HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th June, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 5th June, 2015, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Lizzy Adam**
Telephone: **03000 412775**

Tea/Coffee will be available from 9:45 am

Membership

Conservative (7):	Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, MBE, Mr N J D Chard, Mr A J King, MBE, Mr G Lymer and Mr C R Pearman
UKIP (2):	Mr A D Crowther and Mr J Elenor
Labour (3):	Mrs P Brivio, Dr M R Eddy and Ms A Harrison
Liberal Democrat (1):	Mr D S Daley
District/Borough Representatives (4):	Councillor M Peters, Councillor M Ring and two vacancies for East Kent

Webcasting Notice

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UNRESTRICTED ITEMS

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

Item — Timings*

1. Substitutes

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes (Pages 7 - 14)

4. Membership

(1) Following the Council's approval of the revised proportionality statement on 21 May 2015, it was agreed that the Labour group would gain a seat on the Health Overview and Scrutiny Committee at the expense of the UKIP group.

(2) Members of the Health Overview and Scrutiny Committee are asked to note that:

(a) Mrs Brivio (Labour) has replaced Mr Hoare (UKIP) as a member of the Committee.

(b) Cllr Peters (Dartford Borough Council) has replaced Cllr Davison (Sevenoaks District Council) as a West Kent borough representative on the Committee in 2015/16.

(c) Cllr Ring (Maidstone Borough Council) has replaced Cllr Burden (Gravesham Borough Council) as a West Kent borough representative on the Committee in 2015/16.

(3) At the time of publication confirmation was awaited of the two borough representatives from East Kent for 2015/16. The Scrutiny Research Officer will provide an update at the meeting.

5. North Kent: Adult Community Services (Pages 15 - 22) 10.05

6. Medway NHS Foundation Trust: Update (Pages 23 - 34) 10.45

7. East Kent Hospitals University Foundation Trust: Update (Pages 35 - 40) 11.30

a) EKHUFT Clinical Strategy (Pages 41 - 50)

b) EKHUFT Outpatient Services (Pages 51 - 56)

c) EKHUFT CQC Inspection (Pages 57 - 66)

8. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Pages 67 - 136) 12.15

9. Date of next programmed meeting – Friday 17 July 2015 at 10.00

Proposed items:

- East Kent: Community Services
- North Kent: Emergency and Urgent Care Review and Redesign (Long Term)
- South Kent Coast CCG and Thanet CCG: Integrated Care
- West Kent: Out of Hours Services Re-procurement
- NHS England: General Practice and the development of services
- Vascular and Stroke Services Review

- East Kent: Talking Therapy Services (Written Update)
- Faversham MIU (Written Update)
- SECAmb - Future of Emergency Operation Centres (Written Update)

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)

**Timings are approximate*

Peter Sass
Head of Democratic Services
(01622) 694002

28 May 2015

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

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KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 6 March 2015.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mr N J D Chard, Mr A D Crowther, Mr D S Daley, Dr M R Eddy, Ms A Harrison, Mr C P D Hoare, Mr G Lymer, Mr C R Pearman, Cllr P Beresford, Cllr R Davison, Cllr M Lyons, Mrs M E Crabtree (Substitute) (Substitute for Mrs A D Allen, MBE), Mr H Birkby (Substitute) (Substitute for Mr J Elenor) and Mr M J Northey (Substitute) (Substitute for Mr A J King, MBE)

ALSO PRESENT: Mr S Inett and Mr A H T Bowles

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer), Ms D Fitch (Democratic Services Manager (Council)) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

9. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

(1) Mr Nick Chard declared a Disclosable Pecuniary Interest as a Director of Engaging Kent.

(2) Cllr Michael Lyons declared an interest as a Governor of East Kent Hospitals University NHS Foundation Trust

10. Minutes
(Item 3)

(1) The Scrutiny Research Officer updated the Committee on the following actions which had been taken:

(a) Minute Number 4 - NHS South Kent Coast CCG and NHS Thanet CCG: Integrated Care. The CCG was asked to provide a written briefing on the retention of clinics at Deal Hospital. The paper was circulated to the local Member on 4 February 2015.

(2) RESOLVED that the Minutes of the meeting held on 30 January 2015 are correctly recorded and that they be signed by the Chairman.

11. CQC Inspection Report: Maidstone and Tunbridge Wells NHS Trust
(Item 4)

Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust), Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the Committee. Ms Bhatia began by explaining that the CQC inspection took place in October 2014. The CQC published the public reports on 2 February 2015 which included a summary report and separate inspection reports for Maidstone Hospital and Tunbridge Wells Hospital including stroke services at Tonbridge Cottage Hospital. A Quality Summit was held on 29 January 2015 to discuss the reports and the actions to be taken. A number of stakeholders attended including NHS West Kent CCG, Healthwatch Kent, NHS Trust Development Authority and Health Education England. The Trust's overall rating was Required Improvement which the Trust thought was a fair assessment.

(2) Ms Bhatia highlighted a number of areas which the CQC recognised as good practice including strong patient experience, good nursing levels and collaborative working. She stated that the Trust was really proud of the Good rating for caring throughout the organisation which showed that staff were caring and compassionate and treated patients with dignity and respect. The staff were praised by the CQC for using the process to help identify and drive improvements. A number of areas of outstanding practice were identified including the Maidstone Birth Centre, Maternity Services at Tunbridge Wells, dementia care and breast care services. She noted that the Maidstone Birth Centre service reconfiguration had been a very difficult process but since its implementation the Birth Centre had provided a very high standard of care for families and delivered good outcomes.

(3) Ms Bhatia reflected on the key areas for improvement at the Trust. A number of key organisation wide improvements were identified in the report: patient flow and capacity particularly in intensive care, record keeping and access to clinical guidelines, directorate leadership, clinical governance and inconsistency.

(4) A number of compliance actions (areas and services which required urgent improvements in specific areas) had been identified including the working patterns of consultants in critical care, the lack of washing facilities in Intensive Care for patients who were unable to be discharged onto other wards, translation services and the admission of surgical patients onto children's wards. Ms Bhatia stated that the Trust was developing a Quality Improvement Plan with stakeholders which would respond to all the 'must do' (compliance) actions and 'should do' actions identified by the CQC. The plan would be submitted to the CQC on 16 March. She reported that the Trust was working at pace to make changes but acknowledged that some areas such as governance and capacity would take longer to make changes.

(5) Mr Ayres stated that West Kent CCG thought that the Required Improvement rating was a fair representation of the Trust. A number of the issues had already been identified prior to the CQC inspection. He reported that the CCG were working closely with the Trust to develop the Quality Improvement Plan; all the actions were achievable and 90% would be completed within a year. He noted that the Trust had made huge progress over the last seven years

including tackling infection control and merging two hospitals into one PFI hospital. He was pleased that caring, staffing levels, maternity services and dementia care were identified as good and outstanding practice. Mr Inett reported that Healthwatch Kent had worked closely with the Trust to develop the Quality Improvement Plan; the Trust had been supportive and facilitative of Enter and View visits undertaken by Healthwatch.

(6) Members of the Committee then proceeded to ask a series of questions and make a number of comments. A Member enquired about concerns raised by some staff to CQC inspectors about the lack of an open culture and the sustainability of some services being run across both hospital sites. Ms Bhatia explained an unknown number of the Trust's nursing staff had raised concerns about the culture within the organisation. In the National Staff Survey, 66% of staff felt that they could raise concerns safely which was just under the national average of 67%. She noted that 68% of nursing staff within the Trust felt they could raise concerns safely which was one of the highest percentages in the Trust; the lowest percentage was amongst administrative and facilities staff. She reported that the Trust was embarking on a piece of work on culture and engagement with staff as part of the Quality Improvement Plan. The Trust had set up a patient safety think-tank and had implemented the Step up to Safety Campaign. She noted that all Trusts, following the Freedom to Speak Up Review, would be required to appoint independent whistleblowing guardians and have dedicated Executive and Non-Executive Directors for whistleblowing.

(7) Mr Ayres stated that services were constantly under review by the Trust and CCG. He highlighted the improved outcomes following the centralisation of cancer services at Maidstone Hospital and centralisation of stroke services in London. He noted that NHS England was undertaking a review of stroke services in Kent and Medway. A further question was asked about the sustainability of improvements. Dr Sigston stated that the Trust was reviewing the winter surge of activity and identifying sustainable improvements to utilise acute beds and community providers in future years. He noted that improvements become sustainable once they were embedded as normal practice. He stated the importance of communicating service changes to the public so that they understood the rationale behind the proposals. He reported that the Trust had been working with Healthwatch Kent to engage with the public about improvements to stroke services.

(8) A number of comments were made about translation services. Ms Bhatia explained that the current contract with the translation service provider required a translator to be physically sent to the hospital which took time and was expensive. She stated that the Trust was looking to procure a new telephone based translation service, as used by Trusts' in urban areas, which would be faster, provide access to more languages and be less costly. She noted that independent translators were required, rather than family members, to enable patients to give consent. Mr Ayres explained that translation services were provided for free as part of national policy. He stated that he would provide the cost of translation services to the Committee.

(9) In response to a specific question about the Maidstone Birth Centre, Dr Sigston explained that it was a midwife led centre which delivered over 500

babies a year. He noted that with the early identification of problems mothers were transferred to Pembury immediately. He stated that mothers' could choose where they wanted to give birth.

(10) A number of comments were made about critical care consultant contracts, out of hours GP services and whistleblowing. Dr Sigston explained that the outcomes for critical care patients were good. He stated that consultants' contracts had no bearing on working patterns. He noted that the CCG was looking to locate out of hours GP services in close proximity to the A&E to enable collaboration on the same site. He noted that senior management encouraged and welcomed whistleblowing as it provided an opportunity to make improvements. He stated that staff had access to their personnel files under the Data Protection Act.

(11) A Member enquired about morale. Ms Bhatia stated that the Trust's Executive had spent a lot of time, following the publication of the CQC inspection reports, speaking to staff including open forums with the Trust's Chief Executive, Glenn Douglas. She stated that staff felt that it was a fair reflection of the organisation but were disappointed that the Trust had not done better. The staff had had a difficult couple of months due to an extremely busy winter but morale was good at the moment. Mr Ayres stated expressed his support for the Trust and recorded the CCG's thanks to the Trust and its staff for their committed work.

(12) RESOLVED that:

(a) the Committee sends it thanks and appreciation to the hardworking staff of Maidstone and Tunbridge Wells NHS Trust

(b) the report be noted and the Maidstone and Tunbridge Wells NHS Trust be invited to attend a meeting of the Committee in six months to give an update on their Quality Improvement Plan.

12. Maidstone and Tunbridge Wells NHS Trust: Clinical Strategy and Stroke Services

(Item 5)

Avey Bhatia (Chief Nurse, Maidstone and Tunbridge Wells NHS Trust), Dr Paul Sigston (Medical Director, Maidstone and Tunbridge Wells NHS Trust) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) Dr Sigston began by explaining that a number of strategic clinical opportunities had been identified as part of the refreshed clinical strategy including aligning out of hours GP services with A&E; the aspiration to run the Crowborough Birthing Centre; recruiting a paediatric A&E consultant at Tunbridge Wells Hospital; expanding orthopaedic paediatrics; increasing the number of critical care consultants and expanding pain services to meet the demand of increased GP referrals. He noted that the Trust would not be reinstating upper gastrointestinal cancer surgery; NHS England would decide how this type of surgery would be provided in the future.

(2) Dr Sigston stated that stroke services had improved at both hospital sites. He noted that there was a national shortage of stroke consultants due to the radical changes to stroke care over the last ten years. He stressed the importance of patients understanding the rationale for changes to stroke services. He noted that NHS England was undertaking a review of stroke services in Kent and Medway which could affect the Trust's Stroke Improvement Programme.

(3) Mr Inett explained that Healthwatch Kent had been working with the Trust to engage with the public about the Trust's Stroke Improvement Programme. Healthwatch Kent was holding a number of events with members of the public.

(4) A Member enquired about the adjustment of the Maidstone score from B to D rating. Dr Sigston explained that the Trust was providing better care than the figures suggested; the overall rating was downgraded as a result of an audit compliance issue. He stated that the Trust had action plans to improve services at both sites. He noted that the rating was awarded by the Sentinel Stroke National Audit Programme (SSNAP) which audits stroke services nationally.

(5) In response to a specific question about Operation Stack, Mr Ayres explained that commissioners and providers in Kent and Medway worked very closely to enable emergency vehicles to have priority on the roads during the period of its operation. He stated that in West Kent there had been no serious incidents as a result of Operation Stack.

(6) RESOLVED that there be ongoing engagement with HOSC as Maidstone and Tunbridge Wells NHS Trust's five year clinical strategy and strategy for stroke is developed.

13. Patient Transport Services

(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG) was in attendance for this item.

(1) Mr Ayres began by giving an update on the actions taken to re-procure Patient Transport Services in advance of the current contract's expiry in June 2016. He stated that the new service specification would not change the service provided to patients; it would place new requirements on the provider of the service. He reported that the national and South East Coast eligibility criteria would not change. He explained that the South East Coast eligibility criteria was more generous than the national criteria which was set by the Department of Health.

(2) Mr Ayres identified the specific changes to the new service specification: the exclusion of Darent Valley Hospital from the procurement; the reintegration of the call centre function into the contract; a separate contract for the transportation of renal patients; improved liaison between the provider and the Trusts; improved performance standards with penalties for not meeting key performance indicators; recording of accurate data and the inclusion of

clearer operational descriptions of the interface with other transport providers such as the ambulance trusts. He reported that a number of public and trust engagement events had taken place. He explained that the CCG would issue an invitation to tender in May 2015, the contract would be awarded in October 2015 and the provider would take over the contract in July 2016.

(3) A number of comments were made about performance. Mr Ayres explained that he was unable to give the amount of an automatic penalty due to procurement confidentiality. He confirmed that automatic fines would be introduced for failure to meet key performance indicators. He stated that he would provide the Committee with the most recent performance data.

(4) In response to a specific question about the eligibility criteria, Mr Ayres explained that following patient engagement a one page summary would be included in the new service specification.

(5) Mr Inett stated that Healthwatch Kent did not deem the new service specification to be a substantial variation of service. Healthwatch Kent hoped that the new provider would improve the patient experience.

(6) RESOLVED that:

(a) the Committee does not deem the new service specification to be a substantial variation of service.

(b) West Kent CCG be invited to submit a report to the Committee on Patient Transport Services in six months.

14. East Kent CCGs: Out-of-Hours Services
(Item 7)

Simon Perks (Accountable Officer, NHS Ashford CCG and NHS Canterbury and Coastal CCG) was in attendance for this item.

(1) Mr Parks began by providing an update on the procurement of a new out of hours GP service in East Kent. Patient feedback had indicated the need to integrate a number of services and provide clearer signposting for patients. He noted that the four East Kent CCGs had introduced a number of developments including the launch of an advanced care navigation pathway through a local referral unit and the development of pathway with the local Ambulance service to enable more patients to be seen and treated closer to home. Initial data had shown that whilst call rates to the Ambulance service had increased, the number of conveyances to hospitals had remained stable.

(2) Mr Perks stated that a proposed model had been developed utilising patient feedback, working with clinical and operational stakeholders and commissioning PriceWaterhouseCoopers to highlight best practice and scrutinise the service specification. He explained that the key requirements for the new service needed to be patient-centred; promote greater integration between front line services; be more responsive; deliver for and within East Kent; be flexible and affordable.

(3) Mr Perks noted some of the other key milestone delivered as part of the overall Urgent Care Transformation process. He stated that the Community Geriatrician project in NHS Ashford CCG had won the Health Service Journal's Efficiency in Community Service Redesign Award. He reported that Healthwatch Kent had recently carried out successful Enter and View visits to the primary care hubs at the Queen Elizabeth The Queen Mother Hospital and the William Harvey Hospital. He explained that market testing would begin in April 2015 and the new service would be procured in April 2016.

(4) A Member enquired whether the new service model would be implemented across Kent. Mr Perks explained that the new service model was specifically for East Kent. He noted that the four East Kent CCGs were going out to procurement earlier than the other Kent CCGs in order to respond to local pressures. He stated that the learning from the East Kent CCGs' procurement would be fed into the North and West Kent CCGs procurement process.

(5) In response to specific questions about the 111 service and Patientline, Mr Perks explained that the 111 service and out of hours service would be procured together into an integrated localised care navigation service. He stated that Patientline was a telephone service for the highest users of NHS services in East Kent to enable them, as part of their care plans, to stay in their own homes during an episode of care.

(6) RESOLVED that the report be noted and the East Kent CCGs be requested to keep the Committee informed with progress.

15. NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG: Adult Community Services (Written Update)
(Item 8)

(1) The Committee received a report from NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG which provided an update on Adult Community Services.

(2) RESOLVED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be invited to attend the June meeting of the Committee.

16. Date of next programmed meeting – Friday 10 April 2014 at 10:00 am
(Item 9)

(1) The Scrutiny Research Officer informed the Committee that due to a lack of time sensitive business on the Agenda for the 10 April meeting, the Chairman, in consultation with the Group Representatives, had decided to cancel the meeting. She stated that the next programmed meeting would therefore be Friday 5 June.

(2) Cllr Davison informed the Committee that as he was retiring as an elected Member of Sevenoaks District Council. He stated that this meeting was his last as a district representative on the Committee.

(3) RESOLVED that:

(a) the Committee noted that the next scheduled meeting was Friday 5 June 2015.

(b) the Committee thanked Cllr Davison for his long service as a district representative on the Health Overview and Scrutiny Committee.

Item 5: North Kent: Adult Community Services

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 June 2015

Subject: North Kent: Adult Community Services

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG.

There are a number of items on the Agenda relating to community services. General information on community services is included in the covering report to this item as the first of these.

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1. Introduction

(a) On 11 April 2014, the Committee considered the redesign of community services and out-of-hours services in the NHS Swale CCG area. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the Committee determines the proposed service change as a substantial variation of service and that a timetable for consideration of the change would be agreed between the HOSC and NHS Swale CCG after the meeting.*

(b) On 10 October 2014, the Committee considered an update on the out-of-hours proposals as part of the wider reconfiguration and recommissioning of emergency and urgent care services by NHS Medway CCG, NHS Swale CCG and NHS Dartford, Gravesham, Swanley CCG. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) the Committee do not deem this change to be substantial.

  (b) the guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and that they be invited to attend a meeting of the Committee in six months

(c) On 6 March 2015, the Committee considered an update report on proposals for adult community services by NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and NHS Dartford, Gravesham and Swanley CCG and NHS Swale CCG be invited to attend the June meeting of the Committee.*

2. Community Services

(a) Community health services cover a range of services provided by a variety of organisations and staff including:

- Community nurses;
- Health visitors;
- Community dentistry;
- Podiatry;
- Physiotherapy;
- Speech and language therapy;
- Family planning services;
- Community rehabilitation.

(b) Prior to 2009, the vast majority of Primary Care Trusts (PCTs) both commissioned and provided community health services. By 2009, PCTs had to organisationally split their commissioning and provider arms.

(c) A wide range of options for the future organisational form of provider arms was set down in the 2009 Transforming Community Services programme. The "most likely options" were given as integration with an NHS acute or mental health provider; integration with another community-based provider; or a Social Enterprise.

(d) By April 2011 PCTs had to divest themselves of their provider arms. A number of Community Health Trusts were created following the merger of community-based providers.

(e) The Health and Social Care Act 2012 established Clinical Commissioning Groups (CCGs) which replaced PCTs on 1 April 2013. CCGs are now responsible for the planning and commissioning of health care services for their local area including community services; whilst NHS England is responsible for directly commissioning primary care and specialised services.

(f) Monitor approved the Foundation Trust applications of Derbyshire Community Services NHS Trust and Bridgewater Community Healthcare NHS Trust on 30 October 2014. They became the first community health trusts to achieve foundation trust status.

2. Kent Community Health NHS Foundation Trust

(a) Kent Community Health NHS Trust was formed on 1 April 2011 from the merger of Eastern and Coastal Kent Community Services NHS Trust and West Kent Community Health.

(b) It is one of the largest NHS community health providers in England, serving a population of two million; 1.4 million living in Kent and 600,000 people in areas outside of Kent. The Trust employs 5,500 staff including community nurses, physiotherapists, dietitians and many other healthcare professionals. The Trust's budget was £229 million in 2013/14.

(c) The Trust provides wide-ranging NHS care for people, in their community, in a

range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units; a walk-in centre and in mobile units. The Trust has three million contacts with patients a year.

(d) Monitor authorised Kent Community Health NHS Trust to become an NHS Foundation Trust on 1 March 2015.

3. Medway Community Healthcare

(a) Medway Community Healthcare was formed as a social enterprise Community Interest Company (CIC) on 1 April 2011 on the transfer of services previously provided by NHS Medway PCT.

(b) Medway Community Healthcare is a £57 million business with 1,250 staff providing a wide range of both planned and unscheduled care in local settings such as healthy living centres, inpatient units and people's homes.

4. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the changes to Adult Community Services constitute a substantial variation of service.

(b) Where the HOSC deems the change as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to the CCGs.

(c) Where the HOSC determines the change to be substantial, a timetable for consideration of the change will need to be agreed between the HOSC and CCGs after the meeting. The timetable shall include the proposed date that the CCGs intends to make a decision as to whether to proceed with the proposal and the date by which the HOSC will provide any comments on the proposal.

5. Recommendation

If the change is *not substantial:*

RECOMMENDED that:

(a) the Committee does not deem the changes to Adult Community Services to be a substantial variation of service.

(b) North Kent CCGs be invited to submit a report to the Committee in six months.

If the change is *substantial*:

RECOMMENDED that:

(a) the Committee deems the changes to Adult Community Services to be a substantial variation of service.

(b) North Kent CCGs be invited to attend a meeting of the Committee in three months.

Background Documents

Department of Health (2013) '*Transforming community services transformational guides (08/02/2011)*', https://www.gov.uk/government/publications/transforming-community-services-transformational-guides

Kent Community Health NHS Foundation Trust (2015) *'About (01/03/2015)*', http://www.kentcht.nhs.uk/home/about-us/

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (11/04/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27880

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5400&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (60/03/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5838&Ver=4

NHS Trust Development Authority (2014) *'Monitor approves 3 FT applications (30/10/2014)'*, http://www.ntda.nhs.uk/blog/2014/10/30/monitor-approves-3-ft-applications/

Medway Community Healthcare (2015) '*About Us (23/04/2015)'*, http://www.medwaycommunityhealthcare.nhs.uk/about-us/

Contact Details

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Dartford Gravesham and Swanley Clinical Commissioning Group

Swale Clinical Commissioning Group

Adult Community Services Review & Procurement

Briefing note to the HOSC – June 2015

Introduction
In late 2014 outline business cases were taken to the Governing Bodies of the Dartford, Gravesham & Swanley and Swale Clinical Commissioning Groups' (CCG's) to seek approval to undertake a review of the current adult community services with a view to taking the services out to tender. These services are currently provided by Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH). The Governing Bodies approved this course of action and a project was initiated to oversee the process.

At previous presentations to the HOSC on this subject, the CCGs' welcomed the opportunity to discuss their plans and to receive comments. We committed to return to the HOSC in March 2015 with a further update on progress. The CCG's plans about how to proceed altered however and a brief update paper was provided in March and permission sought to return to the HOSC slightly later in June when a fuller picture could be presented. As such this update details the change to the CCG's plans including the reduced scale of the proposed plans in advance of attending the June meeting to discuss in more detail.

As a brief reminder the service contained within the current plans for re-procurement are expected to be:

- Community Hospitals
- Community Liaison
- Community Nursing (including matrons)
- Community continence service
- Intermediate Care service
- Community physiotherapy service
- Community podiatry
- Speech and language therapy
- Community specialist nursing

Background
The challenge for health and social care nationally is predominantly 2-fold:

- Resources, both financial and human are finite and require further efficiency gains
- The number and complexity of morbidities within, particularly, the elderly population are increasing year on year. This is however, true for all age groups with long term conditions.

How to respond to these challenges is central to the 5 Year Commissioning Strategy and the 2 Year Operational Plan for both CCG's. These plans give, respectively, detail on a commissioning strategy designed to tackle these issues alongside the expected demographic changes predominated by an ever increasing elderly population and the implications of the new Ebbsfleet development.

It is widely acknowledged that in order to respond to the increasing needs in the community there needs to be closer and greater integration between all health & social care providers. Models of care need to reflect a joint response with all parties need to work together around the service users and centred on promoting health, independence and safety, thus reducing dependence on hospitals

and long term care. Core to the success of the delivery of the plans are Adult Community Health Services. .

The CCG's are minded to test the market for a provider of Adult Community Services as the contract with the incumbent provider comes to an end in April 2016. The reasons for this are as follows:

- to market test to ensure that Commissioners understand the market and achieve best value
- to evaluate capacity and demand
- to continually review and improve the quality of care to achieve best practice
- to explore possible alternative models via a dialogue with bidders (noting that this may require public consultation)

The process to date

Essentially the plans no longer include a revision to the service delivery or models of care at this stage but seek only to test the market and let a new contract. Initially the CCG's planned to undertake a full review of the adult community services with a view to developing new models of care designed to respond to the changes outlined above. Given the timescale dictated by the contract term however, it became clear that the better way to proceed would be to let the contract 'as is', since we feel that this offers the best option for a provider or providers of service to work together to provide more integrated provision in the future.

The intention therefore, is to let the contract according to the same service specifications as exists currently, that is no significant change and no new or re-configured services will be secured through the procurement process. Whilst the CCGs recognise the need to develop improved pathways and services and to ensure sustainability both financially and in quality terms going forward, this will not be undertaken in advance of the new contract being let. This is a change of contract not in the way that services are provided. It also provides an opportunity to design quality and productivity improvements into the new contract with penalties and incentives associated with performance and delivery.

The CCGs are following a competitive dialogue process, working with potential providers to understand their proposals and solutions to the local health issues and to establish the credentials of the prospective providers to deliver high quality, financially sustainable services but also to work with us to develop innovative approaches to how integrated care can be delivered in ways consistent with meeting the long term health and social care needs of the communities.

As such a new approach was agreed by the Procurement Project Board at its meeting in February 2015 to commence procurement straight away for a new contract to provide the same model of care and services as we currently procure from KCHFT and MCH. It was agreed that we would proceed at reasonable speed with a view to getting a new contract in place by March 2016 with the contract term being 7-10 years to encourage a long term, developmental partnership. The evaluation criteria for the new provider will be heavily weighted around innovation, flexibility, and creativity in service development and delivery.

The current value of services within the tender is in the order of £26m per annum.

Further detail in terms of chronology is provided below:

Process	**Date**
Proposal presented to the Governing Bodies of the respective CCG's	October 2014
Project Board established and key project support identified and secured	November 2014
Prior Information Notice issued	January 2015

Project Board agreed changed approach in order to expedite new contract award within required timescale of current contract expiry	February 2015
First Market Engagement event	February 2015
Advert & PQQ/MOI published	8th May 2015
Second Market Engagement event	19th May 2015
Submission of clarification questions	27th May 2015
PQQ submission deadline	5th June 2015
Competitive dialogue phase	Summer/Winter 2015
Award of contract	December 2015
Planned new contract commencement	1st April 2016

Recommendation
That the proposal does not constitute significant change and that the CCG's will return with regular updates as the procurement process proceeds.

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Item 6: Medway NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 June 2015

Subject: Medway NHS Foundation Trust: Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Medway NHS Foundation Trust and NHS Swale CCG.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Health Overview and Scrutiny Committee has considered Medway NHS Foundation Trust on six occasions (6 September 2013, 7 March 2014, 5 September 2014, 10 October 2014, 28 November 2014 and 30 January 2015) following the publication of Professor Sir Bruce Keogh KBE's review into the quality of care and treatment provided by 14 hospital trusts in July 2013.

2. Keogh Review

(a) Following the publication of the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report), on 6 February 2013 Sir Bruce Keogh was asked by the Prime Minister and Secretary of State for Health to conduct an immediate investigation into the care at hospitals with the highest mortality rates and to check that urgent remedial action was being taken (NHS England 2013a).

(b) 14 Trusts were selected on the basis of being outliers for two consecutive years on one of two measures of mortality: Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR). HSMR measures whether mortality is higher or lower than would be expected. A high HSMR does not mean for certain there are failings in care but can be a ‘warning sign that things are going wrong.’ SHMI is a high level indicator published quarterly by the Department of Health. It is a measure based upon a nationally expected value and can be used as a ‘smoke alarm for potential deviations away from regular practice’ (NHS England 2013a; NHS England 2013b; NHS England 2013c).

(c) Medway NHS Foundation Trust was selected for the review due to a HSMR above the expected level for the last two years (a score of 115 for financial year 2011 and 112 for financial year 2012). A score greater than 100 indicates that a hospital’s mortality rate exceeds the expected value (NHS England 2013d).

(d) In July 2013, 11 of the 14 Trusts including Medway NHS Foundation Trust were put into 'special measures'. Special measures was a new regime introduced following the Keogh Review in 2013. It involves action and scrutiny by three organisations: the Care Quality Commission (CQC), Monitor (for NHS Foundation Trusts) and the NHS Trust Development Authority (TDA) (for NHS Trusts) (CQC 2014a).

3. Monitor

(a) The NHS TDA and Monitor put in place support packages for the 11 trusts in special measures.

(b) The support package provided by Monitor for Medway NHS Foundation Trust included:

- the appointment of an improvement director to the trust to provide challenge and support to board members on the delivery of the Keogh action plan;
- the appointment of an interim Chair and Chief Executive in February 2014 to strengthen the Trust's leadership;
- A buddying arrangement with East Kent Hospitals University NHS Foundation Trust to support Medway in improving its quality reporting systems (CQC 2014a).

4. CQC

(a) Professor Sir Mike Richards, the Chief Inspector of Hospitals, prioritised full inspections of the 14 trusts that were in the Keogh Review (including the 11 trusts in special measures) under CQC's new inspection model for acute hospitals (CQC 2014a).

(b) The inspections took place between mid-March and early May 2014. A wide range of quantitative and qualitative information was gathered before the inspections. The inspections were undertaken by a team comprising of clinicians, Experts by Experience and CQC inspectors. Eight core services were inspected, with each being assessed against the five key questions. A rating was given to each service for each of the five questions on a four-point scale (outstanding, good, requires improvement or inadequate). An overall rating for the 11 trusts was given (CQC 2014a).

(c) The CQC inspected Medway NHS Foundation Trust between 23 and 25 April 2014 with an unannounced inspection visit on 1 May 2014. The Trust was rated inadequate overall. The ratings awarded for the five key questions were:

Safe?	Inadequate
Effective?	Requires improvement
Caring?	Good
Responsive?	Inadequate
Well-led?	Inadequate

(d) Following the CQC's inspections, the Chief Inspector of Hospitals made recommendations about special measures for the 11 trusts to Monitor and the NHS TDA. The Chief Inspector of Hospitals concluded that significant progress had been made at 10 of the 11 trusts. Two had made exceptional progress and were rated 'good' overall. A further three had made good progress but required further improvements; it was recommended that they should exit special measures with ongoing support. Five trusts were recommended a further period in special measures, with an inspection in six months to ensure that they are continuing to make progress (CQC 2014a).

(e) Medway NHS Foundation Trust was the only Trust found to have failed in making significant overall progress. It was recommended that the Trust remained in special measures. The reasons for this recommendation were given:

- Significant improvements had been made in the maternity services, but overall there has been little or no progression the quality and safety of care;
- Multiple inadequate CQC ratings;
- Unstable leadership throughout the past year;
- Poorly defined vision/strategy;
- Very poor alignment or engagement of clinicians (CQC 2014a).

(f) The CQC carried out an unannounced inspection of the Emergency Department on 27 and 28 July 2014 to follow up on its findings from April and in response to receiving information of concern from two separate sources. The key findings from the inspection were:

- The Emergency Department was in a state of crisis with poor clinical leadership;
- The Emergency Department had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' patients;
- The Emergency Department continued to fail to ensure that children attending the department underwent initial assessment which was in line with national standards (CQC 2014b).

(g) On 30 July 2014 the CQC formally wrote to the Chief Executive of Medway NHS Foundation Trust setting out its concerns and to request the necessary assurances that appropriate action would be taken to ensure the safety and welfare of patients who used the service (CQC 2014b). A Section 31 Notice was issued. Under Section 31, the CQC can suspend the registration or extend a period of suspension of a registered person for a specified period of time; it can also vary, remove or impose conditions to registration. The CQC must have reasonable cause to believe that unless it acts using this section, a person will or may be exposed to the risk of harm (CQC 2013).

(h) The CQC carried out a further inspection of the Emergency Department on 26 August 2014; they found that the Emergency Department

continued to lack any form of effective clinical leadership and there remained a lack of cohesive working amongst nursing, medical and allied healthcare professionals. The process of initially assessing patients in a timely manner remained flawed; in some instances patients were experiencing delays of more than two hours before any effective clinical intervention or treatment was commenced. The inspection report was published on 26 November 2014 (CQC 2014b).

(i) In response to the Section 31 Notice, NHS commissioners and providers in Kent and Medway met with Monitor and NHS England to develop a partnership plan to support Medway Maritime Hospital.

(j) On 10 October 2014 the Committee considered proposals by NHS Swale CCG to reduce elective activity at Medway Maritime Hospital in order to increase internal capacity. Maidstone and Tunbridge Wells NHS Trust agreed to offer Swale patients the option to be seen at Maidstone Hospital for their elective outpatient appointments in three specialties – care of the elderly, respiratory and cardiology. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the Committee are supportive of the decision to take urgent action at Medway NHS Foundation Trust, that the CCG be thanked for their attendance at the meeting and that they be invited to attend the Committee in January with a progress report.*

(k) On 28 November 2014 the Committee considered a written update on Medway NHS Foundation Trust. The Committee agreed the following recommendation:

- *RESOLVED that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the January meeting of the Committee to provide an update on actions taken to support Medway's Emergency Department.*

(l) On 30 January 2015 the Committee considered an update by Medway NHS Foundation Trust and NHS Swale CCG. The Committee agreed the following recommendation:

- *RESOLVED that the reports be noted and that Medway NHS Foundation Trust and NHS Swale CCG be invited to attend the June meeting of the Committee.*

5. Recommendation

RECOMMENDED that the reports be noted and Medway NHS Foundation Trust and NHS Swale CCG be invited to submit an update to the Committee at an appropriate time.

Background Documents

CQC (2013) *'Enforcement Policy (28/06/2013)*', http://www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

CQC (2014a) *'Special Measures: One Year On (05/08/2014)*', http://www.cqc.org.uk/content/special-measures-one-year

CQC (2014b) *'Medway Maritime Hospital Reports (26/11/2014)*', http://www.cqc.org.uk/location/RPA02/reports

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (06/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=25799

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (07/03/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27666

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29237

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30032

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (28/11/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5401&Ver=4

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (30/01/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=30553

Medway NHS Foundation Trust (2014) *'News Release 26 June 2014 (27/06/2014)*', http://www.medway.nhs.uk/news-and-events/latest-news/news-release-26-june-2014/

NHS England (2013a) *'Professor Sir Bruce Keogh to investigate hospital outliers (06/02/2013)*', http://www.england.nhs.uk/2013/02/06/sir-bruce-keogh/

NHS England (2013b) '*Sir Bruce Keogh announces final list of outliers (11/02/2013),*' http://www.england.nhs.uk/2013/02/11/final-outliers/

NHS England (2013c) *'Rapid Responsive Review Report for Risk Summit - Medway NHS Foundation Trust (01/06/2013)*',

http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/Medway%20NHS%20Foundation%20Trust%20RRR%20report.pdf

NHS England (2013d) *'Medway NHS Foundation Trust: Keogh Review Data Pack (09/08/2013)*', http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/trust-data-packs/130709-keogh-review-medway-data-packs.pdf

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NHS
Swale Clinical Commissioning Group

Briefing to Kent County Council HOSC Friday 5 June 2015

Subject: Medway NHS Foundation Trust: NHS Swale Clinical Commissioning Group Update

Date: 5 June 2015

Introduction:

This paper provides members of the Kent County Council Health Overview and Scrutiny Committee (HOSC) with an update on the actions taken by NHS Swale Clinical Commissioning Group (CCG) to support Medway NHS Foundation Trust (MFT).

At the January meeting of the HOSC, NHS Swale CCG provided an update on the short term interventions implemented in line with recommendations made by the Care Quality Commission (CQC) for the Emergency Department (ED), following the issue of a Section 31 Notice by the CQC which could fully or partially close the ED.

The short term interventions, supported by the HOSC at the October 2014 meeting, were proposed to give MFT some headroom during the winter period and make key changes to ensure that care provided by the hospital is safe.

The short-term interventions were:

1. The reduction of elective activity at MFT by encouraging Swale patients to be seen at Maidstone and Tunbridge Wells NHS Trust (MTW) for their elective outpatient appointments. This would increase internal capacity at Medway Maritime Hospital (MMH).
   Update: This was implemented for cardiology and care of the elderly (CoE) in November 2014. Data supplied by MTW to January has shown an increase in cardiology referrals from Swale but not at the numbers anticipated (44% compared to preceding 3 months). Dr Derek Harrington a consultant cardiologist at MTW attended a GP education event in late January and early data for Feb to April (which remains to be validated and does not have granularity of specialities) is showing a large increase in referrals to MTW (although not a concurrent reduction at MFT). Further data is due from MTW on week ending 22nd May.

   We have not seen an increase in referrals to Care of the Elderly at MTW. We had a focus on these two key areas but in fact we have seen an overall increase in referrals. More work is needed on the care of the elderly as these patients tend not to have their own transport and transport links are an issue. We also currently have local out-patient clinics, provided by MFT, run from our community hospitals. Our intention is to explore the development of outreach outpatient clinics run by other providers at our community hospitals as feedback from GPs is that the majority of patients still choose MFT because of tradition, location and the availability of outreach into the community hospital. In addition, longer term we need to work through the Health and Wellbeing Board on the development of public transport links to other hospital sites, which are also seen as a barrier to patients actively choosing alternative providers as a place for their care.

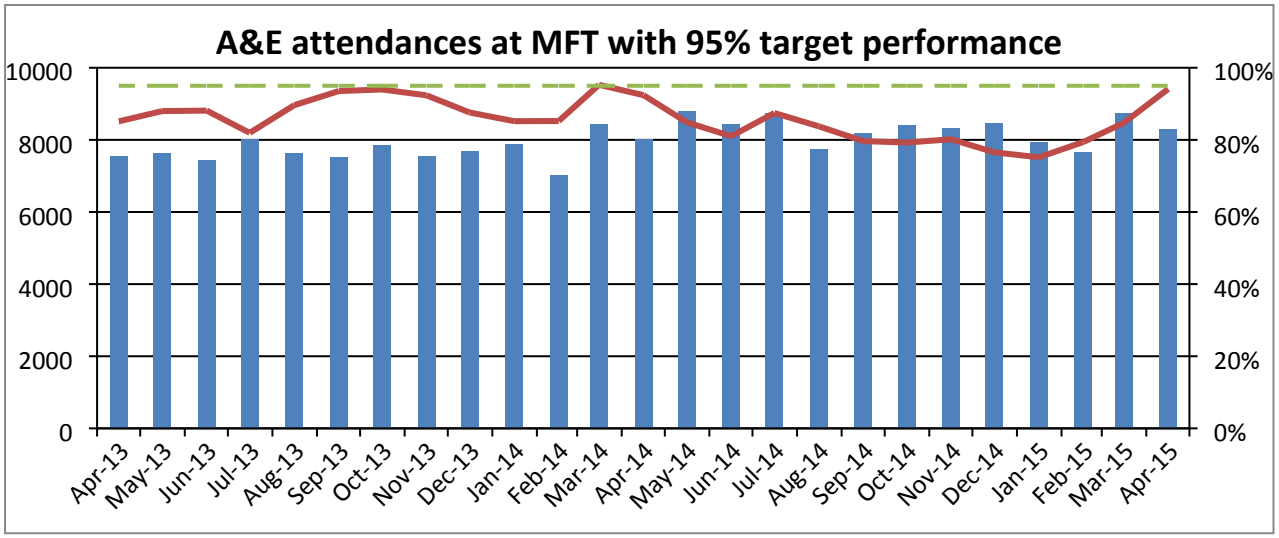
2. Provision of a 24/7 Primary Care unscheduled care service through MedOCC at Medway Hospital. Originally funded through operational resilience funds (see below), this was managed by increasing GP capacity, specifically during the evening and overnight and relocating the MedOCC out of hours service from its base at Quayside to the MedOCC base within Medway Maritime Hospital.
Update: On average 27% of patients arriving at ED are now being navigated onto the service following clinical triage, an increase of 6% since implementation. This scheme continues to be funded by NHS Swale and NHS Medway CCGs through 2015/16.

Current Performance Management :

The four hour access target has not been met by MFT in line with their agreed trajectory with Simon Stevens, Chief Executive NHS England, seen below:

	Nov	Dec	Jan	Feb	Mar
Agreed average monthly performance	80%	85%	85%	90%	95%
Actual monthly performance	80.16%	76.56%	75.16%	79.41%	84.68%

Current performance (validated position shown below) shows that although the trajectory was met for November it was not met for the remainder of 2014/15. December and March saw higher levels of activity across the whole of Kent and Medway with Medway Maritime Hospital being no exception to this.



There was an increase of 7.8% in attendances in 2014/15 with 92,231 people attending in 2013/14 compared to 99,457 in 2014/15.

It should be noted, that Swale is served with two minor injury units; Sittingbourne and Sheppey, and therefore patients attending MFT ED tend to be those with higher acuity.

The revised MFT plan for 2015/16 is:

Q1	Q2	Q3	Q4
93%	95%	85%	90%

(Although this revised trajectory has been submitted as part of CCG planning, it has not been agreed by NHS England or Monitor as yet).

During the first quarter of 2015/16, the 95% access target has been achieved since week ending 12 April up until week ending 17 May, highlighting the risk of sustainability.

Week ending	Performance
17 May 2015	94.14%
10 May 2015	95.08%
26 April 2015	95.25%
12 April 2015	96.29%
5 April 2015	93.01%

Cancer waiting times performance has deteriorated significantly in March 2015 (reported May 2015) with non-achievement in standard in 2WW, 31 day treatment and 62 day treatment pathways, due to issues not previously reported to the CCGs by MFT. There are also acknowledged issues regarding data quality following a review by PricewaterhouseCoopers (PwC). This was immediately escalated and a contract performance notice was sent on 13 May 2015 noting the position within the briefing supplied by the Trust, but requesting further assurance on specific areas. Whilst performance is of concern in a number of areas, the key specialities of concern and non-compliance at a Trust level are Lower and Upper GI and Dermatology. Swale CCG continue to monitor and raise issues on performance as they arise.

Operational Resilience and Capacity Plan (ORCP)– to support delivery of the four-hour access target:

In October 2014, NHS England released funds of £5.491million to NHS Medway and NHS Swale CCGs to support MFT in achieving the four-hour access target). (£2.394million in Tranche 1, £3.097million in Tranche 2). MFT received 85% of the Tranche 2 funds.

The paper presented to the January HOSC provided a breakdown of the schemes that were implemented through these funds to provide maximum operational headroom for MFT to accelerate its Trust plan. The 34 schemes funded supported the following:

1. Admission avoidance
2. Emergency Department
3. Internal Waits
4. Operational Resilience
5. External Waits
6. Communications and Engagement

Following a review of the outcomes of the ORCP by the Medway and Swale Executive Programme Board, schemes which provided evidence of benefitting the system were considered for re-commissioning or were continued as part of provider business as usual operations. The schemes agreed for continued operation include:

- Increased capacity at MedOCC (see point 2 in Introduction)
- Additional consultant psychiatrist in ED
- Additional Dementia support in ED to facilitate timely discharge
- Expansion of the Integrated Discharge Team to facilitate complex discharges, with a focus on patients discharged from ED (see Frailty Pathway and Social Care Care Managers below)

- Equipment store on Sheppey to improve availability and timeliness of equipment on the island
- Swale Home from Hospital Befriending Service, provided by Age UK.

Additional Initiatives to support sustainability:

- Frailty Pathway – MFT have introduced a Geriatrician at the front door of ED for rapid assessment of frail elderly patients presenting between the hours of 08:00-17:00 Monday to Friday. The Geriatrician is supported by a dedicated speciality nurse, therapists and health and social care staff from the Integrated Discharge Team to facilitate discharge from the unit and reduce the length of stay for those patients requiring admission.

- Swale Care Managers-Social Care, within the IDT. These care managers work to the principle of 'home is best', identifying the appropriate support packages to enable patients to return home as opposed to a short term admission to a community bed.
  95% of patients admitted to MFT and identified as requiring a community bed on discharge manage to return home with care managers identifying and arranging appropriate enablement packages on discharge.

- A health and social care discharge group has been established to review the medically stable group of patients on a weekly basis. Any key themes and issues identified with barriers to discharge once patients are deemed medically stable are escalated directly to the weekly 'system' call (executive attendance) and where necessary, to the monthly Medway and Swale Executive Programme Board.

- A new joint health and social care checklist has been agreed and implemented which provides a consistent and simplified approach to discharge planning for those patients that require a care home placement or significant support on discharge.

- NHS Medway and NHS Swale CCGs have worked with the Department of Health's Behavioural Insights Team to identify interventions which raise awareness of appropriate use of ED and ways to access other services. As a result of this, patients who are navigated from ED to MedOCC are provided with a letter which includes information of alternative local care options, registering with a GP and the financial cost to the NHS.
  Running alongside this is a local media campaign 'For some people there is no choice but A&E' to encourage people to use alternative services. This is advertised using bus, billboard, supermarket, radio, newspaper and roadside advertising, backed up by web content and social media.

- In line with planning guidance, outcomes framework and the Better Care Fund, Swale CCG is commissioning an Integrated Community Mental Health and Wellbeing Service jointly with the local authority to improve and increase access to early intervention and prevention of deterioration which may lead to acute admissions.

- In January, NHS Medway and NHS Swale CCGs commissioned The Oak Group to complete an audit of admissions and bed stays across acute and community beds.

  The results of the audit were presented to the February Executive Programme Board. At a headline level the audits demonstrated:

Overall patient cohort:

- 51% of patients were over the age of 70 years
- 71% had associated complexities of care
- 91% of patients came from their own home.
- 26% of all admissions were non-qualified*
- 9% of all admissions were readmissions.

Alternative levels of care:

- The non-qualified rate for Swale CCG was 25% and 28% for Medway CCG

The audit included A CCG comparison with regard to patients admitted to a community hospital following discharge from MFT:

Patient cohort:

- The cohort was similar for the CCGs with 84% of patients over the age of 70 and almost 90% with associated complexities of care.

Non-qualified admissions:

- 13% of admissions were non-qualified for Swale CCG as compared to 27% for Medway CCG (Sittingbourne Community Hospital had a low non-qualified admission rate of 6%)

Continuing stay:

- 63% of continuing stay days could have been provided at an alternative level of care for Medway CCG as compared to 39% for Swale CCG
- Sittingbourne Community Hospital (Swale CCG) had a low non-qualified continuing stay day rate of 20%
- 49% of all non-qualified continuing stay days of care could have been provided at home with a variety of services for Swale CCG compared to 66% for Medway CCG.

The audit demonstrated that overall 12% of patients admitted to MFT through ED were *non-qualified, meaning an alternative level of care could have been provided. (It should be noted however that some alternative services may not be currently available).

The audit also highlighted that 13% of patients in a Swale community bed were non-qualified compared to 27% of patients in a Medway community bed.
This is a direct result of the Swale Care Managers-social care, employed by KCC working within the IDT (see above).

Through resilience funding, Medway and Swale CCGs funded the Oaks Group to implement a live data review, 'STREAM' (Support Team for Redirecting Emergency Admissions). This will provide the CCGs with an understanding of the basis for non-qualified admissions by identifying the appropriate community health and social care pathways, response times in to these services, service needs and any gaps in service.
Initial outcomes from the STREAM work will be presented to the Medway and Swale Executive Programme Board in June.

Next steps:

In addition to the initiatives noted above, further work streams sit alongside this to support sustainability in the system in the medium and longer-term. These are:

Community services review:
Re-specification of community services in Swale following review of current provision and future need, aligned to the review of urgent and emergency care.

Urgent and Emergency Care Review:
NHS Swale CCG in partnership with NHS Medway and NHS Dartford, Gravesham and Swanley CCGs are undertaking a review of urgent care services across the three localities. The outcome of this review will determine urgent and emergency service requirements on a locality basis, both in and out of hours to deliver as much care as possible in the community.

Community Paramedic Practitioners:
NHS Swale CCG is working with the South East Coast Ambulance Trust to implement Paramedic Practitioner support to GP practices.
The Paramedic Practitioners would support practices by carrying out home visits requested of the GP to enable the GP to remain within their practice and prevent avoidable conveyances to an ED. Going forward, this would support the urgent and emergency care model in Swale where there is a focus to support patients to remain within their home.

Integrated Primary Care Teams (iPCTs):
Continued development of the health and social care multi-disciplinary teams supporting GP practices to provide a proactive, responsive and joined up approach to support patients with long-term conditions and complex care needs. Focusing on keeping people well and on self-management by using a prediction tool (risk stratification) to determine those patients at the highest risk of hospital or long-term care admission or re-admission.

The iPCTs include community nursing, care managers, mental health nurses, specialist services, pharmacists, palliative care nurses. Further development will see outreach hospital specialists and paramedic practitioners supporting these teams.

Conclusion:

Although encouraged to see an improvement in A&E performance, NHS Swale CCG remains concerned with regard to patient safety and quality issues at MMH, particularly in relation to the deterioration of waiting time performance for cancer, Lower and Upper GI and Dermatology. The CCG continues to monitor performance and raise issues with the Trust as they arise.

END

Item 7: East Kent Hospitals University NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 June 2015

Subject: East Kent Hospitals University NHS Foundation Trust: Update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) East Kent Hospitals University NHS Foundation Trust (EKHUFT) has asked that the attached reports be presented to the Committee.

(b) The Trust is a group of hospitals providing acute, specialist and community services to a population of 759,000 across all of East Kent. The trust has a total of 1,173 beds in its three acute hospitals: 476 at William Harvey Hospital based in Ashford; 410 at Queen Elizabeth The Queen Mother Hospital based in Margate and 287 at Kent & Canterbury Hospital based in Canterbury. It also has two community hospitals – Buckland which is based in Dover and Royal Victoria which is based in Folkestone. The trust directly employs over 7,000 staff.

2. Clinical Strategy

(a) HOSC has considered the development of Trust's previous clinical strategy on three occasions: 3 February 2012, 12 October 2012 and 7 June 2013.

(b) On 30 January 2015, the Committee considered the Trust's proposals for a new clinical strategy. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) there be on-going engagement between East Kent Hospitals University NHS Foundation Trust and HOSC as plans are developed.

  (b) East Kent Hospitals University NHS Foundation Trust presents a report to a meeting of the Committee in April.

(c) Due to a lack of time sensitive business on the Agenda for the 10 April 2015 meeting, the Chairman, in consultation with the Group Representatives, cancelled the meeting. This item has therefore been rescheduled for this meeting.

3. Outpatient Services

(a) An area of particular focus, during the development of the Trust's previous clinical strategy, was outpatient services which the Committee considered on 7 June 2013, 11 October 2013, 11 April 2014, 6 June 2014 and 5 September 2014.

(b) On 7 June 2013 the Committee agreed the following recommendation:

- *AGREED that the Committee thanks its guests for their attendance and contributions today, agrees that the proposed changes to outpatient services and breast surgery services do represent a substantial variation of service and look forward to receiving further updates in the future; and also requests that East Kent Hospitals NHS University Foundation Trust take on board the Committee's comments regarding public consultation before the Trust takes any final decision on wider consultation.*

(c) On 11 October 2013 the Committee considered a written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

- *AGREED that the Committee note the report, ask the NHS to take on board the comments and questions raised by the Committee and that a small group be formed to liaise with the NHS on the draft consultation document.*

(d) Dr M Eddy, Mr R Latchford, OBE and Councillor Michael Lyons formed a working group to read and comment on the draft consultation document.

(e) On 11 April 2014 the Committee considered a further written update provided by East Kent Hospitals University NHS Foundation Trust and NHS Canterbury and Coastal Clinical Commissioning Group. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Chairman to write to EKUHFT to clarify the concerns raised regarding the redeployment of non-clinical staff prior to the independent analysis of the consultation.*

(f) Miss A Harrison was invited to observe the option re-appraisal for the North Kent Coastal site on 22 April and 29 May. The re-appraisal was held following new information and comments received during the consultation and to incorporate additional information which had been requested by members of the public.

(g) Dr M Eddy and Mr A Crowther visited Victoria Memorial Hospital in Deal on 29 April with representatives from NHS South Kent Coast CCG

and Kent Community Health NHS Trust. The visit was arranged for Members to gain a better understanding of the nature of the site and the services currently provided as well as have the opportunity to hear about how commissioning plans for developing community and outpatient services on the East Kent Coast were developing.

(h) Representatives of the Trust attended the Committee on 6 June 2014 to present the findings of the consultation and provide an update on the option appraisals for the North Kent site. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that:*

  (a) The Committee records its appreciation of the hard work the Trust has put into the consultation.

  (b) The comments made by Members of the HOSC are considered and taken into account.

  (c) The Committee asks for a return visit in September when a final decision has been taken.

(i) On 5 September 2014 the Committee considered the Trust's final decision on outpatient services. At the conclusion of this item, the Committee agreed the following recommendation:

- *RESOLVED that the Trust be thanked for their attendance at the meeting and the update provided on the progress of the Board's plans for Outpatient Services in Kent and that they be invited to submit a progress report to the Committee within six months.*

4. CQC Inspection

(a) The CQC inspected the Trust's three acute hospitals from 4 to 7 March 2014. The CQC also carried out an unannounced inspection on 19 and 20 March 2014. On 13 August 2014 the CQC published its findings, the Trust was rated inadequate overall. The ratings awarded for the five key questions were:

Safe?	Inadequate
Effective?	Requires improvement
Caring?	Good
Responsive?	Requires improvement
Well-led?	Inadequate

(b) Following the publication of the CQC inspection report, the Trust was placed into special measures by Monitor. Monitor appointed an Improvement Director to provide support to the Trust and hold it to account for making progress against the Improvement Plan. CQC inspectors will return to the hospital in due course to check that the required improvements have been made.

(c) On 5 September 2014 the Committee considered the Trust's initial response to the inspection findings. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted, the Trust take note of the comments made by Members during the meeting and be invited to attend the October meeting of the Committee.*

(d) On 10 October 2014 the Committee considered the Trust's Improvement Plan and an update on progress since the inspection. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and be invited to attend a meeting of the Committee within six months with a progress report.*

5. Recommendations

Agenda Item 7a – EKHUFT Clinical Strategy

RECOMMENDED that there be ongoing engagement with HOSC as the Trust's clinical strategy is developed including a return visit to the Committee prior to public consultation to enable the Committee to determine if the options for proposal are a substantial variation of service.

Agenda Item 7b – EKHUFT Outpatient Services

RECOMMENDED that the report on Outpatient Services be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

Agenda Item 7c – CQC Inspection

RECOMMENDED that the report be on CQC Inspection noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

Background Documents

Kent County Council (2012) '*Agenda, Health Overview and Scrutiny Committee (03/02/2012)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=19539

Kent County Council (2012) '*Agenda, Health Overview and Scrutiny Committee (12/10/2012)*',

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=3983&Ver=4

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (07/06/2013)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=25151

Kent County Council (2013) '*Agenda, Health Overview and Scrutiny Committee (11/10/2013)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5075&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (11/04/2014)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5396&Ver=4

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (06/06/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=27887
Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (05/09/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29239

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (10/10/2014)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=29902

Kent County Council (2014) '*Agenda, Health Overview and Scrutiny Committee (30/01/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=31450

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East Kent Hospitals University NHS
NHS Foundation Trust

Delivering our Future

2 to 10 Year Strategy

We care

East Kent Hospitals NHS Foundation Trust

- 2013/14 Turnover *(nearly £526 million / £6 million surplus)*
- Financial position is rapidly changing

- Developing new models of care and service improvement *(one-stop OP clinic facilities and the new hospital in Dover etc.)*

- Hospital death ratio *(20% ≤ lower than the national average)*

- Good infection control rates (*MRSA / C diff)*

East Kent Hospitals University NHS
NHS Foundation Trust

Challenges which must be addressed:

- Recent CQC report
  (e.g. emergency services A&E, medicine, surgery)
- A&E operational issues
- Waiting time targets issues
- Workforce constraints
- 2020 Financial Challenge
  (£40m deficit by 2017/18 & £147m by 2020)

We care

East Kent Hospitals University NHS
NHS Foundation Trust

We can't stand still as ……

- Increasing demand *(1.0% growth/year = 76,000 people over 10 year period)*
- 75+ age population *(3.5% growth/year = 29,000 people over 10 year period)*
- East Kent increasing younger population *(1.3% growth/year = 18,000 over 10 year period)*
- Obesity rate *(continuous rise)*
- Facilities *(old / modern facilities, technology advancement)*
- Patient expectation *(quality care/close to home)*

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Can we continue to do what we are currently doing?

If we say 'No' to change, by 2023:

- Activity would increase by:
  - *Inpatient: +16% (15,000 people)*
  - *Day case: +17% (12,000 people)*
  - *Outpatient: +15% (92,000 people)*

- The Trust does not have the spare capacity to deliver growth at this level *(staff, estate or beds)*

We care

East Kent Hospitals University NHS
NHS Foundation Trust

So, what's the answer?

- Unsustainable current pattern of services *(3 hospital sites)*

- Re-consideration of future care delivery
  - Local service delivery
  - Service centralisation/consolidation
  - Start new service delivery
  - Service delivery in different setting

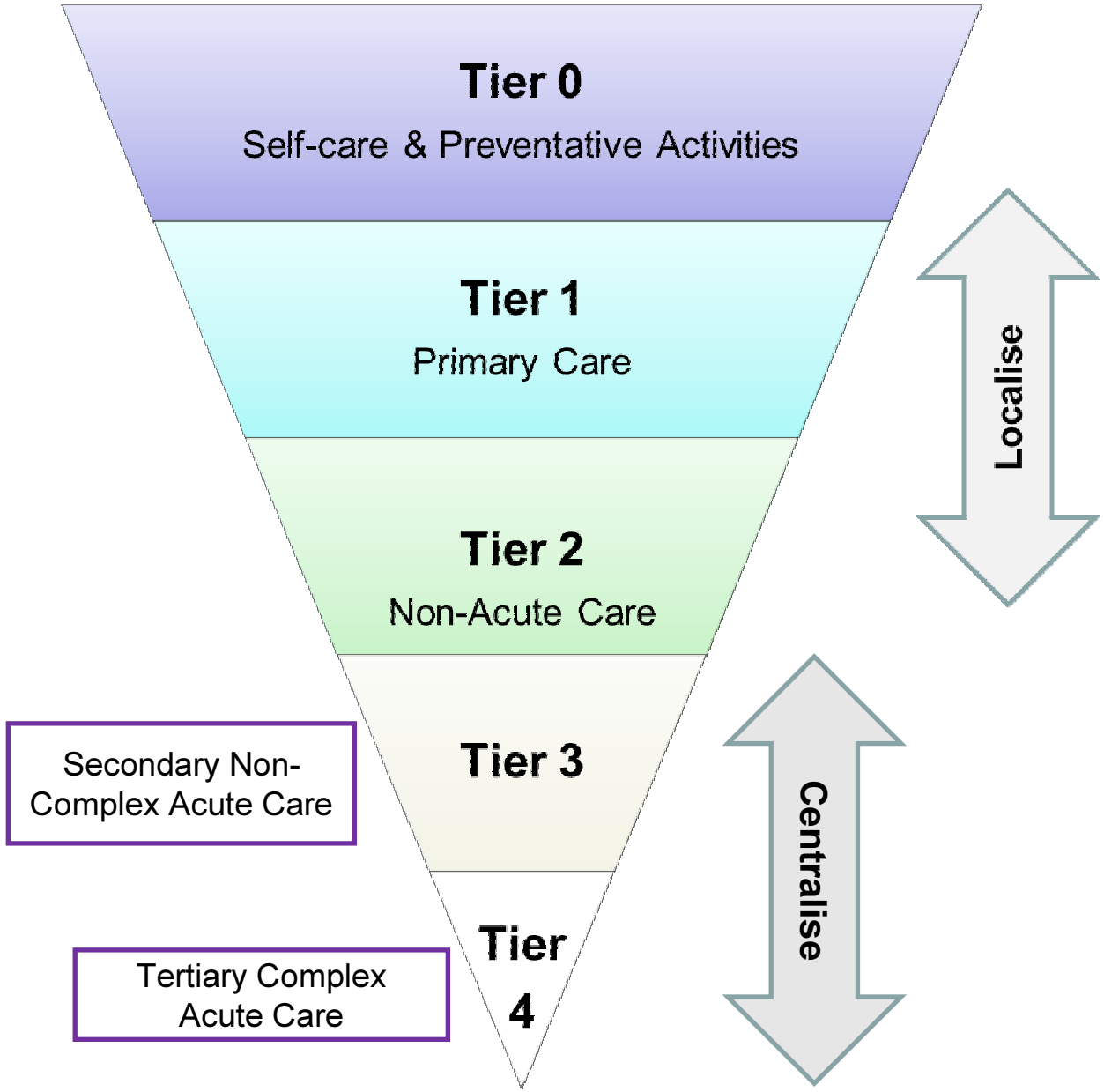
- Integrated care strategy (*health and social care campus)*
  - tiers of care;
  - integration with primary care *(shared strategic aims)*
  - teaching nursing homes.

- Considering different options

We care

What are tiers of care?

East Kent Hospitals University NHS
NHS Foundation Trust



East Kent Hospitals University NHS
NHS Foundation Trust

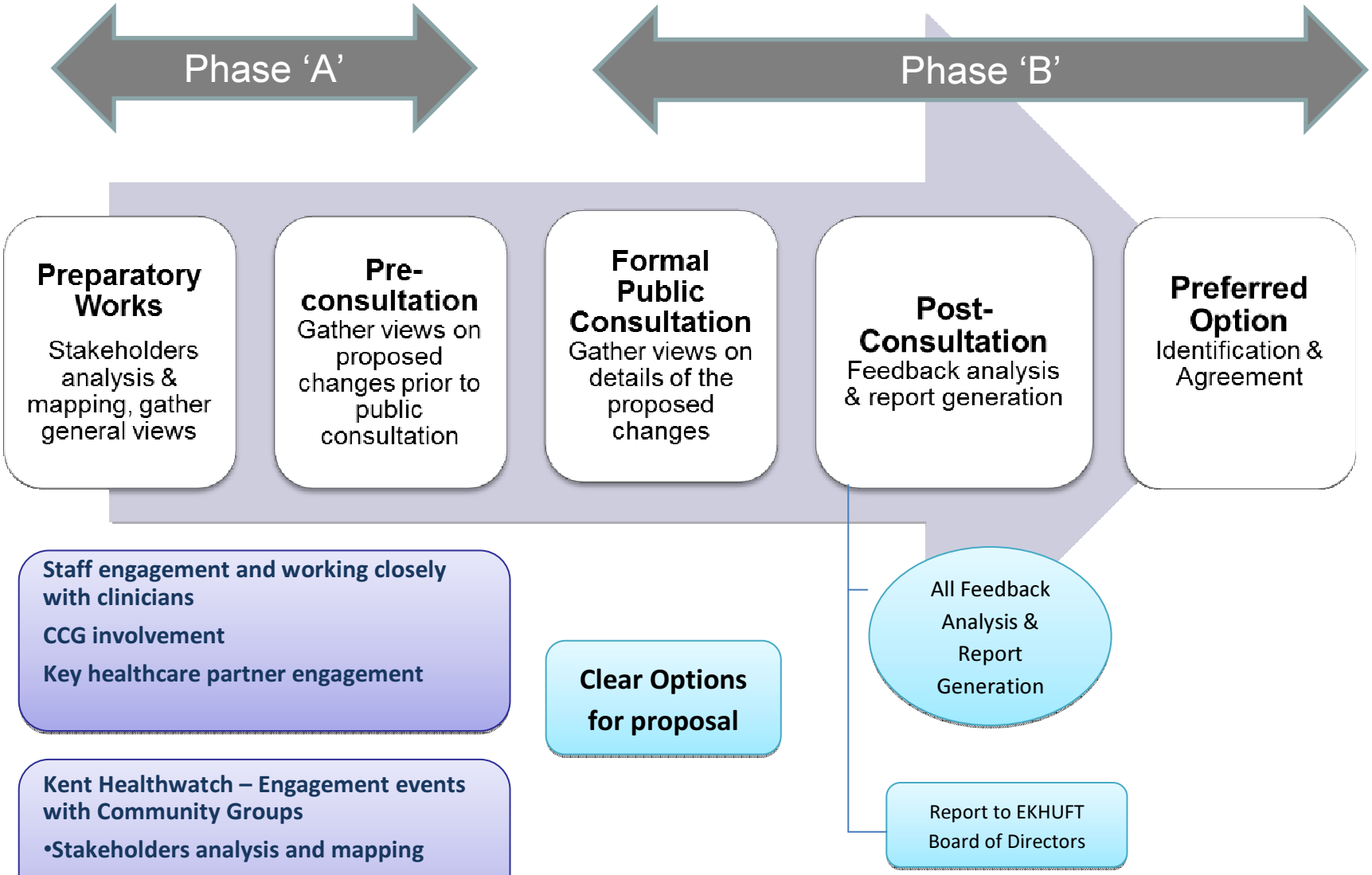
Steps taken toward 'Delivering Our Future'

- Working with Ernst &Young to model options
- Working with Clinicians and staff (ongoing) and the Clinical senate to agree Clinical Model
- Researching good practice and models of care
  e.g. Clinically led visit to Holland in September 2014, visits to other Trusts
- Working jointly with CCGs and other providers to agree East Kent Health Economy wide approach
- Patients & Public engagement strategy *(ongoing)*
  - Kent Healthwatch engagement events *(ongoing)*
    - *9 events scheduled across East Kent*
    - *Spoken to over 767 people (56% face-face)*
    - *Over 180 speakout forms completed (88% positive)*
    - *Feedback received from all post codes in East Kent*
- Development of a range of options using the above information

We care

Overview of Process:

East Kent Hospitals University NHS
NHS Foundation Trust



East Kent Hospitals University NHS
NHS Foundation Trust

Current situation

- Wide recognition we cannot stay as we are and clinical consensus that reconfiguration is required.
- Acuity analysis and options around possible local care models has been completed.
- Public consultation will be required for reconfiguration and a date for this to start will be agreed as the options are agreed.
- Discussions have raised concern that 3 site unselected medicine is unsustainable in the medium term and so specialty risk assessments are now being finalised to inform the options
- The Trust's financial position has directly impacted our ability to borrow significant capital.
- The solution must take the Trust to a clinically, operationally and financially sustainable position.

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Outpatient Clinical Strategy Update

June 2015

Mary Tunbridge – Divisional Director, CSSD

East Kent Hospitals University NHS
NHS Foundation Trust

Our Outpatient Clinical Strategy

Key principles:

- a **reduction** in the number of sites from which the Trust provides general outpatient services, from 15 site down **to 6 or 7 sites** (historically the Trust had 22 sites but currently 15);
- **improving patient access** based on local postcodes;
- each site offering a **broad spectrum of specialities**;
- a **20 minute travel** time by car for a majority of the population;
- **extending the working day** to offer a greater choice of appointment times;
- **extending the one stop model** to reduce follow-up attendances and improve efficiency;
- **introduction of Telemedicine** to reduce face-to-face contacts for some patients; and
- ensuring the **facilities** from which the Trust provides outpatient services **are fit-for-purpose** i.e. upgraded where necessary.

East Kent Hospitals University NHS
NHS Foundation Trust

Our Outpatient Clinical Strategy

Phase 1

Reduce to 6 sites

Design and build the infrastructure:
- New Dover Hospital
- Estuary View
- Invest in procedure suites

Move current workforce, clinics and provisions

Phase 2

Improve patient experience

- Clinics early morning, evenings and Saturday morning
- Extend one stop models
- Introduce telemedicine

Outpatient Improvement Programme - Overview

East Kent Hospitals University NHS
NHS Foundation Trust

The Outpatient Programme Timeline

Short Term
April to June 2015

CQC Improvement plan

Establish our 6 site model

Establish our baseline and future plans for specialties

Agree our capital spend for OPD improvements

Medium Term
July 15 to April 16

Establishing our divisional / specialty outpatient strategies

Optimising our service delivery
- Roll out of improved processes e.g. partial booking
- Review and support capacity and demand management
- Roll out Productive Outpatient Programme
- Support increase in Choose and Book compliance

Continuing our estates and infrastructure improvements

Longer Term
April 2016 onwards

Embedding our divisional / specialty outpatient strategies

Optimising our service delivery
- Continue Productive Outpatient Programme
- Review and refine our improved processes
- Review OPD workforce requirements
- Exploitation of new technology

Review capital expenditure programme and make future plans

Supporting continuous improvement culture

Measures for success
Improvement rating from CQC inspection
Agreed plans and compliance with principles and expected outcomes

Expected Benefits
Improved patient and staff experience
Improve patient safety and outcomes
Reduced operating costs

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CQC INSPECTION REPORT: EAST KENT HOSPITALS NHS FOUNDATION TRUST

By: David Hargroves, Consultant Physician, Chair of the Improvement Plan Delivery Board

To: Health Overview and Scrutiny Committee, Friday 5 June 2015

Subject: CQC Inspection Report: East Kent Hospitals NHS Foundation Trust

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals NHS Foundation Trust.

1. Introduction

The Care Quality Commission (CQC) is the national regulator for health and adult social care. Its role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish what they find, including performance ratings to help people choose care.

The CQC sets out what good and outstanding care looks like and makes sure that services meet fundamental standards of care.

When undertaking an inspection the CQC asks five questions:

- Are services safe?
- Are services effective?
- Are services caring?
- Are services responsive to people's needs?
- Are services well-led?

For health and social care these questions are defined as follows:

Safe	By safe, we mean that people are protected from abuse and avoidable harm.
Effective	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.
Well-led	By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Each of the five key questions is broken down into a further set of questions called key lines of enquiry (KLOEs); with different KLOEs for each sector. The KLOEs helps ensure consistency in approach and that CQC inspectors focus on the areas that matter most.

There are eight core services that the CQC inspect in every acute hospital, irrespective of risk. These services are:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynecology
- Services for Children and young people
- End of life care
- Outpatients and diagnostic imaging.

Inspections are usually limited to these core areas.

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2. Background Documents

CQC (2015) '*How CQC regulates NHS and independent acute hospitals Provider handbook'*
http://www.cqc.org.uk/sites/default/files/20150327_acute_hospital_provider_handbook_march_15_update_01.pdf

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3. EKHUFT CQC inspection, March 2014

3.1 Introduction

East Kent Hospital University Foundation Trust (EKHUFT) was inspected by the Care Quality Commission (CQC) in March 2014 with the final report issued in August 2014.

The overall rating for the organisation was Inadequate. This is summarised below.

EKHUFT	
Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective	Requires improvement
Are services at this trust caring	Good
Are services at this trust responsive	Requires improvement
Are services at this trust well-led	Inadequate

3.2 Key findings

The report identified the following key findings:

- There was a concerning divide between senior management and frontline staff.
- The governance assurance process and the papers received by the Board did not reflect our findings on the ground.
- The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.
- Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.
- The number of staff who would recommend thehospital as both a place to work or to be treated is significantly less than the England average.
- Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.
- Throughout the trust there were a number of individual clinical services that were poorly led.
- There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.
- Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were nottrained and had not participated in a practiceexercise, given the location of this trust and itsproximity to the channel tunnel this is a significantconcern.
- We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.
- An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.
- Policies and procedures for children outside of the neonatal unit did not reflect National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.
- Children’s care outside of recognised children’s areas (such as the children’s ward, the neonatal unit and the children’s centre) fell below expected standards.
- Equipment in areas where children were being treated was identified as being out of date and not safe.
- There was a lack of evidence-based policies and procedures relating to safety practices across the sites, and a number of out of date policies across the trust.
- In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.
- We saw examples where audits had not been undertaken effectively and provided false assurance.

- We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe.
- Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen.
- Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life.
- The complaints process was not clear or easy toaccess. The trust applied its own interpretation of the regulations and had two categories of complaints. A high number of complaints were referred to the Ombudsman, and there were 16 open cases as of December 2013.

3.3 Overview of ratings by site

The three main sites: Queen Elizabeth The Queen Mother (QEQM), William Harvey Hospital (WHH) and Kent and Canterbury Hospital (K&C) were each inspected. Their ratings are below.

QEQM							
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**		**Overall**
A&E	Inadequate	Not rated	Good	Inadequate	Inadequate		Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Good	Inadequate		Requires improvement
Critical care	Good	Good	Good	Good	Good		Good
Maternity & family planning	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Children and young people	Good	Inadequate	Good	Requires improvement	Requires improvement		Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement		Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate		Requires improvement

WHH							
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**		**Overall**
A&E	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate		Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Inadequate	Requires improvement	Good	Inadequate	Inadequate		Inadequate
Critical care	Good	Good	Good	Good	Good		Good
Maternity & family planning	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement		Requires improvement
Children and young people	Inadequate	Requires improvement	Good	Good	Inadequate		Inadequate
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement		Requires improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate		Inadequate

K&C							
	Safe	**Effective**	**Caring**	**Responsive**	**Well-led**		**Overall**
Emergency Care Centre	Requires improvement	Not rated	Good	Requires improvement	Inadequate		Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement		Requires improvement
Surgery	Inadequate	Good	Good	Good	Inadequate		Inadequate
Critical care	Requires improvement	Good	Good	Good	Good		Good
Maternity & family planning	Service not available at K&C						
Children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement		Requires improvement
End of life	Requires	Requires	Good	Requires	Requires		Requires

care	improvement	improvement		improvement	improvement		improvement
Outpatients	Inadequate	Not rated	Good	Requires improvement	Requires improvement		Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate		Inadequate

3.4 Quality Summit and EKHUFT response

Following the inspection, the CQC organised a Quality Summit, chaired by Monitor, to discuss their findings. All key stakeholders were invited to the meeting including: NHS England, CCGs, Healthwatch, GMC, HEKKS and KCC.

EKHUFT welcomed the CQCs report and are using the recommendations to inform plans for our longer term improvement journey. Although the overall results were disappointing, we were pleased to see that the Trust performed particularly well across all sites on both caring and the provision of critical care services.

Following publication of the reports the results of the inspection were shared with staff across the Trust at open forums led by the Chief Nurse, Director of Quality or Chief Executive.

3.5 Special measures

As a result of the inadequate CQC rating, Monitor placed the trust in special measures on 29 August 2014 and appointed an Improvement Director (Sue Lewis) to oversee delivery of change.

3.6Development of an Improvement Plan

A High Level Improvement Plan (HLIP), based on the Must Dos and Key Findings in the reports, was produced and submitted to CQC for review. A more detailed action plan, developed with staff from across the Trust, was then produced to support achievement of the HLIP. The detailed action plan breaks down the Must Dos and Key Findings from the HLIP into measurable steps and identifies the responsible officer, due date for completion and an assessment of the risks to delivery and actions needed to mitigate risks.

The Improvement Plan Delivery Board (IPDB), which reports to the Trust Board, was established to monitor progress against the HLIP and associated action plans. The IPDB is chaired by Dr David Hargroves, Consultant Physician (who commenced in December). It has met monthly since 29 Oct 2014. The terms of reference for the IPDB were approved by the Trust Board on 30 October 2014.

A programme office was established to oversee delivery of the plan. This is overseen by the clinical lead (Dr David Hargroves) and is staffed by a full time programme manager and a part time administrative assistant.

3.7 Monthly review process

Divisional leads are asked to provide a monthly progress report to the Programme Management Office on each of their detailed actions and to send evidence for all completed actions.

Each detailed action is then RAG rated by the Programme Office where:
Blue = Completed(and evidence received)
Green = On track to deliver by the due date
Amber = Some issues with delivery and may not deliver by due date
Red = Not on track to deliver by due date

The updates and RAG ratings are used to populate the detailed plan which is accessible to all staff through the staff intranet. This isthen summarised and used to record progress against the HLIP and the monthly NHS Choices Special Measure Action Plan, both of which are submitted on a monthly basis to Monitor.

TheRAG ratings for actions on the HLIP since January 2015 are given below. (Table 1) These show a steadily improving position.

Table 1: RAG ratings

	Definition						**Forecast**
		7 Jan 2015	**4 Feb 2015**	**18 Mar 2015**	**15 Apr 2015**	**20 May 2015**	**July 2015**
Blue	Delivered	2 (4%)	1 (2%)	2 (4%)	10 (21%)	15 (32%)	20 (43%)
Green	On track to deliver	25 (53%)	24 (51%)	22 (47%)	22 (47%)	15 (32%)	14 (30%)
Amber	Some issues – narrative disclosure	18 (38%)	17 (36%)	19 (40%)	14 (30%)	14 (30%)	13 (26%)
Red	Not on track to deliver	2 (4%)	5(11%)	4 (9%)	1 (2%)	3 (6%)	0 (0%)

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3.8 Areas of concern

The main areas of concern are:

Staffing

Recruitment of staff, particularly in some areas, is challenging. We have, however, taking action to address this by adopting more innovative recruitment practices. We are also working to improve staff retention through: introducing new induction processes, addressing pressures caused by long term sickness and absence and offering exit interviews to help understanding of why staff are leaving.

Paediatric trained staff in A&E

We have paediatric trained staff working in A&Ebetween the hours of 8am and 8pm - which is when the majority of children attend A&E. We have not yet been able to recruit paediatric trained staff to work outside these hours; if children arrive in A&E during the night then staff from the paediatric wards are called to provide support.

From September 2015, however,paediatric training will be provided for 'adult' nurses working on A&E.

Medicines management

There are still some areas of the trust where medicines management is not as strong as expected. The site matrons are working on improvements with the identified wards and performance is being monitored through regular audits.

Patient flow

Work is being done to improve patient pathways and flow through the hospital. We have also recruited more pharmacists (expected to start in September). Once these are in post, we will be able to assign pharmacists to wards which will help speed up the discharge process.

Outpatient booking

We have recruited more booking clerks and have introduced partial booking of follow up appointments in ophthalmology and cardiology. There is, however, still a lot more to be done in this area.

Estate and environment

We have undertaken significant work to improve the quality of the environment in which patients are cared for; we have had plans drawn up to improve the outpatient departments at QEQM and WHH, we have started upgrading the A&E department at WHH and we have produced a maintenance programme for all areas. There is, however, still more work to be done. We are still not wholly compliant with mixed sex requirements, for example, though work is underway to try and address this.

4.0 EKHUFT CQC re-inspection, July 2015

The CQC have announced that they will be re-inspecting the Trust in the week commencing 13 July 2015.In addition there will be unannounced visits - probably in the two weeks prior to 13 July 2015.

The re-inspection will be a full inspection covering K&C, QEQM, WHH and Dover. It is expected that there will be around 30 inspectors based at WHH and 30 based at QEQM; members of these teams will also cover Dover and K&C.

A short-term multi-disciplinary steering group has been set up to oversee preparations for the CQC re-inspection. This group meets weekly and reports into the Improvement Plan Delivery Board. The steering group has agreed the approach for preparing for re-inspection and has focussed efforts on setting up site based teams and developing materials to support them in preparing for re-inspection.

On Friday 8 May we held our first mock inspection of QEQM, K&C and WHH; over 60 staff, patients, carers and external colleagues participated in the event. Using the CQC's key lines of enquiry (KLOEs), visits were undertaken to inspect our progress against the improvement plan and the five domains of safe, effective, caring, responsive and well-led. In addition, three focus groups took place, and a separate group reviewed our data and information packs.

Feedback was given on the day and clarification and queries discussed. There were celebrations around the way some of our services are delivered and, in particular, around the compassion and caring displayed by our staff. There were a number of improvement points identified including: cleanliness, information governance compliance and medicines management compliance. These were discussed at the IPDB away day that took place on May 11th.

5.0 Next steps

We will continue to work with staff across the trust to prepare for re-inspection.

The preparation for the re-inspection and the re-inspection itself are seen as key milestones in our improvement journey which is going to take much longer to ensure that effective clinical leadership and cultural change is embedded.

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By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 5 June 2015

Subject: Emotional Wellbeing Strategy for Children, Young People and Young Adults

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided on the Emotional Wellbeing Strategy for Children, Young People and Young Adults.

It provides additional background information which may prove useful to Members.

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1. Introduction

(a) The Health Overview and Scrutiny Committee considered reports on emotional wellbeing and mental health services for children and young people in Kent on 31 January 2014, 11 April 2014, 6 June 2014 and 10 October 2014.

(b) On 10 October 2014, the Committee agreed the following recommendation:

- *RESOLVED that the guests be thanked for their attendance at the meeting, that they be requested to take note of the comments made by Members during the meeting and be invited to submit progress reports to the Committee within six months and at the end of the financial year.*

(c) NHS West Kent CCG and Kent County Council have requested the opportunity to bring the attached reports to the attention of the Committee.

2. Recommendation

RECOMMENDED that the report be noted and NHS West Kent CCG and Kent County Council be invited to submit an update to the Committee at an appropriate time.

Background Documents

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (31/01/2014)'*,
https://democracy.kent.gov.uk/mgAi.aspx?ID=27048

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (11/04/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=27877

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (06/06/2014)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5397&Ver=4

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (10/10/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=29245

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NHS
West Kent
Clinical Commissioning Group

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years) (CAMHS)

Health Overview and Scrutiny Committee

5th June 2015

Patient focused, providing quality, improving outcomes

Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25 years)

Summary

This paper provides a progress report on the development of the Emotional Wellbeing Strategy for Children, Young People and Young Adults and associated Delivery Plan.

Extensive consultation events have taken place during 2014 and in early 2015 to develop a whole system approach to emotional wellbeing and mental health. Work is now taking place to implement the associated Delivery Plan; short term actions have been identified and are in progress and longer term work on the pathway, service model and future commissioning plans has started.

Work is continuing with partners to look at how existing resources can be aligned to support this work. A draft service model is being developed that will inform the contract procurement process to commence in the autumn 2015.

Recommendation

Members of the Kent Health Overview Scrutiny Committee are asked to note the contents of this report.

1. Introduction and Background:

1.1. In January 2014 Kent HOSC raised concerns regarding the performance of child and adolescent mental health services across Kent. This prompted a review of the services and whole system agreement that a new approach to children's mental health in Kent was required.

1.2. This issue is clearly of national concern. A national task group set up by Norman Lamb, Minister for Care and Support reported similar concerns to those in Kent. This important work stream for Kent strategically fits with work across the country in improving children's emotional wellbeing provision. It strategically aligns with the NHS Fiver Year Forward View, the mental crisis care concordat and KCC transformation programme for 0-25 year olds.

1.3. Emotional wellbeing underpins a range of positive outcomes for children and young people and is a key multi-agency agenda. Nationally and locally, demand is rising for specialist mental health services; three children in every class have a diagnosable

mental health condition (10 per cent) and there is recognition of the need for a whole-system approach to promote wellbeing, identify need appropriately, and intervene earlier.

1.4. Over the last year a huge amount of work and negotiation has taken place to transform children's emotional wellbeing services in Kent. The emotional and wellbeing strategy has been developed and consulted on widely with children, young people and families.

1.5. In light of the complexity of the challenge, agreement was reached across the system to extend two major children and young people's contracts to allow the time for organisations to develop a major transformation programme for children's and young peoples emotional wellbeing services across Kent.

1.6. This work has been developed though a range of partnership structures and governance arrangements to ensure whole system commitment and agreement. This has included regular reporting to both the Children's' and Kent Health and Wellbeing Board, bespoke strategic summit events, clinical commissioning group governance structures and KCC 0-25 Portfolio Board.

This report summarises the:

- Final version of the Strategic Framework
- A multi-agency Delivery Plan
- The emerging draft model.

2. Overview of Activity

2.1. Development of the Emotional Wellbeing Strategy (appendix 1) and supporting delivery plan (appendix 2) has been driven by a real desire to engage with and listen to the views of children, young people, families and professionals of all backgrounds. In total, around 650 contributions have been received since June 2014 via a range of online surveys, workshops, and engagement events. The amount of interest and quality of responses given by such a wide cross-section of the local population and workforce underline the importance of this agenda, both at a strategic level and in the everyday experience of families in Kent.

2.2. The aim of such extensive engagement was to piece together a variety of perspectives in order to understand how best to design a 'whole system' approach; one not only focussed on the quality of commissioned services (crucial though these are), but also on strengthening partnership working at every stage, improving the visibility and accessibility of support, and underlining the role of all partners to promote and protect emotional wellbeing.

2.3. In addition to engagement activity, the content of both the Strategy and Delivery Plan has been directed by the findings of a refreshed Emotional Wellbeing Needs Assessment, and from a range of national and local reviews and best practice guidelines.

2.4. This issue is everybody's business. Families, schools and universal services play the key role in promoting children's emotional wellbeing. In addition to universal provision KCC commissions and manages contracts that deliver a range of services in relation to emotional wellbeing and is responsible for two key contracts relating to emotional wellbeing - the Young Healthy Minds Service and the Children in Care element of the CAMHS contract. The NHS clinical commissioning groups are responsible for commissioning targeted Child and Adolescent Mental Health Service. The specialist services are commissioned by NHS England.

3. Strategic Framework

3.1. The Strategy was developed following initial surveys and facilitated discussion groups with children, young people and families and from service providers.

3.2. The draft Strategy has been consulted on widely and a 12-week period of engagement ran from 20 October 2014 to 5 January 2015 through the following channels:

- **Online consultation survey**, hosted on kent.gov.uk and CCG platforms, with links through the Live it Well website and KELSI. The survey was further promoted through the Schools e-Bulletin, GP bulletins, Members' bulletins, District Council and Voluntary and Community Sector (VCS) networks, Health Watch Kent and Kent Public Health Observatory.

- **Presentation of the draft Strategy and consultation discussions** held at a wide range of strategic and local multi-agency forums, including Kent Health and Wellbeing Board, Health and Social Care Cabinet Committee, clinical

commissioning groups, Mental Health Action Group Chairs, local Health and Wellbeing Boards, patient involvement forums, and Children's Operational Groups.

3.3. In addition to the discussions held, a range of individuals and organisations responded to the consultation. Overall findings indicated:

- 100% of respondents identified parents and carers as the primary group needing additional information and support around emotional wellbeing issues.
- Schools were identified as the second key group needing additional information and support around responding to emotional wellbeing**.**
- The structure of the strategy is around four themes; Early Help, Access, Whole Family Approaches, Recovery and Transition, however importantly the underpinning action to promote emotional wellbeing at every opportunity was unanimously welcomed.

3.4. Following consultation, a number of amendments have been made to the original Strategy to incorporate feedback received (including the addition of content relating to children affected by Child Sexual Exploitation and to target health inequalities). The final version of the strategy is provided in appendix 1 of this paper.

4. Development and Engagement Activity for The Delivery Plan

4.1. In addition to the online consultation, a number of engagement events were held during November and December 2014 to inform development of the supporting Delivery Plan. These included:

- Practitioner workshops
- Further engagement with young people, including the development of a second film sharing young people's views about the most valuable methods of delivering support
- A second Emotional Wellbeing Summit (18 December 2014). A number of KCC members attended the summit events.

4.2. The draft Delivery Plan summarises findings from the Kent Emotional Wellbeing Needs Assessment, engagement activity, and best practice reviews and outlines a series of recommended actions that together will lay the foundation for a whole-system approach to emotional wellbeing.

4.3. The recommended actions will be achieved through a combination of improved partnership working, particularly in relation to much more and more effective communication, training for universal services staff, and also access to consultation with specialist professionals, as well as key procurement activity.

4.4. This means that some of the actions can be implemented in the short-term, which began in March 2015, while others will need to be included within procurement exercises for new services beginning in October 2016 (when existing contracts with providers will expire). Suggested timescales are included within the Delivery Plan, alongside recommended lead agencies.

4.5. This is clearly a multi-agency action plan; founded on the vision agreed by key strategic stakeholders and partners at the Emotional Wellbeing Summit in July 2014 that emotional wellbeing is 'everybody's business'. The recommended actions will therefore only be achievable with involvement and commitment from a wider range of partners than before – for example, in supporting relevant workforce development or embedding it within planned programmes of training.

4.6. Work is therefore continuing with partners to identify how existing resources can be realigned to support the 'whole system' approach, recognising that this is intrinsically connected to the success of specialist commissioned services in meeting need. The emotional wellbeing and mental health needs of children in care will be considered as part of this work. A technical group is being drawn together to lead on this element, led by the clinical commissioning groups (CCGs).

4.7. **The model**

4.8. The detail required to deliver the model will be contained within the national specs guidance and the specs will inform the future contracts and the contractual framework required. A contract technical group has been established and is developing the draft model with commissioners and clinicians.

4.9. Key points of the model include the following

- Promoting emotional wellbeing – how to embed this in all the work that we do this will include a multi-agency communications strategy.

- A single point of access/triage pathway model across emotional wellbeing early intervention and mental health services.

- Enabling children and young people to receive timely access to support; development of drop-ins or safe spaces in schools.

- Increased availability of consultation from specialist services.

- A 'whole family' protocol, defining how parents and carers will be involved and identifying and responding to the wider needs of the family within assessments of the child's emotional wellbeing.

- Effective implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support.

- Emphasis in the model for continued improvement of performance to agreed contract requirements across the system

5. Next steps:

5.1. During summer 2015, the following activity is planned:

- Continue the implementation of short-term improvement actions identified in Delivery Plan

- Continued scoping of the interdependencies of current pathway developments e.g. neuro development, learning disabilities, Early help, health visiting, eating disorders pathways.

- Finalise the service model

- Develop the new NHS Child and Adolescent Mental Health Service specification, including the Child in Care element of the contract and the early intervention contract and agreeing contract procurement frameworks.

- Technical group to complete activity , capacity mapping and recommend resource allocation

- Consider consultation route for new model and contract framework

- Market engagement to inform development and costing of the model

5.2. It is anticipated that formal procurement processes will begin in the autumn 2015, subject to approval of specifications.

Recommendations

Members of the Kent Health and Overview Committee are asked to

(i) NOTE the contents of this report.

Appendices

1)The Way Ahead, Kent's Emotional and Wellbeing Strategy for Children , Young people and Families

2)The way Ahead, Kent's Emotional and Wellbeing Strategy for Children, Young people and Families

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May 2015

The way ahead

Kent's Emotional Wellbeing Strategy

for children, young people and young adults

Part one: Strategic Framework

Published by Kent County Council on behalf of the Kent Health and Wellbeing Board

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.

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 beyondto 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

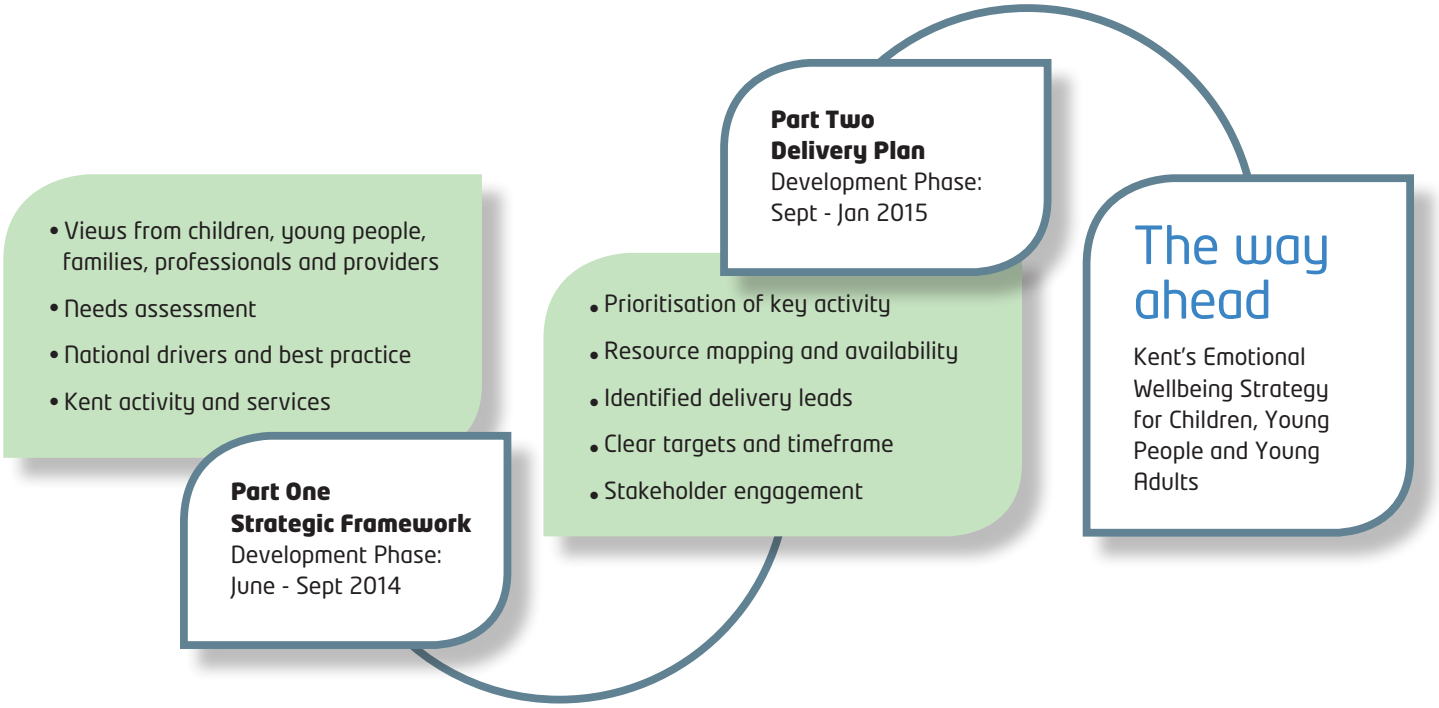
What is 'The way ahead'?

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. This has been further strengthened by a number of legislative drivers, including section 10 of the Children Act 2010, which requires local authorities and their partners to co-operate in improving the wellbeing of children and young people, including mental health and emotional wellbeing.

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 at risk of CSE or who may have been sexually exploited 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 Conditions (ASC).
  - 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.
  - Children and young people affected by family poverty

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.

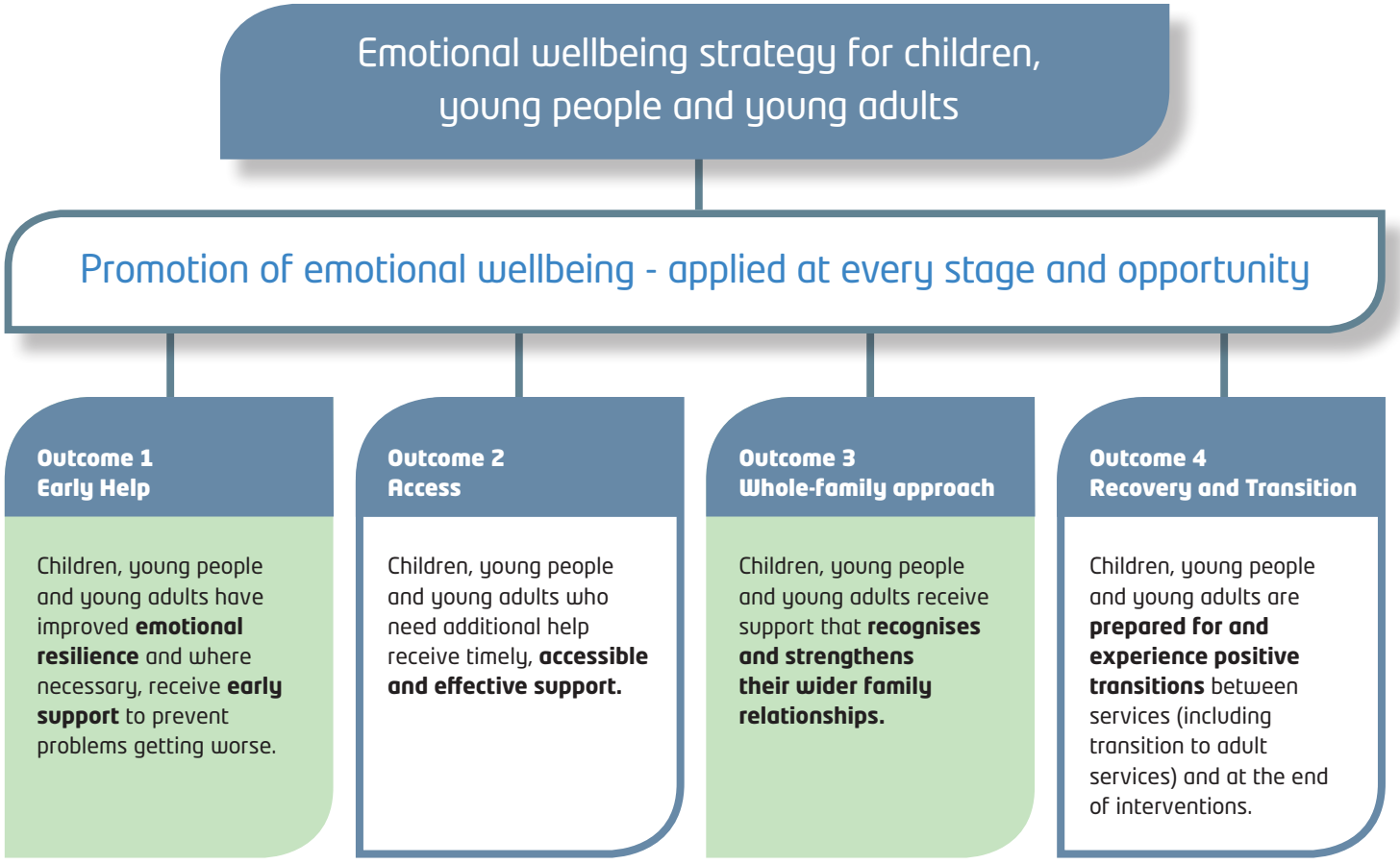
5 Supporting Young People's Mental Health: *Eight Points for Action: A Policy Briefing from the Mental Health Foundation* (2007) and International Association for Youth Mental Health: *International Declaration on Youth Mental Health* (2013)

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 (such as family poverty).
- 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 (ASC) and families.

5. Improve our targeted outreach to the most vulnerable groups, particularly young offenders, children in care, those at risk of CSE or who may have been sexually exploited 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 receive support that **promotes recovery,** and they 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 *promote and demonstrate a set of values that supports recovery through empowering children, young people and families;* recognising strengths and building resilience; promoting choice; and enabling them to achieve and sustain positive long-term outcomes.

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 second part of this document, the Delivery Plan, forms a multi-agency action plan for implementation from 2015 onwards, based upon wider engagement with the public, partners and professionals. This document will define the key actions needed to achieve our four outcomes, including service design, commissioning intentions, and performance measures.

This Strategy will continue to be overseen and monitoring by the Kent Children's Health and Well-being Board, which will hold responsibility for ensuring that both elements of this strategy are widely understood and committed to by partners.

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.*

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Department of Health (2012) *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer 2012*

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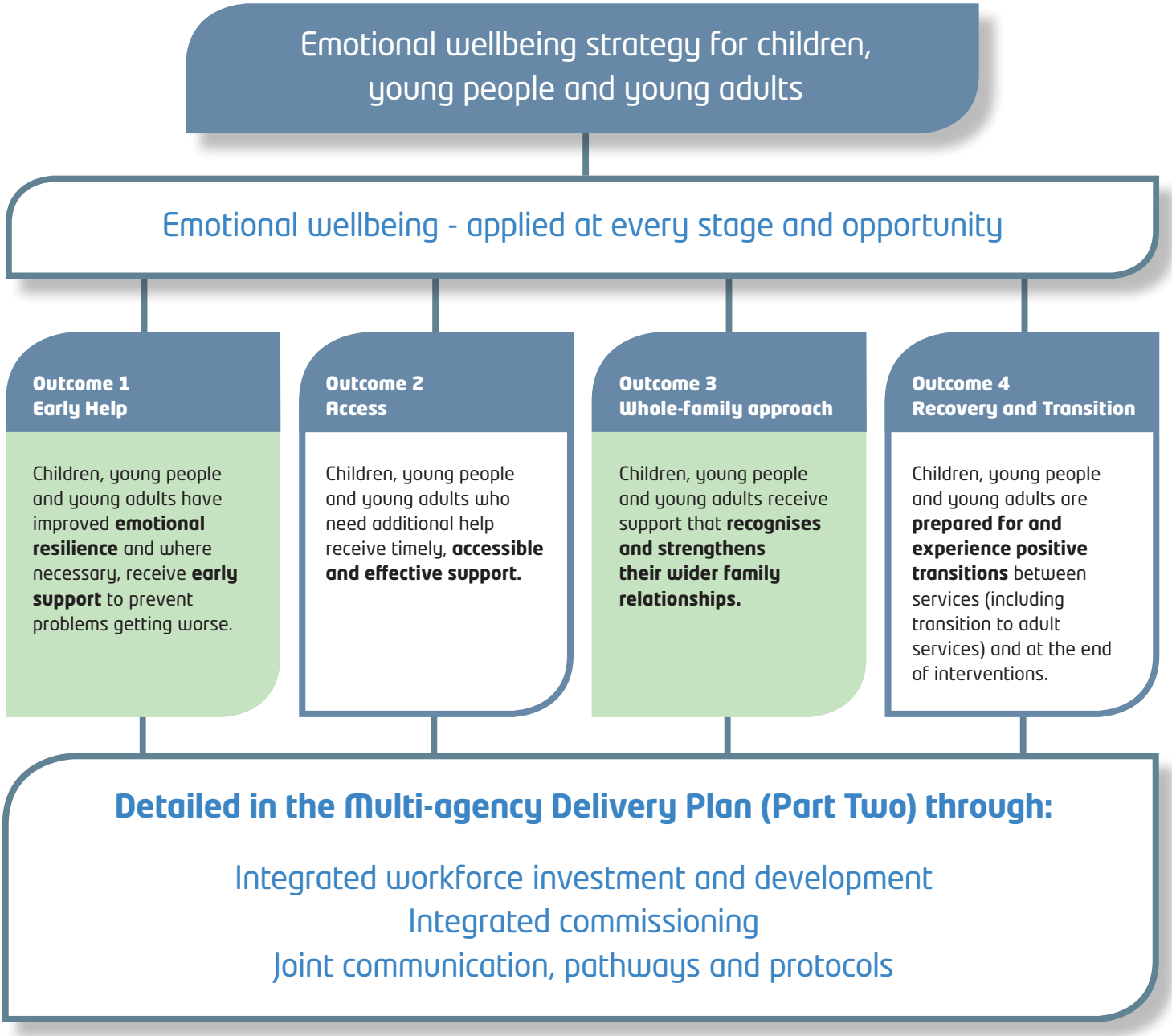
Quick reference: Outcomes Framework



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

The Way Ahead: Kent's Emotional Wellbeing Strategy for Children, Young People and Young Adults and Families

Part 2 – Delivery Plan

Foreword

In September 2014, partners on Kent Children's Health and Wellbeing Board published the first part of a new Emotional Wellbeing Strategy for children, young people and young adults. This document set out a framework of four key outcomes, based on national and local research and early consultation activity with families and professionals, and made the commitment to translate these principles into a multi-agency delivery plan, ready for 2015.

The proposed delivery plan is set out within the following pages and forms Part 2 of our Strategy. The recommendations we are making lay the foundations for **a new system of support that extends beyond the traditional reach of commissioned services**, recognising that promoting and protecting the emotional wellbeing of our children and young people is far bigger than any individual organisation. Equally, this means that its success will depend upon the strength of commitment from a far wider range of partners in Kent than before: a commitment that recent months have indicated is in place, through the level of interest, support and consensus for this agenda across organisational and professional boundaries. Improving emotional wellbeing is not only 'everybody's business' – but, as our conversations have repeatedly shown, is the common ground at the heart of all we do.

Words will only take us so far, and this Delivery Plan marks the beginning of the action - distilling a range of short-term improvement actions, workforce development plans, and recommendations for longer-term future commissioning from the large amount of contributions we have received from families and professionals, and the detailed needs analysis which has now been completed.

It will be as much a journey for us as partners, as for those we seek to support – and we will need to return to this expression of commitment through the challenges and changes ahead. Just as **learning to communicate our ideas, thoughts and feelings, and developing strong and healthy relationships** are vital aspects of emotional wellbeing, so these same values will need to be the basis of our relationship as partners who seek to promote and deliver this agenda.

Andrew Ireland

Chair of Kent Children's Health and Wellbeing Board

April 2015

Part 2: Overview

The first part of our Strategy set out key outcomes for children and young people aged 0-25, supported by an underpinning principle of the need to **'promote positive emotional wellbeing'** at all stages and levels of need.

Early Help	Children, young people and young adults have improved **emotional resilience** and where necessary receive **early support** to prevent problems getting worse.
Access	Children, young people and young adults who need additional help receive **timely, accessible and effective support**.
Whole Family Approaches	Children, young people and young adults receive support that **recognises and strengthens their wider family relationships**.
Recovery and Transition	Children, young people and young adults receive support that **promotes recovery**, **and they are prepared for and experience positive transitions** between services (including transition to adult services) and at the end of interventions.

This document develops the principles set out in Part 1 of the Strategy and translates them into a series of short and medium term actions, to be taken forward by partner agencies in Kent.

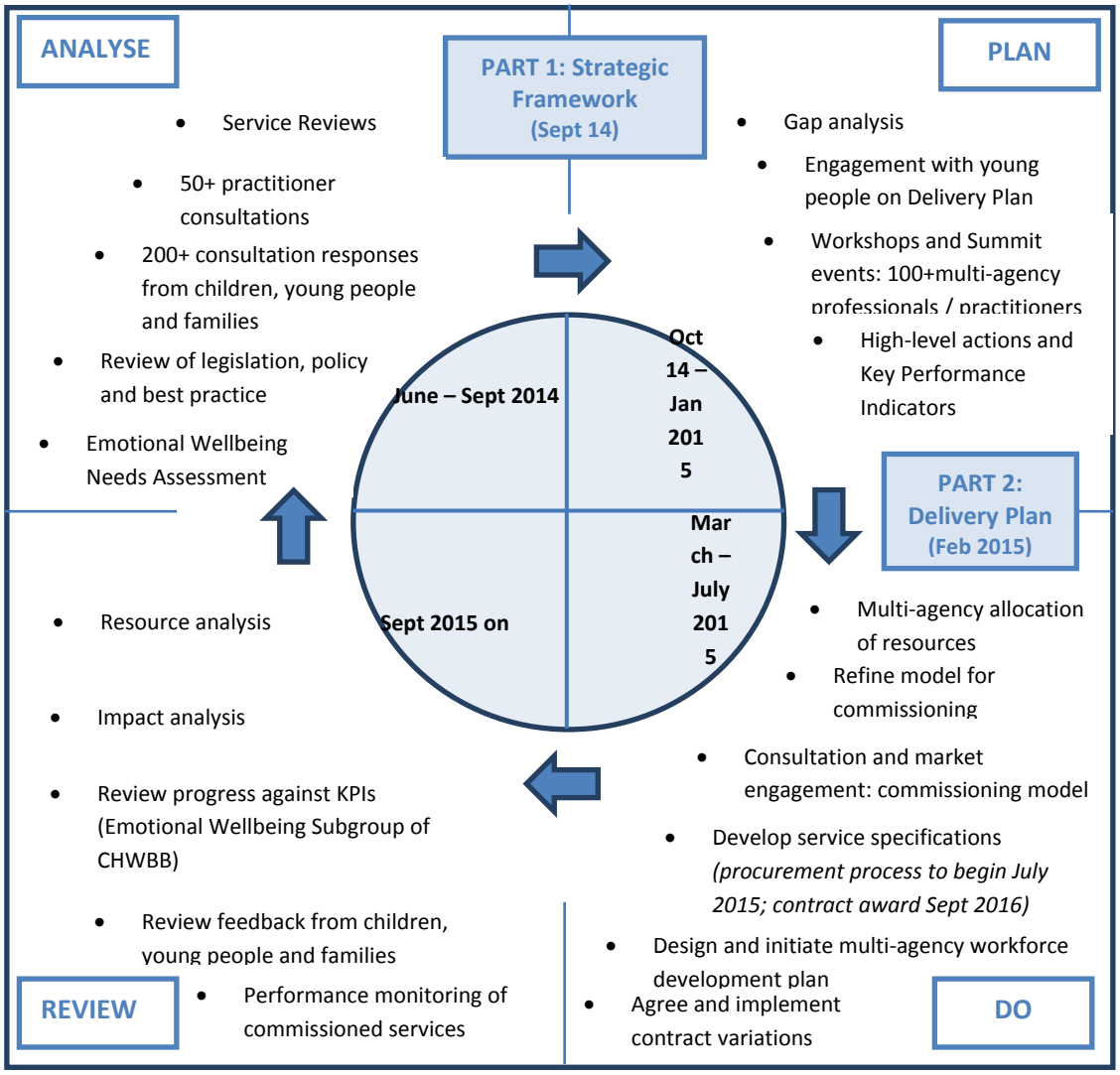
How has this Delivery Plan been developed?

In developing both the Strategy and this Delivery Plan, partners in Kent have drawn information from a wide range of sources and led a number of activities involving children, young people and families, in order to gain a fuller understanding of the level of need in Kent and the actions needed to establish a more connected 'whole system' of support around emotional wellbeing.

The interpretation of these findings has also been shaped by awareness of, and sensitivity to, changes that are underway in related services and workstreams – for example, within Kent County Council's Early Help offer; with integration plans between Health and Social Care; with development of the HeadStart programme, and with the commissioning intentions of Kent's Clinical Commissioning Groups (CCGs).

A more detailed summary of the development undertaken is available at Appendix 2. The following diagram is based around the commissioning cycle and gives an overview of progress and projected activities:

Developing a whole-system approach to Emotional Wellbeing:



The phases following this Delivery Plan will focus on implementing the recommended actions, through a combination of partnership working, workforce development, variations to existing services, and procurement processes leading to the next generation of commissioned services. Together, these actions will support emotional wellbeing in its widest sense, but will first require re-consideration of how existing resources are allocated, and how they might be better assigned in order to establish a 'whole system' approach.

Some of these actions will have the potential to be implemented swiftly, beginning from April 2015; others will need to be incorporated within a longer-term process of procurement (set out in the **'plan'** and **'do'** phases of the commissioning cycle diagram above).

Executive Summary: Key findings from the 'analyse' and 'plan' phases

Through research, analysis of local and national evidence, and consultation with local children, young people and practitioners, the following key principles have emerged. This information is set out under each of the outcome areas described in Part 1 of the Emotional Wellbeing Strategy:

1. Promotion of Emotional Wellbeing

> *"Everyone talks about sex education, but there is nothing about Mental Health Education"*
>
> *"Mental Health needs to form part of everyday conversations in school – perhaps as part of a PSHE module to reduce the stigma and make mental health issues normal."*
>
> **2014 Emotional Health and Wellbeing Summit**

- Universal services, including children's centres, health visitors, schools, colleges, and youth settings have a key role to play in promoting positive emotional wellbeing and attachments and reducing the perceived stigma around emotional wellbeing difficulties, demonstrating to children, young people and families how to understand and express feelings and manage relationships safely and appropriately. We need to strengthen **whole-setting or whole-school approaches**, as well as sharing best practice in relation to **classroom techniques**, **pastoral or parenting support**.
- We will learn from the national and local Big Lottery Funded HeadStart programme which aims to equip young people to cope better with difficult circumstances by building resilience. This will include building on learning from; school programmes, peer education, mentoring and coproduction, safe spaces, community activities, social marketing campaigns and use of the digital world.
- Promotion of positive emotional wellbeing is particularly vital in the **antenatal and postnatal period**, a time which can place additional strain on relationships and may exacerbate any underlying parental emotional wellbeing difficulties. We need to strengthen partnership working between universal and specialist services around identification and assessment of need, and make clearer the pathways for accessing support during pregnancy and early parenthood. As part of this, we need to review local practice against newly published NICE guidelines (2015)[1].
- Promoting positive emotional wellbeing is similarly vital to groups who have been traditionally less likely to access support, including those from Black and Minority Ethnic (BME) groups, Gypsy Roma Traveller (GRT) communities, and young people and young adults who are lesbian, gay, bisexual or transgender (LGBT). This needs to be clearly linked to whole-school, and whole-setting, approaches around issues relating to **identity, diversity and inclusion.**
- Recent consultation activity with LGBT young people has particularly highlighted the importance of settings being inclusive and non-judgemental, and the value of a multi-agency 'hub' model to engage LGBT young people, build friendships and offer support from services.
- Promotion of emotional wellbeing must not just be focussed on universal settings, but should form a **part of interventions at all levels of need.** This means that emotional wellbeing promotion will need to form part of a partnership-led workforce development plan.

[1] *Antenatal and postnatal mental health* (National Institute for Clinical Excellence, 2015).

2. Early Help

> *"Being there from the start. Universal and targeted services in settings where both individuals and families feel comfortable accessing services, with staff that are trained to recognise when families or individuals need support accompanied by a no wrong door approach"*
>
> **2014 Emotional Health and Wellbeing on-line engagement survey part 1.**

- Universal services need a **clearly defined and communicated offer to support identification** of emotional wellbeing difficulties in children, young people and their families and with them develop an appropriate response. This needs to include workforce development, which enables a holistic picture of assets and capabilities as well as having access to professional consultation from qualified mental health practitioners prior to making referrals, and improved communication and ability of everyone to negotiate and navigate of what support is available locally and for whom.
- **Assessment of need should be overseen by a qualified mental health practitioner** at the 'front door', and should explore and take account of broader family functioning to identify underlying needs, prior to bringing in any additional support. This is likely to work best as part of a co-located multi-agency model, with mental health practitioners offering consultation advice and group supervision to staff in universal settings.
- A range of **effective and adequately resourced early help approaches** are needed to support emotional wellbeing, recognising that children, young people and families will be involved in the negotiating the required individual packages tailored to their circumstances and needs. The focus should be as much as possible on developing the resilience and skills needed of the child, young person and family to manage their own emotional wellbeing within their familial and community resources, and be equipped to navigate and negotiate their way to the resources which meet their needs. Clear communication through negotiation is needed with children, young people and families at the outset to build a shared understanding of aims of the mutually agreed approaches.
- **Early help approaches and parenting support** (with input from qualified mental health practitioners, paediatricians and other professionals) also needs to be made available in the community for children, young people and families affected by **neurodevelopmental disorders**, as well as for children in care (where this is felt to be appropriate by specialist services).
- The Marmot Review[2] recognises that **health and wellbeing are affected by a wide range of environmental, social and developmental factors** which 'accumulate' over a lifetime, beginning before birth. In order to address the underlying determinants of poor emotional wellbeing, a much broader multi-agency approach is needed which are culturally and contextually appropriate, with early help approaches being developed and delivered across the different life stages, supporting pre-natal wellbeing, early years, school-age and adolescence, right through to the transition to adulthood and family formation.
- Promotion of an integrated approach to **Emotional Wellbeing** and **Speech and Language**. It is widely acknowledged that speech; language and communication skills are essential in supporting the development of skills for life and is fundamental in both the development of learning and social and emotional well-being of a child or young person.

[2] Fair Society, Healthy Lives: The Marmot Review Strategic Review of Health Inequalities in England post 2010. **London: Marmot Review; 2010 referenced in** *Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays* **(Department of Health, 2013).**

3. Access

- **Services need to be more accessible and visible in the community, with capacity to accept self-referral.** As part of this, young people have overwhelmingly recommended drop-in facilities based within schools and other community settings.

- **A single pathway is needed into emotional wellbeing services, with assessment undertaken by a team including a qualified mental health practitioner** to identify underlying needs and risks and explore the broader family functioning, prior to recommending any service-led response. This should help ensure that when necessary, children and young people are directed to the right service first time.
- There must be **effective, and adequately resourced, triage and risk-assessment** at the 'front door' to ensure that those presenting with the highest level of risk access support within appropriate timescales. At all levels of need, but particularly for those requiring intensive interventions, parents and carers must receive **complementary information, advice and guidance, overseen by qualified mental health practitioners,** to ensure that they can appropriately understand and respond to the child or young person's needs and behaviours.

> *"A simple process that can be accessed by professionals, parents and young people with support services that are available promptly."*
>
> *"Better advertising and awareness of available support as well as an on-line or telephone bridging support available whilst waiting for appointments"*
>
> *"Dedicated 24hr phone line or internet support, plus community drop-ins."*
>
> **2014 Emotional Health and Wellbeing on-line engagement survey part 1.**

- Assessment of mental health needs and targeted interventions must be provided routinely to the **most vulnerable groups - particularly Children in Care and Young Offenders**.

4. Whole Family Approaches

> *"Support and guidance without judgement or prejudice is needed for the whole family."*
>
> *"Parents are often left in the dark as to what is going on. To improve the wellbeing of the child/young person we must consider the whole family as when the external support is gone, the family is still there."*
>
> **2014 Emotional Health and Wellbeing on-line engagement survey part 1.**

- **Access to consultation and advice** for parents and carers should be made more widely available and publicised. Practitioners have also recommended that foster carers receive additional specialist training around supporting children in care with emotional wellbeing difficulties as part of their initial and continuing programmes of training.
- Assessment of a child or young person's emotional wellbeing needs should take into account **the wider family context** to ensure that the right support is offered first-time.
- **Protocols** need to be put in place within commissioned services to set out clearly how parents, carers and the wider family will be listened to and (where appropriate) involved as active partners in the design and delivery of support to the child or young person (an approach is known as **co-production** - see definition at Appendix 1).
- This should include sharing complementary information, advice and guidance about understanding and responding to the child's needs and presenting behaviours. This is particularly important to families at times of transition.

"There is a need for a more joined up approach to working – a child needs a central 'passport' that all specialists can see who else is working with the child/young person/family and what they are offering."

2014 Emotional Health and Wellbeing on-line engagement survey part 1.

5. Recovery and Transition

- We need to promote a greater focus on **recovery** within emotional wellbeing services. This doesn't mean that everyone experiencing emotional wellbeing difficulties will be 'cured', but instead represents "a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms."[3] This means adopting and embedding a set of values in the way we work with children, young people and families at all levels, focussed on building resilience; taking a holistic view of the child or young person that looks beyond presenting difficulties; working with children, young people and families as 'partners' rather than passive recipients of services, and empowering children and young people to use their own resilient moves to achieve and sustain positive long-term outcomes.
- Young people and families have told us how important it is to have **continuity of care** and to build relationships with practitioners in order to get the most from the support available. This has implications for transition points **between services**, **at the close of interventions**, and for the **transition process between children and adult services** (which has traditionally been at 18).
- When it is necessary to consider transition between services, children, young people and families should be **involved in decision-making** and be given information and advice to support them in the process.
- We need to see clear and consistent practice around preparing and supporting children, young people and families at the close of interventions, and a clear **'step down pathway'** involving multiple agencies so that positive outcomes can be sustained. This needs to plan with them at the beginning of support.
- The Government's Mental Health Action Plan, *Closing the Gap* (2014) reiterates a commitment to ending the 'cliff edge' of specialist mental health support available after a young person reaches 18. In addition, the Care Act 2014 clarifies duties for local authorities around assessing the needs of a young person (and their family) where it appears that they are likely to need care and support post-18, and where appropriate, planning for the transition to adult services. Within the provisions of the Act, a young person (or their carer) may request a transition assessment and this must be considered.
- In Kent, work is underway to implement a **multi-agency transition protocol** between children's and adult specialist mental health services to smooth the transition where a young person's needs are at a level where they should be transferred to Adult Mental Health; however, there remains a need to better understand the outcomes of those who are signposted at 18 to voluntary / community sector services to inform future commissioning.
- We need to adopt **a young-adult friendly approach for 16-25 year olds.** The proposed development of a new adult **Primary Care and Wellbeing Service**, with a focus on early intervention and prevention, and an integrated pathway between adult primary care mental health services, adult social care, Public Health and the voluntary sector, offers potential for improved transition from Children and Young People's Services to support for young adults. We need to explore options both within this model, and within the proposed 0-25 community hubs, to ensure we offer services in a way most likely to engage young adults.

[3] *Implementing Recovery: A new framework for organisational change* (Sainsbury Centre for Mental Health, 2009)

Our pledge to children, young people and practitioners

The following six statements summarise our commitment to deliver the key recommendations made by the children, young people, professionals and practitioners who have shaped development of this Delivery Plan. This is not intended as a comprehensive list of all the actions required, but offers a summary of underpinning principles needed for a whole-system of emotional wellbeing support:

1. **We will challenge the stigma of poor emotional wellbeing** by providing information, tools and training to children and young people, families, and the children's workforce. This will include strengthening whole school approaches, peer mentoring, parenting support and community groups.

2. We will **support the whole family in relation to emotional wellbeing**, helping parents/carers to identify early signs, be able to access expert advice and support, and build resilience within the family. This needs to include a focus on perinatal and early childhood emotional wellbeing.

3. We need to **bring emotional wellbeing services into children's centres, primary and secondary schools and community settings** and offer a 'drop in' facility for those who need it that gives choice about how and where support is delivered.

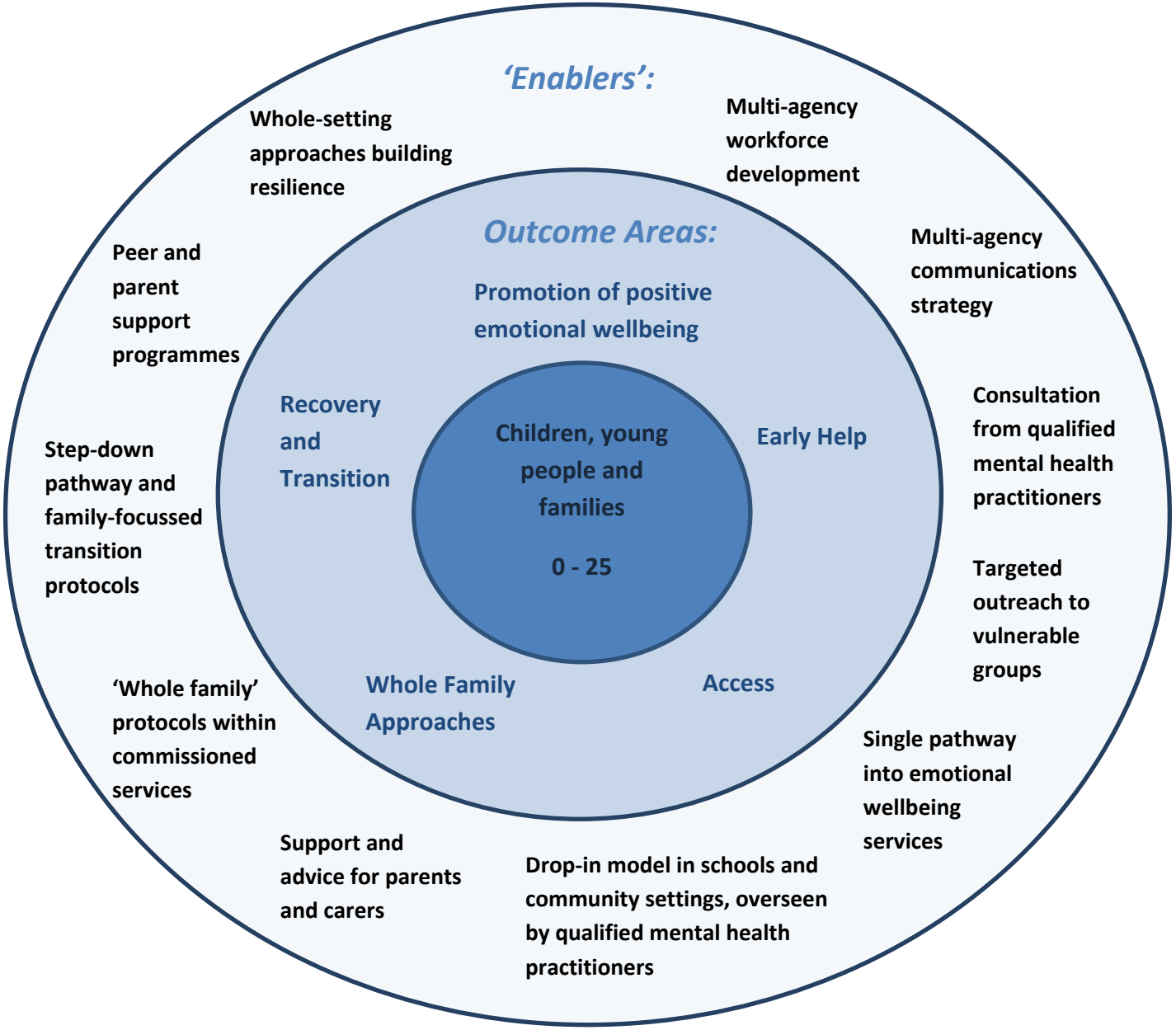
4. We will ensure those working with children and young people have **skills and confidence to identify, seek advice, and respond** appropriately to emotional wellbeing issues, through a multi-agency workforce development programme. This needs to include a clear 'offer' of information, communications and consultation support to front-line staff.

5. **We will develop a clear, single emotional wellbeing pathway**, with qualified, supervised mental health practitioners on the 'front door' to assess underlying needs and potential risks at the earliest possible stage before recommending support options.

6. We will ensure **specialist assessment of our most vulnerable children and young people's emotional wellbeing needs,** including children in care, care leavers, young offenders, and children with learning disabilities and provide a targeted offer to support them.

7. We will **promote and demonstrate a set of values that empowers children, young people and families**, recognising strengths and building resilience; promoting choice and supporting transitions, and enabling them to achieve and sustain positive long-term outcomes.

How do these principles relate to our Emotional Wellbeing Outcomes?



Structure of the Delivery Plan: Outcomes and Actions

The overarching outcomes described in Part 1 of our Strategy (*Promoting Emotional Wellbeing; Early Help; Access; Whole Family Approaches* and *Recovery and Transition*) offer a frame of reference, centred on the child and family's experience. This will help us consider how best we can design 'whole-system' around emotional wellbeing that promotes resilience and meets a range of needs, swiftly and effectively.

These outcomes are relevant across a range of different levels of need – from children and young people who are generally coping well with daily life and experiencing positive wellbeing, to those with more significant emotional difficulties and those with complex or acute needs. **The actions, by which these outcomes can be achieved, however, will need to differ in their design and application at different levels of need.**

This document can therefore be read in two ways:

- The following pages set out our **recommended actions by levels of need.** This includes description of the likely presenting difficulties at each level, estimated numbers (drawing on our Kent Emotional Wellbeing Needs Assessment) and a summary of 'what works', based on a review of the evidence base and contributions from families and professionals who have helped to shape this Delivery Plan. Together, these pages aim to set out a summary of what a 'good' system would offer to achieve our outcomes for children and young people across a continuum of need.

- Alternatively, pages 36 - 42 set out an **index table of all of the actions by outcome area**.

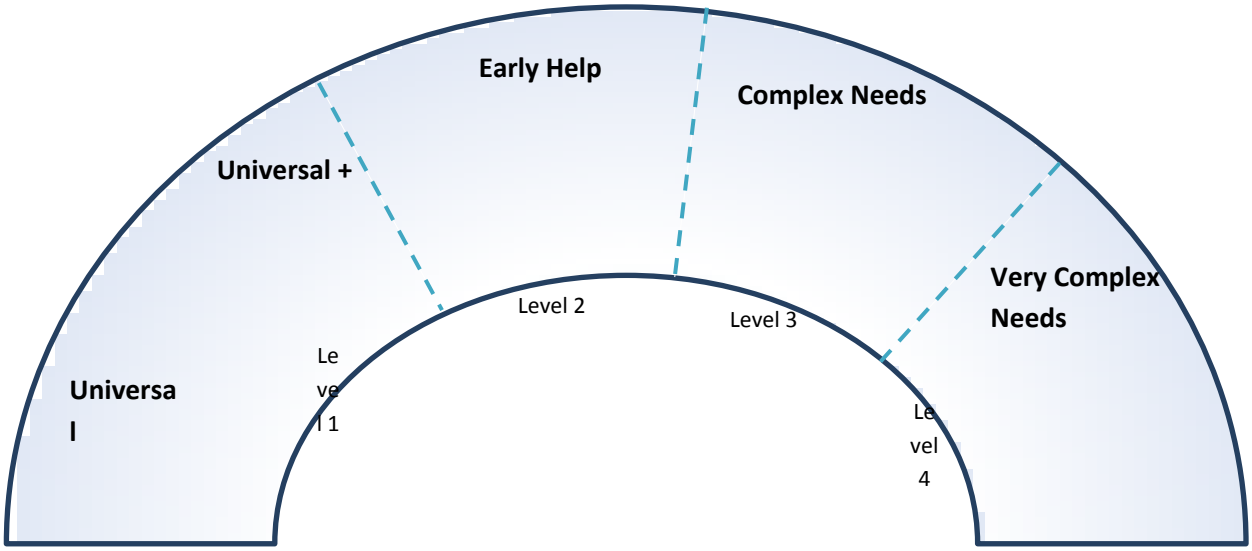
Some definitions and cautions: describing levels of need

Emotional wellbeing is a broad term used to indicate 'a positive state of mind and body: feeling safe and able to cope, with a connection with people, communities, and the wider environment' (World Health Organisation, 2004).

At an individual level, it is much harder to define. Emotional wellbeing can change rapidly in relation to life events, physical and developmental changes, and the quality of our daily interactions with peers, family, and our wider communities. The ability to withstand challenging circumstances and maintain emotional wellbeing (often called 'resilience') is influenced by a number of factors too, including the quality of relationships within the key domains of home, school or education setting, community and peers (as well as our inherent values, behaviour, and interests – all of which are also shaped by exposure within these key settings).

This means that no two individuals will necessarily respond in the same way to similar life experiences or circumstances, and that individuals will experience different levels of need at different times– and so the support we offer needs to be individually-led throughout.

To ensure we can meet a range of needs within the system, we are following some broad definitions which describe some of the **likely levels within the broad continuum of emotional wellbeing**. These definitions are set out in the following diagram:



Level 1: Universal and Universal +

The vast majority of children, young people and young adults will experience positive emotional wellbeing most of the time, and develop along normal emotional, social and behavioural pathways. They will almost certainly experience challenges, and periods of instability, as part of the process of growing up – but will receive sufficient support from the family, school and wider community to cope with times of stress without serious or long-term impact on their wellbeing.

'Universal +' refers to the support that is often given within universal settings (particularly in early years settings and schools) to nurture those children and young people who are felt to be experiencing a level of temporary difficulty that can be met without further referral: for example, through 1:1 discussions with a pastoral tutor, through nurture groups, 'safe spaces', befriending or mentoring schemes. It is thought that **10 – 15% of children and young people** will need this kind of at some point in their childhood.

Providing support quickly at this stage can often give sufficient reassurance to address needs and prevent problems escalating.

Who delivers at this level of need?

This will involve professionals with a remit wider than emotional wellbeing, and usually includes:

- GPs, Health Visitors (*Healthy Child Programme: Pregnancy and the first five years*) and Public Health School Service including School Nurses (*Healthy Child Programme 5 - 19*)
- Teachers and school staff
- Youth workers, community and voluntary sector group leaders

Meeting need at this level relies upon:

- **Promotion of positive emotional wellbeing and reducing stigma**: demonstrating to children and young people how to manage and communicate feelings safely and appropriately, and where help is available should they need to talk further.
- **Promoting equality and respect for diversity within schools and other universal settings,** including the rights of protected characteristic groups (such as lesbian, gay and bisexual or transgender people).
- **Early help, in the form of general advice and supportive dialogue** from empathetic adults
- **Identification** of those who may need some additional help, by seeking consultation advice from more specialised services.

Universal and Universal + : What actions are needed?

Outcome Area	#	Actions:	Best practice: Universal and Universal +	Evidence base / sources:	Lead Agency / Agencies
Emotional Wellbeing Promotion	**1.1**	• Schools to be empowered to deliver **whole school approaches in relation to resilience building and emotional wellbeing**, with involvement from trained clinicians. • Whole-school approaches should include delivery of age-appropriate emotional wellbeing and e-safety components within Social and Emotional Aspects of Learning (SEAL) and through **Personal, Social and Health Education** (PSHE), which is resilience building curriculum and activities. • This also needs to include the sharing of best practice between schools around **e-safety measures and digital culture**, supported by inclusion of these topics within a multi-agency workforce development plan (1.1).	**Strengthened whole school approaches** can challenge the 'stigma' that may be associated with emotional wellbeing and play a vital role in supporting children and young people to understand what constitutes 'positive' emotional wellbeing and to develop the language to express their feelings when they experience times of difficulty. This needs to be developed in the context of a wider 'offer' to schools around workforce development (1.1) and consultation advice (2.1) raising confidence and skill around identifying and appropriately responding to children and young people who have emotional wellbeing difficulties.	• ***Mental Health and Behaviour in Schools: Departmental Advice*** **(DfE, 2014):** *"A healthy school approach to promoting the health and wellbeing of all pupils in the school… Schools with these characteristics mitigate the risk of mental health problems in their pupils by supporting them to become more resilient and preventing problems before they arise."* • ***The link between Pupil Health and Wellbeing and Attainment*** **(Public Health England, 2014):** *"A systematic review of co-ordinated school health programmes (that promote health through explicit teaching in the curriculum and broader work to promote a healthier school environment) suggests positive effects on attainment"*[4] • ***Free school resources: MindEd*** *(www.minded.org.uk);* ***ChiMat*** *(www.Chimat.org.uk) ; Time to Change (www.time-to-change.org.uk/resources); TES (www.tes.org.uk and the Safeguarding in Education self-assessment tool (*www.nspcc.org.uk/esat) and Social and Emotional Aspects of Learning (SEAL). • ***Promoting equality and diversity:*** see *Equality Act 2010: Advice for Schools* (DfE, 2013)	**Individual schools to lead, supported by KCC Education and Young People's Services and the Public Health School Service.**

[4] Murray N, Low B, Hollis C, Cross A, Davis S (2007): *Coordinated school health programmes and academic achievement: a systematic review of the literature*. Reproduced in *The link between Pupil Health and Wellbeing and Attainment* (Public Health England, 2014), p.5.

Emotional Wellbeing Promotion / Early Help	**2.1**	• **A comprehensive multi-agency workforce development plan to be developed and offered on a rolling programme to staff in universal settings,** focusing on promotion, identification, resilience building and responding to emotional wellbeing needs among children and young people, using an accredited programme such as Mental Health First Aid training. This action links to: • **3.6** : *Raising awareness and confidence in identifying and responding to children and young people affected by neurodevelopmental disorders* • **2.5**: *Raising awareness and confidence around perinatal mental health.* • **4.1:** *Promoting 'recovery'.* This action is also linked to the forthcoming review of Health Visiting Services, and the implementation of the **Kent multi-agency Speech, Language and Communication Needs (SLCN) framework.**	**Broader workforce training in emotional wellbeing issues** (identification and response) to ensure that emerging emotional difficulties are recognised (and not just the presenting behaviours), that an appropriate supportive response can be given by universal settings, and that where necessary further advice is taken and appropriate referrals made. It is well-evidenced that there is a relationship between **emotional difficulties and speech, language and communication needs (SLCN)**, with SLCN needs greatly increasing the likelihood of emotional difficulty and underlying needs being easily mis-identified. For this reason it is vital that workforce training around emotional wellbeing is linked to implementation of the **Kent multi-agency Speech, Language and Communication Needs (SLCN) framework**. Young people in Kent have told us that they need a **broader base of professionals within schools** who have understanding of these issues, and that this needs to include broader support staff as well as pastoral leads. Continuing professional development in this area applies equally to **GPs and Public Health School Nurses and Health Visitors**, who need access to training explaining procedures and options for accessing support.	• ***Mental Health and Behaviour in Schools: Departmental Advice*** **(DfE, 2014):** *"Culture and structures within a school can promote their pupils' mental health through… continuous professional development for staff that makes it clear that promoting good mental health is the responsibility of all members of school staff and community, informs them about the early signs of mental health problems, what is and isn't a cause for concern, and what to do if they think they have spotted a developing problem…"* • ***Select Committee Report into Children and Adolescents' Mental Health and CAMHS*** **(House of Commons, 2014):** *"Schools have a crucial role to play in relation to children's and young people's mental health. This involves promoting good mental health and emotional wellbeing: detecting emerging mental health problems and supporting children with them, for example through in-school counselling services; educating children and young people about mental health issues."* (p.77) • ***Better communication – shaping speech, language and communication services for children and young people*** (Royal College of Speech and Language Therapists, 2012). • ***Kent Multi-agency Commissioning Framework for children and young people with Speech, Language and Communication Needs*** (SLCN), 2014.	**KCC Public Health** to lead a multi-agency group to design and promote, with recommendation that individual agencies contribute towards upskilling staff and cascading training. KCC Public Health to ensure links made when undertaking system-wide review of Health Visiting service.

Emotional Wellbeing Promotion	**1.2**	Review, identify and promote best practice in relation to **peer support schemes** among 14-19 year olds in Kent with a view to increasing the proportion of schools and youth settings offering peer support programmes.	**A review of evidence suggests that peer mentoring schemes can be valuable sources of support for older children and young people,** offering a potentially less stigmatising approach and an alternative route of building support networks within school. **Peer mentors need appropriate training and on-going supervision** to ensure that they are able to offer encouragement safely, that they are not over-burdened (particularly where vulnerable young people are involved as mentors) and that they know when and how to seek adult support.	• **HeadStart Kent** – Knowledge Hub • ***Supporting Young People's Mental Health: Eight Point for Action: A Policy Briefing from the Mental Health Foundation:*** *"This will mean a much greater emphasis on the support that is provided in non-mental health settings, the places where children and young people work and play, in primary care, and on enhancing family and peer support."*	**HeadStart Kent (KCC Education and Young People's Services) to promote; individual schools and settings to lead on implementation.**

Level 2: Early Help

Early help means doing all we can to prevent or minimise the risks of problems emerging, and responding early if difficulties emerge.

Early help is a principle to be applied at every level of need (and is therefore one of our key outcomes within this Strategy) but in this context, we are using the term to describe those children and young people who are experiencing **more prolonged periods of emotional, social or behavioural difficulties** than can be managed within universal settings, and who would be likely to benefit from some additional support. This might include feelings of low-mood, bullying, anxiety, or experience of bereavement.

"The focus and investment in Child and Adolescent Mental Health Services (CAMHS) should be on early intervention: providing timely support to children and young people before mental health problems become entrenched and increase in severity…"

Children's and Adolescents Mental Health and CAMHS: House of Commons, 2014).

It is thought that approximately **7% of children and young people** would benefit from more targeted support within schools or involving external agencies, such as school counsellors. Early Help takes a wide variety of forms, from brief interventions (1:1 or group work) to creative therapeutic interventions (such as play therapy) and more traditional forms of counselling. At the higher end of this spectrum, support is likely to be delivered by paediatricians or by primary mental health workers, usually as a single intervention (as opposed to the multi-modal treatment usually offered at Level 3 and above).

Early Help needs to recognise and respond to the wider family context and draw in broader support where necessary to ensure that underlying factors are identified and addressed – without which, the impact of any therapeutic intervention is likely to be undermined. Parenting support is often a critical factor, both in relation to understanding the needs of the child or young person, and responding appropriately to their presenting behaviours and symptoms. This is particularly crucial in the **perinatal period**, when poor mental health is thought to affect at least 10% of mothers.

Meeting need at this level relies upon:

- **Effective assessment** of need on a multi-agency basis within a clearly defined pathway, which explores and takes account of the broader family functioning, and seeks to address the underlying needs (which may necessitate bringing in support from more than one source).
- Where appropriate, **swift access** to an appropriate Early Help service: with clear communication at the outset with children, young people and families and a shared understanding of what the aims are.
- A range of **effective and adequately resourced Early Help services** to respond to emerging difficulties and prevent further escalation.
- Building **understanding among the child or young person's 'network'** – their family, school, and community links, to reinforce the support being given and reduce the risk of it being inadvertently compromised.

- Clear **step-down plans** to ensure that following an intervention, the child or young person can continue to be supported in universal services, and can access help if they need it again.
- A **clearly defined and communicated care pathway for perinatal mental health** between maternity and health visiting services and specialist mental health services, strengthened by multi-agency workforce development to raise awareness between primary and specialist care of appropriate means of identifying and responding to perinatal mental health needs.

Who delivers Early Help?

- Targeted programmes within Children's Centres, often delivered by Voluntary and Community Sector organisations, midwives and health visitors.
- School staff, particularly those with pastoral responsibilities
- Educational Psychologists, specialist teachers and Portage.
- Services commissioned through schools or local authorities (such as school counsellors, or countywide services such as 'Young Healthy Minds' commissioned by Kent County Council).
- Voluntary and community sector services for children, young people and families supporting family functioning and relationships.
- Primary Mental Health Workers
- Paediatricians (particularly community paediatricians) and other therapists (including Speech & Language Therapists).
- At the higher end of this level: child and adolescent psychologists (usually within Children and Young People's Services).

Early Help: What do practitioners tell us?

The following key messages were identified by practitioners attending an Early Help workshop in December 2014 as part of the development of this plan:

- "Assessment tools need to identify **underlying issues and root causes**: not be 'symptom-led'."
- The importance of having the **'right person with the right skills' at the front door**, doing the initial assessment to ensure needs and risks are appropriately identified, and so that the child or young person is set on the right path from the start".
- "We need to invest in raising awareness and training around emotional wellbeing for professionals in universal services – not only teachers, but also GPs."
- We need a **'systematic offer to schools'** including training, information about where and how to get additional consultation and advice and help."
- "We need a **'blended' model which brings qualified practitioners** into universal services to offer consultation, assessment and brief interventions – and to ensure that referrals being escalated are appropriate to that level of intervention."
- "We need to be much more **child-centred**: asking the child / young person what they most want and need, and delivering it in an environment where they are comfortable."
- "We need **more support for parents / carers**: a consultation facility, and support in responding to and managing child's needs and behaviour."

Early Help: What actions are needed?

Outcome	#	Action	Best practice: Early Help	Evidence base / further details:	Lead Agency / Agencies
Early Help	**2.2**	• **A well-resourced consultation offer from specialist mental health services** to be implemented across Kent, available via email and telephone, for professionals from any agency who are concerned about the emotional wellbeing of a child or young person and need advice about the appropriate response.	**Consultation with qualified mental health practitioners provides a vital function in supporting staff in universal settings to manage a child or young person's day to day needs, and know when it is appropriate to seek more specialised involvement. This can also have the effect of reducing inappropriate referrals through the system.**	• ***Mental Health and Behaviour in Schools: Departmental Advice*** **(DfE, 2014):** *"Schools have told us, however, that several things can be helpful to them in referring pupils effectively to specialist CAMHS… having a close working relationship with local specialist CAMHS, including knowing who to call to discuss a possible referral… and consulting CAMHS about the most effective things the school can do to support children whose needs aren't so severe that they require specialist CAMHS." (p.27)* • Feedback from Kent practitioner workshops, Dec 2014 (see p.16 and Appendix 2).	**Clinical Commissioning Groups**
Access	**3.1**	• **A single emotional wellbeing pathway** into support at Level 2 and above. This should operate with assessment from qualified mental health practitioners to ensure identification of underlying needs and any risks and, and be followed by **a multi-agency triage process** to ensure access to the service best placed to meet need.	• **The establishment of a single emotional wellbeing pathway, with assessment overseen by qualified mental health practitioners, offers opportunity to ensure underlying needs and risks are accurately identified before recommending any service response.** This pathway needs to be designed and delivered with multi-agency involvement to ensure the most appropriate configuration and the range of professionals who will need to be involved. This is recommended as a priority action for partners (with a view to piloting during 2015/16).	• ***Service Review of Kent and Medway CAMHS, Oxford Health NHS Trust, 2014:*** *"We recommend work to develop a pathway with a single point of entry…"* • ***A Commissioners' Guide to Primary Mental Health Care, NHS England (2014)****: "A constant plea is for a good single point of access that can help children, young people and families work out the most appropriate response… not a single point of rejection."* • Feedback from Kent practitioner workshops, Dec 2014 (see p.16 and Appendix 2).	**Clinical Commissioning Groups** to lead a multi-agency design and implementation within the next generation of commissioned services.

Access	**3.2**	**Support at Level 2 needs to be structured around, and based within, schools and community hubs** – with the facility to screen **self-referrals and drop-in** contacts, and either respond directly or arrange onward referrals. Every practitioner will be able to respond to Emotional Health and Wellbeing issues as part of a whole school response	**Both local and national reviews have indicated the need for improved visibility and accessibility of support,** with services based in community settings that children, young people and families access as part of their daily lives. Wider findings from our review indicate the need for these settings to be overseen by qualified mental health practitioners at the 'front door' to ensure appropriate assessment prior to any service being recommended. This approach may be strengthened through adopting a **supervision model**, whereby non-clinical staff working within community settings can receive informal group-based consultation and advice to help them continue to manage needs safely and appropriately, without unnecessary escalation to more specialised services.	• **Feedback from children and young people in Kent, December 2014.** • **Select Committee Report into Children and Adolescents' Mental Health and CAMHS (2014):** *"My recommendations would be thus: a trial of a hub / school based access to lower-tier CAMHS provision… An increase of resources available to CAMHS in order to increase capacity and provision for children at risk of disengagement or exclusion…"* *"Schools are completely vital in identifying early signs of mental health or low-lying issues that might develop into something serious…"* (p.79) • **Supporting Young People's Mental Health - Eight Points For Action: A Policy Briefing from the Mental Health Foundation (2007):** *"Some key needs identified by young people…included places to go for young people that are informal; are open in the evenings; work on a drop-in rather than appointment basis; and are staffed by skilled youth workers with knowledge of mental health issues." (p.11)*	Clinical Commissioning Groups to lead within future commissioning model for Children and Young People's Mental Health Services.
Early Help	**2.3**	• **A multi-agency communications strategy** to be developed and implemented in order to improve awareness of the different kinds of support available to meet different emotional wellbeing needs, and how and	Calls for improvements in communication around emotional wellbeing services were a key point of feedback from Kent practitioners, appearing to undermine the effectiveness of the system at all levels. The communications plan will need to involve development of supporting protocols (such as guidance for schools and GPs) and it is recommended that the **Live it Well portal** is expanded to include information, advice and	• Feedback from Kent practitioner workshops, December 2014.	Kent Public Health

		where support can be accessed. • **A consultation line for parents, carers and professionals** will be a vital part of this offer to offer guidance on referral criteria and signposting.	guidance for multi-agency professionals. Accessible information about the service being offered also needs to be available for children, young people and families.		
	2.4	• **To review existing arrangements and communicate a clearly defined care pathway for perinatal mental health,** in line with best practice articulated in the refreshed 2015 NICE guidelines.	**We need to establish a partnership approach to perinatal mental health** including maternity and health visiting services, specialist mental health services, children's centres, beginning with a clearly defined and promoted care pathway that sets out the role and responsibility of each agency. This needs to be linked to multi-agency workforce development (2.1), raising awareness among adult mental health services of the needs of pregnant women and new mothers, and increasing skill and confidence among children's centres, midwives and health visitors in identifying and appropriately referring women experiencing perinatal mental health difficulties.	• ***Antenatal and postnatal mental health (NICE, January 2015).*** • ***Select Committee Report into Children and Adolescents' Mental Health and CAMHS (2014):*** *"About 1 in 10 women suffer from post natal depression, which can impact on the mother's ability to become securely attached to their child; but provision for these women is very poor. Like CAMHS, infant mental health provision requires different levels of service. It should include universal services that promote healthy parent-infant interactions; services for infants who are displaying early signs of mental health problems, and specialist perinatal mental health provision which supports both mothers with mental illnesses and their babies."*	**Clinical Commissioning Groups and KCC Public Health to jointly lead.**

Level 3: Complex Needs

A smaller proportion of children and young people (2-3%) will have more significant and sustained difficulties and will require support from specialist mental health services. These difficulties may include severe anxiety or depression, significant neurodevelopmental difficulties, self-harm or sustained eating disorders and early onset psychosis and will often need a multi-modal treatment (i.e. involving more than one mental health practitioner).

Children and young people accessing support at this level will often have a number of **other factors in their lives increasing their vulnerability**, such as being in care, experiencing domestic abuse or family breakdown, school exclusion, involvement with the youth justice system, or substance misuse – and specialist mental health services will therefore need to work in close partnership with a variety of other professionals, such as social workers and youth justice workers, as well as with the child or young person and their family to ensure the maximum benefit is reaped from any intervention.

In order to meet the needs of the most vulnerable children and young people at this level, services need to offer **a targeted approach and in some cases, specific 'pathways'** – for example, for young offenders or children in care. This is considered in more detail further on within this section.

Who delivers support for children and young people with Complex Needs?

- Primary Care Mental Health workers
- Child and adolescent psychiatrists, clinical child psychologists and psychotherapists (based within Children and Young People's Mental Health Services).
- Community Nurses
- Occupational Therapists
- Speech and Language Therapists, specialist teachers and Educational Psychologists.
- Art, music and drama therapists

At this level of need, mental health professionals are often working in partnership with social workers, foster carers, Youth Offending Team (YOT) workers, substance misuse practitioners, and alternative education settings.

Meeting need at this level relies upon:

- **Effective triage and risk-assessment to ensure that those presenting with the highest level of risk access support within appropriate timescales.** This process needs to be clinically-led, with greater dialogue between commissioners and those delivering specialist services.
- **Urgent assessment and access to support for children and young people in crisis, in line with the Crisis Care Concordat,** including a place of safety for those requiring assessment under s.136 and other sections of the Mental Health Act.
- **Effective implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support.**

- **Working with, and providing support to, the child or young person's broader 'network'** – their family, school, and community links, to identify and address underlying factors. At this level, it is also likely to require close partnership working with a range of additional professionals such as social workers or youth justice workers.
- **A clearly defined 'step down' pathway, with partnership agreement in place between services**, to ensure that following an intervention, progress can continue to be sustained within early help or universal services, supported by specialist consultation where needed.
- **Targeted outreach and assessment of mental health needs for the most vulnerable groups, including children in care and young offenders** for whom the greater majority (60 – 70%) will have a diagnosable mental health disorder and/or Speech, Language and Communication Needs (which can present as behavioural difficulties and be misdiagnosed).
- **Clear pathways for assessment and treatment of children and young people with neurodevelopmental difficulties** (including Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder) to ensure that they (and their families) can access support within the community. This needs to include a strategic multi-agency approach to deliver the Winterbourne View Concordat for disabled children and young people with an autistic spectrum disorder with a learning disability / mental health need and challenging behaviour.
- **Strategic and operational responses to improve the system of care and support for children and young people in a crisis** by working across the system to prevent crisis happening where possible, meeting the needs of young people in urgent situations and supporting them to move towards recovery.

Vulnerable children and specialist services: what do practitioners tell us?

The following key messages were given by practitioners attending a workshop in December 2014 to develop this plan, focussed on the provision of specialist mental health services:

- "Escalation is happening to specialist mental health services where in many cases the **needs could have been met earlier** and the requirement for specialist intervention avoided."
- "We need to move people with the right skills to the right place: **Early Help must be well-skilled enough to appropriately understand the needs**, or it just risks delaying the right response."
- "We need a **self-referral option that puts patients in control** – not gate-keepers. This needs to include a contact line for young people which can initiate a referral if needed."
- "We need a **locality Single Point of Access**, and co-located, collaborative partnerships with different agencies involved."
- "In many cases, **parenting support needs to be given prior to referral to specialist services** – often wider family needs are seen post-assessment and could have been identified earlier."
- "We need to see much better **continuity of care** for children, young people and families: the way services are commissioned can create a barrier to continuity of care."
- "We need greater resource to **commission a Tier 3.5 intensive outreach service** as an alternative to admission."

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Meeting the needs of vulnerable groups - Young Offenders

Children and young people known to youth offending services are often some of the most vulnerable, with a range of complex and interconnected factors in their lives that increase the risk of poor outcomes.

The emotional wellbeing needs of these young people are also complex: a study in 2009 found at least 43% of children and young people with community orders are likely to have emotional and mental health needs[5], while separate studies indicate that between a third and half of children in custody have a diagnosable mental health disorder[6].

A 2009 study found that if untreated, 33% of children with communication needs are likely to develop mental illness – and over 50% will become involved in criminal activity.4

"Children and young people who experience emotional distress and mental health problems often exhibit challenging behaviour and the focus on this behaviour for interventions can mask other problems and issues."

(*'I think I must have been born bad'*- Office of the Children's Commissioner, 2012, p.24)

Emotional wellbeing and Speech, Language and Communication Needs (SLCN)

Evidence suggests that there may be significant association between poor mental health and SCLN – and significant risk of misdiagnosis. At least **60% of young people known to Youth Offending Teams are likely to have SLCN** (against up to 8% in the general population of young people)[7]. In secure settings this figure may rise as high as 90%.

Pathfinder studies in Kent during 2014 have found that approximately 70% of those in contact with the youth justice system, and 90% of those in custody, had speech, language and communication needs – reducing their ability to access a range of rehabilitation programmes and health interventions. This means that a joint approach is needed.

Meeting need for these children and young people relies upon:

- A multi-agency response to emotional wellbeing, with **joint assessment taking place between mental health practitioners, speech and language therapists, and substance misuse** practitioners to ensure needs are accurately identified and a co-ordinated response given. The efficacy of this approach has been demonstrated through pathfinder in South / East Kent during 2014, and evaluation of the former *Dual Diagnosis* programme in Thanet. This joint assessment should be **available to all young people at the point of entry** to the youth justice system – with a clear partnership agreement between youth justice and health services.
- **A targeted offer and pathway within specialist mental health services for young offenders**, based upon intensive working – with greater representation of mental health practitioners within Youth Offending Teams.

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[5] Healthcare Commission and HMI Probation, (February 2009). '*Actions Speak Louder, A Second Review ofHealthcare in the Community for Young People who Offend*'

[6] Chitsabesan P, Kroll L, Bailey S, Kenning CA, Sneider S, MacDonald W & Theodosiou L (2006). *Mental health needs of young offenders in custody and in the community.* British Journal of Psychiatry, 188:534-548 – referenced in '*Turning Young Lives Around: How health and justice services can respond to children with mental health problems and learning disabilities who offend*' (Prison Reform Trust).

[7] *Speech, Language and Communication Needs in the Criminal Justice System and Best Practice responses: DOSSIER OF EVIDENCE – (*Royal College of Speech and Language Therapists, *2012)*

- **Targeted workforce development** around the mental health and speech, language and communication needs for social workers, YOT practitioners and foster carers.

Meeting the needs of vulnerable groups - Children in Care and Care Leavers

It is well-evidenced that for children and young people in care to overcome early negative experiences and go on to achieve positive long-term outcomes, the primary need is for support in relation to developing and maintaining emotional wellbeing: a factor that is also crucial to their likelihood of achieving permanence.

The ***NICE Quality Standards for the Health and Wellbeing of Looked After Children Young People***, produced in 2013, set out clearly the importance of accurate assessment of emotional wellbeing needs: "Looked-after children and young people have particular physical, emotional and behavioural needs related to their earlier experiences before they were looked after. These earlier experiences have an influence on brain development and attachment behaviour…. Holistic and accurate assessment is needed to address the specific needs of each child, with multidisciplinary support provided where it is needed. It is important that services are provided in a timely manner to prevent the escalation of challenging behaviour and reduce the risk of placement breakdown; these should be based on the child or young person's needs and not on service availability."[8]

64% of children in care are thought to experience a diagnosable mental health disorder (Biehal et al, 2012) but data suggests that children in care continue to be under-represented in specialist mental health services.

Care leavers

Care leavers are an equally vulnerable group, and it is widely recognised that their risk of experiencing poor emotional wellbeing is far higher than their peers, and often compounded by transition into adult life.

The NICE Quality Standards Framework referenced above also recognises that young people leaving care are "particularly vulnerable and need continued support from specialist services", and a number of national reports call for care leavers to be seen as a priority group alongside children in care.

"Many aspects of young people's health have been shown to worsen in the year after leaving care. Compared to measures taken within three months of leaving care, young people interviewed a year later were almost twice as likely to have problems with drugs or alcohol (increased from 18% to 32%) and to report mental health problems (12% to 24%).

Dixon (2008) referenced in *Promoting the Health and Wellbeing of Looked After Children* (DCSF, 2009).

Young people leaving care may also experience difficulties in accessing services due to the transition from Children and Young People's Mental Health Services, which has traditionally been available for young people up to the age of 18. The recent cross-sector report, *Access all Areas* (2012) recommends that health and social care partners look at either 'developing specialist emotional health and wellbeing services for 17-25 year olds to address the gap between adult and children's mental health services or extending CAMHS provision to 25 for care leavers'.

[8] Quality Statement 5: *Tailored resource for corporate parents and providers on health and wellbeing of looked-after children and young people* (NICE, 2013). Available at: http://www.nice.org.uk/about/nice-communities/social-care/tailored-resources/lacyp

Meeting need for these children and young people relies upon:

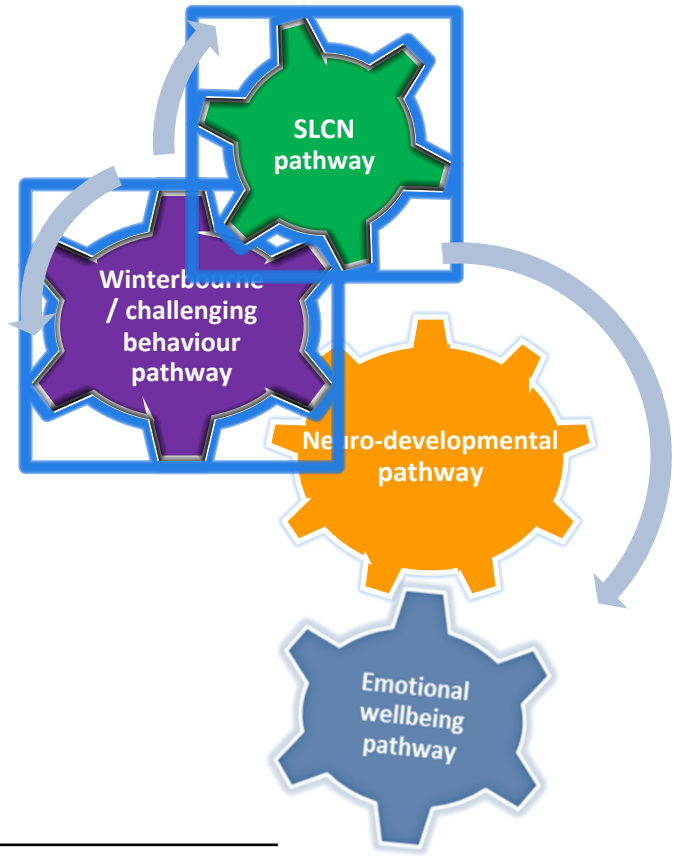
- Ensure young people get support so they can reflect on their strengths, building and developing their resilience; and actions of services look to strengthen this.
- Ensuring swift **access to specialist mental health assessment for all children and young people at the point of entry** to care.
- A clearly defined and communicated **pathway for children in care** to access specialist mental health services, including clinically-led **support for their professional network and foster carers**.
- **Children in care and care leavers being able to access early help approaches**, (where this is felt to be safe and appropriate by the specialist professionals working with them and consistent with the Care Plan).
- Clear **communication and partnership** working between clinicians and social workers around the offer available for children in care, expected outcomes, and the process for accessing support.
- Effective implementation of multi-agency tools and protocols to identify children and young people in care who have been affected by **Child Sexual Exploitation (CSE)** and rapid access to **specialist post-abuse support**. This needs to include a focus on those who have been known to be missing from care, as well as Unaccompanied Asylum-Seeking Children. (For further information see the *Kent and Medway Safeguarding Children Board's CSE Toolkit*: http://www.kscb.org.uk/kscb_resources_and_library/child_sexual_exploitation.aspx)
- Access to **consultation support** from mental health practitioners for foster carers and social workers.
- A clearly defined pathway for **care leavers to access specialist mental health support**, within a 0-25 model of service.
- **Workforce development** for social workers, Personal Advisors, and foster carers around identifying and responding to emotional wellbeing needs among children and young people in care and care leavers, incorporated in initial training and on-going development programmes.

Meeting the needs of vulnerable groups: Neurodevelopmental disorders and Learning Disabilities

Neurodevelopmental disorders refer to a wide range of different conditions, and the ways in which they present and affect the lives of children and young people varies widely from individual to individual, and at different stages of the life course. Neurodevelopmental disorders include, but are not limited, to Autistic Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD).

These are not mental health disorders in themselves, but children and young people with neurodevelopmental disorders are at an increased risk of experiencing poor emotional wellbeing: researchers at King's College London suggest that they are **3- 6 times more likely to experience a diagnosable mental health condition**[9]. Another study found that 40% of children and young people referred to specialist mental health services had an undiagnosed language impairment[10] It is also widely recognised that there is significant overlap between neurodevelopmental disorders and Speech, Language and Communication Needs (SLCN).

Neurodevelopmental disorders can affect children and young people **socially** (affecting relationships within the family and with peers); **educationally** (influencing their ability to engage and attain) and **psychologically**, and as such, a multi-agency approach is needed. However, consultation with Kent children, young people and families suggests that diagnosis takes time and often little support is available afterwards.



Integration and Joint Commissioning

A number of individual pathways have existed locally to support children and young people affected by emotional wellbeing difficulties, neurodevelopmental disorders and SCLN needs, but recent legislation sets out clear duties for health, social care, and education to collaborate in improving outcomes for children and young people (up to 25) who have **Special Educational Needs (SEN) or are disabled**. S.25 of the *Children and Families Act* (2014) requires collaboration to 'promote wellbeing' of these children and young people: a duty which specifically includes their mental health and emotional wellbeing. This is reinforced by s.26 of the *Health and Social Care Act 2012* to promote integrated services.

[9] See http://www.kcl.ac.uk/ioppn/depts/cap/research/MentalHealthProblemsinNeurodevelopmentalDisorders/index.aspx

[10] Cohen et al, 1998, reproduced in Gascoigne MT, *Better communication – shaping speech, language and communication services for children and young people (2012)*

Learning Disabilities

There are many conditions and syndromes that are encompassed and defined under the umbrella term 'learning disabilities'. A child or young person with a general learning disability finds it more difficult to learn, understand and do things compared with other children of the same age. According to Mencap, a learning disability is 'a reduced intellectual ability and difficulty with everyday activities which affects someone for their whole life'. The degree of disability can vary greatly, being classified as mild, moderate, severe or profound.

Children and young people with learning disabilities are over six times more likely to have a diagnosable mental health disorder than their peers. **In total, over one in three children and adolescents with a learning disability in Britain (36%) have a diagnosable mental health disorder.**

Children with learning disabilities can find it hard to build social relationships, and are more likely to say that they have difficulties getting on with their peers than children without learning disabilities.[11] Children and young people with learning disabilities are also much more likely to live in poverty, to have few friends and to have additional long term health problems and disabilities such as epilepsy and sensory impairments. A learning disability is also likely to reduce a child's capacity for finding creative and adaptive solutions to life's challenges. **All of these factors are known to have a negative impact on mental health, putting people with learning disabilities at greater risk of developing mental health problems**.

Children and young people with learning disabilities are:

- *4 times more likely to have an emotional disorder*
- *6 times more likely to have a conduct disorder*
- *3 times more likely to experience schizophrenia*
- *1.7 times more likely to have a depressive disorder*

(Emerson and Hatton (2007)

These problems may be worsened for those with greater support needs, particularly if they are unable to communicate about their feelings or communicate their distress.

It can be difficult to diagnose mental health problems in children and young people with learning disabilities. This can be because:

- Behaviour difficulties are attributed to the learning disability
- They have unusual/infrequent presentation of symptoms
- They might not express the symptoms clinicians would expect
- Medicines taken for physical health problems may mask mental health symptoms.

The **Winterbourne View Concordat** sets out a commitment to improve support for people who have mental health difficulties or challenging behaviour as well as learning difficulties and/or neurodevelopmental disorders. This involves a commitment to reducing reliance on in-patient care and supporting more people safely in the community, and a requirement on local authorities and Clinical Commissioning Groups to work together to "commission the range of support which will enable them to lead fulfilling and safe lives in their communities"[12] Work has begun in Kent to develop a new multi-agency integrated pathway and intensive support team (tier 3.5 service) modelled on Positive Behavioural Support (PBS), that will respond to the needs of these children and young people with a local intensive support offer to reduce the risk of family breakdown, improve the resilience of local schools and community services and support young people to return from out

[11] Emerson and Hatton (2007) referenced in *The Mental Health of Children and Adolescents with Learning Disabilities in Britain* (Institute for Health Research, Lancaster University, 2007)

[12] Winterbourne View Review Concordat: Programme of Action (DH, 2012)

of county placements to more local provision. A core element of this approach will include the assessment and support of children and young people's emotional wellbeing.

Summary: Meeting need for these children and young people relies upon:

- **Ensure young people get support so they can reflect on their strengths, building and developing their resilience; and actions of services look to strengthen this**.
- **Supporting children and young people to feel safe and included within their educational setting** (see www.whataboutus.org.uk).
- **Ensuring that Education, Health and Care (EHC) Plans take account of emotional wellbeing and mental health needs.**
- **Broader understanding and confidence within in wider children's workforce** around identifying and responding appropriately to children and young people with learning disabilities, neurodevelopmental disorders (particularly Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder) and those with challenging behaviour. This will need to be part of a multi-agency workforce development programme, with defined standards and competencies.
- **Implementation of the children and young people's element of the Winterbourne View Concordat.**
- **Specialist parenting support groups,** overseen by trained and experienced mental health / LD practitioners – with the aim of empowering families to be able to support one another over the longer-term.
- **A careful approach to transition,** planning well in advance with children, young people, families.
- **An all-age neurodevelopmental pathway** involving a range of multi-agency professionals, including health, social care and education. Work towards developing a Kent pathway is currently underway, led by a multi-agency group. This needs to be followed by more **collaborative models of procurement** around community support for children, young people and their families affected by neurodevelopmental disorders. Commissioning approaches for these children and young people needs to be shaped by the principles set out in *Ensuring Quality Services* (Local Government Association and NHS England 2014).

Meeting the needs of vulnerable groups: children who have been or who are at risk of child sexual exploitation

Sexual exploitation of children (CSE) is completely unacceptable; the only effective way to tackle sexual exploitation of children is via effective multi agency and partnership working. Kent and Medway Local Safeguarding Childrens Board (KSCB) works in partnership with local and national organisations and networks to speak up for young people who are sexually exploited and to share knowledge and good practice. We recognise that sexual exploitation can have serious long term impact on every aspect of a child or young person's life, health and education.

The **Principles which underpin multi-agency responses in Kent and Medway**

- Sexual exploitation incorporates sexual, physical and emotional abuse, as well as, in some cases, neglect;
- Children do not make informed choices to enter or remain in sexual exploitation. Rather, they do so from coercion, enticement, manipulation or desperation;
- Children under 16 years old cannot consent to sexual activity; sexual activity with children under the age of 13 is statutory rape ;
- Sexually exploited children should be treated as victims of abuse, not as offenders. Children under 16 will always be dealt with as actual or potential victims.
- For young people from 16 to 18 years old, consideration may be given, in limited circumstances and where all other options have failed, to the use of criminal justice action;
- Many sexually exploited children have difficulty distinguishing between their own choices around sex and sexuality and the sexual activities into which they are coerced. This potential confusion needs to be handled with care and sensitivity by the adults working to protect them from harm.
- The primary law enforcement effort must be against the coercers and sex abusers who may be adult, but could also be the child's peers or young people who are older than the children some cases, neglect;

It is important that all young people develop the knowledge and skills they need to make safe and healthy choices about relationships and sexual health. This will help them to avoid situations that put them at risk of sexual exploitation and to know who to turn to if they need advice and support.

The need for information also goes wider ... to raise the awareness of communities, parents and all adults who work with or on behalf of children and young people. This includes ensuring that the needs of children and young people who have been, or may be, sexually exploited and their families are considered when planning and commissioning services; developing policies and procedures; ensuring that appropriate training is in place for parents, Foster Carers and other professionals.

Summary of Complex Needs: What actions are needed?

Outcome:	#	Action:	Best practice: Complex Needs	Evidence base / further details:	Lead Agency / Agencies
Whole Family Approach	**41**	• **A clearly defined 'whole family' protocol, defining how parents and carers will be involved and identifying and responding to the needs and/or behaviours of their child or young person, and how the wider needs of the family will be considered within assessments of the child's emotional wellbeing.**	Supporting children with complex needs must take into account the wider family functioning and support needs, and be delivered with parallel advice and guidance to families on understanding and responding to their child's needs and behaviours. **Any actions needs to strengthen the resilience of the family and its members.** **Consideration must also be given to providing information and support to the broader 'network' around the child or young person** – including schools and any other services involved, to ensure understanding of needs and a co-ordinated response.	• Feedback from children, young people, families and practitioners in Kent (June – December 2014). *See p.16 and Appendix 2.*	**Clinical Commissioning Groups**
Whole Family Approach / Recovery and Transition	**3.1**	• **A multi-agency 'step down' pathway to be developed across all levels of need**, with a focus on increasing step-down from specialist mental health services (linked to the Transition Protocol between ChYPS and Adult Mental Health Services). This should be developed in collaboration with children, young people and families and include a focus on developing appropriate communication materials to support families through transition and recovery.	**Clear step-down offers are vital to ensuring improvements made by children and young people can be sustained** within less specialised, and ultimately universal services. This will involve building capacity and confidence within universal and early help services through the workforce development programme (2.1) as well as multi-agency protocols around supporting families through transition.	• ***Child and Adolescent Mental Health and CAMHS (House of Commons Select Committee, 2014):*** *"We can only increase throughput through CAMHS services where there are effective step-down services in place.*	**Clinical Commissioning Groups to lead multi-agency partners, including commissioners of Early Help services**
Access	**3.3**	• **Specialist mental health assessment to be offered to children and young people at the point of entry to care, and a clearly defined pathway for children in care and care leavers to access specialist mental health support.**	Ensuring access to specialist mental health assessment at the point of entry to care allows opportunity for underlying emotional needs to be identified and an appropriate service response given that can help to improve placement stability, as well as building understanding and confidence among social workers and foster carers.	• ***SCIE / NICE guidance: Promoting the quality of life of looked-after children and young people: "****Evidence suggests that early intervention to promote mental health and wellbeing can prevent the escalation of*	**Joint lead between Clinical Commissioning Groups and KCC Social Care, Health and**

		This needs to include consultation and advice available for foster carers and the professional network.	Children in care and care leavers should also be considered for access to early help approaches, where this is felt to be safe and appropriate by the specialist professionals working with them, and consistent with their Care Plan.	*challenging behaviours and reduce the risk of placement breakdown. Flexible and accessible mental health services are needed that offer skilled interventions to looked-after children and young people and their carers."*	**Wellbeing.**
Access	**3.4**	• **A collaborative approach to be commissioned between specialist mental health services, speech and language services, substance misuse and youth offending practitioners to jointly screen and identify appropriate support to meet the needs of young offenders.** • **This needs to include definition of a bespoke pathway for young offenders to access specialist mental health support.**	**Building upon the pathfinder work in South and East Kent during 2014, and the Dual Diagnosis project which ran from 2006-11 we need to extend multi-agency support for YOT teams through** involvement from mental health practitioners, speech and language therapists, and substance misuse practitioners – ideally on an expanded outreach model within Youth Offending Teams. This work also needs to be informed by the findings of the forthcoming report on the Health Needs of Young Offenders from Kent Public Health and Kent Youth Offending Service.	• ***Young Lives Behind Bars*** (British Medical Association, 2014) p.32-34 • ***'I think I must have been born bad': Emotional wellbeing and mental health of children and young people in the youth justice system*** (Office of the Children's Commissioner, 2012)	**Clinical Commissioning Groups, KCC Public Health, Education and Young People's Services and Kent Youth Offending Service.**
Access	**3.5**	• **Multi-agency workforce development programme for social workers, Personal Advisors, youth offending teams, foster carers and Early Help practitioners** around the identification and response to children and young people affected by emotional wellbeing difficulties, included in both initial training and on-going development.	This needs to be linked to the core 'offer' of consultation and advice (2.1), drawing in capacity to support professionals working with the most vulnerable children and young people. This programme also needs to focus upon **Child Sexual Exploitation (CSE)** and the Kent &Medway CSE Toolkit, and be linked to the Kent CSE Training Strategy: (http://www.kscb.org.uk/kscb_resources_and_library/child_sexual_exploitation.aspx)	• ***'I think I must have been born bad': Emotional wellbeing and mental health of children and young people in the youth justice system*** (Office of the Children's Commissioner, 2012) • Feedback from practitioners in Kent, Dec 2014. *See p.16 and Appendix 2.*	**Clinical Commissioning Groups in partnership with KCC Social Care, Health & Wellbeing, Education and Young People's Services and Kent Youth Offending Service**
Access	**3.6**	• **Improve identification and protection of all children and young people at risk of CSE, including children in care. Effective**	This needs to be linked to the core 'offer' of consultation and advice (2.1), drawing in capacity to support professionals working with the most	• ***'I think I must have been born bad': Emotional wellbeing and mental health of children and***	**KCSB, Strategic Commissioning**

		implementation of multi-agency tools and protocols to identify children and young people who have been affected by Child Sexual Exploitation (CSE), and rapid access to specialist post-abuse support.	vulnerable children and young people. This programme also needs to focus upon **Child Sexual Exploitation (CSE)** and the Kent &Medway CSE Toolkit, and be linked to the Kent CSE Training Strategy: (http://www.kscb.org.uk/kscb_resources_and_library/child_sexual_exploitation.aspx)	***young people in the youth justice system*** (Office of the Children's Commissioner, 2012) • Feedback from practitioners in Kent, Dec 2014. *See p.16 and Appendix 2.*	**and Public Health**
Access	**3.7**	• **Design and commission community support model for children, young people and their families affected by learning disabilities and/or neurodevelopmental disorders**, including specialist parenting support.	**This needs to be achieved through a collaborative commissioning approach between health, social care and education.** **It also needs to be linked to the core multi-agency workforce development programme (2.1)** to raise awareness and confidence around identifying and responding appropriately to children and young people with Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder.	• Feedback from children, young people, families and practitioners in Kent, June - Dec 2014. *See p.16 and Appendix 2.*	**Neurodevelopmental Pathway Group to lead.**
	3.8	• **Design and commission an intensive support service within the community around a Positive Behavioural Support model for children and young people with learning disabilities.**	**This needs to be achieved through a collaborative commissioning approach between health, social care and education.**	• ***Winterbourne View Review: Concordat*** • ***Ensuring Quality Services*** (Local Government Association and NHS England, 2012)	**CCGs and KCC Social Care, Health & Wellbeing**
Access	**3.9**	• **Specialist therapeutic services for post sexual abuse, including CSE, harmful sexual behaviours and risk assessments to be commissioned,** based on review of existing service and emerging needs (assessment currently underway within Kent Public Health).	These services need to be commissioned with skill and capacity to respond to the needs of children and young people affected by abuse, including Child Sexual Exploitation, with a clearly defined and promoted pathway to access them and the capability to offer specialist consultation where required.	• ***Real Voices: Child Sexual Exploitation in Greater Manchester*** *(reference below)*[13] • **Free information and resources** *at www.itnsnotokay.co.uk* • Links to Action 4.4 in the *KCC Specialist Children's Services Improvement Action Plan 2014-16.*	**KCC Children's Commissioning Unit and CCGs in collaboration with Specialist Children's Services and multi-agency partners.**

[13] Real Voices: Child Sexual Exploitation in Greater Manchester: An independent report by Ann Coffey, M.P. October 2014

	3.10	• **A multi-agency response to commissioning models of access for crisis support for children and young people** including children in care, care leavers and those leaving custody in the youth justice system.	This needs to be linked to the Kent-wide Mental Health Crisis care concordat action plan and requires robust partnership working between primary care and specialist secondary care provision.	• ***Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.***	**Kent Crisis Care Concordat strategy group**
	3.11	• **Review and commission a community support pathway for children, young people and their families affected by eating disorders.**	The National Institute for Clinical Excellence (NICE) makes recommendations for the identification, treatment and management of a range of eating disorders in primary, secondary and tertiary care for children and young people aged 8 and above. Assessments should be comprehensive and include physical, psychological and social needs and a comprehensive assessment of risk to self. Whole-family approaches may be particularly important in supporting the child or young person. (NICE guidance Jan 2004).	• ***Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*** (NICE, 2004).	**CCGs**
	3.12	• **Review practice against NICE guidelines for responding to the needs of children and young people affected by self-harm** and identify evidence-based interventions to meet need (which may include DBT).	The National Institute for Clinical Excellence (NICE) recommends that people who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and risks of repetition or suicide. Commissioners should consider commissioning a local service to provide 3-12 sessions of psychological intervention, specifically structured for people who self-harm. (NICE guidance June 2013).	***Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*** (NICE, 2014).	**CCGs**

Level 4: Very Complex Needs

Children and young people at this level of need are experiencing episodes of being seriously mentally ill to the extent that they require in-patient support, or intensive intervention and monitoring within the community. These difficulties may include conditions such as significant eating disorders, emerging borderline personality disorder, schizophrenia or suicidality.

Revised estimates suggest that approximately **0.5% of children and young people** may need support at this level, equating to between 250 – 1500 children and young people in Kent.

Who delivers at this level?

- **Specialists within acute child and adolescent in-patient settings.**
- **Specialist outreach, day and outpatient services**
- **Psychiatric Intensive Care Units**
- **Staff within secure and semi-secure accommodation and forensic provision.**

Meeting need at this level relies upon:

- Appropriate places of safety for children and young people who need to be accommodated under the Mental Health Act.
- Effective out-of-hours crisis services and paediatric liaison teams within acute hospitals
- Tier 3.5 assertive outreach teams, to prevent admission and facilitate discharge among the highest risk children and young people.
- Effective partnership between commissioners of Level 4 services (NHS England) and local Clinical Commissioning Groups, responsible for commissioning specialist mental health services at Level 3.

Some of the challenges identified in a recent NHS England report (July 2014) about access to in-patient support include:

- Problems accessing beds when needed
- Children and young people having to travel long distances to access a bed
- Inequity in provision across the country.

Outcome	#	Action:	Best Practice:	Evidence Base / Further Details:	Lead Agency / Agencies:
Access	**3.13**	Young people and their families require **timely access to appropriately staffed mental health inpatient facilities** for those young people requiring admission that should be geographically close to their family and community.	National guidance on inpatient CAMHS states that admission must operate within a pathway of care, involving the local community teams. This is essential to avoid a protracted length of stay or care episode; the development of dependency on inpatient treatment; and loss of contact by the young person with their family, local community and professionals that may be supporting them.	Sergeant A. (2009). ***Working within child and adolescent inpatient services: A practitioner's handbook*** (HMSO)	NHS England & CCGs
Recovery and Transition	**5.1**	**Develop and enhance Tier 3.5 assertive outreach teams** to prevent admission and facilitate discharge where appropriate.	Services that are developed as alternatives to admission must be capable of providing safe care to young people who are assessed as being at risk of self-harm and/or suicide if they are to substantially reduce demand for inpatient care. (*The care paths of young people referred but not admitted to inpatient CAMHS* (CCAR/RCP 2008)	***Child and Adolescent Mental Health and CAMHS (House of Commons Select Committee, 2014):*** *"*Perverse incentives in the funding and commissioning arrangements for CAMHS should be eliminated to ensure that commissioners invest in Tier 3.5 services, which may have significant value in minimising the need for inpatient admission and reducing length of stay."	NHS England & CCGs

Appendix 1: Glossary

Emotional Wellbeing:

Emotional well-being 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).

Resilience:

"Ability to be mentally strong enough to bounce back from the problems in life" (definition agreed by young people involved in HeadStart Kent).

Recovery:

'Recovery' is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life" *(Centre for Mental Health).*

Co-production:

"Coproduction happens when all team members together agree outcomes, co-produce recommendations, plans, actions and materials as a collective. It is an approach which builds upon meaningful participation and assumes effective consultation and information sharing… Parent carers are not just there to illustrate the experience of service users, but rather to take responsibility to help shape future experiences and be an active part of delivering the solutions." Britton & Taylor (2013): *Co-*

Step-down:

Reducing the level of support offered as outcomes are met and needs reduce. This is an important part of recovery and needs to be carefully managed to ensure positive outcomes are sustained.

Resilience:

The Big lotteries definition define resilience as 'The opportunity for and capacity of young people – in the context of adversity – to negotiate for and navigate their own way to resources that sustain their mental health'.

In Kent our approach is more ecological and is taken from Michael Ungar *'In the contect of, families and communities have the capacity to navigate and negotiate their way to the psychological, social, cultural and physical resources that sustain their well being'.*

Appendix 2: Summary of engagement activity

The following activities have been undertaken to engage children, young people, families, practitioners and professionals in developing the Emotional Wellbeing Strategy and Delivery Plan:

Children, Young People and Families

- Online survey (May – July 2014): 250 responses received
- Focus groups with young people (May – June 2014)
- Short film, 'Let it Out' produced with young people to inform Part 1 of the Strategy, sharing experiences of emotional difficulty and where system change is needed (presented at Emotional Wellbeing Summit, 9 July 2014)
- Further focus groups held as part of Delivery Plan development (November 2014)
- Second short-film produced with young people to inform Part 2 Delivery Plan, to share their views about which forms of support are most valuable and how they should be delivered (presented at second Emotional Wellbeing Summit, 18 December 2014).
- Formal online consultation around Part 1 of the Strategy (October – Jan 2015), hosted and promoted through multiple partnership routes.

Practitioners and Professionals

- Multi-agency subgroup (meeting bi-monthly) overseeing agenda.
- Online survey for practitioners in existing service providers (May – June 2014): 50 responses received.
- Workshop sessions (November and December 2014) involving around 60 professionals from a wide range of partner agencies, exploring anonymised real-life case studies and focussing on improving the pathways between services (at the levels of universal services, early help and specialist services).
- Specialist themed meetings with multi-agency professionals around needs of vulnerable groups.
- Formal online consultation around Part 1 of the Strategy (October – January 2015), hosted across multi-agency platforms.

Senior leaders and elected councillors:

- **Emotional Wellbeing Summit Part 1** (9 July 2014) involving over 60 senior leaders from multiple agencies in Kent to agree outline vision and outcomes.
- **Emotional Wellbeing Summit Part 2** (18 July 2014) involving 75 leaders and practitioners to review interim consultation findings and outline principles for Delivery Plan.

Appendix 3: Sources

National Reviews and Guidelines

Antenatal and postnatal mental health (National Institute for Clinical Excellence, 2015).

Chief Medical Officer's annual report 2012: Our Children Deserve Better: Prevention Pays (Department of Health, 2013).

Implementing Recovery: A new framework for organisational change (Sainsbury Centre for Mental Health, 2009)

Mental Health and Behaviour in Schools: Departmental Advice (Department for Education, 2014)

The link between Pupil Health and Wellbeing and Attainment (Public Health England, 2014)

Equality Act 2010: Advice for Schools (DfE, 2013)

Closing the Gap: Priorities for Essential Change in Mental Health (Department of Health, 2014)

Select Committee Report into Children and Adolescents' Mental Health and CAMHS (House of Commons, 2014)

Supporting Young People's Mental Health: Eight Point for Action: A Policy Briefing from the Mental Health Foundation (Mental Health Foundation, 2007).

A Commissioners' Guide to Primary Mental Health Care, NHS England *(2014):*

'I think I must have been born bad': Emotional wellbeing and mental health of children and young people in the youth justice system (Office of the Children's Commissioner, 2012)

Actions Speak Louder, A Second Review of Healthcare in the Community for Young People who Offend (Healthcare Commission and HMI Probation, 2009).

Turning Young Lives Around: How health and justice services can respond to children with mental health problems and learning disabilities who offend (Prison Reform Trust, 2012).

Speech, Language and Communication Needs in the Criminal Justice System and Best Practice responses: Dossier of Evidence *(*Royal College of Speech and Language Therapists, *2012)*

Quality Statement 5: Tailored resource for corporate parents and providers on health and wellbeing of looked-after children and young people (NICE, 2013). Available at: http://www.nice.org.uk/about/nice-communities/social-care/tailored-resources/lacyp

Promoting the Health and Wellbeing of Looked After Children (DCSF, 2009).

Better communication – shaping speech, language and communication services for children and young people (Royal College of Speech and Language Therapists, 2012)

The Mental Health of Children and Adolescents with Learning Disabilities in Britain (Institute for Health Research, Lancaster University, 2007)

Winterbourne View Review Concordat: Programme of Action (DH, 2012)

Ensuring Quality Services (Local Government Association and NHS England 2014).

Young Lives Behind Bars (British Medical Association, 2014)

Real Voices: Child Sexual Exploitation in Greater Manchester: An independent report by Ann Coffey, M.P. (October 2014)

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis *(DH, 2014)*

Sergeant A. (2009). ***Working within child and adolescent inpatient services: A practitioner's handbook*** (HMSO)

Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (NICE, 2004).

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (NICE, 2014).

Local Plans and Strategies:

Refreshed Emotional Wellbeing Needs Assessment for Children and Young People in Kent (Kent Public Health, 2015)

Service Review of Kent and Medway CAMHS (Oxford Health NHS Trust, 2014)

KCC Specialist Children's Services Improvement Action Plan 2014-16 (Kent County Council, 2014).

Kent Joint Health and Well-being Strategy (Kent Health and Well-being Board, 2014).

Every Day Matters: Kent County Council's Children and Young People's Strategic Plan. (Kent County Council, 2013).

Social Care, Health and Well-being 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)

Kent Multi-agency Commissioning Framework for children and young people with Speech, Language and Communication Needs (2014).