HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th October, 2015

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th October, 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 H Birkby and Mr A D Crowther
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 J Howes, Councillor M Lyons, Councillor M Peters and Councillor M Ring

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. Dates of 2016 Committee Meetings

   (1) The Committee is asked to note the following dates for meetings in 2016:

   Friday 29 January
   Friday 4 March
   Friday 8 April
   Friday 3 June
   Friday 15 July
   Friday 2 September
   Friday 7 October
   Friday 25 November

5. East Kent Hospitals University NHS Foundation Trust: Update (Pages 15 - 18) 10:05

   a) EKHUFT Clinical Strategy (Pages 19 - 32)
   b) EKHUFT Finance Update (Pages 33 - 44)
   c) EKHUFT Chemotherapy Services (Pages 45 - 46)

6. NHS South Kent Coast CCG and NHS Thanet: Integrated Care (Pages 47 - 74) 10:30

7. Kent and Medway Specialist Vascular Services Review (Pages 75 - 82) 11:00

8. Public Health Transformation (Pages 83 - 92) 11:45

9. West Kent: Out of Hours Services Re-procurement (Written Update) (Pages 93 - 100)

10. Date of next programmed meeting – Friday 27 November 2015 at 10:00

11. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Pages 101 - 144) 12:15

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

That, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.

12. Emotional Wellbeing Strategy for Children, Young People and Young Adults (Exempt Appendices to Item 11) (Pages 145 - 236)

**Timings are approximate*

Peter Sass
Head of Democratic Services
03000 416647

1 October 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, 4 September 2015.

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

ALSO PRESENT: Mr S Inett

IN ATTENDANCE: Miss L Adam (Scrutiny Research Officer) and Mr A Scott-Clark (Director of Public Health)

UNRESTRICTED ITEMS

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

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

37. Minutes
(Item 3)

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

(a) Minute Number 28 - NHS Ashford CCG and NHS Canterbury and Coastal CCG: Community Networks. A joint briefing by all Kent CCGs was circulated to Members on the new statutory duties for CCGs regarding Education Health Care Plans on 27 August.

(b) Minute Number 30 – Kent and Medway Hyper Acute and Acute Stroke Services Review. In response to a specific question about stroke rehabilitation at HOSC on 17 July, it was explained that rehabilitation services were not part of the Stroke Review. However Kent CCGs provided appendices on stroke rehabilitation services as background information for item 4 on the Agenda.

(c) Minute Number 33 - Faversham MIU. At the end of the discussion at HOSC on 17 July, the Committee resolved that the Chairman write to NHS Canterbury & Coastal CCG to express the Committee's satisfaction with the outcome of Faversham MIU. The Chairman wrote to the CCG on 22 July.

(d) Minute Number 35 – Date of next programmed meeting. The Kent and Medway Specialist Vascular Services Review had been deferred until the October meeting. The North Kent: Emergency and Urgent Care Review had been deferred until the November meeting.

(2) RESOLVED that the Minutes of the meeting held on 4 September are correctly recorded and that they be signed by the Chairman.

38. Kent and Medway Hyper Acute and Acute Stroke Services Review
(Item 4)

Oena Windibank (Programme Director, Kent & Medway Stroke Review, NHS England) and Ian Ayres (Accountable Officer, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the meeting. Mr Ayres began by outlining the scope of the review; he explained that the focus of the review was hyper acute services - the treatment that needed to be given within the first 72 hours of a patient having a stroke. He advised that once the hyper acute pathway had been established, each health system in Kent would then review their acute and rehabilitation pathway and present their proposals to the Committee. He stated that the CCGs considered the proposals to be a substantial variation of service and would require formal public consultation. He noted that the Medway HASC had determined the proposals to be substantial and if the Kent HOSC also considered the changes to be substantial, a joint HOSC would need to be established.

(2) Ms Windibank explained that the review was being overseen by a Review Programme Board which included representatives from all Kent and Medway CCGs, NHS England, South East Cardiovascular Network and a Clinical Reference Group. She noted that a number of clinically led modelling groups had been developed to look at travel and access; patient profile and capacity; workforce and value for money. She stated that 10 public listening events had been held; additional events were being arranged in conjunction with the Stroke Association and Healthwatch Kent. Phase two of the engagement process would include stakeholder involvement with option development and appraisal. She stated initial consideration had indicated that one or two site configurations would not be viable. A range of potential configurations were being developed from three to seven sites. A public consultation was planned for early next year.

(3) Members of the Committee then proceeded to ask a number of questions and make a number of comments. A Member enquired about financial planning and the impact on the public health budget. Mr Ayres explained that it was not a financially driven review; the aim was to ensure the delivery of clinically sustainable and high quality hyper acute stroke services. He noted that the consideration of cost came after quality, access and workforce. He stated that there was no additional money available to fund changes to hyper acute services and if an expensive configuration was chosen the money would have to come from another service. He confirmed that the review was only considering the NHS funded services; preventative services provided by KCC

were separate. Mr Scott-Clark explained that a cut to the public health budget would be set out in the Autumn Spending Review; it was not known if it would be a one-off or continuous reduction to the budget. Mr Scott-Clark stated that stop smoking services, NHS health checks and the promotion of physical exercise were key preventative services provided by Kent County Council. He noted that public health services would not meet the needs of the entire Kent population; its focus would be on a small cohort of the population who found it difficult to remain healthy particularly in areas of deprivation.

(4) In response to a specific question about modelling demographic change, Ms Windibank explained that there were 35,000 patients registered with a GP in Kent who had had a stroke. In 2014/15 2559 patients in Kent & Medway were confirmed to had had a stroke. Mr Scott-Clark noted that the hyper acute services would be commissioned using an evidence base provided by Public Health; a number of demographic variables would be taken into account. Mr Ayres stated that any proposed configurations would also include capacity for people who presented with a suspected stroke, known as a stroke mimic.

(5) RESOLVED that:

(a) the Committee deems the stroke proposals to be a substantial variation of service.

(b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

39. Emotional Wellbeing Strategy for Children, Young People and Young Adults
(Item 5)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dave Holman (Head of Mental Health Programme Area, NHS West Kent CCG) and Karen Sharp (Head of Public Health Commissioning, Kent County Council) were in attendance for this item.

(1) The Chairman welcomed the guests to the meeting. Mr Ayres began by giving an overview of the new model of care; the model offered a single point of access for children, young people and their carers; stronger partnership working and improved transition into adult mental health services. He noted that there had been extensive public engagement in the development of the Emotional Wellbeing Strategy. He stated that his provisional view was that the model was not a substantial variation of service and did not require public consultation.

(2) Ms Sharp noted that she had committed to returning to the Committee at its June meeting to provide answers to questions about emotional wellbeing in schools and early intervention. She explained that the new model would support schools to teach good emotional wellbeing and resilience. She stated that Kent was one of 12 local authorities to pilot Headstart, a resilience building programme. She explained that there were a high number of young people with emotional wellbeing issues such as bullying, anxiety and low level depression who needed an additional level of support but did not require CAMHS services. As part of the new model, all hubs would have a specialist

mental health practitioner to support young people who required an additional level of support at an early stage. She reported that early intervention prevented the emotional wellbeing issues from escalating and reduced demand on specialist services.

(3) Mr Holman explained that there were some minor changes being made, to the model and draft specification, before the contract procurement began in early October. The new contract would begin in August 2016. He noted that the Children's Health & Wellbeing Board would act as the Contract Procurement Board using NHS and KCC's joint expertise during the procurement process.

(4) Members enquired about the new service specification and requested sight of it before making a determination as to whether the new model of care and service specification constituted a substantial variation of service. Mr Ayres committed to returning to the October meeting with the specification.

(5) A Member raised concerns about the new model placing an additional burden on schools. Ms Sharp explained that schools previously had to refer students externally for early intervention services; under the new model, early intervention services could be provided directly within the school, enabling children and young people to be seen more quickly. She noted that guidance on the best resources for promoting emotional wellbeing and resilience would be provided to schools. She reported that the promotion of emotional wellbeing, as part of new national guidance, had recently become an Ofsted inspection criteria. Mr Ayres noted that the majority of school were self-governing and schools did not have to follow the guidance on promoting emotional wellbeing and resilience.

(6) A number of comments were made about the additional demand on services by unaccompanied asylum seekers and Children in Care; Big Lottery Funding; point of access in a crisis; and early intervention. Mr Holman explained that there was an overall service specification and an individual specification for Children in Care and children affected by Child Sexual Exploitation in order to meet the needs of the individual. Ms Sharp confirmed that Kent had been part of a successful national bid for Big Lottery Funding; the allocation for Kent had not been announced. The funding would be aligned to the Emotional Wellbeing Strategy and Model. Mr Holman highlighted the Kent & Medway Mental Health Crisis Care Concordat signed by 22 stakeholders to provide a multi-agency response for people including children and young people. Mr Ayres explained that greater access and early intervention reduced demand on specialist services and created whole life savings.

(7) Mr Inett enquired if there would be an ongoing mechanism for children and young people to evaluate and feedback about services as part of the specification. Mr Ayres stated the importance of continuous engagement and evaluation with children and young people and the need for this to be made explicit within the specification.

(8) RESOLVED that the report be noted and the new service specification be presented to the Committee on 9 October.

40. West Kent CCG: Diabetes Care
(Item 6)

Ian Ayres (Accountable Officer, NHS West Kent CCG), Dr Sanjay Singh (Chief GP Commissioner, NHS West Kent CCG) and Naz Chauhan (Commissioning Manager – Long Term Conditions, NHS West Kent CCG) were in attendance for this item.

(1) The Chairman welcomed the guests to the meeting. Dr Singh began by outlining the case for change. He explained that diabetes services had been identified as an area to improve quality and increase capacity in order to cope with a rising demand and prevalence. He noted that the current pathway was fragmented between primary and secondary care; a new integrated pathway had been developed as part of the review to enable a larger proportion of care to be delivered in the community with increased access to multidisciplinary services such as podiatry and psychological support. A proposed model of care had been developed based on the outcome of patient and stakeholder engagement. Mr Ayres advised that NHS West Kent CCG was seeking the Committee's views and comments on the proposed model of care. Once a service specification had been developed, the CCG would return to the Committee to ask for a determination on whether it constituted a substantial variation of service.

(2) A Member enquired about the community based spokes. Dr Singh explained that a spoke would cater for a cluster population of 30,000. The spoke would provide multidisciplinary clinics providing access to consultants, specialist practice nurses and dietetics which could move between surgeries in the cluster population.

(3) A number of comments were made about referral, early intervention and workforce. Dr Singh explained that patients would continue to be referred to level two and three community based services by their GP. He explained that it was important to identify diabetes at an early stage to prevent patients developing complex needs and requiring secondary care interventions such as amputations. He stressed the important of caring for level three patients in a community setting in order to release capacity inside the acute hospital for the treatment of complex level 4 patients. Dr Singh reported that it was expensive to provide specialist diabetic services within an acute setting and there were workforce shortages in secondary care. He noted that the primary care workforce could be upskilled to provide specialist support in the community to reach a larger population at a more sustainable cost.

(4) Mr Inett enquired about the figures provided by NHS West Kent CCG regarding the prevalence of diabetes; he noted a variation with the National Diabetes Audit. Dr Singh confirmed that the figures had been provided and verified by Public Health. Mr Inett also enquired about the promotion of self-management. Ms Chauhan acknowledged that more work needed to be done around self-help and intervention. Dr Singh noted that there was a focus on patient education as part of the review, the CCG was developing a Preventing and Obesity Strategy with Public Health and the CCG was part of a first wave national prevention pilot.

(5) RESOLVED that the report be noted and NHS West Kent CCG be requested to present the service specification to the Committee at the appropriate time.

41. Healthwatch Kent: Strategic Priorities
(Item 7)

Steve Inett (Chief Executive, Healthwatch Kent) was in attendance for this item.

(1) Mr Chard, in accordance with his Disclosable Pecuniary Interested as a Director of Engaging Kent, withdrew from the meeting for the duration of this item.

(2) The Chairman welcomed Mr Inett to the Committee. Mr Inett began by thanking the Committee for the opportunity to present Healthwatch Kent's Annual Report and Strategy 2015/16. He explained that Healthwatch Kent was required to produce an Annual Report and had aligned it to their strategic priorities. He highlighted the free Information & Signposting Service which was a key mechanism which patients used to give feedback. In 2014/15 over 2000 people directly contacted Healthwatch Kent; this figure had increased from 1225 people published in the report as a result of the Big Red Bus Tour during the summer. Healthwatch Kent held four public meetings a year, visited a different council area each month and held public voice sessions. Healthwatch volunteers analysed feedback from the public to identify trends and issues to determine its priorities. A priority in 2014 was mental health services and its complaints process; due to a good relationship with the commissioner and provider, Healthwatch Kent was able to examine how learning from complaints was embedded. He explained that Healthwatch Kent could not deal with complaints but provided information about how to complain to the relevant organisation. Healthwatch Kent responded urgently to cases where people were potentially at risk or the quality of service was extremely poor by contacting the organising directly.

(3) Mr Inett noted that Healthwatch Kent had a remit to carry out Enter and View visits to adult health and social care services. Healthwatch Kent had found that patients at hospitals placed in special measures reported a good service. As a result Healthwatch Kent would be changing its approach and focusing on transition between different health and social care services. He stated that the first Enter and View visit using the new approach would be the Integrated Discharge Team at Darent Valley Hospital. Healthwatch Kent volunteers would speak to patients in hospital who were being discharged and would then contact them a couple of weeks later to see if their support plan had been put in place and delivered.

(4) He reported that the strategic priorities for 2015/16 included the end of life care pathway, dentistry in Tunbridge Wells, social care services and the implementation of the Care Act, children and young people services and the integration of health and social care services. He noted that Healthwatch Kent was writing good practice guidance about public consultation and engagement on service changes; Healthwatch Kent was able to act as a critical friend and use their volunteers to review consultations.

(5) Members of the Committee then proceed to ask a series of questions and make a number of comments. A Member enquired about Healthwatch Kent's

relationship with the Care Quality Commission, additional income and complaint referral. Mr Inett explained that Healthwatch Kent had a regular monthly meeting with the CQC. Healthwatch Kent provided information to CQC inspectors and attended Quality Summits to share the public view and support the organisation to improve. He noted that Healthwatch Kent was generating income through its engagement work. He reported that when Healthwatch was notified of a complaint it shared and referred the complaint to the relevant complaints department.

(6) In response to a specific question about complaints regarding the provision of blood thinning drugs in a community setting, Mr Inett reported that this was not something Healthwatch had been contacted about. He reported that if Healthwatch Kent had a concern about a service, the provider had a duty to respond. He stated that relationships with commissioners and providers were key; he noted that Healthwatch Kent contacted the Trust directly for comment if an issue was raised in the local media

(7) A Member noted that one of Healthwatch Kent's priorities in 2015/16 was to gather feedback from young people and families. The Member advised Mr Inett that Kent County Council's Corporate Parenting Panel had three representatives from the local Children in Care Council and each district had a youth council. Mr Inett thanked the Member for the information. He noted that Healthwatch Kent had recently commissioned a feedback session with children and young people in Thanet to gather their views on health and social care. He reported that no specific issues were raised but explained that they wanted their voices heard. He noted that this was a new area for Healthwatch Kent and its volunteers.

(8) A number of comments were made about hard to reach groups, dentistry in Tunbridge Wells and the publication of Healthwatch Kent reports. Mr Inett reported that Healthwatch Kent would be using a more intelligence based approach to connect with hard to reach groups by utilising links with local voluntary organisations. He reported that dentistry in Tunbridge Wells was chosen as a priority following concerns raised at the West Kent Health and Wellbeing Board which was aligned to feedback received by Healthwatch Kent. With regards to the publication of reports, Mr Inett explained that volunteers compiled the reports which were then shared with the organisation for comment before the publication. He noted that the reports were published on their website and publicised in their monthly newsletter.

(9) RESOLVED that the report be noted and Healthwatch Kent be requested to provide an update to the Committee annually.

42. Chemotherapy Services in East Kent (Written Briefing)

(Item 8)

(1) The Committee received a report from East Kent Hospitals University NHS Foundation Trust which provided an update on chemotherapy services in East Kent.

(2) RESOLVED that the report be noted and the Trust be requested to provide a verbal update on chemotherapy services when it returns to the Committee on 10 October with an update on its Clinical Strategy.

Item 5: East Kent Hospitals University NHS Foundation Trust: Update

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 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 and the four East Kent CCGs.

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

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1. Introduction

(a) Members are asked to consider the attached reports as part of the East Kent Hospitals University NHS Foundation Trust Update item:

Item 5a - EKHUFT Clinical Strategy	pages 19 - 32
Item 5b - EKHUFT Finance Update	pages 33 - 44
Item 5c - EKHUFT Chemotherapy Services	pages 45 - 46

2. Item 5a - EKHUFT Clinical Strategy

(a) HOSC has considered the development of the Trust's clinical strategy on 30 January 2015 and 5 June 2015.

(b) On 5 June 2015, the Committee considered an update on the Trust's proposals for a new clinical strategy. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that there be ongoing engagement with HOSC as the EKHUFT's clinical strategy is developed including a draft copy of the public consultation and 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*.

(c) The four East Kent CCGs have requested to update the Committee on the establishment of the East Kent Health and Social Care Strategy Board which is aligned to the EKHUFT Clinical Strategy.

(d) EKHUFT and the four East Kent CCGs have asked for the attached reports to be presented to the Committee:

EKHUFT Report	pages 19 - 28
East Kent CCGs' Report	pages 29 - 32

3. Item 5b - EKHUFT Finance Update

(a) Following the announcement of regulatory action by Monitor in August 2015 regarding the Trust's current financial position, the Chairman requested an update be brought to this meeting.

4. Item 5c - EKHUFT Chemotherapy Services

(a) On 4 September, the Committee considered a report from East Kent Hospitals University NHS Foundation Trust which provided an update on chemotherapy services in East Kent. At the end of the discussion, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the Trust be requested to provide a verbal update on chemotherapy services when it returns to the Committee on 10 October with an update on its Clinical Strategy.*

5. Recommendation

Agenda Item 5a – EKHUFT Clinical Strategy

RECOMMENDED that:

(a) 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.

(b) there be ongoing engagement with HOSC as the East Kent Health and Social Care Strategy Board is developed and the Board be invited to submit an update to the Committee at an appropriate time.

Agenda Item 5b – EKHUFT Finance Update

RECOMMENDED that the report on the Trust's current financial position be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

Agenda Item 5c – EKHUFT Chemotherapy Services

RECOMMENDED that the report on the chemotherapy services in East Kent be noted and EKHUFT be invited to submit an update to the Committee at an appropriate time.

Background Documents

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

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (05/06/2015)*', https://democracy.kent.gov.uk/mgAi.aspx?ID=32545

Kent County Council (2015) '*Agenda, Health Overview and Scrutiny Committee (04/09/2015)*', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5842&Ver=4

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East Kent Hospitals University NHS
NHS Foundation Trust

Delivering our Future

HOSC Update

October 2015

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Current Position (Summer 2015)

The Trust is currently in a similar position to many other foundation Trusts in England – and our position has significantly deteriorated in the last 12 months

We need to provide Monitor with an overview of our proposed approach to address the clinical and financial challenges to sustainability.

We remain one of the safest acute Trusts in the country maintaining high performance for infection control and our hospital death rates remain around 20% lower than the national average

Our turnover for 2015/16 is expected to reach a new high of nearly £550 million but we are forecasting a deficit of £37m (for 2015/16)

We care

Why do we need to change?

East Kent Hospitals University NHS
NHS Foundation Trust

	2012	2015
Population	629.700	642,100
% over 75	9.5%	9.8%
Activity		YTD
Emergency (A&E)	200,085	85,989
Elective (El & DC)	85,308	38,188
Performance		
A&E (4 hour)	95.09%	88.02%
Cancer		
2ww	95.43%	91.83%
31 day (diag–treat)	99.09%	93.28%
62 day (GP ref)	87.83%	70.32%
18week RTT (admit)	91.95%	81.32%
Finance		
Income	£500,056,000	£534,450,000 projected
Surplus / Deficit	£15,100,000	£36,710,000 projected
Safety		
Mortality		
Crude EL (per 1000)	0.489	0.25 (average YTD)
Crude NEL (per 1000)	30.9	28.11 (average YTD)
Infection rate	4 MRSA & 40 C Diff cumm	0 MRSA & 14 C Diff (YTD)
Vacancy % (Sept Trust Average)	6.7%	8%

East Kent Hospitals University NHS
NHS Foundation Trust

Why do we need to change?

- CQC report.
- Increasingly stringent quality criteria for various clinical specialties.
- 7 day working pressures and KEOGH recommendations.
- Patients and public expectation of high-quality care close to home.
- Failure to achieve RTT in some areas.
- Increasing outsourcing of elective activity.
- Failure to achieve cancer targets in some areas.
- Failure to achieve the A/E standards

We care

So, what's the answer?

East Kent Hospitals University NHS
NHS Foundation Trust

- We need to re-consider how we deliver care in the future
- We cannot continue to provide the current pattern of services on three hospital sites and there is wide recognition that reconfiguration is required
- But we need to ensure we continue to deliver services locally wherever possible

We care

So, what's the answer?

East Kent Hospitals University NHS
NHS Foundation Trust

- Where absolutely necessary we have to consolidate services

- Financial position directly impacts the ability to borrow so the solution must be financially deliverable. We have assessed a borrowing capacity of circa £100m (alongside delivery of a Financial Recovery Plan).

- Delivery of **any** model is only achievable if we have a truly integrated care strategy with primary care, community & social care

We care

What have we done so far?

- Phase 1 of public engagement is complete and phase 2, ahead of a formal consultation process, will be planned for later in the year.
- Risk assessments have completed for all specialties.
- We have analysed the level of need (acuity) of our patients.
- We understand the financial envelope.

East Kent Hospitals University NHS
NHS Foundation Trust

What have we done so far?

- The CCGs have established an East Kent Strategy Board to lead a health economy approach.

  Members include:

  - Current providers EKHUFT, SeCAMB, KMPT, KCHFT.
  - Developing providers of the future – SKC, Thanet and Ashford Integrated care organisations led by GPs (primary care), Canterbury Vanguard Multi speciality provider led by GP Dr John Ribchester.

We care

Next Steps

East Kent Hospitals University NHS
NHS Foundation Trust

- We must agree a set of criteria including patient experience, clinical, financial and workforce aspects that will support option development.

- All options will need to be modelled against a range of viability metrics including specialist professional workforce availability and cost.

- We are working towards CCGs consulting with the public of any consequent significant service change in early/mid 2016.

We care

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Meeting:	Health Overview and Scrutiny Committee
Date of Meeting:	9 October 2015
Subject:	Briefing Paper: Establishment of the East Kent Health and Social Care Strategy Board
Action Required:	This paper is for information
Purpose:	To update the Health Overview and Scrutiny Committee on developments on the establishment of the East Kent Health and Social Care Strategy Board, its purpose, method of working and aims.

1. Introduction

The HOSC has received a number of briefings and update reports over the last two years from both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and the four east Kent Clinical Commissioning Groups (CCGs) relating to clinical strategy and the development of new models of care.

With the ongoing development of the Trust's clinical strategy, the now accelerated development of new models of care in primary and community services, and the ongoing need to integrate social care with health, it has become increasingly clear that east Kent needs the means to develop a whole system strategy.

Not least, east Kent needs to ensure the full benefits of the out of hospital new models of care are realised, a sustainable future for both hospital and primary care services is developed, and integration of social care is achieved that ensures future service needs are met making the very best use of scarce resources.

To this end a Board has been established comprising the Clinical Chairs and Accountable Officers of the CCGs, the Chief Executives and Medical Directors of the health Trusts, the Corporate Director of Social Care, Health and Wellbeing for KCC, the Chair of the Whitstable and Canterbury Vanguard and NHS England. The Board had its first meeting in September and will continue to meet monthly.

There is wide recognition among Board members of the need for collaboration to oversee the development of strategic change and reconfiguration plans and the need to share resources to do so. There is also a good understanding that we need to build on work already started, not begin again. Early work of the Board will be to:

- Develop clinical criteria for change through key stakeholders.
- Determine the jointly developed and owned assumptions that underpin wider strategy.
- Bring together and develop existing work on capacity and demand modelling at an east Kent level.
- Develop communications and engagement capacity and a clear plan to support this work.

The focus of the Board will be to develop new models of care, develop new provider models and to determine the future shape of commissioning arrangements. At this stage this programme of work will be developed with the expectation of formally consulting with the public on future plans in early spring of 2016.

This paper provides a briefing to the HOSC on how the east Kent Board will operate.

2. Role of the Board

The respective individual organisations will retain decision making authority while recognising that delegated authority to develop the plans will be given to the Programme Board. The role of the East Kent Strategy Programme Board is to ensure that the Programme is delivered within the scope and to timescales agreed at the September 2015 Programme Board meeting by:

- Ensuring the delivery of a safe, quality, affordable and sustainable clinical strategy for the population of east Kent.
- Overseeing the work of and providing strategic guidance to the programme team and other associated work streams.
- Approving project plans and managing any deviations.
- Ensuring resources are managed appropriately across the Programme;
- Reporting, by exception, any risks, issues and exceptions related to the Programme.
- Brokering the competing priorities, providing advice and support on the strategic management and direction of the Programme.
- Approving, supporting and disseminating the communication and engagement programme related to this Programme.

3. Responsibilities

The East Kent Strategy Programme Board will have oversight of the Programme, ensure its delivery and make recommendations regarding future health and social care service configuration.

The Board's responsibilities are to:

- Promote and endorse the vision and objectives of the Programme.
- Oversee the work of, and provide strategic guidance to, the Programme Team and other associated work streams.
- Ensure that the Programme is delivered within scope and to timescales.
- Establish and ensure compliance with the communications strategy.
- Ensure that patient interests, rather than organisation-specific vested interests, remain at the heart of the process and to ensure they are actively engaged in discussions on service re-design.
- Broker competing implementation priorities across the Programme, ensuring adherence to agreed criteria for prioritisation.
- Ensure regular review of risks and issues that could impact on the Programme.
- Consider any external strategic impact on the delivery of the Programme.

- Manage/coordinate any change requirements necessary to maintain alignment with the Programme.
- Advise the respective organisations as necessary and appropriate.
- Ensure the Programme runs within budget.

4. Recommendation

The HOSC is asked to note the establishment of the East Kent Health and Social Care Strategy Board, its purpose, method of working and aims.

The HOSC is asked to advise how it wishes to work with this Board as it develops its work.

Author: Simon Perks, Accountable Officer NHS Ashford and NHS Canterbury and Coastal CCGs

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East Kent Hospitals University NHS
NHS Foundation Trust

HOSC
Financial Briefing

October 2015

Putting patients first

Facts & Figures

East Kent Hospitals University NHS
NHS Foundation Trust

- Our total income this year will be £535m
- We spend £23.6m per month on salaries and wages for our own staff
- In July we spent £4.2m on agency, bank and overtime
- In the first 4 months of the year we spent £9.85m on agency staff (medical £5m, nursing £2.5m, Professions Allied to Medicine £1.6m)
- We spend £5m per month on drugs
- We spend £6m per month on clinical supplies and £3.5m on non-clinical supplies
- Our savings plan this year is £16m
- Our forecast is that we will spend £37m more this year than we receive in income
- After 4 months our deficit is £13.5m
- We will have no cash in the bank at the end of the year if we achieve the forecast position

What has Caused The Deficit?

East Kent Hospitals University NHS
NHS Foundation Trust

Although the change in the Trust's financial position may seem sudden, the deterioration can be tracked over the last few years:

- The Trust has not achieved its target level of savings
- The Trust has invested significant capital in developing services
- More clinical posts have been approved to ensure that the Trust delivers safe staffing levels
- We have seen a significant rise in temporary staff costs.
- We have also had to fund many additional clinical sessions to keep up with demand and outsource work to the private sector to keep ahead of our waiting list targets.

Is it only East Kent in Trouble?

East Kent Hospitals University NHS
NHS Foundation Trust

- No, the majority of hospital providers are facing similar pressures to us with some commentators suggesting that the provider sector is facing a £2 billion deficit this year.
- However, at East Kent we do have some more local issues:
- Operating from 3 small general hospitals means particular issues running medical staff rotas
- Our multi site structure means that we don't benefit from the efficiencies that would come with scale
- We have a lot of poor accommodation and infrastructure and ageing equipment
- The financial issues impact on the development of the clinical strategy options
- There have been many changes at senior management level

Q&A

East Kent Hospitals University NHS
NHS Foundation Trust

Q. Has anything been done immediately to control costs? There is a full range of savings plans each with a lead Executive Director and supported by a number of project staff. Immediate steps taken include:

- Stop buying office furniture and equipment
- Stop providing hospitality in most circumstances
- Chief Nurse to approve all non ward based nursing appointments
- Divisional Directors to approve any use of 'off framework' agency usage
- Ensure all orders for goods and services go through a competitive process
- Established a Programme Office to oversee all savings plans
- Set up a workforce group to review all staffing issues
- Introduced a Financial Recovery Group chaired by the CEO
- Held CEO Forums and a Finance Summit

Q&A

East Kent Hospitals University NHS
NHS Foundation Trust

- Review of all clinical and corporate budgets
- Review all third party service agreements
- Introduce weekly cash flow forecasts
- Ensure pharmacy controls in place
- Making sure that the new Dover Hospital is being used fully
- Put in place taxis and transport cost controls
- Bring in expertise on medical staff job planning and rotas
- Re-establish the theatre productivity group
- Review all the Trust's financial controls
- Undertake a review of the HR Department
- Bring in expertise to help the Trust look at how productive it is compared to other hospitals

Q&A

East Kent Hospitals University NHS
NHS Foundation Trust

Q. Will this mean less money for accommodation, IT and equipment? In order to ensure that we are able to pay salaries at the end of the year is has been necessary to look very carefully at what we spend on these areas and the capital budget has been reduced by £5m. We will still be spending over £12m on facilities, IT and medical equipment, but have to stop buying office furniture

Q. Is it true that the Trust is having to sell its sites? To generate cash we are disposing of a number of pieces of land and residential properties that are not required for healthcare services.

Q. Will this mean we stop providing some services? We will examine in detail all the services we provide to ensure they are efficient, effective and safe. We have no plans in the short term for stopping any of our services.

Q&A

East Kent Hospitals University NHS
NHS Foundation Trust

Q. What are we doing to reduce the need to employ expensive agency staff? We have set up a Reduction in Agency Spend Programme that is working to actively recruit permanent staff faster, retain existing staff, ensure best value, whilst ensuring that patient care is not affected.

Q. How will we solve the problems with A and E times? There are a number of things we are doing. By working with our partners to signpost patients to the most appropriate source of care we can focus on those patients who most need our help. Through collaboration with partners we can improve the through flow of patients to a safe discharge, which will reduce waiting times for admissions and finally by recruiting and retaining staff in A and E we will be able to maintain staffing levels.

Q&A

East Kent Hospitals University NHS
NHS Foundation Trust

Q. What is the £16m savings plan? The main elements of the plan include the categories identified below but we must seek to identify further opportunities:

- Procurement (non-pay) savings £2m
- Agency spend savings £3m
- Theatre efficiencies £1m
- Drugs savings £0.7m
- Third party agreement s £0.6m
- Energy, estates, facilities management £1.2m
- IT savings £0.7m
- Clinical Divisions schemes £2.7m
- Budget review £1m
- Other schemes £3,1m

What Does Monitor Want Us To Do?

East Kent Hospitals University NHS
NHS Foundation Trust

- We have to submit a detailed A&E improvement plan by 31 August 2015
- We have to develop and submit a long term strategy for financial and clinical sustainability by 31 Dec 2015
- We have to submit a short term financial recovery plan for 2015/16 by 30 Sept 2015
- We have to submit detailed demand and capacity models by 31 Oct 2015
- We have to submit detailed operational and strategic workforce plans by 31 Oct 2015
- We have to submit a detailed Financial Governance Plan by 30 Sept 2015

What Does Monitor Want Us To Do?

East Kent Hospitals University NHS
NHS Foundation Trust

- The CEO has to submit an assessment of the Trust's management arrangements by 30 Sept 2015
- If requested by Monitor, we may need to have an external review of the Trust's plans
- We have to appoint a Turnaround Director to help us deliver financial improvement by 30 Sept 15

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East Kent Hospitals University NHS
NHS Foundation Trust

Briefing on the Chemotherapy Services in East Kent
Kent Health Overview and Scrutiny Committee

October 2015

The position remains broadly in line with that last reported to the HOSC in September 2015.

Background

East Kent Hospitals University Foundation Trust delivers Chemotherapy services from its three acute sites (Celia Blakey Day Unit at Ashford, Cathedral Day Unit, Canterbury and Viking Day Unit, Margate); we also have a Chemotherapy Mobile Unit which delivers services at Herne Bay, Dover and Hythe.

In the early part of June this year the Celia Blakey unit at Ashford reported an emerging staffing risk which would see the unit down to 50% of its permanent workforce, by the end of June, due to a mixture of Vacancy, Maternity leave and long term sickness. This presented a patient safety issue and required the service to consider how it would safely continue to deliver care to patients. A number of options were considered and discussed with the Divisional Leadership Team and Executives. There were two clear options one involved agency staff and the other to extend the hours at Canterbury Cathedral day Unit and use the Chemotherapy Mobile unit on the Ashford site for appropriate chemotherapy regimens for a temporary period.

The agency option was very expensive and required us to use off framework agency staff, due to the specialism of this service. The estimated cost for twelve months was in the region of £660k. Furthermore, it is not recommended to run services on such high agency staffing and therefore, the alternative option to provide care from the mobile unit at Ashford 3 days a week and to move those who needed more complex care to Canterbury, was considered the better option. All other non-chemotherapy appointments remain at the William Harvey Hospital if more convenient for patients.

Current Situation

The patient appointments were moved to Canterbury on the 6th July. The Cathedral Day Unit has extended its hours of opening to 9pm Monday to Friday and is opening on a Saturday. Alongside this the Chemotherapy Mobile Unit is available at Ashford three days per week. These arrangements are expected to remain in place for

between nine and twelve months. All new chemotherapy appointments remain within the unit on the William Harvey Hospital site.

It is very unusual for our chemotherapy units to recruit chemotherapy competent staff, as there is a national shortage. Normally we recruit band 5 registered nurses and train them, the training takes twelve months. A programme of recruitment has started and we are planning to be back in the Celia Blakey unit within the year. In addition to recruiting new staff we are in the process of contacting staff who have left our chemotherapy services in the last twelve months. The aim is to find out why they left and could we have done anything differently to have encouraged them to stay. We are also benchmarking ourselves against other Trusts in Kent, Medway and London to establish what grades chemotherapy trained staff are recruited in order to make us a competitive employer.

We have tried to communicate with all concerned and involved in the service. We wrote to and rang patients before we introduced the move and have used media, our CCG and MP's to share the message widely. To support patients we have shared the telephone contact details for the Cancer Care Line to allow them access to our staff, who can support or signpost their concerns.

Next Steps

- We intend to have a full complement of band 5 nurses in place by December 2015.
- We will fast track training for new chemotherapy nurses to ensure, dependent on existing knowledge and skills, they are competent in 6 to 8 months. This will mean the band 5 nurses will be competent by August 2016.
- We are intending to reinstate delivery of chemotherapy from the Celia Blakey unit from July 2016.

Item 6: NHS South Kent Coast CCG and NHS Thanet CCG: Integrated Care

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 2015

Subject: NHS South Kent Coast CCG and NHS Thanet: Integrated Care

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS South Kent Coast CCG and NHS Thanet CCG.

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

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1. Introduction

(a) On 30 January 2015 the Committee considered the case for change and the vison for integrated care in Thanet and the South Kent Coast. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that:*

  (a) there be on-going engagement between NHS South Kent Coast CCG, NHS Thanet CCG and HOSC as plans are developed

  (b) NHS South Kent Coast CCG and NHS Thanet CCG present a report to the Committee in six months.

(b) NHS South Kent Coast CCG and NHS Thanet CCG have asked for the attached reports to be presented to the Committee:

CCGs' Report	Pages 49 - 58
CCGs' Presentation	Pages 59 - 62
South Kent Coast Compact Agreement	Pages 63 - 74

2. Recommendation

RECOMMENDED that there be ongoing engagement with HOSC as plans are developed with a return visit to a meeting of the Committee at the appropriate time.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (30/01/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5837&Ver=4

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Developing Integrated Care in South Kent Coast and Thanet

Progress Report – September 2015

1. Introduction

NHS South Kent Coast Clinical Commissioning Group (CCG) and Thanet CCG presented a paper to the Health Overview and Scrutiny Committee (January 2015) outlining strategic plans for developing an Integrated Care Organisation (ICO).

The HOSC were supportive of the direction of travel and requested regular briefings on progress.

This briefing presents both CCGs' progress against these plans, and in developing integrated out of hospital care in each of the local communities.

It also outlines progress in developing a local system for leadership through the local Health and Wellbeing Boards.

2. Background

Local NHS and Social Care partners recognised that the current pattern of health and social care locally cannot continue in its current form.

With an increasing demand for services, a growing older population, a rise in multiple long-term conditions and health and social care budget restraints, better integrated care is seen as an essential requirement to improve the quality and efficiency of NHS and Social Care.

At present the provision of out-of-hospital care is highly fragmented. It is provided by multiple organisations that are often differently engaged and governed through the NHS or local government. Provision spans statutory public organisations such as NHS trusts, Kent County Council (KCC) and local government directly managed provision, private sector, voluntary and charitable organisations.

The South Kent Coast CCG and Thanet CCG visions for Integrated Health and Social Care, through an Integrated Care Organisation (ICO), is for patients to always be at the centre of their care and support, receiving coordinated services that are easy to access 24/7, without organisational barriers, of high-quality and which maximise their ability to live independently and safely in their community and in their own homes wherever possible.

It will ensure service users and their carers can navigate the services they need and that their health and wellbeing needs are always met by the right service in the right location.

This vision has been developed through a 'bottom up' approach with wide consultation and engagement with the CCGs' membership, patients and the public as well as partners and providers across South Kent Coast and Thanet.

This will be achieved by building a local model of health and care delivery within the natural neighbourhoods of South Kent Coast and Thanet, with each comprising of a hub of community health, social and primary medical care services, undertaking an integrated health and social care approach.

Alongside this there will be schemes to support education and empower people to make decisions about their own health and wellbeing by building on and enhancing some of the local projects already implemented or planned and introducing other schemes to ensure faster evolution of what we are already setting out to achieve.

This is a major transformation programme and requires system and culture change. The programme of work has been in place since September 2014 and it is expected that delivery of the vision for Integrated Health and Social Care locally will be an incremental process over the next five years.

A roadmap to change has been developed with the expectation of the Integrated Care Organisation being run in shadow form by 2018/19 **(Appendix 1)**

3. Programme Progress

Partnership

It is well documented that by working in partnership more can be achieved than by working apart and therefore in South Kent Coast and Thanet a multi organisational partnership approach has been established in order to develop and deliver a new model of Health and Social care provision.

Delivery of the South Kent Coast and Thanet Integrated Care Organisation, focusing on a multi-specialty provider model of organising care, (incorporating new models of care as set out in the NHSE 5-Year Forward View http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) is the key focus of partnership activity.

Our agreed aim is, "to ensure that South Kent Coast and Thanet people are supported to be well and healthy in their own homes and communities, by delivering a connected system, designed and delivered around local people, located in natural neighbourhoods."

To support delivery of this aim a compact agreement has been developed and adopted by all partner organisations. The Compact provides the framework for the Health and Social care, Voluntary and Community sector and other compact partners in South Kent Coast and Thanet to work together.

It describes the relationships, behaviours and values of all organisations working in partnership to achieve a common aim.

This Compact expresses the commitment of public sector and voluntary and community sector organisations to work in partnership and is a voluntary agreement between public sector organisations, voluntary and community organisations.

Whilst no partner is legally bound by this Compact, all partners have expressly stated their intent to work in the spirit of the agreement **(Appendix 2).**

Governance
An Integrated Executive Programme Board (IEPB) has been established in both South Kent Coast and Thanet consisting of senior leaders across the Health and Social Care system.

The IEPBs have been established to enable executive leaders from commissioner and provider organisations, and local authorities to have oversight of, and be responsible for ensuring effective and sustainable delivery of the agreed integrated health and social care plans.

A Programme Director is in place working on behalf of the two CCGs and Kent County Council, providing strategic leadership and programme management, in addition to a project support officer.

A programme plan and roadmap have been developed and agreed identifying high level key milestones and actions. A number of supporting workstreams have been established to support delivery of the programme in addition to locality delivery groups focusing on changing and implementing the new model of care. The following gives a brief outline of workstream progress

Workforce Development
A critical element of delivering the new model of Integrated Care is ensuring we have a sustainable and skilled future workforce. As part of the SKC and Thanet ICO programmes, we have been lucky enough to work with universities across Kent, Surrey and Sussex on the development of an ICO workforce plan for the future.

A synthesis of the work packages they are carrying out will provide guidance and advice on the development and delivery of education and training to ensure future workforce is fit for practice, realistic and affordable.

In taking this work forward we have held workshops aimed at frontline clinicians and practitioners across health, social care and the voluntary sector facilitated by Dr Michael Tremblay, focusing on the new model of care and the skills required to deliver that model.

The outcomes from these workshops will feed into the development of a future workforce plan for the ICO.

In addition it is important to 'grow our own' future workforce locally. An open day will be held in October in east Kent focusing on careers working in Health and Social Care. All schools have been invited with the aim of developing young people's interest in health and social care of the future.

Research and Development

The ICO programmes of work include a focus on research and evaluation, and a workstream devoted to this has been established in SKC and Thanet and is being led by the Centre for Health Service Studies at the University of Kent. This will ensure an evidence-based approach, alongside the generation of local evidence of effectiveness of the integrated care initiatives. Initiatives in both SKC and Thanet have been agreed for formal evaluation. Lessons learned will be fed into the design and implementation of the programme.

Good data is critical when evaluating and planning future services. Across Kent we have an integrated database which takes data from services across health and social care and will enable us to plan future care effectively. Primary care data is critical and practices across SKC and Thanet have agreed to release pseudonymised activity data.

All partners have agreed in principle to fund the evaluation programme over the next three years.

Information Management and Technology (IM&T)

An IM&T strategy group has been established, made up of all partners and is there to oversee the development and implementation of Information Technology (IT) as a key enabler to integrated care.

This group will develop an IM&T strategy and plan to support the ICO delivery ensuring that full interoperability across provider systems are in place, as well as identifying new technologies across the CCGs to support quality and effectiveness of patient services.

Work is already underway focusing on developing a mechanism for sharing patient information between the hospitals and GPs. This will be expanded to other groups of Health and Social Care professionals as the project gains momentum this year.

Patient care plans will be shareable shortly with East Kent Hospitals Trust (EKHUFT) and then other providers as the functionality becomes available.

Finance
It is recognised that there is a need to collate Social Care and Health Finance and Performance data to help inform the Integration agenda, therefore an integrated finance working group has been established.

As a start this group is looking at data for Thanet and South Kent Coast for Older People (65+) and Physically Disabled (18-64) related services.

In addition there has been an agreement within the local Health and Wellbeing Board (HWBB) for the CCG, KCC and the local council to develop a transparent budget approach where the CCG, social care and district budgets are presented together.

Work has also started on developing a capitated budget for CCG localities to support locality commissioning with shadow place-based health and social care budgets in situ by August 16/17.

The aim is to have an Integrated Health and Social Care commissioning budget established by 17/18.

Communication and Engagement
A communication and engagement working group is in place. This group is working to ensure alignment of communications relating to transformation and development of the ICO and ensure that this is aligned with any wider east Kent or Kent consultations.

The engagement team agreed a creative approach to involving local people in co-designing care in their areas and having a real input into identifying their area's needs, service priorities and opportunities for their community and making the most of community assets.

This has resulted in the model of integrated care being designed by more than 200 clinicians and the public with co design from the outset, building upon a shared sense of ownership and ambition for health and care in the area.

The group have developed a draft communications and engagement plan which will support the ICO work.

4. Developing an Integrated Commissioning System

Health and Wellbeing Boards (HWBB) provide a genuine opportunity to develop a place based, preventative approach to commissioning health and care services, improving health and tackling health inequalities and the wider determinants of health.

Their role is as a local system leader and with further development they could provide the foundations on which wider devolution of health and care and responsiveness to local needs can be built. This is reinforced In 'Making it better together': a call to action on the future of Health and Wellbeing Boards, published in June 2015 by the Local Government Association and NHS Clinical Commissioners.

In SKC and Thanet the local HWBB have been exploring how they could become a commissioning/decision-making body. A small working group has been established to explore options and look at best practice in other areas.

This work is being overseen by the District CEOs, CCG Accountable Officer and senior officers from KCC. It is clear that membership and governance would need to develop and change to enable this vision. This needs to be aligned with the strategic role and framework of the statutory Kent HWBB.

Development of the SKC HWBB and the Thanet HWBB has already started and is running in parallel with the development of the Integrated Care Organisation with the idea of running the new HWBB model in shadow form from April 2016.

Both local HWBB have agreed the commitment and ambition to become a vehicle for change.

5. Progress on developing and delivering a new integrated model of care (service provision)

NHS South Kent Coast and NHS Thanet CCGs are now at the position where an outline model for integration has been designed locally.

Whilst this work was happening, the *Five-Year Forward View* was published which outlined four new models of care for integration. The work that both CCGs are doing fully aligns with this direction of travel. The following outlines the progress made in each CCG locality.

South Kent Coast

The local GPs in South Kent Coast are looking to lead the establishment of an 'Integrated Care Organisation' (based on the nationally described Multi-Specialty Community Provider Model). Ultimately this will become a full risk-sharing, population-based approach to organising integrated care locally.

The CCG is beginning to implement the ICO operational model in SKC. The focus is on the function and redesign of the currently commissioned services across Health, Social Care and the third sector, the form of the ICO will follow at a later date.

There are four natural localities in SKC CCG, Deal, Dover, Folkestone and Romney Marsh, the four local delivery groups are in place and meet bi-monthly.

The membership includes; statutory and voluntary services including patients and public membership, some also involve local councillors. The groups provide oversight and scrutiny to the developing ICO operating model across SKC.

There are a number of workstreams that have been established in order to deliver the operating model. The following work streams are either running or just starting:

- Integrated primary care
- Prevention and self-care
- Pathway changes - mental health, rheumatology, cardiology, respiratory, dermatology, diabetes
- Locality urgent care, rehabilitation and enablement
- Pharmacy and medicines management
- Information management and technology
- Health, housing and social care
- End-of-life care improvement.

We are working closely with KCC social care and the district councils who are supporting, in particularly the health, housing and social care and prevention and self-care. There are opportunities to communicate targeted messages to each household by partnering with the councils to place information in their magazines and to also send out message through adding flyers to the council tax bills.

In addition we are starting work together to build a comprehensive directory, to include public health of services, interventions and technology that can support improved health and wellbeing, reduce isolation and promote independence through innovative housing options.

In October, we intend to pilot the integrated intermediate care service together with KCC social services, Kent and Medway Partnership Trust (KMPT) and the voluntary sector. This is phase 1 of the integration of such services with phase 2 looking to utilise the KCC Area Referral Management Services (ARMS) as the single point of referral for delivery of the integrated intermediate care pathway.

We also intend to pilot an integrated locality level urgent care pathway that will involve the Minor Injury Unit (MIU) nurse practitioner, rapid response nurses and paramedic practitioners working together to deliver an integrated urgent and crisis response.

In relation to Information management and technology the strategy work stream will oversee the continued implementation of the interoperable IT system within general practice that will eventually allow consensual access to patient summary record and anticipatory care plan.

Phase 1 implementation is completed and is moving into Phase 2. The workstream will ensure delivery of the work plan that includes the mobilisation of all available and appropriate technologies.

Work has just started on the bringing together and developing the integrated team around general practice which is designed to put in place a care coordination model for the most vulnerable patients.

This will also deliver care coordination for patients at the end-of-life care and the groups have started that will be responsible for the pathway redesign and education and workforce.

Additionally, we recognise the value contribution of domiciliary care agency staff and are planning to provide an educational programme for them to assist in the identification of the deteriorating service user to ensure that staff are skilled enough to undertake a simple assessment of their service user should they feel that they may becoming unwell to act quickly to avert a crisis and potentially improve the outcome.

We are beginning to scope with KCC the opportunities for 'community agents' who can support the wider community to improve health and wellbeing and will ultimately support the prevention agenda.

The CCG is working to develop managed care pathways and 'tiers of care' across speciality areas such as diabetes, cardiology, respiratory, dermatology and rheumatology as a focus.

We are testing the nurse consultant led rheumatology pathway from September 2015 in Deal. It is our intention that the redesigned pathway will be SKC CCG's blueprint for other specialty areas for appropriate management of patient groups across the acute and primary care system.

The final work stream, pharmacy and medicines management is due to start late November, early December.

Thanet

Thanet CCG recognises that as more people live longer and with complex co-morbidities, there is a need to address the fragmentation of care which is apparent across the health and social care system. Integrated care aims to close any gaps in care provision and ensure care co-ordination leads to improved patient experience and outcomes.

Ultimately, Thanet CCG and partners will commission and provide person centred services where care is delivered around the individual via a single point of access.

In Thanet a number of design sessions have been held to advance thinking on the locality model for integration focusing on the role of QEQMH as an integral element of the model providing community orientated acute provision ensuring that services are drawn into Thanet wherever possible. Further engagement is currently taking place to design with residents and clinicians the service details of the local areas within Thanet (Broadstairs, Margate, and Ramsgate) and those services which are all across Thanet.

Two workstreams have commenced in Thanet as the first steps in developing the ICO:

1) **Local hospital (Queen Elizabeth the Queen Mother) design as a community asset**
   This includes development of Integrated Primary Care at 'the front door' and redesigning the frailty pathway to improve patient flow and safety for frail, older patients.

2) **'Stay at home' services**
   This includes the Integrated Health and Social Care 'wrap-around' teams servicing four 'clusters' of practices within Thanet, increasing access to paramedic practitioners, implementing discharge to assess and enhancing support to care homes.

Emerging Clusters
Practices in Thanet have formed into groups, or clusters, resulting in four clearly defined localities: Broadstairs, Margate, Ramsgate and the Quex Cluster (comprising Birchington, Garlinge, Minster and Westgate).

Work has taken place with two of the four clusters to map the proposed provision of integrated health and social care teams which could operate at a practice level, cluster level or Thanet wide level to ensure effective use of resources whilst meeting the needs of the population within the cluster.

Workshops are planned with current providers, practices, patients and the public to consider what current pathways would look like if they were delivered in an integrated way. This ensures the patient voice is central to any redesign and frontline staff delivering those services are empowered to effect the changes needed to ensure true integration of patient care.

6. Next Steps

- Further development of the HWBB to become local commissioner of health and care services.
- System modelling of out of hospital care and acute provision for the future.
- Implementation of the model of care in localities.
- Development of the potential community service models for mental health.
- Development of the potential service models in Thanet for Children's services, focused on support for emotional health and wellbeing.
- Strengthening of local leadership to deliver the model of care.
- Investigation into contracting mechanisms for the future and future provider organisation models, for example, Accountable Care organisations.

Alison Davis
ICO Programme Director
Working on behalf of KCC and Thanet and SKC CCGs
25/09/2015

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Integrated Care Organisation Progress

NHS Thanet CCG and NHS South Kent Coast CCG

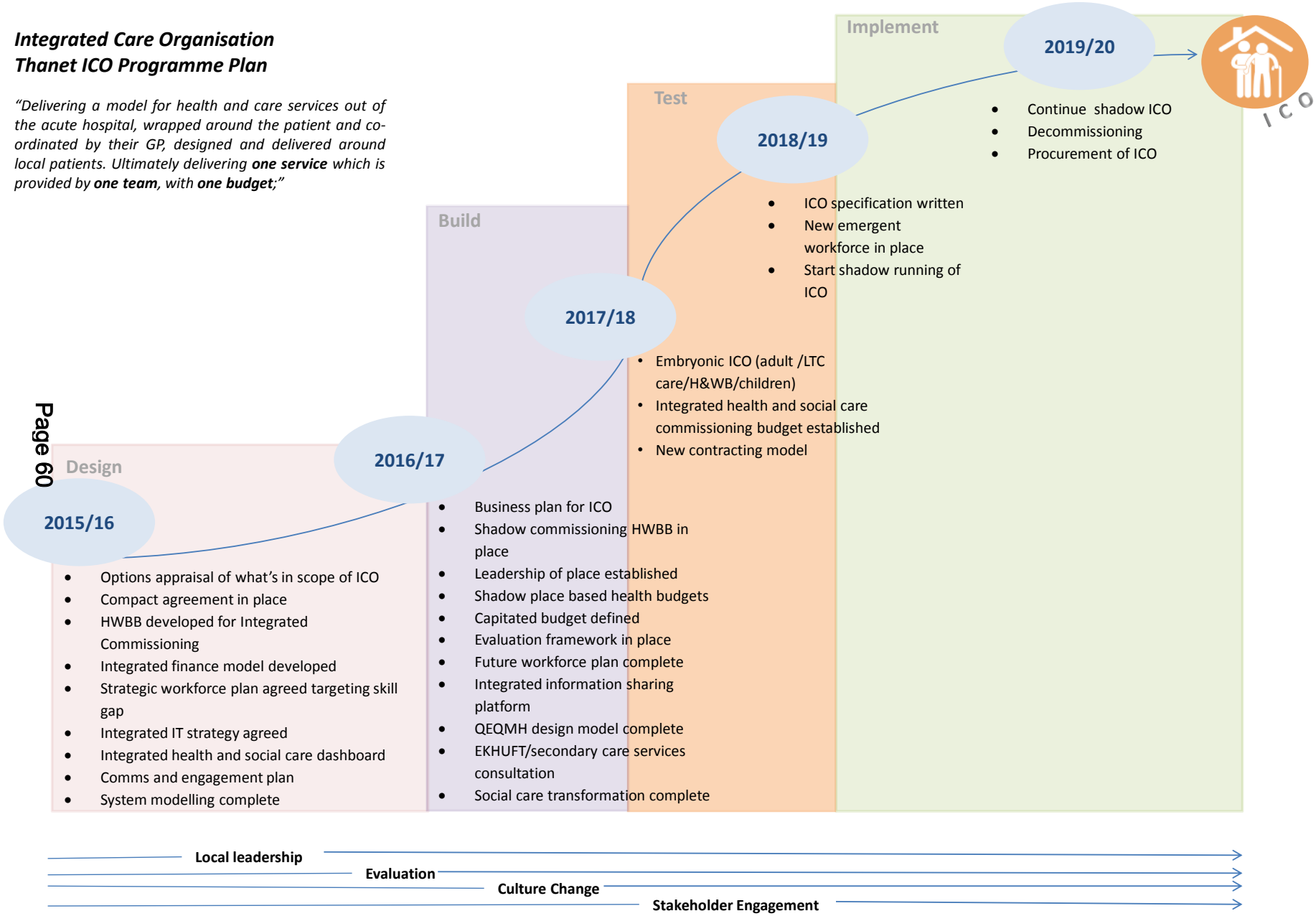
October 2015

NHS South Kent Coast Clinical Commissioning Group

NHS Thanet Clinical Commissioning Group

Integrated Care Organisation
Thanet ICO Programme Plan

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP, designed and delivered around local patients. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*



Leading Integrated Health and Social Care Commissioning THWBB - Year One Roadmap

September

- Executive Group is established
- Agree Year One Roadmap
- Agree Draft financial model and next steps to deliver alignment
- Agree THWBB commissioning priorities

November

- Agree Governance Roadmap
- Agree establishment of Partnership Groups to drive the work programme
- Agree TOR Inequalities Partnership Group
- Agree TOR Local Children's Partnership Group
- Better Care Fund progress update

January

- Agree integrated commissioning plan
- Agree outcome measures
- Agree public communication /engagement plan
- Agree integrated commissioning performance dashboard

March

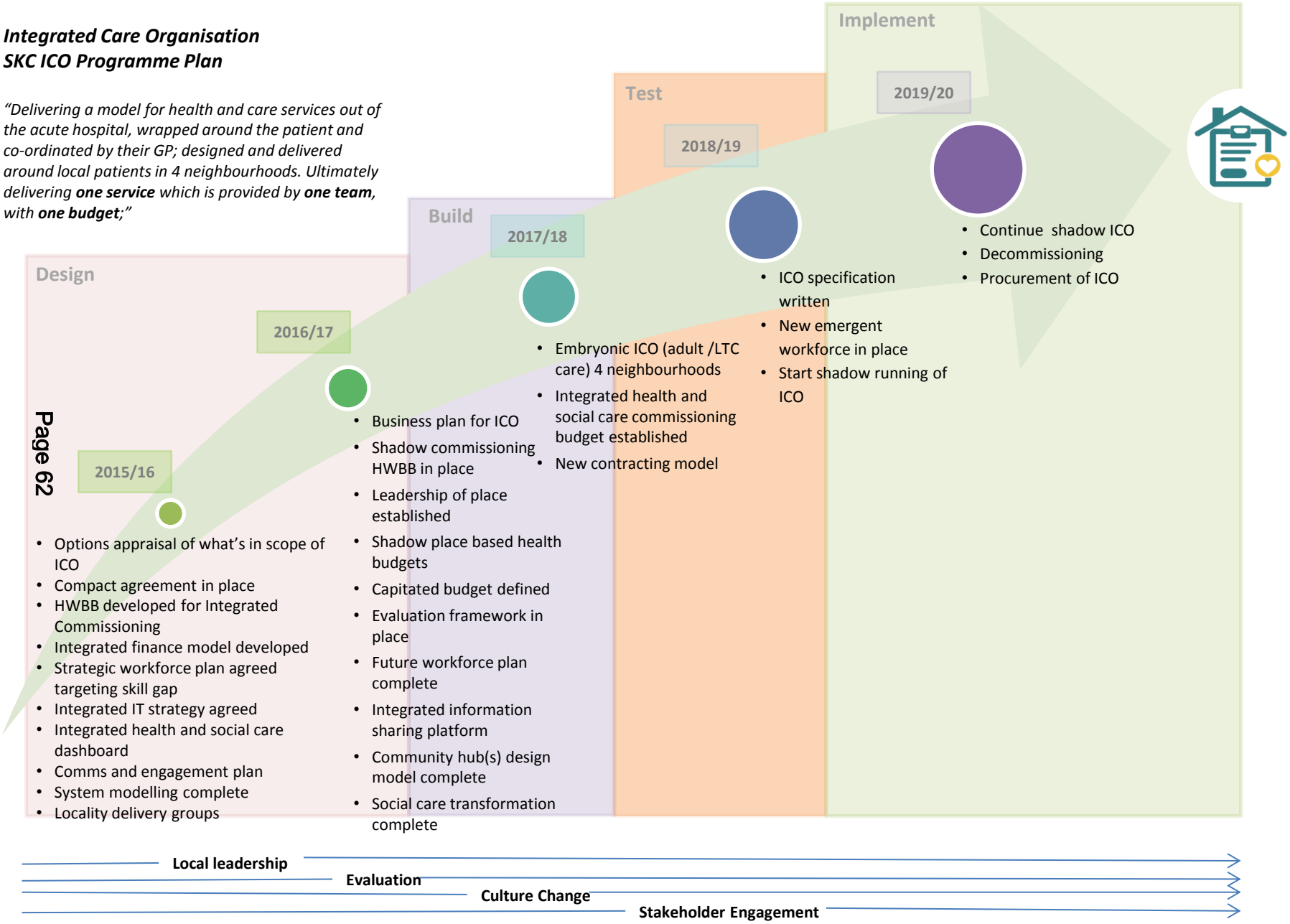
- Agree final integrated commissioning plan 2016/2017
- Review THWBB Membership

2016/ 2017

- Deliver agreed integrated commissioning plan and monitor performance via the dashboard
- Deliver 'quick win'
- Shadow place based budget in place
- New contracting models
- Development plan 2017

Integrated Care Organisation
SKC ICO Programme Plan

*"Delivering a model for health and care services out of the acute hospital, wrapped around the patient and co-ordinated by their GP; designed and delivered around local patients in 4 neighbourhoods. Ultimately delivering **one service** which is provided by **one team**, with **one budget**;"*



Delivering Together for the people of South Kent Coast

Integrating Health and Social Care

"One Service, One Team, One Budget"

Draft Compact Agreement 2015-2018

Forward

This Compact captures each organisations commitment to partnership working to deliver improved integrated health and social care for the populations they serve.

There is collective recognition that as the populations become older and are living longer with more complex conditions, there is a growing demand on Health and Care services. This in addition to the economic downturn means that Health and Social Care provision is unsustainable in its current form.

Integration of Health and Social Care has been acknowledged as the way forward; delivering better care, improving quality and outcomes for citizens as well as efficiencies across the system.

This means a new imperative for joint and collaborative working across all the organisations that commission and deliver health and wellbeing in our area.

It is well documented that by working in partnership we can achieve much more than working apart and therefore in South Kent Coast we have established a multi organisational partnership approach to developing and delivering a new model of Health and Social care provision.

This compact has been developed to help support development and delivery of this common purpose and is a voluntary agreement between public sector organisations, voluntary and community organisations.

It describes the relationships, behaviours and values of all organisations working in partnership to achieve a common aim.

This Compact expresses the commitment of public sector and voluntary and community sector organisations to work in partnership.

Introduction

The Compact provides the framework for the Health and Social care, Voluntary and Community sector and other compact partners in South Kent Coast to work together.

Whilst no partner is legally bound by this Compact all partners have expressly stated their intent to work in the spirit of the agreement

The aim is to maximise the benefits to the whole community by sharing knowledge, experience, expertise and resources.

The success of our South Kent Coast Compact will be measured by the improvements this new partnership working makes to the lives of local people. This will be measured through a robust review and evaluation process led by the University of Kent and also against achievement of milestones in the programme.

Delivery of the South Kent Coast Integrated Care Organisation, focusing on a multi-specialty provider model of organising care, (incorporating new models of care as set out in the NHSE 5 Year Forward View

http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) will be the key focus of partnership activity.

This transformational programme of work has been in place since September 2014 and it is expected that delivery of the vision for integrated health and social care locally will be an incremental process over the next 5 years.

The Integrated Executive Programme Board oversees the development and delivery of the new model of organising care for South Kent Coast people and delivery of the strategic goals.

Running in parallel is the South Kent Coast Health and Wellbeing Board, established currently as a sub-group of the Kent HWBB. This local board aims to oversee and discuss local health and wellbeing issues, identifying priorities and working to together to influence and deliver locally for improvements in health and wellbeing outcomes, including the wider determinants such as housing, regeneration, environment and skills. Development of the Board into a collaborative commissioning body is one of the streams in the programme of works. This reflects the need to develop the integration of commissioning in light of the new integrated provision and models of care.

Shared Purpose

Mission Statement

"Our aim is to ensure that South Kent Coast people are supported to be well and healthy in their own homes and communities, by delivering a connected system, designed and delivered around local people, located in 4 natural neighbourhoods"

Strategic Goals

Five outcome areas for delivery have been agreed

1. **People take greater responsibility for their own health**
   The development of services that support the people of South Kent Coast to stay well and take a more active role in their own health and wellbeing.

2. **People stay well in their own homes (wherever that home may be)**
   The developments of primary and community care services to support the people of South Kent Coast in a community based setting and provide a point of ongoing continuity, which for most people will be general practice.

3. **People receive timely and appropriate high quality care**
   The freeing up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care; ensuring timely access to urgent and acute specialist care.

4. **People receive safe care and have a positive experience of care**
   Patient safety and experience is at the centre of everything we do improving outcomes for the people of SKC.

5. **There is better use of the SKC pound**
   Ensure that collectively we can demonstrate value for money and delivery of cost effective services. Through integration we can reduce duplication and agree collaborative spend priorities in order to improve outcomes for the people of SKC.

Agreed Direction of Travel:

The outcomes are grounded on the following principles of delivery developed through the stakeholder groups, so in future services will look like this:

- **Integrated Care** –one service, one team, one budget
- **Membership** – its all of us, the citizen together with clinicians and professionals
- **Location** – people are looked after locally
- **Managed Care** – early intervention and prevention, one care plan
- **First Contact** – always get the right service, no door is the wrong door
- **Organisation** – a single purpose
- **Community Cohesion** – developing and building community assets and capacity
- **Health and Wellbeing** – keeping people well, including taking into account the wider health determinants, e.g., housing, environment, regeneration, skills

What will the people of South Kent Coast see as a result?

- Easier and earlier access to services that promote wellbeing or that provide help in a crisis
- People empowered to take control of their own health and wellbeing
- Local communities in South Kent Coast are increasingly supported by strong links between GPs, Nurses, care workers, voluntary and community organisations, which helps people like them to stay independent for longer.
- Older people who have come out of hospital are helped to stay at home.
- Families and carers will not have to chase professionals or ask them to talk to each other. Information will be shared with the citizen and professionals and everyone will know the plan of care
- Families and carers are supported in managing their needs
- Capable communities and social capital that will enhance the lives of people in South Kent Coast through providing local resources that support a greater emphasis on prevention and early intervention

It's about *all* of us…

- We are all members of this 'enterprise/society' all the time – not just when we are patients
- We will be supported in taking more responsibility for our health and well being - as individuals and as communities
- We will have information and advice to help us stay healthy and to help us know how/when to seek professional advice.
- There is proactive, early identification and support for people whose health could be at risk

Membership

We always get the right service…

- A single approach to assessing people's needs means my details are shared with the professionals that will help me
- One phone call will me to the right advice or service first time.
- If I access care through a different route I can be confident that I will get the right services for my needs without unnecessary delays
- Health and care professionals know the services and support that's available and can direct me to the right place

First contact

Our care is integrated…

- We are supported by multi-professional teams are organised around common functions
- They work as one team even when not co-located and share information to enable better care to be provided
- Everybody in the system is aware of what others are doing and following the care plan
- My care is integrated across locations, over time and by conditions

Integrated care

Our care is actively managed…

- I have one care plan that supports my health and wellbeing
- My plan is understood and followed by everybody in the system
- The plan summarises my responsibilities and the support I can expect.
- If I have complex needs a care co-ordinator helps me manage the different elements of my care so it meets my needs and preferences
- If I need to get specialist treatment in a hospital, my local team will know about it and put in place the care and support I need to return home

Managed Care

We are looked after locally…

- I can get most of my care at home, in GP surgeries or in a larger community health & wellbeing centre
- Consultant advice will be available to me and my doctor locally wherever possible
- Modern technology helps in monitoring people's health and keeping health professionals in touch
- Integrated care is organised for the whole of SKC but its tailored for my community

Location

We have clear and consistent funding…

- There is one consolidated budget that supports the health and care needs of the whole population
- We use our community's assets to support health and wellbeing as well as the budget for public services
- Value for money is constantly reviewed to make sure that resources are used to match changes in need and to maximise health outcomes and wellbeing
- We are able to hold the organisation to account for how it looks after us and spends our money

Organisation

Shared Values and Principles

All partners to this Compact seek to adhere to the following values and principles:

- Good quality communication - there is an obligation on Compact Partners to engage in constructive dialogue at all stages of partnership work.
- Equality of opportunity - employment and service delivery issues should be handled in a non-discriminatory manner and equality of opportunity should be built into initiatives to ensure that all services are equally accessible to everyone.
- Social inclusion - activities undertaken in partnership should be developed in ways that enable involvement of as many sections of society as possible, by actively addressing factors that can lead to exclusion (for example child care, poor transport, low incomes, lack of information, debt).
- Sustainability - joint action to improve the quality of life should not be at the expense of the environment and/or jeopardise the natural resources available for future generations.
- Openness and accountability - joint work / financial transactions should be conducted in an open and honest manner with clear documentation.
- Information/intelligence sharing - to ensure that initiatives are developed in light of all available facts (subject to confidentiality constraints).

Shared Vision

This Compact recognises that voluntary and community organisations and the Public Sector both contribute considerably towards improving the quality of life of the people in South Kent Coast. As partners to the compact, we believe this can be achieved more effectively by working together:

The partners jointly undertake to:

- Communicate and listen to each other;
- Share knowledge, experience and expertise;
- Work together in partnership for the benefit of the local people and their needs;
- Work towards common aims and objectives according to the capacity of each organisation;
- Encourage and support voluntary and community activity;
- Demonstrate commitment to the importance of sustainability in the planning and provision of services;
- Promote equal opportunity and diversity;
- Demonstrate commitment to communication and sharing of information;
- Promote mutual understanding of each other's ethos and roles and create relationships where partners are equally valued;
- Encourage the resolution of issues that may arise through an agreed process where negotiations break down.
- Commit organisations to delivering the Direction of Travel
- Respect each other's needs to deliver individual objectives alongside the shared ones

We believe that by working together towards the achievement of democratic and socially-inclusive objectives, we can achieve positive benefits for the people of South Kent Coast.

The programme of work

The programme of work includes the following; all partners are committed to their delivery:

1. **Co-Design and Citizen Inclusion:**
   This workstream will identify how citizens are at the heart of the service developments and will also look at building community capacity and social capital[1], ensuring we build on existing community assets (people and buildings) and empower citizens to be responsible for their own health and wellbeing.

2. **Locality Delivery:**
   This workstream focuses on the actions and partnerships required to deliver the Model of Care in each natural community/hub – Dover, Deal, Folkestone and Romney Marsh (including Hythe).

3. **Enabling and Facilitating:**
   This workstream focuses on the practical solutions needed to ensure smooth and seamless delivery of services and access to information and includes such areas as IT, Accommodation of staff, strengthening recruitment and retention of staff**.**

4. **Shared Leadership:**
   This workstream looks to facilitate local leadership through the development of both the Integrated Executive Programme Board and South Kent Coast Health and Wellbeing Board and locality delivery groups; identifying decision makers, influencers, and how to overcome challenges to local delivery.

5. **Data Integration/Sharing:**
   This workstream will develop an integrated strategy to support delivery of better integrated health and care services. The solutions will enable data and information sharing, care planning, new ways of working and technologies to support people to be cared for at home.

6. **Evaluation and Research:**
   This workstream is led by the University of Kent we have developed a evaluation framework that will enable us to implement and evaluate all the changes to health and social care that we make ensuring that we achieve the desired patient outcomes.

7. **Communication and Engagement:**
   This workstream ensures that all stakeholders are informed of the changes that are taking place in a timely and appropriate way. This includes messages to staff and the public. All communication and engagement activity needs to be coordinated between organisations ensuring alignment to the agreed vision for health and social Care.

[1] Social Capital: the collective value of all social networks (who people know) and the shared value that arise from these networks/the inclinations that arise from these networks to do things for each other.

Culture

Achieving meaningful and sustainable quality improvements in health and care requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in health and care services to improve quality locally.

The kings fund (www.kingsfund.org.uk) outline 6 characteristics fundamental to a healthy culture. All partners are in agreement to ensure that these characteristics are displayed and disseminated through individual organisations as we move through this transformation.

1. **Inspiring vision and compelling strategy**
   The top priority is for leaders at every level to communicate an inspiring, forward- looking and ambitious vision focused on offering high-quality, compassionate care to the communities they serve.

2. **Clear objectives and priorities at every level**
   Having a clear vision and mission statements about high-quality, compassionate care provide a directional path for staff. But they must be translated into clear, aligned, agreed and challenging objectives at all levels of the organisation, from the board to frontline teams and individuals. This must be matched by timely, helpful and formative feedback for those delivering care if they are to continually improve quality.

3. **Supportive management and leadership**
   Staff views of their leaders are strongly related to patients' perceptions of the quality of care. The higher the levels of satisfaction and commitment that staff report, the higher the levels of satisfaction patients report. If leaders and managers create positive, supportive environments for staff, the staff, in turn, create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement.

4. **High levels of staff engagement in services**
   Staff engagement in health services refers to an experience of work that is involving, at times exciting, meaningful, energising, affirming, stretching and connecting. It is characterised by strong identification with the organisation and a drive to be involved in decision-making and innovation to improve the delivery of care.

5. **Learning and innovation**
   Sustaining cultures of high-quality care involves all staff focusing on continual learning and improvement of patient care, 'top to bottom and end to end', and thereby taking leadership responsibility for improving quality.

6. **Effective team working**
   Where multi-professional teams work together, patient satisfaction is higher, health care delivery is more effective, there are higher levels of innovation in ways of caring for patients, lower levels of stress, absenteeism and turnover, and more consistent communication with patients.

Ensuring the Compact is sustainable

Occasionally, in partnership working there can be disagreements and disputes- these can help identify important issues and by approaching them in a positive and non-confrontational way they can help to improve the way we work together.

We also need to be prepared to hold ourselves and each other to account for abiding by the values and delivering the commitments in this compact. If any party believes this is not the case, it is for themselves and the relevant party to resolve the issue with each other in the fist instance. However, in exceptional circumstances where agreement cannot be reached, the issue should be raised at the relevant organizing and leadership arrangement at that time for consideration and resolution.

All those involved in a disagreement/dispute should recognize the other's right to raise the issue and give time to listen and respond to concerns.

Each organization will have it's own complaints process and governing body should the matter need to be referred.

Compact Partners- signatories to this agreement (to be added to)

The partners to this agreement are:

South Kent Coast (SKC) Clinical Commissioning Group Signed [redacted] Hazel Carpenter Dated……25 Aug 2015……..	**Kent Community Health Foundation Trust** Signed [redacted] Marion Dimwoodie Dated……25 Aug 2015……..	**Kent County Council** Signed…….. Dated……..
East Kent Hospitals University Foundation Trust Signed [redacted] Chris Bown Dated……..25 Aug 2015	**Dover District Council** Signed [redacted] Paul Watkins Dated……25 Aug 2015……..	**Shepway District Council** Signed [redacted] David Monk Dated……25 Aug 2015……..
Kent and Medway Partnership Trust Signed [redacted] Angela McNabb Dated……25 Aug 2015	**Healthwatch** Signed [redacted] Steve Inett Dated……25 Aug 2015……..	**Kent Integrated Care Alliance (KICA)** Signed [redacted] Noreen Long Dated……25 Aug 2015…..

Mike Parks Chair Local Medical Committee (LMC) Signed  Dated……25 Aug 2015……..	Invicta Health CiC Signed  Kim Horsford Dated……25 Aug 2015……..	South East Coast Ambulance Service (SECAmb) Signed……  Paul Sutton Dated…10 Sept 2015……..
Integrated Care 24 (IC24) Signed  Lorraine Gray Dated……25 Aug 2015……..		

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Item 7: Kent and Medway Specialist Vascular Services Review

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 2015

Subject: Kent and Medway Specialist Vascular Services Review

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS England.

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

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1. Introduction

(a) On 17 July 2015 the Committee considered the case for change for the Kent and Medway Specialist Vascular Services Review. The Committee's deliberations resulted in agreeing the following recommendation:

- *RESOLVED that the report be noted and NHS England be invited to submit an update to the Committee at its September meeting.*

2. Potential Substantial Variation of Service

(a) If the Committee believes it has been provided with sufficient information, it may choose to make a determination as to whether the proposal constitutes a substantial variation of service, please refer to the recommendations below.

(b) The Committee may defer making a determination if it feels additional information is required and may request further briefings and attendance at future meetings of the Committee.

(b) Medway Health and Adult Social Care Overview and Scrutiny Committee considered the item on 11 August 2015. They determined that this item constituted a substantial variation of service. If the HOSC determines the proposed service change to be substantial, a Joint HOSC will need to be established.

(c) If the HOSC deems the proposals as <u>not being substantial</u>, this does not prevent the HOSC from reviewing the proposals at its discretion and making reports and recommendations to NHS England.

(d) If the HOSC determines the proposals <u>to be substantial</u>, a timetable for consideration of the change will need to be agreed between the Joint HOSC and NHS England. The timetable will include the proposed date that NHS England 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.

(e) If a Joint HOSC is established, the power to refer to the Secretary of State will not be delegated to the joint committee, the power to refer will remain with the individual committees (Kent HOSC and Medway HASC) which appointed the joint committee.

3. Recommendation

If the proposals are *not substantial:*

RECOMMENDED that:

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

(b) NHS England be invited to submit a report to the Committee in six months.

If the proposals are *substantial*:

RECOMMENDED that:

(a) the Committee deems the proposals to be a substantial variation of service.

(b) a Joint HOSC be established with Medway Council, with the Kent HOSC receiving updates on the work of the Joint Committee.

Background Documents

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (17/07/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=32771

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Kent Health Overview and Scrutiny Committee Briefing - Kent and Medway Vascular Services Review
October 2015

Paper presented to:	Kent Health Overview and Scrutiny Committee
Paper subject:	Kent and Medway Vascular services Review.
Date:	9 October 2015
Presented by:	Oena Windibank, Programme Director; NHS England South (South East)
Senior Responsible Officer:	James Thallon, Medical Director NHS England South (South East)
Purpose of Paper:	To update the HOSC on the progress of the Kent and Medway vascular services review and to ask for consideration of the establishment of a Kent and Medway Joint Overview and Scrutiny Committee.

Introduction:

Following concerns about the outcomes for patients in England and Wales receiving vascular services, a national service specification was published in 2013. The standards within the specification were developed through a specialised Clinical Reference Group (CRG) and reflect the best practice guidance of the National Vascular Society 2012.

The key aim of the specification and guidance is to improve outcomes, so that patients with vascular disease benefit from the lowest possible disability and mortality rates, for both elective and emergency care. The clinical evidence underpinning the specification and guidance recognises the relationship between treating adequate numbers of patients and improved patient outcomes.

Vascular services are a specialised area of healthcare which, evidence has shown, will benefit from organisation into larger centres covering a population that will facilitate significant volumes of activity in all areas of service, with a robustly staffed workforce able to deliver services 24 /7, 365 days of the year. There is an opportunity to ensure that excellence in patient care and outcomes can be provided and that resource is always available for the vascular service to continue to improve on the type and standards of care provided. In Kent and Medway, the opportunity exists to develop this. Establishing a vascular service of excellence will offer the opportunity for a much improved and comprehensive service to patients. In particular, the right model of care could deliver the opportunity to provide more local care to Kent and Medway residents and the type of care could include more complex procedures. Such a centre(s) will be better able to embrace new technology

and innovation in practice. A regional centre(s) of excellence is most likely to facilitate a change in patient flows. Such a centre (s) is most likely to be able to attract the highest calibre workforce and offer sustainability. The training boards will look to centres of excellence to be involved in training the future generation of vascular clinicians. This not only benefits the service but invests in the future provision of excellence in patient care. A suitably sized centre (s) with the appropriate population could offer opportunity for quality audit and research.

The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that offers all of these benefits.

Kent and Medway residents currently receive specialised vascular care from two units within Kent and Medway; Medway NHS Foundation Trust (MFT) in Medway and East Kent Hospitals University NHS Foundation Trust (EKHUFT) in Canterbury. A significant proportion of Kent and Medway residents, namely from Tonbridge, Tunbridge Wells, Sevenoaks, Dartford, Gravesham and Swanley areas receive their care in London, predominantly at St.Thomas' hospital.
Kent and Medway Vascular Services Review commenced December 2014 in response to commissioner led derogation on both the Kent and Medway providers of specialist vascular services: Medway NHS Foundation Trust and East Kent Hospitals University NHS Foundation Trust. The derogation relates to non-compliance against the national specification 2013, in this case it is the commissioners who have raised this concern.

The aim of the review is to ensure that quality, safe and sustainable vascular services can be delivered now and into the future.

The review process is overseen by a Vascular Review Programme Advisory Board, which is clinically led and includes both external and local clinical experts in vascular care.

The membership includes consultants from the main providers of vascular care to Kent and Medway residents, the ambulance trust, NHS England specialised commissioning, public health, communication and engagement leads and representation from the Vascular Society.
The Vascular Review Programme Advisory Board is chaired by the Medical Director for NHS England, South (South East).
.
A clinical reference group supports and advises the Vascular Review Programme Advisory Board, providing clinical advice and expertise to the review process. The group is currently developing the clinical models for appraisal and leading on detailed modelling to understand some of the challenges, which will inform the options appraisal process. The options appraisal will have input from a range of stakeholders.

The review is also supported by a communications and engagement plan which sets out how the review will ensure effective engagement and communications throughout the process.

Progress to date:

The Case for Change and Decision Making Process have been approved by the Vascular Review Programme Advisory Board and agreed by NHS England South (South East) specialised commissioners. They have also been reviewed by the South East Clinical Senate which has made recommendations that will be used as part of the assurance process of the review.

The Case for Change has been shared with the Kent Health and Overview Scrutiny Committee (HOSC) and the Medway Health and Adult Social care Overview and Scrutiny Committee (HASC).

Ten 'Listening Events' have been held across Kent and Medway to share the case for change and raise awareness with the public. Sixty four members of the public attended the events although, in some areas, there were low numbers. Further work is underway to increase the numbers of the public involved including targeting specific communities of interest, patient groups and an online survey.

Phase two of the engagement process will include involving a wider stakeholder group and a deliberative event to test the options development and appraisal.

A range of modelling groups have been developed and tasks undertaken to test and inform the clinical models developed by the lead clinicians. These include:

- **Travel/Access:** considering ambulance travel times across Kent and Medway and into London based on 60 minute travel times and impact on the ambulance trust. Reviewing public transport facilities/times.
- **Patient demand:** assessing the numbers of patients requiring specialist inpatient and day patient vascular care, noting the numbers of patients attending London units.
- Co-**dependencies:** assessing the impact on other clinical areas and the need for co-located services.
- **Vascular interventional radiology (minimally invasive interventions performed endoscopically by radiologists):** ensuring that this service is co-located and viable and assessing the impact on non-vascular interventional radiology work.
- **Workforce:** confirming the workforce requirements, including on call rotas for specialist 24-hour vascular care. Assessing the current gaps and options for delivering seven-day services. Reviewing workforce training and supply and possible workforce options. Assessing competencies across the vascular pathway.
- **Public health:** assessing population growth and demand, Identifying key demographic influences and impacts on service configuration.
- **Financial planning:** assessing current financial envelope/flows for Kent and Medway. Identifying cost implications of options including

increased transfers, additional facilities, workforce implications, implementation costs.

Public Listening Events;

Overall, the participants we spoke to reported a **positive experience of vascular services both in Kent and Medway and in London.**
The attendees recognised the **case for change**.

Emerging priorities include

- The ability to make choices, but there are a lot of factors which will influence that choice, so good information is needed to assess and make that choice.
- Information and communication, particularly for anxious family and carers
- The need for high calibre staff with the specialist skills, and capacity to deliver the service 24/7. The best treatment possible as quickly as possible.
- Speedy access in an emergency situation, and smooth access for elective care – improved appointment systems
- A strong, consultant team with the relevant support staff
- The need for support particularly following amputations, and to know what assistance is available, including care in the wider community, when people return home.
- Joined up working between services and disciplines, working within a clinical network, including improving the ability to recognise vascular disease.

Participants felt that having access to a specialist vascular team or centre was most important and reassuring in a life threatening situation, and having good access to such a service in Kent and Medway was vital.

When developing the options the public /patient feedback to date highlighted the importance of:

- Workforce and the possibility of attracting the best specialists to Kent
- Speed of access to and availability of specialist care
- Considering the specifics of local populations when planning and designing options for vascular services as the review goes forward.
- Recognising that patient/clinical choice is important.
- The population growth in Kent and Medway, particularly in Dartford

Options development:

Early assessment notes that continuing with the status quo will not address the current gaps against the national specification or address the sustainability issues.

Initial assessment has determined that there are two possible clinical models for consideration. These are:

- developing a two site network model building on the existing provision
- developing a single hub and spoke model in Kent and Medway.

The communication and engagement plan is being further developed to ensure that the process provides a number of ways in which patients and the public and key stakeholders can engage with the process and inform the emerging thinking as we consider the advantages and disadvantages of the two models.

The Vascular Review Programme Advisory Board advises that the review is likely to result in a significant service change for vascular services across Kent and Medway.

Since the review is covering both Kent and Medway, we understand that a Joint Health Overview and Scrutiny committee would need to be formed to consider the options, when developed, and advise on the consultation plan to ensure it describes a robust and inclusive process.

Next Steps

The clinical reference group is developing the two clinical models for testing against the national specification and Vascular Society guidance. The next phase of engagement will inform this process and the development of the options for full appraisal. The review is aiming to have an agreed and assessed clinical model by the end of the calendar year for recommendation to NHS England specialised commissioners for consideration. This will lead to public consultation as required.

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Item 8: Public Health Transformation

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 2015

Subject: Public Health Transformation

Summary: This report provides background information on the Public Health Transformation. This report is for information only.

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1. Introduction

(a) Kent County Council has asked for the attached report to be presented to the Committee.

(b) Local authorities have, since 1 April 2013, had an enlarged remit for improving the health of their local population as the public health role of Primary Care Trusts transferred to them. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to Public Health England (House of Commons Library 2014).

(c) Since commissioning responsibilities for public health services lie with local authorities, the statutory remit of the Health Overview and Scrutiny does not extend to these services. Therefore there is no requirement to consult this Committee on any proposal for a substantial development of health services in the area of the local authority. However, there is no bar on local authorities' public health departments engaging with health scrutiny and there are areas of common interest.

2. Public Health Responsibilities - Local Authorities

(a) Local authorities' statutory responsibilities for public health services are set out in the Health and Social Care Act. The Act conferred new duties on local authorities to improve public health. It abolished Primary Care Trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013. From this date local authorities have had a new duty to take such steps as they consider appropriate for improving the health of the people in their areas (House of Commons Library 2014).

(b) Under the Act, upper-tier and unitary local authorities are required to commission or provide mandatory services which include:

- appropriate access to sexual health services;
- ensuring there are plans in place to protect the health of the population;
- public health services for children and young people aged 5 to 19;
- the National Child Measurement Programme;
- NHS Health Check programme for people between 40 and 74;
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening

programmes, including giving advice to CCGs (Local Government Association 2014).

(c) Other services are at the discretion of local authorities, depending on national and local priorities but all local authorities will also commission a wide range of key public health services, including smoking cessation, promoting physical activity, addressing obesity and promoting better sexual health. Local authorities are required to have regard to the Public Health Outcomes Framework which sets out the key indicators the Department of Health expects local authorities to work towards. (Local Government Association 2014).

(d) Local authorities' general statutory duties to protect and improve health and wellbeing and to tackle inequalities and the 'social determinants' of health mean taking on a very broad range of health-directed activity. This can range from considering and mitigating the impact on health of poor housing, spatial planning, education, employment, leisure and other local authority services to encouraging local businesses to become 'healthy employers' to initiatives to reduce smoking, alcohol and drug consumption, obesity and traffic collisions (Local Government Association 2014).

(e) Each upper-tier and unitary authority, acting jointly with the Secretary of State, is required to appoint a Director of Public Health who is supported by a public health team. The Director of Public Health is a chief officer of the council and a statutory member of the Health and Wellbeing Board (Local Government Association 2014).

3. Public Health England

(a) Public Health England was established as an executive agency of the Department of Health to bring together public health specialists from more than 70 organisations, including Health Protection England, into a single public health service (House of Commons Library 2014).

(b) Public Health England has four core functions: protect the public's health from infectious diseases and other public health hazards; improve the public's health and wellbeing; improve population health through sustainable health and care services; and build the capacity and capability of the public health system (Public Health England 2015).

(c) PHE has 9 local centres and 4 regions – North of England, South of England, Midlands & East of England, and London. The South of England region is made up of 2 centres: South East and South West (Public Health England 2015).

4. Recommendation

RECOMMENDED that the report be noted and the Director of Public Health be requested to provide an update on the Public Health Transformation to the Committee at the appropriate time.

Background Documents

House of Commons Library (2014) *'Local authorities' public health responsibilities (England) (13/03/2014)*', http://researchbriefings.files.parliament.uk/documents/SN06844/SN06844.pdf

Local Government Association (2014) *'A councillor's guide to the health system in England (01/05/2014)*', http://www.local.gov.uk/documents/10180/5854661/A+councillor%C3%95s+guide+to+the+health+system+in+England/430cde9f-567f-4e29-a48b-1c449961e31f

Public Health England (2015) *'Who we are and what we do: annual plan for 2015 to 2016 (31/07/2015)*', https://www.gov.uk/government/publications/public-health-england-annual-plan

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To: **Health Overview Scrutiny Committee**

From: **Graham Gibbens, Kent County Council Cabinet Member for Adult Social Care and Health**

Andrew Scott Clark, Director of Public Health

Date: **9th October 2015**

Subject: **Public Health Services Transformation and Commissioning Plans**

Summary

The Public Health team at Kent County Council (KCC) are undertaking a review of the programmes commissioned from the public health grant. Engagement is taking place with a range of partners, to develop and improve our approach to public health. Our aim is to ensure that we promote health and wellbeing locally in collaboration with all partners, and that key services are focused on tackling health inequalities. This paper outlines some of the work to date.

Health Overview Scrutiny Committee is asked to:

1. Note and comment on the work to date.
2. Note the public consultation on public health programmes during November 2015.

1. Introduction

1.1. This paper is to update the members of the KCC Health Overview Scrutiny Committee on the Public Health transformation programme that is currently underway.

2. Background

2.1. In April 2015 KCC decided to review the programmes commissioned through the Public health grant. National drivers for this review included The NHS Five Year Forward View which identifies the need to radically increase the role of prevention, and The Care Act which describes new responsibilities that clearly show that effective prevention is crucial.

2.2. Kent is not the only Local Authority to undertake this programme of work, it is clear that in many parts of the country Local Authorities are examining the approach to public health, in particular the adult health improvement services that are commissioned.

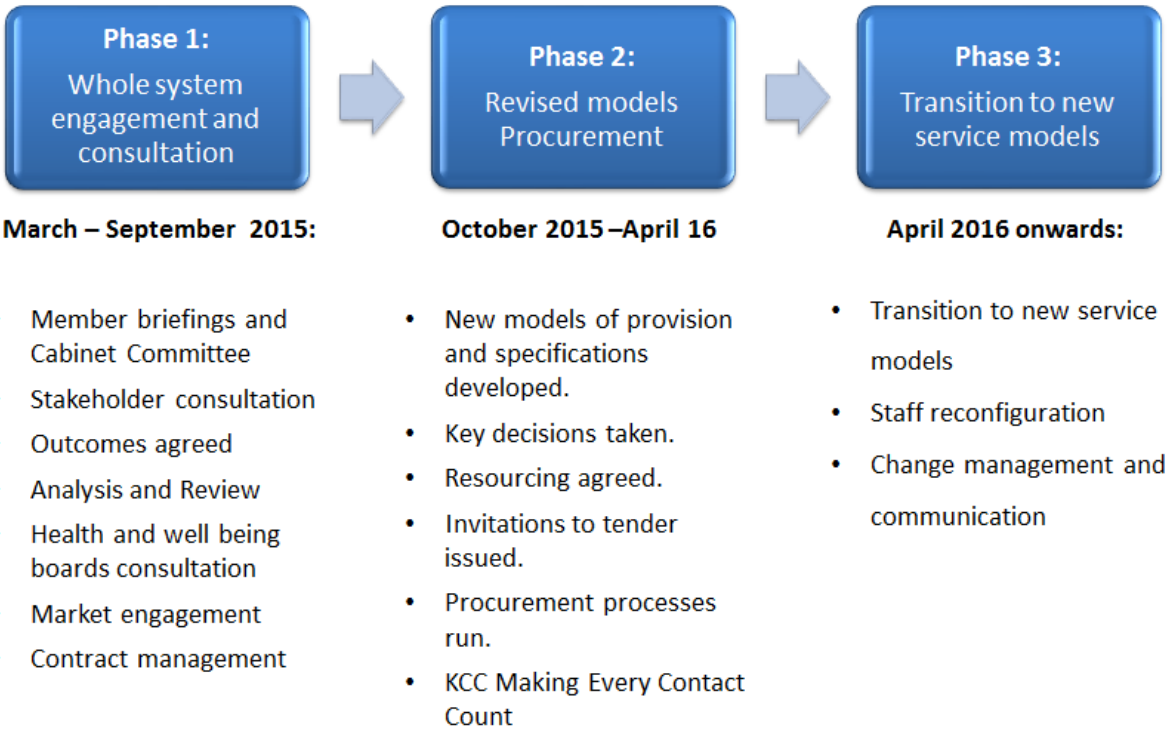
2.3. Reports such as The King's Fund Report – *Clustering of Unhealthy Behaviours Over Time* (2012) set out the need to review services and focus on a holistic approach to health improvement and the wider health system. Other parts of the country are also proposing changes in line with these drivers, with the aim to integrate and realign these services.

2.4. The Public Health team have therefore been conducting a review and analysis of the programmes commissioned through the Public Health grant. This review is providing a

more thorough understanding of the potential and the limitations of the current services and there are clear opportunities for a new and more integrated approach.

3. Timeline

3.1. The timeline for this programme of work is as follows.



3.2. A full public consultation of the proposals will be undertaken in November 2015.

4. Progress to date

4.1. In June 2015 KCC Adult Social Care and Public Health Cabinet Committee agreed to extend, as needed, and align all of the current adult health improvement contract dates so that a new model of provision could include within scope the range of services currently commissioned as standalone services.

4.2. Using the drivers for change outlined above a vision and outcomes framework has been developed. The vision is: “to improve and protect the health of the people across Kent, enabling them to lead healthy lives, with a focus on the differences in outcomes within and between communities”.

4.3. The analysis has been structured locally and also into a Life Course approach as outlined in Sir Michael Marmots review. This life course review structures the understanding of our approach into the following

- Starting Well
- Living Well
- Ageing Well

4.4. The health outcomes and priorities have been mapped with each stage of the Life Course Approach. The priority areas are:

- Smoking
- Healthy eating, physical activity and obesity
- Alcohol and substance abuse
- Wellbeing (including Mental Health and Social Isolation)
- Sexual Health & Communicable Disease
- Wider Determinants of health

5. Wider engagement

5.1. Public Health have conducted a series of market engagement events which indicated a strong willingness by many providers to engage in the transformation work. The exercise involved representatives from more than 80 service provider organisations from the public, private and voluntary sector. Feedback included the below points :

- A strong appetite to engage in the programme.
- Different models emerging nationwide: many providers come with knowledge wider than Kent and & keen to share what has and hasn't worked elsewhere.
- Keenness to collaborate between public private and voluntary sector providers.
- Providers keen to explore new contract opportunities, in many cases beyond services that they are already providing - many providers are keen to diversify the service offer
- Suggestions that go beyond traditional 'service-based' approaches e.g. using behavioural science and marketing approaches to generate motivation.
- Many providers are thinking about their strategies and in some cases re-focusing their service offer in order to respond to the potential market for health improvement
- A number of different providers suggested commissioning a generic 'behaviour change service'
- Pharmacies keen to be more engaged

5.2. Customer insight work is also in progress. A focussed piece of work into women who smoke during pregnancy has been completed. Insight work will take place in November and December, with the aim of gaining further insight into why people engage in multiple unhealthy behaviours and what will motivate them to access a health improvement service. A full public consultation will begin in November and December and will include an on-line survey to gather the general public's views and opinions on the model, and secondly focus groups will be held and targeted at those with greater need so that we gather in depth feedback from the populations that we want to access the new service.

5.2.1. A number of themes have come out of the stakeholder engagement to date which will inform some of the core principles for the approach moving forwards.

5.3. Health promotion across the population

5.3.1. One of the strongest pieces of feedback has been that the approach to public health messaging could be hugely strengthened and coordinated much more with partners. There is a need for a highly proactive approach to increase the use of campaigns, social marketing and communication channels across partners to produce high profile, high impact messages.

5.4. A focus on health inequalities

5.4.1. A key theme for both children and adult services has been to further identify the opportunity to enhance public health into partner programmes of work already in place in communities where there are high health inequalities. It is also clear that better use of data and intelligence that is available can be used to target communities with high health inequalities

5.5. Locally flexible services

5.5.1. The current approach has been based on a one size fits all across Kent. Future procurement should include local representation to ensure a model which varies according to local priorities. The service models in development must enable better alignment with local population need. Local representatives are welcomed to be involved in developing this model.

5.6. Adult health improvement services

5.6.1. A core theme has been to move from provision which only tackles one health issue, to a more integrated approach.

5.7. Children and Young People's services

5.7.1. A review of Children and Young People's services is also underway, including the School Public Health (School Nursing) service and Substance Misuse services for young people. In addition from October 2015 KCC will inherit the commissioning responsibility for the Health Visiting Service from NHS England. Prior to transfer we have worked closely with CCG's, General Practice and KCC to ask them for their experience of the service, and to develop the specification for the service from October 2015.

5.7.2. Key themes from these reviews have a need for better visibility of core services, shared records, the importance of the safeguarding role and a more closely aligned approach with KCC Early help services particularly in relation to emotional wellbeing and drug and alcohol services. In addition there must be a much more integrated approach to embedding health in core children's and families services.

6. Conclusion

6.1. Since May, Public Health has been undertaking a review and analysis of the services commissioned through the public health grant and which it welcomes engagement and feedback on the key themes emerging from this review.

7. Recommendation

7.1. Health Overview Scrutiny Committee are asked to:

1. Note and comment on the work to date.

2. Note the public consultation on public health programmes during November.

Report Author

Karen Sharp

Head of Public Health Commissioning
Kent County Council

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Item 9: West Kent: Out of Hours Services Re-procurement

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 2015

Subject: West Kent: Out of Hours Services Re-procurement (Written Update)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by NHS West Kent CCG.

It is a written update only and no guests will be present to speak on this item.

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

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1. Introduction

(a) On 10 October 2014 the Committee considered NHS West Kent CCG's proposal to combine three core primary care services that delivered urgent and emergency care into one contract: an out-of-hours GP service, an enhanced rapid response service, and GPs working in A&E to see and treat primary care type patients.

(b) The Committee's deliberations resulted in agreeing 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 submit a report to the Committee in six months.

2. Recommendation

RECOMMENDED that the report be noted and NHS West Kent CCG be requested to provide an update to the Committee at the appropriate time.

Background Documents

Kent County Council (2014) *'Agenda, Health Overview and Scrutiny Committee (10/10/2014)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=29900

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NHS
West Kent
Clinical Commissioning Group

Mobilisation of contract for the West Kent Urgent Care Service (GP Out of Hours, Primary Care Service and Home Treatment Service)

October 2015

Patient focused, providing quality, improving outcomes

1. Background

Prior to 1 September 2015, NHS West Kent CCG commissioned three core primary care services delivering urgent and emergency care. These were an out-of-hours GP service, GPs working in A&E to see and treat primary care type patients, and an enhanced rapid response service (ERRS). ERRS provided care in the community for patients who are acutely unwell and at risk of a hospital admission as well as working closely with Maidstone and Tunbridge Wells NHS Trust's (MTW) discharge teams and primary care teams to facilitate early discharge of patients, providing a step down service for patients who are assessed as being medical fit.

In order to comply with NHS financial regulations and competition rules, NHS West Kent CCG re-tendered West Kent out-of-hours provision. Agreement from the CCG Clinical Strategy Group (CSG) to procure a single primary care urgent care service that encompassed the out-of-hours service, GPs seeing and treating patients in A&E and a hospital at home service, was achieved in September 2014.

The aim of this reconfiguration was to improve integration of urgent care services and reduce fragmentation across the health economy. This simplification of the system will improve efficiencies as well as helping to ensure patients access the right treatment in the right place and are treated by the most appropriate clinician.

A paper outlining the award of the contract process and decision making for the urgent care service procurement was presented to the CCG Governing Body on 26 May 2015. This included:

- Procurement process governance and delivery
- Key milestones delivered during the procurement
- Award of the West Kent Urgent Care Service Contract
- Communication and mobilisation plan requirements

2. Procurement key milestones

The procurement process has followed the following timeline:

- 1 December 2014 – PQQ advertised on Contracts Finder
- January 2015 – PQQ evaluation period
- 1 February 2015 – ITT advertised on Contracts Finder
- March 2015 – ITT evaluation period
- 28 April 2015 – Governing Body sign off
- May 2015 – Contract awarded
- June 2015 – August 2015 – Service mobilisation
- 1 September 2015 – New service implemented

3. Awarding the west Kent Urgent Care Service Contract

The Governing Body approved the process, assessment criteria and reasons for selecting the preferred bidder at its meeting on 28 April 2015, which was followed by a 10 day standstill period. The CCG received no challenges and therefore formally awarded the contract to IC24 as the lead contractor with subcontractors Kent Community Health Foundation Trust (KCHFT) and Maidstone & Tunbridge Wells NHS Trust.

4. Contract mobilisation

To gain detailed assurance of the mobilisation of the contract by the lead provider IC24, WK CCG has put in place a service mobilisation team who have held regular mobilisation meetings and teleconferences with the lead provider and South East Commissioning Support Unit (SECSU) to monitor contract mobilisation progress. The action plan and progress has been updated on a weekly basis.

4.1. Governance

The joint leadership and operational oversight for service has been convened under a Joint Operating Board (JOB). The JOB meets monthly and has representation from the lead contractor and sub-contractor organisations.

4.2. Contract and performance management

SECSU has provided contract and performance management support to the CCG and contract negotiations have commenced.

Contract sent by SECSU to IC24's contracting team for signing 18 September 2015

The key aspects of the contract are:

- The contract term is for two years and will be a standard NHS Contract
- Key performance indicators (KPIs) developed to reflect appropriate and deliverable outcome measures.
- Quality information will be provided in the monthly quality report received by the CCG Board
- The contract has been awarded as block contract with indicative activity levels pre-defined. There is no Payment by Results (PbR) elements to the contract.
- Finance levels have been amended during contract negotiations to reflect additional finance added for prescribing, and deductions for a delayed start to the Tunbridge Wells Hospital, Primary Care Service (see 4.8 Finance). Other alterations have been made to remove funding for overnight GPs in A&E, which was included by IC24 but not required by the Service Level Agreement. Re-deployment of this funding to support a multi-shift incentive scheme to reimburse doctors for indemnity costs incurred for working above thresholds defined in indemnity cover arrangements (see 4.3 Workforce).

Reporting of the contract performance will be monthly in the first instance, with the first WKUCS performance meeting being held 6 October 2015.

4.3. Workforce

The current clinical recruitment difficulties in primary care have impacted on the workforce recruitment for the West Kent Urgent Care Service.

Delays in recruitment to the Primary Care Service at Tunbridge Wells Hospital have put back the expected start date from 1 September 2015 to 2 November 2015. All other elements of the service were sufficiently staffed to enable launch on 1 September 2015.

In order to mitigate against this risk a multi-shift incentive scheme has been implemented by IC24. This sets out to compensate GPs for the increased in indemnity payments required to work over a certain threshold of shifts. Funding for this scheme was released from re-deployment of savings made by reducing the overnight GP hours in A&E, which were incorrectly included in the bid.

The CCG has been assured by IC24 that since the introduction of the scheme the rota fill for both Primary Care services has improved to viable levels.

4.4. IM&T

The streaming process and the interoperability of the various electronic records keeping systems i.e. Patient Administration System and Electronic Patient record, (PAS and EPR).

Appropriate interoperability of the various electronic record keeping systems was assured, during the bidders' presentations.

To date these systems have yet to be integrated, however the need for a working group to address these issues has been identified, and actions to facilitate this work have been assigned to individuals.

4.5. Communication

As part of the procurement process the CCG, supported by SECSU, reviewed existing insights, engaging patients/public in the procurement process and communicated them about the change.

Communication teams from IC24, SECSU and KCHFT have been involved in the development of a service Frequently Asked Questions document which has been circulated to GPs, SECAmb and A&E teams to inform them of the service changes, referral criteria and processes. The information has been stored on the DORIS system.

Further communication and engagement with GPs is planned for the CCG AGM on 15 October 2015.

4.6. Finance

Commissioner	Expected Annual Contract Value
Year 1 - Urgent Care Service 1 September 2015 - 31 August 2016	6,059,211*
Year 1 - GP Indemnity Additional Funding ** (Q1 &Q 2 only - Sept to Feb 16 inclusive)	£100,000
Year 2 Urgent Care Service 1 September 2016 - 31 August 2016	6,153,622
Total	**12,129,995**

* Due to the expected delay in the start to the Tunbridge Wells element of the service it is agreed that for each month the service in Tunbridge Wells is not operational there will be a downward financial adjustment of £56,232.
**This funding has been agreed for a period of six months. If the additional funding for the GP indemnity does not show an increase in GP interest and shift fill in line with expectation commissioners will withdraw funding at this point. Any continuation of funding beyond 16 February must be agreed via a contract variation. If a national solution is found and/or funding for GP indemnity is no longer needed an early termination date for funding will be agreed between the two parties.

4.7. Risk management

IC24 and sub-contractor representatives agreed in principle on the presentation day that a robust process would be put in place to stop any double counting or charging for activity occurring in the Primary Care Service and other interfaces of the three providers. Clarity on the

sub-contracting arrangements for the Primary Care Service between IC24 and MTW is still being sought by IC24, particularly around the triaging function of the service. This has been taken to the highest level of these organisations for resolution. SECSU wrote to IC24 on 24 September 2015 to inform the contracting lead that this issue must be resolved between the organisations, but offered to support IC24 with advice or to suggest ways forward in order to reach resolution.

5. Procurement beyond September 2017

The KPIs, quality indicators and audits developed for the combined service will enable tracking and monitoring of the benefits associated from the integrated service.

An evaluation of the cost-effectiveness of the integrated service will be planned to justify the increased contract price when compared with the three current component contracts.

Evidence will be sought to confirm whether the consolidation of the medical workforce, increased medical cover at weekends and at night would enable the Home Treatment Service to accommodate patients with a higher acuity and extend the hours of the service. The benefit of this additional investment would be a reduction in Non Elective (NEL) admissions to hospital.

Learning gained from the implementation of the contract will inform the next phase of the urgent care procurement beyond September 2017.

Item 11: Emotional Wellbeing Strategy for Children, Young People and Young Adults

By: Peter Sass, Head of Democratic Services

To: Health Overview and Scrutiny Committee, 9 October 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 and to determine whether the NHS commissioned aspect of the new service specification constitutes a substantial variation of service.

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 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, 10 October 2014, 6 June 2015 and 4 September 2015.

(b) On 4 September 2015, the Committee agreed the following recommendation:

- *RESOLVED that the report be noted and the new service specification be presented to the Committee on 9 October.*

(c) NHS West Kent CCG have asked for the attached reports to be presented to the Committee:

CCG Report	pages 105 - 112
Appendix 1 Draft Service Model	pages 113 - 142
Appendix 2 Draft Early Help Specification (Exempt)	pages 145 - 178
Appendix 3 Draft Mental Health Specification(Exempt)	pages 179 - 236
Appendix 4 Summary of Draft Early Help and Mental Health Specifications	pages 143 - 144

2. Potential Substantial Variation of Service

(a) It is for the Committee to determine if the NHS commissioned aspect of the new service specification constitutes a substantial variation of service.

(b) Where the HOSC deems the NHS commissioned aspect of the new service specification as not being substantial, this shall not prevent the HOSC from reviewing the proposed change at its discretion and making reports and recommendations to NHS West Kent CCG.

(c) Where the HOSC determines the NHS commissioned aspect of the new service specification as substantial, a timetable for consideration of the change will need to be agreed between the HOSC and NHS West Kent CCG after the meeting. The timetable shall include the proposed date that NHS West Kent CCG 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.

3. Recommendation

If the NHS commissioned aspect of the new service specification is **not substantial:**

RECOMMENDED that:

(a) the Committee does not deem the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service.

(b) NHS West Kent CCG be invited to submit a report to the Committee in six months.

If the NHS commissioned aspect of the new service specification is ***substantial*** and the Committee **does not support** the procurement of the new service specification:

RECOMMENDED that:

(a) the Committee deems the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service;

(b) the Committee does not support the procurement of the new service specification for the following reasons [to be inserted during the meeting];

(c) NHS West Kent CCG be requested to respond to the Committee's recommendation in writing and attend an extraordinary meeting of the Committee.

If the NHS commissioned aspect of the new service specification is ***substantial*** **and the Committee does support the procurement of the service specification:**

RECOMMENDED that:

(a) the Committee deems the new service specification in relation to the NHS commissioned aspect to be a substantial variation of service;

(b) the Committee supports the procurement of the new service specification;

(c) NHS West Kent CCG be invited to attend a meeting of the Committee in three months.

Item 11: Emotional Wellbeing Strategy for Children, Young People and Young Adults

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

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (05/06/2015)'*, https://democracy.kent.gov.uk/mgAi.aspx?ID=31953

Kent County Council (2015) *'Agenda, Health Overview and Scrutiny Committee (04/09/2015)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=5842&Ver=4

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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

9 October 2015

Patient focused, providing quality,

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

Summary

This paper provides a further progress report on the development of the Emotional Wellbeing and Mental Health Service for Children, Young People and Young Adults in Kent and provides draft copies of the service model and specifications as requested by the committee at the last meeting on 4 September 2015.

Kent County Council and the Kent Clinical Commissioning Groups have been working together for the last 18 months to increase universal provision to deliver a new whole system of support that extends beyond the traditional reach of commissioned services.

The new model, which has been developed alongside the principles and approaches articulated within Future in Mind, outlines a whole system approach to emotional wellbeing and mental health in which there is a single point of access, clear seamless pathways to support, ranging from universal 'Early Help' through to highly specialist care with better transition between services.

Following the final agreement of the service model and accompanying specifications, the contract procurement process will commence in autumn 2015.

Recommendation

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

Due to legal obligations relating to the extension of the current contract, a procurement process is necessary in order to identify a new provider.

Members are reminded of their statutory duty to declare any conflict and have it properly resolved.

1.0 The Service Model

1.1 The detail required to deliver the model will be contained within the national specification guidance and the service specification will inform future contracts and the contractual framework required. A contract technical group has developed the Service Model in partnership with commissioners and clinicians (see Appendix 1).

1.2 *Figure 1* demonstrates how the whole system will work together:

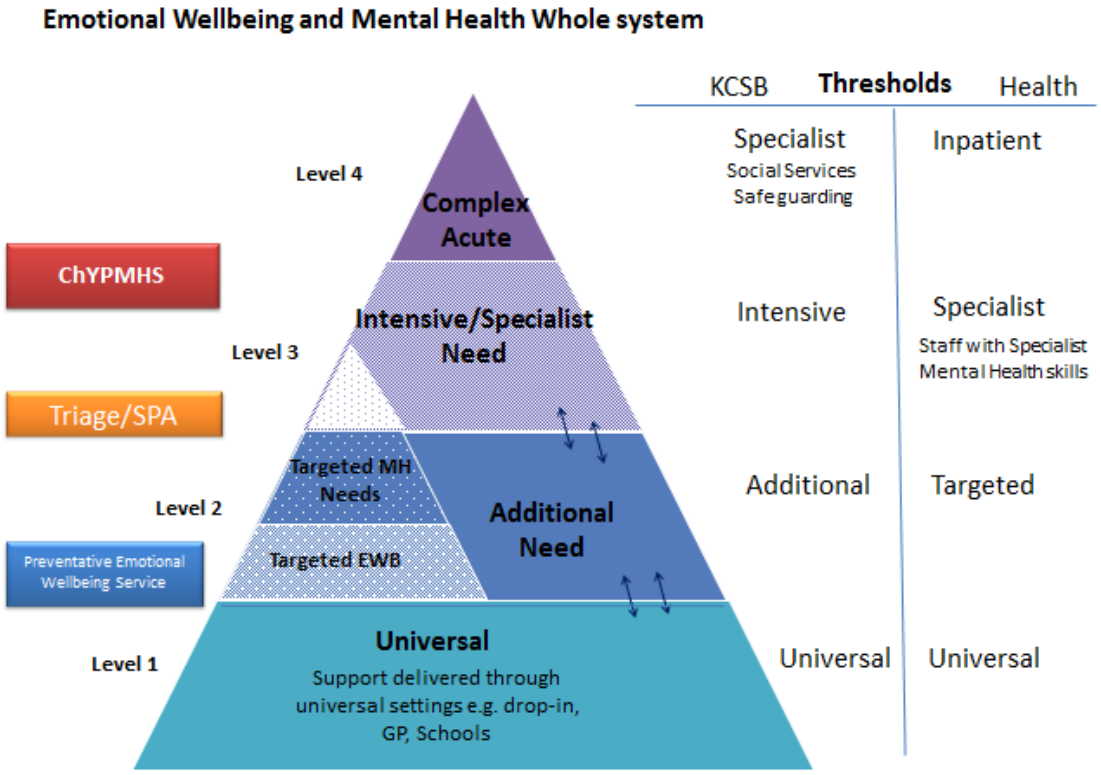

Figure 1: the whole system model

1.3 *Table 1* outlines the differences in service provision between the current model and the new model which fundamentally improves navigation of the totality of support services available to children and young people and allows commissioners to better hold the provider to account:

How things are now	The new model
Decision about resource allocation made in silos.	Understanding of the totalling of resource and how it aligns across the system.
Lack of CYP's voice in current service design, inconsistent approach within services.	Ensure CYP and their families are involved in the design and commissioning of services especially technology.
Lack of family approach	Think Family
Tiered approach to commissioning is not supporting children adequately	Focus on children wherever they are in the system
Services do not consider sufficiently family dynamics.	Responding to family dynamics with support.

Thresholds unclear and inappropriate referrals.	Multi-agency decisions about resource allocation. Information sharing protocols in place.
Inappropriate referrals and long waiting lists.	Single point of access. Referrals directed to right provision sooner through integrated model.
Rising demand for self- harm not met.	Focus on self- harm
Not enough capacity in system - EHWB belongs to one service.	Delivery and support through universal hubs with a focus on schools.
Insufficient strategic links between other critical pathways and transition protocols.	Clear relationship for LD and neurodevelopmental pathway.
CAMH service used as a “catch all”.	Smooth transition to adult mental health for CYP 14-25 who require long term support.
Does not build capacity or support others to develop their understanding sufficiently. Lack of sufficient and flexible provision for emotional wellbeing.	Consistent approach to promote good emotional wellbeing and resilience including upskilling workforce.
Lack of clarity about eligibility.	Deliver a consistent service reducing transfer between services ensuring CYP have named worker for continuity of care.
Lack of clarity in relation to LD and neurodevelopmental pathways.	Clear pathways for assessment and treatment of CYP with neurodevelopment difficulties.
Insufficient evidence around outcomes being achieved. Inconsistent performance monitoring methods for different services.	Kent wide outcomes based framework and dataset to enable effective monitoring across the system. Systematic contract monitoring to ensure model remains aligned.
No clear model for reporting performance data that is child related.	Child related performance data informing model of adult services.

Table 1: The differences between the current and new models

1.4 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, and delivery and support through universal hubs with a focus on schools.

- A clear focus on the child wherever they are in the system, 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, upskilling of workforce and a named worker for every child and young person.

- A 'whole family' approach, responding to family dynamics, 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 as well as the continued design and commissioning of services, especially technology.

- 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 as well as a focus on reducing self-harm.

- An understanding of the totalling of resource and how it aligns across the system, multi-agency decisions about resource allocation, information sharing protocols and an emphasis on continued improvement of performance to agreed contract requirements across the system.

- Smoother transition between services, particularly from children's to adult's mental health services and additional support for those aged 14-25 and leaving care. Clear links to critical pathways such as LD and appropriate assessment and treatment for neurodevelopmental disorders.

2.0 Service Specifications

2.1 Two separate specifications have been developed to meet the diverse needs of the Emotional Health and Wellbeing Model.

2.2 The first specification sets out the provision of the universal provision, which promotes positive emotional wellbeing and provides a lower level service in universal settings such as schools. The goal of this service is to ensure that children and young people and their families are supported at the earliest opportunity, to prevent their needs escalating and requiring the intervention of specialist mental health services (see Appendix 2).

2.3 The purpose of the second specification is to specify the provision of mental health services at the additional and specialist level of Children and Young People Mental Health Services (ChYPS), previously referred to as Tier 2 and Tier 3 of Child and Adolescent Mental Health Services (CAMHS) (see Appendix 3).

3 Procurement Process and Contracting

3.1 A Contract Procurement Board has been established, co-chaired by Andrew Ireland (KCC) and Ian Ayres (WK CCG), and will meet for the first time on 9 November 2015.

3.2 Two procurement plans have been developed utilising the expertise of the Commissioning Support Unit:

i) an abbreviated competitive dialog procedure (own dialog stage only)
ii) a normal restricted procedure (conventional Pre-Qualification Questionnaire (PQQ) and Invitation To Tender (ITT)

3.3 The procurement process is set to begin at the end of September 2015 and will be completed at the end of August 2016. The following key points have been taken into account in the development of these plans:

- three week allowance to establish the commissioning programme which will enable the procurement work to be conducted
- allowance for scheduling over the Christmas period
- four week allowance for the governance process to enable award of contract to the preferred bidder (PB)
- three months for mobilisation – starting as soon as the PB decision is announced (so running in parallel with standstill and contract completion).

3.4 The service specification should be finalised by the time bidders are asked to develop their solution against it (being 16 December 2015). However, for the dialog procedure, we could extend that until the date the Invitation to Submit Final Tender (ITSFT) is published 4 March 2016 – BUT ONLY IF (a) we publish a draft specification with the Invitation to Submit Outline Solution (ITSOS) on 16 December AND (B) we don't exclude any bidders in the outline solution stage on the basis of their outline solution.

4.0 Next steps:

- Refinement of service specifications
- Refinement of a performance framework
- Finalise workforce development plan
- Implement procurement
- New contracts commence – 1 September 2016

5.0 Recommendations

Members of the Health and Overview Committee are asked to

(i) NOTE the contents of this report.

6.0 Appendices

Appendix 1 Draft Service Model
Appendix 2 Draft Early Help Specification (Exempt)
Appendix 3 Draft Mental Health Specification (Exempt)
Appendix 4 – Summary of Draft Early Help and Mental Health Specifications

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APPENDIX 1

KENT COUNTY COUNCIL AND
CLINICAL COMMISSIONING GROUPS

The Kent Child and Young People's Emotional Wellbeing and Mental Health Model

Contents

1. Introduction

As partners in Kent, we want to support children, young people, young adults and their families as they make their journey through life, and work together in helping them respond to and overcome specific challenges that they may face. 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 adult independence. This document sets out the model which will deliver an improved response to children's emotional wellbeing and mental health needs.

A collaborative partnership needs to be developed between all providers if a single coordinated and integrated model is to be achieved. To achieve this we need different and flexible approaches to partnership working.

The achievement of integrated care relies on a different approach to procuring and contracting and the relationships between organisations will need to be dynamic and flexible to achieve the desired outcomes.

Key partners, stakeholders and service users have been involved in the consultation process to design this model. The new model will improve the whole-system understanding of the thresholds of care and support that a young person needs. It is the intention that this will stop inappropriate referrals and long waiting times.

This paper builds on the key principles outlined in the Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults and the associated Delivery Plan. It pulls together through combined partnership working the key elements that are required to deliver an age specific service which will meet the needs of Children, Young People and Young Adults within Kent (0-25).

The underpinning principle of the need to ***'promote positive emotional wellbeing' at all stages and levels of need*** is prevalent throughout.

The model specifies elements that are whole system, age specific and service or setting specific whilst building on the learning from HeadStart Kent which identifies that building emotional health in the context of adversity requires models of practice that promote young people's resilience.

This document covers Universal, Additional and Intensive/Specialist levels of service across agencies. As such, it attempts to align two discourses that refer to levels of intervention. We have provided a description against each level to demonstrate how this model is aligned, diagram of which can be found on Page 8.

The key outcomes of the strategy are:

Early Help (EH)	Children, young people and young adults have improved **emotional resilience** and where necessary receive **early support** to prevent problems getting worse.
Access (A)	Children, young people and young adults who need additional help receive **timely, accessible and effective support**.
Whole Family Approaches (F)	Children, young people and young adults receive support that **recognises and strengthens their wider family relationships**.
Recovery and Transition (R)	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.

These key outcomes need to be built on a foundation of positive emotional health and resilience promotion delivered to all children and young people.

2. Context

In early 2014 concerns were raised by the Health and Overview Scrutiny Committee about the ability of the CAMHS system and service to meet the demand and need across Kent. This prompted a review of the services, a refreshed needs assessment and an updated whole system strategic agreement to create a new approach to children's mental health in Kent.

The needs assessments (now published on the Kent and Medway Public Health Observatory) highlighted that despite significant improvement in certain areas (e.g. waiting times in west Kent), there was still inequity of access to some services, there was a treatment gap for children in care, rates of hospital admissions for self-harm were increasing and there was evidence that the services for preventing young people from reaching specialist CAMHS were not appropriately joined up or clear about what level of need they were delivering. This led to a highly demand driven CAMHS service with high case loads.

Nationally and locally, demand is rising for emotional wellbeing and mental health support. (Three children in every class have a diagnosable mental health condition - 10 per cent)[1].

As well as this our current concerns include the rising demand of inappropriate referrals, children falling through gaps in between services, and an urgent need to improve on and to support universal providers to identify and manage demand. In light of this there is recognition of the need for a whole-system approach to promote wellbeing, identify need appropriately, and intervene earlier and at the appropriate threshold.

These issues are not Kent's alone – it mirrors national concerns. A national task group set up by Norman Lamb, the then Minister for Care and Support, reported similar concerns to those in Kent. The work progressing in Kent is aligned both to national strategies for CAMHS and with the NHS Five Year Forward View, the mental crisis care concordat and KCC transformation programme for 0-25 years old.

Emotional wellbeing underpins a range of positive outcomes for children and young people. It must be owned by many agencies across Kent who need to co-operate in order to both prevent young people needing treatment as well as providing safe and high quality treatment e.g. schools, primary care, KCC Early Help and the NHS.

As part of the assessment of need there was a process of engagement and consultation with over 650 young people, families and providers. Current service activity was mapped along with listening to the voices of young people around the current service care pathway.

[1] Joint Strategic Needs Assessment 2014

Young people told us the following:[2]

- Current service care pathway feels impersonal and has long waiting times.
- Would like to be able to talk to someone straight away, with knowledge and who can arrange an appointment for a young person.
- Make good use of technology, receive confirmation of your appointment by text message, have website to access for support, online forums.
- Have local ongoing support through the use of youth centres and local drop-in sites.

Further information on the national context is included in the appendix.

[2] Consultation with service users 24/11/14

3. Key Principles

These key principles have arisen from consultation with children and young people, their families, practitioners, and are informed by learning from the HeadStart Kent Programme and the CAMHS Health Needs Assessment.

The children and young people's system will:

1. Ensure children and young people and their parents and carers are actively engaged in the development, commissioning and review of services.

2. Promote how to enjoy good emotional wellbeing at every opportunity, and challenge the stigma associated with poor mental health.

3. Learn and embed education and interventions which improve children and young people's resilience.

4. Ensure more children, young people and their families/carers are appropriately supported within universal settings, and through technology not just services.

5. Provide a simple and streamlined access for children and young people with emotional wellbeing and mental health needs and their family/carer by introducing a single point of access (SPA).

6. Ensure that all interventions are delivered in the right place, at the right time and by the right person using the least intrusive and most accessible method.

7. Use resources effectively and efficiently, delivering evidence based interventions to be able to respond to increasing demand, including increases in the population of children and young people by integrating delivery across health and the local authority.

8. Deliver a more holistic service for children, young people and families, reducing transfer between services and ensuring that young people have a named adult who is able to provide continuity of care.

9. Ensure information sharing protocols are in place and used to enable coherent care for young people.

10. Ensure that children and young people's recovery is everyone's business. Child centred recovery planning and step down will be shared across the emotional health system.

11. Ensure children and young people aged 14-25 needing long-term mental health support receive appropriate support and have a smooth transition to adult mental health services.

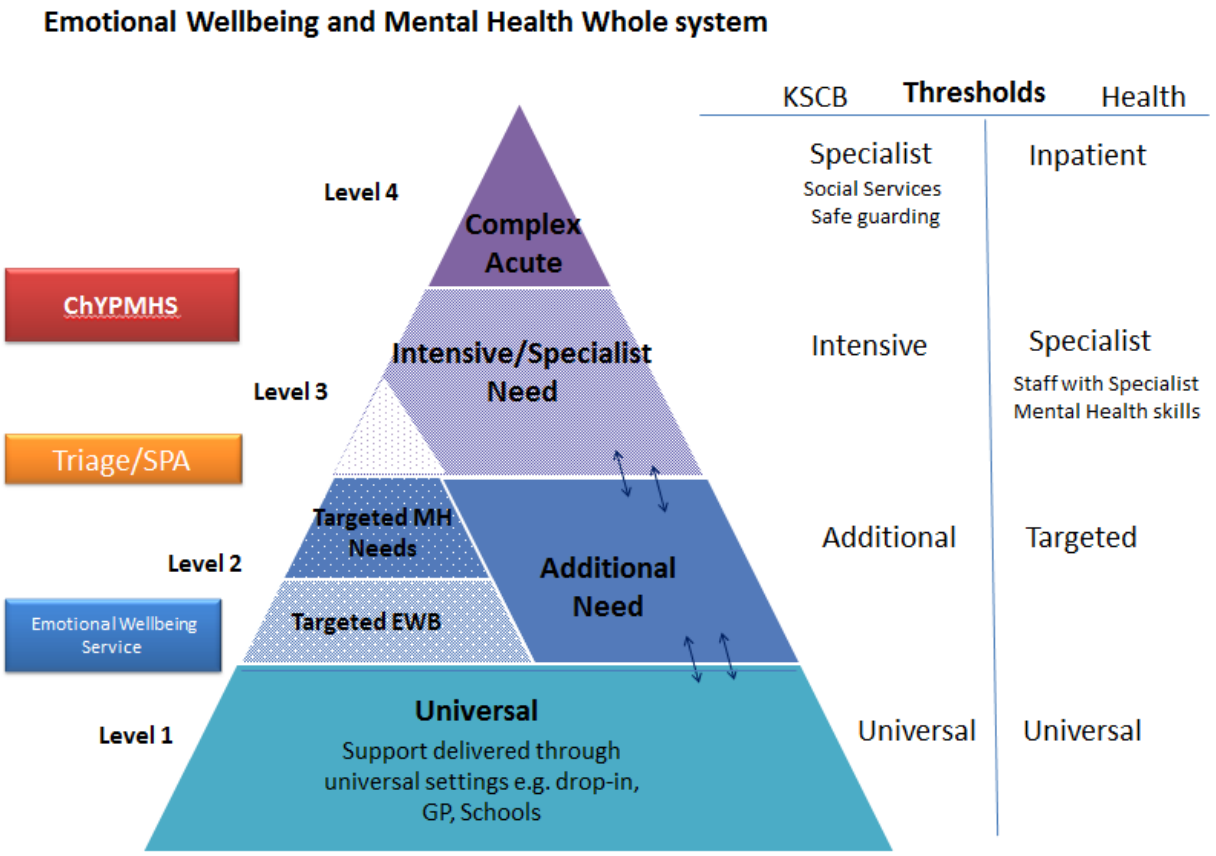
12. Take a resilience based approach to assessing children's strengths in relation to the six key resilience domains and supporting the development of protective factors in individuals and families and communities.

13. Ensure that the workforce is skilled to support resilience and identify emotional distress in children, including in those children who have been exposed to trauma including domestic violence, parental ill-health and substance misuse, and understands that building resilience is everybody's business.

14. Ensure each setting and service will have a named contact point for mental and emotional health including schools.

15. Adhere to a Kent wide dataset and outcomes framework for emotional health and wellbeing which enables monitoring of supply across the system against population changes, in relation to age, housing status, ethnicity and sexuality as well as comparison between services.

4. Proposed service model



Legend:
SPA – Single Point of Access
CHYPS MHS – Children, Young People Mental Health Service
EWB – Emotional Wellbeing
MH – Mental Health
KCSB – Kent Children's Safeguarding Board

4.1 Key elements- whole system

- The new service model and commissioning approach aim to redress the current situation with regard to the pathway that children, young people, young adults and their families tell us they experience when accessing mental health services in Kent.
- The Whole System Model illustrates how schools, local communities and specialist services will work in a more integrated way and how emotional wellbeing will be promoted and embedded in all aspects of the model which will include a multi-agency communications strategy.
- There will be a single point of access/triage across emotional wellbeing, early intervention and mental health services.

- Children and young people will receive timely access to support via the development of new ‘drop-ins’ and/or safe spaces in schools.
- There will be increased availability of consultation from trained mental health practitioners to schools, universal settings and other partners.
- A ‘whole family’ protocol will be developed, 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. The system will adopt a think family approach.
- Children will be kept safe via the effective implementation of multi-agency tools and protocols that identify children and young people who have been affected by Child Sexual Exploitation (CSE), and they will get rapid access to specialist post-abuse support.
- There is emphasis in the model for continued improvement of performance to agreed contract requirements across the system (good commissioning processes).
- There will be 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.
- There will be 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 per cent) will have a diagnosable mental health disorder and/or Speech, Language and Communication Needs (which can present as behavioural difficulties and be misdiagnosed).
- There will be 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 will include a strategic multi-agency approach to providing intensive support for those children being discharged from inpatient services or leaving residential schools to transition safely back to the community. This is known as the Winterbourne View Concordat.
- There will be an improvement in the provision of 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.
- The Provider(s) will hold significant responsibility for making the system work effectively and ensuring no children fall through the gap. This will be a key performance target.
- There will be an increase in provision in Early Help and Preventative Service for children who have complex needs but may as yet not have a diagnosis.
- There will be a clear strategy for improving the management of lower level demand through Universal settings including support and challenge surrounding “perceived” v’s “actual” need.

4.2. Workforce development

With regard to the wider workforce, the new model will ensure the following:

- All staff working within universal services e.g. schools will have had training to help them recognise and manage early emotional distress.

- Public Health will continue to support workforce development through the commissioning of the Youth Mental Health First Aid course which is accessible to all professionals and youth practitioners in Kent County Council.

- All the partners and agencies who work with children and young people know what services are available and how to access them.

- All partners know how and when to refer for specialist input.

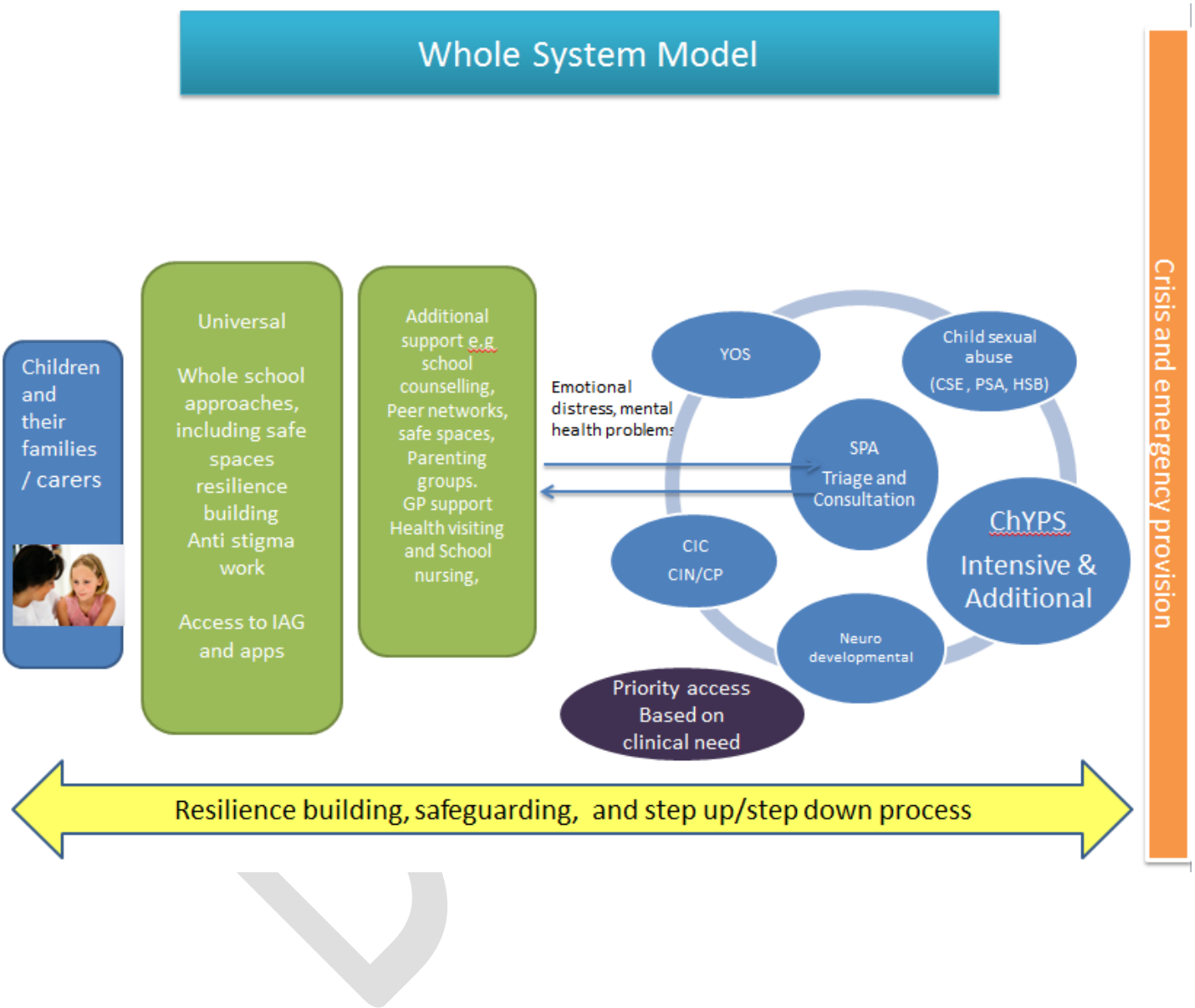
- There is easy responsive access to primary mental health workers.

- There are clear escalation routes for partner agencies when worried about a child or young person.

4.3 Model Diagram

The diagram below outlines the Whole System model proposed

Legend:
CSE – Child Sexual Exploitation
PSA – Post Sexual Abuse
HSB –Harmful Sexual Behaviour
SPA – Single Point of Access
CIC – Children in Care
YOS – Youth Offending Service
CHYPS – Children, Young People service



4.4 Types of need across the system

The table below outlines the different types of needs that will be supported at each level of the system

Kent Children Safeguarding Board level	Presenting needs
Universal	All children and families have core needs such as parenting, health and education.
Additional	Children and young people will be making good progress in most areas of development. However some children will display emerging early signs of withdrawal, anxiety or distress indicating some difficulty.
Intensive	Moderate emotional health issues, those who are facing or have faced adversity but are coping and able to be supported through school and family. These children and families will benefit from or require extra help to improve education, parenting and/or behaviour, or to meet specific health or emotional needs or to improve material situation.
Specialist services	Persistent, complex or severe mental health problems which are diagnosable and require treatment from a specialist service in order for sustained, significant improvement.

4.4 Differentiating support in ages and stages

a) Support for children aged birth to five years:

In the early years, the emotional health of children is dependent on attachment of the primary care giver and the reduction of risk in particular maternal mental health, parental substance misuse and domestic violence. Risk factors include low economic status and poor living conditions (and malnutrition) (WHO 2012). Children's centres and early education settings and their staff along with health visitors are critical to promoting maternal health in pregnancy and emotional health and attachment in the perinatal period and early years. They are also able to identify, assess and refer those families where additional help is needed.

b) Support for children aged five to 11 years:

In the primary school years the school and family are critical. Risks to a child's mental health include bullying and difficulties in school and exposure to trauma and maltreatment in their families. Children are developing behaviours and skills that support their emotional development through whole school programmes like social and emotional aspects of learning (SEAL). Their resilience can be built through identification and development of talents. Play is a critical developmental need and an appropriate therapeutic intervention.

c) Support for children aged 12 to 19/25 years:

In adolescence, young people are exposed to additional risk factors, are monitored less by parents, have greater freedoms in relation to social media and the virtual world, have exams at school. The impact of early trauma or ongoing exposure may result in emotional distress displayed in their behaviour including difficulties in self-regulation impulsivity. Their resilience is tested. For a small percentage of young people health harming behaviours emerge including substance

misuse and smoking. Self-harming may start and severe mental illness which requires specialist intervention may also start to show symptoms.

Given the co-existence of mental ill health and other health harming behaviours, it is critical that a holistic assessment is undertaken including physical and mental health with young people and robust and integrated packages of care are developed and coordinated. Particular attention needs to be paid to how these behaviours and health conditions are affected by disability.

At the same time these young people have evolving capacities and need to be more proactively engaged in services, provided with choice and the opportunity to shape the help that is provided.

The table below describes the types of interventions which are delivered across the ages elements.

	Universal	**Additional**	**Intensive/Specialist**
0-5 years	Health Visiting Service Drop in's and group work in Children's Centres, building resilience, active listening, parents website	Delivering whole family approaches, parenting programmes, debt counselling and reducing risk to children through referral to Early Help services.	Perinatal Mental Health, therapeutic interventions. Family Nurse Partnership
5-11 years	School Public Health Service Whole school interventions including SEAL, anti-bullying policies. Parent website.	Support in schools to respond to adversity as it arises to cope, build on strengths and resilience, identification of childre who are vulnerable to poor transition to secondary school.Parenting courses. Whole family approach, individual and group work in Youth hubs and reducing risk to children through referral to Early Help services using solution focused methods.	Assessment (including for children in care) and intervention and referral to Early Help, treatment and recovery. Referral to pychosocial support when children have been exposed to trauma including domestic violence.
12-19/25 years	School Public Health Service Whole school interventions, support in schools including drop ins, active listening, website for young people, youth	Support in schools through substance misuse and sexual health services to promote young people's resilience and respond to adversity when it arises. Support and assessment of self-harm.	Referral to pychosocial support to help children when exposed to trauma including domestic violence, support for young people who self-harm. Assessment (including children in care, young offenders) and intervention, treatment and recovery.

	hubs.	Early Help practitioner delivering whole family approaches and reducing risk to children through referral to Early Help services, DV services and mental health services.	

4.5 The new model and service redesign- Service delivery across the Tiers

a) Universal approaches to Emotional Health and Wellbeing

Universal settings, in particular the health visiting service and schools, will play an important 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. Many schools in Kent place real emphasis on whole-school approaches to emotional wellbeing, and offer additional pastoral support, counselling, or therapeutic services. There is a 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.

Key features:

1. Social Marketing Campaign will deliver messages to 10-14 year olds with the aim of improving young people's self-awareness of their own resilience and wellbeing.
2. Development of KCC's website for parents to ask questions on emotional health and wellbeing and links to relevant services.
3. Development of the KCC website for young people.
4. Expansion of Headstart whole school approaches to curriculum and development of extra-curricular activities.
5. Further development of the use of the Resilience Domains tool.

Delivered by: Universal providers /HeadStart programme

b) Additional Emotional Health & Wellbeing support through Universal Settings

For some children, additional support is required to manage their feelings. It may be that they need extra time to talk to a trusted adult, a different type of support – either face to face, in a group of other children with similar issues or in some cases support and encouragement to feel safe to open up at school or to the family. This level is a critical part of the strategy to reduce demand coming into specialist mental health services and into the Early Help Units as it seeks to prevent issues escalating and becoming more entrenched in the child or young person's life. Through the Emotional Wellbeing Strategy, young people were clear that they wanted to access services easily without having to go through complex referral processes. This element of the service will be delivered through universal settings, in the places where children, young people and families already go and feel comfortable without the requirement of a referral process or triage.

Key features

1. An offer of direct access to individual and group sessions for children and young people with mild/moderate needs who have been identified by schools, GPs and other services as needing additional support.

2. An outreach/consultation, support and advice service to schools, youth clubs and children's centres which will provide support in understanding emotional wellbeing/mental health thresholds and tools to manage demand at that level
3. Additional support for children young people and parents of children undiagnosed with Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder (ADHD, ASD). This will also include behavior issues.
4. Support for parents to build their capacity to support children's emotional wellbeing and sustain resilience
5. Offering joint delivery of support with staff from universal settings for children, young people and their families with particular emphasis on evidenced based interventions. This will contribute in upskilling the wider workforce

Delivered by: Practitioners who have skills, experience and qualifications in supporting children, young people and families with emotional health and wellbeing issues.

They do not need to be qualified mental health practitioners.

c) Mental health support for children with additional and intensive needs who do not have a medical diagnosis.

For more complex cases, but where a child or young person does not meet the threshold for intensive/specialist mental health series, we are proposing to introduce more experienced, qualified mental health practitioners into the Early Help Units to deliver a more intensive service to those children whose issues cannot be resolved through Open Access (universal) and additional support. In addition, recognising that emotional wellbeing/mental health issues impact heavily on family dynamics and positive outcomes for children, this service will take a whole family approach using evidence based therapeutic interventions before any further escalation to intensive/specialist mental health services or social care is required.

Key features:

1. Delivery of a range of effective and adequately resourced evidence based approaches to support emotional wellbeing, recognising that children, young people and families will be involved in negotiating the required individual packages tailored to their circumstances and needs. This may include Cognitive Behavioural therapy, Systemic Family work and Counselling.
2. Delivery of appropriate evidence based parenting support in the community for children, young people and families where appropriate.
3. Has an assertive outreach approach where necessary that uses innovative engagement approaches and does not close cases for missed appointments or non-engagement, if risk and vulnerability still remain.
4. Has a clear pathway 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 through Kent Family Support Framework (KFSF).
5. Delivery of support for parents who are experiencing low level mental health problems where the family dynamics is negatively impacting and affecting the children. This may include supporting liaison with Adults mental health services to enable assessment.
6. Offer guidance and, where necessary, constructively challenge those working directly with children, young people and their families/carers to ensure they fulfil their role and provide sufficient information at referral to enable a swift and effective response.
7. Hold a case load as part of the wider family work within Early Help and Preventative Services (EHPS) units.

8. Work with children across the continuum who do not meet the threshold for intensive/specialist mental health service but still need high level support.
9. Promote family preservation and sustaining positive relationships, building resilience
10. Higher level interventions through community settings for children who have additional needs but would benefit from greater expertise.

Delivered by: Qualified mental health practitioners in Early Help units (0.5 FTE/unit) who have the abilities to explore and take account of broader family functioning to identify underlying needs. This is likely to work best by co-locating these roles within the EHPS units.

d) Triage/ Single Point of Access:

There will be a Single Point of Access acting as a single point of entry across the system services, except where it is clear that there is a safeguarding concern or an emergency, severe or complex mental health need.

Key features:

The Triage/ SPA service will

1. Receive telephone calls from and provide advice to all practitioners who work with children and young people and from parents/carers about children and young people with emotional wellbeing and mental health needs.
2. Receive referrals including self-referrals from children and young people over 14-years-old (by post, fax or email with the agreed information provided by the referrer in an agreed secure format on the appropriate local form), review, obtain any additional background information needed to enable effective screening, check/link with other relevant databases and run appropriate checks to establish other services involved in working with the child/young person/ family/carer contacting them directly when necessary to discuss involvement and then screen the referral and direct it to the intensive and specialist service or other appropriate services. Triage will assess the cases in a timely manner and pass the referral on to the Early Help unit or direct to the commissioned service provider as appropriate.

3 Provide easier and swifter access for children and young people with emotional wellbeing and mental health needs and their family/carer to appropriate interventions by introducing a single point of access. This will be in parallel to Early Help and social care triage teams and will be co-located.
4 Ensure 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.
5 Offer direct advice and consultation to schools and other universal settings, to improve demand management.
6 Ensure that there are easier access routes and ensure referrals are directed to appropriate services and referrers receive feedback by having this as a function of the SPA.
7 Ensure more children/young people and their family/carer are appropriately supported within universal and other targeted services by making provision for the Early Help unit to provide advice and support that reduces the need for specialist intervention or provides this while waiting for more specialist input.

8 Ensure a systemic family based approach that works with the needs of the whole family rather than a focus solely on the individual child or young person with the presenting problem.
9 Deliver a more holistic service for professionals and users, improving transfer between services by integrating the emotional wellbeing and mental health service and ensuring that coordination with other services is part of the specification and monitored through contract management meetings.
10 Avoid and reduce the inappropriate use of A&E to access intensive and specialist services by quick screening and direction to appropriate service through the SPA, quick provision of help from services which operate for longer hours and ensuring crisis services are effective and adopt an assertive outreach approach.

Delivered by: Qualified mental health practitioners working alongside KCC practitioners.

e) Child and young people mental health services.

Approximately 2-3 per cent of children will have more significant and sustained difficulties and will require support from specialist community mental health services. These difficulties may include severe anxiety or depression, significant neurodevelopmental difficulties, self-harm or sustained eating disorders and early onset psychosis.

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.

Interventions will often involve more than one mental health clinician and often in partnership with other professionals, such as social workers, substance misuse practitioners and youth justice workers, along with family members and foster carers to ensure a wrap-around support network. The model seeks to avoid unnecessary escalation and inpatient treatment and ensure children and young people and their families/carers are supported as near to home as possible.

Key features:

1. Provision of 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. Assertive outreach and home treatment for children and young people and their family/carer will also be a provision of the service.
2. Swift and effective response to any crisis and work closely with acute and community services to avoid inappropriate use of Accident & Emergency services and to ensure that an alternative to inpatient provision is available.
3. Provision of a Home Treatment Rapid Response service to respond to emergencies and support vulnerable young people in the community so that they do not need to go to acute/inpatient settings.
4. Work with GPs and other appropriate services when necessary to ensure appropriate care and support is provided to respond to any continuing emotional wellbeing and mental health needs of children and young people when they are discharged from hospital or residential settings into other accommodation in Kent.

5. All staff will use a multi-agency toolkit to identify children and young people who have been affected by Child Sexual Exploitation (CSE), with rapid access to specialist post-abuse support.
6. Undertake assessments 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.
7. Ensure that there is appropriate intensive support for those being discharged from inpatient or residential schools when they move back to the local community. (Winterbourne Concordat).
8. Ensure that there is a clearly defined 'step down' pathway, with partnership agreement in place between services, following an intervention. Progress can continue to be sustained within early help or universal services, supported by specialist consultation where needed.
9. Offer targeted outreach and assessment of mental health needs for the most vulnerable groups, including children in care and young offenders to ensure accurate diagnosis of needs followed by a 'bespoke' care pathway for the most vulnerable.
10. Ensure comprehensive assessment and treatment of eating-disorders to include physical, psychological, social needs and risk to self, and involving a whole-family approach.
11. Provision of swift support and timely access for children in care and care leavers informed by a specialist mental health assessment at the point of entry to care.
12. Where these children and young people have emotional wellbeing and mental health needs, the specialist service will need to provide appropriate direct interventions and work closely with other professionals and services working with children and young people such as paediatricians, Child Development Centres, special schools, other health and Local Authority services.
13. The specialist service will also need to respond to children/young people who have long-term physical conditions and their family/carer and who develop emotional wellbeing and mental health needs and will need to work closely with other services involved.

A flexible approach is required as there will be times when a child/young person and their family/carer has needs that cross several pathways, including with pathways other than emotional wellbeing and mental health, e.g. substance misuse.

Delivered by:

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

Please note more detail for vulnerable groups will be discussed in Section 6.

f) Transition support for young people who are likely to requite adult mental health support as they reach 18.

When children and young people aged 16 onwards are assessed as likely to have ongoing mental health needs that will require support from Adult Mental Health Services, the specialist service will identify and initiate contact with Adult Mental Health and other appropriate Adult Services and jointly assess and plan appropriate services.

Key features

1. The service will adhere to and implement the mental health sections of the Transition Protocol.
2. The service will provide direct interventions up to the young person's 18th birthday or up to the age of 25 if the young person is a Care Leaver or has special educational needs or a disability and their needs will be best met by the children and young person's service.
3. The service will identify and work together with the appropriate Adult Mental Health Service (including adult IAPT, the voluntary sector, Early Intervention Psychosis Team and community mental health or inpatient services) to share information and jointly plan and deliver interventions to ensure a seamless transition to adult life.
4. The service will continue to work with those vulnerable young people with complex needs where they do not meet Adult Mental Health criteria beyond their 18th birthday to complete interventions and link them to other community support.

Delivered by

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

g) Children in Care:

Children and young people in local authority care will in the majority of cases have entered care because of neglect and/or other forms of abuse, and will have experienced high levels of complex trauma. As a result they may well have significant difficulties that reach beyond childhood and into their adult lives. These are likely to include significant attachment-related difficulties which will impact upon their ability to develop and maintain stable relationships with others in their lives, leaving them vulnerable to placement breakdown, lower achievements in education and training, developing abusive relationships, developing poor mental health (45 per cent have a diagnosable mental health condition) and the risk of entering the criminal justice system. Therefore, children in care need to be considered a priority by the services that are resourced to meet their needs, and these services must support those professionals (foster carers, social workers and their managers, and birth relatives) who are responsible for the ongoing care of the children and young people.

Key features

1. This service will work creatively and flexibly to engage each child or young person at their own time and pace.
2. Encourage and support effective working relationships between agencies to ensure a swift response to the child or young person, particularly in time of crisis and on the edge of care.
3. Offer consultation, supervision, support and training on a regular and ad hoc basis to those working in multi-agency teams who support children in care, including foster carers.
4. Offer additional consultation, supervision, support and training on a regular and ad hoc basis to adopters, foster carers and connected people (relatives and friends) to help them maintain therapeutic and stable environments for the children they look after and to avoid placement breakdown.
5. Enable referred children and young people to access services regardless of placement stability.
6. Support and sometimes take the lead in specialist or 'contract' fostering placement schemes to maintain and support the child or young person within a family placement and within area where possible, and to achieve better outcomes for those children and young people. Examples are Therapeutic Re-Parenting (TRP), Adolescent Wrap Around You (AWAY) and Remand Fostering.
7. Children and young people in care, leaving care, subject to special guardianship orders or child arrangement orders (were called Residence Orders), unaccompanied asylum seeking children, children placed for adoption, and those on the edge of care have a range of mental health and behavioural needs and should follow the relevant pathway and be prioritised based on their need and diagnosis.
8. Self-referrals from children in care should be accepted.
9. Interventions should recognise and address the inter-relationship between emotional/mental and behavioural needs including inappropriately sexualised behaviour.

Delivered by

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

Staff must particularly understand the impact of complex trauma on children and young people and who are trained in attachment-related interventions.

h) Other vulnerable children and young people

Where vulnerable children and young people have emotional wellbeing and mental health needs the services will need to provide appropriate interventions and work closely with other professionals. The services will support children with disabilities, as defined under the equalities duty. This includes disabled children with a physical and/or learning disability who may also have an emotional or mental health need. Research has shown that children and young people with learning difficulties are four times more likely to experience difficulties and poor outcomes than those without a learning difficulty.

The term neurodevelopmental disorders refer to a disorder of brain function that affects emotion, learning ability, self-control and memory. Of particular significance within this group are Autistic

Spectrum Conditions (ASC) and Attention Deficit Hyperactivity Disorder (ADHD). The term 'challenging behaviour' is also used for children who may have neurodevelopmental disorders. This covers a wide range of different behaviours, which include self-injury or physical aggression, severe agitation and extreme withdrawal, as well behaviours that can result in contact with the criminal justice system - in some cases leading to someone being arrested, charged and convicted of an offence. All of these described behaviours may vary in intensity and severity. The simplest definition of the term is: behaviour that has a significant adverse effect on the quality of life of the individual and / or the health and safety of the individual or others (taken from "Supporting people with a learning disability and/or autism who have a mental health condition or display behaviour that challenges" – Draft service model July 2015).

This is often found in young people who may not readily engage with services and where there are significant co-morbidities (e.g. those with complex trauma histories, development and/or attachment support needs) and those whose emotional and mental health needs are expressed through behaviour (including CSE or self-harm, psychosis, suicidal ideation, more severe self-harm, eating disorders and reactive attachment disorder).

Key features

1. The service will provide direct interventions to these children and young people and will work closely with other appropriate services to ensure an integrated response.

Delivered by

Staff must particularly understand the impact of complex trauma on children and young people and who are trained in attachment-related interventions.

5. What will be different about this new model?

How things are now	The new model
Decision about resource allocation made in silos.	Understanding of the totalling of resource and how it aligns across the system.
Lack of CYP voice in current service design, inconsistent approach within services.	Ensure CYP and their families are involved in the design and commissioning of services especially technology.
Lack of family approach.	Think Family.
Tiered approach to commissioning is not supporting children adequately.	Focus on children wherever they are in the system.
Services do not consider sufficiently family dynamics.	Responding to family dynamics with support.
Thresholds unclear and inappropriate referrals.	Multi-agency decisions about resource allocation. Information sharing protocols in place.
Inappropriate referrals and long waiting lists.	Single point of access. Referrals directed to right provision sooner through integrated model.
Rising demand for self-harm not met.	Focus on self-harm.
Not enough capacity in system - EHWB belongs to one service.	Delivery and support through universal hubs with a focus on schools.
Insufficient strategic links between other critical pathways and transition protocols.	Clear relationship for LD and neurodevelopmental pathway.
CAMH service used as a “catch all”.	Smooth transition to adult mental health for CYP 14-25 who require long-term support.
Does not build capacity or support others to develop their understanding sufficiently. Lack of sufficient and flexible provision for emotional wellbeing.	Consistent approach to promote good emotional wellbeing and resilience including upskilling workforce.
Lack of clarity about eligibility.	Deliver a consistent service reducing transfer between services ensuring CYP have named worker for continuity of care.
Lack of clarity in relation to LD and neurodevelopmental pathways.	Clear pathways for assessment and treatment of CYP with neurodevelopment difficulties.
Insufficient evidence around outcomes being achieved. Inconsistent performance monitoring methods for different services.	Kent wide outcomes based framework and dataset to enable effective monitoring across the system. Systematic contract monitoring to ensure model remains aligned.
No clear model for reporting performance data that is child related.	Child related performance data informing model of adult services.

6 - Summary

The new approach will ensure that there is better partnership working across all agencies' and that all services are fully integrated across a multi-agency whole system. The implementation of the new service model will enhance early intervention, supporting more children and young people earlier, before their needs escalate and require intensive/specialist provision.

The next steps are:

- Development of service specifications – completion date October 2015.
- Development of a performance framework – in development
- Workforce development plan – in development
- Procurement – timetable in development
- New contracts commence – 1 September 2016

Appendix 1

National Context and Reference documents:

The development of a 0-25 year old Mental Health Service is fully in line with both national and local strategies and policies. Government recently outlined the new Mental Health Action Plan. This sets out the top 25 areas where Government want to see immediate action to ensure equality for mental health and increase access to the best-possible support and treatment.
The following summary of national strategies shows that a 0–25 year old service plays an important part in delivering this ambition

The NHS England report **"Future in mind; Promoting, protecting and improving our children and young people's mental health and wellbeing"** (Department of Health, March 2015) sets out a vision for a comprehensive approach to promoting, supporting and treating children and young people's mental health, and to supporting their families. It puts forward a set of proposals to enable this vision to be translated into national and local frameworks - aiming to have these in place by 2020 - and provides guidance which future governments should consider. The Children and Young People's Mental Health and Wellbeing Taskforce were used to gather insights and evidence to inform this report, and it provides substantial context and case for change. Examples of methods to ensure this change is put in place include focussing on resilience and early intervention, developing whole school approaches to support young people's wellbeing and encouraging national conversations on mental health. The report makes it clear that young people's mental health and wellbeing is a national ambition and mental health needs to be everybody's business where collective resilience and mental strength is seen as an asset to the nation.

The Public Health paper **"Promoting Children and Young People's Health and Wellbeing; A Whole School and College Approach"** (P. Lavis, Public Health England, March 2015) provides key actions which schools and colleges can take to ensure a whole school/college approach is embedded when promoting and supporting children and young people's emotional health and wellbeing. This paper uses the Ofsted framework and The National Institute for Health and Care Excellence (NICE) guidelines to emphasise the importance of comprehensive health and wellbeing promotion and support. Examples of practice from different schools and colleges are also provided to highlight how different elements of health and wellbeing can be embedded within the education sector. The paper describes eight key principles which can be used to promote emotional health and wellbeing within schools and colleges: 1. Leadership and management support. 2. A school ethos and environment which promotes and supports mental health. 3. The embedding of emotional health and wellbeing within the school and college curriculum. 4. Students have a voice. 5. Staff are continually developed to support their own wellbeing as well as young people's mental health. 6. Young people's needs are identified and the impact of interventions is monitored. 7. Schools and colleges work with parents and carers. 8. Targeted support and specialist provisions are provided. The paper provides a comprehensive list of a wide range of resources available to promote and support children and young people's emotional health and wellbeing.

The **"Social and Emotional Learning: Skills for Life and Work"** (L. Feinstein, Early Intervention Foundation, 2015) review paper has been commissioned by the Early Intervention Foundation, the Cabinet Office and the Social Mobility and Child Poverty Commission. It considers the findings of three different reports from universities and an independent research consultancy to establish evidence for investing in young people's mental and emotional health and wellbeing. The report makes it clear that a local and national commitment is needed to support children and young people's social and emotional development, to avoid escalating mental health problems when young people reach adulthood. It emphasises that social and emotional learning provision needs

to be available to all, staff need continual training to ensure quality provision, and social and emotional learning needs robustly evaluated. The report highlights that a whole school approach to social and emotional learning is key, and this needs to be modelled and reinforced throughout the entire school. Furthermore, policy leadership is necessary to implement and prioritise social and emotional learning, and the voice of young people needs to be heard throughout this process. The report makes it clear that social and emotional skills play a fundamental role in shaping the life chances of children and young people and this will impact their adult lives. Schools have an influence on these life chances, but consistency is needed to ensure provisions in schools are effective and universal.

The "**Right Here: How to provide youth-friendly mental health and wellbeing services**" guide (Paul Hamlyn Foundation and Mental Health Foundation, January 2015) offers recommendations to support the mental wellbeing of young people aged 16-25. It focusses on youth-friendly mental health and wellbeing services across the UK, providing practical pointers and suggestions to support the development of innovative and effective responses to young people's mental wellbeing. This guide has been written to help services address the needs of young people aged 16-25, and tackle barriers which prevent young people from accessing mental health services. This guide provides the context that early adolescence is the peak of onset for mental ill-health, so young people need to be seen and treated early. Furthermore, current mental health services have long waiting lists so there is a need for a more creative response to young people's mental health issues, such as youth counselling, online intervention and youth agency and VCS programmes. The guide emphasises that 16-25-year-olds have distinct mental health needs and can find it difficult to fit into adult mental health services. Suggestions for providing youth-friendly mental health and wellbeing services within this paper include effective promotion of services to young people, focussing on activities rather than services so young people feel engaged, simplifying the referral and assessment process, providing a creative healthcare setting, sustaining support and relationships with young people and involving young people in the service design and delivery.

The Department for Education paper "**Mental health and behaviour in schools: Departmental advice for school staff**" (Department for Education, March 2015), provides non-statutory advice clarifying the responsibility of schools to support a child or young person whose behaviour may be related to unmet mental health needs. The report states that one in ten children or young people aged between 5 and 16 will have a clinically diagnosed mental health disorder, so this paper aims to provide advice and practical tools to help schools promote positive mental health in pupils and identify and address less severe mental health issues and build pupil's resilience. This report also helps schools identify and support young people with more severe mental health needs so they can be referred appropriately to specialist services. The paper outlines risk and protective factors which influence children and young people's resilience to mental health problems, giving examples of events that may affect pupil's mental health. It outlines ways schools can promote pupil's mental health, leading to young people being more resilient to problems before they arise. The paper discusses the importance of monitoring and identifying young people with possible mental health problems, such as tracking their attendance and attainment, using Strengths and Difficulties Questionnaires and working with GPs. It provides strategies to promote positive mental health such as PSHE lessons, group work, one to one work, counselling, working with parents and peer mentoring. It clarifies how schools can get involved in defining local mental health services through Health and Wellbeing boards and working with other agencies. This report lists sources of support and information, and provides an annex of mental health needs and how to support these young people.

The Public Health England paper "**The link between pupil health and wellbeing and attainment: A briefing for head teachers, governors, and staff in education settings**" (F. Brooks, Public Health England, November 2014), provides a summary of key evidence which

highlights the link between health and wellbeing and education attainment. This paper emphasises the value of promoting health and wellbeing as an integral part of the school's effectiveness strategy and highlights the important contribution of a whole-school approach. Key evidence discussed in this paper is: 1. Pupils with improved health and wellbeing are likely to achieve better academically. 2. Effective social and emotional competencies are associated with greater health and wellbeing and better achievement. 3. The culture, ethos and environment of schools influence the health and wellbeing of pupils and their readiness to learn. 4. There is a positive association between academic attainment and physical activity in young people. This paper links these key evidence findings to the Ofsted framework; for example the Ofsted strand Quality of Teaching is linked to evidence that the teaching of emotional life skills has the potential to increase emotional wellbeing and academic achievement. The Behaviour and Safety of Pupils at the School strand is linked to evidence that pupil's sense of belonging to a school is a key determinant of their wellbeing. The paper emphasises the value of promoting health and wellbeing as a whole-school strategy, describing the need for schools to go beyond just teaching and learning to support pupil's health and wellbeing as well.

The PSHE Association paper "**Teacher Guidance: Preparing to Teach About Mental Health and Emotional Wellbeing**" (PSHE Association, March 2015) provides suggestions for teaching staff to incorporate into their PSHE curriculum. It describes how teaching pupils about mental health and emotional wellbeing is important as it keeps pupils safe, pupils can develop healthy coping strategies, they learn about their own and other pupil's emotions and pupils can support themselves and each other. If pupils are learning about mental health in PSHE lessons, they will discover how to seek help for themselves and for other pupils and the stigma often associated with mental health will be broken down. This paper aims to make teaching mental health and emotional wellbeing less daunting for teachers in a safe and sensitive manner. The paper highlights that teaching mental health and emotional wellbeing is important for all key stages and this should be built upon from an early age to promote positive behaviour and coping strategies. Mental health needs to be embedded into, not separate from, PSHE lessons, and the paper sets out key learning objectives under Health and Wellbeing, Relationships and Living in the Wider World. The paper emphasises the importance of promoting wellbeing and resilience from an early age and describes factors which could impact a pupil's emotional and mental wellbeing, such as bullying, body image and the online environment.

The Public Health paper "**Improving young people's health and wellbeing: A framework for public health**" (Public Health England, January 2015) provides a framework highlighting the importance of ensuring every young person has the right support to maximise their potential. It is an asset-based approach focussing on young people's wellbeing and resilience. The paper emphasises that young people's services need to be integrated and holistic, and sets out core principles to achieve this, building on the concept of resilience: 1. Recognising and supporting relationships should be central to improving young people's physical and mental health. 2. What makes young people feel well and able to cope, focussing on the positive, resources available, strengthening life skills and encouraging creativity? 3. Reducing health inequalities. 4. Championing integrated services, with a seamless connection and navigation between these services. 5. Understanding changing health needs as young people develop. 6. Delivering accessible, youth friendly services. The paper outlines why young people's emotional and mental health should be invested in both for the short and long-term. Furthermore, it sets out critical health outcomes such as the reduction of young people living in poverty, targeted support for vulnerable groups and improving young people's safety. The paper outlines a recommended health and wellbeing offer to young people which would include a holistic approach, focus on prevention as well as intervention, building resilience and offering appropriate support.

Department for Education and Department of Health, **'Promoting the health and well-being of looked-after children'**,Statutory guidance for local authorities, clinical commissioning groups and

NHS England. (March 2015.) This is joint statutory guidance from the Department for Education and the Department of Health. It is for local authorities, CCGs and NHS England and applies to England only. This guidance is issued to local authorities, CCGs and NHS England under sections 10 and 11 of the Children Act 2004 and they must have regard to it when exercising their functions. Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults.

Appendix 2 **Glossary of abbreviations**

ADHD – Attention Deficit Hyperactivity Disorder
ASC – Autistic Spectrum Condition
AWAY – Adolescent Wrap Around You
CAMHS - Child and adolescent mental health service
ChYPS – Child and young person
CSE – Child Sexual Exploitation
CYP – Child/ren and young people
EHN – Early Help Notification
EHPS – Early Help and Preventative Service
EWB – Emotional wellbeing
FTE – Full time equivalent
KFSF – Kent Family Support Framework
SPA – Single Point of Access
TRP – Therapeutic Re-Parenting

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APPENDIX 2 - Draft Early Help Specification (Summary)

Key features of the Universal Emotional Wellbeing Specification are:

1.0 Effective and trusted relationships with leaders and managers in universal settings in order to build the capacity needed to meet the emotional health and resilience needs of children and young people.

1.1 Information, advice and guidance to children, young people, their parents and carers and the wider children and young people's workforce in universal settings.

1.2 Training and consultation support for practitioners in universal settings.

1.3 Promotion of and support in implementing whole setting interventions which promote emotional health and resilience.

1.4 Support for parents/carers to build their capacity to support children's emotional wellbeing and sustain resilience.

1.5 An offer of direct access for children , young people and parents /carers for children and young people with mild/moderate needs who have identified themselves, dropped in or have been identified by schools, GPs and other services as needing additional support.

1.6 An offer in universal settings of ensuring that children and young people with early help and specialist needs are able to maintain their resilience.

APPENDIX 3 – Draft Mental Health Specification (Summary)

The Key features of the Children and Young People's Mental Health Service (ChYPS) specification are:

2.1 This draft specification sets out the requirements for the delivery of a comprehensive and integrated emotional wellbeing and mental health service for children and young people.

2.2 The criteria outlined in the document mirrors the model in relation to the feedback from consultation with a range of stakeholders about what is needed from an effective service, as well as aligning to current national policy and guidance.

2.3 The purpose of this document is to specify the provision of mental health services at the Additional and Intensive/Specialist level (previously referred to as Tier 2 and Tier 3 of Child and Adolescent Mental Health Services (CAMHS)).

2.4 This health specification forms part of the national CAMHS Transformation Programme and sits alongside the Universal Emotional Wellbeing specification (Appendix 2) which outlines the universal provision commissioned by Kent County Council.

2.5 Highly Specialist Inpatient Services (Level 4) are not within the scope of this specification as they are commissioned by NHS England.

2.6 In brief, the services outlined within this specification are linked to and are interdependent with other services across Kent. For example (this is not an exhaustive list):

- Early Help Emotional Wellbeing services
- Public Health
- Health Visiting
- School Nursing
- Community Child Health
- Sexual Assault Referral Centre (SARC) & Sexual Health
- Acute Paediatrics
- Accident and Emergency Services
- Perinatal Mental Health Services, including Mother & Infant Mental Health Service (MIMHS)
- Adult Mental Health services including the community mental health and wellbeing service

2.7 Within the overall target population of 0 – 25-year-olds, the provision of ChYPS will also meet the additional level of emotional and wellbeing needs of those at risk and vulnerable groups, where there is an identifiable mental health need, for example, Children in Care, Children in Need, victims of Child Sexual Exploitation and Young Carers.

2.8 The specification has been designed to deliver against all five domains of the NHS Outcomes Framework and Domains Two and Four of the Public Health Framework. SMART local outcome measures are currently being developed in partnership with University of Central London.

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