AGENDA

KENT HEALTH AND WELLBEING BOARD

Thursday, 7th February, 2019, at 2.00 pm Ask for: **Ann Hunter**

Darent Room - Sessions House Telephone **03000 416287**

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

Membership

Mr P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Cllr S Aldridge, Dr F Armstrong, Mr I Ayres, Mr P B Carter, CBE, Dr S Chaudhuri, Ms F Cox, Mr M Dunkley CBE, Dr S Dunn, Mr G K Gibbens, Cllr F Gooch, Mr R W Gough, Mr S Inett, Dr N Kumta, Dr S MacDermott, Dr J Malasi, Mr A Scott-Clark, Ms C Selkirk, Ms P Southern, Dr R Stewart and Vacancy - District Council Representative

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UNRESTRICTED ITEMS

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

1 Chairman's Welcome

2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes

3 Declarations of Interest by Members in items on the agenda for this meeting

To receive any declarations of Interest by Members in items on the agenda for the meeting

4 Minutes of the Meeting held on 21 March 2018 (Pages 3 - 8)

To receive and agree the minutes of the last meeting

5 Integrated Adult Learning Disability Commissioning - Section 75 Agreement (Pages 9 - 56)

6 Kent Better Care Fund Annual Report (Pages 57 - 60)

7 Kent Joint Strategic Needs Assessment (JSNA) Exceptions Report 2018/19 (Pages 61 - 74)

8 0-25 HWB Update and Forward Pan (Pages 75 - 82)

9 Kent and Medway Health Crisis Care Concordat 2017/18 Annual Report (Pages 83 - 108)

10 Pharmaceutical Needs Assessment Updates and Supplementary Statements (Pages 109 - 112)

11 Date of Next Meeting - 26 February 2020

To agree that the next meeting of the Kent Health and Wellbeing Board will take place on 26 February 2020.

EXEMPT ITEMS

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

Benjamin Watts
General Counsel
03000 416814

Wednesday, 30 January 2019

KENT COUNTY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Health and Wellbeing Board held in the Darent Room - Sessions House on Wednesday, 21 March 2018.

PRESENT: Mr P J Oakford (Chairman), Dr B Bowes (Vice-Chairman), Dr M Cantor (Substitute for Dr F Armstrong), Mr P B Carter, CBE, Dr S Chaudhuri, Dr A Duggal (Substitute for Mr A Scott-Clark), Mr G K Gibbens, Cllr F Gooch, Mr R W Gough, Dr S MacDermott, Dr T Martin, Mr S Perks, Ms P Southern (Substitute for Ms A Singh) and Dr R Stewart

ALSO PRESENT: Ms C Selkirk

IN ATTENDANCE: Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

321. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Dr Fiona Armstrong, Ian Ayres, Andrew Scott-Clark, Matt Dunkley and Anu Singh.

Dr Mick Cantor was present as a substitute for Dr Fiona Armstrong, Dr Allison Duggal for Mr Scott-Clark and Ms Southern for Ms Singh.

322. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

There were no declarations of interest.

323. Minutes of the Meeting held on 22 November 2017
(Item 4)

(1) The minutes of the last meeting, held on 22 November 2017, were agreed as a correct record, subject to the following amendment:

a) Dr Tony Martin be deleted from the list of those present.

(2) The minutes were signed by the Chairman accordingly.

324. Establishment of a new Kent and Medway JOINT Health and Wellbeing Board
(Item 5)

(1) Karen Cook (Policy and Relationships Adviser (Health)) introduced the report which set out a proposal to secure a collaborative approach between the Kent

and Medway Health and Wellbeing Boards as they contribute to the development of the Sustainability and Transformation Partnership Plans.

(2) In response to questions, Karen Cook said the proposed Membership of the Kent and Medway Joint Health and Wellbeing Board would be two representatives representing the district councils across Kent and Medway. She said that there would also be representation from Local Medical Committees to assist with clinical representation.

(3) Resolved that:

a) The Health and Wellbeing Board agree to the establishment of a new Kent and Medway Joint Health and Wellbeing Board constituted as an Advisory Sub-Committee, with Terms of Reference and procedure rules as set out in the report;

b) The membership of the Sub Committee be as set out in paragraph 5 of Appendix 1 to this report; and

c) The role and continuation of the KAMJHWB be reviewed after two years.

325. KSCB Update on Ofsted Recommendations from the Review of the Local Safeguarding Children Board (LSCB), March 2017
(Item 6)

(1) Gill Rigg (Independent Chair - Kent Safeguarding Children Board (KSCB) and Mark Janaway (Programme and Performance Manager, Kent Safeguarding Children Board) introduced the report which provided an update on the Ofsted recommendations from the review of the Local Safeguarding Children Board and the progress that had been made against the recommendations.

(2) In response to a question, Gill Rigg discussed safeguarding in schools and said that the Safeguarding Children Board only scrutinised and assessed the schools or early years settings in Kent which were not rated as good or outstanding to avoid duplicating the work that had been carried out by Ofsted.

(3) Resolved that the report be noted.

326. Joint Strategic Needs Assessment - Exceptions Report 2017-18
(Item 7)

(1) Abraham George (Public Health Consultant) introduced the report which set out the changes made to the Joint Strategic Needs Assessment development process and provided a summary of the new priorities emerging from audits, briefings, chapter summaries and needs assessments as well as case studies from the Kent whole population cohort model.

(2) In response to a question, Allison Duggal (Deputy Director of Public Health/Public Health Consultant) said the analysis and reports that had been undertaken by the Kent Public Health team included health inequalities. She added that the Sustainability Transformation Plan (STP) and prevention workstream

concentrated on addressing the life expectancy gap between the least and most deprived.

(3) In response to a question, Abraham George said that it was important for Public Health to continue to monitor health inequalities and understand the causes of health inequalities and the impact of various programmes. He emphasised the importance of understanding which programmes were the most effective, and that further investment in early diagnosis and treatment was required.

(4) In response to a question, Abraham George said that for progress to be made, it was important that the Kent Public Health team had access to data to undertake analyses, and to have an integrated protocol to ensure that efficient ways of reporting the analyses were in place.

(5) In response to a question, Allison Duggal said that greater investment from the STP delivery board and KCC was required on primary prevention services.

(6) Resolved that:

(a) It be agreed to adopt a broader consistent structure for outlining priorities for population health improvement, encompassing: primary prevention (lifestyle modification) for the whole population; secondary prevention (early diagnosis and treatment) for those at risk of LTCs e.g. Cancer and Mental Health; and tertiary prevention (recovery, rehabilitation and reablement of patients with complex needs), ensuring better quality of care;

(b) Greater investment from the STP delivery board and KCC was required on primary prevention services such as smoking cessation and weight management integrated directly into local care and acute care models of the Kent & Medway STP;

(c) Emphasis should be placed on *Making Every Contact Count* for workforce planning and understand in more detail how frontline NHS and social care staff can incorporate key principles such as better identification of risky behaviour, brief advice and onward referrals for lifestyle modification;

(d) Social prescribing from primary care and onward referral to district and other public-sector services such as Fire and Rescue Safe and Well visits, Warm Home interventions to tackle fuel poverty and other home improvements to reduce unintentional injuries such as slips trips and falls be industrialised;

(e) The use of risk profiling tools in primary care to identify patients at high risk of rehospitalisation who might benefit from social prescribing be industrialised and existing tools be improved by incorporating more information on social determinants of health, such as information on housing insulation and better governance arrangements to allow district officers and NHS clinicians to work together to access such tools; and

(f) An update be added to a future agenda of the new Kent and Medway Joint Health and Wellbeing Board for review.

327. Kent Pharmaceutical Needs Assessment 2018 - 2021
(Item 8)

(1) Allison Duggal introduced the report which set out information relating to pharmaceutical and dispensing services in GP surgeries.

(2) In response to a question, Allison Duggal said the Kent Pharmaceutical Needs Assessment was based on the requirements from NHS England, and there were regulations which needed to be adhered to regarding the process and consultation stages.

(3) In response to a question, Allison Duggal said that community pharmacies were driven by commercial interests. She added that Kent were ensuring that there were pharmacies available to all its residents.

(4) Resolved that:

(a) The Health and Wellbeing Board approve the process and timeframe.

(b) The Health and Wellbeing Board approve the final PNA ready for publication subject to final checking with NHS England regarding any pharmaceutical service application grants made following the consultation and any final changes arising from proofing- reading and editing.

328. Kent & Medway Safeguarding Adults' Board Annual Report - April 2016 - March 2017
(Item 9)

(1) Mr Gibbens introduced the report which set out the Kent and Medway Safeguarding Adults' Annual Report for 2016/17 and detailed the work of the multi-agency partnership in managing safeguarding adults' issues in 2016-2017.

(2) Resolved that the report be noted.

329. 0-25 Health and Wellbeing Board
(Item 10)

Resolved that the minutes of the 0-25 Health and Wellbeing Board be noted.

330. Minutes of the Local Health and Wellbeing Boards
(Item 11)

Resolved that the minutes of the local health and wellbeing boards be noted as follows:

Ashford – 17 January 2018
Canterbury and Coastal – 11 January 2018
Dartford, Gravesham and Swanley – 21 February 2018
South Kent Coast – 7 November 2017
Thanet – 9 November 2017 and 11 January 2018
West Kent – 20 February 2018

331. Date of Next Meeting
(Item 12)

(1) Mr Oakford said that it was important that the first Kent and Medway Health and Wellbeing Board focused on significant topics to make best use of the board.

(2) Resolved that from April 2018 the meetings of the Kent Health and Wellbeing Board be held during the working day.

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From: Penny Southern, Corporate Director of Social Care, Health and Wellbeing

To: Kent Health and Wellbeing Board - 7th February 2019

Subject: **INTEGRATED ADULT LEARNING DISABILITY COMMISSIONING - SECTION 75 AGREEMENT**

Classification: Unrestricted

Summary: This report provides an update regarding the Learning Disability Section 75 Agreement which was established to host integrated commissioning arrangements between Kent County Council and the seven Kent Clinical Commissioning Groups (CCGs).

1. Introduction

1.1 This report provides an update regarding integrated commissioning arrangements for adult learning disability services which became operational in April 2016. Under a formal Section 75 Agreement Kent County Council (KCC) leads this work on behalf of all of Kent's Clinical Commissioning Groups (CCGs).

1.2 The purpose of the arrangement is to provide a central point of expertise on adult learning disability for all the partners to the Section 75 Agreement. This ensures there is expertise and knowledge around the commissioning of support and provides a consistent approach to health and social care commissioning for adults with a learning disability across Kent. It also ensures that the organisational memory of the considerable positive changes which have been achieved in recent years is retained and built upon through continued improvements.

1.3 The Council acts as representative commissioner for the delivery of this agreement which supports KCC's strategic aims:

- To develop and rapidly deliver a shared vision for the integration and redesign of health and social care services across Kent
- Ensure more people receive quality care at home avoiding unnecessary admissions to hospital and care homes
- The health and social care systems work together to deliver high quality community services

2. Policy Framework

2.1 A core principle of the Integrated Learning Disability Commissioning Team Specification is '*to put the individual with a learning disability at the centre of decision making, giving them more choice and control over their lives'*. The pooled resource ensures a joined-up approach to both the commissioning and delivery of strategies to reduce the inequalities and disadvantage faced

by people with a learning disability. This work enables the health and social care system to work together to deliver high quality community services.

2.2 The Section 75 Agreement supports the whole system to deliver the following for people with Learning Disabilities:

- Supporting those with long term conditions to manage their conditions through access to good quality care and support
- Enabling more people to receive quality care in the community avoiding unnecessary admissions to hospital and care homes
- Enabling the health and social care system to work together to deliver high quality services
- Improving physical and mental health by supporting people to take more responsibility for their own health and wellbeing

2.3 The NHS Long Term Plan published January 2019 commits the NHS to deliver continuous improvements to benefit people with learning and/or Autism. The Integrated Commissioning, and LD Alliance arrangements have established sound foundations needed for the delivery of the actions outlined in the NHS Plan.

3. The Section 75 Agreement:

3.1 Has established, and set out the governance arrangements for, the Section 75 Learning Disability Partnership Board, which is chaired by the KCC Strategic Commissioner. The Board ensures collaborative decision making and consistency with governance arrangements of each of the partner organisations.

3.2 Has established the Integrated Commissioning Team for Learning Disability which is hosted by KCC. This brings together and centralises commissioning expertise relating to learning disabilities across health and social care in Kent to commission and improve services in the collective interests of the Section 75 Partners. This team performance manages the integrated Community Learning Disability Teams (CLDT) and supports their work by ensuring appropriate high-quality community services are available to support adults with learning disabilities.

3.3 Has created a functioning health and social care pooled budget which sets out the final contributions for each partner. This is hosted by KCC on behalf of the Section 75 Partners to fund the Integrated Commissioning Team for Learning Disability and brings together the previously separate learning disability services funding. This has enabled the Section 75 Board to integrate Health and Social Care Learning Disability Services into an Alliance Agreement.

3.4 The integrated commissioning arrangement under the Section 75 has enabled the successful negotiation and completion of the Learning Disability Alliance Agreement. Kent Community Health Foundation Trust (KCHFT), Kent and Medway Partnership Trust (KMPT), and Kent County Council

(KCC) have come together to create an Alliance Agreement, the alliance comprises of the individual organisations underpinning service contracts. This means that the KCC's staffing budget for the CLDTs is now part of the pooled budget. Any plans for spending on CLDTs are now developed in consultation with the CCGs through the Section 75 Learning Disability Partnership Board and managed through the pooled budget.

3.5 Has established a sound foundation and expansion is being considered to include other associated areas of commissioning, e.g. health funded support packages for adults with learning disabilities and/or Autism.

4. The Learning Disability Alliance Agreement:

4.1 The Alliance underpins and makes real the aspirations of the Section 75 Agreement and has been established for the provision of integrated care. The Alliance has been in place since 1st February 2018 and has an initial three-year term. To our knowledge, this is the first of its kind. This work has been acknowledged by the Kings Fund who have made information about the Alliance available via their website to support other areas who are progressing similar work.

4.2 The Alliance ensures a collaborative approach between the three providers, KCC, KCHFT and KMPT and Commissioners. It enables better joined up conversations about how best to meet people's needs, it is supporting providers to think more strategically and beyond the boundaries of their own organisation. Christine Beany, Assistant Director for Community Learning Disability Teams, stated in September 2017 "*we've shifted the focus from where does my responsibility end, to how do we depend on each other and how can we strengthen that?"* There have been many benefits of this approach, one example being that now teams can refer to each other without having to go through a GP, this has sped up access and removed a layer of bureaucracy from the primary care system taking work from hard pressed GP surgeries.

5. Key Achievements

5.1 The Transforming Care Programme came out of the post Winterbourne View scandal; is a structured programme to ensure people with learning disabilities and/or Autism do not stay in hospital for longer than is necessary. To date the Kent and Medway Transforming Care Partnership has supported 108 adults and 47 children to be discharged for NHS Acute Assessments and treatment units, so they can lead more independent and fulfilled lives in the community. The three-year Transforming Care Programme (2016-19) is being extended to March 2020 and possibly beyond with emphasis on expanding CTRs/CeTRs and improving delivery for the CYP cohort. See Appendix A for a full report about this work.

5.2 A Service Operational Manual (SOM) is in development, the SOM sets out clearly the role of the Integrated Community Learning Disability Teams. What the professional roles are within the team and what they do. It also

explains how the different professions work together to support people with learning disabilities and their families. The creation of the SOM will help when planning for the future workforce and addressing the issues we are currently facing ensuring that community learning disability teams have the right skill mix to provide high-quality person-centred support.

5.3 Annual Health Checks are essential in ensuring that people living with learning disabilities can access health care and reduce the inequalities they have historically experienced. Work is required to increase the number of Annual Health Checks delivered across Kent, the Integrated Commissioning team and Alliance Partners have highlighted this, and it is now being explored by the CCGs through quality governance routes with NHS England's support. 100% of GPs have been offered Annual Health Checks Training and all practices have an allocated link nurse from the Alliance Team who they can call on for advice and support when meeting the needs of people with a learning disability on their practice list.

5.4 The Integrated Commissioning Team have successfully rolled out the national LeDeR Programme across Kent and Medway, with a Steering Group chaired by Public Health. The LeDeR Programme reviews all deaths of people with learning disabilities. The review process:

- ensures that any lessons learnt about how the system could have provided better care are actioned in the continuous improvement of services and support.
- contributes to reducing premature deaths among the learning-disabled population by informing better commissioning and delivery of services by informing practice change across the health and social care system.

5.5 In conjunction with the Alliance the Integrated Commissioning Team has implemented the Care (Education) and Treatment Review process. Care and Treatment Reviews for those of 18 years of age with Education being part of the process for people under 18 years of age. This process brings providers and commissioners together to discuss individuals with complex needs in order to design packages of support to better meet their needs and prevent inappropriate hospital admissions.

5.6 The Alliance has also successfully implemented a new Complex Care Response (CCR) service. This new service is delivered by the Alliance partners to support individual's outcomes and to prevent breakdowns in community support. The service works with other community care providers to manage difficult situations in the community and to facilitate timely discharges. Since this service has been in place, we have seen a dramatic reduction in community admissions to NHS assessment and treatment facilities.

5.7 The Good Health Group, Alliance Partners and the Integrated Commissioning Team are working with hospital trusts across Kent and Medway to ensure people with a learning disability have a positive experience and equal access of hospital care. People with a learning

disability are influencing this work directly as key members of the Good Health Group, two people with a learning disability co-chair the group alongside a member of the integrated commissioning team.

5.8 Each hospital has a learning disability liaison nurse whose role it is to improve service delivery and quality of care across the Trust. This has already resulted in the sharing of best practice and acute trust tailoring care to be appropriate to people with additional needs by making reasonable adjustments. For example, Medway Maritime have implemented and shared with the three Kent Trusts a system for ensuring people with a learning disability are identified and offered the support they need in line with the NHS Improvement Standards.

5.9 A Positive Support Framework has been established to support the commissioning of individually tailored services to prevent future admissions, widening the remit of learning disability commissioning to include people with a single diagnosis of Autism, and to young people.

6. Next Steps & Future Developments

6.1 To support the Transforming Care Programme an additional investment of £2.25m has been secured from NHS England, to enhance community services for people with learning disabilities and/or Autism. This investment is intended to further develop the community services to both support people leaving acute hospital settings, and better meet needs in the community to prevent further admission.

6.2 The Section 75 Board is about to consider widening the Integrated Commissioning remit to include Autism and will also consider the alignment of the team across children's commissioning in order to effectively deliver the outcomes within the NHS Long Term Plan, and the highly anticipated Social Care Green Paper.

6.3 Work with STP Local Care leads to ensure that work of the Integrated Partnership dovetails, and enables better outcomes for people with Learning Disabilities and/or Autism.

7. Financial Implications

7.1 The Section 75 Agreement sets out how the integrated commissioning arrangement operates, describes the respective responsibilities of the partners and the governance arrangements to ensure all partners to the Agreement are fully engaged.

7.2 The Section 75 Agreement has a functioning pooled budget which has respective funding contributions for the Integrated Commissioning Team, and the Kent wide integrated community teams (including mental health) under the Alliance contract

7.3 Development of processes to ensure that funding contributions from NHS England and Kent's CCGs in relation to known patients with specific complex needs are made through the pooled budget.

8. Equality Implications

8.1 The commissioning specification which is part of the Section 75 Agreement address equality issues, a major purpose of the arrangement is to reduce the inequalities faced by people with learning disabilities.

9. Legal Implications

9.1 A Section 75 Agreement is a legally binding document which provides the legal basis for integrating health and social care commissioning of service for people with learning disabilities in Kent.

9.2 A Deed of Variation has been prepared for the Section 75 Board to consider in February 2019. This will ensure the integrated commissioning arrangements remain legal and consideration is given to widening the scope of integrated commissioning to include autism and young people with learning disability and / or autism.

9.3 Medway CCG are currently seeking approval through their internal governance in order to prepare a specification to submit to the Section 75 Board with the view to becoming a partner to the S75 Agreement. This would enable available funding to be spent in the most effective way across the Sustainability and Transformation Partnership footprint.

10. Conclusions

10.1 The Section 75 Agreement has formalised the partnership between KCC and the seven CCGs in Kent, ensuring that adults with learning disabilities in Kent are served by an experienced and knowledgeable team, maintaining expertise to advise all partners regarding delivery against the NHS Long Term Plan.

10.2 The Agreement has also ensured that the resources of all partners can be effectively and efficiently used to deliver good quality integrated care for people with learning disabilities and continue to reduce the inequalities which they face.

10.3 The Agreement will continue to develop the partnership arrangements so that the resources of all partners deliver good quality integrated care to benefit people with autism, and prevention of escalation of need in young people with learning disability and/or autism, to both reduce inequality and ensure that money is more effectively spent.

11. **Report Author -** Xanten Brooker and Emma Hanson
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Kent County Council Adult Social Care and Health

Transforming Care Review Project

Our progress on implementing the Transforming Care Review against the national framework, identifying gaps and taking action.

June 2018

Kent County Council
kent.gov.uk

Contents

Foreword

By Penny Southern,
Corporate Director for Adult Social Care and Health

I have been part of the Kent Transforming Care Programme for over six years. I am committed to ensuring we deliver the right outcomes for individuals who require bespoke support services and we continue to develop an understanding of their needs to ensure our programme delivers a safe local service.

I do not know anyone in our services in Kent who were not affected by the reporting of the significant failings which rested in the culture of abuse at Winterbourne View.

It was shocking to see and to read about this scandal and I was determined to make sure that the Kent Transforming Care Programme learnt lessons from this, and that it delivered person centred services to individuals and their families who do not need to remain in a hospital environment.

To date, Kent have discharged 44 individuals into local services. Although the National Programme's focus was on planning and discharge of individuals from acute hospital settings, the Kent and Medway Transforming Care Board supported my request to undertake a comprehensive review of everyone we worked with who had moved from an acute hospital setting over the last four years of the programme.

I felt it was crucial to hear the voice of the individual and their families on the experience of the programme, but also the voice of the staff in Health & Social Care and to find out how they had responded to the programme.

I wanted to know how services have been commissioned, how providers have responded to the challenges and what lessons could be learnt of the Transforming Care Project Team for the people we need to continually work with to ensure a timely discharge and a sustainable service to meet their needs.

I am delighted that the Board supported this piece of work and they have agreed to monitor the implementation of the 14 recommendations made in the report. This will enable us to continually improve our services and how we response to the individuals we still need to support through the Kent and Medway Transformation Programme.

I want to thank Alan Stewart for the commitment to this piece of work and the care he has taken to spend time and listen to the people he visited during the review. I also want to thank all the individuals and their families, the staff and providers of services for all their contributions to this review.

Penny Southern
Corporate Director for Adult Social Care and Health

Transforming Care Review Project



Written by Alan Stewart
Transforming Care Project Officer

1. Introduction

Transforming Care is a national programme which has been established to improve services for people with learning disabilities and/or autism who display behaviour which is challenging and who may also suffer from different mental health conditions.

Locally, Kent and Medway have been grouped together to form the Kent and Medway Transforming Care Partnership. Kent and Medway are both committed to working in Partnership to implement Transforming Care when it is prudent to do so, such as when there is a clear benefit to service users and their families and carers or when there is a clear cost benefit to working together.

An integrated commissioning structure has been in place in Kent since 1st April 2016 to enable Kent County Council and the seven Kent Clinical Commissioning Groups (CCGs), to make sure the NHS in Kent and KCC work together to make a real difference for people with learning disabilities, by pooling their resource and expertise. In Kent, we have been working hard across health and social care to ensure that people in hospital, who are no longer receiving active treatment, can be discharged safely into the community.

2. Project brief

At the Kent and Medway Transforming Care Partnership Board which met on September 29th 2017 it was agreed to plan and implement an independent review of all the Kent patients who had at that point been discharged from hospital under the Transforming Care programme. The review would determine:

If the programme is delivering:

- better outcomes and/or quality of life for service users.

If the programme's requirements are being met by:

- integrated commissioning
- provider delivery
- specialist health and social care assessment and review.

If the provision is providing:

- value for money for the commissioner.

3. Methodology and time-frame.

It was decided that the information that would inform the outcome of the review would be best obtained by visiting providers, and carrying out face to face interviews with placement managers and with as many service users and their families as possible.

The basis for these interviews would be the key questions facing the review;

- **Has the transforming care programme succeeded in improving service users' quality of life?**
- **How has this been achieved?**
- **What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital?**

Care managers and care coordinators would also be contacted and joint visits to placements would take place with attendance at some reviews where possible. It also became clear that the views of carers who have experienced all the highs and lows of their relatives' journey through their care pathway, would be essential if we are to obtain a full and clear picture of how effective the Transforming Care Programme has been, and shape services for the future. Interviews would therefore be arranged with some carers to collect their views and record their experiences.

The effectiveness of the discharge process would also be evaluated by examining the discharges that took place in 2017. The care managers and care coordinators involved would be contacted for information which would determine whether the responsible agencies are managing discharges to an acceptable standard.

Stage 1: Information gathering and initial data collection: four weeks

The project started at the beginning of October 2017 with a clear brief, but before setting out to review all the patients who had been discharged and measure the effectiveness of the Transforming Care Programme I needed to do two things:

1a) Read key documents to acquaint myself with relevant information about national and local Transforming Care Implementation Programmes.

These included:

- Building the Right Support (2015)
- Service model for commissioners of health and social care services (2015)
- Care and Treatment Reviews (CTR's): Policy and Guidance
- Kent and Medway Transforming Care Plan
- Transforming Care Programme 'Medway The Current Picture'.

There is a comprehensive list of documents available on the NHS England website: www.england.nhs.uk/learning-disabilities/care/

1b) Produce an effective set of data.

The size of the task was unclear and there was no collective information or central Transforming Care database detailing who this specific group of service users are, where they are placed and who is involved. I was provided with a list of names held by the commissioners and a spreadsheet provided by finance. These needed to be cross-referenced to achieve a coherent picture of the workload of the review.

It soon became clear that the information that was held was out of date, with three service users having moved placement, and a number having had a change of care manager or care coordinator.

At the outset the number of Kent patients who had been discharged from hospital under the Transforming Care Programme stood at 35, and

as the review has progressed the number has increased to 44. All the service users' details needed to be checked on the electronic information systems of both Kent County Council (KCC) (SWIFT) and the Kent & Medway NHS and Social Care Partnership Trust (KMPT) (RiO) to ensure that there were accurate details of address, provider and care manager/care coordinator.

KCC has Local Authority responsibility for this group of service users, but in some cases the lead professional is one of the KCC staff seconded to KMPT the local secondary mental health provider. In all cases I had to obtain the service users' KCC SWIFT number before I could confirm their details and the identity of their care manager and then establish whether the case was being managed by KMPT. Where KMPT was the lead agency involved I contacted the appropriate CMHT to confirm the identity of the care coordinator. I also liaised with the administrator for the mental health Complex Needs Panel to confirm the details of the service users who had been referred to the panel.

Meetings were also arranged with the following key individuals:

- Chris Beaney, Assistant Director Lifespan Pathway, Community Learning Disability Teams.
- Stuart Day, KCC Senior Accountant, to review the information held by the finance department and included in their spreadsheet.
- James Kerrigan, Commissioning Manager of Kent Integrated Learning Disability Services, to cross reference the information held by the commissioners with that held by finance.
- Sue Young, National Health Service England Case Manager, to confirm that details of the Kent patients discharged from National Health Service England funded secure hospital placements.
- Troy Jones, KCC Commissioning Officer, to obtain up to date details of providers and their service managers.

- Cheryl Fenton, KCC Assistant Director Mental Health, to review those service users who had been placed via the Complex Needs Panel.
- Lorraine Foster, Medway Council and Medway Clinical Commissioning Group Programme Lead for Partnership Commissioning, to discuss the report Transforming Care Programme 'Medway The Current Picture'.
- Keith Wyncoll, Transforming Care lead for Skillnet Group, to discuss the Co-Production Forums.
- Hannah Chandler, KCC Administration Officer for Transforming Care, who would manage the database.

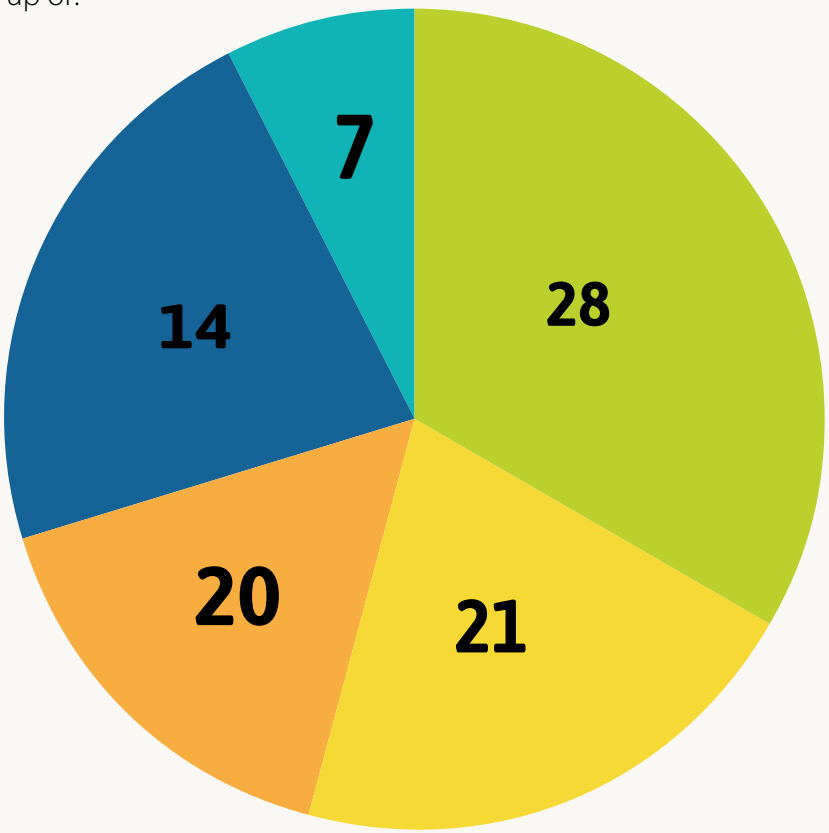
The finance spreadsheet formed the basis for the database, and it was expanded to include SWIFT ID numbers, personal details (date of birth etc), placement, care manager/care coordinator details and costs.

The spreadsheet also includes a list of all the providers who are or have been involved in providing services to this group (both by organisation and by individual facility) and the date and result of the latest Care Quality Commission inspection has been added. There is also a comprehensive list of the 77 current Kent in-patients which includes their personal details, the progress that they have made in their treatment programmes and the stage that they have reached in their Transforming Care Pathway.

Interviews by type

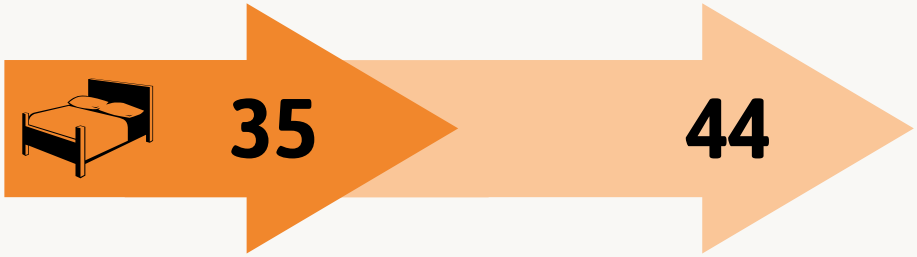
I interviewed a total of 81 made up of:

- Care managers and care coordinators 28
- Providers 21
- Service users 20
- Carers 14
- Reviews 7



Number of discharges

The number of service users discharged under Transforming Care has increased from 35 to 44 during the course of the review.



The creation of a comprehensive database has been essential in the effective review and ongoing monitoring of this important group of service users. A group of staff have been given read only access to the database, but to ensure accuracy the responsibility for modification remains with only two staff - the transforming care administrator and the senior accountant from finance. It is the responsibility of all other staff to inform them of any changes that need to be made.

Recommendation 1: *The creation of a database is essential.*

Stage 2: Communication - contacting care managers, care coordinators providers and service users: two weeks

Once the database was created and the initial contact information collected I was then able to begin planning the next stage of the review process which was to inform care managers, care coordinators providers and service users of the review and begin arranging to visit placements.

Letters were produced for care managers and care coordinators which informed them of the review project, explained why it was being undertaken and outlined its aims. The letter also informed them that more information was available on the KCC website and included a link to the NHS England website and a recommendation that *Building the Right Support* would provide a very helpful summary of the Transforming Care Programme.

A letter in easy read format was also produced for service users and sent out to providers asking them to discuss the review with the care manager or care coordinator and decide who would be the best person to share the letter with the service user.

Stage 3: Face to face interviews with providers, service users, care managers/ care coordinators and carers

Interviews were arranged to start during the second week of November. Information gathering took the form of face to face interviews where the following eight questions were addressed:

A. Does the current care package meet the needs of the individual?

B. Has the individual's quality of life improved?

C. Have the level and range of risks presented and described as in-patients reduced, decreased or not presented in the community.

D. Have the current costs of after-care decreased from the costs at the point of discharge?

E. Does each individual have an identified representative from the relevant community learning disability or mental health team who reviews their care, has the appropriate skills to manage the case and has completed the statutory reviews?

F. What is the frequency and range of MDT of support to the individual from the locality community teams?

G. Is the provider providing capable and sustainable support to the individual despite their needs?

H. Has the placement been appropriately commissioned and is there evidence of:

- Person Centred Planning
- A detailed Placement Specification incorporating the PCP and clinical and risk assessments.
- Training, skills and experience of the provider that is matched to the provider requirements in the Placement Specification
- The support plans and commissioned hours matching the assessed needs of the client.

Currently the number of face to face interviews and email/telephone contacts is as follows:

- Service users: 16 at face to face interviews, four attended their review and two I met briefly at their placement
- Carers: 14 in total
- Reviews: seven - (four service users did not attend)
- Providers: 21 visited and one by phone discussion
- Care manager/ care coordinator: 28 in total by interview, at review or by email/ telephone.

4. Findings and recommendations

A. Does the current care package meet the needs of the individual?

The interviews did not produce any major concerns about the current placement or the package of care. The overwhelming view of the nine sets of carers interviewed was that they were just glad that their relative was no longer in hospital and the predominant emotion was one of relief. Five voiced their concerns about the quality of care provided in hospital, and the distances involved in visiting on a regular basis.

Concern was expressed by two sets of carers that placement reviews should be more frequent, and two carers expressed the view that care managers and care coordinators should be far more rigorous in ensuring that the package that is being commissioned is actually being delivered, and that what is being delivered is satisfactorily meeting the service users' needs. Three carers stated that the placement may not meet all their relatives needs but that was preferable to their relative remaining in hospital.

I have had direct discussions or correspondence with 28 care managers and care coordinators and have not been informed of any concerns about the quality of placements. They have informed me that they are satisfied that the packages of care do meet the needs of the individual, although they recognise that reviews are not as often as they should be to ensure accurate monitoring. In many cases the care manager or care coordinator was relatively new to the case. Changes seem to be frequent.

One case was unallocated at the time of the review and being dealt with via the locality duty system.

Eight carers and three service users raised concerns that there is a lack of continuity because of the regular changes of care manager or care coordinator. One provider mentioned that the care manager attending the review can be a different one each time which makes it difficult for the rigorous monitoring of care packages that some relatives would like to see if the only monitoring of the care package is annually and by a different professional who has no knowledge of the case. It was suggested by one provider and by two carers that occasionally reviews have been carried out by an unqualified member of staff in the absence of a care manager or care coordinator. I also attended two reviews that were carried out by a care management assistant.

Everyone involved appears satisfied with the packages of care being offered, so the conclusion to be drawn is that this amounts to a general acceptance that needs are being met in the absence of more detailed information. It is not evident that the current monitoring process is in any way designed to reassure everyone that care packages do meet the needs of the individual. The reporting process should demonstrate how the commissioned hours are being provided, and whether those hours are commissioned accurately.

Recommendation 2: *There is a need for more regular reviews given the complexity of these cases. The frequency of reviews (1,3 or 6 monthly) should be agreed and evidenced in supervision by the case holder.*

B. Has the individual's quality of life improved?

19 of the service users, and all 14 of the carers interviewed were overwhelmingly in agreement that their quality of life had improved since they were discharged from hospital. It was clear that the very fact that they had been discharged from hospital was seen as an automatic improvement in their eyes. This is in some ways a great positive, but it is essential that everyone recognises that discharge is not simply the end objective and that staying out of hospital and presenting few problems should not lead to an assumption that the care package is providing all that it should.

The positives for the relatives and service users were often not about the current placement but were focused on the improvements in their circumstances since discharge from hospital. There were no longer long distances for relatives to travel, and they therefore felt much more involved in the care process. They were also not having to deal with hospitals who they felt were not very helpful, and in some cases delivered poor care. Changes in Care Coordinator or Care Manager meant that they did not hear from the local authority as often as they would have liked. They complained of poor communication from the hospital, with three carers describing the regime as oppressive, and stating that periods of inpatient treatment were over-long. They also spoke of their relative's excessive weight gain in hospital and concerns for their physical health.

Although carers felt very strongly that their relatives' quality of life had improved since discharge there were some who felt that there could still be more community integration and an increase in activities that are available.

One relative suggested that providers could be more imaginative when identifying and providing activities. Two service users also said that their opportunities were somewhat limited by staff availability and that there should be a wider range of activities. When asked about this, providers did say that opportunities can be limited by the conditions under which some service users have been discharged and not all requests can be facilitated. One residential home has five residents discharged under Transforming Care who have complex histories, three of whom are subject to formal supervision. The manager's view is that despite the risks which still remain their quality of life has improved since discharge.

***Recommendation 3**: In the care plans there must be evidence that robust discussions have taken place concerning the suitability of activities requested by a service user who is subject to supervision.*

Service users were generally of a mind that their circumstances and quality of life had improved, and particularly mentioned the ability of their families to visit them more regularly.

I have attended seven reviews, liaised directly with 28 care managers and care coordinators and undertaken a survey of 11 discharges in 2017/18 and all agree that there has been an improvement in service users' circumstances and feel that there is considerable support on offer with access to the community where at all possible. There must be some restrictions in certain cases but there has still been an overall improvement in their quality of life.

***Recommendation 4:** When considering suitable community activities for service users there must be evidence that robust risk assessments have taken place.*

C. Have the level and range of risks presented and described as in-patients reduced, decreased or not presented in the community.

There have now been 44 people discharged under Transforming Care and there is clear evidence of positive risk taking given that some cases are very complex with offending and forensic mental health histories. Some service users have a range of disabilities and require close management with considerable health and social care input.

Care managers and care coordinators felt that despite the potential for problems following discharge risks have been managed effectively with no readmissions and only one example of re-offending. Risks have even been reduced as has the level of supervision with some service users being discharged from their Community Treatment Order. Regular Care Programme Approach Reviews and Multidisciplinary Team Meetings have been essential in providing a coordinated clinical approach to case management. Only one service user complained of late CPA Reviews. Two providers stated that they are reassured by the availability of the Complex Case Response process if problems arise.

So far there have been some issues raised which demonstrate the problems that can arise if communication isn't effective. Five providers have suggested that sometimes there is a lack of detailed risk information made available, and that on occasion they have had to chase professionals for basic information and clarification of specific details which they need if they are to manage the placement effectively.

***Recommendation 5**: Professionals involved in the discharge of a patient from hospital should ensure that all relevant clinical information, (particularly information relating to risk (including lessons learned from SI investigations) is made available to the service managers of possible placements to ensure that the appropriate provider is identified.*

Providers also feel that the lack of care manager and care coordinator continuity is a risk as it seriously affects their ability to communicate with the local authority and the mental health trust. Quite often they do not know who they should approach if they have issues that they want to discuss. This can be particularly important when the service user is subject to statutory supervision. One provider was awaiting the allocation of a social supervisor for a service user subject to Ministry of Justice supervision under Section 42 of the Mental Health Act. There were decisions to be made about this resident's leave which were being delayed because of the lack of an allocated social supervisor. Two providers and three carers suggested that there should be a specialist service to manage this group of service users.

There was also concern expressed about the lack of forensic community follow up for service users with a learning disability. There are also examples of late CPA reviews. This is not necessarily due to the lack of an allocated care coordinator but a combination of issues including poor administration, large case-loads, and organisational changes.

***Recommendation 6**: This is a group of service users with complex clinical histories. Some will have had contact with the Criminal Justice System and may be subject to statutory supervision. Cases should only be allocated to staff with the appropriate knowledge, skills and experience.*

Six carers and five providers raised their concerns about the lack of suitable local emergency provision for anyone with a learning disability who requires readmission to hospital. Since the closure of the Birling Centre in 2014 it is likely that an emergency readmission would result in an out of area admission. Four carers

were complimentary about the Birling Centre as it provided a safe and secure environment for their relative after a period of unsettled and disturbed behaviour in the community. They are not keen on further experiences of out of area placements.

One service user in a residential care home was concerned about a lack of suitable move on accommodation as he would like to be near his parents, but there isn't anything that would be appropriate in that area of the county. This issue was also mentioned by five providers.

They feel that many service users have complex histories and that the step down from residential care to supported accommodation is currently too great for them. One manager felt that the gap between residential care and supported accommodation was far too great for many of his residents and that gap needs to be filled by appropriately commissioned services.

***Recommendation 7**: Commissioners in Kent should give serious consideration to the creation of enhanced supported accommodation as part of the Transforming Care pathway.*

D. Have the current costs of after-care decreased from the costs at the point of discharge?

The KCC finance department have continued to improve the quality of the information held on the database, and regular meetings have been set up to ensure that current and accurate information is available which informs the Transforming Care Board about the cost of each care package. The number of service users discharged under the Transforming Care Programme now stands at 44.

KCC finance have struggled to obtain information at the point of discharge and often were only aware of a discharge under the Transforming Care Programme when payment costs began appearing on the KCC Oracle system. This could be some months after the service user was discharged from hospital.

They have also not been informed of NHS costs so have not been clear in many cases of the proportion of the total local authority and NHS costs per care package. This has made it difficult to establish the total cost of the programme.

Finance have obtained a SWIFT printout of all the care packages under Transforming Care and have been able to compare current costs to those at the point of discharge. The initial finding is that there has been very little reduction in the cost of the after-care packages.

When contacted care managers and care coordinators stated that cases may show a slight reduction in costs as some have been 'tweaked'. However the general response from them which is borne out by the work of KCC finance is that packages remain mostly unchanged.

The current review process means that packages of care can remain unchanged for considerable periods of time. Some of the packages are high cost and that there needs to be a change in the frequency of the reviews if there is to be accurate monitoring of the delivery of these packages of care, appropriate changes made according to client need and costs adjusted accordingly.

It must be said that this group of service users have complex needs and this is reflected in the cost of their after-care. It is essential that we regularly check to ensure that the packages of care are appropriately commissioned, that they are being delivered and that they meet the needs of the service user. The only way to ensure this is to review them on a more frequent basis and ensure that these reviews are robust. Whether the reviews should be carried out by the care manager or care coordinator is an issue that should be considered. At the moment the lack of continuity of allocated professionals appears to impact on the regularity of reviews, and when the review is carried out by a new worker it is quite possible that a lack of knowledge of the case means that changes to the package are less likely to be suggested.

***Recommendation 8**: KCC should consider whether all service users discharged under Transforming Care should be supervised by a central specialist team rather than by local care managers or care coordinators.*

E. Does each individual have an identified representative from the relevant community learning disability or mental health team who reviews their care, has the appropriate skills to manage the case and has completed the statutory reviews?

It became clear that care managers and care coordinators change on a regular basis, and it was soon apparent that the care manager or care coordinator who had been involved in the discharge process was no longer the allocated professional at the time of this review project. Most cases did have an allocated care manager or care coordinator but quite often they were new to the case and the latest review would be their first meeting with the service user.

One case is currently being held by the duty team and as the review project has proceeded there have been changes, and in some cases more than one. This is not to suggest that care management reviews and care programme approach reviews are not taking place, but it can mean that they are delayed. Also, it can be the case that a review can be the first time that the provider and the service user have met the allocated worker. This can unquestionably lead to a lack of continuity.

Four relatives complained of constant changes of worker and a lack of contact with KCC or KMPT. Eight providers have also said this and suggest that this may mean that reviews are not occurring as frequently as they should. It has also been said by one provider that unqualified staff have been sent to reviews either because the allocated worker is unavailable or because the review has come at a time when the case needs reallocation. I attended two reviews that were led by an unqualified care manager assistant.

There have been concerns expressed by providers that the mental health trust seems to be having staffing problems and that allocated care coordinators are not very 'visible'. One provider stated that their attendance at statutory Mental Health Review Tribunals or Managers Hearings cannot be guaranteed. Communication with providers, service users and relatives could be much improved. I have been informed of a service user who doesn't know the identity of his statutory supervisor under Section 42 of the Mental Health Act (Ministry of Justice Supervision), and another who has struggled to establish the identity of her care coordinator at a time when her CPA Review is three months overdue.

At the beginning of the review project I found that many of the names that were given as the allocated professional were wrong and it took some time to obtain up to date information. When emails were sent to the worker responses were slow and even between updating the list and contacting the worker there were occasions when I found that there had been another change. One would hope that the significance of Transforming Care would ensure that priority would be given to this group of service users, but care managers and care coordinators are managing very large case-loads with conflicting priorities. Knowledge of Transforming Care seemed to be rudimentary and when asked if they had received any training many said that they had not. KCC has had a major reorganisation during the last few years and this was cited by staff as a reason for the lack of continuity of worker and for the inability to attend training on Transforming Care.

***Recommendation 9**: The training programme for Transforming Care should be reviewed.*

F. What is the frequency and range of MDT of support to the individual from the locality community teams?

One service user did complain about continuity and changes of worker. Eight providers and four relatives said much the same thing and feel that

although reviews do take place they are not always to time. There also appears to be some uncertainty about which team is involved and whether it is the CMHT from the mental health trust or the integrated CLDT from the local authority.

Most of the service users had been detained in hospital under the Mental Health Act and are subject to Section 117 after-care. They have complex histories and diagnoses, and in many cases can present risks both to themselves and to others. A number have committed offences and five are subject to statutory supervision by the Ministry of Justice under Section 42 of the Mental Health Act or monitoring and supervision via MAPPA, SHPO and the Sex Offender Register. Five others are subject to supervision under a Community Treatment Order (CTO) and five others were originally supervised under a CTO before it was discharged.

One service user and her relatives have raised concerns about the range of MDT support available.

A recommendation had been made as part of her discharge plan that she should be followed up by the eating disorder service and the psychological services. This had not happened, and the provider in this case has suggested that access to local psychological services is affected by the length of waiting lists. This service user was placed back in Kent after a long period of out of area inpatient treatment and was placed with clear treatment recommendations. It has been difficult to facilitate these recommendations.

Given that many service users have complex mental health histories one care manager voiced some concerns that these cases may be closed to the local CMHT and managed by the local adult services team, or that if still open to mental health the transfer to the local CMHT may be delayed. There are delays transferring CPA responsibility to the CMHT local to the placement if they have been managed and placed by a team from another part of the county. These issues have raised anxieties for providers if there is a clear mental health history, and mental health support is being provided from a distance. One care coordinator is currently trying to arrange a handover CPA review to the CMHT which is local to the placement after managing the case at distance for nine months.

Some service users are placed in residential homes where the provider has a contract which includes the provision of in-house multidisciplinary support, but local services remain involved in a care management or care coordination role. These providers have MDT support and there are fortnightly multidisciplinary meetings held which have regular input from other disciplines. Three such service users have mentioned the importance to them of regular sessions with the psychologist. It has been suggested that liaison between this in-house provision and local services could be better. The management of the service user under the mental health act still requires local input from KMPT and according to providers this could be better.

Generally, care managers, care coordinators and providers who have contributed to the review think that the frequency and range of MDT support is acceptable, but could be improved if there was more clarity about areas of responsibility. One service user also was unclear why his case was closed to KMPT once his CTO was discharged.

***Recommendation 10**: The discharge planning process begins in hospital with the Care and Treatment Reviews. NHS Care & Treatment Reviews: Policy and Guidance (Appendix 2) sets out the 10 discharge standards which should be met by effective use of Person Centred Planning.*

G. Is the provider providing capable and sustainable support to the individual despite their needs?

I have attended seven reviews, and undertaken a survey of 11 discharges in 2017/18. I have also liaised directly with 28 care managers and care

coordinators and they are of a view that most placements are satisfactory and that providable and sustainable support is being delivered. There is a range of provision on offer which is designed to meet the needs of a group of service users with complex needs. They also talk of the experience of some of the providers who have been managing service users with complex histories and challenging behaviour for many years.

Many of the 44 service users are placed in residential care and some of the placements include the provision of a multidisciplinary team. There are providers who specialise in dealing with service users with a learning disability who also have mental health problems. It is essential that these providers have a full understanding of the issues involved and that they have all the necessary information available to enable them to manage some of the complex behaviours that are presented.

Four providers did say that they sometimes do not receive all the information that should be available to them. It is necessary that they communicate effectively with the local authority and with the mental health trust and that they are also able to feel confident that support from those agencies and from primary care is available when required. Four providers have stated that they do feel "left to their own devices" at times and the lack of continuity of care managers and care coordinators and their inability to visit as often as providers would like does leave them feeling isolated.

***Recommendation 11**: Case holders must ensure that information relating specifically to risk and which would affect the providers ongoing ability to provide capable and sustainable support should always be shared.*

All 14 carers interviewed are relieved that their relatives are no longer detained in hospital and see that as the greatest positive of their placement in the community. Most are satisfied with the placement and praise the efforts and the quality of support provided. One carer has felt the need to request copies of reports to satisfy herself that her son has an active programme and that his needs are being met. They have some issues that they would like to see addressed and five carers would like to see an improvement in the communication from the provider, and one suggested a more imaginative use of activities and more support to get involved in occupational activities in the community.

Of the 16 service users who have had a face to face interview only one said that he doesn't like his placement. His view was not shared by the two other service users at this facility who were interviewed, and his opinion may be coloured by the fact that he says that he did not want to return to Kent when he originally left hospital.

H. Has the placement been appropriately commissioned and is there evidence of:

- Person Centred Planning
- A detailed placement specification incorporating the PCP and clinical and risk assessments.
- Training, skills and experience of the provider that is matched to the provider requirements in the placement specification
- The support plans and commissioned hours matching the assessed needs of the client.

When considering appropriate and effective commissioning I looked most closely at 11 discharges from hospital which took place in 2017/8. I hoped that by focussing on recent discharges the care manager/care coordinator involved in the discharge planning would still be in post, and that there would be a completed placement specification form (This had been developed by the commissioning manager/transforming care lead) I also met with Sue Young the National Health Service England case manager who leads some of the Care and Treatment Reviews at the hospitals.

Person Centred Care Planning: There was clear evidence of person centred care planning. In all the 11 2017/18 discharges reviewed the service

user was fully involved in discussions about the proposed placement. Sue Young confirmed that Service users are always invited to their CTR's and that most choose to attend.

There was evidence that service users were fully supported. One was finding the process quite upsetting as identifying a placement was proving difficult. Her VoiceAbility advocate therefore took an active role in supporting her. Two service users were placed out of area, and they were fully involved in the discussions about their future placements. One could not return to Kent because of victim issues, and the other wanted to live closer to his parents in the southwest. Both gave consent for their teams to seek placements and were fully involved throughout the process. They also both consented for their clinical and personal information to be shared with the mental health services who would take over their management.

Service users were given as much choice as possible and all 11 had the opportunity to meet staff and visit their proposed placements before discharge. They were fully involved in the discharge process and consulted about potential placements. Carers were also as involved as possible.

Placement Specification: The placement specification form produced by the Commissioning Manager of Kent Integrated Learning Disability Services was not used in any of the 11 2017/18 discharges.

However, it was clear that all discharges had followed full multidisciplinary and multi-agency discussions which relied upon comprehensive clinical and risk assessments to inform decisions regarding the most suitable type of placement. Sue Young confirmed that discharge plans were always formulated after considering full multidisciplinary reports and needs assessments which would be presented at the Care and Treatment Review. They also have the chance to discuss their discharge plans at multidisciplinary ward rounds and at CPA Reviews. CTR's should work alongside the CPA process.

One case required the use of an independent assessor to recommend an appropriate placement as the family were unhappy with the proposed care pathway. There were also diagnostic issues, and once these were resolved an appropriate placement was found.

The placement produced a very detailed specification which demonstrated that the service users' needs could be appropriately met.

Recommendation 12: *The Kent and Medway Transforming Care Programme Person Centred Placement Specification form must be used in all cases. The form must be recirculated to all teams to ensure its use.*

Training, Skills and experience of the provider: All the Care Coordinators and Care Managers involved in the 2017/8 discharges were satisfied with the outcomes. They were guided by knowledge of the commissioning team and often the discharging hospital had previous experience of the proposed provider. In three cases the commissioners had already identified the most appropriate placement in advance of the care manager or care coordinator.

The review of 2017/18 discharges didn't establish how much information care managers and care coordinators have about the training, skills and experience of the provider. In many cases the original choice of placement was the

only one available. The placement chosen was usually at the recommendation of the hospital team, the commissioners or the care manager/ care coordinator and those choices were based on previous experience of working with the provider and confidence that they were able to meet the needs of the service user. In two of the 2017/18 cases the choice was not based on previous use of the placement as the service user was placed out of area. In those instances, liaison with local health and social care providers plus personal assessment of the placements being offered reassured those involved that the provider had staff with the necessary training, skills and experience to meet the needs of the service user.

***Recommendation 13**: Staff who are seeking to identify placements should always consult the Commissioning Team.*

The support plans and commissioned hours matching the assessed needs of the client.

Care managers and care coordinators did not express any concerns about the choice of placement, and despite the lack of a detailed placement specification form feel that the process worked effectively with the local authority and Clinical Commissioning Group (CCG) leading the discussions. There were full multidisciplinary meetings held at the hospital where clinical issues and risk factors informed the discharge plans and the choice of placement. Service users and relatives were as fully involved as possible, and advocacy services used when required.

I have had meetings and correspondence with 28 Care Managers/Care Coordinators and all were satisfied that the support plans that were put in place were appropriate and agreed after considerable in-depth discussion.

Providers were of the view that the commissioning process is effective and that the different stages of the transition process from initial referral through to discharge from hospital ensures that the service user is ready to move in to their placement. Providers also stated that they were satisfied that the assessment and subsequent familiarisation process ensured that the agreed package of support would match the needs of the client.

Discussions about the 2017/18 discharges and about earlier placements under Transforming Care raised some concerns about the transition process. 13 providers said that they felt that the transition process is too long and therefore costly. They recognise that this group of service users have complex needs, are detained under the Mental Health Act, and that there are various reasons why the client cannot be immediately discharged and that there must be a thorough assessment and familiarisation process if the placement is to proceed.

However, they feel that this comes at a cost to the provider that can be prohibitive, particularly if the provider is one of the smaller ones. There is the initial cost of their visits to the hospital to carry out their assessment. If they then agree that a placement would be appropriate there is the cost of keeping a vacancy in order that the client is able to have day visits followed by overnight leave. The transition process can take months and represents a considerable loss of revenue.

Recommendation 14: *The local authority and the NHS commissioners should develop a whole systems approach to the funding of the transition process.*

One provider also raised the issue of readmission, and the cost of support that might be needed from the provider if the vacancy is being held. Providers also have concerns about the funding process and three specifically mentioned the length of time that can be taken before funding is agreed. They also spoke of unacceptable delays in receiving payment. One stated that there was a problem with the Financial Activation Notice, and four complained of slow payments from both the local authority and the NHS. Three also

mentioned the different invoicing and payment cycles of the local authority and the NHS.

Five carers also raised their concerns about the length of time that transition takes and how keen they were to leave hospital. Four service users said that said that they hated hospital and couldn't wait to move. Four others said that it took far too long for their move to take place and two complained about funding difficulties which slowed the process. It must be said though that there were no major concerns raised by service users or carers about the placements or the support plans that have been put in place.

The effectiveness of the discharges in 2017/18 reflects the way in which the process has been developed and refined since the beginning of the Transforming Care Programme. This is demonstrated by a discharge which took place in 2015 where the provider was told by the hospital on the day of a scheduled visit that the service user was in fact being discharged and would be left at the placement. There have been no recent examples of such practice.

5. Conclusions

The Transforming Care Review project began in October 2017. The task was to review all the Kent patients who had been discharged from hospital under the Transforming Care programme. At that point the number stood at 35, and the effectiveness of the programme can be illustrated by the fact that the number of discharges has increased to 44 as the review has progressed.

I have had the opportunity to meet service users, carers, providers and professionals with first-hand experience of the Transforming Care Programme and have been pleased with the positive responses that I have received, both to my initial request to meet and to the questions put at interview. Everyone who has contributed has been positive and upbeat about the success of the programme in facilitating the discharge of a group of service users with complex needs and challenging histories who in many cases have spent considerable lengths of time in secure institutional care. For many the very fact that the service user has been discharged from hospital is success in itself.

The review set out to obtain the views of everyone involved to establish whether the Transforming Care process was effective and the interviews and the analysis of the 2017/18 discharges were intended to highlight areas where the programme was succeeding and identify where improvements could be made.

As stated above there have now been 44 people discharged under the Transforming Care Programme, and this number is set to increase noticeably as new facilities being developed through the work of the integrated commissioning team together with local providers come on stream during the next year.

During the programme there has only been one example of a failed placement with the person involved committing an offence and being imprisoned. There have been no readmissions to hospital. That represents a major success as this is a very challenging group of individuals with complex needs, and difficult histories.

Many discharges could be described as examples of positive risk taking combined with detailed and comprehensive care planning and effective support and supervision in the community.

The review has confirmed that the programme has been very successful in facilitating the discharges of a large group of people who might still in hospital but for the positive approach and commitment of the Kent and Medway Transforming Care Partnership, the leadership of the Executive Board and the commitment of all involved in delivering services. The review has also detailed areas which could be improved and includes suggestions and 14 recommendations about how changes could be made.

The discharge process begins at the hospital, and carers have commented about the quality of inpatient care provided, and about the difficulty that they have in sustaining their relationship with their family member at distance. They have also commented that this isolation is exacerbated by the quality of the communication from the hospital and not improved by the communication with services in Kent who are also some distance from the hospital.

Service users, carers and providers have all commented on the length of time that transition takes. It can take a considerable time for placements to be identified, particularly when there are disagreements about where someone should be placed, and then for funding to be agreed. Resolving whether there should be single agency or joint local authority and NHS funding can take time as can the internal discussions within KCC when there are diagnostic issues which can require the involvement of the local mental health services. Once the placement is identified and a discharge programme put in place there is then the problem of protracted periods of leave. It is obviously crucial that leave is facilitated to ensure that a placement is an appropriate one, and to put all the elements of the Care and Support Plan in place, but this does come at a cost to the provider who must keep a vacancy throughout the leave process to enable the service user to have day visits and then overnight leave. Providers are also concerned about the amount of information that they receive when referrals are made, stating that they occasionally only discover important details about the service user after they have been discharged from hospital.

The constant changes of care manager and care coordinator have been raised by some service users, carers and providers. There have been many examples of this as the review has progressed, and there are many reasons for this both within KCC and KMPT. The obvious one is the volume of work that both organisations have and the size of caseloads. There have also been internal reorganisations, and in addition there have been problems in filling posts which have placed further pressure on teams. KCC has been taking positive steps to address the recruitment problems.

It has been suggested that this complex group of service users should receive a specialist community service particularly as many have a forensic history. Unlike service users with mental health problems discharged by the forensic service, here is no forensic outreach service provided for people with a learning disability, nor is there a community forensic service. For service users with a dual diagnosis there is confusion for service users, carers and providers about how decisions are reached about who will manage a case in the community. They also suggest that this lack of clarity is demonstrated by poor communication between organisations.

The review process following discharge also has its weaknesses, with care management reviews only being carried out annually by KCC, unlike service users being managed by KMPT who have 6 monthly reviews under the Care Programme Approach, The local authority funds virtually all the 44 people discharge under the Transforming Care programme either fully or in part, so it is essential that the local authority monitors and reviews Care and Support Plans to ensure that they are appropriate and cost effective. This responsibility is delegated to staff seconded by KCC to KMPT when the case is managed by the mental health services.

Although this group of service users receive a six monthly review of their clinical progress under CPA, it is difficult to establish whether their Care and Support Plans are also being reviewed within the CPA framework. KCC is looking to address this issue during the next few months.

The success of the programme has resulted in a large group of service users with differing needs and abilities being discharged from hospital. The placements have all demonstrated a commitment to providing a caring and

supportive environment in which the service user can continue to develop their personal skills and become as independent as possible. Opportunities within the community for social and vocational day activities are harder to come by and carers have spoken of limited opportunities. Providers facilitate social activities as much as they can but there is a need for more vocational support to encourage and enable service users to use their time more creatively. The Transforming Care Forums in East Kent which are facilitated by the Skillnet Group (a learning disability charity which supports self-advocacy) have highlighted this issue. The forums are attended both by people who are still in hospital and people who have been discharged into the community under the Transforming Care Programme.

A key finding of the forum is that people discharged under Transforming Care feel less restricted or constrained but are asking "is this all there is?" They would like the chance to have a more active community life and are asking for more vocational opportunities. In Kent there are locality forums where KCC and providers meet to discuss issues arising from the Transforming Care Programme, and it is recommended that the provision of supported employment is a standing agenda item.

There were three key questions facing the Transforming Care Review Project, which were the basis for the interviews:

- Has the transforming care programme succeeded in improving service users' quality of life?
- How has this been achieved?
- What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital.

Has the transforming care programme succeeded in improving service users' quality of life?

The view of service users and carers is that this is certainly the case. Many were very unhappy with their treatment in hospital so to be discharged was inevitably going to be seen by them as an improvement in their quality of life. This is a great positive, but discharge should not be the end objective, and remaining out of hospital and presenting few problems should not lead to an assumption that all has been achieved.

My meetings with service users, carers and providers confirmed that there is much to be commended about the changes in, and improvements to the circumstances of this group of people. They now have much more contact with their families, and in some cases have re-established regular contact with certain family members who they hadn't seen for some time. Although some are still subject to formal supervision, they have more freedom to become involved in community activities and do not feel as constrained. Some service users have made enough progress for their level of supervision to be reduced (Community Treatment Orders being discharged) and others are being considered for step down from residential to supported accommodation.

How has this been achieved?

There is no doubt that the move to integrated commissioning has had a positive effect and driven the transforming care programme. The implementation of the Care and Treatment Reviews has resulted in a more person-centred discharge focused approach, and has seen commissioners working actively to support care managers and care coordinators to facilitate discharge plans.

The discharge process has been streamlined and improved and providers feel that they are more involved in the process. The introduction of the CCR's has also given them the confidence to manage risk and offer placements to people who they may have turned down before.

Commissioners are also encouraging positive risk taking and supporting care managers and care coordinators to make creative use

of existing resources and developing care packages to enable people to be placed who once would have been considered not to fit the profile of the placement.

Providers have also demonstrated a commitment to this group of people despite the challenges that they face. The complexity around history, diagnosis and behaviour has not deterred them despite the difficulties faced by KCC and KMPT in providing regular and consistent support. Most carers are satisfied with placements and praise the efforts and quality of the support provided. They do have some issues that they would like to see addressed including an improvement in the communication from the provider, more imaginative use of activities and more support to become involved in occupational activities in the community.

What more needs to be done to improve community services and reduce the need for people diagnosed with a learning disability or autism being admitted to hospital?

The success of the Transforming Care programme is evident with 44 people having been discharged into the community and only 1 placement failing. This is a group of service users with complex needs, multiple diagnoses and histories of challenging behaviour. Some have forensic histories and are subject to formal multi-agency supervision in the community. We now need to consider what more can be done not only to sustain this success but to improve on current performance and widen the range of services on offer in the future.

Service users and carers have both said that they are pleased that discharge has been facilitated and that progress has been made in the community. The next question for many has been "what happens next?"

The type of accommodation that is available is an issue, and there appear to be gaps in the care pathway which result in limited choice. There are some service users who have been discharged to residential care who will both

want and need to move on in the future if they continue to display a consistent level of progress and remain well and present no behavioural problems. Their current placements provide considerable support and can include the provision of a Multidisciplinary Team to meet their clinical needs. However, these service users have quite well established daily living skills and in their current residential care environment have limited scope to enable them to develop more independence. They continue to require supervision but would benefit from having more personal space and responsibility.

The forensic mental health service has worked in partnership with a local provider and the commissioners to develop resources which provide an enhanced supported accommodation service. This provides individual flats or bedsits within a block, with the provider providing support and 24-hour supervision seven days per week, and communal areas for residents who want to spend time with staff or other residents. This model enables residents to have more personal space, cater for themselves and manage their day to day activities. I would recommend that commissioners consider developing this type of accommodation for service users who are ready to step down from residential care.

Vocational support is also required. There seem to be limited opportunities for service users and providers would like to be able to offer more choice for their residents. Social activities are essential to enable and support community inclusion, but there are service users who want

to develop their skills and ultimately undertake initially some voluntary work to establish whether they could be considered for paid employment.

There is also the need to consider how this group of service users are supported in the community. There seems to be confusion for service users, carers and providers alike about how decisions are reached about funding, and community follow up.
The forensic service provides outreach to people with mental health diagnoses who are discharged from secure care. Currently this service is not available to those people with a learning disability and/or autism who are discharged under Transforming Care. This gap in provision needs to be addressed as many of this group of service users have complex histories and some are subject to formal statutory supervision. The lack of involvement of the forensic service is something that providers have mentioned. They would feel more confident about managing this challenging group of individuals with specialist support. It would also hopefully provide the continuity that local teams are struggling to deliver, and they would feel more comfortable if they were able to work alongside the forensic service before assuming case responsibility following a seamless handover.

In conclusion I would like to offer the following positive comments about the performance of the Transforming Care programme in Kent during the course of the review project.

1.The programme has proved to be very successful with the number of discharges from hospital increasing from 35 to 44.

2. Only one placement has failed.

3. There is clear evidence of positive risk taking.

4. All service users and carers who contributed to the review felt that their quality of life had improved.

5. There is clear evidence of full multidisciplinary person-centred discharge planning.

6. Integrated commissioning has had a positive effect on the discharge process with Care and Treatment reviews providing a commissioner led and therefore less clinically driven discharge process.

6. Integrated commissioning has had a positive effect on the whole discharge process with CTR's providing a commissioner led and therefore less clinically driven review process.
It is essential that all 14 recommendations are agreed by the Kent and Medway Partnership Board and that an action plan and an implementation plan with named individuals is agreed and monitored by the board in order to continue to meet they needs of the individuals who have already benefited from this programme and for future people having the support to live an ordinary life in the county of Kent.

Appendix 1

Kent and Medway Transforming Care Partnership

Kent Cohort Review – Project outline - 2017

Project Description

To plan and undertake an independent review of all Kent patients discharged under the Transforming Care programme to date to determine if the programme is delivering better outcomes and/or quality of life for individuals, that integrated commissioning activity, provider delivery and specialist health and social care assessment and review are meeting the programmes requirements and the provision is providing value for money for commissioners.

Project Approach

A collaborative approach to the review of each patient with care providers, care managers/community based clinicians and CCG/KCC commissioning.

The approach will include a mix of table top reviews and face to face visits to the individual and provider as appropriate.

This TC cohort Review will dovetail with existing KCC projects aimed at reviewing support packages to avoid duplication of work

- KCC has 3 assessment tools that care managers use for assessing care and support needs; one for residential service and two for individuals that live in their own tenancies, one for support that would be in a shared property and one for individuals that live on their own.
- Targeted Interventions; this project is looking into support that is delivered above core on a one to one basis so all individuals that have commissioned support on an additional basis will be reviewed

Project Scope

The project will cover 35 patients (as at 04/07/17) for which KCC are commissioning aftercare support.

Reviews will be carried out on a provider by provider basis. There are nineteen providers including

- Craegmoor (1)
- United Response (1)
- LDC Dover (2)
- Cartref Homes Ltd (2)
- Sequence Care (5)
- CMG (1)
- Elysium Supported Living (1)
- CLBD (1)
- Nexus Programme Ltd (1)
- Caretech (2)
- Insight Partnership (2)
- Optima Care (8)

- Holly Lodge (1)
- Frontline Assoc Supported Tenancies (1)
- Bayview Care (1)
- Oaklands (1)
- Voyage Care (2)
- Phoenix House (1)
- Langley House Trust (1)

Duration of Project

Reviews will be carried out over a 3-4 month period from August 2017 with a report of findings drafted by December 2017.

Project sponsor

Penny Southern – KCC Director of Mental Health, Learning Disability and Disabled Children

Project Outcomes

1. A summary of each individual's care and support that addresses the following

- Current care package meet the needs of the individual.?
- Quality of life has improved for the individual (Community integration/participation)
- Level and range of risks presented/described as in-patients have decreased/not presented in the community
- Current costs of aftercare have decreased from costs at the point of discharge?
- Each individual has an identified representative from the relevant community LD or MH team reviewing their care, who has the appropriate skills to manage the case and has completed the statutory reviews?
- The frequency and range of MDT of support to the individual from the locality community teams? i.e. labour intensive aftercare?
- The provider can provide capable and sustainable support to the individual despite their needs?
- The placement has been appropriately commissioned i.e.
  - Evidence of Person Centred Planning (patient/family views of type and location)
  - The choice of placement was based on a detailed Placement Specification that incorporates the PCP and clinical and risk assessments.
  - The training, skills and experience of the provider is matched to the provider requirements in the placement specification
  - The support plans and commissioned hours match the assessed needs of the client

2. A summary statement of the impact of the overall programme on individuals lives.

Link to other projects

The quality and outcomes research unit at University of Kent, continues to work on a scoping review for a larger evaluation of the quality of life and quality of care outcomes experienced by people with learning disability, autism or both as they move into the community from inpatient services, as well as those who are at risk of moving into inpatient services. The

Department of Health have now advertised for the main evaluation of Transforming Care with the main emphasis on quality of life and quality of care.

Commissioners will meet with representatives from the UoK to explore opportunities for linking this project with the wider national project commissioned by the DH.
Jimmy Kerrigan

28/7/17

Appendix 2 - Recommendations

1. The creation and management of an accurate and up to date database is essential.

2. There is a need for more regular reviews given the complexity of these cases. The frequency of reviews (1,3 or 6 monthly) should be agreed and evidenced in supervision by the case holder.

3. In the care plans there must be evidence that robust discussions have taken place concerning the suitability of activities requested by a service user who is subject to supervision.

4. When considering suitable community activities for service users there must be evidence that robust risk assessments have taken place.

5. Professionals involved in the discharge of a patient from hospital should ensure that all relevant clinical information, (particularly information relating to risk (including lessons learned from SI investigations) is made available to the service managers of possible placements to ensure that the appropriate provider is identified.

6. This is a group of service users with complex clinical histories. Some will have had contact with the Criminal Justice System and may be subject to statutory supervision. Cases should only be allocated to staff with the appropriate knowledge, skills and experience.

7. Commissioners in Kent should give serious consideration to the creation of enhanced supported accommodation as part of the Transforming Care pathway.

8. KCC should consider whether all service users discharged under Transforming Care should be supervised by a central specialist team rather than by local care managers or care coordinators.

9. The training programme for Transforming Care should be reviewed.

10. The discharge planning process begins in hospital with the Care and Treatment Reviews. NHS Care & Treatment Reviews: Policy and Guidance (Appendix 2) sets out the 10 discharge standards which should be met by effective use of Person Centred Planning.

11. Case holders must ensure that information relating specifically to risk and which would affect the providers ongoing ability to provide capable and sustainable support should always be shared.

12. The Kent and Medway Transforming Care Programme Person Centred Placement Specification form must be used in all cases. The form must be recirculated to all teams to ensure its use.

13. Staff who are seeking to identify placements should always consult the Commissioning Team.

14. The local authority and the NHS commissioners should develop a whole systems approach to the funding of the transition process.

Appendix 3 - Acknowledgements

It has been a pleasure to work with all the people who have contributed to the completion of this report. I would like to extend my thanks to all the service users and their relatives who were willing to describe their experiences, and to the many staff from Kent County Council and the Kent & Medway NHS and Social Care Partnership Trust who have been involved.

I would also like to thank the following individuals and organisations:

James Kerrigan - Commissioning Manager of Kent Integrated Learning Disability Services
Cheryl Fenton - Assistant Director of Mental Health Kent County Council
Stuart Day - Senior Accountant Kent County Council
Troy Jones - Commissioning Officer Kent County Council
Hannah Chandler - Administration Officer for Transforming Care Kent County Council
Sue Young - Case Manager Specialised Commissioning NHS England
Matt Clifton - Chief Executive Skillnet Group
Keith Wyncoll - Project Lead for Transforming Care - Skillnet Group
Chris Beaney Assistant Director of Community Learning Disabilities Team Kent County Council

Voyage Care
Learning Disabilities Care (Dover)Ltd
Scott's Project Trust
Insight Specialist Behaviours Service Ltd
Optima Care
Sequence Care
Cartref Homes UK Ltd
Langley House Trust
CLBD (Changing Lives Building Dreams) Ltd
Frontline Associates Supported Tenancies
Bay View Care
Care Management Group Ltd
CareTech Community Services Ltd
Little Oyster Ltd
United Response
Avenues Trust
Harbour Homes
MCCH (Maidstone Community Care Housing Society) Ltd

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Kent Integrated Adult Learning Disability – Section 75 Partnership Arrangements

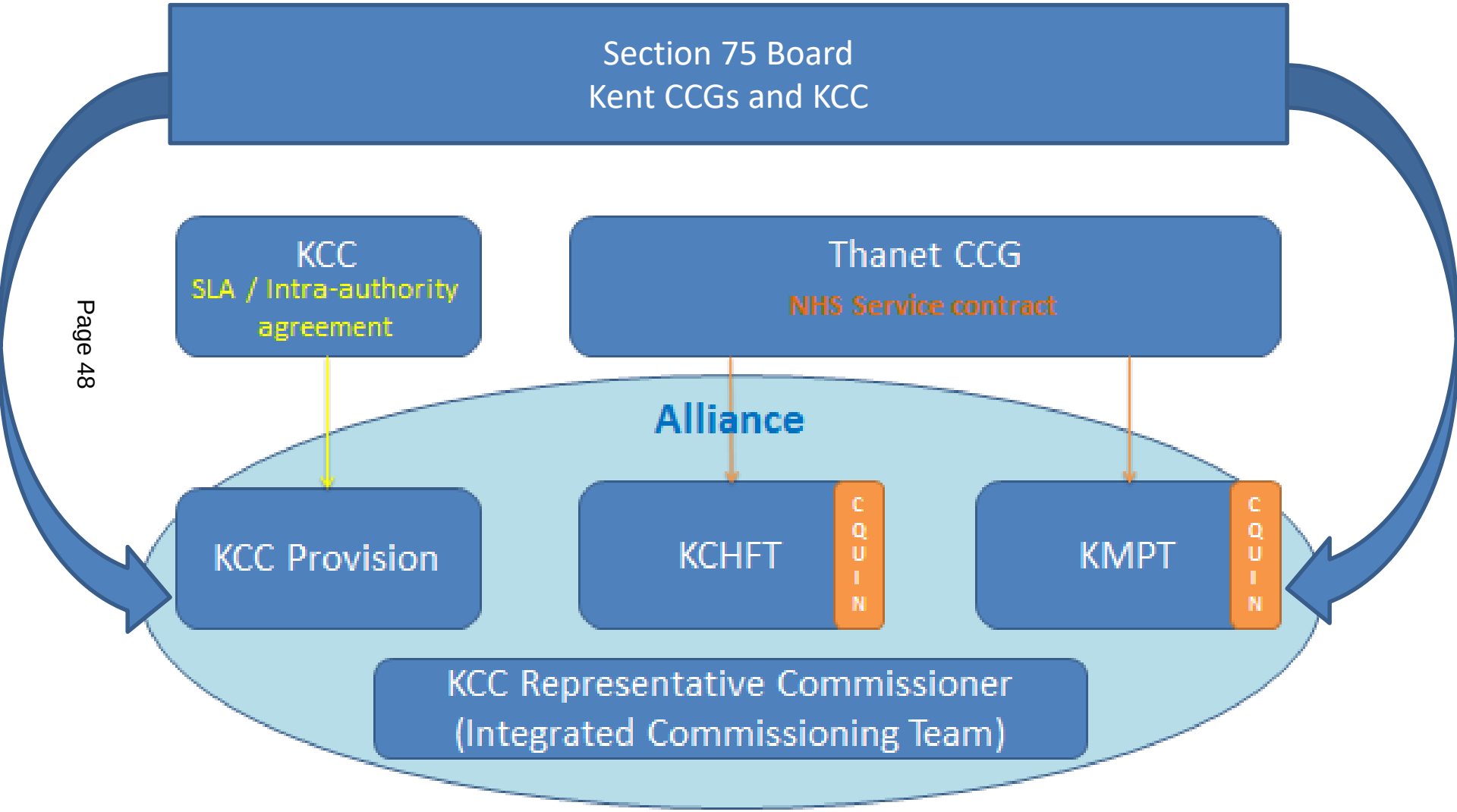
Health and Wellbeing Board
7th February 2019
Emma Hanson and Xan Brooker
Senior Commissioners - KCC

Why we integrated commissioning

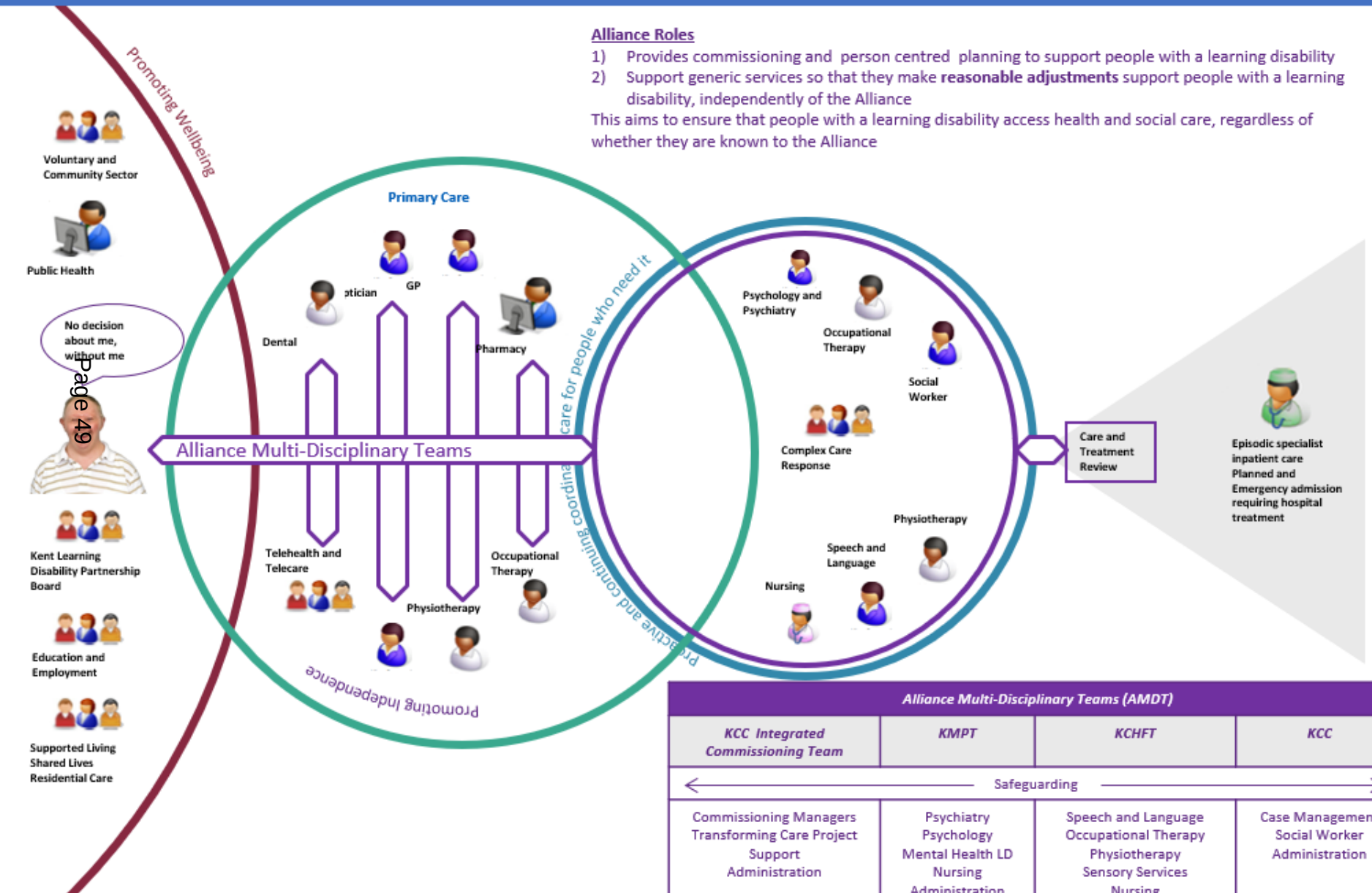
- To secure integrated care for people with learning disabilities for the future
- Deliver quality and efficiency
- Provide flexible and responsive services
- Developing a shared focus between Commissioners and Providers
- Ensure access to all health and social care for people with learning disabilities
- To provide a county wide system but delivered locally
- Contracting for improved outcomes
- Working with people with learning disabilities to co-produce service developments in a meaningful way

Why we need to continue?

How is the LD Alliance Commissioned?



What is the Alliance?



Alliance Roles

1) Provides commissioning and person centred planning to support people with a learning disability
2) Support generic services so that they make **reasonable adjustments** support people with a learning disability, independently of the Alliance

This aims to ensure that people with a learning disability access health and social care, regardless of whether they are known to the Alliance

Alliance Multi-Disciplinary Teams (AMDT)			
KCC Integrated Commissioning Team	*KMPT*	*KCHFT*	*KCC*
Safeguarding			
Commissioning Managers Transforming Care Project Support Administration	Psychiatry Psychology Mental Health LD Nursing Administration	Speech and Language Occupational Therapy Physiotherapy Sensory Services Nursing Administration	Case Management Social Worker Administration

NHS Long Term Plan - Learning Disability and Autism

1. **Tackle preventable deaths: stopping overmedication and improving health checks**
   - ❑ STOMP - Stop the Over Medication of People with Learning Disabilities
   - ❑ STAMP - Supporting Treatment and Appropriate Medication in Paediatrics
   - ❑ Health Check Programme to continue and be increased to include: Residential Schools & for people living with Autism
   - ❑ Continuing LeDeR - Learning Disabilities Mortality Review

NHS Long Term Plan - Learning Disability and Autism

2. Improve understanding of learning disabilities and autism within the NHS

- STP/ICS ensure reasonable adjustments & that NHS Staff Trained
- NHS support to DfE & LAs to improve awareness & support to Children and Young People
- NHS Improvement Standards apply to all NHS Care within 5 years
- By 2022/23 – Digital Flag

NHS Long Term Plan - Learning Disability and Autism

3. Reduce waiting times for specialist Services

- ❑ Autism diagnostics for Children and Young People & alongside Mental Health
- ❑ NHS & Child Social Care & Education care packages for neurodiversity
- ❑ By 2023/24 Keyworkers for Children and Young People with complex needs (inpatient, at risk or vulnerable)

NHS Long Term Plan - Learning Disability and Autism

4. Increase investment in Community Support: Reducing inpatient admissions

- Personalised care in the community & reducing preventable admissions
- By 2023/24 reduction in inpatients
  - adults 30 per 1 million
  - Children and Young People 12-15 per 1 million
- 7 day specialist multidisciplinary services including crisis care

NHS Long Term Plan - Learning Disability and Autism

5. Improve quality of inpatient care across NHS & Independent sector

- By 2023/24 NHS Commissioned care to meet Learning Disability Improvement Standards – focus on seclusion, segregation and restraint reduction
- Reduce admissions & support earlier transfer to community care
- 12 point discharge plan implementation and monitoring
- C(e)TR policy improvement – working with people and their families

What Next?

- Our Partnership arrangements stand us in good stead to deliver the 10 year plan and Social Care Green paper

- Ensure delivery dovetails and enables STP local care model development

- Alliance to be extended by 12 months until March 2021

- Further conversations to maintain the momentum and ensure this model can continue to deliver as the Integrated Care System Develops

Thank you any questions ?

From: Anne Tidmarsh, Director of Partnerships, Adult Social Care and Health

To: Kent Health and Wellbeing Board – 7 February 2019

Subject: **Kent Better Care Fund Annual Report**

Classification: **Unrestricted**

Summary:

This paper provides an annual update on the progress of the Kent Better Care Fund.

Recommendation:

The Kent Health and Wellbeing Board is asked to note this report and if any further submission is required for the extension of the BCF plan to delegate sign-off responsibilities to the Chairman.

1. Introduction

1.1 The Better Care Fund (BCF) has been in place since April 2014. The current plan was submitted in 2017 and was a two-year plan to run until 2019. The BCF is made up of money identified by the CCGs, KCC and grants for Districts and the Disabled Facilities Grant. In addition, the iBCF was launched in 2017 for 3 years (to 2020) to focus on High Impact Changes to reduce DTOC. This money is a central allocation that goes direct to social care.

1.2 This paper provides an annual update on the progress of the BCF.

2. Financial Implications

2.1 The financial schedule submitted for the Kent BCF was as follows:

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Kent	£14,387,024	£15,645,644
Lower Tier DFG Breakdown (for applicable two-tier authorities)		
Ashford	£775,304	£842,979
Canterbury	£1,017,727	£1,101,325
Dartford	£513,627	£558,301
Dover	£1,113,133	£1,203,366
Gravesham	£882,691	£961,866
Maidstone	£1,131,348	£1,230,870
Sevenoaks	£976,757	£1,064,336
Shepway	£1,138,882	£1,229,558
Swale	£2,182,185	£2,382,555
Thanet	£2,568,686	£2,794,932
Tonbridge and Malling	£1,007,235	£1,097,910
Tunbridge Wells	£1,079,451	£1,177,645

Total Minimum LA Contribution exc iBCF	**£14,387,024**	**£15,645,644**
Local Authority Additional Contribution	**2017/18 Gross Contribution**	**2018/19 Gross Contribution**
Total Local Authority Contribution	**£14,387,024**	**£15,645,644**

iBCF Contribution	**2017/18 Gross Contribution**	**2018/19 Gross Contribution**
Kent	**£26,392,010**	**£35,018,901**
Total iBCF Contribution	**£26,392,010**	**£35,018,901**

CCG Minimum Contribution	**2017/18 Gross Contribution**	**2018/19 Gross Contribution**
NHS Ashford CCG	**£7,324,821**	**£7,463,993**
NHS Canterbury and Coastal CCG	**£12,861,063**	**£13,105,423**
NHS Dartford, Gravesham and Swanley CCG	**£15,566,069**	**£15,861,824**
NHS South Kent Coast CCG	**£13,451,140**	**£13,706,711**
NHS Swale CCG	**£6,936,651**	**£7,068,448**
NHS Thanet CCG	**£9,810,694**	**£9,997,097**
NHS West Kent CCG	**£27,870,714**	**£28,400,258**
Total Minimum CCG Contribution	**£93,821,153**	**£95,603,755**

Additional CCG Contribution	**2017/18 Gross Contribution**	**2018/19 Gross Contribution**
Total Additional CCG Contribution	**£0**	**£0**

	2017/18	**2018/19**
Total BCF pooled budget	**£134,600,188**	**£146,268,300**

3. Policy Framework

3.1 The NHS Long Term Plan and the forthcoming Green Paper on Older people will both focus on better integration of health and social care, so that care is seamless when patients are moved between systems. The Long Term Plan confirms an audit is taking place of the BCF, but it will be extended for a further year, to bring the BCF and iBCF in line.

3.2 The Kent and Medway Sustainability and Transformation Partnership outlines the vision "Quality of Life, Quality of Care" with an intention the Kent and Medway health and care system will deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently and for as long as possible in their home setting.

Work has taken place to align the objectives of the BCF with the implementation plans for Local Care and ensure that all schemes are focused on delivering the same outcomes.

4. Better Care Fund Annual Update

4.1 Each quarter Kent provides an update position against the national metrics:

- Reduction in non-elective admissions
- Residential Admissions - rate of permanent admissions to residential care per 100,000 population (65+)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed Transfers of Care (delayed days)

The latest return indicates we are on track to meet most targets, but further work required regarding some areas.

4.2 In addition to the quarterly returns it is recommended that the monitoring of the impact of the BCF be brought in line with Local Care governance and the new Local Care Executive Board, supported by the Local Care Delivery Framework. This will ensure the BCF is focussed on delivering the same aims and objectives of Local Care.

4.3 A review of the BCF plan has taken place with all leads across CCGs and Kent County Council which agreed to bring together all existing spend on BCF and joint health and social care schemes to review if any changes should be made. A verbal update on this will be provided at the meeting.

5. Conclusion

5.1 Following the review of the existing BCF and the outcomes of the planning guidance and any update on BCF requirements it is recommended that a one-off meeting of the CCG Clinical Chairs and relevant Local Authority staff review the outcomes and collectively agree a shared strategy for going forward.

5.2 If any further submission is required for the extension of the BCF plan the Health and Wellbeing Board are asked to delegate sign-off responsibilities to the Chairman.

6. Recommendation

The Kent Health and Wellbeing Board is asked to note this report and if any further submission is required for the extension of the BCF plan to delegate sign-off responsibilities to the Chairman.

7. Contact details

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

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

7 February 2019

Subject: Kent Joint Strategic Needs Assessment (JSNA) Exceptions Report 2018/19

Classification: Unrestricted

Summary:
This paper provides a brief list of key population health risks and issues arising from the refresh of the Kent Joint Strategic Needs Assessment through more detailed Needs Assessments or other public health analysis. This list enables the Kent Health and Wellbeing Board, the Joint Kent and Medway Health and Wellbeing Board and the Kent and Medway Sustainable Transformation Partnership to be aware of the relevant issues and trends which need to be addressed and reflect the key priorities and outcomes of the refreshed STP plans based on the recently published NHS Long Term Plan.

Recommendation:
The Kent Health and Wellbeing Board are asked to **COMMENT** and **ENDORSE** the following recommendations:

- Ensure a system wide focus on prevention especially the continued whole system focus on the reduction of smoking prevalence particularly for women who smoke during pregnancy.
- Continue the focus on local populations that have the lowest life expectancy.
- Work to ensure that whole systems are communicating systematically and effectively in order to gain the best outcomes, particularly to address multiple long term conditions and both physical and mental health, across the life course.
- Continue to focus on improving Stroke and Cancer pathways from prevention through diagnosis, treatment, rehabilitation and palliative care.
- Embed key highlights and emerging issues into the reiterated Kent and Medway Case for Change.

1. Context

1.1 This report updates the Kent Health and Wellbeing Board on the refresh of the Kent Joint Strategic Needs Assessment through the more detailed Needs Assessments published in this financial year (2018/2019).

1.2 In 2018 the Kent and Medway STP published an updated Case for Change[i], the Needs Assessment that drives all the work transforming health and care services across Kent and Medway.

1.3 In early January the NHS published the NHS Long Term Plan. The next task for the STP is to reiterate the Kent and Medway Case for Change based on the NHS Long Term Plan.

1.4 The findings of the needs assessment work highlighted in this paper, the existing Kent and Medway Case for Change and NHS Long Term Plan will be reflected in the refreshed STP Case for Change.

2.0 Background

2.1 The Kent JSNA[ii] is a set of:

- Reports
- Visual map including health and social care maps
- Need assessments

These describe and inform priorities to improve and transform health and wellbeing of the Kent population.

2.2 Now that Integrated Care Partnership footprints are becoming clearer, we are also developing analysis at this level to ensure a greater understanding of local population health needs and priorities. A West Kent footprint needs assessment has been produced and work planned to complete North Kent and East Kent.

2.3 Previous Kent Health and Wellbeing Boards have endorsed the use of population cohort modelling and this work is now being used in a number of local care service transformation projects including West Kent, Dartford Gravesham and Swanley and Swale and the Vanguard.

3.0 JSNA Reports (Briefings, Needs Assessments, Deep Dives and Analyses)

3.1 The following reports were completed by the Public Health team in the last year:

- Pharmaceutical Needs Assessment[iii]
- Suicide Prevention Needs Assessment[iv]
- Tobacco Dependency Needs Assessment[v]
- Sexual Health Needs Assessment[vi]
- Children and Young People with Disabilities Needs Assessment[vii]
- Director of Public Health Annual Report (Sexual and Reproductive Health)[viii]
- Local Authority Health Profiles[ix]
- Air Quality[x]
- Childhood Obesity[xi]
- Obesity Deep Dive[xii]
- Multimorbidity in Kent Developmental Statistics[xiii]
- Kent Fire and Rescue Service, an Evaluation of the Health Impacts of Safe and Well Visits[xiv]
- Analysis of Hospital Admissions for Self-Harm in Children and Young People in Kent[xv]
- Family Weight Management[xvi]
- Using Acorn Wellbeing & the Kent Integrated Dataset (KID) to Identify and Analyse Older People More Likely to be Experiencing Social Isolation and Loneliness[xvii]

- National Child Measurement Programme Data [xviii]
- Inequalities in Obesity and Excess Weight in Childhood 2017/18 Update[xix]
- The Infant Feeding Service Consultation Report[xx]

3.2 The following reports were completed by the Public Health team in the last year and await sign off:

- Maternal Weight
- Children and Young People with Special Education Needs
- The Use of Preventative Health Services by People with Learning Disabilities (Brief Analysis)
- Stopping Over-Medication of People with a Learning Disability, Autism or Both (STOMP) in Kent

3.3 The following reports are in production:

- End of Life Care for Children and Young People in Kent
- Percutaneous Coronary Intervention (PCI) Procedures in Kent and Medway
- An Estimate of Undiagnosed Atrial Fibrillation and Assessment of Targeting in the Health Checks Programme in Kent
- Dual Diagnosis: Developmental Statistics Exploring General Practice Recording, Hospital Admissions and Contact with Community Mental Health Teams
- Population Health Needs, Inequalities and Commissioning Opportunities in West Kent CCG
- Substance Misuse in Adults: Drugs
- Substance Misuse in Adults: Alcohol
- Children's and Young People's Substance Misuse
- Regression Analyses to Explore Equity of Uptake of Learning Disability (LD)-Specific Health Checks, and the Impact of LD Health Checks on Acute Emergency Care
- Cancer Annual Public Health Report

4.0 Key Highlights and Emerging Issues

4.1 Population

4.1.1 The KCC Housing Led Forecast suggests population growth is due to rise in Dartford and Maidstone, particularly in Ebbsfleet. In total, the Kent population is due to grow by 74,800 (5.0%) from 2019 to 2024. Older people are the fastest growing group of people in Kent. Latest projections estimate that the population aged 65 and over will grow by 10.2% over the same time period, compared to 3.8% for those under 65 (see infographics showing key indicators and health and wellbeing information in Appendix 2).

4.1.2 From 2015-17 the leading causes of premature death (considered preventable) in the Kent population for the under 75 age group are:

- Cancer 76.9/100,000 trend decreasing
- Cardiovascular disease 38.6/100,000 trend decreasing
- Respiratory disease 18.1/100,000 trend static

- Liver disease 14/100,000 trend increasing

4.2 Health Inequalities

4.2.1 Health inequalities across the county are getting wider. Most recent analysis on mortality shows that whilst the rates have been falling over the last decade, the 'gap' in mortality rates between the most deprived and least deprived in Kent persists. See Appendix 1 for the trend of Health Inequalities and the variation in life expectancy.

4.3 Smoking

4.3.1 Adult smoking prevalence in Kent has continued to fall, from 20.7% in 2012 to 16.3% in 2017. The reduction is largely attributed to e-cigarette use and has resulted in a significant reduction in the number of individuals setting a quit date using traditional smoking cessation services. However, differences across populations continue to widen. For example, people in routine and manual occupations are 3.5 times more likely to smoke than other occupations.

4.3.2 Smoking at the time of delivery continues to be a significant concern in Kent with the rates above national average (Kent 14.4%, National 10.8%) and the recent trend increasing. A new model of support for women who smoke during pregnancy is required if Kent is to achieve the national target of 6% or less by 2022.

4.4 Air Pollution

4.4.1 Air pollution is a significant contributor to preventable ill health and premature mortality. In 2016, 5.6% of mortality in the under 75 population in Kent was attributable to particulate air pollution, which is similar to mortality rates attributable to respiratory disease and liver disease.

4.5 Mental Health and Substance Misuse

4.5.1 Despite a recent slight fall, suicide rates in Kent are still higher than national and regional comparators, particularly amongst men. There is variation in rates across the CCG areas, with Thanet having the highest male suicide rate, and West Kent CCG having the lowest. However, West Kent CCG has the 2nd highest female suicide rate. Approximately 70% of people who die by suicide are not known to secondary mental health services.

4.5.2 The rates of depression co-existing with comorbidities, including anxiety, obesity, smoking, poor self-care, alcohol misuse and self harm, are increasing. People with mental illness are also six times more likely to have a co-existing Long Term Conditions.

4.5.3 Mental health continues to present challenges including:

- Primary care data suggests that there were almost 130,000 adults with depression in 2017-18.
- Approximately 13% of young people aged 5-19 years have mental ill health.
- Rates of police section 136 (S136) detentions are higher in Kent than the

national average.

- 68% of people using Kent substance misuse services have suicidal ideation.
- Approximately 50% of hospital admissions for self-harm involving young people involve those aged 14-18, the majority of whom are females.
- A third of admissions for self-harm involve children and young people living in the 20% most deprived areas in Kent.

4.5.4 There is a change in pattern of drug use amongst young people in Kent. There are now more young people reporting abstinence. However, those that are using substances (both drugs and alcohol) are engaging in high risk activities with more varied drug availability (e.g. online) and the substances are often unknown and complex.

4.6 Excess Weight

4.6.1 In 2016/17, 63% of adults in Kent were identified as having excess weight (overweight or obese) based on the Active Lives Survey, which is higher than England. Within Kent, the prevalence of excess weight in Maidstone and Swale was higher than Kent. National and local analyses demonstrate that there is a strong relationship between obesity and multimorbidity, independent of age, gender and deprivation. In 2017/18, multimorbidity affected 29.5% of those classified as normal weight, 38.6% of those overweight and 65.9% of those classified as obese. Hospital admissions where obesity is a factor have increased across Kent, in line with England, from 267.3 in 2011/12 to 946.9 per 100 000 resident population in 2016/17.

4.6.2 In 2017, 50% of pregnant women were identified as having excess weight at booking. However, there are inconsistencies in measuring weight as part of BMI at booking, with little and varied information given to pregnant women about healthy eating and physical activity.

4.6.3 The National Child Measurement Programme in 2017/18 in Kent found that 20.7% of reception aged children and 33.2% of Year 6 children had excess weight. In 2017/8, the prevalence of excess weight in Year R children in Dartford, Dover and Swale was higher than Kent and the South East, whereas the prevalence of excess weight in Year 6 in Dartford, Gravesham and Thanet was higher than for Kent, the South East and England.

4.7 Oral Health

4.7.1 The Indicators for oral health is the number of decayed missing or filled teeth in children of 5 years. Data shows Kent has a lower rate than the national average although the rate of children being free from dental decay in Kent is similar to the national average.

4.8 NHS Health Checks

4.8.1 NHS Health Checks is a vascular screening programme mandated to Upper Tier Local Authorities to commission. In Kent, for the last five years the whole annual cohort have been invited, with the average uptake now standing at approximately 42%. This is significantly below the national average of 48%.

4.9 Learning Disability and Special Educational Needs

4.9.1 There are as many as 24,000 people with an undiagnosed learning disability (LD) across Kent. In 2016/17, only 40.8% of diagnosed cases were reported to have had a health check, which is lower than the national average. The proportion varied by CCG area, with DG&S CCGs delivering checks to only 26.5%.

4.9.2 National analysis has shown that 17% of adults with a diagnosed LD are prescribed an antipsychotic medication, with over half not having a diagnosis on their GP record of a condition which the medication is designed to treat, including psychosis, bipolar disorder, depression and anxiety. A local analysis has indicated that the Kent prevalence is likely to be similar to the national prevalence.

4.9.3 The prevalence of SEN in children and young people in Kent has reduced significantly over the past 4 years to 28,787 (12.4%) in 2018 and is now lower than England. However, prevalence is highest amongst Children In Need (CHIN) and Children In Care (CIC). Children with SEN often require specific SEN support, Educational and Health Care Plans (EHCP), and a multi-agency approach to improve health outcomes.

5.0 Finding of the JSNA Population Cohort Model[xxi] (Progress Update)

5.1 Several workshops have been delivered to improve the engagement and feedback around the JSNA Population Cohort Model.

5.2 Outputs from the JSNA Population Cohort Model, including existing service configuration, provide a needs-based projection for hospital services. These outputs have been used to inform the 'do nothing' baseline for models that are designed to explore service transformation, particularly in Kent around the introduction of Local Care. A Population Cohort Model has been generated specifically for West Kent, which was actively used and applied in the West Kent Needs Assessment. Similar cohort models for North Kent and East Kent will be completed in due course.

5.3 Within Public Health, the Population Cohort Model has been used to produce projections for the latest needs assessment on tobacco dependency. For example, if we are to achieve the 12% smoking prevalence target by 2022, we estimate it would mean 620 fewer cases of lung cancer, 832 fewer cases of COPD, 480 fewer cases of coronary heart disease, and 461 fewer cases of stroke by 2032.

5.4 The Population Cohort Model has been used to assess the impacts of targeted public health interventions on healthy life expectancy in Kent. The interventions are shown in Table 1.
If all of the interventions were applied to the target outlined we estimate that healthy life expectancy at birth would increase from 72.5 years to 77.9 years by 2037 (Fig. 1).

Table 1 Public Health intervention impact targets

Intervention Areas	Impact	Impact (%)	Number	Start	End
Breastfeeding	Increase prevalence	20		2019	2024
Smoking in pregnancy	Decrease prevalence	6		2019	2025
Childhood obesity	Decrease prevalence	20		2019	2025
Fuel poverty in children	Decrease prevalence	10		2019	2022
ACE in childhood	Decrease prevalence	20		2020	2030
Hypertension	Increase percentage treated	30		2020	2025
Hypercholesterolaemia	Increase percentage treated	30		2020	2025
Smoking	Decrease prevalence	8		2019	2024
Obesity	Decrease prevalence	10		2019	2024
Alcohol screening		Screening	50,000	2019	2025
Alcohol treatment		Treatment	5,000	2019	2030
Fuel poverty in older people	Decrease prevalence	20		2019	2024
Impact of ACE in adulthood	Decrease prevalence	20		2020	2030

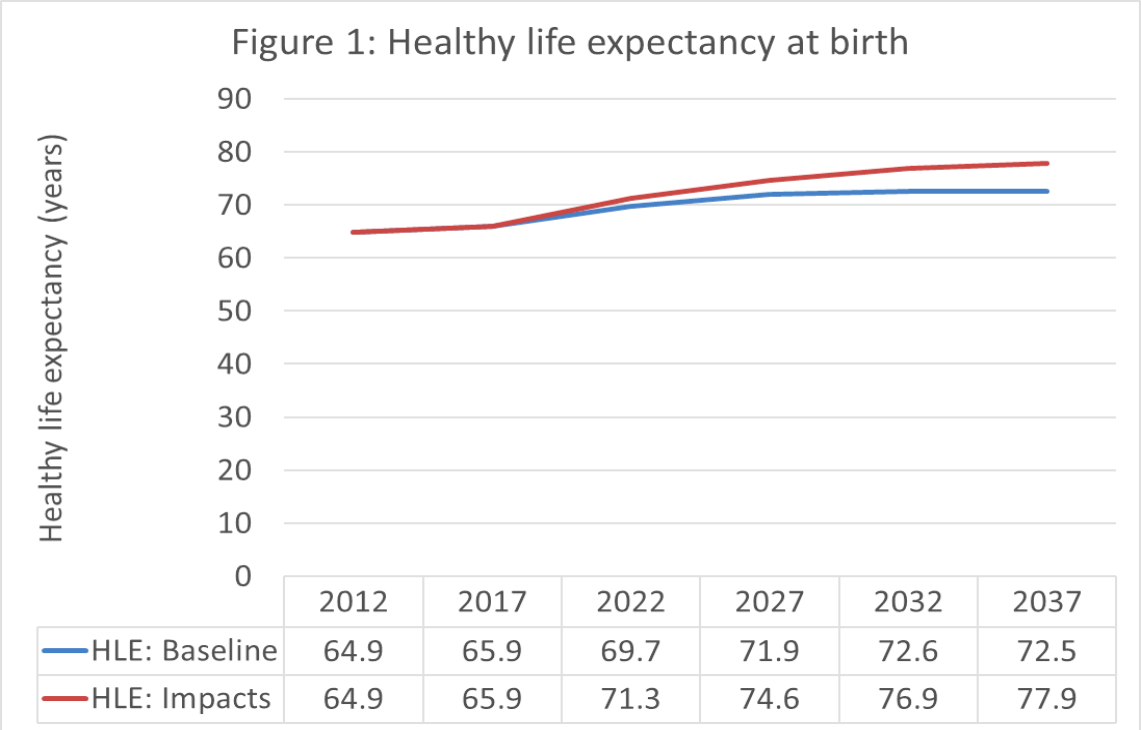

Figure 1 above shows the modelled impacts on health life expectancy at birth with all of the Public Health intervention impacts applied

6.0 Recommendations

The Kent Health and Wellbeing Board are asked to **COMMENT** and **ENDORSE** the following recommendations:

- Ensure a system wide focus on prevention especially the continued whole system focus on the reduction of smoking prevalence particularly for woman who smoke during pregnancy.
- Continue the focus on local populations that have the lowest life expectancy.
- Work to ensure that whole systems are communicating systematically and effectively in order to gain the best outcomes, particularly to address multiple long term conditions and both physical and mental health across the life course.
- Continue to focus on improving Stroke and Cancer pathways from prevention through diagnosis treatment, rehabilitation and palliative care.
- Embed key highlights and emerging issues into the reiterated Kent and Medway Case for Change.

7.0 Contact Details

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Background Documents:

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[i] https://kentandmedway.nhs.uk/wp-content/uploads/2018/07/KM_STP_case_for_change__March_2018_vF2.pdf

[ii] https://www.kpho.org.uk/joint-strategic-needs-assessment

[iii] https://www.kpho.org.uk/__data/assets/pdf_file/0004/76747/Kent-Pharmaceutical-Needs-Assessment-2018.pdf

[iv] https://democracy.kent.gov.uk/documents/s86560/Item%209%20appx%20-%20Suicide%20Prevention%20Needs%20Assessment%20Sept%202018%20v1.dotx.pdf

[v] https://www.kpho.org.uk/__data/assets/pdf_file/0018/90702/Tobacco-Dependency-Needs-Assessment.pdf

[vi] https://www.kpho.org.uk/__data/assets/pdf_file/0006/89151/Kent-sexual-health-needs-assessment-Final.pdf

[vii] https://www.kpho.org.uk/__data/assets/pdf_file/0006/83913/CYP-with-Disabilities-Needs-Assessment.pdf

[viii] https://www.kent.gov.uk/__data/assets/pdf_file/0009/89397/Sexual-and-reproductive-health-annual-report-2017.pdf

[ix] https://fingertips.phe.org.uk/profile/health-profiles/area-search-results/E12000008?search_type=list-child-areas&place_name=South East

[x] https://www.kpho.org.uk/__data/assets/pdf_file/0004/80617/Air-Quality.pdf

[xi] committee https://democracy.kent.gov.uk/documents/g8322/Public%20reports%20pack%2015th-Jan-2019%2009.00%20Health%20Reform%20and%20Public%20Health%20Cabinet%20Committee.pdf?T=10

[xii] https://democracy.medway.gov.uk/mgconvert2pdf.aspx?id=44928

[xiii] https://www.kpho.org.uk/__data/assets/pdf_file/0010/80398/Multimorbidity-report-D2.pdf

[xiv] https://www.kpho.org.uk/__data/assets/pdf_file/0007/58444/KPHO-Evaluation-of-Safe-and-Well-visits-FINAL.pdf

[xv] https://www.kpho.org.uk/__data/assets/pdf_file/0019/82054/CYP-self-harm.pdf

[xvi] https://www.kpho.org.uk/__data/assets/pdf_file/0008/90548/FINAL_APRV_1.pdf

[xvii] https://democracy.kent.gov.uk/documents/s86149/Social%20isolation%20and%20loneliness%20in%20Kent%20-%20Public%20Health.pdf

[xviii] https://www.kpho.org.uk/__data/assets/pdf_file/0003/88167/NCMP-2017-18-Data-Report-Accessible-version_FINAL.pdf

[xix] https://www.kpho.org.uk/__data/assets/pdf_file/0009/88371/NCMP-Equity-201718.pdf

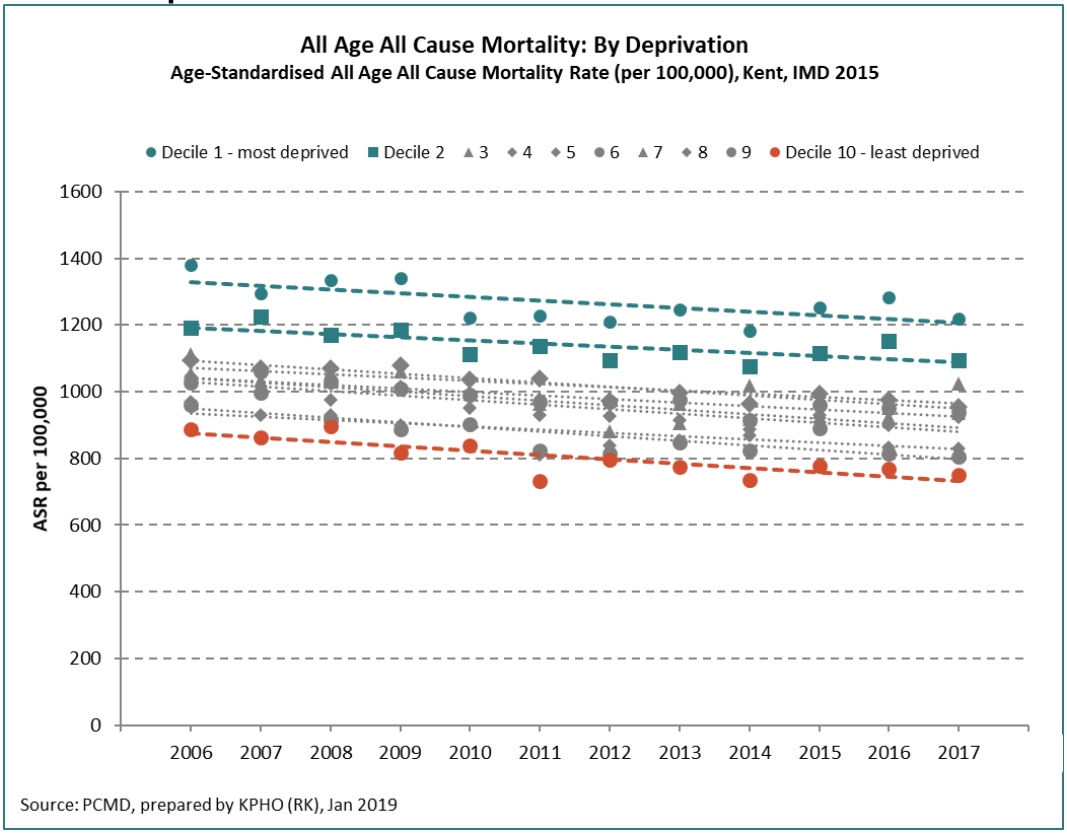
[xx] https://consultations.kent.gov.uk/consult.ti/InfantFeeding

[xxi] https://www.kpho.org.uk/joint-strategic-needs-assessment/jsna-population-cohort-model

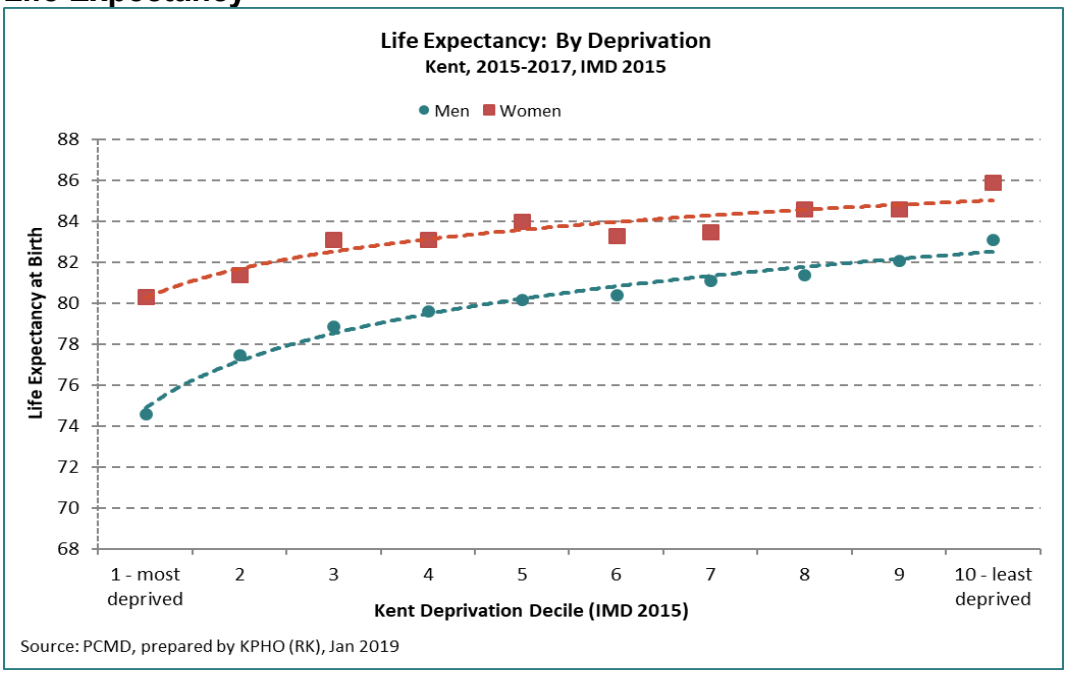
Appendices

Appendix 1

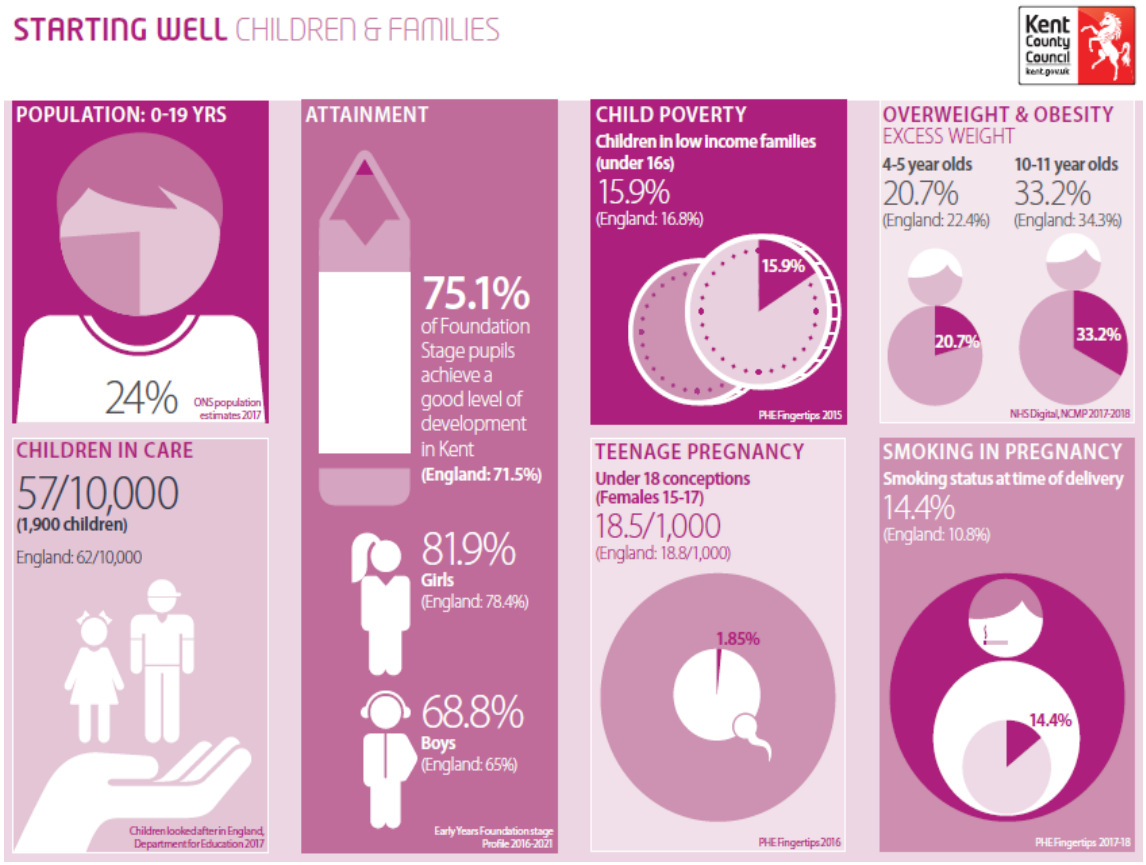
Health Inequalities

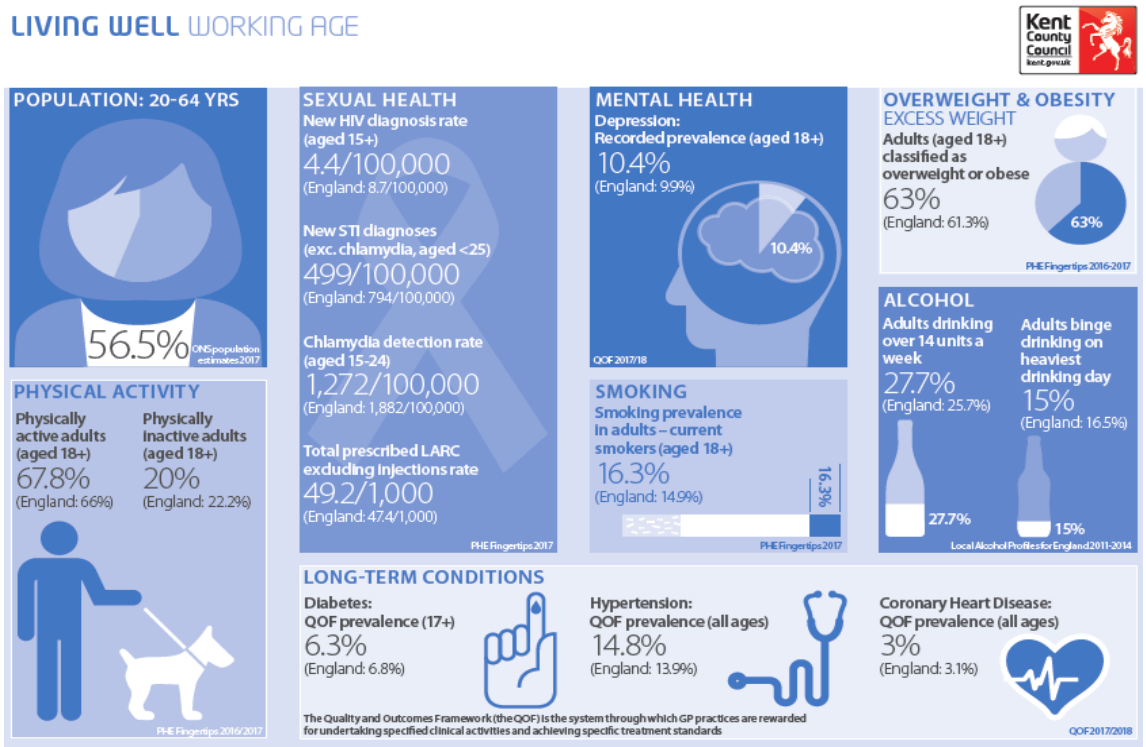


Life Expectancy

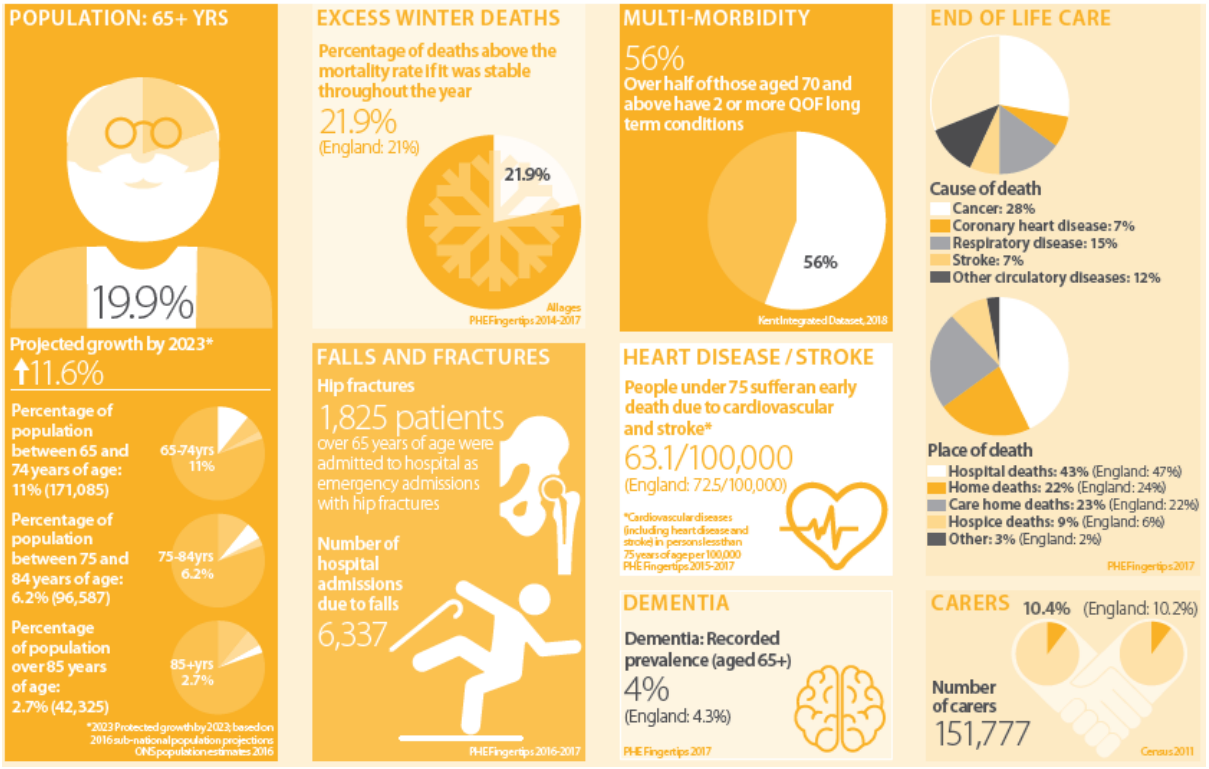


Appendix 2: Infographics

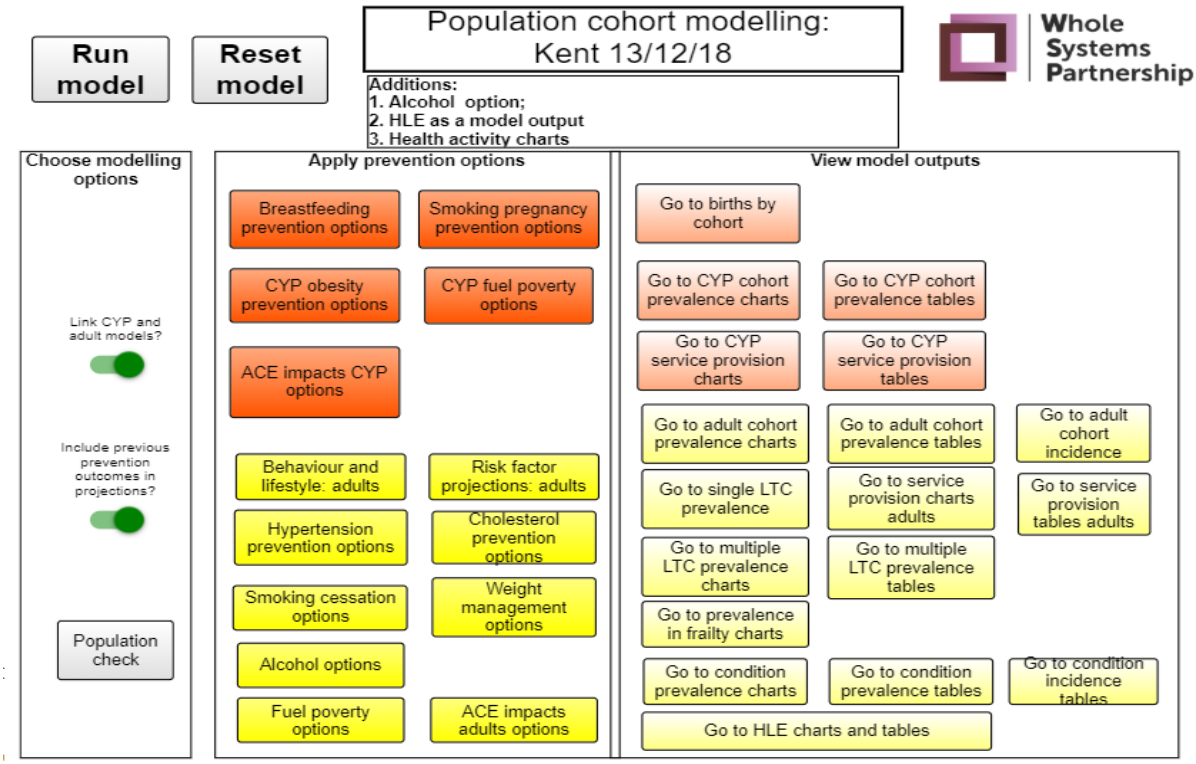




AGEING WELL OLDER PEOPLE



Appendix 3


Run model
Reset model
Population cohort modelling: Kent 13/12/18
Additions:
1. Alcohol option;
2. HLE as a model output
3. Health activity charts
Whole Systems Partnership
Choose modelling options
Link CYP and adult models?
Include previous prevention outcomes in projections?
Population check
Apply prevention options
Breastfeeding prevention options
Smoking pregnancy prevention options
CYP obesity prevention options
CYP fuel poverty options
ACE impacts CYP options
Behaviour and lifestyle: adults
Risk factor projections: adults
Hypertension prevention options
Cholesterol prevention options
Smoking cessation options
Weight management options
Alcohol options
Fuel poverty options
ACE impacts adults options
View model outputs
Go to births by cohort
Go to CYP cohort prevalence charts
Go to CYP cohort prevalence tables
Go to CYP service provision charts
Go to CYP service provision tables
Go to adult cohort prevalence charts
Go to adult cohort prevalence tables
Go to adult cohort incidence
Go to single LTC prevalence
Go to service provision charts adults
Go to service provision tables adults
Go to multiple LTC prevalence charts
Go to multiple LTC prevalence tables
Go to prevalence in frailty charts
Go to condition prevalence charts
Go to condition prevalence tables
Go to condition incidence tables
Go to HLE charts and tables

From: Matt Dunkley, Corporate Director, Children, Young People and Education

Rachel Jones, Director of Acute Strategy and Partnerships, Kent and Medway STP

To: Kent Health and Wellbeing Board – 7 February 2019

Subject: **0-25 HWB update and Forward Pan**

Classification: **Unrestricted**

Summary:

This paper provides an annual update on the progress of the 0-25 Health and Wellbeing Board (HWBB).

Recommendation:

Note the contents of this report, the progress achieved to date and to comment on the proposed direction of travel set out in the Forward Plan.

Support the 0-25 HWB's plans for the identification of further opportunities to strengthen our partnership working.

1. Introduction

1.1 In 2014, the Kent 0-25 Health and Wellbeing Board was established as a key leadership board between KCC, Health and Kent Police for Children's Services.

1.2 This report provides an outline to recent changes made to the Board and the detail of the Boards priorities for the coming year.

2. Governance

1.3 The board is strongly supported by partners and recently there has been a change in senior level commitment from all partners. KCC is represented through both Cabinet Member and senior officer representation. Health supports through both senior management and clinical leadership and has supported that the Board became part of the Sustainability and Transformation Plan governance. Both Kent Police and Kent Police and Crime Commissioner are represented at a senior level alongside District Councils and Healthwatch.

1.3 The recent change in high level representation demonstrates the importance attached to the board's activities, as well as the strategic significance of the board's work.

2.1 Most recently, the Board has become established as part of the governance of the Kent and Medway STP to provide a focus on children's issues. The Board will have a role in reporting directly to the Programme Board and engage with the Clinical and Professional Board.

2.2 Progress on the board's activities is also reported into the Kent Health and Wellbeing Board.

2.3 The case for children's services partner organisations to work together/co-operate is clearly set out in policy and statute. There is a raft of legal, financial and moral imperatives why health care providers and commissioners as well as partner safeguarding agencies, need to have a bespoke and focused approach to their work with children and young people.

2.4 KCC has a legal obligation (Section 10, Children Act 2004) to promote co-operation with partner agencies to improve the health and wellbeing of children and young people in the county. KCC has also identified the need to give every child the best start in life as one of its three strategic outcomes.

3. Forward Plan

3.1 Whilst the Board has been in existence for some time, it lacked a clear forward plan. A workshop took place in July 2018 to begin to refresh the priorities of the Board and to develop a forward plan to guide the approach to working effectively across the partner organisations and delivering against agreed priorities.

3.2 The workshop highlighted the importance of cross-cutting system issues that affect several different partner agencies providing health and care services for children and young people. It also identified a number of clear areas in which to accelerate joint working and improve outcomes.

3.3 A Board discussion on 8 October agreed the attached framework in appendix 1. This sets out the agreed outcomes and deliverables for 2019 – 2020. The indicators align with the current Kent CYP Plan and will be reported against at each meeting.

3.4 The Board has agreed to focus on the following areas:

A) Children and Young People with multiple/complex needs
B) Children and Young People's mental health
C) Special Educational Needs and Disability (SEND)
D) Children and Young People's population health
E) Effective partnership working and joint commissioning arrangements

3.5 A recent focus on Transforming Care and some of the current issues with CAMHS services indicate a need to look at this urgently and as such features as a priority in the forward plan.

3.6 There has been significant activity as a result of the forward plan and the following areas of work have been prioritised:

- Support to the Public Health Adverse Childhood Experiences (ACE) workstream to develop a programme of work which focuses on children who have experienced ACE, Trauma and Resilience.
- The Total Placement Service (TPS) which aims to bring together an improved understanding of purchasing activity with the providers of residential, foster and other accommodation-based care for the most vulnerable children in Kent
- Oversight of delivery of the Kent and Medway Local Transformation plan for Mental Health including Governance
- The children's Suicide prevention work programme
- An agreed model of nursing provision in Special Schools
- Oversight of implementation of the Transforming Care Action Plan
- A number of Public health Needs Assessments including for SEND and sexual health
- Public health: 0-25 Observatory data resource pack
- The development of an overarching framework for reporting Children and Young People's views and experience

4. Conclusion

4.1 There has been a new momentum for change across the strategic leadership for Children services as demonstrated by the establishment of the new 0-25 HWB's governance.

4.2 The board has begun to push forward a programme of integration and joint commissioning arrangements. It has an ambitious forward plan which all partners have signed up to and have agreed to be accountable for.

4.3 All partners are asked to sustain this senior level commitment to the Board and to support the identification of further opportunities to strengthen our partnership working.

5. Recommendation

The Kent Health and Wellbeing Board is asked to:

Note the contents of this report, the progress achieved to date and to comment on the proposed direction of travel set out in the Forward Plan.

Support the 0-25 HWB's plans for the identification of further opportunities to strengthen our partnership working.

6. Contact details

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Appendix 1
0-25 health and Wellbeing Board Indicators and Deliverables

Indicators	Deliverables	Lead(s)	Board Discussion
(A) Children and Young People with multiple/complex needs/high intensity service use			
Children on a Child Protection Plan Children in Care Children missing from Care (24 hrs+) Children Referred to Services Domestic Abuse Notifications (incidence & crimes) Children recorded as offenders Early Years Foundation Stage Profile Reading, Writing & Maths at Key Stage 2 GCSEs (5 A-C including Maths & English) Young People not in Education, Employment or Training Persistent School Absence Young People in Secure Estate Children in Care accessing Mental Health Services	Identification and analysis of high intensity service users by each organisation. To include: profile of high intensity users profile against agreed indicators analysis of spend by organisation review of Joint Resource Allocation Process (JRAP) analysis of frequent fliers to A&E Review of Continuing Health Care (CHC)	Sarah Hammond (KCC) Stuart Collins (KCC) Karen Sharp (KCC) Katie Collier (Kent Police) Sam Bennett (KCC) Dr Richard Patey (NHS) Rachel Jones (NHS)	Jan-19
	Agreed partnership delivery model focused on priorities identified above	As above	

(B) Children and Young People's Mental health			
CAMHS waiting times National access target in all districts Under 25 suicide rate Referrals to KCC ICS for Mental Health Self Harm related Hospital Admissions Impact within schools (early warning signs) Children in care able to access service Headstart Year 7 & 9 survey	Action plan for current waiting times and trajectories	Rachel Jones (NHS)	Jan-19
	Action plan for performance against national access targets	Rachel Jones (NHS)	
	Implementation of Kent & Medway Local Transformation Plan	Rachel Jones (NHS)	Jan-19
	KSCB thematic review of suicide report	Gill Rigg	
	Schools signed up to Head Start	Stuart Collins (KCC)	Jan-19
	Schools signed up to good mental health matters	Rachel Jones (NHS)	Jan-19
	Numbers referred to SP Access	Rachel Jones (NHS)/Karen Sharp (KCC)	Jan-19
	Number of early interventions through KCHFT	Karen Sharp (KCC)	Jan-19
(C) Special Education Needs and Disability (SEND)			
Number and length of stay for young people placed in inpatient settings Educational attainment of children with SEND Rates of diagnosis of ASD and ADHD	Agreed model of nursing provision in special schools	Rachel Jones (NHS) Louise Langley (KCC)	Jan-19
	Establish integrated commissioning arrangements for SEND and Plan for Portage	Louise Langley (KCC) Sarah Lloyd Cocks (KCC) Rachel Jones (NHS)	
	Transforming Care Action Plan	Rachel Jones (NHS) Penny Southern (KCC) Karen Sharp (KCC)	Jan-19

	SEND needs assessment	Sam Bennett (KCC)	Jan-19
	Implementation of Demelza House Community Strategy	Sam Bennett (KCC) Louise Langley (KCC)	Apr-19
	Establish integrated commissioning arrangements for speech and language provision	Rachel Jones (NHS) Sarah Lloyd Cocks (KCC)	
(D) Children and Young People's Population Health			
Year R Excess Weight Year 6 Excess Weight Breastfeeding initiation Drug related Hospital Admissions (under 18s) Alcohol specific Hospital Admissions (under 18s) First time entry to the Youth Justice System Teenage Conception rate Smoking at time of delivery Low birth weight of term babies Chlamydia screening (15-24) Children with one or more deayed, missing or	Young People's Drug and Alcohol Needs Assessment	Sam Bennett (KCC)	
	0-25 sexual health needs assessment	Sam Bennett (KCC)	Jan-19
	Childhood Obesity Needs Assessment	Sam Bennett (KCC)	
	Smoking in pregnancy needs assessment	Sam Bennett (KCC)	
	Vision screening	Sam Bennett (KCC) - in partnership with Health	
	Review of continence service	Sam Bennett (KCC) - in partnership with Health	

filled teeth MMR vacination for one dose (2 years) Dtap/IPV/Hib vaccination (2 years)	Ensure equity of provision for tongue tie	Sam Bennett (KCC) - in partnership with Health	
(E) Effective partnership working and commissioning arrangements			
Regular reporting to 0-25 HWB on key messages for children's participation	Clear joint commissioning vision and strategy for children and young people in Kent	Karen Sharp (KCC)/Rachel Jones (NHS)/ Katie Collier (Kent Police)	Mar-19
	Agreed framework for reporting CYP views and experience	Steve Inett (Health watch Kent)	Jan-19
	Agreed governance for the plan including links to STP	Karen Sharp (KCC)	Oct-18
	Aligned contracting programme (Neil Vickers)	Karen Sharp (KCC)/Rachel Jones (NHS)/ Katie Collier (Kent Police)	Mar-19
	Agreed quality standards (e.g RCPCH standards)	Dr Richard Patey (NHS)	Mar-19
	LCPG Governance		March/April 19

NHS
West Kent
Clinical Commissioning Group

Kent and Medway Mental Health Crisis Care Concordat

2017/ 2018 annual report

Patient focused, providing quality, improving outcomes

Summary
The paper provides an update on the commitments made in the Mental Health Crisis Care Concordat (MHCCC) across Kent and Medway. It provides an overview of the work that has been completed and work that is ongoing in 2017/18.

A multi-agency framework is delivering Kent and Medway MHCCC plans through a partnership approach. This area of work is being addressed by use of existing and planned commissioning intentions and service delivery arrangements and through new partnership arrangements within Crisis Concordat focus working groups.

Recommendation

Members of the Board are asked to note progress and support planned work across agencies

1. Policy Framework:

1.1. The Joint Health and Wellbeing Strategy for Kent set four strategic themes. Theme 4 is set to improve physical and mental health and wellbeing.

1.2. The NHS Forward View and local NHS CCG 2/5 year plans set a key strategic outcome to meet the national objective of improving parity of esteem and reducing inequalities for people with mental health problems.

1.3. There is no additional or dedicated Mental Health Crisis Care Concordat budget identified in the national Crisis Care Concordat. Implementation of its commitments, the cost of governance arrangements and operational changes are matters for partnership agencies and are expected to be made through existing resources, or in future commissioning decisions.

2. Background:

2.1. The Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis, was published by Department of Health on 18th February 2014 and signed by 22 National Organisations, including NHS England, the Association of Chief Police Officers, the Local Government Association, Public Health England, the Care Quality Commission, the Royal College of General Practitioners, Mind, the Association of Directors of Children's Services (ADCS), and Adult Social Services (ADASS) and the Royal College of Psychiatrists.

2.2. The National Concordat Signatories made a commitment "to work together, and with local organisations, to prevent crisis happening whenever possible

through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations. We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery".

2.3. The Concordat also provides important guidance based on service user experience about what is needed as urgent help.
It sets out the case for change, the core principles and four domains around which outcomes should be designed and measured:

- Access to support before Crisis Point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing future crisis

2.4 The signatories of the Concordat expect local partnerships between the NHS, Local Authorities and the Criminal Justice System to work to embed the Concordat principals into service planning, commissioning and service delivery.

2.5 The Mandate from the government to NHS England for 2014-15 established specific objectives including that "Every community to have plans to ensure no one in Crisis will be turned away, based on the principals set out in this Concordat".

2.6 The National Concordat recognised that real change can only be delivered locally and expects every locality across England to work together through local partnerships to adopt and implement its principals. This should be evidenced by/or the publication of a local Mental Health Crisis Care Concordat setting out the commitment of local agencies for:

- The development of a shared action plan to enable delivery;
- A commitment to reduce the use of police stations as places of safety;
- Evidence of sound local governance arrangements.

This expectation was reiterated in a joint letter to the Chairs of Health and Wellbeing Boards on 27th August 2014 from the Minister of State for Care and Support and the minister of State for Policing and Criminal Justice (see Background Papers).

This has been further reiterated by the implementation of the Police and Crime Act 2017 which has reviewed the policing powers elements of the use of sections 135 and 136 of the Mental Health Act 1983, including:

- Prohibiting the use of police cells as places of safety for those under 18 years of age and further reducing their use in the case of adults
- Reducing the 72 hour maximum period of detention to 24hrs
- Extending the power to detain under section 136 to any place other than a private residence

3. Governance and Process:

3.1 Prior to the publication of the National Concordat, a Kent and Medway Policing and Mental Health Partnership Board were already in place with representation from NHS, the Local Authorities and the Police. This group was set up to address concerns over the lack of Mental Health Act S136 place of safety for children and young people in the county. This group provided the basis for the formal Kent and Medway Concordat Steering Group.

The Concordat underwent a governance review in June 2017 which has resulted in new arrangements. There is now a strategic concordat group supporting four geographical based local concordat groups across Kent and Medway to drive the programme forward. The strategic group is chaired by Dave Holman, Head of Mental Health and Children's Commissioning, West Kent CCG & Rachel Curtis, Chief Superintendent Head of Strategic Partnership Command, Kent Police

3.2 Strategic Concordat Review Sept 2018:
A further review of the ToRS for both the Strategic and local concordats in light of mental health developments and STP arrangements is currently being undertaken. It will be an opportunity to take forward this important area in a new direction and to review and understand the goals, objectives, and desired outcomes of the Concordat, taking into consideration the STP, strategic partnerships and governance arrangements that impact on the decision making processes across Kent & Medway that drives improvements in crisis care. Outcome of the review will be published on completion.

3.2 **Membership of the Kent & Medway Concordat Strategic Group includes:**

- Kent and Medway Clinical Commissioning Groups

- South East Coast Ambulance Service (SECAmb)
- Kent & Medway NHS and Social Care Partnership Trust (KMPT)
- Kent Police
- Sussex Partnership NHS Foundation Trust
- North East London NHS Foundation Trust
- Medway Council
- Kent County Council
- Kent PCC

4. Progress to date:

4.1 Overall good progress continues to be made by the Kent & Medway Concordat. However, the emergence of STP's and new governance arrangements are challenging the way the Concordat makes decisions and promotes new planned initiatives. Wider strategic crisis plans including 111 and the development of Urgent Care treatment centres add a new dimension to the Concordat that require consideration and complexity to agreeing a mental health crisis offer. Plans still need to ensure there is urgent and emergency access to crisis care for a person experiencing a mental health crisis, locally the response needs to be proportionate, focuses upon the person's needs and co-ordinated across partner agencies.

A range of Kent and Medway CCG's commissioning plans and intentions 2017/18 have been developed in line with Concordat requirements and good practice. The focus is to develop services to support patients in crisis and preventing attendance at Accident & Emergency and avoiding acute psychiatric admission. These include the developments of 24/7 acute Liaison Psychiatry, 111 service improvements , Street Triage initiative, Crisis cafes and a focus on supporting Frequent attenders within the acute environment with holistic packages of support.

4.2 Reduction of Mental Health Act Section 136 admissions:

The main aim of the crisis prevention agenda is to reduce the need for section 136 admissions under the Mental Health Act and to provide alternative intervention services for people in crisis. Despite initiatives across Kent & Medway there has been an increase in the number of s136 this year; this increase in activity is also reflected in the national figures which have increased over the last 5 years

In the twelve month period from April 2017 to April 2018, 1340 section 136 assessments were undertaken for people presenting to the police from across Kent and Medway, in comparison to 1026 in 2016/17

4.3 The Police and Crime Act 2017

The Police and Crime Act came into force in December 2017 and work has been undertaken to address changes highlighted below as a result of Police

and Crime bill:-

- It will be unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances;
- A police station can now only be used as a place of safety for adults in specific circumstances (where behaviour poses an imminent risk of serious injury or death themselves or another person)
- Before exercising a section 136 power police officers must, where practicable, consult one of the health professionals listed in section 136(1C), or in regulations made under that provision;
- The previous maximum detention period of up to 72 hours has been reduced to 24 hours (unless a doctor certifies that an extension of up to 12 hours is necessary);
- Section 136 powers may now be exercised anywhere other than in a private dwelling;
- Section 135(1) provides for a magistrate to issue a warrant allowing a police officer to enter premises to remove a mentally disordered person to a place of safety. The amended legislation allows an assessment to take place in the premises under certain circumstances

Following these changes the number of S136 placements under the MH Act and eliminating all S136 admissions to police custody suites through a number of jointly agreed partnership initiatives providing officers with alternative options for someone presenting in crisis remains a key priority for the MHCCC for 2017/18 and the continued development of alternative places of safety as part of the crisis pathway is key in supporting this.

The s136 countywide steering group has a local multi-agency improvement plan to monitor and address the specific key issues identified below:

- Reduction in S136 and increased % conversion rates of those admitted
- Improved access to places of safety across the county.
- Improved access to place of safety for children and young people
- Reduction in duration of lengthy S136 detention, focusing on the common causes i.e. AMHP availability / S12 availability / intoxication / access to a bed for admission and access to an interpreter

- Development of alternative place of safety (through a non NHS provider). KMPT and Kent Police have completed a Joint Strategic Threat and Risk Assessment for the Provision of Mental Health Support, Which has made recommendations against the service provision gaps, these recommendations form a part of the action plan.
- Further development of the Mental Health Triage Service
- Avoidance of custody as a place of safety except in cases of extreme violence
- Continued education and training of police officers in recognising mental health issues.

4.3.1 **The Kent & Medway Standards for Section 136 & Health Based Place of Safety Specification**

In light of the amendments made to S135 & S136 by the Police & Crime Act 2017 the Concordat agreed to a six month secondment to write the s136 Strategy and HBPoS specification, as this required a focused, targeted approach that would engage all services in the development of this pathway.

The Strategy builds on the collaborative work already underway in Kent & Medway and supports our vision for developing a 24/7 Mental Health Response Pathway.

A series of task & finish groups were set up to look at the Pan London Strategy that was launched in 2016 and to agree similar standards that met the needs of the population of Kent & Medway. A gap analysis has been completed and actions arising from this now form part of the action plan for the S136 Countywide Steering group, who retain ownership to ensure the actions are reviewed and updated to monitor the work required to fulfil the agreed standards.

The strategy is essential in ensuring that we develop a whole systems approach with agreed protocols for mental health crisis. Engagement from each agency has been very good and a commitment to deliver a pathway together has been exceptionally positive.

The draft strategy has been completed and presented to all the A & E Boards across the county and is going to the Kent & Medway Crisis Care Concordat in September for final sign off. The final Strategy aims to be published in November 2018.

4.4 Crisis Prevention Agenda:

4.4.1 **Street Triage**

The service provides Mental Health support and advice to Police Officers and Ambulance Crews who are dealing with people with possible mental health problems. This advice can include a clinical opinion on the person's condition, or appropriate information sharing about a person's health history.
The aim is, where appropriate, to support police officers in making appropriate decisions, based on a clear understanding of the background to these situations. This is expected to lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of s136

The Kent and Medway countywide service commenced on 12th December 2015, the team consists of one Registered Mental Health Nurse (RMN) to cover the whole geographical area, two Recovery Workers based in Police Force Control and Ambulance Control Room, to support with calls and a Team Leader who has been effective in working with Police and Ambulance staff to offer call handler training, promotion of the service and managing the effective delivery of the service commissioned.

The service function times are continuously reassessed to ensure they are able to meet demand. The service has been consistently operating on Sunday, Monday and Tuesday between 18:00 – 02:00.

The service outcomes are continuously reviewed at a bi -monthly multi agency meeting which includes service representatives from KMPT, SECAmb and Kent Police, commissioners, quality leads and carer and CHYPS representatives and due to the input received at these meetings the outcomes dataset have continued to evolve to ensure the most informative information is received to assess effectiveness of the service and where further improvements are required.

The dataset below identifies data recorded between April 17 and December 17, please note this is not a full year's dataset:

- A total of 576 referrals have been received, this is a 26% increase when comparing April 16 to December 16 in which 426 referrals were received.
- 284 of the referrals received in 2017 (49%) were known to Mental Health services, this is also an increase on 2016 activity in which 37% were known to Mental Health services.

- As a result of a Street Triage assessment, onward referrals were made predominately to CMHT and CRHT. Of all referrals received this equated to 123 to CMHT (21%) and 64 to CRHT (11%).
- 22 (4%) of all referrals still required detention under S136
- 33 (6%) still required police attendance
- 45 (8%) still required attendance at A&E
- A total of 128 referrals indicated drug or alcohol intoxication this equated to 22% of all referrals.
- Between April 2017 and December 2017 the Street Triage service have supported the avoidance of 173 A&E attendances, 157 S136 detentions and 85 non-deployments of ambulances.

Using the Department of Health NHS Reference Costs we are able to apply an approx. cost saving to the health economy on the avoidances supported by the team, between April 2017 and December 2017, which equates to approx. £254,990

Currently an evaluation is being undertaken to assess the outcomes of both the countywide and two community (Medway & Thanet) services, with support indicated to incorporate the services together to support increasing and expanding into a 7 day per week service.

4.4.2 **Acute Liaison Psychiatry:**

People with mental health problems attending or admitted to an acute hospital environment should receive the same priority as those with physical health problems. In October 2014, NHS England and the DoH published Improving Access to Mental Health Services by 2020. This document set out a first set of mental health access and waiting time's standards for introduction in 2015/16. These commitments were reaffirmed in the NHS mandate and in the NHS 5 Year Forward View.

Access to fully integrated Liaison Psychiatry Services, with advice from a consultant specialising in mental health problems, in Acute hospitals needs to be available 24 hours in order to provide an urgent and proactive response. All CCGs are working towards delivering a dedicated 24/7 Liaison Psychiatry service in partnership with KMPT as part of a review of crisis care secondary care support , currently Medway and Thanet CCGs are achieving this.

In West Kent (Maidstone and Tunbridge Wells Hospitals) Adult Liaison Psychiatry operates an 08.00 - 20.00hrs service, seven days a week on two sites. Following a successful bid for NHS England Transformation Pump

Prime Funding there is opportunity to further develop the West Kent service. Work to develop a revised care pathway across the locality is ongoing and will work to ensure a more robust response to patients across the full 24 hour period. and Children and Young Peoples will be running a service from 14.00 - 22.00hrs, seven days a week on two sites.

In North Kent (Darent Valley Hospital, Dartford) Adult Liaison Psychiatry Service are currently operating between 09.00hrs and Midnight, seven days a week on one site and Children and Young Peoples service are present from 14.00 – 22.00hrs. In Medway (Medway Maritime Hospital), Adult Liaison Psychiatry operates 24 hours a day, seven days a week on one site.

Medway has had a 24/7 Liaison Psychiatry Service since November 2013. Following a successful bid for NHS England Transformation Pump Prime Funding the service expanded to provide a Core 24 Service from October 2017 for one year and Children and Young Peoples service are present from 14.00 – 22.00hrs.

In East Kent (Queen Elizabeth the Queen Mother Hospital, Thanet; William Harvey Hospital, Ashford; Kent and Canterbury Hospital, Canterbury) Adult Liaison Psychiatry Services are currently operating 24 hours a day, seven days a week on one site (Thanet), 08.00 - 23.00hrs, seven days a week on one site (Ashford) and 08.00 - 16.00hrs, five days a week on one site (Canterbury). The development at Thanet was as a result of a successful bid for NHS England Transformation Pump Prime Funding, enabling the service expanded to provide a Core 24 Service from November 2017. Children and Young Peoples service are present from 14.00 – 22.00hrs on three sites.

4.4.3 **Kent Police:**

Usage of Sec 136 continues to rise both in Kent and nationally with Kent also experiencing higher than the national average rates of suicide (especially amongst males).

Following evaluation of the triage systems in operation in the county an enhanced service is being progressed that will provide 7 evening a week coverage operating from the Police and Ambulance control rooms. With Community Psychiatric Nurses will be based around the county and able to attend incidents in support of both police and ambulance crews when required.

Alternative options for detention under Sec 136 are also being developed with partners that will see sub-crisis support 7 evenings a week in the East and North of the county, this will work alongside the Crisis cafes that are already in place.

Challenges still exist around transportation of vulnerable people by ambulance once they are detained.

In January 2018 Kent Police commenced delivery of a 2 day mental health training package for all frontline police officers and staff that is co-delivered with KMPT and also has partner agencies attending.

Since the changes to the Mental Health Act in Dec 2017 no persons have been taken into police cells as a place of safety purely for reasons that there was no other place of safety available to them.

4.4.4 **Suicide prevention:**

In early 2018, Kent and Medway STP were invited to bid to NHS England and Public Health England for additional suicide prevention funding £667,978 was awarded for this financial year (ending March 19). This funded programme does not replace the 2015-2020 Strategy, rather it forms part of the Strategy's annual implementation plan.

The aspirational long-term vision is to have zero-suicides across Kent and Medway and to harness all available resources in Kent and Medway in a united, evidence based and co-ordinated effort to reduce suicides. The objective is to achieve a minimum 10% reduction in suicide rates across Kent and Medway by 2021

2017/18 Aims for Suicide prevention:-

- Key high risk groups (particularly middle-aged men) given extra support
- At least 1000 individuals trained in suicide prevention and mental health
- Greater public awareness of suicide warning signs and how to respond
- Greater system understanding about individuals who die by suicide

- Implement zero-suicide action plans within Kent and Medway mental health trusts

4.4.5 **Crisis & Wellbeing Cafés:**

Crisis and wellbeing cafés are intended to offer additional support for people with mental health problems outside of normal office hours. Providing a safe place for people to go and receive support when in crisis without having to access mainstream mental health services. The scheme can be delivered through the voluntary sector.

It is evident that other crisis cafes in Kent (Sheppey, Thanet) and elsewhere (Aldershot) are beginning to demonstrate with additional community based help, crises can be avoided and the impact on other services can be reduced and people with mental health problems show increased mental wellbeing, self-management and reduced isolation.

North Kent CCG opened a pilot wellbeing café in Swale for 6 months, but unfortunately further funding was not available to continue this.

Medway has had a wellbeing café in operation since November 2014. The café is open from 6pm to 9pm on Fridays, 3.30pm to 6.30pm on Saturdays and 1pm to 4pm on Sundays.

East Kent CCG currently has a wellbeing café in Ashford and short term funding has been secured to continue until September 2016 following the end of the pilot scheme. East Kent CCG currently has a wellbeing café in Ashford and short term funding has been secured to continue until September 2016 following the end of the pilot scheme. Ashford CCG have reviewed the service and agreed funding to continue up to end September 2018

West Kent CCG commenced a pilot service in March 2017 Two Crisis cafés opened in Tonbridge and Maidstone; these are run by West Kent Mind & Maidstone Mind. The service was evaluated in September 2017 and funding was extended for a further 6 months which is due to end 31st March 2018. A paper went to the Senior Executive team on 6th March to request continued support of the CCG funding to remain in place for service to continue in line with PCC's commitment for a further 2 years.

4.4.6 **Frequent Service Users (FSU):**

The National CQUIN 4 requires MTW and KMPT to work collaboratively to improve the care provided to frequent service users with mental health needs presenting to A and E.

There is no nationally defined definition of what a frequent service user is. Locally it was agreed that MTW and KMPT should review the most frequent A&E attenders who had attended 10–15 times or more within the previous 12 months (2016/17). An initial subset of 23 people was identified from this group who would benefit from assessment, review and care planning with specialist mental health staff.

MTW and KMPT have established a joint CQUIN delivery group which meets Quarterly and is represented by senior team members from both organisations along with CCG Commissioning leads. The group monitors the delivery of the CQUIN, the performance of liaison psychiatry in relation to the ED department and the implementation of the core 24 service.

The Trusts have provided evidence that a framework is in place to improve services to patient with mental health needs to present frequently to A and E, including working with other key system partners (including SECAmb and NHS111) as appropriate/necessary to ensure that Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort

A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly; Care plans are shared with key system partners (with the patient's permission)

The Liaison Team Manager and the A&E Matron have also provided the relevant staff within A and E with a supportive package of learning so as to enable them to best support A and E frequent attenders with mental health needs.

FSU project (West Kent):

The FSU Manager is a RGN and independent prescriber who has an interest and qualification in substance misuse. Background as an Advance Chronic Pain Practitioner who also delivered pain services in to local prison as well as community based on a biopsychosocial model. The role focuses on the highest users of urgent care services across the whole of West Kent

This has resulted in a clear, demonstrable and measurable reduction in A and E attendances for 2 new cohorts of frequent service users (48 patients). The program has been so successful to date that a business case has been developed and the recruitment of recruit an additional team member is in progress.

Summary of FSU project:

The first cohort identified the top 25 highest users across the sites of Maidstone and Tunbridge Wells, in the four months prior to Frequent Service User Manager starting role. Cohort 2 recruited patients using the same process and a further 25 were identified. The same approach has been used again for Cohort 3 which is currently in progress; this will also consist of 25 patients.

The focus is away from medical model and toward self-management, this means supporting (visits/telephone/text) and preventing crisis occurring planning strategies for the individual; includes signposting but more so on counselling/coaching, attending appointment to advocate for the individual, relaxation techniques, accompany to support groups, mentoring, liaison across multiple service to ensure joined up working, the list goes on but the focus is on what the patients want.

- There continues to be no formal discharge as the service is there but support reduces as patients develop self-management strategies thus support reduces. Patients have the security of knowing they can access FSU manager if they wish.

Results so far (Cohort 1) have been productive:

At one year:

- ED attendances have reduced overall by 79%
- Non elective admissions have reduced by 74%
- Ambulances conveyances have reduced by 75%

Cohort 2 is complete and the data will again be looked at. So far the four month data for Cohort 2 shows on average a reduction of a third in activity.

Patient reported outcomes for anxiety, loneliness and isolation and perceived health show improvements across both cohorts. There have been no complaints or SUI's and the level of patient satisfaction is high.

4.4.7 **Single Point of Access (SPoA):**

Kent and Medway Partnership Trust (KMPT) developed a single point of access to a multi-disciplinary mental health team in April 2016. The SPoA is a referrals management function. The team is staffed by both clinically trained and support staff. The service is available 24hrs, seven days a week, including bank holidays. Patients with an urgent or emergency referral can access services across Kent and Medway. This telephone number has been shared with the Police and local GPs. This service is also linked to Mental Health Matters Helpline and NHS 111 provision.

A recent review of SPoA out of hour's activity indicates the number of calls is low with an average of 10 calls a night across Kent and Medway. Of those most clinical calls are already diverted to the Crisis Home Treatment Team (CRHT). KMPT reviewed the resources available and agreed that the following changes are the best use of funds and the most practical and clinically safe option.

Key changes from June 2018

- SPoA operating hours will be 08:00 to 22:00 hours for all GPs or emergency/urgent referrals for the public.
- The public can still self-refer to SPoA in hours if in crisis.
- The Crisis Home Treatment Teams will accept urgent referrals from GPs and liaison services out of hours.
- No direct self-referrals will be accepted out of hours.
- The Crisis Home Treatment Teams will continue to provide the out of hours crisis support telephone contact for people known to services – people on case load are given the number as part of their contingency planning.
- Emergency assessment options remain for people in urgent crisis with access to 24/7 Crisis Assessment either through 111 or mental health liaison services in A&E.
- The police will continue to get a direct response in line with the requirements of the Police and Crime Act 2017.

4.5 Development of a Health Service Directory:

This has been developed for emergency 111 services, so that callers can be signposted to appropriate services. It is a live directory which is updated regularly and contains all services that people can self-refer to.

4.6 Service user Engagement:

The Concordat Steering Group have accessed various patient and Carer platforms including the Mental Health Action Groups established across Kent & Medway as a means to consult and engage with service user/patient groups and to highlight the commitments made in the local Concordat and improve information sharing. Service user involvement played a key function in the participation of the Task and Finish group that developed the Kent & Medway Standards for S136

There are several other standing groups across Kent and Medway that have within their Terms of Reference outcomes that contribute to achieving the principles of the local MHCCC. Strong links are being forged with each of these groups in order to achieve and ensure delivery of the MHCCC principles.

These groups include:

- The Kent & Medway Suicide Prevention Strategic Steering Group
- Kent Drug and Alcohol Action Team (DAAT) Board
- Kent Safeguarding Children's Board
- Kent and Medway CQUIN Working Group on Safe and Effective Transitions
- Kent and Medway Adults Safeguarding Board
- Community Safety Partnership
- Kent and Medway Domestic Abuse Strategy Group

4.7 Approved Mental Health Practitioner Service (AMHP):

The AMHP service is a key part of the Mental Health Concordat and expects to measure itself against the national framework for the concordat in terms of its ability to respond to s136 and to referrals where a person requires an urgent Mental Health Act assessment.

The Kent AMHP Service has been in operation for four years. Medway have a dedicated daytime service but KCC deliver the AMHP Service on behalf of

Medway out of hours. This is between 5pm until 9am Mon - Friday and all hours Weekends and Bank Holidays.

Since the service began the demand of referrals has continued to rise across each CCG area. The service has used its data and governance to establish the number of AMHPs Kent needs to deliver the service. From this data additional resources have been allocated to the service. When the service is fully recruited to then changes to the service can be undertaken to respond to referrals in a timelier manner.

The partnership transformation work has established a clear workforce strategy for the AMHP Service. In 2018 5 AMHP trainees have been funded to undertake their AMHP training and next year 6 trainees have been awarded funding

The changes to the Mental Health Act that the Police and Crime Act have generated continue to place significant pressure on the AMHP Service and can detract from other pressing Community referrals that do not carry a statutory timeframe.

This year has seen another increase in Kent's police use of section 136.

The work of an AMHP is often protracted by the availability of other services that are required to work in partnership during a Mental Health Act assessment. This means that there are inefficiencies in the service that impact on the services ability to respond in a timely manner.

Outside of the Crisis Pathway, Kent AMHP Service has to ensure that it delivers Kent County Council & Medway Council Statutory Responsibilities for the displacement and appointment of Nearest Relatives, Guardianship Orders and review of Community Treatment Orders under the Mental Health Act.

The Kent AMHP Service has now has an AMHP who leads on all Nearest Relative displacement and regular meetings, a central data base, intelligence around displacements and appointments and a robust system with strong governance, quality assurance and statutory compliance is emerging.
Guardianship is maintained within the Local Authority and through the partnership this is well monitored and supported.

S136 stats are reported upon within KMPT and these can be sourced upon request. As aforementioned the pressure of s136 is a continued concern and

especially that fact that a significant percentage of referral is subject to alcohol or substance and therefore not fit to be interviewed.

Kent & Medway AMHP Service is delivered as part of the section 75 agreement between Kent County Council and Kent and Medway NHS & Social Care Partnership Trust until 1st April 2019 when it returns to KCC. Ongoing work is being completed to ensure that this has no impact on service users and carers.

The AMHP Service was also successful in its bid for high impact change money and has used this money to employ additional admin and 6 Social Work assistants. These additional roles have increased the services efficiency.

4.8 **Community Mental Health and Wellbeing service:**

The Community Mental Health and Wellbeing service - Live Well Kent was launched in April 2016 and is managed and delivered by two strategic partners: Porchlight and Shaw Trust.

Developed and funded by Kent Adult Social Care, Public Health and Clinical Commissioning Groups, the service was set up to:

- Transform fragmented delivery of different grant-funded mental health services into a collaborative network
- Support people to better manage their wellbeing within their local community, focusing on recovery and self-management
- Better understand and evidence the impact of the support provided

The service has continued to go from strength to strength in year 2 of the contract (2017/18). They received 5,422 referrals between April 2017 and end of March 2018 with 3,562 formal sign ups. Services provided through a range of community network providers include advice and support on housing, employment, accessing peer networks and participating in local community groups with a focus on improving mental and physical wellbeing and reducing isolation for those people experiencing mental health issues. Live Well Kent are currently working closely with primary and secondary care colleagues, social care and voluntary sector organisations to improve pathways of those

people with Mental Health issues and identify how gaps in the system can be addressed to improve the user experience so that people can access the right support at the right time.

4.9 Key Priorities for 2018/19:

1. In order to address Children and Young Persons (CYPS) bed provision in light of the reduction of holding time for S136 to 24hrs, a bid was successfully submitted to NHS England to develop a dedicated 136 suite for CYPS at Woodlands in Staplehurst. Plans are now being developed to initiate this project

2. Successful bids were secured from NHSE Transformation Funding to increase Liaison Psychiatry services across sites in Kent & Medway, this money is being used to review and develop the entire crisis offer. Potentially this could include the separation of functions currently provided by the Liaison Psychiatry Service and the Crisis Resolution Home Treatment Team into three distinct strands; Home Treatment, Liaison Psychiatry to inpatient medical and surgical wards, and Urgent Assessments. By remodelling the care pathway in this, way the Urgent Assessment team would be in a position to provide a 1 hour response to both Emergency Departments for Urgent Assessments, 24 hours a day.

   Work will commence on developing this new model in West Kent in partnership with WKCCG and other stakeholders, with a view to finalising a proposal by the end of September 2018.

3. There was an increase in street triage services through the development of the two pilot community triage services in Medway and Thanet. These services ran on the following days:

   Medway:
   Wednesday: Midday - 22.00hrs
   Thursday: Midday - 22.00hrs
   Friday: Midday - 22.00hrs

   Thanet:
   Friday: 14.30 - 01.00hrs
   Saturday: 14.30 - 01.00hrs
   Sunday: 14.30 - 01.00hrs

These were in addition to the countywide street triage out of hour's service which runs on:
Sunday: 16.00 - Midnight
Monday: 16.00 - Midnight
Tuesday: 16.00 - Midnight

4. A review of the current AMHP service identified areas for change and investment in order to be able to work with key stakeholders in delivering the new timeframe for S136.

5. Countywide options are being explored to review alternative places of safety i.e. crisis cafes based on a model currently used by Hestia group in London. The police / SECamb are still being encouraged to consider/utilise alternative support for people in crisis.

6. The Kent & Medway Standards for s136 and Health Based Place of Safety specification have been written and are awaiting publication

5. Financial implications:

There are no identified financial implications for the Board arising from this report. Implementation of the Concordat commitments, the cost of governance arrangements and operational changes are matters for partnership agencies and are expected to be made through existing resources and future commissioning intention. Through the 2016/17 NHS planning framework CCG's have committed finances incorporating the Parity of Esteem agenda; this includes crisis care commissioning plans.

5.1. Legal implications:

The Health and Wellbeing Board has a statutory obligation under section 195 Health and Social Care Act 2012 to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Kent & Medway. Supporting the development of the Kent & Medway Mental Health Crisis Care Concordat is therefore within the remit of the Health and Wellbeing Board.

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Background papers

DOH February 2014
https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

Care Quality Commission October 2014
http://www.cqc.org.uk/sites/default/files/20141021%20CQC_SaferPlace_2014

Policing and Crime Bill 2015-17 to 2016-17
https://www.gov.uk/government/collections/policing-and-crime-bill

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Transforming health and social care in Kent and Medway

Section 136 Mental Health Act Detentions in Kent and Medway Analysis

Information is currently collated by KMPT hospital based place of safety (HBPOS) and Kent Approved Mental Health Practitioner Service (AMPHS) in and out of hours for Kent and out of hours for Medway (Appendix One and Two).

Information available shows each month:

- Which of the three HBPOS the person is detained to
- The age band of the people detained (children, young person, ages 18-64 and over 65)
- Gender
- If the person is open to specialist mental health service
- CCG area the person is from
- Delay reason if the assessment is delayed
- Outcome following assessment.

Information is **not** collated to identify the public place from where the person is moved to the place of safety, the number of people detained more than once, those detained and assessed in other places of safety eg general hospital emergency depts. general hospital wards, custody. Kent AMHPS data is only collated for those assessments carried out in the HBPOS. They are not able to identify assessments completed in other places of safety as these are recorded under "police referrals" and therefore not able to differentiate assessments carried out in custody from a section 136 assessment. Medway AMHPS data was not made available.

The information from April to November 2018 shows that the county's three HBPOS were used 1278 times; Canterbury (559 times) and Maidstone (475 times) being the highest of the three. 95% of detentions were for those aged 18-64 with 3% for CYP mostly from DGS area. 41% of those detained were open to specialist services. Following assessment, just under 53% needed acute mental health care, either in hospital (31%) or at home with CRHTT (22%)[1], 18% required specialist community follow up and 24% were assessed to have no mental disorder and not in need of specialist follow up.

Kent police identified that they arrested for offence or bailed and placed on a section 136 at the same time, one person a month during the same period.

Questions:

1. What is the current number and rate per 100,000 of the population, detained under section 136 in Kent and Medway to HBPOS and all identified places of safety; and how does this compare to the national and regional rate?

[1] 2018 CRHTT evaluation identified that following a Section 136 assessment, some people are accepted on to their caseload to manage disappointment of not being admitted in the absence of a mental disorder.

2. How many people were detained more than once, how many times and % of total section 136 annually and how does this compare to national/regional percentage or rate?

3. How do Kent and Medway outcomes compare to those nationally?

4. What public locations are people usually in when they are moved by the police to place of safety? (Postcode information)

5. What is the use of non HBPOS and is it relevant?

6. Where have people who are detained previously accessed support / tried to access support and what support could have prevented them needing a section 136? (might need qualitative audit)

Some of the data required to answer these questions is already available however additional information, highlighted with an asterisk below is not:

1. **Profile**

- Age
- Male Female
- Ethnicity
- Postcode or partial postcode*

2. **Process**

- Date and time of detention*
- Post code or partial postcode of public place person moved from*
- Place of Safety location or post code/partial postcode person taken to*
- Transfer from custody Y/N*
- Transfer from A&E Y/N*
- Location or postcode/partial post code where MHA assessment completed

3. **Outcomes**

- Open to community mental health services in last month* Y/N
- Open to substance misuse service in last month* Y/N
- Discharged from inpatient ward in last month* Y/N
- Detained on section 136 previously in last 6 months* Y/N if yes how many times?
- Outcome following assessment
- Issues/Notes narratives particularly about access/tried to access those services above*

Recommendation

To include a diagnostic/deep dive as part of the Kent and Medway STP mental health urgent and emergency care programme.

Engage current representation through section 136 group as well as those statutory organisations not involved, to agree a period of collating wider activity data as highlighted above.

The aim is for statutory organisations to gain a shared and broader view of section 136 undertakings in order to inform strategic and policy decisions; joint working; improve outcomes for people detained and increase satisfaction between practitioners and professionals involved in the section 136 process.

Proposed milestones

- Lead identified to coordinate pilot period
- Leads identified to work together and agree timescales for wider activity data collation that includes interviews (phone or face to face) with practitioner and professionals involved from Police, HBPOS clinicians, AMHPS, other to be agreed
- Explore and agree how those who have been detained can give feedback
- Design interview proforma for practitioner and professional feedback as well as statutory organisations' message to workforce involved
- Agree data activity required and design template
- Receive and collate activity data and comparisons for outcomes achieved and impact
- Hold interviews with practitioners and professionals
- Literature search and hypothesis on impact of change in legislation on section 136 detentions
- Receive feedback from those detained and collate
- Analyse data and make regional/national comparisons (expertise to be sought from NHSE)
- Provide a first draft of report for comment
- Provide a second draft for wider comment
- Provide final version of report.

Appendix One	Hospital Based Place of Safety Activity Data April to November 2018	HBPOS activity April-Nov 18.docx
Appendix Two	Kent Approved Mental Health Practitioner Activity	Kent AMHPS activity.docx

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

Andrew Scott-Clark, Director of Public Health

To: Kent Health and Wellbeing Board

Date: 7 February 2019

Subject: Pharmaceutical Needs Assessment Updates and Supplementary Statements

Summary:

- The Pharmaceutical Needs Assessment (PNA) describes the current pharmaceutical service in Kent, systematically identifying any gaps or unmet needs in services, and making recommendations on future development, in consultation with stakeholders.
- This paper describes the process for updating the PNA with supplementary statements, enquiries and consultations and proposes a change to those processes.

Recommendations:

- The Kent Health and Wellbeing Board are asked to **AGREE** that the Pharmaceutical Needs Assessment Steering Group is given delegated responsibility to consult, collate and respond to all written requests from NHS England in relation to the PNA and provision of pharmaceutical services. on behalf of the Health and Wellbeing Board.

1. Introduction

1.1. The Pharmaceutical Needs Assessment (PNA) describes the current pharmaceutical service in Kent, systematically identifying any gaps or unmet needs in services, and making recommendations on future development, in consultation with stakeholders.

1.2. The PNA is a key document used by the local area Pharmaceutical Services Regulations Committee (PSRC) to make decisions on new applications for pharmacies and change of services or relocations by current pharmacies. It is also used by commissioners reviewing the health needs for services within their particular area, to identify if any of their services can be commissioned though pharmacies. Due to the complexity and large geographical area of Kent, a PNA is produced for each Clinic Commissioning Group in Kent County and published as chapters of the Kent County PNA.

1.3. The Health and Social Care Act 2012 transferred responsibility for the Pharmaceutical Needs Assessment (PNA) from the Primary Care Trusts to the Health and Wellbeing Boards on 1 April 2013. A PNA has to be published every 3 years. In addition, the NHS Pharmaceutical Services and Local

Pharmaceutical Services) Regulations 2013 sets out the legislative basis for developing and updating Pharmaceutical Needs Assessments.

1.4. A revised assessment should be made as soon as is reasonably practicable after identifying significant changes since the previous assessment such as significant changes to the number of people in the area that require pharmaceutical services, the demography of the area and the risks to health or well-being in the area.

1.5. Pending publication of a revised assessment, a Health and Wellbeing Board may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of the last PNA. These supplementary statements become part of the PNA when the changes are relevant to granting of applications, where the changes are needed to prevent significant detriment to the provision of pharmaceutical services in its area.

1.6. The Health and Wellbeing Board is consulted on applications for pharmaceutical services such as consolidation of service (i.e. where a pharmacy is giving up a contract, but this does not affect the access to pharmaceutical services in the area) or applications for new pharmaceutical services contracts.

1.7. The current PNA can be found at: https://www.kpho.org.uk/health-intelligence/service-provision/pharmacy/pharmaceutical-needs-assessments

2. Pharmaceutical Needs Assessment Steering Group

2.1. The PNA Steering Group is chaired by a Consultant in Public Health (currently the Deputy Director of Public Health) and includes representatives from the HealthWatch, Local Medical Council, the Local Pharmaceutical Council, NHS England, a pharmacist from the Clinical Commissioning Group, the Kent Public Health Observatory and the Kent Public Health team.

2.2. The Steering Group meets regularly when the PNA needs to be refreshed and queries and consultations are shared with members of the committee for comment.

3. Current Practice for Consultations

3.1. Currently there is an informal process followed for correspondence regarding applications, consolidations etc. These are sent by NHS England to a member of the public health team in KCC who then share these with members of the PNA Steering Group for comment.

3.2. These comments are then collated and sent to NHSE as a response from the PNA Steering Committee by the Chair of the committee.

4. Proposed Process for future

4.1. It is proposed that to ensure that the Health and Wellbeing Board processes queries and consultations in the correct manner, that a formal process is agreed and correspondence from NHSE relating to the PNA is distributed to the PNA Steering Group by email. Any comments would be sent to the Chair

of the Group and incorporated into a response sent on behalf of the Kent Health and Wellbeing Board.

4.2. The Chair of the PNA Steering Group will deliver an Annual Report detailing all written requests from NHS England in relation to the PNA and the provision of pharmaceutical services. This will include any supplementary statements and any responses to NHS England that are provided on behalf of the Kent Health and Wellbeing Board.

5. Recommendations

5.1. The Kent Health and Wellbeing Board is asked to **AGREE** that the Pharmaceutical Needs Assessment Steering Group is given delegated responsibility to consult, collate and respond to all written requests from NHS England in relation to the PNA and provision of pharmaceutical services. on behalf of the Health and Wellbeing Board.

6. Contact details

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Appendix 1: PNA guidance

Pharmaceutical_Needs_Assessment_Info

Appendix 2: PNA Steering Group Terms of Reference

Terms of Reference.doc

Appendix 3: PNA Steering Group Terms of Reference

Appendix 3 - PNA paper.docx