range of subjects for multi-agency partners | |

**Appendix D**

# KSCB Annual Report 2013/14 – Finance Report

| Expenditure | 2013/14 | Projected 2014/15 |
|---|---|---|
| **Staff** | | |
| Salaries | 294,233.22 | 370,000.00 |
| Staff expenses | 4,479.83 | 5,000.00 |
| Staff training and development | 1,479.24 | 6,000.00 |
| Equipment | 6,491.38 | 2,000.00 |
| **Total Staff expenditure** | **306,683.67** | **383,000.00** |
| **Business Unit support** | | |
| Printing, publications and promotions | 1,995.54 | 3,000.00 |
| Room hire and refreshments – Board and Sub Groups | 10,039.66 | 7,500.00 |
| Stationery | 404.85 | 500.00 |
| KSCB website and on line procedures | 5,283.50 | 6,000.00 |
| **Total Business Support expenditure** | **17,723.55** | **17,000.00** |
| **Board expenditure** | | |
| Independent Chair | 24,325.85 | 28,000.00 |
| External consultants | 8,701.70 | 5,000.00 |
| Lay members | 200.00 | 200.00 |
| Case Reviews | 6,800.00 | 16,000.00 |
| Audits | 4,518.75 | 2,500.00 |
| **Total Board expenditure** | **44,546.30** | **51,700.00** |
| **Training** | | |
| Room hire and refreshments | 5,913.22 | 10,000.00 |
| External trainers | 16,000.00 | 5,000.00 |
| Annual conference | 10,000.00 | 12,000.00 |
| E-Learning subscriptions | 10,000.00 | 12,000.00 |
| Specialist Training | 4,269.98 | 65,000.00 |
| CPD subscription | 9,994.00 | 12,000.00 |
| **Total Training expenditure** | **56,177.20** | **116,000.00** |
| **Total expenditure** | **425,130.72** | **567,700.00** |

| Income | 2013/14 | Projected 2014/15 |
|---|---|---|
| Residual funds | -600,679.08 | -686,230.91 |
| Partner contributions | -250,524.00 | -248,134.00 |
| **Total Partner Contributions/Residual Funds** | **-851,203.08** | **-934,364.91** |
| Training - Bespoke | -27,775.25 | -30,000.00 |
| Training – cancellations/non-attendance charges | -18,383.30 | -9,000.00 |
| **Total training income** | **-46,158.55** | **-39,000.00** |
| KCC base funding | **-199,000.00** | **-200,300.00** |
| Receipts in advance | **-15,000.00** | |
| NHS GP training funding | | **-55,000.00** |
| **Total Income** | **-1,111,361.63** | **-1,228,664.91** |

| | | |
|---|---|---|
| **Total Income** | **-1,111,361.63** | **-1,228,664.91** |
| **Total expenditure** | **425,130.72** | **567,700.00** |
| **Residual funds to carry forward to next financial year** | **-686,230.91** | **-660,964.91** |

**Partner Contributions - breakdown**

| Agency | Contribution |
|---|---|
| Education Safeguarding | 40,167.00 |
| YOS | 8,000.00 |
| CSS | 40,157.00 |
| Kent Probations Service | *6,276.00* |
| Kent Police Authority | *50,000.00* |
| CAFCASS | *550.00* |
| Connexions (CXK) | *10,000.00* |
| Kent CCG | *90,374.00* |
| Kent Fire and Rescue Service | *5,000.00* |
| **Total** | ***£250,524*** |

Kent Safeguarding Children Board

**Kent Safeguarding Children Board**
**Room 2.60**
**Sessions House**
**Maidstone**

**01622 694859**

**www.kscb.org.uk**

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

Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director Social Care Health and Wellbeing

To: Health and Wellbeing Board – 19 November 2014

Subject: CARE ACT 2014 – A NEW LEGAL FRAMEWORK FOR ADULT SOCIAL CARE

Classification: Unrestricted

Summary: The Care Act 2014 establishes a new legal framework for adult care and support services. It marks the biggest change to care and support law in England since 1948 and it will replace over a dozen pieces of legislation with a single consolidated modern law. The new legal framework will come into effect from April 2015; however the key funding reforms (including the cap on care costs) are scheduled to come into effect from April 2016.

This report seeks to raise the awareness and understanding of the Health and Wellbeing Board regarding the main changes that have implications for the constituent organisations of the Board.

Recommendation: The Health and Wellbeing Board is asked to note the key issues set out in this report and discuss the main implications as they may impact on the future development of Joint Strategic Needs Assessment (JSNA) and the implementation of Health and Wellbeing Strategy.

## 1. Introduction

1.1 The Care Act 2014 received Royal Assent on 14 May 2014 and the accompanying the final regulations and statutory guidance were published on 23 October 2014. The changes to be implemented from April 2015 will overhaul and modernise the existing complex system of care and support that has evolved over the last sixty years. The changes will have significant implications for Kent residents, Kent County Council and partners.

1.2 The majority of changes to the legal framework will come into effect from April 2015. The main exceptions are the cap on care costs (£72,000 for people over pension age) and the increase in the capital threshold for people in residential care whose former home is taken into account (from the current £23,250 to £118,000).

1.3 Several key provisions of the Care Act such as, promoting individual wellbeing, preventing needs for care and support, promoting integration of care and support with health services, cooperating generally and in specific

areas, all have strong association with the both the JSNA and the implementation of the Kent Joint Health and Wellbeing Strategy.

1.4 The purpose of this report is to provide the Health and Wellbeing Board with the essential overview of the new law, drawing out the main implications for the Health and Wellbeing Board members so that they are better informed about the changes that will take place and by when.

## 2. Overview of the Care Act 2014

### Changes that will take place from April 2015

2.1 **Wellbeing, Prevention, integration, personalisation, diversity and quality in provision of services** – Local authorities will have to address new or extension of existing statutory responsibilities in respect of the core duties listed in this paragraph. The concept of wellbeing is described in relation to nine factors (1) personal dignity, (2) physical and mental health and emotional wellbeing, (3) protection from abuse, (4) control by the individual over day-to-day life), (5) participation in work, education, training or recreation, (6) social and economic wellbeing, (7) domestic, family and personal, (8) suitability of living accommodation and (9) the individual's contribution to society. In addition, local authorities must have regard to 8 other key principles and standards. Local authorities must also promote a diverse and high quality market of care and support services (including prevention services) for people in their local areas. In addition local authorities must ensure there is adequate provision of good quality information, advice and independent advocacy.

2.2 **National minimum eligibility criteria** - One of the key provisions of the Care Act is the introduction from April 2015 of a new national minimum eligibility criterion which all councils must follow (section 13 of the Act). The detail of the new criteria is contained in The Care and Support (Eligibility Criteria) Regulations 2014. As a consequence of this provision a person will be deemed to have eligible needs if they meet all of the following:

- Condition 1: They have care and support needs as a result of a physical, mental condition or illness; because of the
- Condition 2: because of those needs, they are unable to achieve two or more of the outcomes specified in regulations
- Condition 3: as a result, there is a significant impact on their wellbeing.

It should be noted that councils may be able to provide services above the minimum threshold if they so wish.

2.3 **Carers' rights** – The Act places local authorities under a duty to assess carers' need for support, where the carer appears to have such needs. This replaces the existing law, which requires that the carers must be providing "a substantial amount of care on a regular basis" in order to qualify for an assessment. It is expected that more carers may come forward for assessment. In Kent alone, we estimate that the additional carers' assessment in 2015/16 could range from 5,000 to 8,000 and in 2016/17 it could range from 6,000 to 8,000. There is an eligibility criterion for carers comparable to the right of the people they care for.

2.4 **Universal Deferred Payments** – The Act extends the current Deferred Payment scheme whereby people in permanent residential care (including nursing) with property can delay payment of some of their care home fees, subject to certain conditions.

2.5 **Transition** - Local authorities will be under a legal duty to cooperate and to ensure that all the right services work together to ensure an effective transition for children to adult care and support. Local authorities must also consider whether children are likely to have care and support needs on turning 18 and they must continue to provide support during the assessment process until adult care and support is in place or it is decided that adult care and support is not required.

2.6 **Safeguarding** – The Care Act sets out provision for local authorities to make enquiries or cause others to make enquiries if they considered that an adult with care and support needs may be at risk of abuse or neglect in their area to find out what, if any, action may be needed. The Act also requires local authorities to set up a Safeguarding Adults Board (SAB) in their area. The SAB must include, but not limited to, the local authority, the NHS and the police. The Board must arrange a Safeguarding Adult Review under defined situations. The SAB can request information from an organisation or individual in relation to abuse or neglect.

2.7 **Prisoners and people in approved premises-** The Care Act makes it the responsibility of local authorities to assess the care and support needs of prisoners and people in approved premises and, if they meet the eligibility criteria, meet their need for care and support. Prisoners and people in approved premises will be subject to financial assessment to determine how much they will have to pay towards their care, just like people living in the community.

2.8 **Delegation of local authority functions** - Councils will have the power to authorise a third party to carry out specified care and support functions with the exception of promoting integration with health services, cooperating, deciding which service should be charged, and safeguarding adults at risk of abuse or neglect and delegation function itself.

**Changes that will take place from April 2016**

2.9 **Cap on care costs** - there will be a total cap on care costs for people in receipt of residential and non-residential services. The cap for people of state pension age and over will initially be £72,000. There will be a lower cap for people of working age and people who turn 18 with eligible needs will receive free lifetime support for their care costs. The total reasonable amount determined by the local authority to meet eligible needs will count towards the cap regardless of whether the person pays all of this or only contributes a proportion of the cost (following a means-test). People in care homes will still be responsible for their living costs (e.g. food, energy bills and accommodation), if they can afford to pay them. The contribution to living costs will be set at a maximum of about £12,000 a year but will be subject to a means-test so will be significantly less for many people.

2.10 **Extended means-test -** there will be significant changes to the financial support available to people under the new means-test capital limits. People will receive help with their care home costs if they have up to £118,000 (including the value of their home). Currently people with more than £23,250 have to pay full cost of their care without any state support. Where the value of the home is not taken into account because a partner or dependent is living in the home, financial help will be available to those who have up to £27,000. This will also apply to people receiving non-residential care.

2.10 **Direct Payments in residential care** – it is expected that care home residents will be able to use direct payments for some or all of their care and support.

## 3. General operational and financial implications

3.1 The reforms will lead to a significant increase in the number of people coming forward for needs and financial assessments. There may be as much as 21,000 additional assessments in 2016/17.

3.2 The potential impact on the care market should self-funders exercise their right to request the council to meet their needs is yet to be fully determined. (The right to 'request' is being delayed until April 2016). The Department of Health has stated that this will lead to greater transparency in the prices paid by local authorities and "will change the care and support market, although it is not clear whether pressure may fall on commissioners, care and support providers or both".[1]

3.3 There are significant challenges in ensuring that the public understand the reforms and for individuals to know when the changes will apply and more importantly how they may be affected.

3.4 The reforms provide opportunities for more prevention and early intervention work, thus supporting the wider integration agenda.

3.5 The Government has announced funding for the first year (2015/16) of the implementation. Councils do not know the level of funding that will be made available for 2016/17 and beyond thereby raising the issue of affordability and sustainability of the implementation for local authorities.

3.6 Some costs will impact in 2015-16 and some in 2016-17 and the years after. The main impact in 2015-16 is for costs related to the assessment and provision of support to carers, prisoners and the introduction of the national minimum eligibility criteria. In 2016-17 the main impacts will be on the assessment and review of service users particularly self-funders, associated financial assessments and then the increased provision of services due to the increased capital thresholds.

## 4. Specific implications for JSNA and the Health and Wellbeing Strategy

[1] DH 'Caring for our future: Consultation on reforming what and how people pay for their care and support', July 2013

4.1 There is a strong alignment of key statutory provisions and principles of the Care Act with the agreed outcomes in the Kent Joint Health and Wellbeing Strategy. The Act emphasises the role of prevention and increased focus on the promoting the wellbeing of individuals as outlined in paragraphs 2.1 above. The guidance defines primary, secondary and tertiary prevention which gives prominence to support systems intervening early to support individuals to help them to retain or regain their skills and confidence as a result, prevent need or delay deterioration whenever possible.

4.2 The following key outcomes of the Health and Wellbeing Strategy closely relate to the key provisions of the Care Act as mentioned above:

Outcome 2

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

Outcome 3

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

Outcome 4

- People with mental ill health issues are supported to live well

Outcome 5

- People with dementia are assessed and treated earlier

4.3 Primary prevention and promoting wellbeing is locally best expressed through the building community capacity discussion, in particular, the concept of 'Community Agents' as catalysts who will work with individuals to avoid developing needs for care and support, or to avoid a carer developing support needs by maintaining independence, good health and promoting wellbeing.

4.4 The implementation of the Health and Wellbeing Strategy has to be seen in the context of promoting integration between local authorities and health services, cooperating between councils and other public bodies including the Care Quality Commission. Improving the range and quality of services available locally is important to the Health and Wellbeing Board in respect of sustainability of high quality health and social care services in Kent.

## 5. Conclusions

5.1 The Care Act gives new rights to certain people (for example, carers and self-funders) as well as providing statutory underpinning to a number existing policies will be implemented in two phases. Phase 1 (April 2015) is largely to do with the care and support reforms and the introduction of the new and consolidated legal framework. Phase 2 (April 2016) is about the main changes linked to the 'Dilnot' funding reforms.

5.2 The critical outline of the new law has been brought to the attention of the Health and Wellbeing Board. Furthermore, the broad implications for the local authority as well as the specific links with the Health and Wellbeing Strategy have also been sketched out. It is expected that Health and Wellbeing Board members would be better informed about the changes which will soon take place.

## 6. Recommendation

6.1 The Health and Wellbeing Board is asked to:

(a) **DISCUSS** the contents of this report.

**Contact details**

Michael Thomas-Sam
Strategic Business Adviser to Social Care
Tel: 01622 696116
Email: Michael.thomas-sam@kent.gov.uk

**By:** Dr Robert Stewart, Chair Integration Pioneer Steering Group

**To:** Kent Health and Wellbeing Board, 19 November 2014

**Subject:** **Kent Integration Pioneer Programme Update**

**Classification:** Unrestricted

**Summary:**
The Kent Health and Wellbeing Board is asked to:

**Note** the report and progress to date within Kent's Pioneer programme.
Support the approach for developing workstreams in evaluation, Europe and the innovation lab.

**For Information**

## 1. Introduction

1.1 The national Integrated Care and Support Pioneer programme was launched in November 2013. As one of the fourteen Pioneer sites Kent established an Integration Pioneer Steering Group (IPSG) as a sub-group of the Health and Wellbeing Board to coordinate the delivery of the objectives identified in the Kent Pioneer bid.

1.2 Kent's Pioneer programme was structured to support implementation at a local level. Providing added value to CCG areas as they work to implement their vision for integration and facilitating shared learning across Kent in areas of commonality. This was further supported by the Better Care Fund as the driver for integration in 2015/16 and the Kent structure of local plans building to a Kent picture.

1.3 This report highlights some of the key developments during the first year of the Pioneer programme, an update on the national programme and expected next steps.

## 2. First Year Highlights

2.1 The Kent Vision: A key outcome of the Pioneer programme was to agree a strategic vision for Kent's integration which reflects the differing nature of local implementation but enables partners to present a coherent message. The Kent vision with the citizen at the centre of what is important to them is now a recognised emblem for the aims and objectives of integration across all CCG areas.

2.2 The Better Care Fund: The IPSG were asked to help coordinate the development of Kent's BCF plan to ensure it was developed from a local perspective and engaged providers. Kent's BCF has now been approved with support. This is a positive outcome, meaning the plans have no areas of high risk so can progress for implementation.

2.3 The Innovation Hub: The Kent Innovation Hub provides a way for members of the public and organisations to help establish an integrated health and social care system. It is made up of a network of local, national and

international organisations from across health, social care, the voluntary sector, industry and academia. These organisations share good practice, tackle key challenges and help develop and implement solutions for service change. The Innovation Hub has hosted a number of events, conferences and Tweet Chats during the year on subjects such as information governance, shared care planning and good practice in care homes.

The Innovation Hub has recently been recognised by the EU as a site of excellence as part of the CASA European Innovation programme in the category of Integrated Regional Policy, Business and Knowledge. Kent as a pioneer is taking a lead role on Europe across national and international partners.

2.4 Leadership: The IPSG is also now being supported by the Leadership Centre to further consider how it can best ensure it functions to achieve the aims and objectives of Kent as a pioneer and is used more effectively to spread lessons learned, best practice, and barrier bust in a way that is real and practical to local areas.

2.5 Think Local Act Personal: Kent as a pioneer has signed up to the Making it Real programme - Making it Real sets out what people who use services and carers expect to see and experience if support services are truly personalised. This builds on the "I Statement" work that Kent has started and will involve developing an action plan and using "I statement" outcomes to check that what we do makes a real difference to the way people experience health and social care here in Kent.

2.6 Shared Care Planning: A key building block of integration within Kent is to develop shared care plans. The IPSG agreed that West Kent CCG would lead on the procurement and implementation of a shared care plan approach. To support this a combined bid for the Integrated Digital Care Fund was submitted, the outcome of this and the process for West Kent procurement is still taking place.

The CCG has provided links to the national pioneer informatics workstream and further work will take place to share learning across Kent. This is supported by the appointment of Bruce Pollington as Chief Clinical Information Officer within Kent under the pioneer programme.

2.7 Community Capacity Building: The vision for developing the role of the voluntary sector and making better use of community based resources has been presented to the IPSG and some individual CCGs. There is strong agreement for this approach and the links between the development of community agents and establishing neighbourhood community teams around primary care is clear.

Further work will now take place aligned to the implementation of Better Care Fund plans and Adult Social Care's Transformation Programme to develop an action plan for implementation.

2.8 Locality Implementation: Delivery of plans at a local level continues with priorities based around the detail within the BCF. Key highlights of progress include the procurement of a care plan management system in West Kent, further development of the integrated primary care teams in North Kent, the

implementation of community networks in Ashford and Canterbury and the start of an integrated care organisation in Thanet and South Kent Coast.

2.9 Further details of work within the programme and the implementation of integration at a local level is attached in the summary statement report in Appendix 1.

## 3. Next Steps

3.1 The national Pioneer programme will be holding a first anniversary event in January 2015. This will review progress to date by all Pioneers and identify future priorities within the national programme. To coincide with this Norman Lamb has announced an extension to the Pioneer programme, with up to 10 additional Pioneers to be included.

3.2 Following the outcomes of the work with the Leadership Centre it is expected that Kent as a Pioneer will be better placed to bring added value to the implementation of schemes at a local level. Facilitating learning, helping to barrier bust and sharing of good practice. This will be important in supporting the level of transformation required, in particular within workforce and estate, in order to meet the integration challenge and fulfil the Kent vision. Key streams have been identified to begin this process as outlined below:

3.3 Evaluation and Europe: these will seek to bring added value to local implementation through shared learning and approaches which can be applied at a CCG level. This includes the opportunity to coordinate across Kent's Pioneer members, including academic partners to bring in international resource and expertise. Within this Kent will continue to take the lead role across the national programme. A further update on evaluation will be provided at the January Health and Wellbeing Board.

3.4 Innovation Lab: Building on the success of the Innovation Hub work is taking place as part of the Prime Minister's Challenge Fund in South Kent Coast to develop an innovation lab concept. This will allow for the testing of models of integrated care in a live environment. Following the initial work in SKC it is planned to work with other CCGs providing a real opportunity to locally integrate health and social care, implement new ways of working and transform our ways of working based on the needs and goals of the citizen.

## 4. Recommendations

The Kent Health and Wellbeing Board is asked to:

4.1 **Note** the report and progress to date within Kent's pioneer programme.

4.2 Support the approach for developing workstreams in evaluation, Europe and the Innovation Lab.

## 5. Contact details

Report author: Jo Frazer, Programme Manager Health and Social Care Integration, Social Care Health and Wellbeing, Kent County Council, Jo.Frazer@kent.gov.uk
0300 333 5490

This page is intentionally left blank

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| **I Statements** | • I Statements and TLAP statements now need to be delivered to groups as a joint initiative between KCC, KCC Commissioning, KMCS and KCHT. | • I Statements not being presented to groups using an integrated approach.<br>• I Statements presentation not suitable for all users to understand. | • I Statements working group to be established with representation from KCC, KCHT, KMCS, KMPT.<br>• New action plan to be created using an integrated approach. |
| **Integrated Commissioning** | • Review of Integrated Commissioning Groups across CCG areas. | | • Terms of Reference are being developed currently |
| **Operational Integration** | | | |
| North Kent | • BCF plans progressing.<br>• Initiation of BCF delivery with 3 work streams Integrated Primary Care Teams, Integrated Discharge Team, and Integrated Dementia Services. | | • BCF plans finalised and signed off.<br>• Work stream groups underway.<br>• Lead for IT to outline way forward. |
| Ashford & Canterbury | • BCF plans progressing.<br>• Summit meeting took place on 10 July.<br>• Community Network Events held early September.<br>• Joint workshop took place on 21 October | • Detail of next steps, including governance to be established. | • Project Plan in development. |
| Thanet | • Developing Integrated Care Organisation<br>• Ageless Thanet – Thanet has been successful in its bid for £3 million over 5 years<br>• Summit Meeting 4 September agreed approach to defining a model of integration | | • "Big picture event" on the 4 November which will build on the first event further defining the model for the integrated care organisation. |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| SKC | • Developing Integrated Care Organisation<br>• Summit meeting took place on 25 July.<br>• Innovation lab approach in Folkestone which will support the process of integration and learning from implementation<br>• A new extended access GP service at the Royal Victoria Hospital will start on the 1 October.<br>• Folkestone Walk-in Centre will became a Minor Injury Unit on the 01 October<br>• Defining model of integrated care workshop took place on 8 October, over 60 provider frontline staff attended to begin the process of designing the organisation of integrated care<br>• Oversight meeting took place on 22 October with organisation leaders meeting together as part of the governance | | • Workshop to be held with the public in Romney Marsh to discuss services they would like provided locally<br>• Big picture workshop took place on the 5th November where a wider group of attendees across health and social care will come together to further define, build and refine the model for the Integrated Care Organisation |
| West Kent | • BCF workshop took place on the 23 September<br>• Reviewing tenders for Care Plan Management System (CPMS) | | • CPMS provider to be confirmed and implementation plan to begin. |
| **Innovation Hub** | • The Pioneer Kent.gov page is now live and the Kent Innovation Hub page can be found via the following link | • Picking themes that need barrier busting and having the right target audience at events. | • Feedback from Personalisation event to Integration Pioneer Steering group<br>• Actions to be taken forward by |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| | • www.kent.gov.uk/pioneer<br>• Events held on Shared Care Plans and Information Governance and Personalisation<br>• Increase in membership including first service user involvement | • Linking Hub activity to EU project deliverables.<br>• Everyone remembering to update the Hub to ensure it's a worthwhile tool.<br>• Assistance in growing membership of the hub. | Personalisation Board |
| **Risk Stratification/ Data Intelligence** | • Paper presented to Kent HWB | • Further consideration needed | • Integration Pioneer Steering Group tasked with reviewing next steps |
| **Year of Care** | • Kent whole population work published at the end of June with all 7 CCG logos/KCC and PH<br>• Case study agreed with National team for publication<br>• Shortlisted for HSJ awards – Enhancing Care by Sharing Data. Winners to be announced on 19th Nov in London.<br>• Kent whole population work distributed to CCGs http://www.nhsiq.nhs.uk/resource-search/publications/population-level-commissioning-for-the-future.aspx | • Plan is for YoC to be managed at CCG level following dissolution of the EK federated approach and this will impact on focus within each CCG and the programme's ability to deliver.<br>• IG and flowing KCC data to DSCRO. Query to National HSCIC around DSCRO's legal ability to accept clear patient level Social Care data. | • Engage front line services to understand the models of care being delivered in each of the health systems<br>• Increase the number of services flowing data (Ambulance, IC24, Hospices –WK & NK, CHC, Telehealth & Telecare).<br>• Identify the global budget for YoC Cohorts, by Practice, by CCG, from the services to date – 10th Nov EK, WK and NK to follow<br>• Develop further the specification for the dashboard. |
| **Contracting Models** | • Short-life working group led by University of Kent complete<br>• Monitor offering workshop for Kent on subject of our choosing | | • Agree on further work with Monitor |
| **Personalisation/Self-Management** | • As a Kent Pioneer we have now | • Key representatives for | • TLAP Action plan being |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| | signed up to TLAP 'Making it Real'<br>• Top three priorities to be identified and delivered through action plan.<br>• Personalisation Board membership being reviewed to support consistent delivery in the future. | Personalisation Board to be identified across all sectors. | developed, this will then form the focus of the Personalisation Board agenda.<br>• One day Workshop being planned with KCC, TLAP, CiLK, Healthwatch and Simon Paul Foundation.<br>• Create a service user Sub-Group to sit under Personalisation Board. Supporting delivery of action plan and actively involved in the personalisation Boards developments.<br>• To work through TLAP's twelve step approach. |
| **Integrated Budgets** | • 25 people with an integrated budget in South Kent Coast. 24 of the budget holders receive their IPB through a direct payment – Kent card.<br>• Interim IPB evaluation report was released March 2014. This has been shared on icase and with other interested stakeholders.<br>• Memorandum of Understanding (MOU) in place between KCC and SKC CCG to allow the CCG to use KCC financial systems to make direct payments. Established processes and governance in place to oversee the project, which will | • There were significant Information Governance constraints as holding patient identifiable information within the CCG, other than for invoice validation purposes was not acceptable. This impacted on the ability to track patient activity to allow benchmarking of costs incurred prior to uptake of budget. It also caused delays for patients, and increased complicated processes.<br>• Some stakeholders were | • South Kent Coast CCG plan to continue to offer IPBs to 50 patients with LTCs in 2014/15.<br>• South Kent Coast CCG has applied to extend the Going Further Faster programme with NHS England. The CCG will be required to develop a 5 year rollout plan and support other Kent CCGs with implementing PHBs/IPBs.<br>• Final IPB evaluation report will be released October /November '14. |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| | be reviewed as part of next steps to ensure sustainability for larger scale rollout. | reluctant to engage and move away from the established medical approach & clinical-patient relationship.<br>• Building the relationship between the provider market and commissioners is required to explore market readiness for personalised services and reducing block contracts in order to provide more choice for budget holders. | |
| **Workforce** | • The key would be for the HEE and other national workforce bodies align their future work to the reality of out of hospital integration work. | • At present the HEE and other national workforce bodies are working with NHS providers who are not integrated and not even in primary care so are unlikely to lead a future plan, the Clinical Assembly and the Kent Pioneer NHSIQ support unit have been made aware. | • Currently working with our local HEE/ KSS to see what can be done locally – but the change really needs to be national. |
| **Personal Health Records** | • HAS Global presented at ENGAGED mutual learning workshop in June 14. Working with them on Shared Care Planning.<br>• KCC and Microsoft working in partnership to provide eDayBook via the HealthVault platform. Will | • Data security / ownership. MDTs understanding and using the Shared Care Plan correctly and embedding it into their day to day practice.<br>• Data security / ownership. Ability to roll out at scale to | |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| | support Home Care workers in delivery of care and also provide a Personal Health Record. | all Home Care providers. | |
| **Integrated IT** | • General support to review progress. | • Need to consider impact of possible different approaches across Kent – this may challenge communication of care and increase risks to patients when services such as KCC, 111 and SECAmb work county wide. | • CASA Dissemination Event in November showcasing possible technical solutions / solutions adopted by our EU partners / workshops with practitioners re overcoming barriers. |
| **Information Governance** | • Pioneer Informatics group leading on work at national level | • Pioneer sites being offered 251 exemption, currently felt no requirement for Kent to apply. | • Review ongoing work of Informatics work.<br>• Plans are underway to recruit 2 new staff within the LGA to support the delivery and coordination of the projects that have been committed to. |
| **End of Life** | • Steering Group in place | • Further consideration needed on actions<br>• Date of next meeting to be set | |
| **Housing** | • Joint Policy and Planning Board agreed to use Think Housing First Action Plan. | • Not all actions relevant to Pioneer, agreed to produce revised 'Pioneer' version.<br>• Discussion needed on engagement of CCGs and Integrated Commissioning Groups in delivery of action plan | • Presentation at IPSG on action plan. |
| **Voluntary Sector** | • In the process of finding a | | • Further implement Community |

| PIONEER WORK STREAM SUMMARY REPORT- November 2014 | | | |
|---|---|---|---|
| | **Key Update** | **Key Issues** | **Next Steps** |
| | Voluntary Community and Social Enterprise Sector Representative for Kent Integration Pioneer Steering Group, job role has been devised and being circulated. | | Capacity Model.<br>• Possible pilot with Age UK.<br>• Pioneer development support managers planning to set up a specific community around Vol on ICASE as there is a huge amount of work going on across the country to learn form. |
| **Evaluation Framework** | • Meeting with Kent universities took place on 29 August.<br>• Pioneer evaluation taking place through DH. | • Review of activity under DH evaluation requires all Pioneer organisations to agree to research governance. | • Evaluation workshop to be held in December. |
| **Performance Management** | • BCF metrics / Kent HWB assurance framework established. | • Further performance requirements may be requested through Pioneer. | • Finalise metrics as part of BCF. |

This page is intentionally left blank

**By:** Roger Gough, Cabinet Member for Education and Health Reform

**To:** Health and Wellbeing Board, 19 November 2014

**Subject:** **Systems Resilience**

**Classification:** Unrestricted

**Summary:** While there is a shared consensus around the vision as to how health and care services need to change to improve patient care, the Board needs to be aware of a number of challenges which may require a whole-systems response.

**Recommendation(s):**

The Board is asked to note the report and discuss what steps it needs to take to seek assurance that the appropriate steps are being taken to minimise the risks these challenges pose to the sustainability of local health and care services.

## 1. Introduction

(a) The shared vision of health, public health, and social care commissioner across Kent is clear and set out in the Joint Health and Wellbeing Strategy. The health and care system cannot carry on doing the same things. Health and Social care needs to be reformed to offer people much greater individualisation of services and more control over what and how the services they need are provided. Kent has responded enthusiastically to this challenge through its Integration Pioneer programme and with the support of the Better Care Fund.

(b) Achieving these changes will not be easy. Pressures on the health and social care system are building, threatening its sustainability. These demands often manifest themselves in the acute hospital sector but addressing them requires a response from the whole system.

## 2. Local Challenges

(a) No one part of the health and care system can be seen in isolation and problems in one area have an impact on the whole County. There are a number of risks to the goal of putting the Kent's health and care system on a sustainable footing for the longer term. Some of the key ones are set out below:

- Dartford and Gravesham NHS Trust – Dealing with capacity issues related to patient flows from South East London;

- East Kent Hospitals NHS University Foundation Trust - Currently in special measures;
- Maidstone and Tunbridge Wells NHS Trust – Expecting results of a recent CQC inspection (issues raised in visits earlier this year);
- Medway NHS Foundation Trust – Currently in special measures.

(b) The Board has a role in seeking assurance that the appropriate steps are being taken to minimise the risk that any one of these could escalate to the point of destabilising the whole health and care system and subsequently make it less likely that Kent will be able to achieve its shared vision.

**Recommendation(s)**

The Board is asked to note the report and discuss what steps it needs to take to seek assurance that the appropriate steps are being taken to minimise the risks these challenges pose to the sustainability of local health and care services.

**Background Documents**

Kent Joint Health and Wellbeing Strategy

**Contact Details**

Tristan Godfrey
Policy Manager (Health)
(01622) 694270
tristan.godfrey@kent.gov.uk

# Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **22nd October 2014.**

**Present:**

Councillor Michael Claughton – Chairman - Cabinet Member ABC;
Navin Kumta – Vice-Chairman - Clinical Lead, Ashford CCG;

Sheila Davison – Public Health, ABC;
Simon Perks – Accountable Officer, CCG;
Mark Lemon – Policy and Strategic Relationships, KCC;
Christina Fuller – Cultural Projects Manager, ABC;
Simon Harris – Sports Projects Manager and Active Ashford Co-ordinator, ABC;
Debbie Smith – Public Health, KCC;
Annette Haigh – Community Engagement Officer, Ashford;
Stuart Bain – Chief Executive, East Kent Hospitals Trust;
Rachael Spencer – Kent Fire and Rescue Service;
Val Miller – Public Health, KCC;
Sharon Williams – Housing Operations Manager, ABC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC;
Renu Sherchan – Environmental Services, ABC

**Also Present:**

Councillors Chilton, Clokie and Sims.

**Apologies:**

Philip Segurola - KCC Social Services, Paula Parker – KCC Social Services, Caroline Harris – HealthWatch Representative, Martin Harvey – Patient Participation Representative Lay Member CCG, Tracy Dighton – Voluntary Sector Representative, Stephen Bell – Local Childrens' Trust, John Bunnett – Chief Executive - ABC.

## 1 Notes of the Meeting of the Board held on the 23rd July 2014

**The Board agreed that the Notes were a correct record subject to an amendment to Minute No. 1 "Declarations of Interest" to read "Martin Harvey made a "Voluntary Announcement" as his wife had obtained a placement with Turning Point and that may well be Turning Point Ashford and the addition of the following words at the end of the sentence at paragraph 4.3 "…for both employer and employee".**

# 2 Care Quality Commission (CQC) Report on the William Harvey Hospital - Action Plan

2.1 Simon Perks introduced Stuart Bain explaining that there were no quick fixes to the problems identified and that some of the items in the CQC report may need to come back to future Board meetings and that further updates might be appropriate.

2.2 Stuart Bain, Chief Executive of the East Kent Hospitals University NHS Foundation Trust explained the background to the CQC report and said that visits used to be unannounced and covered 16 criteria and over the past seven years a number of such visits had been undertaken. In Summer 2013, 14 Trusts across the country had been subject to more vigorous tests responding to national concern over hospital mortality rates i.e. the Keogh review. Stemming from these checks, the new CQC inspection arrangements were being rolled out over every Trust and in early March three hospitals under the control of the East Kent Trust were examined. The inspection was against five domains covering eight different services. Stuart Bain said that the report was quite critical in terms of the William Harvey Hospital over a number of areas but he said that in terms of critical care had been identified as being good over all sites and within all services. The hospital was also rated as good for care and response to patients' needs. The Trust had reflected upon this report and had looked at key areas to improve. Stuart Bain explained in more detail the changes being pursued within the outpatients service which had been under pressure due to the introduction of a cancer two week pathway target which had resulted in follow on appointments for patients being pushed further back than desired. The East Kent Trust saw more cancer patients on a two-week pathway than any other hospital in the country. Work on this particular action point would be the culmination of six new purpose built units, one of which was the new hospital in Dover which, when it opened in Spring 2015, would take pressure off Ashford and Canterbury.

2.3 In terms of Accident & Emergency, Stuart Bain said they recognised that demand had risen sharply and had reached a level of 600 patients per day being seen in July. He said that people were using A & E for different reasons but the most prevalent age group was the 18 to 30's. He said that the vast majority did not necessarily need to be seen in A & E and instead efforts needed to be made to direct those people to alternative and more appropriate forms of assistance. Staffing was another issue with nationally over 300 consultant posts currently vacant with not enough qualified personnel to fill these posts. Stuart Bain also said these were the main areas which concerned the Trust. Disconnect between staff and management was seen as something that the Trust needed to put right. Stuart Bain emphasised the connection between a targets culture and a patient centred culture i.e. essentially they both wanted the same thing but believed that this did not always gets explained clearly enough. He said that they needed to be better at helping staff to understand that the targets for services were not imposed for the sake of it but were based on what was believed to be appropriate standards of care.

2.4 In terms of action to be undertaken, he explained that the hospitals had been placed under special measures which required the Trust to meet every month with Monitor who had appointed an Improvement Director to advise the Chairman and the Board. Stuart Bain explained the role of Monitor who were the independent regulators of foundation trusts. It was their responsibility to make sure that hospitals were run well on behalf of patients. An Action Plan had been produced to measure progress against the various steps identified for improvement. In conclusion he said if members of the Board wished to view the Action Plan, it was available on NHS Choices website.

2.5 The Chairman said he supported the point about appropriate standards and targets for care and said that in the report he was concerned there had been no mention of dementia or dementia care. He had also been concerned at the lack of staff, in particular trained staff to fill the vacant posts.

2.6 Stuart Bain said there was a national shortage of appropriately trained staff and advised that in January 2013 they had identified an appropriate budget to recruit the nurses they needed for the posts available but they had had great difficulty in recruiting them. They had recruited staff from Ireland and Portugal however there was a problem as once staff were established they often moved up to one of the London teaching Hospitals. At the present time, 75% of the vacant posts had now been filled. In terms of A and E, four or five new consultants had been recruited but he said they too were attracted to move to London to work in the Teaching Hospitals. The best estimate nationally in terms of availability of nurses was in the region of 10,000 too-few fully qualified nurses. In response to a question, he advised that it was Government policy that each nurse now had to have a degree and this was adding pressure where in some specialist areas other professionals could provide care but as they were not qualified nurses this was not permitted. However, the Trust was undertaking work with health care assistants in terms of the role they performed in the hospitals.

2.7 Mark Lemon said the Kent County Council believed that the CQC report was a wake-up call for all the hospitals in Kent and Medway and indicated that wide scale system change was necessary to see more hospital services transferring into the community and a greater focus for the hospitals on the highly specialised care. The role of the primary health sector and social care was seen as fundamental. He said that Health and Wellbeing Boards and indeed the Ashford Health and Wellbeing Board had a role to help this particular issue.

2.8 The Chairman confirmed that the Board would provide assistance in any areas it could.

2.9 Sheila Davison said that she had received a question from HealthWatch on this particular agenda item in which they had raised the issue of the new houses that would be developed at Chilmington and asked what work was being undertaken to assess the impact that this would have on GP surgeries. Sheila Davison advised that there was an established health infrastructure group who would work with the CCG to look at population growth and encourage and re-engineer at an early stage any changes required to

services. Stuart Bain confirmed that the Trust had undertaken a number of areas of work which included transportation whereby the Trust had with the Council looked at bus routes with the view to helping patients gain access to the various hospital locations.

2.10 Councillor Clokie said that there was a particular issue in Tenterden whereby a Doctors' surgery wished to expand but the NHS who owned the building next door were unwilling to make their property available. Sheila Davison said that a meeting had been set up to look at this particular issue.

2.11 Deborah Smith referred to the demand for services within A & E and said that Public Health KCC and the voluntary sector staff were available to help relieve the pressure on the services in terms of focusing messages for specific health issues on the 18-30 age group. It was agreed that a campaign to promote people seeking the advice of pharmacists could be useful. In conclusion the Chairman thanked Stuart Bain for addressing the meeting.

# 3 CCG Merger: Update

3.1 Included within the Agenda papers was a copy of a presentation entitled "Preparing for the Future" produced by the Ashford, Canterbury and Coastal Clinical Commissioning Group.

3.2 The Chairman advised that the proposed merger had been discussed at Patient Participation Group meetings and one of the principal comments made was the lack of communication about the merger from GP's to the patients in terms of how it impacted on patients.

3.3 Navin Kumta advised that 92% of the Ashford General Practices voted in favour of the merger and in Canterbury the figure was 80%. He explained that the principal aim behind the merger was to improve services to patients and provide more care in the community. The merger would help support the development of Community Networks which were seen as the strategic solution to reducing pressure on the hospital and improving the service. The request to merge had been submitted to NHS England who had considered the matter on the 16th October 2014. Feedback to date had been positive. The final decision was however awaited.

3.4 Simon Perks explained that the implementation date was still set at April 2015 and the CCG were re-aligning their commissioning staff, setting up the appropriate geography of networks and agreeing budgets at network levels.

**The Board noted the report.**

# 4 CCG Strategic Commissioning Plan 2014-19

4.1 Included with the agenda papers was the Strategic Commissioning Plan for 2014-2019. This was the CCG's first five year plan which also contained a two year operational aspect.

4.2 Navin Kumta explained that the five year Commissioning Plan followed the production of the Operational Plan and showed the basic needs for Ashford. He asked that if any of the members of the Board had comments on the document, they should direct them to the CCG. Simon Perks explained that announcements were expected from NHS England on the 24th October 2014 about what areas Commissioning Plans might also need to look at and therefore there would be a need for the CCG to reflect on the messages stemming from any statement from NHS England. This was the NHS England's Five Year Forward Review.

**The Board noted the report.**

# 5 Focus on Healthy Weight

5.1 Included within the agenda papers was an introduction and covering report which set out details of the presentations the Board would receive and included recommendations for consideration.

**(a) Kent Fire and Rescue Service Firefit Scheme**

Rachael Spencer the Vulnerable Person Liaison Officer gave the above presentation. The "Firefit" Initiative focussed on improving inclusion, quality of life and was an excellent engagement tool which could support multiple campaigns within KFRS and external partners. The presentation drew attention to the "Pop-Up Events" which were used by Kent Fire Service to promote a healthy lifestyle and Smoke Free Homes whilst conducting home safety visits.

**(b) Healthy Weight - County Perspective**

Val Miller, Public Health Specialist gave a presentation on how KCC Public Health was working towards creating a healthy weight strategy. This would be considered by the Kent Health and Wellbeing in due course. Val Miller went through the slides of her presentation, a copy of which had been included within the agenda for the meeting.

**(c) Healthy Weight Perspective - Ashford**

Simon Harris gave a presentation on the Healthy Weight Perspective as it related to Ashford and a copy of the slides he used was included within the agenda papers for the meeting. Simon Harris explained that Ashford was the coordinator on healthy weight but the initiative was being handled in partnership by Ashford Borough Council, Kent County Council Public Health and the CCG. In terms of timescales he hoped to have established the Task and Finish Groups who would commence work in November with a view to the plan being produced in May to July 2015.

**General Discussion**

Navin Kumta said he endorsed all the recommendations within the report and considered there was a need to communicate with stakeholders what issues

the Board and its partners were currently undertaking. In terms of what was the definition of being overweight and obese, Navin Kumta explained that it related to a person's Body Mass Index and explained that this could be checked online. He also believed that the initiative outlined during the Firefit presentation was excellent as it would encourage children to feed back to the parents information that they had been given during the sessions that they attended.

Val Miller referred to the previous work on "Action on Salt" whereby there had been a phased reduction in the amount of salt in processed foods and considered that the same principles could work if applied to the reduction of sugar in processed foods. Simon Perks commented that this largely related to the food industry and therefore the Board had limited influence over their actions. Val Miller explained that the initiative could be taken forward if the Secretary of State for Health gave a strong message to the food manufacturers that they should reduce the level of sugar in their products. She advised that she had attended a recent conference when the speaker, Professor McGregor had said that he was sure that manufacturers would agree to reductions if there was a level playing field and all companies had to comply. Val Miller also explained that local authorities could reduce the availability of fast food by controlling the location and opening hours of fast food outlets by the use of planning and licensing legislation.

In response to a question Val Miller said both the weight and the height of a child was taken into account in determining whether a child was classed as overweight or obese. In terms of the process all parents would be sent a letter two weeks before their child was due to be weighed and within six weeks they would be advised on the outcome.

Sheila Davison advised that there was a need to establish a project lead for this initiative and it was agreed that Board Members would discuss this offline and report back to the Board in due course.

**The Board recommended that:**

**(a) Support be given to the need for a localised Action Plan for subsequent consideration by the Board.**

**(b) An Action Plan be requested that promotes healthy weight interventions and be brought before a future meeting of the Board.**

**(c) The work of the Kent Fire and Rescue Service (KFRS) as relevant to the Board's priorities as a "Must Do" project be supported.**

# 6 Lead Officer Quarterly Report

6.1 The report provided an update of the work which had been progressing since the previous meeting held on the 23rd July 2014. The report also included information and progress on each of the "Must Do" projects. Farrow Court was highlighted as being currently on target.

6.2 The Kent Board required local Health and Wellbeing Boards to ensure local plans "demonstrate how the priorities, approaches and outcomes of the strategy would be implemented at local levels". An assurance was required to be given to the Kent Board in November. The Board also confirmed that they agreed that Navin Kumta should represent the Board at the Kent Board when this issue was discussed.

6.3 Sheila Davison also explained that HealthWatch had asked a question about when there would be an update on homelessness. She advised that this could be dealt with in the update submitted to the January meeting of the Board. She also reported that Linda Caldwell of NHS South East Commissioning would be producing a business case for establishing day care services for people with Dementia in conjunction with Age UK. It was also confirmed that Sue Luff remained the lead for the Community Networks project.

**The Board recommended that:**

**(a) It be noted that the Lead Officer Groups need to meet to respond to the Kent Health and Wellbeing Board's request to evidence local engagement and implementation of the Joint Health and Wellbeing Strategy.**

**(b) The Ashford representative be authorised to report on outcomes at the Kent Health and Wellbeing Board meeting in November (this will be Navin Kumta).**

**(c) A report be submitted to the Board in January on the outcome of the meeting as set out in (b) above.**

**(d) The progress of the "Must Do" projects to date be noted.**

**(e) Approval be given to the handling of requests for the Ashford Board to consider strategy, policy and other similar documents through the Local Officer Group where appropriate.**

**(f) The need for a voluntary sector representative and HealthWatch to include a Partner Update if needed be endorsed.**

# 7 Partner Updates

7.1 Included with the agenda were A4 templates submitted by partners.

**(a) Clinical Commissioning Group (CCG)**

Sheila Davison reported that Health-Watch wanted their continued support for the community networks being established to be noted and their offer of any help and assistance they could give to the process.

**(b) Kent County Council (Social Services)**

The Chairman said it was difficult for the Board to consider this issue when there were no Social Services representatives from Kent County Council.He considered it was important to have the relevant people at the meeting.

**(c) Kent County Council (Public Health)**

Deborah Smith reported that the assurance framework for Ashford was available to be viewed on the KCC website.

**(d) Ashford Borough Council**

Sheila Davison reported that Ashford had committed funding to creating a new post to support work on Domestic Abuse.

**(e) Ashford Childrens' Health and Wellbeing Board**

Annette Haigh explained that the second meeting had been held on the 15th October 2014 and that they had agreed the establishment of the Ashford Childrens' and Young Peoples' Health and Wellbeing Board. Navin Kumta commented that the name was not appropriate as it was not a Board because it was a Sub-Committee of the Ashford Health and Wellbeing Board. Annette Haigh agreed to take this comment back to the organisation and asked that the following priorities be agreed.

- Not in Education Employment or Training (Lead - Louise Fisher)
- Mental Health (Lead – Stephen Bell)
- Healthy Living to include healthy weight and smoking (Lead – Sarah Mills)
- Play (Lead – Emma Dyer who was the Head Teachers representative)

**The Board noted the progress reports and agreed the priorities to be set up by the Ashford Childrens' Health and Wellbeing Board.**

# 8 Forward Plan

8.1 The Board noted the Forward Plan for subsequent meetings of the Board.

# 9 Next Meeting and Dates for 2015

9.1 The Chairman sought Members of the Board's views as to whether to change the meeting time to 9.30 am to therefore allow up to three hours for the meeting to consider all its business. Those Members of the Board present agreed to this suggestion. The next meeting would be held on Wednesday 21st January 2015 at 9.30 am.

9.2 The subsequent dates as set out below were noted:-

22nd April 2015
22nd July 2015

21st October 2015
20th January 2016

(KRF/AEH)

MINS:Ashford Health & Wellbeing Board - 22.10.14

---

Queries concerning these minutes? Please contact Keith Fearon:
Telephone: 01233 330564 Email: keith.fearon@ashford.gov.uk
Agendas, Reports and Minutes are available on: www.ashford.gov.uk/committee

This page is intentionally left blank

**CANTERBURY CITY COUNCIL**

**CANTERBURY AND COASTAL HEALTH AND WELLBEING BOARD**

**Minutes of a meeting held on Thursday, 18th September, 2014 at 6.00 pm in the The Canteen, Canterbury City Council, Military Road, Canterbury CT1 1YW**

**Present:** Dr Mark Jones (Chairman)

Councillor S Chandler
Velia Coffey
Michelle Farrow
Mr Gibbens
Councillor Gilbey
Councillor Howes
Steve Inett
Paula Parker
Simon Perks
Councillor Cllr Pugh
Jonathan Sexton
Sari Sirkia-Weaver
Anne Tidmarsh
Mark Kilbey

1 **APOLOGIES FOR ABSENCE**

Cllr Paul Watkins
Mark Lemon
Chris Ives
Cllr Andrew Bowles
Amber Cristou
Neil Fisher

2 **WELCOME AND INTRODUCTIONS**

Mark Jones welcomed all to the meeting and all introduced themselves.

3 **MINUTES AND ACTIONS FROM THE PREVIOUS MEETING 11 JUNE 2014**

The minutes were agreed as a true record.

**Action updates:**

**Mark Jones to write a letter to Steve Auty expressing disappointment that he had not attended the meeting and offering the support of the Board and its stakeholders.** Complete

**Sari Sirkia-Weaver to investigate how the Children's Health and Wellbeing Board (HWB) will report to the Kent HWB and also how the Canterbury and Coastal HWB can input into it**. Sari Sirkia-Weaver advised that she has spoken to Stephen Bell, the Children's Operational Group chairs' representative. Kent have not yet confirmed a set of priorities but this is expected soon and six monthly reports will be provided to KHWB.

**Neil Fisher to liaise with the Mental Health Action Group (MHAG) to review commissioning and the 3 current key issues and bring back to Core Group meeting in August with a view to when they return to the HWB for review.** Neil Fisher was not present to give an update but it was noted that the Community Network had highlighted engagement with service users as a key point. MHAG is due to start a 'crisis and funding is currently being sought for this.

Cllr Pugh advised that Kent and Medway NHS and Social Care Partnership Trust (KMPT) has recently undergone a review and a meeting will be held next week to discuss the findings.
***Action: Cllr Pugh to circulate the report regarding the KMPT review as soon as it is available***.

Steve Inett advised that Healthwatch are conducting a review of acute services in Canterbury.-
***Action: Steve Inett to circulate the Healthwatch Review of acute services in Canterbury when available.***

***Action: It was agreed that this action should be reviewed regularly and progress reported back to the board. Neil Fisher.***

4 **PILGRIMS HOSPICES - SHAUN STACEY**

Mark Jones reported that Shaun Stacey, Chief Executive of Pilgrims Hospices had sent his apologies that he could not attend the meeting. Simon Perks advised that he has recently been appointed as a Trustee and there has been a change in senior management. They are currently reassessing their priorities.

Velia Coffey reported that Richard Davies, the new Chairman will be meeting with herself and the Chief Executive of Canterbury City Council (CCC) to follow up on a request made by the council to give assistance where they could.

It was agreed that it would be beneficial for a representative from Pilgrims Hospices to attend the next meeting.
***Action: Alison Hargreaves to invite Pilgrims Hospices to the next meeting.***

5 **HEALTH AND WELLBEING STRATEGY - FAIZA KHAN**

Faiza Khan advised that she had undertaken a piece of work to take all the outcomes and priorities listed in the Kent Health and Wellbeing Strategy and match them to activity in the Canterbury and Coastal Clinical Commissioning Groups (CCG) area. She stated that she is confident that activity is taking place around all the areas listed but had not yet had an opportunity to include dementia work.

The report will be completed and circulated in the next few days. It was felt that the ownership of some of the outcomes should be more local and an additional column added to the report to show how these outcomes will be addressed by local organisations and how they can be embedded into local plans and strategies. It was noted that plans and strategies cannot easily be adjusted once in place however they can be modified as necessary in the future.

It was agreed that commitment is needed by all partners to ensure the success of this.

Paula Parker offered to share work done by the Integrated Commissioning Group particularly around dementia.

Cllr Pugh advised that the Health and Wellbeing Strategy is included in Swale Borough Council's Corporate Plan refresh and offered to share the work done. Cllr Gilbey thanked Cllr Pugh and stressed the need for local authorities so share information and work together on how best to incorporate the Health and Wellbeing Strategy into their future plans.

Steve Inett commented that the Health and Wellbeing Strategy had undergone a very short process of engagement and that Healthwatch are keen to get the key themes out to local organisations so that they can include aspects in their own literature. Healthwatch England have produced a YouTube video.
***Action Steve Inett to share the YouTube video produced by Healthwatch England***

6 **MERGER OF CANTERBURY AND COASTAL AND ASHFORD CLINICAL COMMISSIONING GROUPS - SIMON PERKS**

Simon Perks reported that a panel comprising members of the governing body and officers have met with NHS England and a report has been drafted to go to the National Committee on 14 October with a positive recommendation of the merger.

A number of actions have been identified for the Clinical Commissioning Groups (CCG) prior to the merger including further work on engagement and a significant amount of technical work regarding the merger.

Simon Perks commented that the benefits of the merger include reducing overhead burden; releasing resource; allowing commissioning to be more localised through the development of eight Community Networks; creating a bigger pool of GPs from which to draw Board members. Both the Ashford and Canterbury Health and Wellbeing Boards will be retained.

It was noted that the merger will take time and resource and that one of the challenges is to ensure that it is not a distraction from the day to day commissioning work of the CCG.

7 **CARE QUALITY COMMISSION REPORT INTO STANDARDS AT THE EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - SIMON PERKS**

Simon Perks reported that the recent CQC report had looked at five domains (care should be; safe, effective, caring, well led and responsive). The domains of safe and well led had gained a score of inadequate and Monitor has placed the Trust in special measures.

The draft of the action plan has been received by the CCG and a meeting will be held on Monday 22 September to review it before it is presented to the CQC. Monitor will now take greater responsibility for the Trust's performance than the CCG but will continue to liaise with them. Early work is around data reliability and standards.

It was noted that work around leadership by the Trust is key and this will take time. The current Chief Executive retires in December 2014 and the Trust has recently appointed a new Human Resources Director and will have a new Finance Director before end of the year giving a good opportunity for change in the senior management.

It was agreed that the Trust needs to address attitudes in all their staff, not just the leadership and Simon Perks sought the input of the HWB in developing ways this could be progressed. It was noted that Healthwatch have already offered support to the Trust.

Velia Coffey queried what the risks were for the HWB and Simon Perks advised that distraction from the core commissioning tasks and focus on key performance indicators was the greatest risk. The Board offered their support to the CCG and to the Trust.

It was suggested that a representative from the Trust attend the next meeting so that the Board could formally offer their support.
***Action: Mark Jones to write to EKHUFT to invite them to the next HWB meeting.***

8 **BETTER CARE FUND - SIMON PERKS**

Simon Perks reported that the Kent Wide BCF was signed off by the Kent HWB on 17 September. The Board was asked to note that the BCF is not new money but is about funding being used differently and shared across boundaries with a common aim of keeping patients out of hospital and supported in their own community. Simon Perks commented that BCF is a sub set of the Community Networks programme and will be used to fuel the Community Networks. It was agreed that there are challenges around this, specifically around the need to share resources and finances between different parts of the system which requires a greater degree of trust. It was agreed that this needs to be overcome if true joint working and integration is to be achieved.
***Action: Cllr Gilbey suggested that this topic was added to the agenda for a future Joint Kent Leaders meeting.***

In response to a request regarding dementia friendly communities Simon Perks reported that he had met with the Leader of Ashford Borough Council who are building dementia friendly communities into their new housing developments. Cllr Howes advised that he will be visiting Sevenoaks Borough Council and Ashford Borough Council on fact finding visits and will report back to the next Core Group meeting. It was agreed that there are good dementia models in practice across the country and that their best practice should be followed.
***Action: Faiza Khan to send examples of good dementia models to Anne Tidmarsh.***

It was noted how important the voluntary sector is in providing support for people in their community and facilitating self care. Healthwatch asked for greater co-ordination of volunteer groups and it was advised that a report will be presented to the Integration Pioneer Steering Group around this and that the voluntary sector is always included in engagement events and have taken on a much greater role than in the past.

Cllr Howes reported that East Kent Housing have undertaken work on independent living for older people to provide safe and secure homes to allow people to be as independent as possible.
***Action: The East Kent Housing report on independent living can be found on page 71 of the Executive Agenda*** ***Executive Agenda 11 Sept***

9 **ALCOHOL STRATEGY - VELIA COFFEY**

Velia Coffey gave a brief overview of the Kent Alcohol Strategy and advised that the Board had been asked to provide a local lead and an action group to plan how the pledges in the Alcohol Strategy will be delivered locally.

Cllr Chandler reported that Dover has already considered the Alcohol Strategy and that this is being led by the Substance Misuse sub group of their Community Safety Partnership.

The Board discussed aspects of the alcohol strategy including the local demographic differences within the region, the need for any interventions to cater for all sectors of the population and be accessible to all and the importance of including mental health aspects and peer support.

It was suggested that the Canterbury Community Safety Partnership lead on this in Canterbury and in the first instance undertake a gap analysis on provision and bring the findings back to the Core Group.
***Action: Velia Coffey to lead on this piece of work.***

10 **CHILDREN'S HEALTH AND WELLBEING BOARD - SARI SIRKIA WEAVER**

Sari Sirkia Weaver gave an update on the Children's HWB priorities and advised that they are in line with the Health and Wellbeing Strategy and that the Board are focusing on ensuring that all practitioners are fully engaged.

A self harm pilot is being run in Canterbury and the Children's HWB are tracking progress with this. A disconnect between adult and children's mental health services had been identified and this connection has now been made and the issue resolved.

A meeting is due on 19 September regarding the Safeguarding Sub-group and it is planned to share intelligence and inform other related agencies. There is a focus on sharing information and best practice across the county and there needs to be a consistent approach.

The Board discussed the Children and Adolescent Mental Health Service (CAMHS) and the consistently poor reports that it has received from both within and without the education system with regards to waiting times, referrals and poor communication. A CAMHS lead and a commissioner have been invited to the next meeting to take this forward. Cllr Howes reiterated that this is a county wide problem.

Jonathan Sexton suggested that further investigation was made into CAMHS in schools as the provision used to be funded by public health and there may still be funding available.

Healthwatch have recently published a report on CAMHS highlighting the poor experience of many of its users. It was noted that CAMHS has had a high profile for a number of months with a focus on waiting times and that the service has responded positively to these criticisms.

***Action: Healthwatch report on CAMHS to be circulated.***

***Action: It was agreed that Neil Fisher would continue to lead on this and report back once the meeting had taken place with the CAMHS representative and the commissioner.***

11 **ANY OTHER BUSINESS**
None.

12 **DATE OF NEXT MEETING**
25 November 18.00
27 January 18.00
25 March 18.00
26 May 18.00

# DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 27 August 2014 at 3.00pm.

Present:
Councillor Ann Allen (In the Chair)
Councillor Tony Searles (Sevenoaks District Council)

| | |
|---|---|
| Graham Harris | Dartford Borough Council |
| Lesley Bowles | Sevenoaks District Council |
| Melanie Norris | Gravesham Borough Council |
| Tristan Godfrey | Kent County Council |
| | |
| Jay Edwins | Kent County Council |
| Su Xavier | Kent County Council |
| Andrew Scott - Clark | Kent County Council |
| | |
| Debbie Stock | Clinical Commissioning Group |
| Dr Elizabeth Lunt | Clinical Commissioning Group |

14. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Roger Gough and Jane Cribbons, and from John Britt, Sheri Green, Anne Tidmarsh, and Cecilia Yardley.

In view of the absence of the Chairman, Councillor Gough, it was noted that Councillor Ann Allen would chair the meeting.

15. DECLARATIONS OF INTEREST

There were no declarations of interest received.

16. URGENT ITEMS

The Chairman reported that there were no urgent items for the Board to consider.

17. THE MINUTES OF THE MEETING OF THE BOARD HELD ON 18 JUNE 2014 TOGETHER WITH ANY MATTERS ARISING THEREFROM.

The Minutes of the meeting of the Board held on 18 June 2014 were agreed as a correct record subject to the amendment of the name of Dr Catherine Handey.

18. THE MINUTES OF THE MEETING OF THE KENT HEALTH AND WELLBEING BOARD HELD ON 16 JULY 2014 AND MATTERS ARISING THEREFROM.

The Board considered the Agenda for the meeting of the Kent Health and Wellbeing Board held on 16 July 2014, and the following issues were raised:

Kent Fire and Rescue Service. (KFRS)

It was reported that the KFRS had made a very informative presentation to the Kent Board and that it would be useful for our Board to receive such a presentation, as the Service had definite links with a number of service areas represented on our Board.

It was also suggested that it would be beneficial to stage a workshop type event within the next three months to disseminate relevant information between KRFS and services such as Housing, Community Safety Teams, and Children and Families services.

Local Implementation of the Joint Health and Wellbeing Strategy

It was noted that the Kent Board had requested details of consultation / publicity events being undertaken by local HWB Boards to highlight the priorities that each local Board was pursuing.

It was also noted that this Board had adopted the issues of Falls Prevention, Childhood Obesity and Domestic Violence as the priorities which were of particular relevance to local residents.

Additionally it was reported that publicity work on these issues was being undertaken by the Gravesham Gateway, in a number of half term events by Sevenoaks DC and that such work could be undertaken by Dartford BC and that Elaine Henson and Anna Card would be the Officers to contact regarding this.

It was suggested by Debbie Stock that a report on the work would be presented to the next Board meeting.

19. BETTER CARE FUND - UPDATE

The Board received a report, initially presented to the Kent Health and Wellbeing Board, which explained changes to the Better Care Funding (BCF) arrangements with particular emphasis on mitigating the risks associated with failure to reduce emergency admissions. Additionally the report set out progress on the BCF nationally, the next steps which were planned in its implementation and issues that need to be resolved before any decisions on BCF are finalised.

It was noted that up to £1 billion of the BCF nationally will be allocated to local areas to spend on out of hospital services according to the level of reduction in emergency admissions they achieve.

Additionally local areas will be expected to identify their own targets for reductions in emergency admissions levels and they will be allocated a portion of the £1 billion performance money in the fund in accordance with the level of performance against this ambition.

It was understood that the exact impact of this was not clear, as guideline reductions identified by government related to 3.5% or 185,000 fewer admissions annually, and how local targets fit in with this was not explicit.

Concern was expressed regarding the re - provisioning of community health walk in services the contracts for which were coming to an end, and it was agreed that a report on this be added to the Agenda for our next meeting.

Additionally it was noted that there seemed to be quite a high vacancy level in the Community Nurse service and the Board asked for an update on this and on efforts to recruit to this service.

The Board agreed to note the content of the report.

20. MENTAL HEALTH GROUP REPORT

The Board considered a report which gave details of the work of the Mental Health commissioning Service, including that relating to Children's Mental Health Services.

The report detailed progress on the following areas

Primary Care Psychological Therapy Service
Primary Care Mental Health Specialists
Personality Disorder Peer Support Group (Medway Engagement Group and Network – MEGAN)
Porchlight Community Link Workers
Dementia Services
Children and Adolescent Mental Health Service. (CAHMS)

Some concern was expressed by Board members at a lack of information from the Commissioning Groups was reaching senior levels in borough hierarchies, and consequently it was agreed that the Agendas for the group meetings be forwarded to borough representatives for information only.

Additionally it was agreed that Naomi Harris would brief senior borough Officers on Mental Health matters when appropriate.

With regard to the CAMHS provision, it was reported that there had been a reduction in waiting times for clients and this was generally welcomed, that there was a possibly a joint responsibility with Children's Boards, and that investigations were underway into the integration of commissioning on a Kent wide basis.

21. COMMISSIONED CAHMS PRESENTATION AND UPDATE

It was agreed that in view of the close connections between the information contained two topics, a single report would be given to cover items 20 and 21 on the Agenda.

22. DEMOGRAPHIC CHANGES IN THE BOARD AREA.

The Board was reminded that it had requested a demographic breakdown of its area of responsibility together with a projection of population growth and ethnic composition for the next 25 year period.

The Board therefore received a report from Andrew Scott – Clark which detailed the projected changes in population and ethnic make – up for the area.

It was noted that the projections made were not forecasts, in that they took no account of policy nor development aims which had not yet had an impact on observed trends.

The statistics indicated that there would be a population increase across the whole area of around 50,000 people with an above average growth in the numbers of people from ethnic minority backgrounds although this was not spread evenly across the Board area..

The Board expressed concern that the growth in population would require a substantial increase in health resource provision, and that this would need to be borne in mind by the newly formed Urban Development Corporation responsible for the Garden City Development.

Consequently it was agreed that Dr Lunt would write to the Chairman of the Kent Health and Wellbeing board stressing our concerns and seeking reassurance on this issue.

The Board noted the report.

23. INTEGRATED COMMISSIONING GROUP - FURTHER REPORT

It was noted that consideration of this item was to be deferred to the next meeting.

24. UPDATE TO BOARD WORKPLAN

The Board considered its published work plan for the forthcoming year and agreed changes as set out in the attached Appendix.

25. INFORMATION EXCHANGE

There were no issues raised.

26. PROGRAMME OF MEETINGS 2014 - 2015

The Board received details of the schedule of meetings for the remainder of the Municipal Year.

---

The meeting closed at 5.10pm

This page is intentionally left blank

Minutes of the meeting of the **SOUTH KENT COAST HEALTH AND WELLBEING BOARD** held at the Council Offices, Whitfield on Tuesday, 24 June 2014 at 3.00 pm.

Present:

| | |
|---|---|
| Chairman: | Councillor P A Watkins |
| Board: | Dr J Chaudhuri<br>Ms K Benbow<br>Councillor S S Chandler<br>Councillor P G Heath<br>Ms C Holden (as substitute for Mr M Lobban)<br>Councillor J Hollingsbee<br>Mr S Inett<br>Councillor M Lyons<br>Ms J Mookherjee<br>Ms J Perfect |
| Also Present: | Councillor P M Beresford (Dover District Council)<br>Mr R Jackson (Shepway District Council)<br>Mr P Marsh (Kent County Council)<br>Ms S Rolfe (Kent County Council)<br>Ms P Watson (Kent County Council) |
| Officers: | Chief Executive<br>Head of Leadership Support<br>Head of Strategic Housing<br>Team Leader – Democratic Support |

1 APOLOGIES

Apologies for absence were received from Mr M Lobban (Kent County Council) and Councillor G Lymer (Kent County Council).

2 APPOINTMENT OF SUBSTITUTE MEMBERS

In accordance with the agreed Terms of Reference, it was noted that Ms C Holden had been appointed as substitute for Mr M Lobban.

3 DECLARATIONS OF INTEREST

There were no declarations of interest made by members of the Board.

4 MINUTES

It was agreed that the Minutes of the Board meeting held on 29 April 2014 be approved as a correct record and signed by the Chairman.

5 MATTERS RAISED ON NOTICE BY MEMBERS OF THE BOARD

There were no matters raising on notice by members of the Board.

6 LEARNING DISABILITY SERVICES - DOVER DAY SERVICES CONSULTATION

Ms P Watson, Commissioning Manager and GDP Programme Manager (Kent County Council) and Ms S Rolfe, Commissioning Officer (Kent County Council) gave a presentation to the Board on the Dover Day Services Consultation.

The Board was advised that the objective of the consultation, which affected the Dover District, was to deliver a new 'person centred' model of service that improved the lives of people with learning disabilities by providing them with activities and opportunities in their local communities as opposed to segregated services. To do this the new service model would invest in community hubs to deliver opportunities within the local community, sustain skilled staff to support people to access services within the local community and move away from large traditional style building based services. This change also reflected the dissatisfaction of younger people with learning disabilities with the existing service model.

The Board was advised that no savings targets were attached to the new model and any savings resulting from the new model would be reinvested into the service.

In the Dover District, 77 people accessed the current service with approximately 58 of those people attending on a daily basis.

The consultation ran from 29 November 2013 to 14 February 2014 and sought the views of people who currently attended the Walmer Centre, parent/family and carers, those who might want to use the services in the future, staff and union representatives, local councillors and county members and other organisations such as advocacy services.

It was proposed that the new model would be based around two hubs, 1 in Deal and 1 in Dover, although the specific sites had not yet been identified. There was concern that the current site in Walmer was too isolated to be suitable for the new model. However, none of the existing services would be closed until the new hubs were operational.

RESOLVED: That the presentation be noted.

7 YOUR LEISURE: PREVENTING ILL-HEALTH THROUGH PHYSICAL ACTIVITY

This item was withdrawn.

8 BETTER CARE FUND VERBAL UPDATE

Ms K Benbow advised that an update would be provided to a future meeting of the Board on the continuing progress of Better Care Fund projects within the Integrated Commissioning Plan.

RESOLVED: That the update be noted.

9 ACCOMMODATION STRATEGY UPDATE

Ms C Holden (Kent County Council) provided an update to the Board on the Accommodation Strategy.

The Board was advised that for the South Kent Coast area, there were problems around accessing sufficient high level dementia and challenging behaviour services, with intermediate care beds often occupied by the wrong people.

As part of the strategy, Kent County Council, which funded 40% of placements, was seeking to provide for 140 new extra care units and 110 nursing beds in conjunction with Dover District Council, Shepway District Council and private developers. The strategy would also consider what existing sheltered provision needed to be remodelled as extra care accommodation. Overall, while the number of Intermediate Care beds would remain the same, there needed to be a greater focus on rehabilitation and ensuring that the beds were properly allocated to those who needed intermediate care.

For the South Kent Coast area, the vacancy rate was 2% compared with a national rate of 7%. However, this was a snapshot of data that excluded those vacancies that were unsuitable.

Members of the Board emphasised that Kent County Council was not the only purchaser of accommodation, with many people increasingly buying their own, and that this needed to be factored into the strategy through engaging with the public at an early stage in the consultation process.

The Board was advised that the next steps in the process were:

- To launch the strategy and publish the supporting evidence
- To develop Market Position Statements
- To prioritise and sequence projects
- To develop options appraisals and business cases
- To establish consultation routes where appropriate
- To undertake workshops for all other user groups

RESOLVED: That the update be noted.

10 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Ms K Benbow presented the report on Child and Adolescent Mental Health Services. The report set out the background and current services provided for children and young people with emotional and mental health issues in the South Kent Coast area.

The services were commissioned at four levels:

- Tier 1 – Support delivered within universal settings (Commissioned by Kent County Council from Young Healthy Minds and accessed currently through the Common Assessment Framework)
- Tier 2 – Targeted Support (Commissioned by NHS West Kent CCG on behalf of East Kent and Medway CCGs from Sussex Partnership Foundation Trust)
- Tier 3 – Specialist Support (Commissioned by NHS West Kent CCG on behalf of East Kent and Medway CCGs from Sussex Partnership Foundation Trust)
- Tier 4 – Specialist Mental Health Services including inpatient provision (Commissioned by NHS England)

Over the last year, Dover had 146 referrals and Shepway had 120 referrals under Tier 1.

The report acknowledged that there had been workforce issues affecting Tier 3 services in Shepway and Dover but by August 2014 both areas would have a full complement of staff and this would reduce the time it took to assess cases.

RESOLVED: That the report be noted.

11 DEMENTIA FRIENDLY COMMUNITIES

Mr P Marsh (Kent County Council) gave a presentation to the Board on Dementia Friendly Communities. A similar presentation had been given to the meeting of the Kent Health and Wellbeing Board held on 16 June 2014.

The Board was advised that people living with dementia wanted:

- To be able to live the life they had before their diagnosis with dementia;
- To be able to find their way around and be safe;
- To be able to access local facilities as they used to be able to;
- To be able to maintain their social networks so they feel they belong in the community;
- To pursue hobbies and interests and 'go out' more; and
- To support others in their community by volunteering.

The intention was to use Local Dementia Action Alliances to achieve Dementia Friendly Communities in which these goals could be realised. As part of this, Dover District Council, Shepway District Council and the South Kent Coast Clinical Commissioning Group would be invited to join the Dementia Alliance.

The importance of GP's correctly diagnosing dementia was raised and Mr Marsh stated that the Alliance wanted to consult with GP's as part of the development of a 'Dementia Checklist'.

Ms J Mookherjee indicated that there was also the possibility of collaborative work that could be done with public health on this subject.

RESOLVED: That the presentation be noted.

12 ACCOMMODATION REQUEST - VERBAL UPDATE

Councillor P A Watkins raised the issue of the role of the Board in respect of the location of GP surgeries in the district given the original intentions of the Department of Health.

The Board was advised that the role of the South Kent Coast Clinical Commissioning Group was in relation to the wider strategic planning of service provision rather than determining the location of individual practices. It was suggested that the strategic planning level might be of relevance to the Board.

RESOLVED: That further discussions be held between Dover District Council, Shepway District Council and the South Kent Coast Clinical Commissioning Group to identify the role of the Health and Wellbeing Board in respect of local GP Surgery provision.

13 URGENT BUSINESS ITEMS

There were no items of urgent business.

The meeting ended at 5.27 pm.

This page is intentionally left blank

# MINUTES

## Health and Wellbeing Board – Third Formal Meeting

**Meeting held on Wednesday 16 July 2014 at 09:30am**

**Committee Room, Swale House, East Street, Sittingbourne, ME10 3HT**

| | |
|---|---|
| **Present:** | **Cllr Andrew Bowles (AB), *Leader, SBC (Chair)***<br>**Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC***<br>**Amber Christou (AC), *Head of Housing, SBC***<br>**Patricia Davies (PD), *Accountable Officer, Swale CCG***<br>**Debbie Stock (DS), *Chief Operating Officer, Swale CCG***<br>**Dr Fiona Armstrong (FA), *Chair Swale CCG***<br>**Cllr Geoff Lymer (GL), *Vice-chair Adult Social Care and Health Cabinet Committee, KCC***<br>**Tristan Godfrey (TG), *Policy Manager, KCC***<br>**Terry Hall (TH), *Public Health, KCC***<br>**Bill Ronan (BR), *Community Engagement Manager, KCC***<br>**Sarah Williams (SW), *Assistant Director, Swale CVS***<br>**Steve Furber (SF), *Vice-Chair, Swale Mental Health Action Group***<br>**Lyn Gallimore (LG), *Kent Healthwatch***<br>**Jo Purvis (JP), *Health Partnerships Officer, SBC***<br>**Lesley Clay (LC), *Partnerships Manager, Joint Policy and Planning Board***<br>**Sarah Williamson (SWi), *Project Worker, Joint Policy and Planning Board*** |
| **Apologies:** | **Cllr Chris Smith, *Chair Adult Social Care & Health Cabinet Committee, KCC***<br>**Dr Faiza Khan, *Public Health Consultant, KCC***<br>**Abdool Kara, *Chief Executive, SBC***<br>**Paula Parker, *Commissioning Manager, KCC***<br>**Alan Heyes, *Mental Health Matters***<br>**Penny Southern, *Director Learning Disability and Mental Health, KCC***<br>**Mark Lemon, *Strategic Business Advisor, KCC***<br>**Simon Perks, *Accountable Officer, Canterbury and Coastal CCG*** |

| NO | ITEM | ACTION |
|---|---|---|
| **1.** | **Introductions** | |
| 1.1 | AB welcomed attendees to the meeting. | |
| 1.2 | All attendees introduced themselves and apologies were noted. | |
| **2.** | **Minutes from Last Meeting** | |
| 2.1 | The minutes from the previous meeting were approved. | |
| 2.2 | Outstanding actions were:<br>▪ p.3, 4.2 – meeting between SBC, Swale CCG and KCC to be arranged re local priorities<br>▪ p.3, 4.2 – KS to confirm that local PH data will be available by end July. JP to chase. | **JP/DS/FK**<br>**JP** |

# MINUTES

| | | |
|---|---|---|
| **3.** | **Think Housing First** | |
| 3.1 | LC and SWi gave an overview of Think Housing First, the Housing Health Inequalities Plan for Kent. The key points were:<br>▪ The Joint Policy and Planning Board (JPPB) is a strategic group, bringing housing and health together across Kent. membership includes all 12 Local Authorities, KCC Social Care, Kent Public Health, Kent Probation and the Prison Service<br>▪ Think Housing First is a strategic health inequalities plan with two purposes: 1) to show how housing can reduce health inequalities and 2) to demonstrate to other agencies what housing does.<br>▪ The importance of this work has been recognised by the Smith Institute: http://www.smith-institute.org.uk/file/Housing%20associations%20and%20the%20NHS.pdf<br>▪ There are lots of private sector housing impacts on health. Organisations such as Staying Put, Swale's Home Improvement Agency, can undertake work in people's homes that can save the health service money in the long-run, i.e. around falls prevention<br>▪ Housing is an important part of any partnership alongside health and social care and the Care Act 2014 states that housing is a health-related service<br>▪ Progress has already been made, including LAs agreeing to signpost households placed in temporary accommodation to GP services; working with KFRS to identify households where there is a risk of fire from smoking to develop targeted campaigns and health and safety checks; and promoting healthy eating courses through the Kent Tenant Engagement Group<br>▪ Currently exploring the pathway for rough sleepers with TB, including length of time they spend in hospital unnecessarily<br>▪ Health promotion work can be carried out through Kent HomeChoice, the system used by Kent residents to bid for social homes, which receives around 5,000 visits per day<br>▪ JPPB are also developing a housing and health calculator to show how improving health conditions can reduce costs to health | |
| 3.2 | Points made in the discussion included:<br>▪ Wholehearted support for this agenda and bringing housing and health closer together. The links between housing and health were clearly recognised at the LGA Conference.<br>▪ GPs can currently write prescriptions for exercise but is there a case for them writing prescriptions for housing interventions? In Leicester this is already happening. JP to find out more. http://www.telegraph.co.uk/earth/energy/10842297/GPs-to-prescribe-a-boiler-to-patients-living-in-cold-homes.html<br>▪ Need to establish a baseline, so we can show how we've made a difference. This will be done through Think Housing First monitoring arrangements, which will set a baseline in year one. Staying Put's contract with Swale CCG also has targets which are monitored monthly.<br>▪ SBC Housing Services will be piloting how to better identify people | **JP** |

| | | |
|---|---|---|
| | with mental health issues and get them referred to appropriate services, particularly those who need intervention before they go into crisis. Need to ensure links with psychological therapy services.<br>▪ LC will be attending all local HWBs to highlight Think Housing First and the links between housing and health inequalities. Happy to return and feedback at the November HWB. | **LC/JP** |
| **4.** | **Physical Inactivity Programme** | |
| 4.1 | AF gave a presentation on Kent Public Health's Physical Inactivity Programme. The key points were:<br>▪ Reducing physical inactivity is not just about weight loss. There is a proven link with all cause mortality.<br>▪ Highest risk people are those who do no/less than 30 mins exercise per week.<br>▪ Active People Survey mapped out areas where there is a prevalence for people doing less than 30 mins exercise per week. Sheerness is one of these areas.<br>▪ Main reasons given were: injury/disability; lack of time; lack of money; not seen as important/necessary.<br>▪ Kent Public Health are looking to set up a support programme to help people access appropriate activities and provide motivation to encourage them to partake in exercise.<br>▪ Developing an assessment tool to identify what sections of the population they need to target. Will screen GP patients lists for those at high risk of conditions which suggest they may be physically inactive i.e. diabetes, hypertension. Will then screen down further to those who really need intervention and will potentially cost health more in the future.<br>▪ The assessment tool will establish what type of support they need – brief intervention, 12 months support or recommendations for more activity.<br>▪ Public Health are working with Kent HomeChoice to see how the assessment process can be built into the housing register application process<br>▪ Have a provisional budget, but still needs to be agreed by KCC | |
| 4.2 | Key points raised in the discussion were:<br>▪ Keen to embed this into Swale CCG communications with GPs; FA happy to arrange workshops/presentations to GPs<br>▪ GP time is limited but practice nurses have more time, do health checks and have more dialogue with patients<br>▪ Need to consider how this links into IPCTs<br>▪ Need to consider barriers to activity within the built environment. Are working with Kent Highways and other partners around travel to work.<br>▪ Physical activity can also have great impacts on mental health, need to think how we link this into the mental health pilot work. | **FA/AF**<br><br><br><br><br>**AC** |
| **5.** | **Mental Health POC Review** | |
| 5.1 | KP spoke about the Member review of mental health provision, undertaken by SBC's Policy Overview Committee and circulated their recommendations. The key points were:<br>▪ SBC are not a provider to mental health services but will work with partners to influence. Strong links have already been made with the CCGs and local partnerships, including SBC attending the Swale CCG | |

| | | |
|---|---|---|
| | mental health commissioning groups to oversee MH contracts.<br>▪ Right that mental health is include across all the HWB sub-groups and that we have a metal health representative at the main HWB.<br>▪ Young people's mental health will be picked up by the Children's Operational Group sub-group. Head start services to build young people's emotional resilience are being piloted in Canterbury.<br>▪ The recommendation around a crisis house for those living hospital without somewhere to live has been discussed with KCC, who have shown interest in the idea. Awaiting more details around potential costings and will discuss further with KCC and report back to the HWB.<br>▪ KP suggested that Kent Police attend a future HWB to talk about what they are doing around the mental health concordat and the street triage service. | **JP/AH**<br><br>**JP** |
| **6.** | **Better Care Fund** | |
| 6.1 | TG updated the Board on the Kent submission:<br>▪ Government are looking at setting a target of 3.5% reduction in emergency admissions to A&E. Concerns raised about having a Kent target as there are different levels of admissions across the different hospitals within the Kent economy. | |
| 6.2 | DS updated the Board on the Swale CCG approach to the BCF:<br>▪ Swale CCG are taking a programme management approach –Alison Davies is the programme manger working across Swale CCG, DGS, CCG and KCC Social Care<br>▪ Focussing on the Integrated Primary Care Teams and the Integrated Discharge Teams and putting additional dementia nurses into the community teams. AD can provide an update at a future meeting if required. | **JP/AD** |
| **7.** | **Kent Health and Wellbeing Board** | |
| 7.1 | ▪ Concerns were raised around the late paper tabled on integrated intelligence. Swale CCG had not been consulted on this.<br>▪ Agreement to the principle of integration but concerns about how it is being done. There was a feeling that this was being rushed through.<br>▪ Cllr Joe Howes attending the Kent HWB as a District representative as AB and KP unable to attend. JP to brief on Swale HWB's position before the meeting.<br>▪ PD to raise concerns directly with Roger Gough as Chair of the Kent HWB. | **JP**<br><br>**PD** |
| **8.** | **Partners Update** | |
| 8.1 | <u>Swale CCG</u><br>▪ Dr Phil Barnes is now Acting Chief Executive of Medway Foundation Trust (MFT), following Nigel Beverley's departure.<br>▪ MFT have not made progress since their last CQC inspection and will remain in special measures<br>▪ Swale CCG commission services from MFT, but have limited leverage and are not responsible for their regulation | |
| 8.2 | <u>Swale CVS</u><br>▪ Currently delivering arts intervention across Swale<br>▪ Working with the Healthy Living Centre on the 6 Ways to Wellbeing | |

# MINUTES

| | | |
|---|---|---|
| 8.3 | Kent Healthwatch<br>▪ Undertaking work into CAMHS; deep dive into mental health services and impact of the move of mental health in-patient provision from Medway on patients and families. | |
| 8.4 | KCC<br>▪ Developing an integrated care pathway for alcohol in Swale. Planned stakeholder event for 29th September. All to hold in diary. Invites will be sent by Public Health. | **ALL** |
| 8.5 | Mental Health Matters<br>▪ Also looking at impact of travel to Dartford for acute services on patients and families<br>▪ Welcome the Live it Well hub that Swale CCG are looking to develop within the Sheerness Gateway | |
| **9.** | **Future Meetings** | |
| 9.1 | JP advised that meeting dates for 2015 need to be set. All agreed to continue with bi-monthly meetings based on the Kent Health and Wellbeing Board timetable. JP to arrange. | **JP** |

**Next meeting date:** **Wednesday 17 September 2014***

**Time:** **9.30am – 11.30am**

**Location:** **Committee Room , Swale Borough Council**

***This meeting will be in public**

**Future Meetings Dates (all 9.30 – 11.30 at Swale House):**

**Wednesday 19 November**

This page is intentionally left blank

THANET HEALTH AND WELLBEING BOARD

Minutes of the meeting held on 28 July 2014 at 5.00 pm in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Present: Dr Tony Martin (Chairman); Councillors Ailsa Ogilvie (Thanet Clinical Commissioning Group), Esme Chilton (Thanet Children's Board), Councillor Gibbens (Kent County Council), E Green (Thanet District Council), Madeline Homer (Thanet District Council) and Andrew Scott-Clark (Kent County Council)

52. APOLOGIES FOR ABSENCE

Apologies for absence were received from Hazel Carptenter (for whom Ailsa Ogilvie was substituting), Dominic Carter, Councillor Johnston, Mark Lobban and Sue McGonigal (for whom Madeline Homer was substituting).

53. DECLARATIONS OF INTERESTS

There were no declarations of interests.

54. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 8 May 2014 were approved and signed by the Chairman.

55. PUBLIC HEALTH COMMISSIONING INTENTIONS

Andrew Scott-Clark presented his report, making particular reference to the work streams as set out in the diagram at paragraph 4.10 of the report. He stressed that getting commissioning right at a local level was of fundamental importance.

He added that conversations and meetings were taking place with NHS England to ensure that Public Health was ready to inherit the Health Visiting Commissioning Programme on 1 October 2015.

In response to a query from Esme Chilton regarding certain aspects of children's and young people's services, Andrew Scott-Clark stated that Karen Sharp, Head of Public Health Commissioning, would be responsible for ensuring that those bits of work were carried out.

It was noted that he and Hazel Carpenter would be meeting with Patrick Leeson, Corporate Director of Education, Learning Skills, KCC in order to fully understand the nature of work carried out by other service providers, particularly Kent Integrated Family Support (KIFSS) and Kent Integrated Adolescent Support Services (KIASS), and to enable greater alignment and integration of services to take place.

The report was NOTED and WELCOMED.

56. ASPIRATIONS FOR THANET

Andrew Scott-Clark reported that the only direct comment that he had received since the last meeting had been from Esme Chilton. In accordance with her request, safeguarding of children had been added as an aspiration.

In answer to a query from Councillor Gibbens, Andrew Scott-Clark stated that he believed that the aspiration to achieve a 5% reduction in smoking in pregnancy over the next five years was realistic and deliverable. He referred to the success of the "Baby Clear" initiative at the QEQM hospital, aligned with the cessation of smoking service.

It was RESOLVED:

1. THAT the aspirations, as set out at Annex 1 to the report, be APPROVED;

2. THAT the Board be provided with periodic dashboard reports setting out milestones in relation to each of the aspirations and progress achieved.

Andrew Scott-Clark stated that plans (similar to that for Alcohol on the agenda for this meeting) would be brought to the Board meeting in November 2014 and that detailed work would be carried out in relation to the aspirations for long term conditions.
NOTED.

57. ALCOHOL STRATEGYFORTHANET

Linda Smith, Public Health Specialist, presented the report and a series of slides (now published on the website).

She described what the 6-month project to deliver an Alcohol Integrated Care Pathway (ICP) would involve, particularly in relation to the roll out of IBA's (Identification and Brief Advice). Identification and Brief Advice (IBA) or 'screening and brief advice', has been shown to lead to 1 in 8 people reducing their drinking; IBA is one of the most effective health interventions available to reduce alcohol related harm.

She outlined the other key elements of the project:

a) Understand current gaps in preventing and managing alcohol harm and dependence services in Thanet and South Kent Coast CCGs;

b) Outline clearer integrated pathway across current services and propose solutions to any gaps;

c) Ensure the pathway and new services are evidence based and realistic.

She highlighted the 4 key streams of the Alcohol ICP – set out in Slide No. 10 – (1) Prevention of harm; (2) Screening and early ID; (3) Support and Risk Management; (4) Specialist Treatment and explained how different levels of information on each of those elements would be accessible by the wider workforce via an online system and mass population screening via IBA scratchcards.

She also made reference to the ICP Stakeholder meeting which would take place in Sandwich on 7 August 2014. She encouraged all present at the meeting to attend and to circulate as appropriate.

Andrew Scott-Clark pointed out that another important element of the ICP was having designated alcohol nurses at the QEQM hospital and referred to the need to involve the Thanet Community Safety Partnership in the implementation of the ICP.

He also suggested that Public Health intelligence might be of assistance to Thanet Council in relation to licensing matters - welcomed by Madeline Homer.

It was RESOLVED:

THAT the Board supports the Alcohol ICP for Thanet, including the Stakeholder event on 7 August 2014 and the setting up of a Task and Finish Group (including Thanet Community safety Partnership), to create a local alcohol action plan for Thanet to act upon the six pledge elements and seven High Impact Steps of the Kent Alcohol Strategy (2014-16).

58. FUNDINGFORTHESPORTSAGENDA

On behalf of Councillor Johnston, Madeline Homer asked if there were any pots of money available for activities associated with the sports agenda.

Andrew Scott-Clark stated that he would be willing to have discussions on funding for targeting inactive or obese children, families and adults. However, money would not be available for promoting sports activities for children who were already active and healthy.

He outlined the elements of funding in the KCC's model of care, as follows:

Tier 1 – preventative

Comprising:

i. Health Walks: very popular, providing not only exercise, but also social benefits;
ii. Community Chef: helping communities to understand the science around food; how to shop for fresh food etc;
iii. Campaign around "Kent Moving"

Tier 2 – Support for obese children and adults

Encouraging people to change their lifestyle.

Tier 3 – Helping the morbidly obese

Trying to prevent the need for bariatric surgery.

Madeline Homer thanked Andrew Scott-Clark for this feedback.

In answer to a query from Dr Martin, Andrew explained that the objectives of geriatric gyms were the promotion of postural stability and the prevention of falls.

59. FEEDBACK ON "OUR CHILDREN, OUR FUTURE" WORKSHOP

As well as outlining the points covered in the report, Esme Chilton reported that:

1. Suitable persons had now been identified for appointment to the new Children's Board;
2. It was intended to hold Children's Board meetings four times a year and also to have sub task and finish groups; the inaugural meeting of the Children's Board was likely to take place either late September or early October.
3. It was proposed to align meetings of Children's Board with those of the Health & Wellbeing Board meeting, although it was still unclear whether to hold these in the lead-up to the parent meetings or as a follow-up.

The report and verbal update were NOTED.

60. UPDATEONTHEMENTALHEALTHSUMMIT

Dr Andrew Walton referred to the successfulness of the summit, particularly in terms of bringing so many different stakeholders together. He said that he hoped that the CCG could find innovative ways to go forward.

During an ensuing discussion, it was noted that the integration of providers of mental health services, with each having an understanding of its "bit of the pathway", was of primary importance.

It was further noted that, following the transfer of services from the NHS, Public Health had invested separately in mental health, recognising it as one of its key priorities.

In answer to a query from Councillor Elizabeth Green, Andrew Scott-Clark agreed that the "Task Force" for Margate should be rolled out across the district, particularly to encompass Ramsgate (Central Harbour; Eastcliff and Newington), the Villages and Birchington.

The report was NOTED.

61. UPDATEONTHEOVER75SSUMMIT

Ailsa Ogilvie presented the report on behalf of Dr John Neden, who had sent his apologies for absence, commenting on the enthusiastic participation of attendees.

She referred to out of hospital work, which was currently on-going.

The report was NOTED.

62. AGENDA ITEM FOR NEXT MEETING - THURSDAY, 4 SEPTEMBER 2014, AT 9.45 AM

Dr Tony Martin outlined the purpose of this meeting – to provide reassurances in relation to the various plans, intentions and work streams.

It was AGREED that an alternative venue should be considered for this meeting.

Meeting concluded : 6.20 pm

# WEST KENT CCG HEALTH AND WELLBEING BOARD

## MINUTES OF THE MEETING HELD ON TUESDAY 16 SEPTEMBER 2014

**Present:** **Dr Bob Bowes (Chairman) and Julie Beilby, Benson, Mrs Blackmore, Bowles, Broom, Gough, Heeley, Holgate, Jones, Lemon, Varshney and Weatherly**

**In attendance:** **Louise Matthews and Linda Smith**

12. APOLOGIES FOR ABSENCE

It was noted that apologies for absence had been received from Penny Southern, Gail Arnold, Dr Caroline Jessel, Reg Middleton, Dr Sanjay Singh and Councillor Mrs Alison Cook.

13. DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

There were none.

14. MINUTES OF THE MEETING HELD ON 15 JULY 2014

It was agreed that the bullet points as minuted under Item 5 – Mental Health Needs Assessment for West Kent were important issues that should be kept sight of by the Board and that this should therefore become a regular agenda item.

**RESOLVED**: That the Minutes of the meeting held on 15 July 2014 be approved as a correct record and Mental Health Needs Assessment for West Kent should become a regular agenda item.

15. BOARD DEVELOPMENT AND COG UPDATE - DR BOB BOWES

Dr Bowes gave a presentation to the Board following the work undertaken with John Deffenbaugh. This detailed the journey through JSNA to the WKCCG HWB and who the commissioners were and who the Board providers are.

The Chairman suggested that the next meeting be dedicated to the future development of the Board and the way it is constituted.

A member of the Board suggested that an assessment should be carried out on the Children's Joint Strategy. Malti Varshney (MV) advised that this had last been carried out in 2010. She undertook to circulate a copy with the minutes.

**RESOLVED**: That the next meeting be dedicated to the future development of the Board.

16. BETTER CARE FUND UPDATE, CCG - GAIL ARNOLD/LOUISE MATTHEWS

Louise Matthews, after circulating the papers for the Better Care Fund, emphasised that the plan needed to be submitted by 12 noon on 19th September 2014 and asked for any further comments to be submitted to her by Thursday, 18th September.

The Board's attention was drawn to the following:-

* that major changes had been made around the case for change from page 9

* Section 4 Plan of Action on Page 13 – more detail had been given on the schemes and the details behind them

* Section 5 – Risks and Contingency - although the risk factors had not changed greatly, more linkage had been included with strategic plans

* Section 7 – more detail added to iii) onwards

* Section 8 – More on engagement, separating it out

* Annexes – repackaging the information, investment requirements and key success factors

The Board noted the financial aspects of this submission, which included a saving of £1.9m if A&E admissions could be reduced by 3.5%. The savings would go into a Kent pot and then redistributed to all the districts.

It was noted and agreed that money received for payment by results that comes in for health and social care should be monitored by the Board.

The Board was asked to sign up to the submission and this was agreed. Although some concern was raised as to the level of funding as a whole across all districts.

The Board acknowledged that this was a significant part of the process to get to where they wanted to be. However, it recognised that this only covered about 4% of the budget.

The Board thanked Louise and Gail for their hard work in producing this submission.

**RESOLVED**: That the Board agree and sign up to the Better Care Fund submission.

17. KENT JOINT HEALTH AND WELLBEING STRATEGY; WEST KENT HEALTH AND WELLBEING BOARD'S PARTNER ORGANISATIONS' PLANS FOR PUBLIC ENGAGEMENT, IDENTIFICATION OF GAPS AND PLANS TO CLOSE THEM - DR BOB BOWES

The Chairman emphasised that a report needed to be brought to the Board in November.

Members of the Board commented that:

- a questionnaire had been put on the KCC website which related to the Healthy Weight Promotion and it indicated that the new service would go live in April. This could have implications for other Districts who are carrying out their own service. MV stated that the exercise was to look at what model of commissioning should be taken but no decisions had been taken.

- should the Board look at cold designing of services, ask other colleagues for their suggestions

- should the Board be talking about a partnership service rather than commissioning which is vital to the Board for development

**RESOLVED**: That a report be brought to the Board in November on this issue.

18. KENT JOINT HEALTH AND WELLBEING STRATEGY; WEST KENT HEALTH AND WELLBEING BOARD'S PARTNER ORGANISATIONS' PLANS FOR IMPLEMENTATION, IDENTIFICATION OF GAPS AND PLANS TO CLOSE THEM - DR BOB BOWES

The Chairman introduced this item and emphasised that any areas identified where there was gaps needed to be fed back to him.

**RESOLVED**: That information from partners should be fed back to the Chairman.

19. WEST KENT TOBACCO CONTROL AND SMOKING CESSATION WORKING GROUP - JANE HEELEY

Jane Heeley introduced this item by explaining that the action plan had been presented to the Board in April and following a development session which focused on how all partners could collectively work to address population needs, six principles were identified, which were:

- Problem-based approach

- Articulate ambition

- Population level

- Audiences

- Risk sharing

- Holding to account

The Board noted that:

- although there was a lot of success in reducing smoking nationally, there was still a high rate of smoking related deaths

- there was an emerging picture related to e-cigarettes and there needed to be a piece of work undertaken on this

- there needs to be more advocates within services that can talk confidently to people they come into contact with about quitting smoking, it was noted that a half day training session was available

- rates of referrals by GPs to the scheme had declined but this was thought to be somewhat due to the increased usage of e-cigarettes

- various initiatives had been introduced, including trading standards identifying hot spots where teenagers buy their cigarettes and talking to the shop owners

- GPs had indicated that patients prefer to go to local groups when referred and children seem to respond better when approached within school, rather than on their way out

- It maybe worthwhile engaging with local landlords and housing association to spread the message

- Work had been taken place with the Chamber of Commerce to promote the Healthy Business Award

- A lot of work on the Home First scheme had been carried out – an initiative to help older people stay well and independent

- Work was ongoing to target disadvantaged areas

**RESOLVED**: That the Board noted the approach taken so far and agreed to sign up to the Local Government Declaration on Tobacco control. Jane Heeley stated that she would circulate it to Board Members and also to partners to take this forward.

20. ALCOHOL STRATEGY FOR KENT 2014-2016 - LINDA SMITH

Linda Smith gave a presentation to the Board on the Kent Alcohol Strategy 2014-2016 that was approved by Kent Adult Social Care and Health Cabinet Committee earlier this year.

The key aims of the Alcohol Strategy for Kent 2014-2016 are to:

a) reduce alcohol related specific deaths
b) continue to reduce alcohol-related disorder and violence year on year
c) raise awareness of alcohol-related harm in the population
d) increase pro-active identification and brief advice at primary care
e) increase numbers referred into treatment providers as appropriate

Six Pledges have been developed which are:-

**Prevention and Identification** – Identification and Brief Advice in Primary Care and pharmacies, training, social marketing and targeted promotion
**Treatment** – Improve liaison at A&E
**Enforcement and Responsibility** – Tackling night-time economy, reduction of violence, use of crime and community partnerships, spot checks on traders, working with industry
**Local Action** – Continue good practice using KCAP model and expand into areas where there is no KCAP
**Vulnerable groups and inequalities** – Priorities dual diagnosis by improving the links between mental health workers and substance misuse treatment providers, domestic violence awareness campaigns and working with perpetrators
**Children and young people** – Continue with Riskit, lead a Kent-wide campaign, co-ordinate hidden harm strategy linked to KIASS, systematic screening in A&E

The Board noted that:-

- the majority of people in West Kent and the UK consume alcohol responsibly, however excessive consumption of alcohol is a growing problem in Kent and nationally

- Alcohol contributes to crime and disorder, is linked to domestic violence, mental distress and family disruption

- Liver disease is almost wholly attributed to alcohol misuse and is the fifth largest cause of death in England

- It is a huge cost to the public purse but many costs are not able to be taken into account

- In Kent it is estimated that alcohol harm accounts for approx £108m of health commissioning resource each year

- Initiatives include shops/clubs stocking only alcohol reduced wines and spirits (trialled in Brighton)

**RESOLVED**: That the Board:

a) noted the report and agreed the key actions from the strategy;

b) agree to the development of a Local Alcohol Action Plan to

implement the Kent Alcohol Strategy; and

c) agree to the creation of a multi-partner Task and Finish Group which would address the six pledges.

21. TEENAGE PREGNANCY STRATEGY CONSULTATION - MALTI VARSHNEY

Malti Varshney updated the Board on the work being undertaken in relation to the teenage pregnancy strategy. It was noted the consultation had now finished on the website and all the feedback was being collated which would inform the final version of the strategy.

**RESOLVED**: That the action taken to date be noted.

22. ANY OTHER BUSINESS

Dentistry – The Board had a discussion on access to NHS dentistry which the lack of appeared to be huge problem in Kent, especially for older people.

**RESOLVED**: That Board Members feed back to the Chairman to appraise him of any experiences that they had heard about (within the next couple of weeks) and he would write to NHS England to express the concerns on behalf of the Board.

23. DATE OF NEXT MEETING

The next meeting would be held at Tonbridge & Malling Offices on 21 October 2014 starting at 4 p.m. The meeting would include one agenda item, 'Development of the Board'.

# Children's Health and Wellbeing Board

12th September 2014
Rother Room, Sessions House

## DRAFT MINUTES

**In attendance:**

| | |
|---|---|
| Andrew Ireland | KCC – Director – Social Care, Health & Wellbeing |
| Peter Oakford (PO) | KCC – Cabinet Member SCS |
| Roger Gough (RG) | KCC – Cabinet Member Education and Health Reform |
| Florence Kroll (FK) | KCC – Director of Early Help |
| Rob Price (RP) | Kent Police – Assistant Chief Constable |
| Karen Sharp (KS) | KCC – Head of Public Health Commissioning |
| Thom Wilson (TW) | KCC – Head of Strategic Commissioning (Children's) |
| Stephen Bell (SB) | CXK (VCS Provider rep) |
| Michael Thomas-Sam (MTS) | KCC – Strategic Business Adviser |
| Hazel Carpenter (HC) | NHS South Kent Coast CCG & NHS Thanet CCG, Accountable Officer (Chair) |
| Abdool Kara (AK) | Kent District Councils Chief Executives' Representative |
| Gill Rigg (GR) | Kent Safeguarding Children Board Independent Chair |
| Jill De Paolis (JDP) | KCC – Commissioning Officer |
| Dave Holman (DH) | Mental Health lead West Kent CCGs |
| Ian Darbyshire (ID) | KMCS CAMHS Commissioner |
| Jo Tonkin (JT) | Public Health Specialist |
| Michelle Woodward (MW) | KCC – SCS – Acting Director, West Kent |

**Apologies:**

| | |
|---|---|
| Mark Lobban (ML) | KCC – Director of Strategic Commissioning |
| Charlotte Walker (CW) | KCC – Commissioning Officer |
| Patrick Leeson (PL) | KCC – Corporate Director – Education & Young People's Services |
| Philip Segurola (PS) | KCC – Acting Director for Specialist Children's Services (Michelle Woodward representing) |
| Sonnette Schwarz | HT rep - Tendered her resignation |

| Minutes | Actions |
|---|---|
| **1. Emotional Health & Wellbeing Task & finish group report.** | |
| Presented by Dave Holman – Mental Health lead West Kent CCG, Karen Sharp, Amy Merritt & Sue Mullin (KCC Strategic Commissioning)<br><br>The Task & Finish group was set up by this Board to sort out issues around CAMHS. The Vision & Strategy takes a holistic approach, encompassing promotion of Health Wellbeing right through to the highest levels of need. It builds on work already done and pulling together several strands of work.<br><br>The intention is that once the strategy is approved the delivery plan would be drawn up and implemented at pace.<br><br>Future service models need to be built into new contracts. This is a unique opportunity as all the key contracts expire at the same time in 2015. | |

| | |
|---|---|
| Approval was sought for the draft strategy and for the Task and Finish Group to continue to progress this work.<br><br>AK said he felt that Districts Councils and Housing Associations should be engaged in this work and volunteered to help make this happen. He also felt that Early Intervention was not included and that if this is in a separate document that should be clarified in the strategy and that there should be consideration of monitoring data and when, for example, bullying seems to be developing as an issue in an area how we would know and what we would do.<br><br>AI – Summit was good, document is good. It needs some 'harder edges', for example about cash and our ability to respond to major crisis – but not at the expense of the whole system approach set out.<br><br>The strategy should go to the Health Wellbeing Board next.<br><br>HC said she thought that key stakeholders on Health Wellbeing Board needed to be engaged before the strategy went there. There was a need to present it in a way which would engage them and consider the potential impact on adult mental health spend further.<br><br>FK – likes the strategy. Agreed with AK about Early Intervention.<br>She felt there was a need to do work around reducing stigma, and enabling children to talk about mental health issues, for example through the development of whole school approaches.<br><br>SB said it was important consideration is given to helping the recovery of children who have had an intervention.<br><br>**It was agreed** that subject to the changes discussed being incorporated the strategy could go forward to the Health and Wellbeing Board for their sign off for a period of engagement & consultation and the Task and Finish group could be extended to achieve this within the agreed timescales.<br>It was underlined that this work is a key priority for all agencies and should be prioritised by the organisations involved.<br><br>The Task and Finish Group was asked to report back on progress at the next Board meeting.<br>AI left the meeting | Sue Mullin / Amy Merritt<br><br>Emotional Health and Wellbeing Task and Finish group to make amendments discussed and take revised document to the HWBB |
| 2. **Welcome and Introductions** | |
| **HC noted that there were** no representatives present from North Kent CCGs. | HC to take up with CCG colleagues |

| | |
|---|---|
| **3. Matters Arising** | |
| The item which had been agreed on Speech and Language from KMCS was withdrawn.<br><br>TW informed the board that the expression of interest to develop shared or joint commissioning arrangements for children between CCGs and KCC had been successful and was now moving to the next stage of the bidding process. This is an exciting development and the Board will receive updates as to how this work progresses. HC said that all the commissioning functions and funding streams would need mapping to enable this work to be carried forward.<br><br>There was a discussion about the HWBB, governance and engagement of the COGs.<br><br>RG agreed that little of the Health & Wellbeing Board agenda focussed on children currently but it was planned to change this in future meetings. He was keen for the Emotional Health & Wellbeing strategy to go to the next HWBB meeting. | CW to ask KMCS to bring an item to the next board meeting.<br><br>RG to get CHWB onto November agenda of HWBB. |
| **4. Early Help – Florence Kroll** | |
| FK was welcomed to her first meeting of the CHWBB. She explained that the Kent Family Support Framework (new CAF), Early Help Prospectus and 1 year plan have been approved at the Young People and Education Services Committee at KCC.<br><br>She is currently leading on the following strands of work:<br>• Maternity services working with young parents and vulnerable families & considering how Early Help services can support these children & families at this very early stage, working with partners.<br>• Missing Children arrangements are under review with SCS.<br>• Step up and step down arrangements w and a closer interface between Early Help and SCS<br>• The Kent EH support framework which replaces the CAF & LP role for schools and health.<br><br>She explained that the intention was to make the CAF process simpler, with an integrated family approach and clear exit routes.<br><br>A discussion followed as it was felt that although CAF did have its issues there was a need to act quickly to repair the damage done by recent communication about CAF which has caused much confusion across all partners.<br><br>SB pointed out that there was also a need to consider contractual arrangements with commissioned services as many contracts have CAF incorporated.<br><br>There followed a discussion on how changes to partnership working were | Members of the Board agreed to help with communications within their own agencies. AK agreed to communicate with all Districts. **FK and all Board Members**<br><br>FK- the Early Help Sub group to consider whether to take a summit |

| | |
|---|---|
| agreed and executed. It was felt that partners had a valuable contribution to make. There was a strong consensus that KCC needed to engage Health and other partners at a much earlier stage when changes were under consideration rather than after they had been decided, when only tweaks could be made. For example GPs were only just coming on board with the CAF process and there was a risk that this good work might be undone. FK apologised and said she was very mindful of the need to consult and agree with partners.<br>HC – suggested that it was worth considering an event similar to the Health Wellbeing summit to bring together all the key stakeholders including the COGs to look at the new Early Help service and processes. | forward. |
| **5. Service Redesign – Fabian Pillay, Newton Europe** | |
| A presentation was given of the processes underway to review the way SCS currently operates to find efficiencies and make the required budget savings within SCS and to improve outcomes.<br><br>There was concern that partners haven't been engaged in the design phase.<br><br>KS said that work reviewing service redesign & integration should be carried out in an integrated way, however if it is about internal processes then we probably don't need to work with partners. | FK agreed to reflect and clarify with TW & AI. |
| 6. **Priorities for CYP Needs Assessment and Verbal update from JSNA Steering Group** | |
| JT described the process by which the priorities were identified.<br>The for the next phase of JSNAs are:<br>• **Mental and Emotional Health & Eating Disorders**<br>• **Early Years – Situational analysis and Equity assessment**<br>• **Children with Disabilities**<br><br>RP expressed concern about how issues had been prioritised for the JSNAs and asked if it related to risk & harm and included CSE?<br>GR said CSE work was being led by KSCB. RP asked how the 2 boards were aligned to make sure things don't get missed. A situational analysis would be undertaken in January.<br>There was a further discussion about the role of the CHWBB as the overarching coordination body for children and KSCB calling it to account for safeguarding issues.<br>JT said there will be further opportunities to look at JSNA data analysis in next phase. SB said it was important to triangulate with frontline experience and for needs assessments.<br>HC – Asked the chairs of the 2 boards to double check to ensure that COGs are also happy with the priorities. RP felt this was particularly needed given the CSE experiences of other authorities.<br><br>RG – no one board can cover everything – protocols such as chairs of Boards meetings might be worth considering. HC asked MTS to revisit Memoranda of Understanding (MOU) between this board and KSCB and with the COGs.<br><br>Eileen McKibbin explained the importance of shared data sets across all the | MTS to review MOU between this board and KSCB and bring forward to future agenda item. Also to review relationship between CHWB and the COGS.<br><br>MW to ask AI to nominate SCS lead on data intelligence. |

| | |
|---|---|
| partners. A multi-agency data group has been re-established to carry out this function<br><br>JT asked for a high level lead from SCS to take forward data integration work. | |
| 7. **Adoption – Position Statement – Ian Davies – lead for Vulnerable Children for KCMS** | |
| ID explained that improvements have been made through a multi-agency (MA) task & finish group which had strengthened MA working in the adoption process. More to do, need to get relationships right. Much work has been undertaken in Health to ensure that health checks and support are timely. The work on CAMHS was also part of this and it was welcomed that the CAMHS service is now meeting all its key targets.<br><br>A new high level group of lead commissioners in CCGs has been established and they would like to have KCC included. HC will chair on behalf of AO's across Kent.<br>HC – NHS is also linked with KSCB and this work is reported there.<br>TW – We engagement from SCS provider side too rather than just Coram as a commissioned provider. | TW to liaise with SCS regarding KCC rep on the T&F group. |
| **8. AOB**<br><br>Issues around how the structures for partnership working for children are working was raised.<br>There was discussion around the role and function of the COGs, including their terms of reference and links to this Board.<br><br>Troubled Families Programme.<br>It was suggested that the programme can now include children and families with health issues and it was felt this board should take a view on this. | MTS has action relating to COGs at item 6 above. |
| **Next Meeting:**<br><br>**Friday, 28th November, 2014 - Swale 1, Sessions House, Maidstone** | |

This page is intentionally left blank

**To:** **Kent Health and Wellbeing Board**

**From:** **0-25 Emotional Wellbeing Subgroup of the Kent Children's Health and Wellbeing Board.**

Report by: Karen Sharp, Head of Public Health Commissioning, KCC;

Dave Holman, Head of Mental Health Programme Area, West Kent CCG;

Sue Mullin, Commissioning Manager, Strategic Commissioning Unit, KCC.

**Date:** **19th November 2014**

**Subject:** ***The Way Ahead*: Draft Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25) in Kent – Part 1.**

---


**Summary:**

In April 2014, the Kent Children's Health and Wellbeing Board appointed a multi-agency subgroup to lead development of a new Emotional Wellbeing Strategy for 0-25 year olds.

Following engagement activity with children, young people, families and professionals, Part 1 of the draft Strategy has been written, setting out a shared partnership vision to promote and improve emotional wellbeing.

Kent Children's Health and Wellbeing Board approved Part 1 of the draft Strategy on 12th September for a period of wider consultation, seeking feedback on the proposed outcomes and principles set out in Part 1, as well as views about how these might be translated into a Delivery Plan (which will form Part 2 of the Strategy, to be developed by February 2015).


**Recommendations:**

- **This report invites comments on Part 1 (Strategic Framework) of the draft Strategy and recommends this document to the Board for approval.**

- **It is also recommended that, once consultation is complete, this strategy becomes a supporting element of the Joint Kent Health and Wellbeing Strategy,** as a key part of the response to two of its overarching outcomes: to ensure that 'every child has the best start in life' and that 'people with mental health issues are supported to live well'.

---

## 1. Context:

1.1. Emotional wellbeing is recognised as having a crucial influence on children and young people's life chances and their ability to achieve positive outcomes across a range of domains, including educational engagement and attainment, social inclusion and physical health. Nationally and locally, demand has been rising for specialist child and adolescent mental health services, with a wide range of studies

and reviews concluding that this is likely to continue until more effective support is available to catch problems at an early stage.

1.2. In response to these pressures across the system, the Kent Children's Health & Wellbeing Board established an Emotional Wellbeing Subgroup in April 2014 with the remit of:

- Leading a multi-agency **Emotional Wellbeing Summit** (which took place in July 2014) to set the strategic direction for future delivery of emotional wellbeing services, including mental health;
- Developing a multi-agency **Emotional Wellbeing Strategy**, to encompass a broader age range of 0-25 (in response to emerging national and local data around the importance of integrated care pathways spanning adolescence and early adulthood).

1.3 A multi-agency group was formed, with a high level of participation from partners indicating a real commitment to work together on this agenda. This commitment was underlined in the achievement of its original aims within just over three months.

1.4 The group included representatives from across Kent County Council (including Public Health, Strategic Commissioning, Adult Services, Safeguarding, and Education and Young People's Services, including schools), from Kent's Clinical Commissioning Groups and GPs, as well as from District Councils and the voluntary sector. The group has also taken a partnership approach to its chairing arrangements, with a shared lead between Public Health, West Kent CCG and Strategic Commissioning.

## 2. Key principles of the draft Emotional Wellbeing Strategy

2.1. The draft Emotional Wellbeing Strategy, entitled 'The Way Ahead', has been owned and developed at real pace by multi-agency partners on the Emotional Wellbeing Subgroup, guided by the findings of consultation exercises with children, young people and families as well as views expressed at the Emotional Wellbeing Summit.

2.2. It is proposed that the Strategy becomes a supporting element of the *Kent Joint Health and Wellbeing Strategy*, since it forms a key part of the response to two of its overarching outcomes: to ensure that 'every child has the best start in life' and that 'people with mental health issues are supported to live well'. To this effect, *The Way Ahead* has adopted a complementary approach, and sets out a framework of **four key outcomes** (with **promoting emotional wellbeing** as a fifth overarching outcome, to be delivered across each level of need).

2.3. The framework of outcomes (within which commissioning intentions will be developed in Part 2: Delivery Plan) are as follows:

**Outcome 1** - **Early Help**: Children, young people and young adults have improved emotional resilience and where necessary, receive early support to prevent problems getting worse.

**Outcome 2 – Access:** Children, young people and young adults who need additional help receive timely, accessible and effective support.

**Outcome 3 – Whole-family approaches**: Children, young people and young adults receive support that recognises and strengthens their wider family relationships.

**Outcome 4 – Recovery and Transition**: Children, young people and young adults are prepared for and experience positive transitions between services (including transition to adult services) and at the end of interventions.

**Promoting Emotional Wellbeing** is envisaged as a 'golden thread' running each of these four outcomes, and influencing activity at each level of need.

2.4. These outcomes have been identified through consultation with children, young people, young adults and families. The consultation broadly indicated a need for renewed focus on improving both:

- the **visibility** of emotional wellbeing support (including promoting resilience and positive emotional wellbeing, as well as offering accessible services)
- the **experience** of accessing support (including communication with families and the need for clarity around what support is available, and from whom).

2.5. The vision that this Strategy seeks to set out is therefore:

- **A model designed and implemented as much as possible in partnership** with children, young people, families, responding to their articulation of the priorities.
- **A re-balancing of approach**, with emphasis on supporting professionals within the wider children's workforce, particularly universal services, to **promote emotional wellbeing and respond appropriately** where there are concerns about a child or young person. Overall, the aim will be to **engage earlier**, to reduce escalation to more targeted and specialist services. The multi-agency partnership required to do this will be pivotal – and needs to be practically-focussed, appropriately prioritised and resourced. This ambition is vitally linked to the 0-25 Transformation vision of KCC, and particularly the Early Help agenda, but also includes the wider role of multi-agency partners.
- **A 'whole-system' view,** with consideration given not only to the design and structure of commissioned services, but to the ways in which they interact with universal services.
- **An extended pathway to support young people up to age 25**, recognising emerging evidence of the need to improve transition at 18 and the findings that 50% of all lifetime mental illness occurs by age 14, and 75% by age 25 (*National Institute of Mental Health*, 2004).

2.6. With all of this in mind, the Strategy itself has been deliberately framed as an accessible document, non-clinical in tone and emphasising the need for partnership with children, young people and families – as well as with a much broader range of professionals within the children's workforce. It is concise, but has been well-researched and reflects principles identified in national guidance as being essential to achieving good outcomes.

## 3. Next steps:

### 3.1. Delivery Plan (Part 2):

A period of wider engagement is currently underway around the proposed outcomes and principles in Part 1 of the Strategy, as well as to ensure a robust multi-agency approach to the development of Part 2, the supporting Delivery Plan. Engagement is taking place through a variety of channels including:

- Online consultation via the Kent.gov, Live it Well and CCG websites, promoted to the public, partner organisations and stakeholder groups through shared distribution lists;
- Presentation across a wide range of countywide and local strategic groups, including Local Health and Wellbeing Boards, CCGs, COGs, and Patient Involvement Groups;
- Targeted workshop activities for multi-agency professionals around specific themes, including outreach to vulnerable groups including young offenders, children in care, and children and young people affected by child sexual exploitation;
- Further engagement with children, young people and young adults;
- A large event planned in December to draw together attendees of the July Summit and additional representatives, reviewing emerging findings from the consultation activities.

3.2 The Delivery Plan will synthesise findings from this range of activities, as well as research into best practice and alternative models, and set out recommendations for a 'whole system' approach to promoting and improving emotional wellbeing support. This will include future commissioning options for both internal and external services.

3.3 At this early stage in our consultation around Part 1, we are identifying a number of key issues that will need to be reflected and updated within the document: in particular this includes a recognition of the importance of strong multi-agency responses to identify and meet the needs of children and young people missing from education or from care, or affected by trafficking or child sexual exploitation. Providing effective emotional wellbeing support, as well as promoting the use of risk assessment tools to the wider children's workforce, will be key parts of the response to these issues and will be addressed within the forthcoming Delivery Plan, as well as within an updated draft for Part 1 of the Strategy.

## 4. Timeline

4.1 An interim report on the engagement process will be taken back to the Children's Health and Wellbeing Board on 28th November 2014, with the aim of returning with the full findings, and a draft Delivery Plan, to the meeting in February 2015.

4.2 The implementation date of this model, if approved, will depend upon the outcome of decisions regarding existing commissioned services across Tiers 2-4 (delivered by Young Health Minds, Sussex Partnership Foundation Trust and South London & Maudsley NHS Trust) which are all due to end in October 2015. The Young Healthy Minds and Sussex Partnership Foundation Trust contracts both have an option to extend for up to two years.

4.3 A key principle agreed by the Children's Health and Wellbeing Board was that we need to work together to seize the opportunity that all contracts ending together presents. It was strongly emphasised that new arrangements should be decided jointly, in line with this multi-agency approach.

4.3 Work is currently underway to scope a draft procurement timetable, and discussions are taking place regarding the possible extension of existing contracts. It is recommended that where possible these decisions are informed by the recommendations within the Strategy and forthcoming Delivery Plan.

## 5. Conclusion

The draft Emotional Wellbeing Strategy for Children, Young People and Young Adults represents a recognition by partners in Kent that emotional wellbeing is 'everybody's business', and a significant step forward towards developing an integrated approach to the design and delivery of appropriate support services. This work will be continued at pace over coming weeks, with a draft Delivery Plan anticipated for review in February 2015 which will influence decisions about future service models from 2015/16.

## 6. Summary of recommendations:

The Health and Wellbeing Board are invited to:

- **Review and comment on Part 1 (Strategic Framework) of the draft Emotional Wellbeing Strategy**
- **Recognise the strategy as sitting beneath the Joint Kent Health and Wellbeing Strategy,** as a key part of the response to two of its overarching outcomes: to ensure that 'every child has the best start in life' and that 'people with mental health issues are supported to live well'.
- **Attend an Emotional Wellbeing Summit on Thursday 18th December, 1.30 – 5.00pm** at **Clive Emson Conference Centre, Detling, Maidstone.** This event will support further development of the Delivery Plan. Please RSVP to rose.hadlow@kent.gov.uk by 1st December 2014.

**Karen Sharp**

Head of Public Health Commissioning

Kent County Council

Karen.sharp@kent.gov.uk

**Dave Holman**

Head of Mental Health Programme Area, West Kent CCG

Dave.holman@nhs.net

**Sue Mullin**

Commissioning Manager, Strategic Commissioning Unit

Kent County Council

Sue.mullin@kent.gov.uk

September 2014

# The way ahead

## Kent's Emotional Wellbeing Strategy

for children, young people and young adults

**DRAFT**

**Part one:** Strategic Framework

*Published by Kent County Council on behalf of the Kent Health and Wellbeing Board*



Kent County Council kent.gov.uk

**Part one:** Strategic Framework

# The way ahead

## Kent's Emotional Wellbeing Strategy

for children, young people and young adults

This publication is available in other formats and can be explained in a range of languages.
Please email: fsccommissioningadmin@kent.gov.uk

# Contents

# Foreword

*Emotional wellbeing is a vital factor in each of our lives, shaping the way in which we understand ourselves and one another, and influencing a range of long-term outcomes.*

In the journey from childhood to adolescence and early adulthood, it becomes even more vital. Enjoying positive ***emotional wellbeing*** (which includes mental health) opens the door to improved physical and cognitive development, better relationships with family members and peers, and a smoother transition to independence.

As partners in Kent, we want to support children, young people, young adults and their families as they make this journey, and work together in helping them respond to and overcome specific challenges that they may face.

This first part of our strategy describes the ***principles*** we will follow to do this, and lays the foundation for part two: a multi-agency delivery plan (expected in January 2015).

## Why now?

Emotional wellbeing is an area of both national and local concern, with studies suggesting a marked decline in children and young people's satisfaction with their lives within the last five years[1]. The Good Childhood Report (2013) found that around 20% of children now experience below average levels of wellbeing, and 10% will have a diagnosable mental health condition: that translates to around three children in every class.

***The case for change is both moral, and economic.***
We know that the long-term consequences of inadequate support for children and young people with emotional difficulties can be enormous: one study suggests that half of all adults with mental health problems were diagnosed in childhood – but less than half were treated appropriately at the time[2], leaving them at an increased risk of disengagement from school, poor employment prospects and reduced physical health[3]. Until we have effective support embedded at an early stage, we will continue to see specialist mental health services across the country overwhelmed by demand, and children exposed to these poor outcomes.

In Kent, we are also responding to a real ***call to action*** at this time from children, young people, families, professionals and politicians to focus our attention on securing ***a comprehensive Emotional Wellbeing offer*** for children, young people (up to 25) and their families. We have made significant progress in recent years, but we know that more is needed if we are to fully respond to the needs of our families in Kent: and the solution is far bigger than any individual organisation.

1 Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A. and Main, G. (2013) *The Good Childhood Report 2013*, The Children's Society, London.

2 Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder. Archives of general psychiatry*, Vol 60, pp.709-717.

3 Richards (2009): Sainsbury Centre for Mental Health: *Childhood Mental Health and Life Chances in post-war Britain*.

## What is our vision for Emotional Wellbeing in Kent?

This strategy focuses on the groundwork needed to envision and establish a '***whole-system***' of support for children, young people and young adults experiencing emotional and mental health difficulties - because we simply can't meet all of the needs from individual commissioned services.

In the first instance we depend hugely upon skilled and supportive professionals working with children, young people / adults and families in schools, community groups, health settings and beyond, to help identify children and young people experiencing emotional wellbeing difficulties (which can range from low-level, short-term needs to more complex difficulties and issues of serious harm, such as those affected by trafficking or child sexual exploitation). However, these people also have a wider day-job to perform, and there is a need to build capacity, knowledge and confidence among those who work with children and young people every day, promoting and protecting emotional well-being.

Confidence, in particular, will also rest upon knowing that there are ***effective services*** available to offer extra support to those children and young people who have a higher level of need. We need much greater collaboration in designing and resourcing Emotional Wellbeing services to ensure that what we put in place meets need ***swiftly, flexibly and effectively*** – and that it will be understood and valued by those professionals referring to it.

***In partnership with children, young people, young adults and families, we need to define what a 'good' system of Emotional Wellbeing support would look like – and this strategy is the first step.***

We've been listening to children, young people and families over the last few months and they have given us some clear messages about the way that they want to see – and experience – support being delivered. They aren't necessarily surprising, but we underestimate their importance at our peril.

*This strategy is therefore:*

*i. **Purposefully focussed*** on the messages we have been given by members of the public and professionals, responding to the issues raised and improving the overall experience for children, young people and families who are seeking support;

*ii. **Mindful*** of the journey that we have been on in recent years as professionals aiming to improve our local offer: the progress we have made, the areas where improvement is still needed, and the learning we have gained about the best ways to target our efforts;

*iii. **Committed to a partnership-approach:*** overcoming organisational boundaries and individual agendas to articulate and bring to life our vision of a 'good' system of emotional wellbeing support for 0 – 25 year olds in Kent.

As partners on the Children's Health and Wellbeing Board, we will work together in implementing this strategy, and the four key principles which follow, through service re-design and commissioning to take place from 2014/15 onwards. Success will depend upon leadership and commitment from a wide range of agencies, and on our continuing dialogue with the children, young people, young adults and families that we seek to support.

***Andrew Ireland,***
***Corporate Director, Health and Social Care***
Chair of Kent Children's Health and Wellbeing Board

September 2014

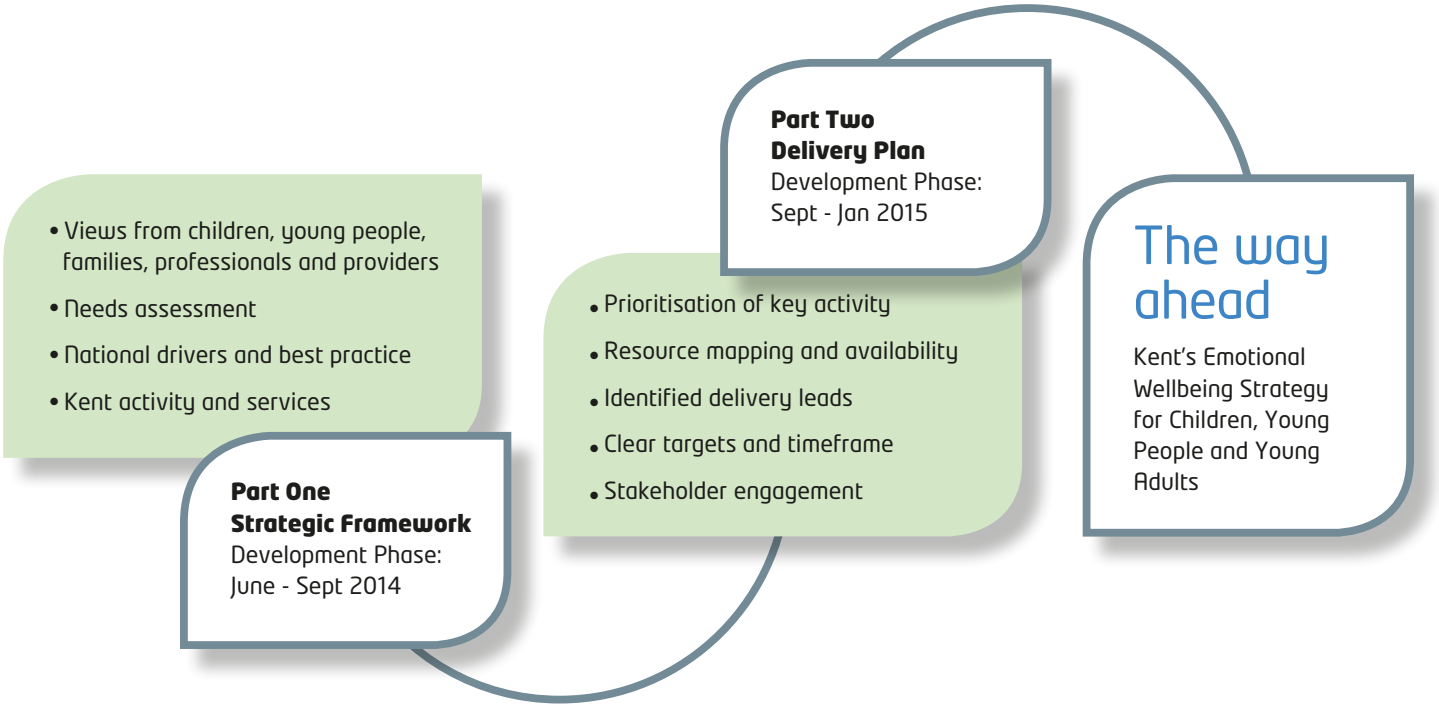
# What is 'The way ahead'?

*This is the first of two documents which together will form our vision as Kent partners for improving the emotional wellbeing of our children and young people.*

***Part One***, outlined in this document, articulates the ***outcomes that we are seeking and the principles we will follow*** to achieve them. These outcomes respond directly to views expressed by children, young people, families, professionals, and providers, as well as the findings of local and national data and best practice.

***Part Two*** will translate these outcomes and principles into ***a practical, multi-agency delivery plan***. This will identify key performance measures, delivery leads, resources and timeframes within which actions will be implemented.

The complete Strategy, comprising both elements, is expected to be presented to the Children's Health and Wellbeing Board in February 2015.



# Where have we come from?

*Although there is still work to do, we've made significant progress in the last few years.*

Since the Child & Adolescent Mental Health Services (CAMHS) National Support Team visited Kent in 2010, we've put in place a number of key recommendations which have led to:

- The introduction of a county-wide Emotional Wellbeing Service for children and young people aged 4-18. This has enabled us to respond earlier to emerging emotional health needs and deliver complementary support to families and frontline professionals.
- The development of a broader, countywide Early Help offer to support children, young people and families who are at risk of experiencing poor outcomes;
- A single service and service provider in place to deliver Tier 2 and 3 mental health services, offering more unified and consistent approach across the county.
- A reduction in waiting times for assessment and treatment from mental health services – but we know there is still more to do.
- An improved partnership between Health and Kent County Council around emotional wellbeing, which has enabled greater sharing of skills and knowledge: to the extent that we are now ready to plan and commission the next generation of these services from a shared viewpoint, together with our wider partners.

We know there is still improvement needed to achieve the ambitions we set ourselves in 2010, and our strengthened partnership now puts us in the right place to do this. This strategy will identify some of the key priorities that we will address together over the coming years.

# What do we know?

*The following summary is based upon emerging priorities from the Joint Strategic Needs Assessment in Kent, led by KCC's Public Health Department. The full needs assessment will be available from November 2014.*

> "Emotional wellbeing is defined as a positive state of mind and body: feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."
>
> ***World Health Organisation, 2004***

Emotional wellbeing fluctuates, often rapidly for children and young people, in response to life events – and their ability to overcome these challenges without long-term harm is determined by the interplay of ***risk and protective factors*** available to them. As professionals working in children's services, we have a unique opportunity to influence this balance.

- ***Universal settings, particularly schools, play a crucial role*** in supporting children and young people to be resilient and emotionally healthy, identifying children or young people who show early signs of difficulty, and knowing when and how to request additional support - as recognised in the recent 'Mental Health and Behaviour in Schools' guidance (DfE, 2014). Many schools in Kent place real emphasis on whole-school approaches to emotional wellbeing, and offer additional pastoral support, counselling, or therapeutic services. ***We need to support these efforts and continue building capacity and skill, as well as knowledge of what is available locally and how to access it, among the children's workforce.***
- ***The vast majority of children, young people and young adults will not need any additional support*** beyond the reach of universal services – however, it is estimated that approximately 15% (approximately

34,000) in Kent will display a higher level of need. Many of these can be supported with some additional '***early help***': an evidence-based approach[4] which seeks to minimise the risks of problems occurring (particularly among at-risk groups) and to act quickly to improve outcomes where there are signs of difficulty. The success of these approaches, particularly around emotional well-being, often depends upon ***working in partnership with families*** –recognised in KCC's recent Early Help Prospectus (2014).

- However, some young people will remain at particularly ***high risk of emotional ill-health due to on-going circumstances*** in their lives, including children in care, those with learning difficulties or disabilities, children of parents with mental health or substance misuse problems, and young carers. Of these groups, statistics indicate that in Kent, we particularly need ***to secure more support for children in care/care leavers and young offenders.***

- ***Specialist services*** exist to meet the needs of children, young people and young adults experiencing acute or prolonged periods of complex emotional, behavioural or relationship difficulties. ***Our local needs assessment in Kent suggests that we particularly need to place more focus on the following groups:***

  - Presentation of self-harm at A&E among the 16-24 year old group
  - The high predicted number of children with Autistic Spectrum Disorder (ASD).
  - Children of parents, particularly mothers, who have mental health problems (among whom there is a 37% higher incidence of developing problems themselves)
  - Young people and young adults who have a 'dual diagnosis' and need support with substance misuse and emotional wellbeing difficulties.

We also know that emotional wellbeing difficulties present as the most common health issue among young people from 16 to 25 – but traditionally services have been divided into a 'child' and 'adult' offer at age 18, with differing resources available. This can cause real difficulty and distress for young people and their families who need consistency at a key point of transition. Research suggests that we need instead ***an integrated offer and pathway that extends from birth to age 25*** [5].

## Levels of need [6]

**1% Severe**
of children and young people will experience episodes of being seriously mentally ill requiring intensive support from specialist services and potentially inpatient care.

**9% Complex**
of children and young people will experience significant emotional and behavioural difficulties which are complex and / or enduring, and will require support from specialist services. Signs may include anxiety, conduct or behavioural problems, attachment issues and eating disorders.

**15% Early Help**
of children, young people and young adults may need some additional help from services. Indicators may include responses to bullying, low mood, behavioural problems, relationship difficulties and school non-attendance.

**75% Prevention**
of children, young people and young adults will not need any additional support from emotional wellbeing services. This doesn't mean that they won't experience periods of emotional instability - but that they will receive sufficient support from their families, peers, schools, and the wider children's workforce to overcome challenges that they face.

4 See *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer* 2012.

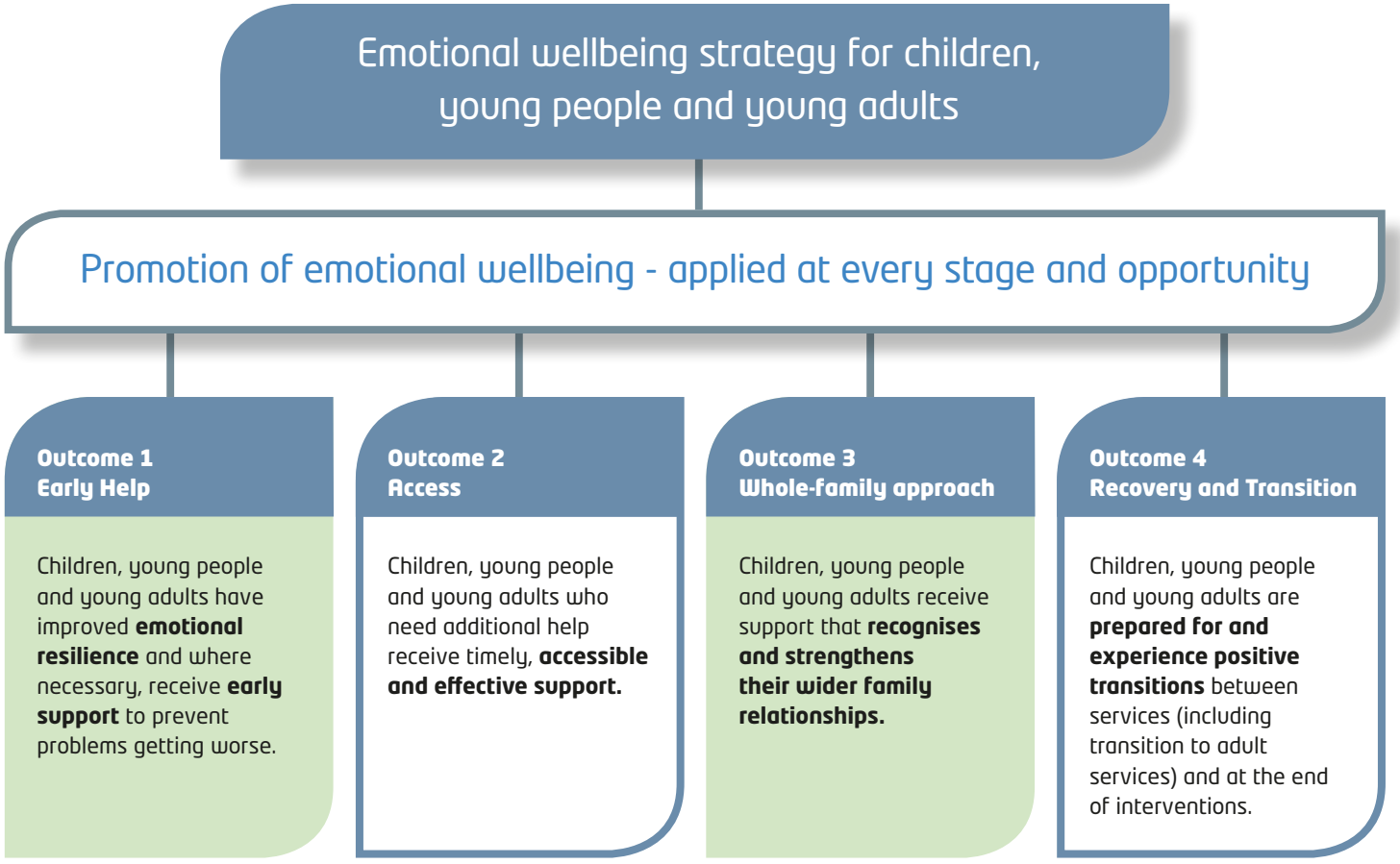
5 Supporting Young People's Mental Health: *Eight Points for Action: A Policy Briefing from the Mental Health Foundation* (2007) and International Association for Youth Mental Health: *International Declaration on Youth Mental Health* (2013)

6 Diagram based on Health & Social Care Advisory Service (HASCAS) model; all percentages approximate.

# What do children, young people and families think a 'good' system would look like?

This strategy has been designed in response to the messages we have heard from children, young people, young adults and their families about the principles that matter most to them about the ways in which they are supported, whether in universal settings or from targeted and specialist services.

Over 200 responses have been gathered between May – July 2014 through surveys, focus groups and interviews, with a further 50 frontline professionals offering the benefit of their experience. The feedback has been analysed and grouped into priorities that fall within ***four overarching outcomes,*** which will form the basis of our strategy and the guiding principles for future service design. These outcomes are shown in the following diagram and discussed in more detail over the next few pages.



# **Outcome 1:** Early help

*Children, young people and young adults have improved **emotional resilience** and where necessary receive **early support** to prevent problems getting worse.*

***Early Help means doing all we can to prevent or minimise the risk of problems arising, and responding early if difficulties do emerge.***

This is the definition at the heart of KCC's recent Early Help and Preventative Services Prospectus: a document which sets out the broader offer of preventative support available to children, young people and families where there are risks of poor outcomes.

Efforts to improve emotional wellbeing are a vital part of this offer, and so the two strategies are intrinsically linked, and we will specifically share the following aims:

- To ***develop self-esteem and resilience among children and young people***, particularly those who are most at risk of poor outcomes due to circumstances in their lives.
- To ***support schools and early years settings*** in improving the emotional resilience of children and young people.
- To ***support parents who are experiencing mental health issues.***

In addition, we want to respond to the following priorities identified by children, young people, young adults and families:

***1*** To support children, young people, young adults and families in ***developing and securing their own emotional wellbeing,*** and where necessary, in navigating and negotiating access to support that meets their needs.

***2*** To ***improve skills and confidence among staff in the children's workforce at all levels,*** through training in identifying and responding to the needs of children and young people who have emotional wellbeing difficulties. This includes consideration of external factors which may affect children and young people's emotional wellbeing, including domestic violence, child sexual exploitation and trafficking.

***3*** To build upon our work to date in ***developing a high-quality, flexible and visible Emotional Wellbeing offer*** within schools and community settings, linked to the broader suite of Early Help support.

"We need more 'drop-in' provision available locally, where we can access help quickly, preferably without an appointment."

"Parents/carers, teachers, and other front-line professionals need more support to identify and work with children and young people who have emotional wellbeing difficulties."

# **Outcome 2:** Access

*Children, young people and young adults who need additional help receive* ***timely, accessible and effective support.***

***Effective support for emotional wellbeing isn't just about the quality of the service offered.***

It is about how easy it is to ask for help; how it feels to have your needs assessed; and (where necessary) how simple and responsive the pathway to getting the right kind of treatment in place. These experiential factors play a determining role in how successful the eventual intervention can actually be - and so they are a priority for us as we think about designing a 'whole system' approach.

In aiming to improve this overall experience, there are a number of priorities which we will need to address and which have been highlighted by children, young people, young adults and their families:

***1.*** A range of options about the ways in which support can be delivered, whether face-to-face, over the phone or virtually.

***2.*** A more flexible approach to service delivery, with more visible local facilities and (where appropriate) the potential for a 'drop in' offer available within the community.

***3.*** Better understanding by professionals (including teachers and GPs) of the kind of support available locally – and a simpler process to access it.

In addition, our needs assessment and feedback underlines the need to:

***4.*** Improve our specialist pathways, particularly for children and young people with Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Conditions (ASC0) and families.

***5.*** Improve our targeted outreach to the most vulnerable groups, particularly young offenders, children in care, and care leavers.

"The adults working with us (teachers, GPs etc) need to understand the total offer of support available to meet our needs locally - and we need a simple process to access it."

"We need a range of different ways to access support: in person, peer-to-peer, in safe online spaces (including social media) and via text or telephone."

# **Outcome 3:** Whole family approaches

*There is a broad consensus of evidence to suggest that professionals and services make most impact on the lives of children, young people and young adults when they work in partnership with the wider family* [7].

Parents/carers have a unique and critical opportunity to influence the emotional wellbeing of their children, and often understand their needs best. With this in mind, our priorities will be to:

***1.*** Improve the ways in which services ***work alongside and in partnership with parents/carers*** and the wider family to manage their own risk and resilience (as far as this is safe to do and, particularly where young adults are involved, consent is given).

***2.*** ***Promote the importance of maintaining positive family relationships***, where this is appropriate, and encourage good communication within families.

***3.*** Ensure that where interventions are offered to a child or young person, their parents and carers are engaged as much as possible in ***understanding the work being done and what they can do to support it***. Within this, we will link to local parenting support opportunities where appropriate.

***4.*** Finally, to pay particular attention to whether there are on-going support needs among families at the point at which services begin to ***step back*** – recognising that this can be a time of real pressure.

"Our wider families need support too: to understand what is happening to us, what work is being done, and how they can best help."

"Stick with our families after the point of 'stepping down' – this is often when we (and they) need most help."

7 See *Think Family Toolkit: Improving Support for Families at Risk – strategic overview*. Department for Children, Schools and Families (2009).

# **Outcome 4:** Recovery and transition

*Children, young people and young adults are **prepared for and experience positive transitions** between services (including transition to adult services) and at the end of interventions.*

***The process of ending support from a service, whether goals have been achieved or needs have changed, is every bit as important as the beginning.***

If successful progress is to be sustained, then the partnership with children, young people, parents/carers, families, and schools is vital – and these key 'partners' need to be supported too, and prepared for the next step. In some cases, this may mean a more gradual 'stepping down' process – and a clear plan needs to be agreed, with routes 'back in' if concerns re-emerge.

When it becomes necessary to change the kind of support that is offered, then this too needs to be a carefully managed process, with children, young people and young adults involved wherever possible in decisions about how best their needs can be met: an overwhelming call from the young correspondents to our surveys [8].

Through designing a 'whole system' offer that meets needs across a continuum from birth to 25, we will aim to ensure that support is no longer shaped by a watershed at age 18, but that it responds instead to the individual needs of a young person as they follow their own unique path into adulthood [9].

***Our priorities are therefore:***

***1.*** To work ***in close partnership with children, young people, parents/carers and families, as far as possible, in preparing for and implementing transitions*** whether at the end of an intervention or when another service becomes involved.

***2.*** To set out ***clear lines of communication and 'routes back'*** if concerns re-emerge.

***3.*** To design an extended offer that is led by the needs of young people as they approach and enter adulthood, with ***consistency and continuity of support available post-18.***

"Make sure that there is a clear plan and clear communication between the different people working with us, especially when we need to move between services."

"Young people who are approaching 18 must be able to access the same level of support from adult services if they need it, and experience a smoother transition."

8 See also *Report of the Children and Young People's Health Outcomes Forum 2013/14*

9 A priority within: *Closing the gap: priorities for essential change in mental health* (Department of Health, 2014).

# Where next?

*This document sets out a framework of four key outcomes which will form the cornerstones of our vision to improve emotional wellbeing for all children, young people and young adults in Kent.*

The next stage of activity, to take place from September 2014 – January 2015, will involve wider engagement with the public, partners and professionals around the design of Part 2 – The Delivery Plan. This process will define the key actions needed to achieve our four outcomes, including service design, commissioning intentions, performance measures and resources.

The Children's Health and Wellbeing Board will continue to oversee this work and hold responsibility for ensuring that both elements of this strategy are widely understood and committed to by partners.

***For further information and updates*** on this work, please visit xxxxxxxxx (TBC).

# Strategic links:

*The Way Ahead: Kent's Emotional Wellbeing Strategy for Children, Young People and Young Adults has been written in reference to the following key local strategies:*

*Kent Joint Health and Wellbeing Strategy* (Kent Health and Wellbeing Board, 2014).

*Every Day Matters: Kent County Council's Children and Young People's Strategic Plan.* (Kent County Council, 2013).

*Social Care, Health and Wellbeing Directorate: 2014/2015 Strategic Priorities Statement* (see p.23). Kent County Council (2014).

*Education and Young People's Services Directorate: 2014/2015 Strategic Priorities Statement* (p.14-16) (Kent County Council, 2014).

*Early Help and Preventative Services Prospectus* (Kent County Council, 2014)

*Joint Strategic Needs Assessment for Children in Kent 2011* (Kent Public Health, 2011)

# References:


Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A. and Main, G. (2013): *The Good Childhood Report 2013.*

Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder.*

Richards (2009): *Sainsbury Centre for Mental Health Childhood Mental Health and Life Chances in post-war Britain.*

Department of Health (2012) *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer 2012*

Fraser, M., Blishen, S. (2007): *Supporting Young People's Mental Health: Eight Points for Action: A Policy Briefing from the Mental Health Foundation.*

International Association for Youth Mental Health (2013): *International Declaration on Youth Mental Health*

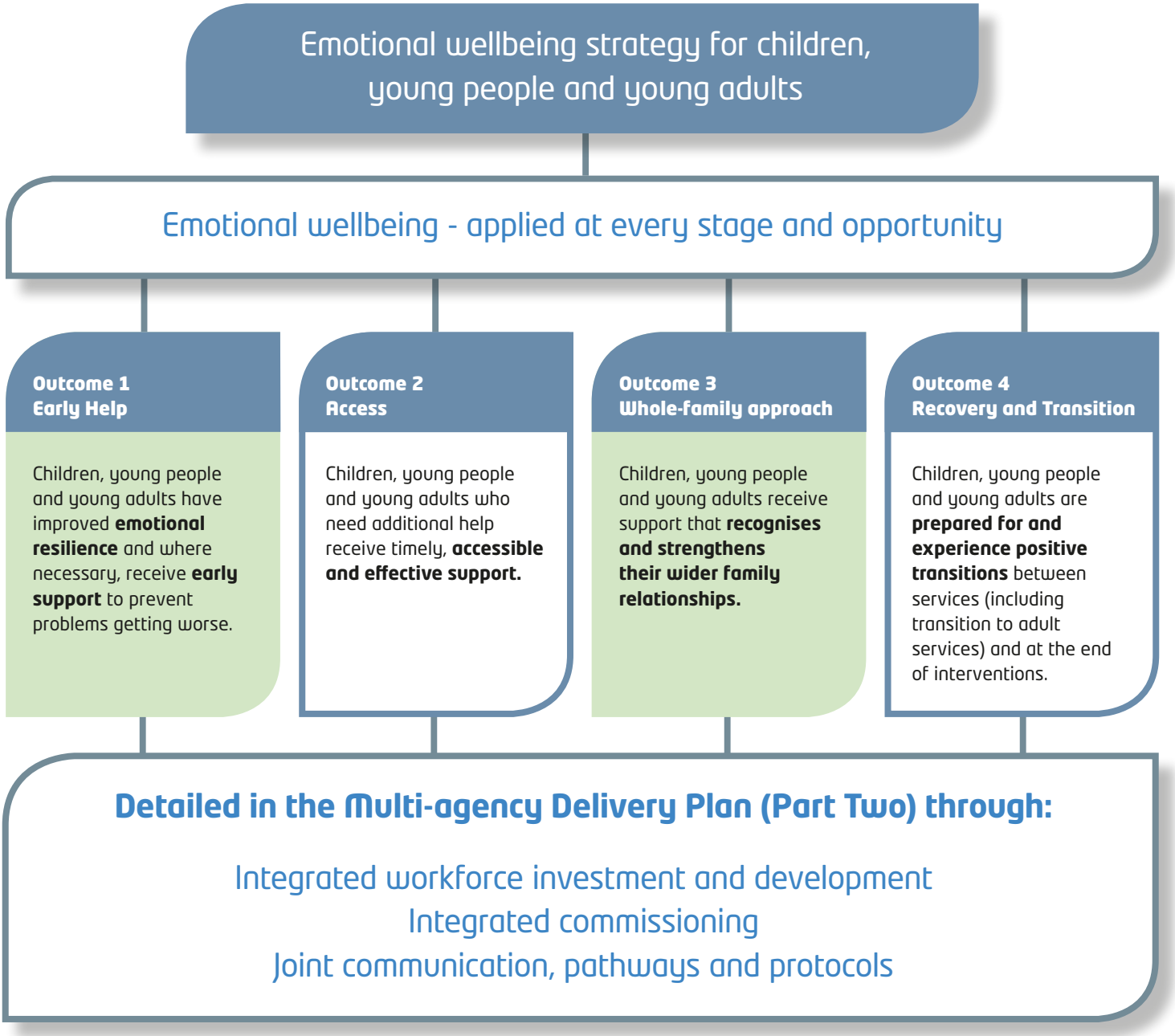
Department for Children, Schools and Families (2009): *Think Family Toolkit: Improving Support for Families at Risk – strategic overview.*

Department of Health (2013): *Report of the Children and Young People's Health Outcomes Forum 2013/14*

Department of Health (2014): *Closing the gap: priorities for essential change in mental health.*

Department for Education (2014): *Mental Health and behaviour in schools: Departmental Advice for School Staff.*

# Quick reference: Outcomes Framework



# Notes

**Part one:** Strategic Framework

# The way ahead

## Kent's Emotional Wellbeing Strategy

for children, young people and young adults

This publication is available in other formats and can be explained in a range of languages.
Please email: fsccommissioningadmin@kent.gov.uk

**From:** **Cllr Michael Claughton, Ashford Health and Wellbeing Board**

**To:** **Kent Health and Wellbeing Board – 19 November 2014**

**Subject:** **Progress Report from the Ashford Health and Wellbeing Board**

**Introduction**

The Ashford HWB have already identified key priorities which have been based on local needs namely dementia, obesity and mental health. The Board is also active in supporting the development of our community networks and recent stakeholder engagement session has again identified mental health as a top priority. Obesity was the focus of our most recent Board meeting. The Ashford HWB forward plan currently includes Mental Health/Dementia Action Plan (January 2015), Independent Living & Self Management for those with Long-term Conditions and Falls Prevention (April 2015) and Sustainable Development for Health & Wellbeing (July 2015). It is important that these positive actions are noted and also we wish highlight the need for further granularity of the local information which will be discussed at the future LOG meeting.

LOG Report to the Ashford's Health & Wellbeing Board (Meeting 22nd October)

Local Implementation of the Kent Joint Health and Wellbeing Strategy

1. The Kent Health and Wellbeing Board at its last meeting considered the final draft of the Joint Health and Wellbeing Strategy. One of the recommendations agreed was that the strategy should be used to engage with the public at a local level in order to stimulate discussion and understanding about the changes that will inevitably occur as integration gathers pace and services are moved out of hospitals and into the community. Local health and wellbeing boards were charged with ensuring that the strategy would be reflected in all public engagement activities planned by partner organisations and that meaningful engagement on the issues involved was being undertaken. If this is not the case then plans should be made to address any gaps. Local health and wellbeing board should report back to the November meeting of the Kent Board on this process.

2. A second recommendation agreed by the Kent Board requires the local Health and Wellbeing Boards to ensure local plans demonstrate how the priorities, approaches and outcomes of the Strategy will be implemented at local levels and report this assurance to the Kent Board in November 2014. Again, if any gaps are identified actions to remedy these deficiencies should be taken.

3. The LOG briefly discussed these requirements and agreed that a dedicated meeting is required to:

    a) study Public Health's recently produced Assurance Framework that provides the direction of travel for Ashford against the indicators in the Joint Health and Wellbeing Strategy;
    b) discuss what further action is required;
    c) agree how best to capture local interpretation of the Kent priorities; and

d) identify gaps in engaging and communicating with local people.

The voluntary sector and Health Watch are key to such discussion and relevant Board members have been invited to attend this meeting.

4. All lead partners have been asked to collate relevant information in readiness. The meeting is scheduled for November just before the Kent Board, allowing Ashford's representative to report as requested. Feedback from the Kent Board will help the LOG report on gaps to the Ashford Health and Wellbeing Board at its meeting in January.

The AHWB is asked to:

- Note the LOG's need to meet to respond to the Kent Health and Wellbeing Board's request to evidence local engagement and implementation of the Joint Health and Wellbeing Strategy;

- Authorise the Ashford representative to report on outcomes at the Kent Health and Wellbeing Board meeting in November; and

- Agree for a report to come to the Board in January on the above.

**Canterbury and Coastal Health and Wellbeing Board**
Ground Floor
Council Building
Military Road
Canterbury
Kent
CT1 1YW

Tel: 01227 795024
Markjones4@nhs.net

Roger Gough
Chairman, Kent Health and
Wellbeing Board

SENT BY E-MAIL

10 November 2014

Dear Roger

The Kent Health and Wellbeing Strategy informs the commissioning plans overseen through the Canterbury Health and Wellbeing Canterbury & Coastal CCG commissioning plans enabling us to focus on the needs of service users and communities, tackle factors that impact on health and wellbeing across service boundaries and influence local services beyond health and care to make a real impact on the wider determinants of health (e.g. employment, housing and environment).

In line with our firm commitment to stakeholder engagement, we embarked on a process of engaging with practices, patients, carers, the public and other stakeholder groups in developing our commissioning priorities. These events focused on information giving, updating stakeholders on our role and activities, and information gathering, enabling us to interact with our 'Patient and Public' and 'organisational' stakeholder groups in a structured way to secure their input into this strategic commissioning plan.

From these efforts, come five key outcomes against which we will measure our success in improving the health of the people of Kent. These key outcomes are:

- **Every Child has the best start in life –**
    - Over the next 3 years we would hope to see an increase in breast feeding take up. We would also like to see targeted support on healthy eating in families leading to an increase in healthy weight levels. There will also be an increase in MMR take up and additional Health Visitors who will support families with young children.
- **People are taking greater responsibility for their health and wellbeing –**
    - This is designed to promote a continued increase in people accessing treatment for drug and alcohol problems; fewer alcohol related admissions to hospital; an increase in people quitting smoking and staying smoke free and more people supported to manage their own conditions.
- **The quality of life for people with long term conditions is enhanced and they have access to good quality care and support**
    - More patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once). More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.

- **People with mental ill health are supported to live well**

    - Early diagnosis of mental ill health will be increased, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support and early intervention services will see an increase in people reporting an improvement in their own mental ill health and wellbeing. The stigma of mental ill health will be reduced.

- **People with dementia are assessed and treated earlier**

    - Early diagnosis of Dementia will become the norm, ensuring that patients and their families can access support at the appropriate time, improving their quality of life. Improved access to community support including housing, supported housing options and dementia friendly communities will lead to patients being able to stay within their own communities for longer.

A number of projects are being lead through a Public Health approach, as detailed in the attached Action Plan, however these run across Kent as a whole and are not specific to the needs to Canterbury.

Additionally, within the Health and Social Care commissioning plans **"Community Networks"** is the title given to a number of projects leading towards an overall strategic aim. The component projects, which also form part of the Better Care Fund initiative, are detailed individually below**:**

**1. Integrated Urgent Care Centre**

Scheme 1 is the integration of urgent care services to ensure that patients receive the same standards of care, entering the same pathways, regardless of which point they access the Urgent Care system.

It will achieve this by providing rapid access to key health economy services which include:

- General Practitioners
- Community Support Services
- Social Services
- Psychiatric Services
- Secondary Care Consultants (including Geriatricians)

The smooth flow of patients through the health and social care system is fundamental to meeting patients' expectations of urgent care services. It is apparent that a significant proportion of urgent and emergency demand could more appropriately be classified as "primary care related" and undertaken by GPs or practice and community nursing.

**2. Mental Health Services**

We recognise that like physical health related long term conditions, mental illness has a huge impact on the quality of life for the patients and their carer. The CCG will work with all partners to deliver improved mental health services for all age ranges to support:

- Increased schemes to support health minds and early interventions
- Crisis support within all pathway
- Integrated models for all pathways to support patients within range of pathway
- Systematised self-care/self-management through assistive technologies
- Improved care navigation
- The development of Dementia Friendly Communities and
- To facilitate access to other support provided by the voluntary sector.

**3. Support for Care Homes**

This model supports older people with a range of needs including physical disabilities and dementia will align specialists across multiple teams, including secondary care, to ensure patients in care homes have anticipatory care plans in place and those that are admitted to hospital have robust discharge plans in place before they are discharged in order to prevent re-admissions.

**4. Health and Social Housing**

To improve the utilisation and appropriate use of existing housing options and increase the range if housing options available to people and to ensure it's used flexibly and enables more people to live independently in the community with the right level of support. This will also require responsive adaptations to enable people to manage their disability in a safe home environment.

**5. Falls Prevention and Management**

The intention is to work with partners to develop an integrated multi-agency, multi-disciplinary falls service across Ashford and Canterbury. This will focus predominantly on those aged over 65 years.

The Kent Health and Wellbeing Board have agreed a framework which promotes an integrated multi-agency, multidisciplinary service for the secondary prevention of falls and fractures and is based on a recommendation made by the Department of Health (DH 2009) for developing an Integrated Falls Service.

The 'framework' covers the entire spectrum across a range of stakeholders including acute trusts, community health trusts, CCGs, adult social services, district authorities and voluntary organisations.

Considering the guidance from NICE and the National Service Framework, the framework recommends following interventions, which if undertaken in a systematic way will prove beneficial at a population level. These include:

1. Screening of adults who are at a higher risk of falls

2. Integrated multi-disciplinary assessment for the secondary prevention of falls and fractures

3. Use of standardised Multifactorial Falls Assessment and Evaluation tool

4. Availability of community based postural stability exercise classes

5. Follow on community support for on-going maintenance closer to home

These interventions should be available as a "core offer" for the population if we are to see a reduction in the number of falls related hospital admissions and reductions in numbers of older people living in residential care as a result of falls.

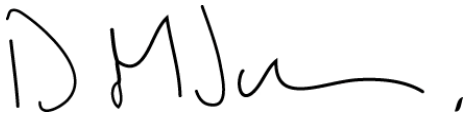
A scoping exercise has been undertaken to review the existing pathways (re-active and pro-active) and services identifying what works well, what requires further development and gaps in existing provision. The outputs of this will be reviewed by the falls task and finish group to support the move to an integrated service.

**6. Integrated Health and Social Care Team**

We will continue to develop our integrated health and social care team to ensure that they will be available 24 hours a day seven days a week and will be contactable through a single access points. The team will be focussed on both ends of the patient journey, through supporting patients, carers, social services and clinicians to avoid the need for patients to be admitted to hospitals, however where this is necessary the team will mobilise to ensure timely discharge of the patient.

These teams will ensure wider integration with other community and primary care based services, including voluntary sector provided services, as well as hospital specialists working out in the community. The ultimate aim is to enable people to be cared for in their own homes or within their own community. The aim of team is to support people to self-manage and to be independent in their own homes.

Yours sincerely



Mark Jones
Chair, Canterbury and Coastal Health and Wellbeing Board

**DRAFT: Canterbury Health and Wellbeing Action Plan**

The Kent Health and Wellbeing Strategy sets out 4 priorities. Each priority has 5 outcome areas.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average
Priority 2 – Tackle health inequalities
Priority 3 – Tackle the gaps in service provision
Priority 4 – Transform services to improve outcomes, patient experience, and value for money

Outcome 1-Every child has the best start in life
Outcome 2-Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
Outcome 3-The quality of life for people with long term conditions is enhanced and they have access to good quality care & support
Outcome 4-People with mental health issues are supported to 'live well'
Outcome 5-People with dementia are assessed and treated earlier, and are supported to live well



| **Outcome 1** | **Every child has the best start in life** | |
|---|---|---|
| **1.1** | A reduction in the number of pregnant women who smoke at time of delivery | Baby Clear programme is being delivered in acute trusts by midwives. There has been commitment from the CCG to get the midwifery services on board with the initiative. This will also be part of the Health Visitor role<br><br>Baby Be Smoke free. A programme for teenage pregnant mums being piloted in Kent.<br><br>Smoke free policy covering hospital grounds<br><br>Work with Children Centres on the ' Smoke free home' agenda (PH)<br><br>Smoke free parks and family spaces |

| | | |
|---|---|---|
| | | KCC Public Health fund KCHT to deliver smoking cessation services to support those looking to quit smoking. |
| **1.2** | An increase in breastfeeding Initiation rates | Best Beginning programme in birthing centres and acute trusts<br><br>Breastfeeding friendly public venues/booths<br><br>Part of HV role<br><br>Breastfeeding is included in the targets for Midwives<br><br>Encourage the uptake of Healthy Start scheme. (HIAP)<br><br>Kent Baby Matters is newly commissioned (by KCC Public Health) to provide community infant feeding services. It has a strong focus on peer support to help increase initiation and continuance of breastfeeding. As part of this service there will be trained peer supporters on hospital wards and a 48 hour target to offer new mums (giving birth in Kent) peer support services. |
| **1.3** | An increase in breastfeeding continuance 6-8 weeks | Improving the quality of data recording and reporting by GPs<br><br>Kent Baby Matters service will aim to increase the rates of breastfeeding but offering a range of community based interventions. Mainly delivered through Childrens Centres. They will work with GPs to improve the quality of the data. |
| **1.4** | A reduction in conception rates for young women aged under 18 years old (rate per 1,000) | Kent Teenage Pregnancy Strategy developed. Would require strong Leadership provided by the local HWBB<br><br>CCG level H&W action plans with SMART targets<br><br>Integrated performance framework for the strategy at CCG and district level |
| **1.5** | An improvement in MMR | Improving call and recall in GP practices |

| | | |
|---|---|---|
| | vaccination uptake two doses (5 years old) | Timely reporting of data<br><br>Accurate information to parents to help them make an informed decision |
| **1.6** | An increase in school readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children | The 'Born to move' initiative is a Health Visitor led project to raise awareness of the importance of human interaction between parent /carer and infant or child to enable optimal development, physically & emotionally.<br>Health improvements are addressing inequalities from the start through a universal multi-agency project: 'Making everywhere as good as the best'. Make sure the whole team understand biological, social and psychological aspects of child health....up to date with neuroscience, with skills to promote positive parenting' *Transforming Community Services: Ambition, Action, Achievement' - Department of Health: 2011*<br>'Move from valuing what we measure to measuring what we value' to demonstrate improved outcomes.<br>The project supports the five key stages in public health: starting well; developing well; living well; working well; ageing well.<br><br>Long term outcomes of the project are:-<br>• Increased vocabulary at 5 years predicts future success at GCSE and beyond, so improving educational attainment and communication skills.<br>• Children develop positive attitudes towards physical activity – reducing childhood obesity levels. Avon longitudinal study identifies 8 risk factors in first year to target help where it is needed most.<br>• Increased parent and carer participation and awareness of their vital role in helping children to achieve improved self-esteem, ability for social interaction and development of problem solving skills. |

| | | |
|---|---|---|
| | | In addition to this there is also a Health Visitor/School Nurses collaborative called 'Clean and Dry, and 'Ready for School' to improve school readiness.<br><br>There us a range of Universal services offered in Children Centres for families with children |
| **1.7** | A reduction in the proportion of 4-5 year olds with excess weight | KCC responsible for commissioning the Mandatory programme weight and measurement programme for Yr R and Yr 6 (National Child Measurement Programme), this programme provided by KCHT School Nursing Team.<br><br>KCHT Healthy Schools Team support local schools, healthy weight is a key element of this provision. Provision of programmes for children and families also provided by KCHT Health Improvement Team. Sports Partnership team at KCC provide many resources for schools to increase physical activity.<br><br>Memorandum of Understanding under development between the Public Health team in KCC and Children's Centres which includes healthy weight and breastfeeding.<br><br>KCC's walking bus scheme. Promote an increased number of dedicated cycle paths and lanes within Canterbury area. Promote development of a map of cycle parking areas across the district. (HIAP) |
| **1.8** | A reduction in the proportion of 10-11 year olds with excess weight | Mandatory programme to weight and measure Yr R and Yr 6 (National Child Measurement Programme), KCC commissions KCHT School Nursing Team to do this.<br><br>KCHT Healthy Schools Team support local schools, healthy weight is a key element of this provision. Provision of programmes for children and families also provided by KCHT Health Improvement Team. Sports Partnership team |

| | | |
|---|---|---|
| | | at KCC provide many resources for schools to increase physical activity.<br><br>As part of the re-badging of public health funding to children's centre there is a Memorandum of Understanding under development which includes healthy weight and breastfeeding.<br><br>KCC's walking bus scheme. Promote an increased number of dedicated cycle paths and lanes within Canterbury area. Promote development of a map of cycle parking areas across the district. (HIAP) |
| **1.9** | An increase in the proportion of SEN assessments within 26 weeks | KCC has published a Strategy to improve the outcomes for Kent's children and young people with SEN and those who are disabled (SEND and create at least 275 additional places for pupils with autism (ASD) or behavioural, emotional and social needs (BESN), increasing the number of Kent special school places and establishing new specialist resourced provision (SRP) within our schools, alongside investment in the skills of school staff creating capacity across all schools. The benefits will include greater choice for parents and a reduction in the number of children placed outside the maintained sector in county. We have steadily increased the number of assessments completed within 26 weeks, however the Children & Families Act, from September 2014, will require assessments to be completed within 20 weeks and we are introducing new systems to be compliant with the statutory changes.<br>• Undertake a process analysis for the new assessment process and implement steps to deliver a 20 week completion timescale<br>• Ensure all professionals engaged in the integrated assessments in each district are aware of revised timescales<br>• Complete a review of paper based processes within the assessment procedures and identify areas where paperless working can minimise timescales and reduce administration in assessments<br>• Evaluate the impact of the pilot for Local decision making for assessments, ensure it is encouraging school to school support and the |

| | | |
|---|---|---|
| | | delivery of Core Standards<br>• Identify and test systems for robust monitoring and timely access to High Needs Funding (HNF) as an alternative to assessment.<br>• Analyse trends in assessments requests and compare with HNF requests |
| **1.10** | A reduction in the number of Kent children with SEN placed in independent or out of county schools | • Implement a 3-year plan to increase specialist resourced provision (SRP) in mainstream<br>• Develop Service Level Agreements for SRPs<br>• Liaise with NHS therapy commissioners and NHS providers to ensure relevant services are in place in new mainstream provision<br>• Ensure that SEN commissioning plans are included in the school capital programme<br>• Implement the outcome from a review of Special school designations<br>• Extend core standards to special schools<br>• Review PEO impact and direct expertise to Kent schools and annual reviews<br>• Introduce a Dynamic Procurement System (DPS) for out county placements<br>• Develop robust systems for College placements and high needs funding |

| | | |
|---|---|---|
| | | • Ensure new commissioning arrangements for Warm Stone PRU are operating effectively |
| **1.11** | A reduction in CAMHS average waiting times for routine assessment from referral | The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for childrens emotional wellbeing.<br><br>At the whole system emotional and wellbeing summit and the Children's Health and wellbeing board has agreed to the development of new children and young people's emotional and wellbeing strategy and the development of a new model of service across all Tiers of activity by December 2014.<br><br>The new agreed children's and young people emotional and wellbeing model will be embedded in new contract arrangements post Aug 2015, this is when the current SPFT, SLAM and Young Healthy Minds contracts end.<br><br>A contract refresh for 2014/15 has been completed to capture the required performance improvements; this has included for the first time a contract CQUIN to improve transition arrangements between children's and adult services. |
| **1.12** | A reduction in the number waiting for a routine treatment CAMHS | The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for children's emotional wellbeing. |

| | | |
|---|---|---|
| | | At the whole system emotional and wellbeing summit and the Children's Health and wellbeing board has agreed to the development of new children and young people's emotional and wellbeing strategy and the development of a new model of service across all Tiers of activity by December 2014.<br><br>The new agreed children's and young people emotional and wellbeing model will be embedded in new contract arrangements post Aug 2015, this is when the current SPFT, SLAM and Young Healthy Minds contracts end.<br><br>A contract refresh for 2014/15 has been completed to capture the required performance improvements; this has included for the first time a contract CQUIN to improve transition arrangements between children's and adult services. |
| **1.13** | An appropriate CAMHS caseload, for patients open at any point during the month | The commissioners of CAMHS services (CCG) are working with Sussex Partnership to reconfigure services and drive up performance. This includes retention and deployment of staff. Performance is closely monitored by CCG ensuring all partners are aware of their responsibility for children and emotional wellbeing.<br><br>At the whole system emotional and wellbeing summit and the Children's Health and wellbeing board has agreed to the development of new children and young people's emotional and wellbeing strategy and the development of a new model of service across all Tiers of activity by December 2014.<br><br>The new agreed children's and young people emotional and wellbeing model will be embedded in new contract arrangements post Aug 2015, this is when the current SPFT, SLAM and Young Healthy Minds contracts end. |

| | | |
|---|---|---|
| | | A contract refresh for 2014/15 has been completed to capture the required performance improvements; this has included for the first time a contract CQUIN to improve transition arrangements between children's and adult services. |
| **1.14** | A reduction in unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 100,000) | Through the 'Transformation Programme for Children and Young People' the rate of admission for asthma in < 19yr olds will be reduced. |
| **1.15** | A reduction in unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 100,000) | Through the 'Transformation Programme for Children and Young People' the rate of admission for diabetes in <19yr olds will be reduced. |
| **1.16** | A reduction in unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 100,000) | Through the 'Transformation Programme for Children and Young People' the rate of admission for epilepsy in <19yr olds will be reduced. |
| **Outcome 2** | **Effective prevention of ill health by people taking greater responsibility for their health and wellbeing** | |
| **2.1** | An increase in Life Expectancy at Birth | Breast feeding services delivered by Kent Baby Matters through Children Centres<br><br>6-8 weeks health check<br><br>Immunisation<br><br>Antenatal screening programme |

| | | |
|---|---|---|
| | | Public Health programmes to reduce smoking in pregnancy<br><br>Post natal support to mother<br><br>Increase the number of healthy births to families within Canterbury<br><br>Sustain the drive to reduce teenage pregnancy in Canterbury. |
| **2.2** | An increase in Healthy Life Expectancy | KCC Public Health commission a range of health improvement services to help the population to live a longer and healthy life. These are largely provided by KCT and include Stop Smoking, Healthy Weight, Health Trainers, Health Walks.<br><br>Public Health are leading on programmes to encourage as many primary aged school children in the borough, as possible, to use active travel to school. The project is running with some current target schools. It needs additional funding to be expanded into target areas of the borough. Due to the age of the children they are accompanied on the walk / cycle / scoot to school by parents or extended family members, increasing exercise by household, on a wholesale basis.<br><br>Smoke free homes project. |
| **2.3** | A reduction in the Slope Index for Health Inequalities | Public Health are looking to develop a project to help support young people at risk of self-harm. The project will aim to link in closely with local schools, GPs and other relevant agencies (including in relation CAMHS and Young Healthy Minds). It is likely that the project will focus on supporting individual young people on a one-to-one basis. There may also be scope to work therapeutically with small groups of young people where this issue has been identified. |

| | | |
|---|---|---|
| | | Public Health Commissioned programmes target interventions so to reduce health inequalities. For example by places services in more deprived wards. |
| **2.4** | A reduction in the proportion of adults with excess weight | Fresh Start is delivered by the local pharmacy advisor and involves a weekly appointment to discuss a personal weight loss plan. The programme includes advice and support on healthy eating, recipes and meal ideas and beating the cravings.<br><br>In addition KCC PH team also commission the Health Trainer programme which offers free, confidential one-to-one support, to help patients make positive lifestyle changes. The programme is active in the most deprived areas of Kent to reduce health inequalities. Up to six free sessions are offered to support, encouragement and practical assistance in local venues. Health Trainers work with individuals to establish what changes the person wishes to make, to develop a personalised behaviour change plan and to provide support and encouragement to enable them to achieve their goals.<br><br>Issues that can be helped you with include: - accessing local services - physical activity - healthy eating - healthy weight - stopping smoking - alcohol/drugs concerns - reducing stress - sexual health concerns<br><br>KCC Public Health currently commissions a Tier 3 service which can be accessed via the GP. 4healthyweight provides a multi-disciplinary team that is the gateway into Bariatric surgery for those who need it and a step down support service for patients post operatively This is delivered by the Bariatric Consultancy in Canterbury. |
| **2.5** | An increase in the number of people quitting smoking via smoking cessation services | KCHT offer smoking cessation services in Kent to help those looking to quit.<br><br>This is an important measure to support the 4 week quit indicator, but there are additional measures that we should include to reduce the take up of smoking under a preventative approach and harm reduction initiatives. Eg: |

| | | |
|---|---|---|
| | | • Promote smoke-free acute and mental health hospitals (NICE PH48))<br>• Support Smoke-free legislation (through standardised packaging of tobacco products and smoke free work vehicles etc.)<br>• Support smokers to cut down to quit where they are not yet ready to quit abruptly (PH45)<br>• Support educational approaches to reducing the risk of young people taking up smoking (through schools, youth settings etc) **(note: national target to reduce smoking prevalence of 15yr olds to 12% by 2015)**<br>There are also other potential indicators for smoking cessation services to record quit smoking rates at 12 weeks and for quits to be CO verified (rather than self reported).<br><br>Another emerging issue is to support of people with learning disabilities and mental health issues to quit smoking or reduce their levels of smoking.<br><br>Explicitly targeting take of stop smoking services and reducing smoking prevalence from routine and manual workers and areas of deprivation . |
| **2.6** | An increase in the proportion of people receiving NHS Health Checks of the target number to be invited | Increase outreach opportunities for those not accessing checks at GP practice.<br><br>Increase awareness about the NHS Health Check across Kent through targeted marketing. |
| **2.7** | A reduction in alcohol related admissions to hospital | Will be addressed via the Kent Alcohol strategy 2014-16. Each HWB area is requested to develop a local alcohol action plan to implement the Kent Alcohol Strategy 2014-16. |
| **2.8** | (Breast Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous years on 31st March | The breast screening units send out regular reports to GP practices regarding screening uptake during the practice's screening round in order to make practices aware of who is attending or not, and to encourage informed choice and uptake. We are currently starting a piece of what to understand how practices use that information and identify how best to use it going forward. |

| | | |
|---|---|---|
| **2.9** | (Cervical Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous 3 years on 31st March | The breast screening units will start to send the Screening and Immunisation Team uptake data on each round so that in advance vans going to particular areas (especially those with low uptake historically), we can support and encourage practices to make use of promotional material to reach their eligible population. |
| **2.10** | A reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000) | KCHT offer smoking cessation services to those looking to quit.<br><br>PH strategy to prevent young people from taking up smoking and also to increase the number of smokers quitting. Targeting areas of deprivation and routine and manual workers, people with mental health and learning disabilities.<br><br>There are also specific indicators on mortality due to lung cancer which could be included (PHOF 51).<br>Also could include PHOF 29: smoking related deaths (all ages) and COPD prevalence |
| **2.11** | A reduction in the under-75 mortality rate from cancer (rate per 100,000) | Ashford, Canterbury and Coastal, South Kent Coast and Thanet Clinical Commissioning Groups and East Kent Hospitals University NHS Foundation Trust have developed a Cancer Recovery Plan to improve cancer care and reduce under 75 mortality from cancer. |
| **2.12** | A reduction in the under-75 mortality rate from respiratory disease (rate per 100,000) | **CCG/ Adult Social Care - KCC** |
| **Outcome 3** | **The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.** | |

| | | |
|---|---|---|
| **3.1** | An increase in clients with community based services who receive a personal budget and/or direct budget | CCG/ **Adult Social Care - KCC** |
| **3.2** | An increase in the number of people using telecare and telehealth technology | This work has formed part of the Integrated Pioneer Programme and the Technology Enabled Care Services (TECS) agenda.<br><br>The work has been concentrated on those individuals with complex co-morbibities under matrons caseload. And we have seen a significant increase in the use of Telehealth and Telecare across Kent. Current users for telehealth are approximately 500 at any one time and Telecare is currently being used by about 5,000 users.<br><br>TECS is an identified work stream on the Pioneer Programme and we have a paper out for consultation regarding how the future TECS offer within Kent will look. |
| **3.3** | An increase in the proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services | CCG/ **Adult Social Care - KCC** |
| **3.4** | A reduction in admissions to permanent residential care for older people | KCC |
| **3.5** | An increase in the percentage of | KCC has recently completed a pilot for people with a learning disability in order |

| | | |
|---|---|---|
| | adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female) | to ensure that they are able to live in their own homes for longer and also to ensure that they can become more independent. The final report is encouraging about the potential for the use of telecare for people with a learning disability and an implementation plan is being developed to ensure that the recommendations are acted on.<br><br>The Pathways to Independence Project looks at enabling people with a learning disability to achieve increasing independence in their daily lives from creating confidence to enable people to travel independently to take part in voluntary work. This enablement projects aims to boost independence with the impact of enabling people with a learning disability to engage with their community and to stay at home for longer.<br>Case studies can be found on KNeT on: http://knet/ourcouncil/Pages/SC-pathways-to-independence-case-studies.aspx. |
| **3.6** | An increase in the percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support. (Persons/Male/Female) | % of people in settled accommodation (NI149) which KMPT have to report on as part of their dashboard the target is. |
| **3.7** | A reduction in the gap in the employment rate between those with a learning disability and the overall employment rate | The Pathways to Independence address this issue. In addition to this there is a lot of work that goes on through the Kent Learning Disability Partnership about employment. Through the 'What I Do Group', the Learning Disability Partnership has engaged with Kent Supported Employment who regularly attend meetings and provide information and advice to people with learning disabilities. |

| | | |
|---|---|---|
| | | The Department of Work and Pensions has a member of staff who attends meetings of the Partnership Board. The What I Do Group has created a training DVD for Job Centre Plus staff which trains the staff in how to meet the needs of people with learning disabilities through longer appointments, having meetings in meeting rooms, being ready to help people with learning disabilities use the computers etc. |
| **3.8** | An increase in the early diagnosis of diabetes. | CCG |
| **3.9** | A reduction in the number of hip fractures for people aged 65 and over (rate per 100,000). | Ashford and Canterbury CCG are working collaboratively in addressing falls amongst older adults aged 65 and over. Based on the Falls Framework which was agreed by the Kent Health and Wellbeing Board, a task and finish group has been set up as a cross organisational group to develop an effective pro-active and re-active falls pathway across the localities of Ashford and Canterbury and Coastal.<br>The group's aim is to implement recommendations in line with the Better Care Fund, development of the Community Networks and the Integrated Urgent Care Centre (IUCC) and the Over 75 CQUIN, over 2014/15:<br><br>The outcomes expected to be achieved is to reduce the rates of injury as a result of a fall in the over 65's by:<br>i) Early identification of those likely to have a fall (e.g. medication reviews, housing issues)<br>ii) Engaging with the community postural stability classes for continued care through therapeutic exercise classes to help reduce the likelihood of another fall. |
| **Outcome 4** | **People with mental ill health issues are supported to 'live well'** | |
| **4.1** | An increased crisis response of | CCG |

| | | |
|---|---|---|
| | A&E liaison within 2 hours – urgent | |
| **4.2** | An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours | CCG |
| **4.3** | An increase in access to IAPT services | CCGs are responsible for commissioning IAPT services and will be able to report on progress against national targets. HWBB partners can assist by letting the public and clients know that the services can be accessed directly or via their GP. For further information on how to access IAPT NHS funded talking therapies in primary care go to www.liveitwell.org.uk.<br><br>KCC Public Health is promoting well-being in the general population through a mental wellbeing investment programme. This is themed around the ways to well-being and includes a wide range of interventions to help people well and increased access to IAPT services.) |
| **4.4** | An increase in the number of adults receiving treatment for alcohol misuse | Promoting well-being in the general population (eg IAPTS & Six ways to well-being)<br><br>Will be addressed via the Kent Alcohol strategy 2014-16. National measures: Kent sits in top quarter for achieving successful / completed treatment outcomes for alcohol treatment.<br><br>Kent Drugs and Alcohol Team commissions services to support those with alcohol misuse |
| **4.5** | An increase in the number of adults receiving treatment for drug misuse | Will be addressed via the Target schedule (contract) based on successful completions<br><br>Kent Drugs and Alcohol Team commissions services to support those with |

| | | |
|---|---|---|
| | | drug misuse |
| **4.6** | A reduction in the number of people entering prison with substance dependence issues who are previously not known to community treatment | Nationally, this can't be measured and community data capture system is not aligned. New national measures have just been announced which is treatments completed. Local work is progressing to implement this new measure via a system to track referrals from community treatment to prisons and vice versa. |
| **4.7** | An increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment | Promoting well-being in the general population (eg IAPTS & Six ways to well-being)<br><br>Reducing the availability and lethality of suicide methods (eg Working with Network Rail re safety measures on the railway)<br><br>The system was recently revised to a Recovery Treatment focus system which is very successful. National measures: Kent sits in top quarter for achieving successful / completed treatment outcomes for drug treatment. A working group is being established to address low service uptake for this cohort and alternative models are being scoped for those with addiction to prescription only medications and OTC. |
| **4.8** | An increased employment rate among people with mental illness/those in contact with secondary mental health services | This is a key target in the 'Live it Well Mental Health 'strategy for Kent. KCC and CCG are going out to consultation to decipher whether the strategy is fit for purpose and meets all priorities.<br><br>There are a range of services for those with a Mental Health Diagnosis which are funded by KCC. Some of these aim to increase employment rates in this group. Visioning work is currently taking place to re-shape these services into a core mental health offer. |

| | | |
|---|---|---|
| **4.9** | A reduction in the number of suicides (rate per 100,000) | Public Health are working with KMPT to reduce the risk of suicide in high risk groups by putting measures in place to support middle aged and older men<br><br>Promoting wellbeing in the general population (eg IAPTS & Six ways to well-being)<br><br>Reducing the availability and lethality of suicide methods (eg Working with Network Rail re safety measures on the railway)<br><br>Improving the reporting of suicide in the media<br><br>Monitoring suicide statistics regularly |
| **4.10** | An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey | KCC-social care |
| **4.11** | An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey | KCC-social care |
| **4.12** | An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile. | KCC-social care |

| | | |
|---|---|---|
| **Outcome 5** | **People with dementia are assessed and treated earlier and are supported to live well.** | |
| **5.1** | An increase in the reported number of patients with Dementia on GP registers as a percentage of estimated prevalence | CCG |
| **5.2** | A reduction in the rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000 | CCG |
| **5.3** | A reduction in the rate of admissions to hospital for patients older than 74 years old with a secondary diagnosis of dementia, rate per 1000 | CCG |
| **5.4** | A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000 | CCG |
| **5.5** | A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000 | CCG |

| | | |
|---|---|---|
| **5.6** | An increase in the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who<br>a. have been identified as potentially having dementia<br>b. who have been identified as potentially having dementia, who are appropriately assessed<br>c. who have been identified as potentially having dementia, who are appropriately assessed, referred on to specialist services in England (by trust) | CCG |
| **5.7** | A reduction in the proportion of people waiting to access Memory Services - waiting time to assessment with MAS. | CCG |
| **5.8** | An increase in the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months | CCG |
| **5.9** | A reduction in care home placements | CCG |

This page is intentionally left blank

**Note from the Dartford, Gravesham and Swanley Health and Wellbeing Board on progress against actions from the Kent Board in relation to the Health and Wellbeing Strategy**

1) *Have you carried out any public engagement activity on the Joint HWB Strategy or any public engagement undertaken that reflects the priorities and outcomes of the Strategy*

   DGS CCG - have attended CVS meetings, PLG, CCG Network, Voluntary Services workshop, etc to discuss our priorities reflected in our Commissioning plans and have a further meeting on 6 November, Better care Together event, to go through in more detail key priorities that reflect outcomes 2,3,4 and 5. There is also an additional meeting on 18 November with stakeholders to discuss the Urgent Care model review.

   DBC – have produced promotional materials to highlight the Strategy at the Dartford Youth Forum on 24 October, the Elders Forum on 27 October and the Better Together Event on 6 November.

   GBC – No specific promotion other than at the Better Together Event on 6 November (as above).

   SDC (Swanley) – Nothing specifically on the Strategy but we have sent the consultation document to the members of the Health Action Team and the voluntary sector. The Strategy was also discussed at last week's Health Action Team meeting.

2) *How you have, or intend to ensure, that the priorities and outcomes of the Joint HWB Strategy are reflected in your own local plans and strategies or how you plan to implement them through your own organisations.*

   DGS CCG - see attached our 2 year plan on the page that identifies how the Joint HWBS priorities are reflected in both our 5 year and 2 year Commissioning Plan.

   DBC – The Council's Corporate Plan recognises that health and wellbeing are impacted by the whole range of Council's activities. The Health and Wellbeing theme therein (attached) sets out the strategic aspirations and intentions focussed on improving residents' health and wellbeing and the Council's response to Mind the Gap contains specific objectives and local targets.

   GBC - The Council's Corporate Plan (currently being revised) recognises the importance of health and wellbeing. The Council's Mind the Gap action plan works towards specific objectives and local targets and the Council uses the 'Six Ways to Wellbeing' to underpin this work.

   SDC (Swanley) - The priorities within the Strategy are highlighted within the Sevenoaks District Community Plan and priorities for health were included as

part of the public consultations carried out earlier this year for our new three year Community Plan. As part of this work, actions are delivered and monitored by partners quarterly to deliver against the priorities identified at a Kent and District level and based on the needs of Sevenoaks residents in relation to health inequalities. The identified priorities within the Strategy also form the basis on the Sevenoaks District 'Mind the Gap' Health Inequalities Action Plan. The Plan is monitored quarterly with outcomes and achievements reported to the Health Action Team at each quarterly meeting.

# DARTFORD BOROUGH COUNCIL
# CORPORATE PLAN 2013 - 2016

The Corporate Plan sets out Dartford Borough Council's overall vision for the area, which is:

## To make Dartford "the place of quality and choice, a place where people choose to live, work and enjoy their leisure time".

The Corporate Plan delivers this vision through the following five themes;

- Economic Development and Regeneration
- Health and Well Being
- Safer Communities
- Environment and Sustainability
- Housing and Stronger Communities

In addition the Plan includes a theme relating to the Council itself:

- A Council Performing Strongly

Under each of these themes are a set of strategic aims and objectives, which state what the Council wants to achieve. Under the aims and objectives are a series of statements setting out what the Council intends to do to meet the aims and objectives. This will either be by itself or in partnership with others. The statements will be linked, where possible, to a relevant service area, and to partner plans.

The Corporate Plan is closely linked to the policies and targets as set out in the Local Development Framework Core Strategy Submission. It will also link to the three ambitions as set out in the refreshed Vision for Kent. Since the Corporate Plan was last updated the Country has faced a global banking crisis and one of the deepest recessions since the Second World War. This has led to a slow down on key regeneration projects such as Eastern Quarry and Ebbsfleet Valley. Despite this the Council remains committed to the aspirations set out in the plan, although it recognises that timescales may change as might the bodies responsible for delivery.

## HEALTH AND WELL BEING

**STRATEGIC AIM: TO REDUCE OVERALL HEALTH INEQUALITY IN DARTFORD AND TO PROVIDE FOR A RICH AND VARIED QUALITY OF LIFE**

**STRATEGIC OBJECTIVES:**

**HW 1.** Increase the opportunities for participating in sporting, cultural and leisure activities.

**HW 2.** Reduce overall health inequalities in the Borough.

**THE COUNCIL PROPOSES TO:**

1. Recognise that all of its activities contribute towards improved health in the Borough, whether through improved housing, lower crime rates, increasing employment opportunities, ensuring food safety and the provision of a high quality local environment.

2. Work with partners to implement consents for sports, recreation and cultural facilities in Eastern Quarry, Ebbsfleet and Bluewater and work with developers and partners to provide sports and cultural facilities on or around major developments which meet the needs of the wider community.

3. Seek to improve the leisure and recreational facilities in Dartford.

4. Facilitate the creation of approximately 300 hectares of new or improved green space as part of new developments by 2026.

5. Encourage residents to become involved with local sport and leisure activities, through sports clubs and volunteering schemes such as those found in Hesketh Park, Dartford Heath and the Dartford Health Walk Scheme.

6. Work with a wide range of partners, including the Dartford, Gravesham and Swanley Clinical Commissioning Group and Kent County Council, to provide residents with information and programmes which help them to make healthy choices leading to improved health outcomes in the Borough.

# NHS DGS CCG VISION & PRIORITIES (2014 – 2019)

| Goals | | | | |
|---|---|---|---|---|
| Focus on right care, right time, right place and right outcomes | Prioritising patients with greatest health needs & ensuring clinical evidence behind every decision | Maintain and Improve Quality | Provide strong clinical leadership across health &Social Care | Deliver a sustainable Health & Social Care System |

## Top Priorities

| Op plan year 1 - QIPP | Op plan year 2 – QIPP | Op plan year 3/5 – QIPP DELIVERY £10.5M |
|---|---|---|
| Integrated Primary Care Teams with GP practices supporting proactive management of vulnerable patients | Procure and Implement integrated community model | Primary Care Strategy implementation |
| Integrated Discharge Team with DVH, KCHT, KCC and KMPT | Full implementation integrated discharge/ rapid response Team | Full Implementation of integrated community service model |
| Single Point of access and integrated rapid response service | Children's Community Nursing Model implementation | Review further clinical pathways and implement improved models of care- |
| Community Ophthalmology service procurement | Implement community Ophthalmology service | Implementation of new Urgent Care Centre 24/7 service (OOH/Walk in Centre/ MIU / NHS 111 service) |
| Clinical pathways reviews – paeds / T&O / repatriation | Urgent Care Centre (Out of Hours / Walk in Centre/ MIU, NHS 111) procurement | Implement all age autism / ASD pathways with KCC |

## Priority Initiatives

- (Yrs 1 & 2) Continuation of targeted preventative screening prioritising of CVD, cancer COPD and Obesity
- (Yrs 1 & 2) Integrated discharge Team inc. Elderly care direct access / Rapid response redesign with acute clinician support Community Services re-commissioned
- (yr1) Increase in Dementia nurses supporting patients in the community
- (Yr 2) Integrated community children's service
- Yr 1 Integrated Primary Care Teams with GP practices
- (Yr1&2) Integrated Health and Social care Single Point of Access
- (Yr 1) Mental Health – Urgent Care re-design / single point of access
- (Yr2) Community Ophthalmology service re-commissioned
- (Yr 1) Mental Health Primary MH Workers supporting patients
- (Yrs 1 & 2) CAMHs / YHM – single point of Access & CAF co-ordination
- (Yr2) End of Life Care /care Homes improved care
- (Yrs 1 & 2) Re-design & commission a Neuro-developmental all age pathway
- (Yr2) Pulmonary Rehab model procured
- (Yr 1) Clinical Pathway Review – paeds / T&O / re-patriation
- (Yr2) clinically agreed priorities
- (Yrs1& 2 OOH / Walk in Centre / MIU service re-commissioned
- (Yr1) Primary Care Strategy development
- (Yrs1& 2) Delivery of Medicines Optimisation strategy'

Whole System Transformational
Service Improvement
On-going Commissioning
Enablers

- Health & Wellness - Primary Prevention and partnership working with Local Council Authorities in the HWBB and Public Health
- Health & Wellness – Increasing Independence (self-care and carers)
- Quality Improvements in all services including prescribing quality reviews with GP practices
- Commissioning Innovation – use of technology to support sharing of clinical information to support patients care

# Dartford, Gravesham and Swanley CCG Plan on a Page (2014 to 2019) TOP PRIORITIES

Our **Vision** is of primary, community, mental health and acute care services working seamlessly together , with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities and ensure a sustainable care economy.

## Clinical Outcomes to be achieved

- •Rapid & appropriate investigation
- •Care in the most appropriate setting e.g. treating people at home or reducing stay in hospital
- •Improved safety & communication through patient records sharing
- * Proactive care planning (through co-ordinated multi-disciplinary care with social &MH needs)
- * Preventative care supporting patients to self manage their care

**Objective One:**
To reduce emergency admissions by 23.3% over 5 years

**Objective Two:**
To reduce the number of patients on the medically stable list to less than 30

**Objective Three:**
Increase the number of patients supported in the community by health and social care teams

**Objective Four:**
Increase the number of patients whose clinical records are available to all providers

**Objective Five:**
Increase the number of patients supported to maintain their independence (measured via Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /Rehabilitation services.)

**Objective six:**
90% of patients with dementia to have a multidisciplinary care plan

**A streamlined common approach to advice and information on community and public sector services.**

*This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the case;

*Providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised.

**Coordinated and intelligence-led early identification and early intervention.**

*Implementing community record and information sharing between the range of organisations supporting individuals at risk of requiring more support in the future.

*Ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved.

**An improved approach to crisis management and recovery.**

*Supporting rapid escalation and action when a crisis occurs in the life of an older person;

*A coordinated response from all agencies working in multi-disciplinary teams, 7 days a week, to provide intensive support in the short term and encompassing services such as respite care and supportive discharge planning.

*Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.

**Integrated Primary Care Teams**

*including acute physicians, community nursing and therapy, mental health and social care, resulting in non-elective admission reductions, care home and mental health placement reductions and ensuring patients with complex needs are managed in a “whole person” way.

*The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality and outcomes

*A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs.

*Tele-care and telemedicine will be more effectively used to support patients to be independent and they will be actively utilised in care homes with support to enable patients to be managed when in acute crisis.

*The core team would have strong working links with community support services using third sector providers such as the voluntary sector and District Councils to ensure full packages of care are provided to meet the needs of the patient, carers and the wider community.

**Governance arrangements:**

*Clear programme management plans managed by Local Programme Delivery Groups accountable to:

*Multiagency Executive Programme Board and CCG Board and Committee Structure & Supported by the DGS and Kent Health and Wellbeing Boards.

**Measured using the following success criteria**:

* By analysis of demand for acute health services (such as emergency bed days) and formal social care services (such as a paid agency carer supporting someone at home, or someone moving into residential or nursing care home),

* We will build on the Outcomes Framework which has been developed to support the CCG. This has a major focus on patient and carer experience, and triangulating data from several sources to measure outcomes.

## Values and Principles:

* Keep people at the heart of everything we do, ensuring they are involved and listened to in the development of our plans
* Maximise independence by providing more integrated support at home and in the community and by empowering people to manage their own health and well-being
* Ensure the health and social care system works better for people, providing seamless, integrated care for patients, particularly those with complex needs
* Safeguard vital services, prioritising people with the greatest health needs and ensuring that there is clinical evidence behind every decision.
* Get the best possible outcomes within the resources we have available;

**Report to:** Kent Health and Wellbeing Board (KHWBB)

**From:** South Kent Coast Health and Wellbeing Board (SKCHWBB)

**Date:** 19 November 2014

**Purpose:** On the 16th July 2014 the KHWBB made the following recommendations –

- Encourage local boards to consider how they could engage with the KFRS, especially in relation to falls and dementia.
- The Joint HWBS should be used to engage with the public at a local level in order to stimulate discussion and understanding as integration gathers pace and services are moved out of hospitals and into the community. Local HWBBs charged with ensuring the strategy is reflected in all public engagement activities planned by partner organisations and meaningful engagement on the issues involved is undertaken.
- Local HWBBs ensure local plans demonstrate how the priorities, approaches and outcomes of the Kent JHWBS will be implemented at local levels.

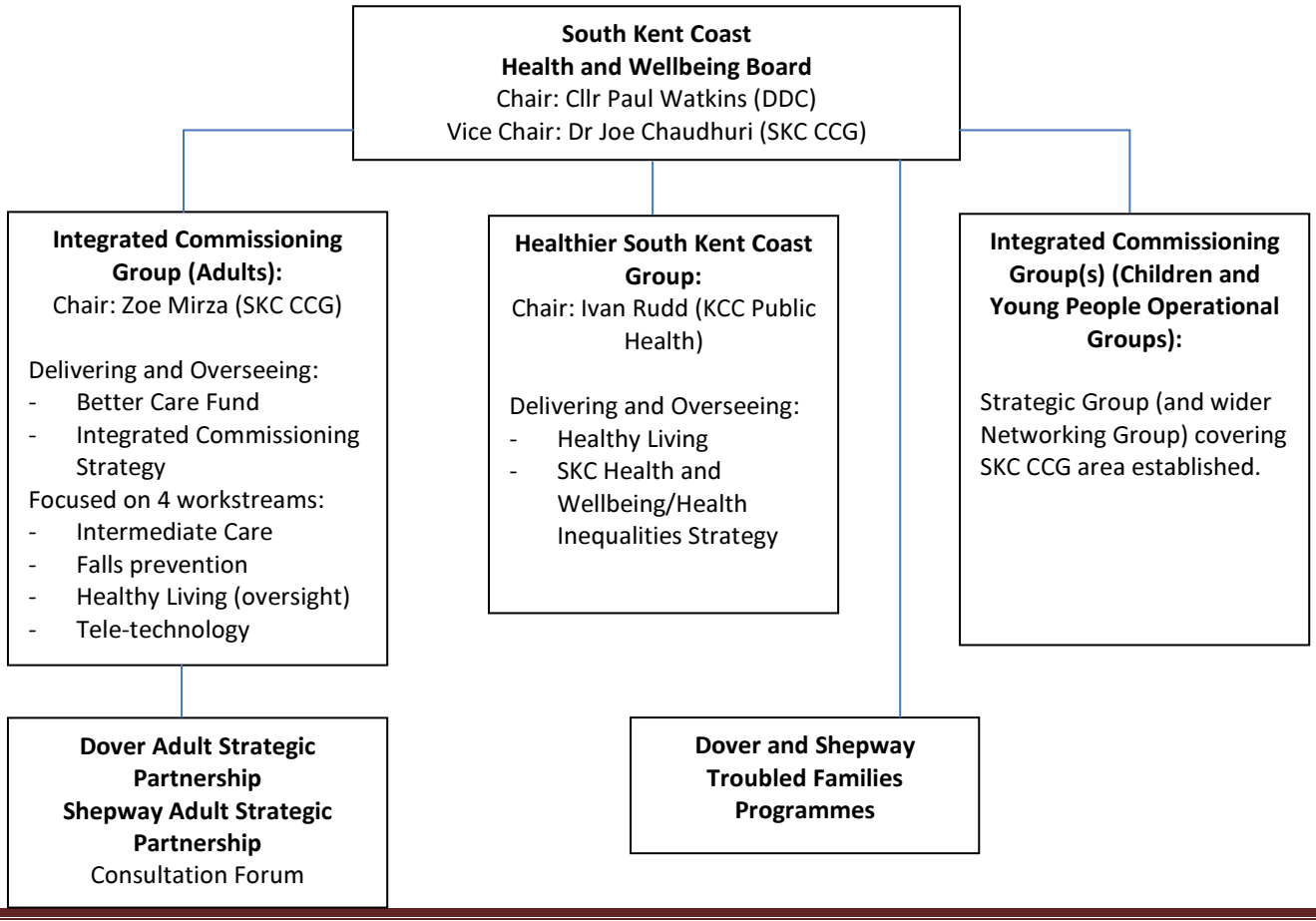
---

**Summary:**

**SKC HWBB, as part of the on-going work programme has localised the Joint Strategic Needs Assessment and the Kent Joint Health and Wellbeing Strategy in order to focus and prioritise the needs of the local population. The paper below highlights the work and provides assurance as to how this relates to the wider Kent picture.**

**Through the integration work there are many opportunities to go further and faster in addressing the local issues, however there are also opportunities around the role of Local HWBBs, including decisions and funding, that require further discussion in order for local integration to achieve its fullest impact.**

**South Kent Coast Health and Wellbeing arrangements:**



**Work Plan:**

The SKC HWBB recently agreed to move to Operational and Strategic meetings – at the former there will continue to be updates, consultations and discussions on strategic projects/matters. The operational meetings are intended for the Board to take a health and wellbeing issue of the SKC area and focus on the topic in depth, resulting in actions for board members (either as a whole or as individual partners) to make a tangible difference to health and wellbeing outcomes. For these meetings additional agencies/partners may be invited to attend to ensure a full understanding of the topic being discussed. It was also agreed the resulting actions are transferred into the local HWB/Health Inequalities Strategy as key indicators (ensuring the Strategy is an evolving document) –monitored by the Healthier South Kent Coast Working Group and managed by the SKC HWBB.

| | **South Kent Coast HWBB** | |
|---|---|---|
| | **Strategic Meetings** | **Operational Meetings (Workshops)** |
| **Date:** | | |
| **Sept. 2014** | 16th<br>(to include trial of Alcohol Strategy as 'operational' item) | |
| **Oct. 2014** | | |
| **Nov. 2014** | | 25th<br>**Topic: Cardio Vascular Disease** (to include smoking and physical activity) |
| **Dec.2014** | | |
| **Jan. 2015** | 20th, to include:<br>• Way forward for Children's Group (s)<br>• HWB Strategy/HI Action Plan<br>• Update on Integrated Care Organisation | |
| **Feb. 2015** | | |
| **Mar. 2015** | | 31st<br>**Topic: Mental and Emotional Health and Wellbeing** |

Future SKC HWBB 'Operational' meeting topics (subject to dates being agreed): Children and Young People (to include Teenage Pregnancy and Children in Poverty), Over-75's summit, Housing and Accommodation, Obesity.

**Kent Fire and Rescue Services:**

A representative attends the Integrated Commissioning Group.

**Meeting the Kent Health and Wellbeing Strategy:**

SKC HWBB is committed to local improvements and action and, as demonstrated by the structure of groups and meetings, is developing and delivering against local priorities. In addition to those listed below there are a number of projects/initiatives aimed at incorporating the 'wider determinants' of health in improving residents health and wellbeing, such as; physical regeneration programmes in both Dover and Shepway Districts, partnerships with Job Centre Plus, apprenticeship schemes, housing and community development projects.

Overview of how the Kent JHWBS is being implemented locally:

| Kent Joint Health and Wellbeing Strategy | SKC HWBB focus and action |
|---|---|
| Outcome 1:<br>Every child has the best start in life | • Children's Commissioning/Operational Group being developed; following 2 large workshops a Strategic Group has been established based on the SKC CCG boundary - this work will build on 'The Way Ahead', Kent's draft Emotional Wellbeing Strategy.<br>• Calorie Map walks developed and publicised (Healthier South Kent Coast Group)<br>• Breastfeeding Friendly Areas (HSKC Group)<br>• Access and availability of services to Children's mental health support (SKC HWBB discussions)<br>• KCFN Teenage Pregnancy Awareness and Education programme (sponsored by SKC HWBB)<br>• Children and Young People HWBB Workshop (to be developed as part of SKC HWBB work programme) |
| Outcome 2:<br>Effective prevention of ill health by people taking greater responsibility for their health and wellbeing | • Development of SKC Health and Wellbeing/Health Inequalities Strategy and Action Plan<br>• SKC HWBB Alcohol workshop held and local actions being drafted (HSKC Group)<br>• SKC HWBB workshops planned to develop joint actions on Cardio Vascular Disease, Obesity, Housing and Accommodation<br>• Calorie Map walks developed and publicised (Healthier South Kent Coast Group)<br>• Extension of Healthy Living Pharmacies (sponsored by SKC HWBB)<br>• A Shepway District Task and Finish Group has been established, initially looking at alcohol and maintaining health and tenancies<br>• Proposal being worked up to work jointly on Folkestone Central<br>• Proposal being worked up to 'deep dive' poorest wards in Dover<br>• Exploring increasing Health Checks and increasing access to talking therapies (HSKC) |
| Outcome 3:<br>The quality of life for people with long term conditions is enhanced and they have access to good quality care and support | • Delivery of Better Care Fund Plan key project areas, monitored through the Integrated Commissioning Group:<br>  ○ Integrated teams and reablement<br>  ○ Enhanced Neighbourhood care teams<br>  ○ Enhanced Primary Care services<br>  ○ Enhanced support to care homes<br>  ○ Integrated health and social housing approaches<br>  ○ Falls prevention<br>• Prime Ministers Challenge Fund work in Shepway – to be rolled out into Dover |
| Outcome 4:<br>People with mental health issues are supported to 'live well' | • Primary Care Link Workers<br>• Community Link Workers<br>• Targeted community development : currently target wards in Folkestone are those that form the 'East Folkestone Together' wards. In Dover, Folkestone Rd (Maxton Elms Vale and Priory) to support the Roma community and St Radigunds.<br>• An 'Asset Mapping' pilot has been undertaken in key local areas to understand local resources and how best to use them, results are expected shortly.<br>• SKC HWBB workshops planned to develop joint actions on Mental and Emotional Health and Wellbeing is planned in early 2015 |

| | |
|---|---|
| Outcome 5:<br>People with dementia are assessed and treated earlier and supported to 'live well' | • SKC HWBB supported 'Dementia Friendly Communities'<br>• A number of partners at the SKC HWBB have signed up to the Dementia Alliance<br>• New dementia pathway to improve diagnosis rates |

The Local HWBB has developed (in draft) a local Health and Wellbeing/Health Inequalities Strategy and agreed the following objectives, principles and priorities in support of the overarching Kent wide HWBS. Outcomes and actions are in development, however the document will be linked to the workshop format of the local Board meetings and updated with actions as agreed and required:

**Crosscutting objectives:**

- Tackling health inequalities
- Mental Wellbeing

**Overarching principles:**

- Equality and Equity of access
- 'Going the extra mile', with the right service, in the right place, at the right time
- Ensuring key services are provided for all residents, but that extra resources and interventions are targeted on those most in need
- Preventing and tackling the wider causes of ill health, poor lifestyle choices and health conditions
- Supporting people to take personal responsibility and make good lifestyle choices.

**Strategic Priorities**

- Tackling Inequalities by improving health outcomes and ensuring the whole population of South Kent Coast has the best health possible.
- Improving the outcomes and treatment of people with Long Term Health Conditions
- Improving the access and quality of treatment in urgent care
- Improving the Mental Health and Well Being of the population of South Kent Coast
- Empower Children and Families to lead healthier and safer lives to achieve their full potential

**Communication and Engagement:**

The public engagement undertaken by the SKC CGG in relation to 5 year strategies and operational commissioning plans incorporates the key outcomes and the District Council has held themed Neighbourhood forums, focusing on health and local services, including information on the Better Care Fund and the move for access to services in the community and out of hospitals. Consultations on changes to local services include having the 'right service in the right place at the right time', however as a local HWBB we are working to engage more proactively around our joint plans, with a draft Communication and Engagement Plan for SKC HWBB being developed.

We continue to support each other with joint circulation of press releases and a HWBB electronic 'sign up' newsletter is also being explored.

From: Andrew Bowles, Chair Swale Health and Wellbeing Board

To: Kent Health and Wellbeing Board – 19 November 2014

Subject: **Progress Report from the Swale Health and Wellbeing Board**

Classification: Unrestricted

**Summary:**

This report provides an update on the progress made by the Swale Health and Wellbeing Board in promoting and delivering the Kent Joint Health and Wellbeing Strategy.

**Recommendations:**

The Health and Wellbeing Board is asked to note the contents of the report.

## 1. Introduction

At the July meeting of the Kent Health and Wellbeing Board, it was agreed that local Health and Wellbeing Boards would be instructed to promote the Kent Joint Health and Wellbeing Strategy and to develop local actions plans to implement the Strategy at the local level.

This report provides a brief update on progress made by the Swale Health and Wellbeing Board on these two issues.

## 2. Communication and engagement

Swale Health and Wellbeing Board as a Board has not itself undertaken any public engagement events around the Joint Strategy. However, individual member organisations of the Board have carried out engagement or communication, either directly about the Strategy, or indirectly about the priorities and outcomes identified in the Strategy. This includes:

(i) Swale Clinical Commissioning Group have attended CVS meetings, PLG, CCG Network, and Voluntary Services workshop to discuss their priorities as reflected in their Commissioning Plans, and have a further event on 5 November, "Better care Together", to go through in more detail key priorities that reflect outcomes 2, 3, 4 and 5 in the Strategy. There is also an additional meeting on 18 November with stakeholders to discuss the Urgent Care model review;

(ii) Swale Borough Council has placed information about, and a link to, the Joint Health and Wellbeing Strategy on their website and on the Swale 'My Place' website, which is used by people in Swale in bid on social housing; and

(iii) Swale CVS have actively promoted the Stoptober initiative to encourage people to quit smoking. Swale CVS also actively promote health information across the Borough through the Swale Community Empowerment Network.

The Swale Health and Wellbeing Board will continue to monitor promotion of the Strategy by individual member organisations and other local partners.

## 3. Local implementation

The Swale Health and Wellbeing Board are in the process of agreeing local health and wellbeing priorities, based on the outcomes set out in the Joint Health and Wellbeing Strategy. Using the Swale local assurance framework for the Joint Strategic Needs Assessment (JSNA), the Board have identified keys areas where Swale is performing below the national and/or Kent average, such as smoking in pregnancy, which will inform its priorities for the next 12 months. The Board will discuss these in more detail at their next meeting on 19 November.

Following agreement of the Board, a local action plan will be developed to identify actions to deliver those priorities. Targets will be set using the JSNA monitoring data, as set out in the local assurance framework, where local level data is available.

Delivery of the action plan will be co-ordinated by the Swale Health Improvement Partnership, a sub-group of the Health and Wellbeing Board. The Partnership will establish single issue Task and Finish Groups to focus on particular priorities as appropriate.

Individual member organisations of the Board are also ensuring that they reflect the Joint Health and Wellbeing Strategy within their own individual strategies and plans. This includes:

(i) the Swale CCG vision and commissioning priorities, as set out in their two year and five year Commissioning Plans, are in line with the priorities and outcomes of the Joint Health and Wellbeing Strategy;

(ii) Swale Borough Council will ensure that it reflects the priorities and outcomes within the appropriate service level plans and strategies, such as housing and physical activity, as well as in its overall Corporate Plan;

(iii) Swale CVS are bidding for funding for projects to support the priorities and outcomes of the Strategy, including delivery of the Ways to Wellbeing Programme and identifying and addressing potential mental health issues with young children; and

(iv) Kent County Council will reflect the priorities and outcomes around learning disability within their health and social care targets, and will seek to deliver those outcomes by working in partnership with Kent Public Health and the Learning Disability Partnership Board.

The Swale Health and Wellbeing Board will monitor progress against its local action plan and targets on a quarterly basis.

Priorities may be refreshed after 12 months depending on the progress made.