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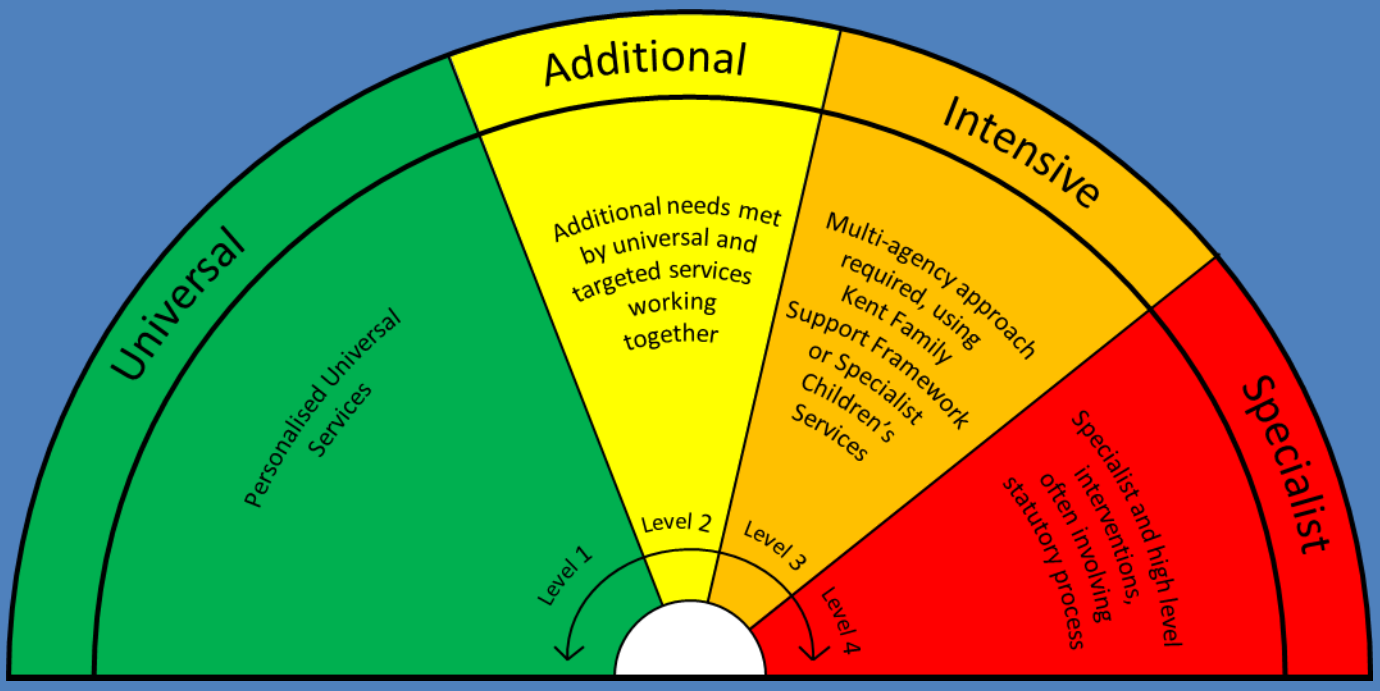
Early Help & Preventative Services (EHPS) Commissioning

Analyse Phase: Executive Summary and Diagnostic Report

July 2015



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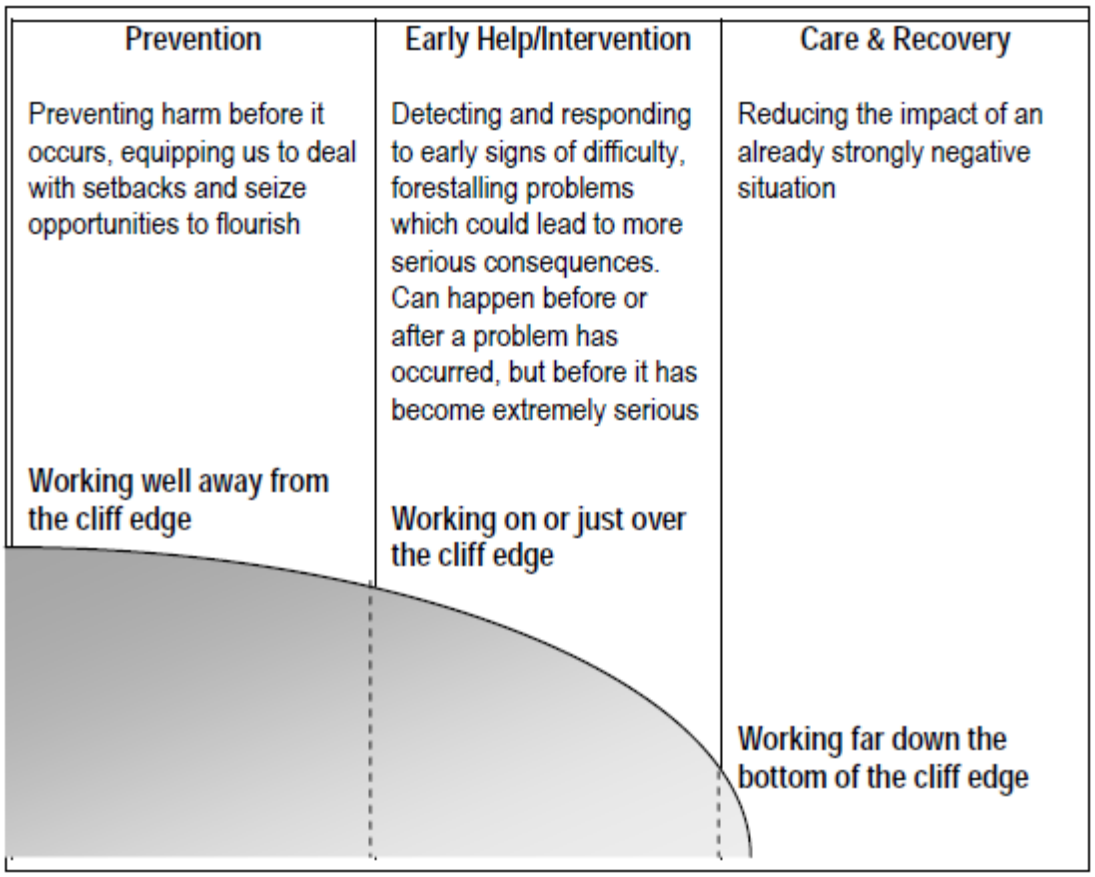
EXECUTIVE SUMMARY

1. THE CHALLENGES FACING US

The Public Sector is currently facing significant financial challenges and it is critical that KCC focuses its resources to ensure that our most vulnerable children, young people and their families are identified and supported as early as possible to prevent escalation into more complex and costly health and social care problems.

Whilst efficiencies are required we have seen changing patterns of referrals in the last year originating largely from Universal settings especially GPs and Schools. EHPS is facing a challenging picture. There are emerging requirements to offer an appropriate and effective service to those families who need it (including Troubled Families) whilst recognising that EHPS is not a blue light service and that Universal services need to be supported to play a part in managing demand and early identification.

At the same time, EHPS plays an important part in the support and recovery of children, young people and families who have experienced adverse situation or have needed to be within statutory social care provision but are ready to move on with their lives with support.



Our existing external offer was put in place when there was little Early Help intensive provision. Services were accessed mostly through CAF which resulted in some children from across the continuum not being able to access an appropriate service despite having high needs. In addition, the introduction of the Troubled Families programme and the development of KCC's Early Help offer has changed the commissioning landscape and service requirements.

As a result our existing external offer does not sufficiently enable us to meets the challenges that face us and we are coming to the end of our existing arrangements. We therefore have an exciting opportunity to re-design our priorities and approaches.

2. HOW WE WILL MEET THESE CHALLENGES

- Build community and family resilience to reduce dependency on high cost services for those who are able to, by utilising community capital, creative and sporting opportunities
- Ensure a wide range of transformational activities, which promote emotional well-being available for the most vulnerable children and young people, including those known to Specialist Children's Services
- Build a holistic early help and preventative services workforce to reduce the number of cases entering into statutory services and ensure a timely and effective step down process of cases into EHPS
- Reduce the number , similarity and duplication of external arrangements
- Provide opportunities for locality based commissioning based on local needs and innovation
- Ensure good utilisation of commissioned services including reduced waiting lists and reduced bureaucracy to access services
- Lessen performance management processes whilst maintaining confidence in the quality of the work through robust contract management
- Build upon social value and encourage the growth of micro and small organisations within Kent.
- Deliver the budget savings required and ensure all commissioned services can demonstrate value for money

3. APPROACH

This diagnostic report summarises the findings of the EHPS commissioning 'Analyse' phase, answering the 12 questions identified in the KCC commissioning framework.[1] It is informed by a needs analysis, stakeholder workshops and data analysis. The evidence will inform proposals for the redesign and re-commissioning of EHPS external services.

A diagram of the Analyse Phase methodology is shown below:

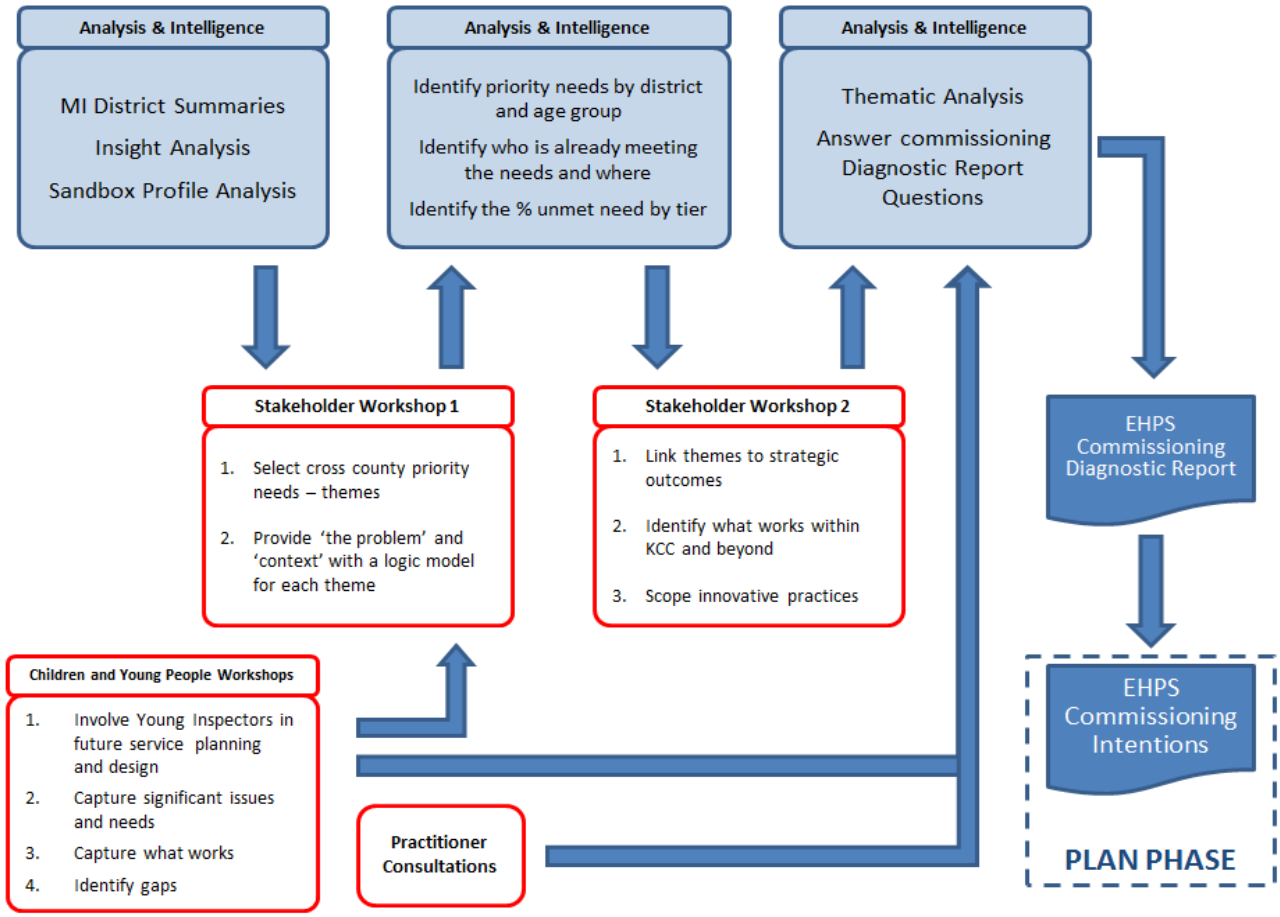


Figure 1: Analyse phase methodology

The key commissioning priorities are also informed by the views of young people and multiagency practitioners. In addition, existing performance monitoring and reviews of current services has provided crucial insight that supports the proposals outlined.

[1] Questions have been extracted Kent County Council (2015) A commissioning framework for Kent County Council: Delivering better outcomes for Kent residents through improved commissioning

4. A brief summary of the diagnostic findings

i. A large proportion of the overall need is concentrated in specific communities

- Many high risk groups are concentrated within specific deprived communities. Analysis shows that many of these children and young people are known to more than one agency and often come from the same families;
- These specific communities are known and the population groups (as defined by Mosaic) L, M, N and O make up 22% of Kent's population. These groups often have multiple needs which result in a disproportionate demand on preventative and specialist services;
- The households of these communities tend to be in some housing estates as well as lower cost privately rented areas. However, some families are more transient but they have in common financial stress, low pay or unemployment, poorer health, limited qualifications and areas of crime; and
- Some schools, academies and other settings have greater proportions of their children and young people coming from these families and communities.

ii. The key issue raised is the need to address emotional health and well-being

- Key characteristics (in no particular order) are behavioural difficulties, education / development issues (including school non-attendance), poor relationships within families, parenting issues, domestic abuse (including child perpetrators), housing and financial issues and substance misuse;
- A large number of families are affected by two or more of these factors with some comorbidity well evidenced (e.g. the "Toxic Trio" of domestic abuse, mental ill health and substance misuse);
- A holistic approach to identify underlying / causal factors, not only the presenting symptomatic problems is key to improving outcomes; and
- Some parental factors (including substance misuse, mental illness or other disabilities can lead to children and young people becoming Young Carers.

These findings are consistent with a whole family approach to working with children, young people and their families

iii There is support for better utilising localised family and community capacity in the wider preventative agenda – especially:

- Community assets such as people, places and organisations like clubs, arts, culture and sport;
- Social enterprises, the wider Voluntary and Community Sector (VCS) and local businesses (particularly to remove any perceived stigma attached to statutory services; and
- Engaging users in the provision of services e.g. expanding the use of volunteers and mentors within services, or enabling children to mentor at school.

This finding supports the current direction of travel in transformation to enable the role of communities in creating positive outcomes and by using local knowledge to inform local solutions. It suggests that local, smaller scale resources offering social value be considered in the commissioning of external services, such as through a localised commissioning approach.

iv. An integrated evaluation approach should be undertake to measure performance and ensure success

- Aligning the performance evaluation of services is critical to ensure that KCC can identify the impact and compare impact of EHPS services.
- The development of an integrated evaluation framework would strengthen this approach.

5. KEY COMMISSIONING PRIORITIES

As a result of the analyse phase the following **three key priorities** have been identified. These collective priorities provide the platform for future commissioning.

1. Emotional Health and well-being

Key concern	Emotional health and well-being is a signficant factor in demand for EHPS and in the needs of many children and young people. Parental low level mental health issues can be a factor in contributing to poor well-being in children/young poeple.
Key outcomes	Improved resilience and wellbeing Reduced mental health and behavioural problems Lower demnad for specialist CAMHS
What is required?	Focused Family emotional wellbeing support to children,young people and their families who are experiencing early signs of emotional and mental health difficulties, at additional and intensive levels with delivery also through Universal settings. such as schools*. Increased ability to manage EHWB demand throughadditional support on Universal settings* * Kent Emotional Health and Well-being Strategy

2. Family support & Parenting

(incl. troubled families, vulnerable young people and NEETs)

Key concern	Vulnerable CYP can have a range of poor outcomes, are in families with complex problems, including generational or long term unelmployment, who are concentrated in deprived communities. Identifying and addressing 'causal' factors, not only presenting 'symptomatic' problems, is central to improving outcomes.
Key outcomes	Improved outcomes of family members, incl. parenting skills to manage challenging behaviours, in more complex and vulnerable families Improved outcomes for vulnerable/disadvantaged young people Improved early childhood outcomes in Kent's more deprived areas
What is required?	*Additional and intensive services for vulnerable adolescents to address a range of risk factors, incl. NEET, positive relationships, family conflict, risk-taking, & CSE* *Intensive whole family approaches for more complex circumstances, including domestic violence and abuse, crisis intervention, bereavement, and other support to enable greater family resilience.*

3. Young Carers and Youth Services

Key concern	Young carers are more vulnerable to a range of poor outcomes, including in areas of education, friendship and emotional well-being Adolescence is a critical developmental stage with a range of complex personal and social needs. Young people can become isolated, have low aspiration, have a range of poor outcomes and often live in deprived communities/areas.
Key outcomes	Young carers and disadvantaged young people experience opportunities and are motivated to achieve positive adult independence and well-being. Children and young people can access or are supported to access opportunities for social and educational development that assists improved engagement in education and training, health, resilience, emotional well-being and social skills
What is required?	*Identify, assess, and provide holistic support to young carers* *Open access support for young carers to reduce isolation, to make friendships, and improve skills/capabilities* *An excellent Youth Offer across all districts that provides opportunities for a wide range of young people and targetted work within universal settings to ensure that support is provided at the earliest possible opportunity to address any emerging difficulties and prevent escalation of problems* *Targetted reach to vulnerable young people and communities In the context of young people's lives which may be highly mobile and digital to ensure reach to rural and urban deprived areas, children in care or other at-risk adolescents*

Early Help & Preventative Services (EHPS) Commissioning

Analyse Phase: Diagnostic Report

July 2015

Diagnostic Report

1. Introduction

This diagnostic report summarises the findings of the EHPS commissioning 'Analyse' phase, answering the 12 questions identified in the KCC commissioning framework.[2] It includes needs analysis, stakeholder workshops and data analysis. The evidence will inform proposals for what should be achieved through the commissioning exercise, documented within the EHPS Commissioning Intentions document.

The report has been jointly completed by the Strategic Business Development & Intelligence Division and the EHPS Commissioning Division in conjunction with the Director for EHPS. A wide range of staff from Public Health and services for children and young people have been involved in developing this report.

2. Background

Early Help means intervening as soon as possible to tackle emerging problems (focusing on needs not symptoms). It is about ensuring that every child and young person from pre-birth to age 19 (and their family) who need Early Help services receive them in an effective and timely way. This will contribute to safeguarding, health, educational, social and emotional needs being met. Early Help reflects the widespread recognition that it is better to identify and deal with problems earlier rather than respond when difficulties have emerged, when intervention can be less effective and often more expensive.

As part of the wider KCC transformation, EHPS is also undergoing transformation. EHPS hold approximately 150 contractual and grant arrangements with external providers to deliver services to children, young people and their families. These contracts are currently being aligned as far as possible to end in March 2016 with the intention of reshaping the offer in line with the revised EHPS restructure and proposed new ways of working, as outlined in 'A commissioning framework for Kent County Council'.

KCC has re-designed EHPS to provide additional support in open access settings and Early Help Units providing intensive targeted casework.

Within the internal offer, one of the key principles is that open access will be used to help children and families improve their life chances and within the units there will be an 80/20 split whereby staff working in the Units will spend 80% of their time on targeted casework and 20% of their time delivering open access services, whilst staff working in open access will spend 80% of their time here and 20% of their time on light touch targeted work.

- In the new EH Unit model, one Early Help practitioner is working with families from end to end. Other members of the EH Unit who have good knowledge of the family,

[2] Questions have been extracted Kent County Council (2015) A commissioning framework for Kent County Council: Delivering better outcomes for Kent residents through improved commissioning

provide support where needed and cover during periods of leave. The model allows practitioners to draw upon the expertise of their colleagues so that, where appropriate, they can work on a 1:1 basis with families, addressing the range of presenting issues. This means families benefit from building a relationship with one practitioner and can rely on consistency throughout their intervention.

- The redesign of EHPS is inextricably linked with the activity taking place in the 0-25 Unified Programme.
- The new structure will support the step up/step down process. The new way of working for EHPS is also critical to the 0-25 Unified Programme and its objectives, as the 80/20 split and early intervention measures will support a reduction in the number of cases that become critical and need to be managed by SCS.

Local government contributes the largest proportion of public funds on late intervention in Kent (approximately £151 million - almost the same amount as other public sector services combined). The most significant areas of late intervention spend in Kent are youth economic inactivity (including those young people Not in Education, Employment or Training (NEETs), Child Protection and safeguarding, and crime and anti-social behaviour; it is widely acknowledged that savings can be made through early intervention.

Practitioners and stakeholders identified other agency resources were meeting the needs of children and young people. This included District Councils, Public Health, the VCS, the police and the private sector. The sum total of this investment is not known.

There are a number of other services that tackle – or will tackle - similar issues and outcomes, in addition to KCC (at universal, additional and intensive levels). An example is the imminent re-commissioning of the School Nursing service and support for vulnerable adolescents or school based provision for emotional wellbeing. The challenges are to achieve the following:

- Delivery of the KCC and EHPS Strategic Outcomes and improve educational,health and safeguarding outcomes for children, young people and families
- To build a holistic early help and preventative services workforce to reduce the number of cases entering into statutory services and speed up the step down process of cases into EHPS
- To ensure as few professionals as possible are involved with a family
- To reduce the number, similarity and duplication of external arrangements
- To provide opportunities for locality based commissioning
- To ensure timely access to support, good utilisation of commissioned services and reduction in waiting lists

- To reduce bureaucracy and unnecessary performance management processes whilst maintaining confidence in the quality of the work through robust contract management
- To build upon social value and encourage the growth of micro and small organisations within Kent
- To build community and family resilience to reduce dependency on high cost services for those who are able to, by utilising community capital, peer based models and creative and sporting opportunities
- To deliver the budget savings required

3. Approach to 'Analyse' Phase

A diagram of the Analyse Phase methodology is shown below:

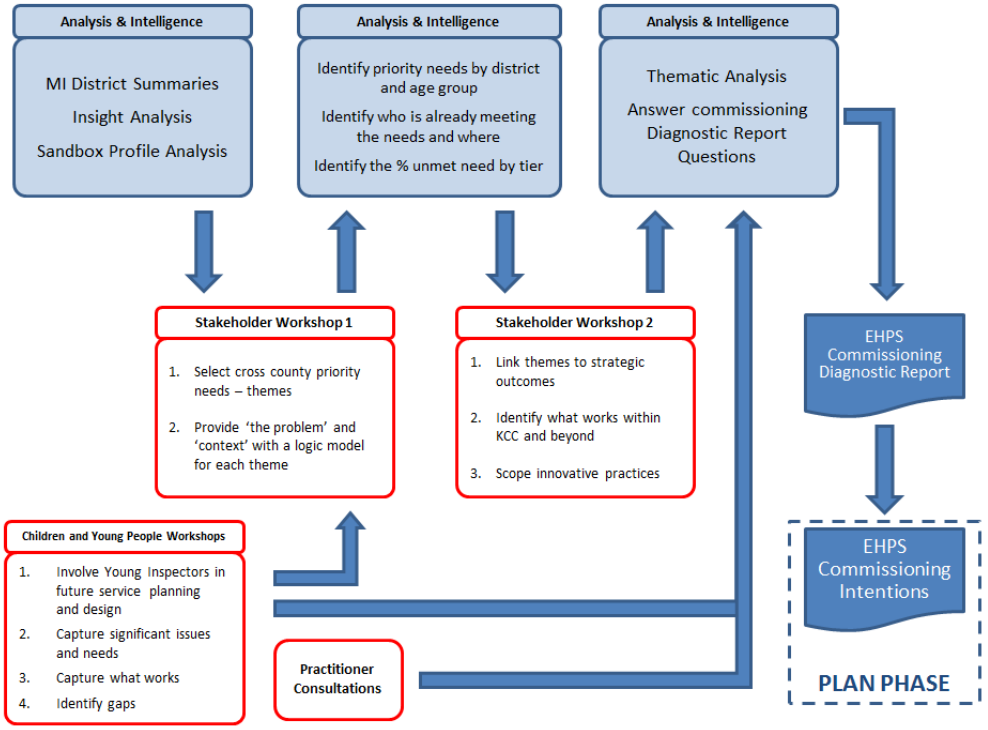


Figure 2: Analyse phase methodology

Consultation with in-house Early Help teams, external service providers, partners, stakeholders and service users underpins every stage of the commissioning cycle. It is an important two-way process whereby feedback is sought and considered in order to inform the development of commissioning intentions. As the process progresses there will be continued checking back to ensure proposals are robust and will address identified needs. This will also ensure that partners and stakeholders have clarity about the Early Help commissioned offer and expectations can be managed effectively.

The stakeholder analysis comprised of:

- Children and young people workshops aimed to better understand their needs and the issues that concern them.
- Workshop 1 identified and prioritised the local perception of need at District level and where EHPS external arrangements need to focus.
- Within the priority themes highlighted from workshop 1, workshop 2 identified the supporting outcomes which would ultimately be improved, gave examples of successful programmes and models and suggested new innovative models.
- Separate Practitioner Consultations, aimed at internal Early Help teams and voluntary sector service providers, identified service gaps across Kent.

4. Budget Scoping

The total net budget for Early Help and Preventative Services is £29,010.5. This budget includes youth offending, troubled families, attendance and inclusion, children's centres, youth hubs and Early Help Intensive support.

The following contracts are in scope to this commissioning programme

- Troubled Families contracts (Family Intervention Project (FIP) and FIP light)
- Youth contracts
- Not in Education, Employment, or Training (NEET) participation contract
- Specialist and targeted Early Intervention contracts and grants.

For these contracts, the current 15/16 budget is set out below[3].

Budget	Contracts
£3,881,526.82	Early Intervention and Prevention
£1,105,001.00	NEET Participation
£1,434,709.79	Youth
£,1,543442.00	Troubled Families
£7,964,679.61	**Total**

Table 1: Current EHPS commissioning 15/16 budget

KCC's Medium Term Financial Plan (MTFP, March 2015) is clear: whilst KCC made £350 million of savings between 2011-12 and 2014-15, there is the need to make further savings of a proportionate magnitude over the next 3 years. The 2016/17 commissioning budget is yet to be finalised; it is anticipated that savings will be made.

Commissioning arrangements are currently in place with the Youth Justice element of EHPS. Scoping is due to start to agree milestones and interdependencies for re-commissioning.

Whilst Troubled Families (TF), FIP workers and FIP light contracts are in scope, a number of TF contracts and grants will continue outside this process.

As Children's Centre re-commissioning is part of the wider Transformation agenda, work to scope the vision and approach will begin from September 2015 with a view to re-commissioning from April 2017. This will align with the renewal of the Health Visitor contract.

[3] Early Help & Preventative Services (EHPS) Commissioning re-design - Update to the 0-25 Portfolio Board

5. Diagnostic report question summaries

A summary of the Analyse Phase analysis and findings, answering the 12 questions identified in the KCC commissioning framework is shown below:

5.1 What are the challenges we are seeking to address?

The Public Sector is facing significant financial challenges and it is critical that KCC focuses its resources to ensure that our most vulnerable children, young people and their families are identified and supported as early as possible to prevent escalation into more complex and costly health and social care problems.

Whilst efficiencies are required we have seen changing patterns of referrals in the last year originating largely from Universal settings especially GPs and Schools. There are emerging requirements to offer an appropriate and effective service to those families who need it whilst recognising that EHPS is not a blue light service and that Universal services need to be supported to play a part in managing demand and early identification.

At the same time, EHPS play an important part in the support and recovery of children, young people and families who have experienced adverse situations or have needed to be within statutory social care provision but are ready to move on with their lives with support.

As our existing external offer does not sufficiently enable us to meets the challenges that face us and we are coming to the end of our existing arrangements we have an exciting opportunity to re-design our priorities and approaches.

5.2 What are the needs of our residents and / or service users and how are these likely to change?

The detailed needs and numbers analysis is shown in section 6. A summary is given below:

- EHPS externally commissioned services mandate is specific to 0-25 year olds.
- National research shows that deprivation in childhood has significant short and longer term impact, particularly in the areas of Health and Education.[4] The EHPS users with a greater likelihood of need live in deprived areas within Kent.[5]
- The top characteristics and reasons for Early Help Notifications (EHN) are the same in every District:
- One or more members of the household with (Tier 2) emotional and / or mental health needs
- Significant behavioural difficulties

[4] http://www.cpag.org.uk/content/impact-poverty Last accessed 09 June 2015.
[5] Segmentation and profile analysis, KCC Business Intelligence, 2015

- Significant non-attendance at school

Residents can experience disadvantage on the grounds of age, gender, disability, race, religion or belief, sexual orientation. Each group may have particular and / or greater needs from EHPS externally commissioned services. Some examples of this are: on average, girls have better educational outcomes than boys at 16; people with disabilities are more likely to live in poverty and experience problems with housing; and Lesbian, Gay, Bisexual and Transgender (LGBT) people are more likely to experience poorer treatment from public services and bullying, hate crime and homelessness,

By the end of primary school, pupils receiving free school meals are estimated to be almost three terms behind their peers. By age 14, this gap grows to over five terms.

5.3 What are practitioners and service users telling us?

Common themes raised by practitioners, stakeholders and service users were support for mental ill-health and a whole family approach.

Thematic analysis from stakeholder workshops emphasised the need to facilitate greater engagement with the community by working with service users, families, facilities and local organisations (i.e. open access services such as businesses, voluntary sector and community groups such as sports and arts).

Children and young people identified the following issues: Mental Health, policing and the need to feel safe, advertising and marketing of services, improvement of public transport and bullying.

5.4 What other resources are being used to tackle similar issues and outcomes?

The following examples are currently being explored as part of an alignment strategy with EHPS.

- Emotional Health and Mental Health services delivered through Schools, KCC, CCGs and Public Health.
- Public Health services such as Health Visitors, Family Nurse Partnerships, School Nursing, Substance misuse and Teenage Pregnancy support.
- District Councils support for Young People, anti-social behaviour, housing and community safety.
- Supporting People support for homeless young people
- Partnership investment in Domestic Abuse.
- Work with Arts and Culture organisations to enhance traditional offers of support.

5.5 What is driving demand for these services and what is our evidence for this?

Demand expressed by EHPS notifications, comes from a number of different organisations but these are predominantly submitted by schools (43%), KCC Services,

including adult's and children's social care, (24.5%) and Health (19.5%). The numbers of Early Help Notifications (EHNs) from September 2014 to March 2015 totalled 4146.

5.6 How is demand for these services likely to change and what will be the impact?

Recent analysis as part of the 0-25 Transformation Programme has demonstrated that demand in EHPS varies month on month and over time. This creates some difficulty for accurately predicting the demand for a range of services, the flow between internal and external provision and how cases are allocated.

The projected increase in the population (approximately 9% over 10 years) could potentially lead to an increase in demand for EHPS commissioned services; what this looks like in the short-medium term is not known.

A number of other contributing factors, both internal and external to KCC, could also drive a change in demand e.g. the shift in schools provision, changes to funding availability in Clinical Commissioning Groups (CCGs) and Public Health and the ability of VCS to continue despite funding cuts.

5.7 How effective are the services currently being delivered and what is the current cost?

Currently there are a range of internal and external EHPS services. Across some tiers and age groups there is evidence of clustering of external services (within additional and intensive for ages 5 – 25). Following the creation of an EHPS directorate and subsequent transformation activity, performance scorecards and targets have been set. Early indicators show a wide reach and improvements in focused work achieving good outcomes. A comprehensive evaluation of this work is planned..
For the EHPS external offer; based upon the original contracts awarded to these services, performance has been either 'good' or 'acceptable', however the impact of these services has been harder to measure. It is essential that systems are in place to measure the impact of both internal and external services in the future.

5.8 What is the state of the current market and how is this likely to change?

Over the last three years some providers have started to work more collaboratively and in partnership and may be well placed to meet new procurement challenges and models such as larger contracts or consortium arrangements with a greater range of partners involved. However, there are still a range of micro and small organisations that have yet to respond effectively to the changing landscape and have the potential to be put at risk through the lack of infrastructure and experience of competing for larger scale contracts. Any commissioning intentions will need to reflect both the need for efficient procurement and localised opportunities to sustain and build upon the current good practice undertaken by the micro and small VCS providers. While some providers are well placed, others (micro and small VCS in particular) have yet to respond effectively. Local research has shown that over 5 a year period smaller VCS organisations were at increased risk of ceasing to exist.

5.9 How can we join up resources and activities with other partners to maximise our impact?

The EHPS commissioning approach comprises joined up working with other partners through several different mechanisms, including: local District-level commissioning, local funding streams, engaging with Public Health and cross partnership bodies. Stakeholders recommended that local, District level commissioning would best facilitate engagement with local communities e.g. service users, universal services, social enterprises, the wider voluntary and community sector and local businesses.

5.10 What are the outcomes we are seeking to achieve through this new commissioning exercise?

EHPS commissioned services aims support the KCC strategic outcome - Children and young people in Kent get the best start in life.

Service specific outcomes will be determined within the service specifications

5.11 What will success look like?

The EHPS Three Year Plan sets out the key performance targets and indicators for 2015-18.These support the key outcomes set out in this document. Other indicators of success will be:

- Increased family resilience
- Narrowing the gap in attainment
- Development of social value and the growth of micro and small organisations
- Meeting budget / efficiency targets

In order to evaluate the impact and effectiveness of EHPS and provider success in the future, appropriate analysis frameworks and measures must be developed at ‘Plan’ stage and implemented.

6. Detailed needs and numbers analysis

This section provides detailed needs and numbers analysis, specifically:

- Deprivation
- Children in education
- NEETs
- Presenting and underlying needs
- The toxic trio
- Equality and diversity
- Young carers
- The community perspective
- Demand for services

6.1 Deprivation

National research[6] illustrates that children from poorer backgrounds are disadvantaged in many areas. These include – but are not limited to – lower birth weight, more likely to live in bad housing, lower educational attainment and social isolation due to poverty.

The Indices of Multiple Deprivation covers a broad range of issues and refer to unmet needs caused by a lack of resource of all kinds, not just financial. The most deprived areas are usually defined as those areas that are among the 10% most deprived. 98% of all of the most deprived areas in England are urban areas, although this is not the case in Kent for some rural areas e.g. Swale and Shepway. See Figure 3 for the Kent Deprivation Scores at lower super output level.

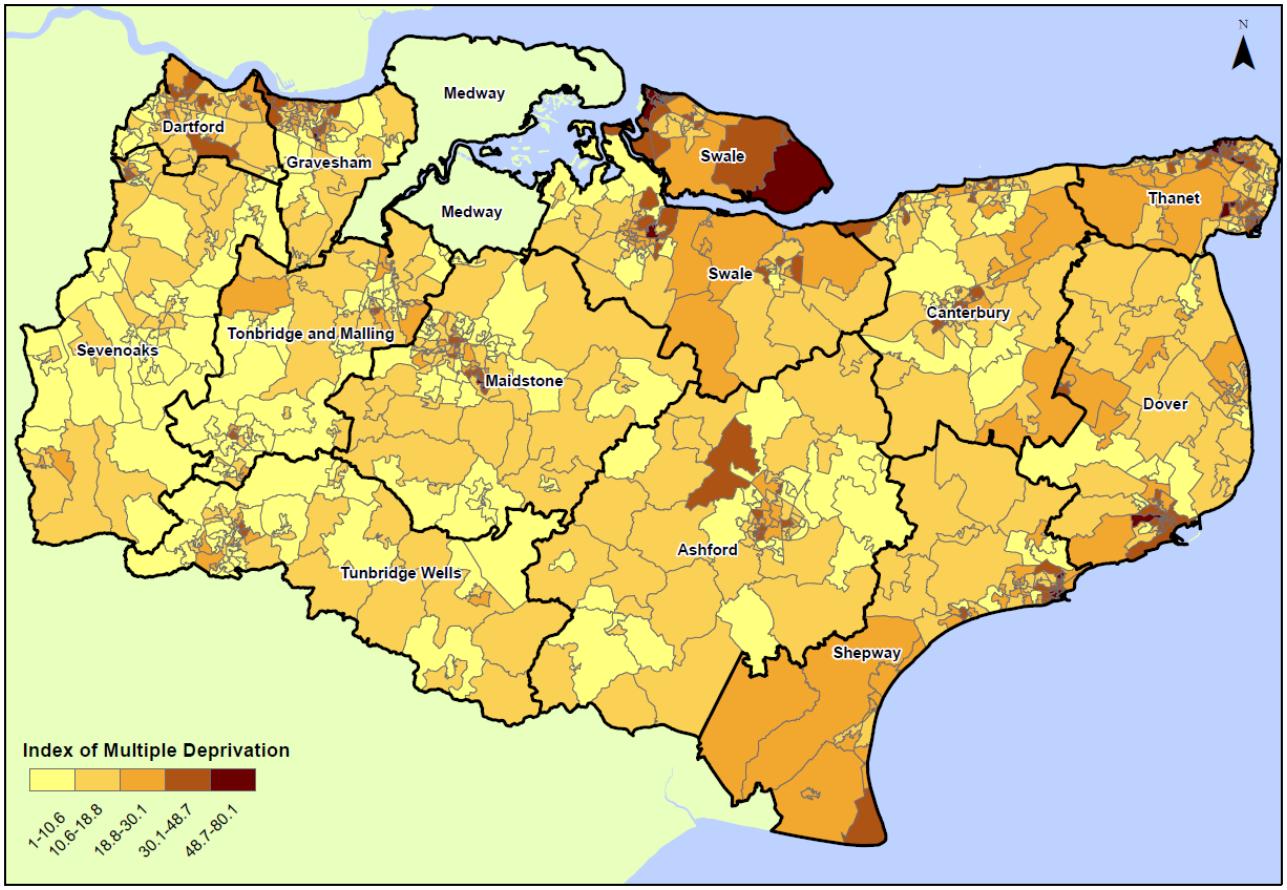


Figure 3: Kent Deprivation Scores at lower super output level (IMD 2010)

In Kent, there are pockets of deprivation usually focused around urban areas. In general, Tonbridge and Malling, Sevenoaks, Maidstone and Tunbridge Wells have much lower levels of deprivation than the rest of Kent. The highest levels are wards in Thanet, Swale and Shepway.

[6] http://www.cpag.org.uk/content/impact-poverty Last accessed 09 June 2015.

Mosaic is a classification system to profile the characteristics of the UK population and classify households as belonging to one of 66 types, which fall into a broader range of 15 groups. These types and groups describe the residents of a household in terms of their typical demographics, behaviours, lifestyle characteristics and attitudes.

Previous studies[7] have highlighted 4 Mosaic Groups, L, M, N and O, as those that are overrepresented in many high risk groups such as social services referrals, EHNs, youth offending, NEETs etc. The Mosaic system provides the location of families that fall into these groups which can therefore be used as a way of predicting the communities and universal source settings from which notifications, referrals and higher risk individuals are more likely to come in the future.

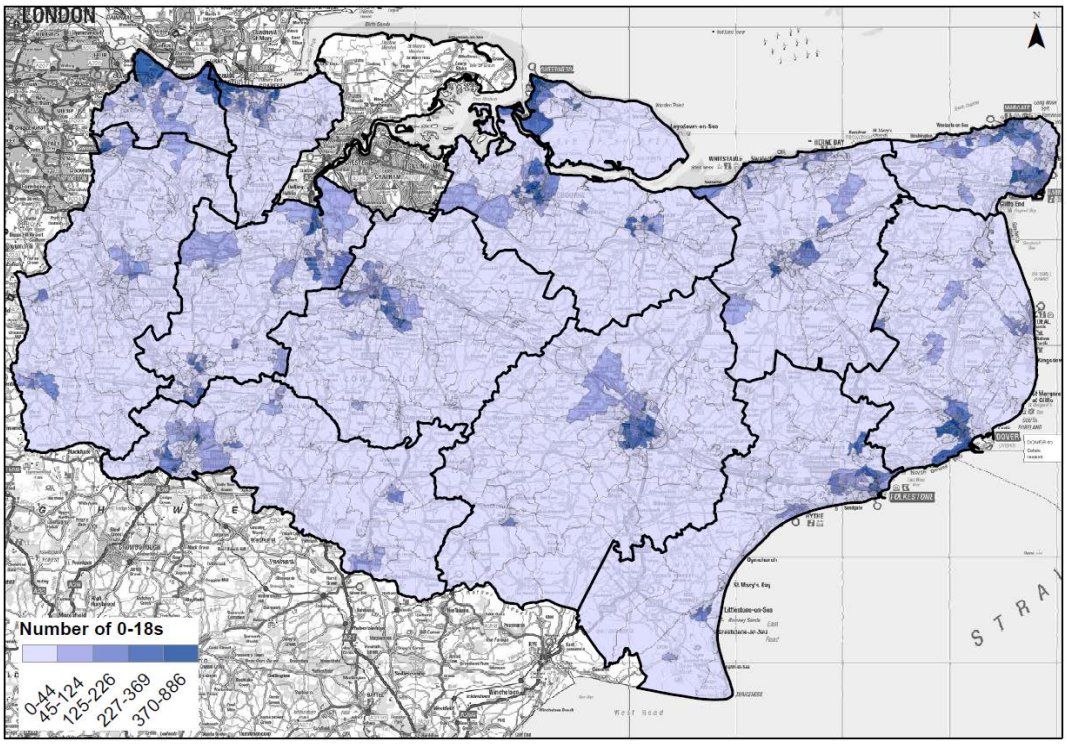


Figure 4: Location of 0-18 year olds in Kent belonging to Mosaic Groups L, M, N and O

Although these groups have different characteristics, they are usually found in urban areas and social housing (or privately rented) estates in city suburbs. These families are the least affluent of the Mosaic Groups and are facing an array of issues. These families make up 22% of the population of Kent. Group profiles can be found in Appendix 2: Mosaic L, M. N, O profile summaries.

Analysis has shown some schools, academies and other settings have greater proportions of their children and young people coming from these families and communities.[8]

[7] Business Intelligence (2014/2015) *Troubled Families – A Mosaic Profile of Families and Outcome, An Analysis of Young People not in Education, Employment or Training, Domestic Abuse Notifications, Insight Report for Children's Centres*

[8] Business Intelligence (2015) *Vulnerable Children and Young People – Key Stage 4 (GCSE) Attainment*

6.2 Children in Education

The information in this section sets out a detailed breakdown of the characteristics of children in education in Kent, therefore identifying their needs.

Kent has a school population of 221, 902.[9] The key characteristics of this population are displayed below for both primary and secondary schools:[10]

	Primary school	Secondary school
Total number of pupils in Kent schools	**113,449**	**98545**
Educational Psychology referral	1077	302
Troubled Family	923	1402
SCS referral	4558	3117
Looked After Children	410	459
Child Protection Plan in place	406	188
Child in Need	1579	1069
Youth Offending	0	344
Permanent exclusion	33	138
More than one fixed term exclusion	479	4185
Children Missing Education referral	290	203
Elective Home Education referral	99	140
Physical SEN	6790	3546
Behavioural SEN	4354	4203
Between 85%-90% attendance	6538	6912
Less than 85% attendance	3518	4544
Free school meals	14976	9325

Table 2: Characteristics of pupils in schools in Kent

[9] KCC (2015) School Census (EY directorate, Information and Intelligence as of January 2015)
[10] Kent County Council (2015) Figures provided by Business Intelligence – based on matched data (not whole population)

According to Department for Education statistics, by the end of primary school, pupils receiving free school meals are estimated to be almost three terms behind their more affluent peers. By 14, this gap grows to over five terms. By 16, children receiving free school meals achieve 1.7 grades lower at GCSE.[11] See Figure 6 below for the characteristics of children eligible for free school meals in Kent.[10]

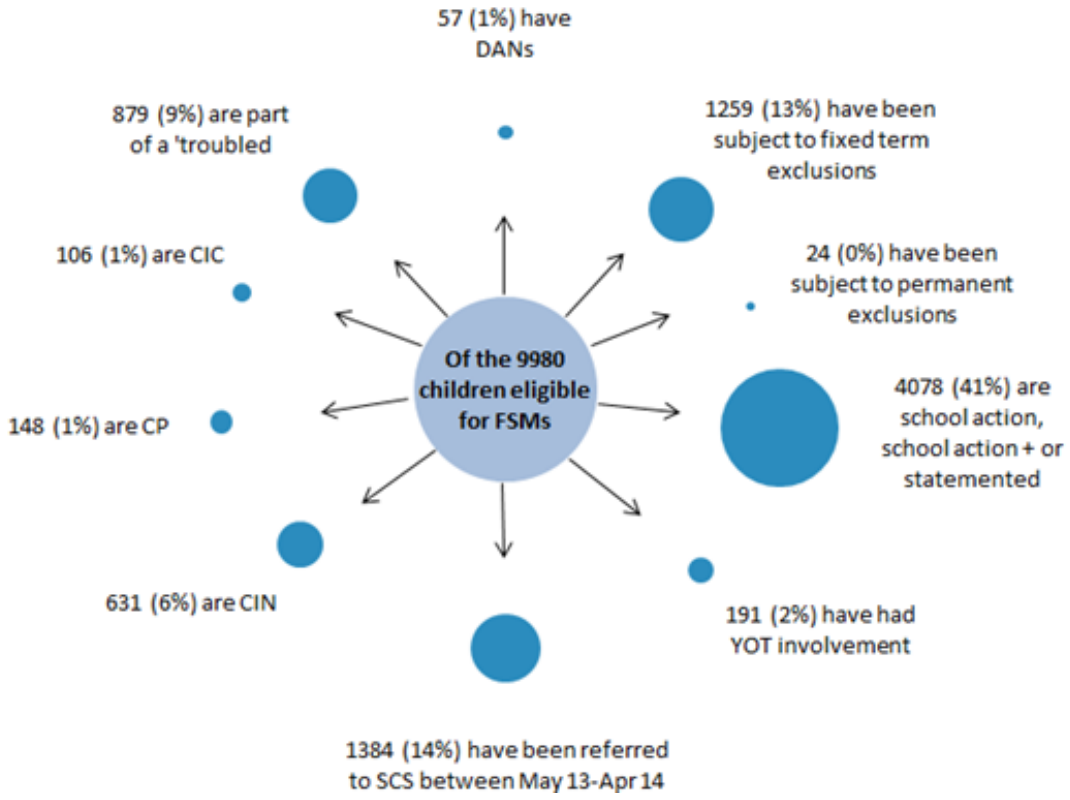


Figure 5: Characteristics of children eligible for Free School Meals (FSM)

[11] http://www.cpag.org.uk/content/impact-poverty Last accessed 09 June 2015.

Of the total Kent school population, around 2.8% (more than 6,500) are children and young people subject to a Statement of Special Educational Needs (SEN). The distribution of statemented pupils across Kent Districts[10] is shown below.

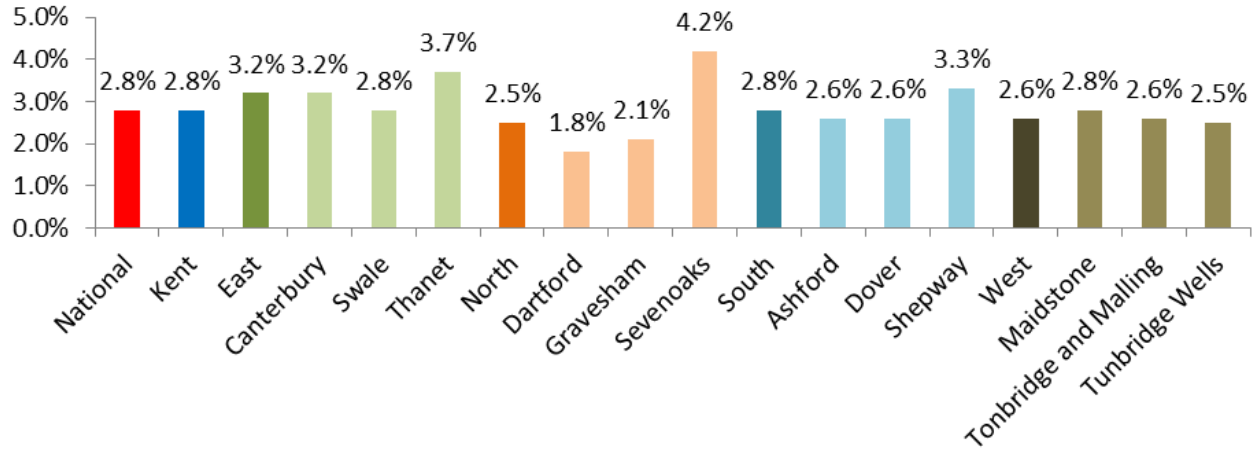


Figure 6: Statements of SEN across Kent

There are a number of additional factors which affect children with SEN (not only those statemented).[10] These include:

- 5% are part of a Troubled Family
- 9% have been subject to fixed term exclusions
- 17% are eligible for free school meals
- 2% are looked after children
- 1% have a Child Protection Plan
- 5% are Child in Need
- 7% have been referred to SCS between May 2013 and April 2014

6.3 NEETs

NEETs are one of the largest proportionate late intervention spending areas in KCC and England and Wales and are disproportionately from low income families with multiple challenges.[12]

A contributing factor to NEETs is exclusion from primary and secondary school.

Factors	Primary school %		Secondary school %	
	Pupils excluded (658 total)	Pupils not excluded	Pupils excluded (6,757 total)	Pupils not excluded
Male	91	51	73	50
Educational Psychology referral	17	1	2	0
Troubled Family	11	0	16	0
SCS referral	20	4	13	3
Looked After Children	4	0	3	0
Child Protection Plan in place	3	0	1	0
Child in Need	9	0	6	1
Youth Offending	0.5	0	7	0
Children Missing Education referral	2	0	2	0
Elective Home Education referral	1	0	2	0
Physical SEN	9	6	6	4
Behavioural SEN	73	4	28	4
Between 85%-90% attendance	11	6	11	6
Less than 85% attendance	19	3	16	3
Free school meals	47	13	22	8

Table 3: Factors related to pupils at school excluded (fixed or permanent) / not excluded

Research has shown that the cost of being NEET between the ages of 16 to 18 is estimated to be around £56,000 in public finance costs and £104,000 in resource costs (lost labour market potential), over the working lifetime of each person who has been NEET at this age.[13]

[12] Business Intelligence (2015) *Vulnerable Children and Young People- Fixed and Permanent Exclusions*
[13] Coles, B., Godfrey, C., Keung, A., Parrott, S., Bradshaw, J. (2010) *Estimating the lifetime cost of NEET: 16-18 year olds not in Education, Employment or Training* University of York

6.4 Presenting and underlying needs

The Kent Family Support Framework (KFSF) is the structure through which families requiring intensive support come to the attention of Early Help services through to assessment, planning and review. It incorporates the Early Help notification form by which any service or individual identifies a child of concern to KCC. It was launched in September 2014, replacing the Common Assessment Framework (CAF).

Top reasons for notification are the same in every District (although the order may change). These are significant behavioural difficulties, one or more member of the household with (tier 2) emotional and/or mental health needs and significant non-attendance at school.

Other key underlying factors include: Education / development issues, poor relationships within families, domestic violence, parenting issues and housing / financial issues. By examining cases and identifying the underlying issues the driving demand for services could be explored further.

When examining the KFSF alongside additional case notes, a further 84% of factors were noted compared to the KFSF alone (in Tonbridge and Malling). This suggests that a number of underlying needs are not being identified at the referral stage.

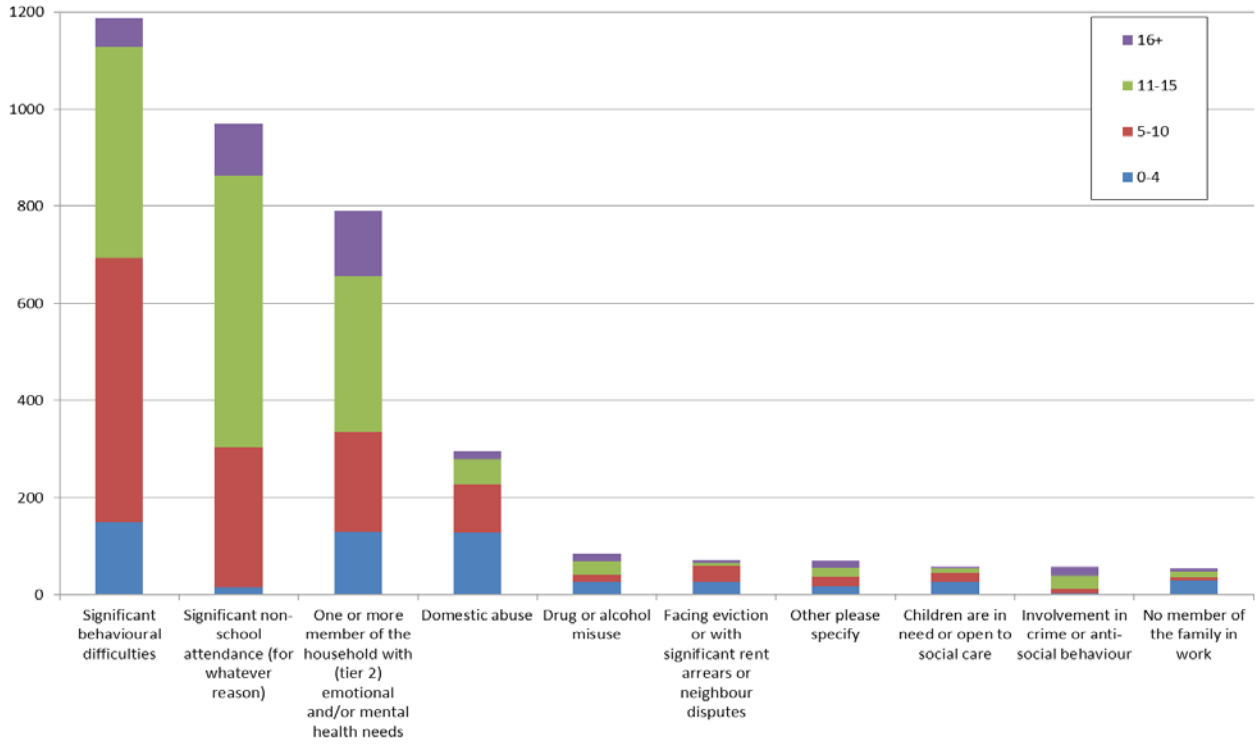


Figure 7: Early Help Notifications - Primary issues by age range

Analysis of external services referrals demonstrates that the presenting issue can often mask the underlying cause, requiring external providers to undertake further assessment to identify the underlying cause. This is not reflected in the EHN categories. See Appendix 3 for details.

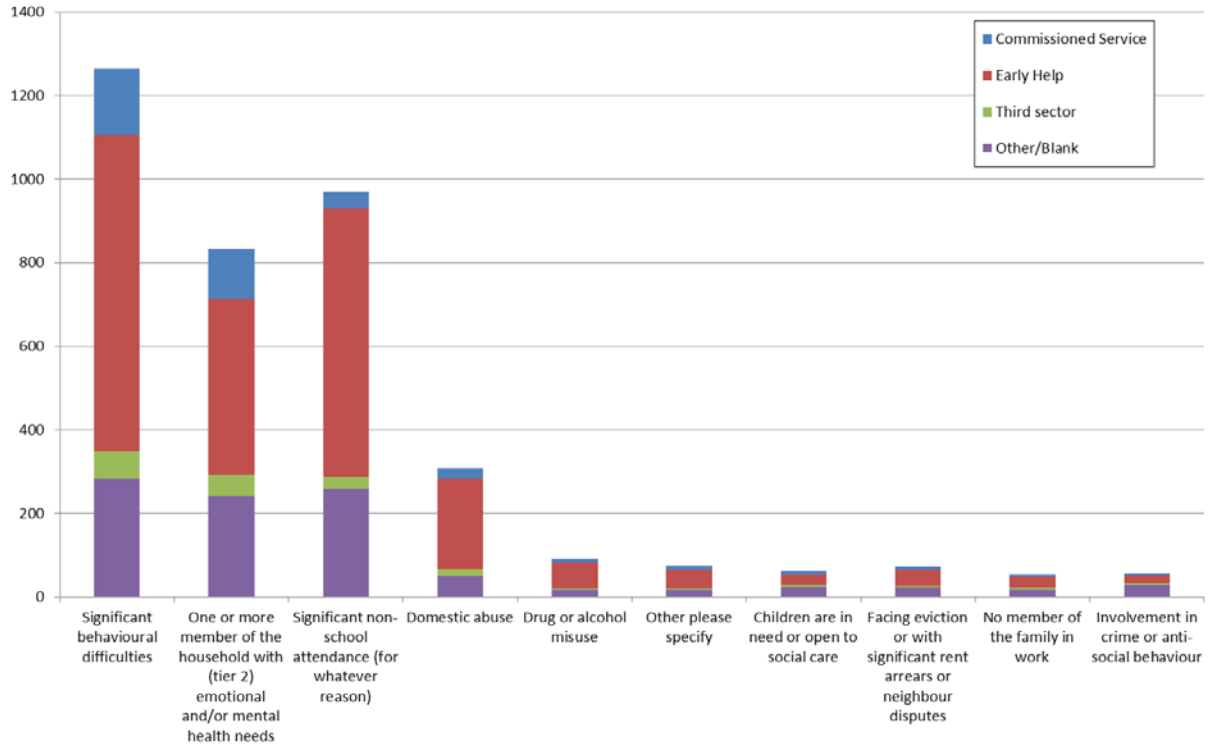


Figure 8: Early Help Notifications - Primary issues by supporting service

Tonbridge and Malling is currently delivering intensive support through the new "Early Help unit model". 774 cases (16%) within Tonbridge and Malling (Sept 14 – April 15), were examined by accessing the KFSF and additional case notes.[14] All factors affecting the child and their family were recorded. The results are shown below:

Rank	Children	Carers	Families
1	Education / Development Issues	Parenting Issues	Mental Ill-Health
2	Mental Ill-Health	Mental Ill-Health	Education / Development Issues
3	Behavioural Issues	Housing / Financial Issues	Poor Relationships
4	Poor Relationships	Domestic Violence	Behavioural Issues
5	Domestic Violence	Poor Relationships	Domestic Violence

Table 4: Ranking of factors within Tonbridge and Malling case notes

[14] Work undertaken by KCC Evaluation and Review, Business Intelligence on behalf of EHPS Commissioning

In total 243 presenting KFSF family factors were recorded in Tonbridge and Malling, after examination of the case notes there were a total of 448 consolidated family factors.

The analysis highlighted the following key points:

- Mental ill-health was reported in 54% of cases
- Where there was Domestic Violence:
    - 53% of children were witnesses
    - 30% of children were perpetrators
    - 17% of children were victims
- 40% of cases had no factors recorded for the carer
- The number of Toxic Trio factors recorded increased after first contact by EHPS
- There was an overlap of recorded carer factors around
    - mental ill-health
    - housing / financial issues
    - parenting issues

Mental ill-health featured predominantly in the factors recorded. Data is available on one aspect of mental ill-health; self-harm. See below:

	Age <15	**Age 15<24**
Males	15	297
Females	81	583

Table 5: Number of attendances at A&E due to self-harm 2012/2013 for Kent residents

These figures show a higher rate of self-harm amongst young females than males, with females from under 15 to 24 having the highest number of attendances to A&E for self-harm.[15] Self-harm has been noted as a major concern emerging from the Emotional Wellbeing Strategy.

[15] Public Health Observatory, KCC

6.5 Toxic Trio

Domestic violence and abuse, parental mental ill-health, and parental substance misuse – individually or in any combination – are recognised as indications of increased risk of harm to children and young people[16]. The term 'Toxic Trio' has commonly been used to describe these three issues.

Children who have parents suffering from the Toxic Trio make up a substantial proportion of the children coming to the attention of the child protection authorities for abuse or neglect. However, it is believed that only a minority of such children come to the attention of social workers.[17]

Work undertaken to estimate the prevalence of these issues (based upon an extrapolation of national figures) found that in Kent, in 2014, approximately: [18]

- 22.1% of children (68,112) have lived with a parent who misuses alcohol (hazardous19)
- 2.5% of children (7,705) have lived with a parent who misuses alcohol (harmful[20])
- 8.0% of children (24,656) have lived with a parent who misuses drugs
- 5.7% of children (17,567) have been exposed to domestic violence and abuse
- 17.8% of children (54,860) have lived with a parent who has mental health problems

A large number of these children will be affected by two or more of these factors in combination.

While it is important to note that children whose parents suffer from the Toxic Trio are not automatically at risk of abuse or neglect, it is recognised that there are potentially higher risks for this group. Therefore while these numbers are not directly indicative of children at risk, it does demonstrate the large proportion that may be more vulnerable to harm as a result of the toxic trio.

The remainder of the section provides information, where available on domestic violence and abuse, parental mental ill-health, and parental substance misuse.

[16] Department of Health (2013), 'No.5: Domestic Violence and Abuse – Professional Guidance'
[17] Social Care Institute for Excellence (2005) Briefing: *Parenting Capacity and Substance Misuse*
[18] KCC (2015) *Needs Analysis of the 'Toxic Trio'* Business Intelligence
[19] Had a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. This is classified as exceeding 14 / 21 units weekly for females / males respectively i.e. over the NHS recommended weekly safe limits of alcohol.
[20] Consumption that results in consequences to physical and mental health. This is defined as exceeding a score of 16 or more on the Severity of Alcohol Dependency Questionnaire (SADQ).

6.5.1 Domestic violence and abuse

Analysis investigating the characteristics of children from families with Domestic Abuse Notifications (DANs) across Kent between 1st May 2013 and 30th April 2014[21] found that children with DANs were much more likely to have a number of associated adverse outcomes as shown below.

Number of children with DANs = 628 **Number of children in the risk model without DANs = 230935**	**With DANs %**	**Without DANs %**
Troubled Family	6	1
SCS referral (May 2013 – Apr 2014)	65	4
Looked After Children	1	0
Child Protection Plan in place	3	0
Child in Need	12	2
Youth Offending	1	0
School action, school action + or statemented	30	20
Subject to permanent exclusion	1	0
Subject to fixed term exclusion	9	6
Free school meals	36	11

Table 6: Additional factors faced by children referred to SCS with DANs compared to children in the risk model without DANs

This analysis shows that, in the population sample used:

- Children from a Troubled Family are 6 times more likely to have DANs
- Children receiving free school meals are 3 times more likely to have DANs
- Children referred to SCS are 16 times more likely to have DANs
- Children subject to a Child Protection plan are 2 times more likely to have DANs

[21] Business Intelligence (2015) *Domestic Abuse Notifications*

6.5.2 Parental mental ill-health

Parents with mental health problems may require additional support in the fulfilment of their role as parents. Their children's needs may also need to be addressed. Research and government reports have highlighted the extent of the problem:[22]

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves. Of the 175,000 young carers identified in the 2001 census, 29% – or just over 50,000 – are estimated to care for a family member with mental health problems.
- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90% of parents on their caseload have mental health problems, alcohol or substance misuse issues.
- In a class of 26 primary school children, it is estimated that six or seven children are living with a mother with mental health difficulties.

The following information was available on parental mental ill-health in Kent:[23]

- Parental mental ill-health was noted a specific factor in 3,127 C&F Assessments (Jan 14 – Dec 14) in SCS.
- In a one-month snapshot, mental health of the adult was noted as the primary reason for request for 23 (6%) and 2 (1%) cases for KCC EHPS (month of Sept 2014 – Oct 2014).
- 570 new mothers were referred to the Mother and Infant Mental Health Service (MIMHS) team due to having mental ill-health (Dec 13 – Nov 14).
- Maidstone, Canterbury, Swale and Thanet have the highest proportion of women of reproductive age accessing mental health services in Kent. Of these women, from 30-60% are likely to have children. Canterbury and Maidstone have the largest estimated numbers of children at risk of having a mother who accesses mental health services.

[22] Social Care Institute for Excellence (2011) *Think child, think parent, think family: a guide to parental mental health and child welfare*
[23] KCC Business Intelligence (2015) *Needs Analysis of the 'Toxic Trio'*

6.5.3 Parental substance misuse

Research has indicated a number of ways in which parental substance misuse can have a negative effect on children in both the short and long term:[23]

- Children of parents who misuse substances are also more likely to enter the care of relatives, who themselves may require help and support in caring for children.
- Children of parents who misuse substances may experience behavioural or psychiatric problems and are more likely to engage in substance misuse themselves.
- Parents who misuse substances may interact poorly or in an authoritarian manner with their children and may also be inconsistent and emotionally unresponsive as a result of their substance misuse.
- The lifestyle of families with a substance-misusing parent can also be characterised by chaos and a lack of routine, as well as social isolation.

The following information was available on parental substance misuse in Kent: [23]

- Parental drug abuse was noted as a specific factor in 1,181 C&F Assessments (Jan 14 – Dec 14). Parental alcohol abuse was noted in 1,533 Children and Family (C&F) Assessments (Jan 14 – Dec 14).
- 1,570 drug users who live with children were in treatment in Kent (Apr 2013 – Mar 2014).
- 475 children of substance misusing parents accessed targeted early interventions in Kent (Apr 2012 – Mar 2013).
- 888 adult clients in substance misuse treatment services had some or all of their children living with them at the time of presenting to the service in Kent (Apr 2012 – Mar 2013).
- 166 also had a comorbid mental health problem (Apr 2012 – Mar 2013).

6.6 Equality and Diversity

Discrimination has a negative impact upon the health and wellbeing of individuals and groups of people. This can lead to social isolation and economic disadvantage. Commissioning Intentions will take account of the fact that Kent residents can experience disadvantage based on age, gender, disability, race, religion or belief or sexual orientation. Some examples of this are that in general, boys seem to do less well than girls in education; children and young people with parents who have a disability are more likely to require support – particularly in the case of those who receive disability benefits.

6.6.1 Age and Gender

51.1% of the total population of Kent is female and 48.9% is male.[24] Nationally on average, girls have better educational outcomes than boys at 16. Out of every 100 pupils, girls have median achievement ranked between 8 and 12 places higher than the median achievement for boys (depending on which nation is examined). Reflecting these results, women are more likely to go on to higher education than men, and are more likely to achieve good (first or upper second class) degrees. More women now have higher education qualifications than men in every age group up to age 44, and fewer have no or only low qualifications, reversing the pattern in older generations.[25]

Kent has a greater proportion of young people aged 5-19 years and people aged 45+ years than the national average.

6.6.2 Disability

Disabled people experience disadvantage in many aspects of daily life. Research has shown that, compared with non-disabled people, disabled people are:[26]

- More likely to live in poverty – the income of disabled people is, on average, less than half of that earned by non-disabled people;
- Less likely to have educational qualifications – disabled people are more likely to have no educational qualifications;
- More likely to be economically inactive – only one in two disabled people of working age are currently in employment, compared with four out of five non-disabled people;
- More likely to experience problems with hate crime or harassment – a quarter of all disabled people say that they have experienced hate crime or harassment, and this number rises to 47% of people with mental health conditions;

[24] Business Intelligence Statistical Bulletin: 2011 Census: Cultural diversity in Kent
[25] Government Equalities Office (2010) *An Anatomy of Economic Inequality in the UK – Summary Report of the National Equality Panel*
[26] DWP (2005) *Improving the life chances of disabled people : Final Report*

- More likely to experience problems with housing – nine out of ten families with disabled children have problems with their housing; and
- More likely to experience problems with transport – the issue given most often by disabled people as their biggest challenge.

The figure below shows the gender breakdown of disability claimants aged 0-15. Overall disability benefits are claimed for 3.8% of the population aged 0-15 accounting for 10.0% of the total number of disability benefit claimants.

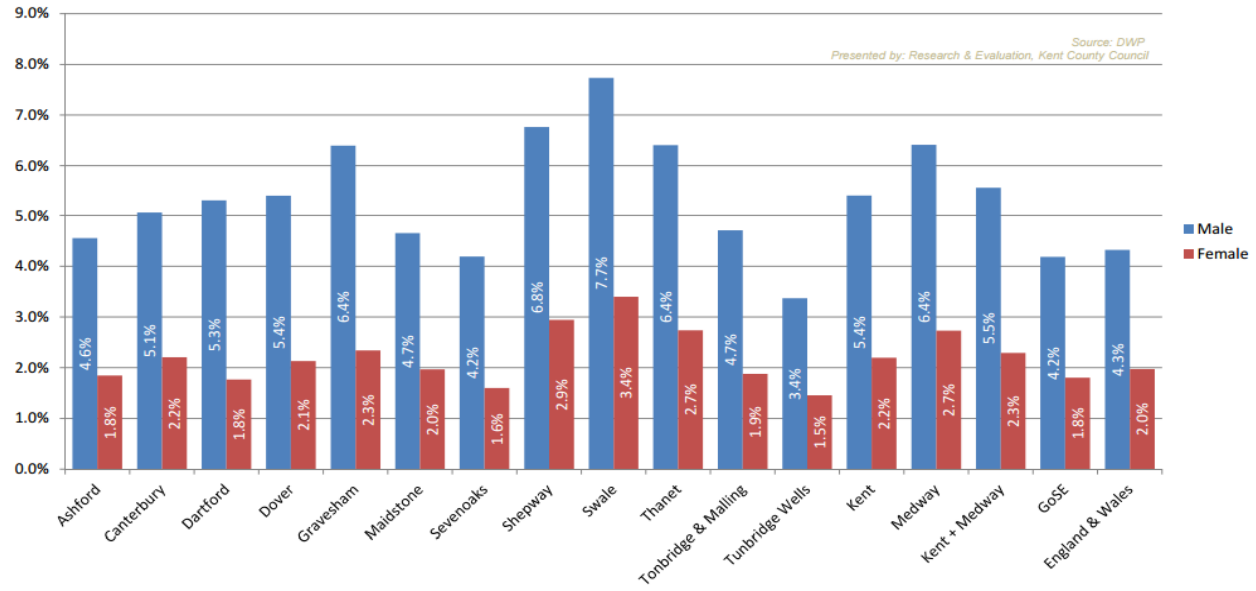


Figure 9: Disability benefit claimants aged 0-15 by Gender[27]

Males have at least twice as many claims for disability benefits than females in the 0-15 age group, in Kent 72.1% of claimants aged 0-15 are male. This age group would only be eligible for Disability Living Allowance. A higher proportion of both males (5.5%) and females (2.2%) aged 0-15 in Kent are claiming disability benefits than is seen nationally. Swale District has the highest number of claimants in the county with Disability Living Allowance being claimed for 1,580 young people aged 15 and under. 7.7% of males and 3.4% females aged 0-15 living in Swale claim benefit.

[27] Source: DWP (Presented in Business Intelligence Statistical Bulletin: Disability in Kent December 2014)

6.6.3 Race, Religion or Belief

Race, religion or belief has a known impact on school and later employment.

National research has shown that some minority ethnic groups that start with test scores well below the national average improve their relative position between ages 7 and 16. At 16, however, Pakistani, Black African and Black Caribbean boys in England have median results well below the national figure for all pupils. Other groups have results well above the national average. A tenth of Chinese girls have results in the top 1 per cent overall. Children recorded as having Traveller or Gypsy backgrounds have assessments that fall further behind during the school years, resulting in much worse results at age16 than others. This gap appears to have widened in recent years. Those from minority ethnic groups with GCSE results around or below the national median are much more likely to go on to higher education than White British pupils with similar results. Black and Pakistani/Bangladeshi students are less likely to go to more prestigious universities or to get higher class degrees.

The 2011 Census indicates that:[28]

- 93.7% of all Kent residents are of White ethnic origin – this includes those who are White British, as well as other identities such as Irish, Eastern European origin etc. Kent also has Gypsy, Roma and Traveller populations greater than national average;
- 6.3% of Kent residents are classified as Black or Minority Ethnic (BME). This proportion is lower than the national average for England (14.6%), although has risen from the previous census and is anticipated to rise over time;
- Gravesham has the highest proportion of residents from a BME group at 17.2% which is higher than national and regional proportions. Dartford has the second highest BME population (12.6%), Canterbury is third with 10,525 residents (7.0%). The Kent average is 6.3% - Dover has the lowest proportion with 3.32%;
- Almost three quarters of Kent residents follow a religion. The majority – 62.5% of people - are Christian which is a higher proportion than the national figure (59.4%) and the regional figure (59.7%);
- The next largest religion in Kent is Muslim with 0.95% of the total population. A large proportion - 26.75% of the population claimed to have no religion; and
- Gravesham has the highest proportion of Muslims with 1.9% of the population. However the Sikh religion accounts for the second largest proportion of Gravesham residents with 7.6%.

[28] Business Intelligence Statistical Bulletin: 2011 Census: Cultural diversity in Kent

6.6.4 Sexual orientation

National research indicates that: Lesbian, Gay, Bisexual and Transgender (LGBT) people:

- Expect poorer treatment from public services including social housing, criminal justice and health services.
- Have experienced homophobic bullying (65% of LGBT young people. Seven in ten feel this has an impact on their work, and half have skipped school as a result.
- Have experienced a homophobic hate crime in the last three years.
- Are more likely to be at risk of homelessness when young because of bullying at school, and rejection from the family home. In addition, half of young LGBT women under the age of 20 have self-harmed in the last year. [29,30,31,32]

6.7 Young Carers

Following the implementation of the Care Act in April 2016, local authorities are required to assess whether young carers within their area have support needs and, if so, what those needs are. The right to an assessment of need for support extends to all young carers under the age of 18, regardless of whom they care for, what type of care they provide and how often they provide it.

National research has shown the following:[33]

- Latest census statistics reveal there are 166,363 young carers in England, compared to around 139,000 in 2001. This is likely to be an underrepresentation of the true picture as many remain under the radar of professionals.
- One in 12 young carers is caring for more than 15 hours per week. Around one in 20 misses school because of their caring responsibilities.
- Young carers are 1.5 times more likely than their peers to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language.
- Young carers are 1.5 times more likely than their peers to have a special educational need or a disability.
- The average annual income for families with a young carer is £5000 less than families who do not have a young carer.

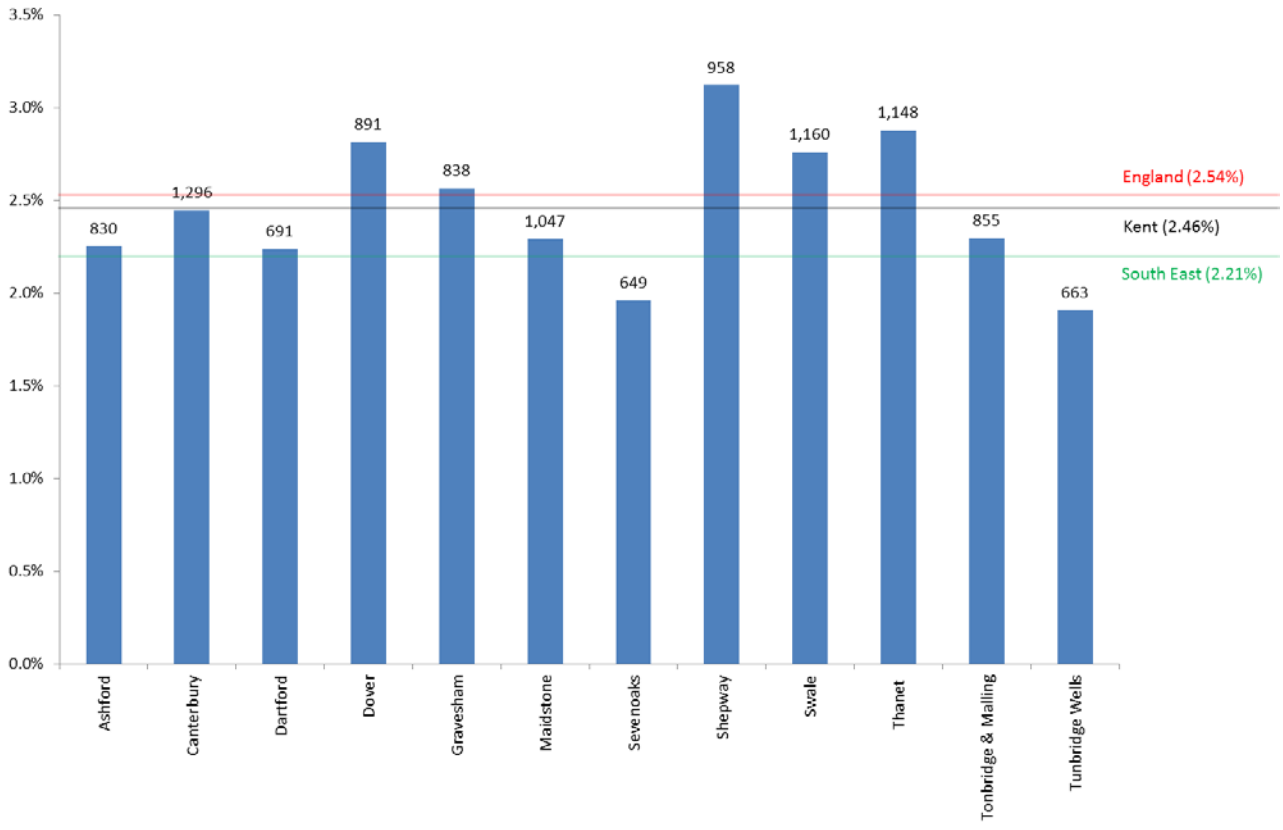
[29] Stonewall (2008) *Serves you right: Lesbian and Gay people's expectations of discrimination*
[30] Stonewall (2007) *The school report: The experiences of young gay people in Britain's schools*
[31] Stonewall (2013) *The Gay British Crime Survey 2013*
[32] Stonewall (2008) *Prescription for change: Lesbian and bisexual women's health check 2008*
[33] The Children's Society (2013) *Hidden from view: The experiences of young carers in England*

- There is no strong evidence that young carers are more likely than their peers to come into contact with support agencies, despite government recognition that this needs to happen;
- Young carers have significantly lower educational attainment at GCSE level, the equivalent to nine grades lower overall than their peers e.g. the difference between nine Bs and nine Cs.
- Young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19.

In Kent, the following information is available on young carers:

Locality	Total persons aged 0-24	Provides Unpaid Care			
		1-19 hrs	20-49 hrs	50< hrs	>0 hrs
England	16,307,596	310,024	59,104	44,651	413,779
South East	2,611,139	44,802	7,244	5,587	57,633
Kent	448,284	8,290	1,494	1,242	11,026

Number of young carers in England, South East and Kent[34]



Number of young carers in Districts in Kent[34]

[34] Source: 2011 Census, table LC3304EW, Office for National Statistics

Kent has proportionally less young carers than England and proportionally more young carers than the South East. However, all of the figures are likely to be an under representation of the true value.

6.8 Capturing the views of Young People

6.8.1 User engagement

Engagement with 28,737 young people in Kent, as part of the Kent Youth County Council (KYCC) election, identified the following issues of concern to young people:

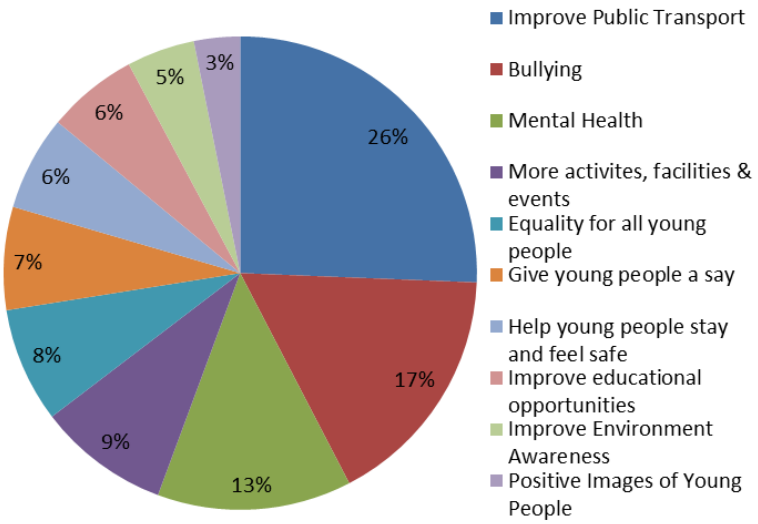


Figure 10: KYCC campaign results

At a separate children's and young people's workshop, participants were asked to identify the most important needs and issues, which are reflected below[35]:

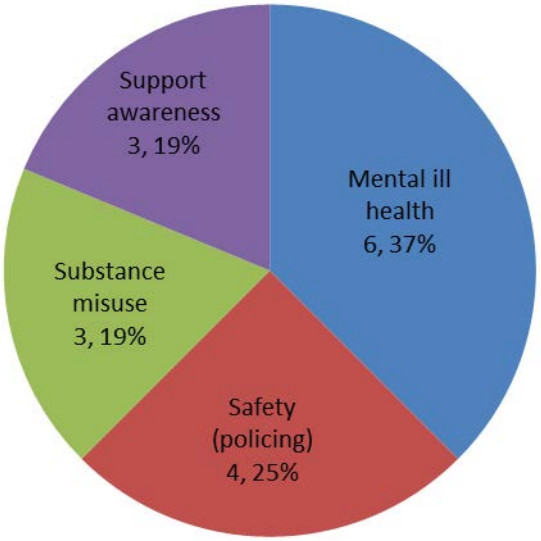


Figure 11: Workshop results

6.8.2 Practitioner consultations

Staff consultation events were held in order to identify service gaps across Kent. The key themes and number of responses are given below:

Number of responses	Identified service gaps
8	Emotional / Mental Health and Wellbeing
6	Whole family approach / support
4	Needs-based approaches and intelligent use of data
3	Family trauma
3	Domestic Abuse
2	Special educational needs
2	Parenting support
2	Resources
2	Education and attendance
2	Pre-CAF flexible support
1	SLC
1	Gambling support
1	Child sexual abuse
1	Consistency of approach
1	Links to VCS / Community
1	Aspiration
1	Step down / Exit strategies

Figure 12: Staff consultations identified areas of need

[35] For a complete summary please refer to the supplementary report: EHPS Commissioning, KCC (May 2015) Early Help & Preventative Services (EHPS) C*ommissioning intentions consultation with children and young people – summary of consultation event.*

6.8.3 Practitioner and stakeholder workshops

At workshop 1 the following were identified: key themes of need, how much of this need is unmet and which tier and age range it was applicable to (see table below):

Category	Sum of Rank	Rank	Average Unmet Need (%)	Tier (if provided)	Pre birth to 5	5 to 11	11 to 16	Preparing for life (16+)	Carer	Crosscutting
Emotional & Mental Health	53	32%	42	1,2,3,4						✓
Domestic Abuse	23	14%	48	1,2,3						✓
Family Skills	21	13%	46	1,2,3,4						✓
Housing & Financial	15	9%	38	1,2					✓	
Substance Misuse	13	8%	41	1,2						✓
Special Educational Needs	13	8%	38	2,3						✓
NEETs: Educational Attendance & Attainment	9	5%	28	1	✓	✓	✓			
NEETs: Youth Education & Employment	7	4%	35	1,2,3,4				✓		
Behaviour	4	2%	65	2,3						✓
Early Development	3	2%	40	2,3	✓					
Youth Offending	2	1%	25			✓	✓	✓		
Obesity	1	1%	50		✓	✓				
Worklessness	1	1%	40						✓	

Figure 13: Workshop 1 Identified areas of need by tier and age group (based on existing knowledge supported by data and information)[36]

For a complete summary of Workshop 1 and 2 outputs please refer to the supplementary report: Business Intelligence, KCC (May 2015) EHPS Commissioning, Analyse Phase: Diagnostic Report, Technical Appendix.

6.8.4 Thematic analysis

Workshop 2 intended to identify common requirements/values which it would be important for commissioned services to hold. The thematic analysis below was carried out on the recorded outputs from Workshop 2. These were widely grouped into the following six categories based upon commonalities in the themes recorded:

- Approaches – the theoretical or value-based grounding upon which the services should be based;
- Engagement – the characteristics and practicalities of services' work with families;
- Location – the environments in which the interactions between practitioners and families should take place;
- Skills – the common skills required in order to effectively perform the services;
- Collaborative working – the partners or relationships required in order for services to function effectively; and
- Information – the requirements around information and intelligence utilised, collected and evaluated.

[36] 'Carer' applies to the parent or a young carer.

As each group in the workshop gave their thoughts on one specific issue, a number of individual/more nuanced requirements were gathered around each of these issues. These issue specific requirements are recorded in 'Appendix 5: Thematic analysis'. The diagram below shows the key common workshop themes provided by category.

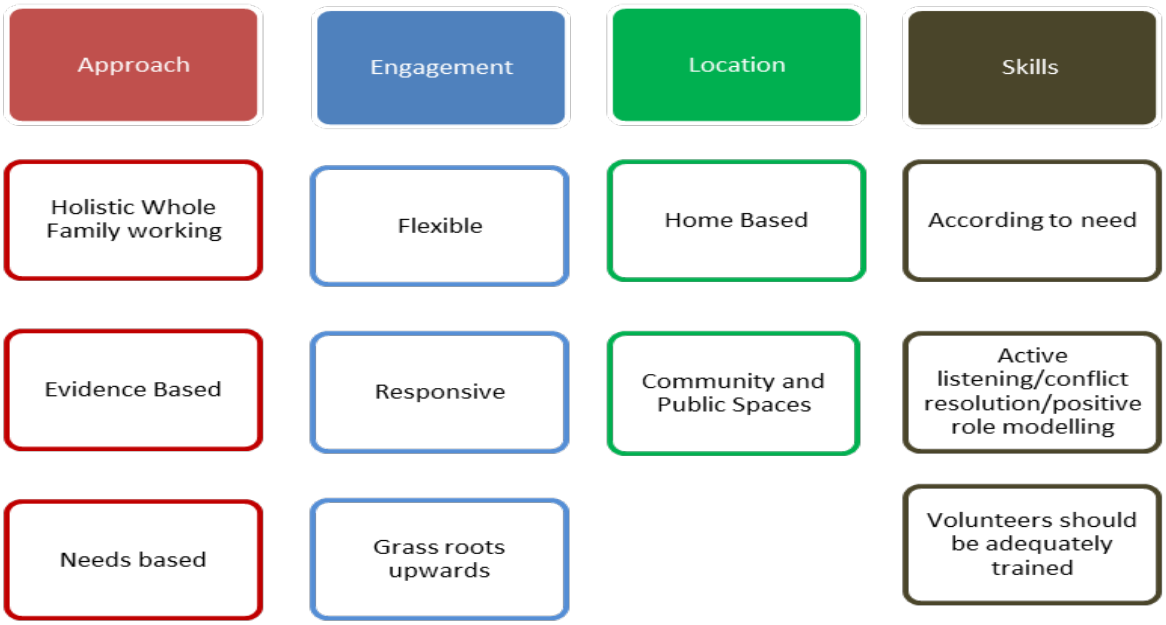


Figure 14: Workshop themes

6.8.5 Other recommendations:

- Where there are fixed-length engagements with families this is considered a weakness -
- Flexibility in plans to allow for both focused and long term engagement is desirable.
- There should be no waiting lists.
- Families who had benefited from a programme could champion the service and in turn, volunteer themselves in order to reach more of the community.
- Information should be shared with partners; in turn information available to partners should be made available via the secure information sharing network. It is important to use the same shared database, along with other EHPS workers.
- The collection of comparable data sets across services should be implemented in order to assess which are the most cost-efficient and effective.
- Local knowledge/experience from practitioners should be systematically collected (one group suggested during supervision). This should be fed back along with other performance data.

7.8 Demand for services

7.8.1 *What is driving demand for these services and what is our evidence for this?*

Requests for EHPS can be investigated by analysing the source of notifications received. See below:

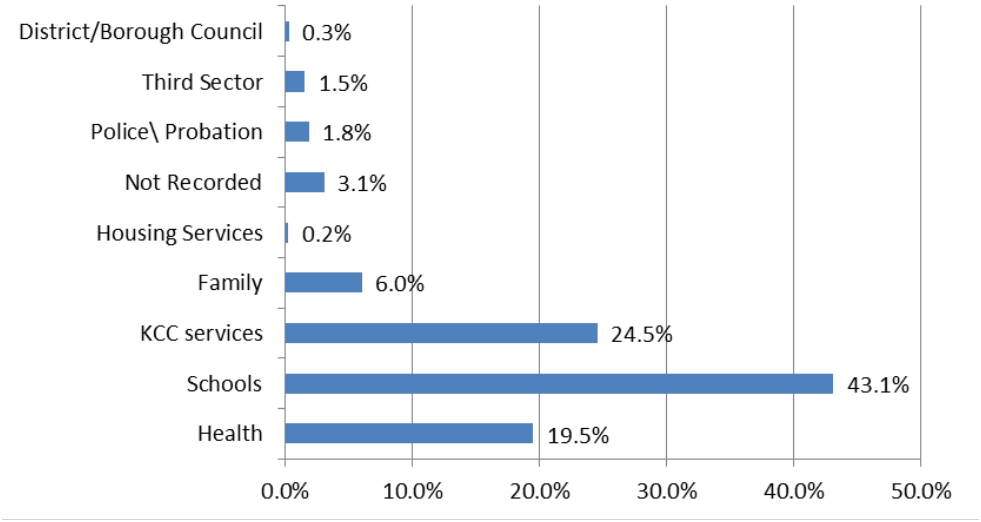


Figure 15: EHPS Notifications by Organisation Type – September 2014 to March 201537

Over 87% of EHPS notifications are from three sources - Health, KCC Services and Schools.

A large proportion of demand for EHPS services is originating from schools (43.1% of all EHPS notifications in total).

The figure below breaks down the sources of notifications from 'KCC services' further. The majority of notifications (12.3% of the total number of notifications received) are made by Children's or Adult's Social Care.

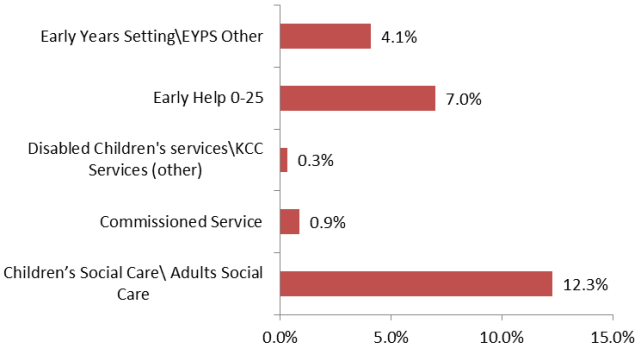


Figure 16: EHPS Notifications by KCC Services (as a percentage of the total number of notifications received by EHPS) – September 2014 to March 201538

[37] Information provided by the Management Information Team, Education and Young People's Services, KCC

The figure below breaks down the sources of notifications from 'health services' further. The largest proportion of EHPS notifications is from community health (15.4% of the total number of notifications received by EHPS). CAHMS and Acute trusts together contribute less than 5% of total EHPS notifications.

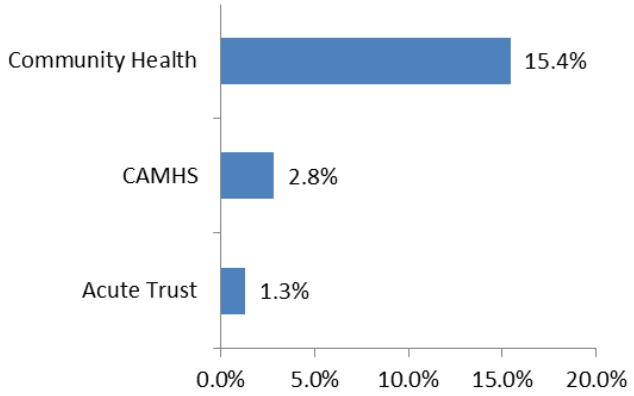


Figure 17: EHPS Notifications by Health Services (as a percentage of the total number of notifications received by EHPS) – September 2014 to March 2015[38]

6.7 How is demand for these services likely to change and what will be the impact?

There are about 5000 open cases of children and young people currently being supported by EHPS. The average case duration is about 12 weeks and currently 69% cases are closed to KCC with a positive outcome. In about 10% of cases, the needs of the child or young person require the protection of statutory intervention and are "Stepped up" to SCS.

Recent analysis as part of the 0-25 Transformation Programme has demonstrated that demand in EHPS is uncertain and varies month on month and over time.

The population data, based upon the 2011 Census information, provides the latest estimate of population growth in Kent (approximately 9% over 10 years). The projected increase in the population could potentially lead to an increase in demand for EHPS commissioned services. See below:

[38] Information provided by the Management Information Team, Education and Young People's Services, KCC

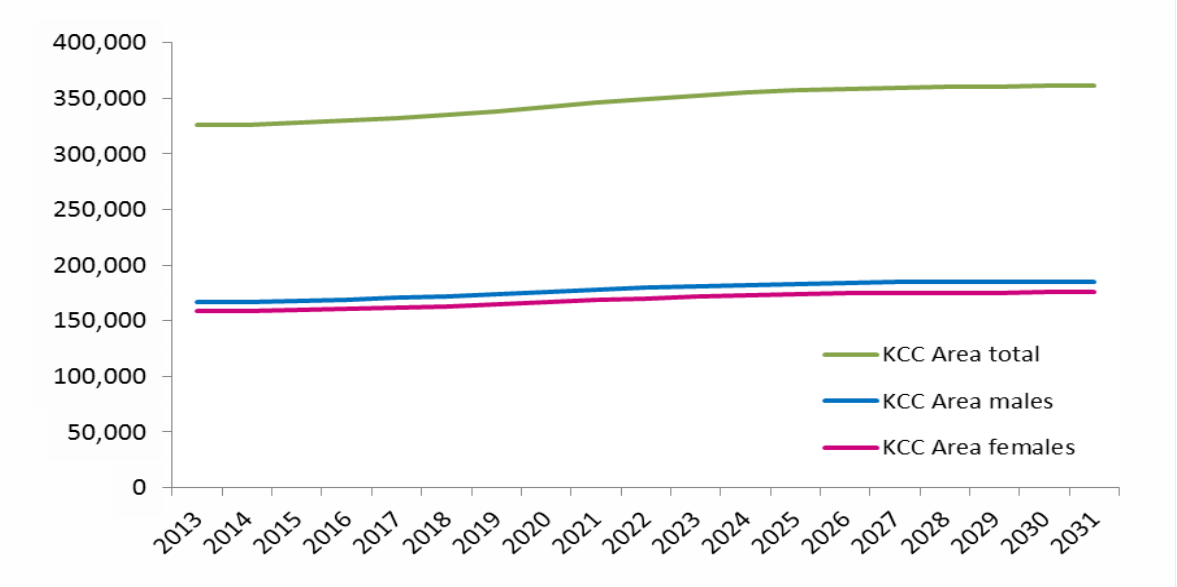


Figure 18: KCC area forecast population aged 0-17[39]

Year	Males	Females	Total
2015	168,200	159,600	327,800
2025	183,300	173,700	357,000
Change	15,100	14,100	29,200
% change	9.0%	8.8%	8.9%

Forecast change in population aged 0-17 in KCC area, 2015 - 2025[39]

It is expected that demand for these services will increase in the short term as the offer is made available to new and existing users.

In the medium term if EHPS commissioned services are successful in reaching user's outcomes, including preventing relapse, there will be less demand. In the long term, if services continue to be effective, behaviour will change – meeting the long term strategic outcomes – and demand will decrease further. See below:

[39] KCC Strategy Forecast (October 2014), Business Intelligence, Research & Evaluation, Kent County Council

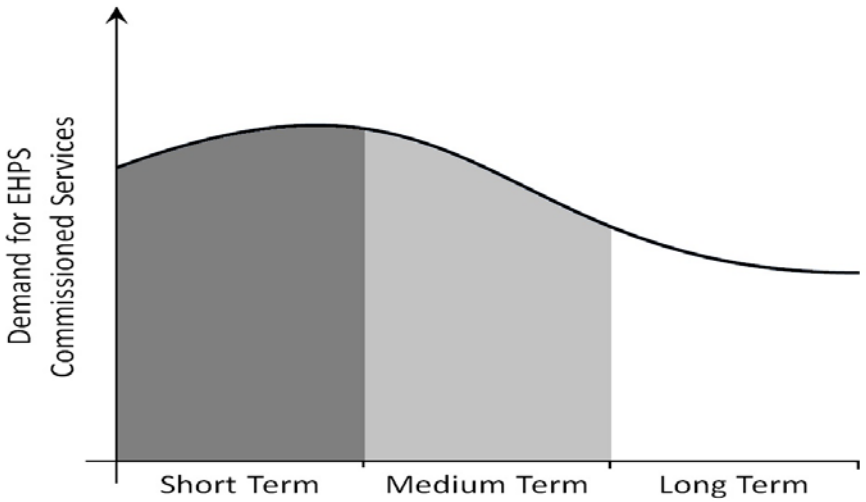


Figure 19: EHPS commissioned services demand

As the new way of working within the EHPS Division is further embedded it is possible that the drivers of demand will change. This change could be influenced by:

- Governance (and partnership working) e.g. the expansion of the pupil premium is designed to "address inequality by giving every school and teacher the resources they need to help their most disadvantaged pupils, allowing them the freedom to respond appropriately to individual circumstances".[40]
- More effective identification of 'need' due to underlying causes, rather than symptoms, through better and more accurate assessment of children, young people and families (e.g. underlying mental ill-health or domestic abuse).
- The earlier identification and addressing of 'need' in order to prevent escalation and the demand for more intensive intervention and SCS.
- The effectiveness of EHPS in facilitating step downs from SCS. As step downs increase, the demand for EHPS will increase accordingly.
- The forthcoming Emotional Health and Wellbeing Strategy, which seeks to focus on the groundwork needed to envision and establish a 'whole-system' of support for children, young people and young adults experiencing emotional and mental health difficulties. The strategy acknowledges that individual commissioned services cannot meet all of the needs and will draw together and focus the efforts of a wide range of agencies.

[40] Department for Education (2015) *2010 to 2015 government policy: education of disadvantaged children* https://www.gov.uk/government/publications/2010-to-2015-government-policy-education-of-disadvantaged-children/2010-to-2015-government-policy-education-of-disadvantaged-children#appendix-2-pupil-premium

7. Current Activities: In-house, externally commissioned and others

7.1 Effectiveness and cost

Currently there are a range of internal and external EHPS services. Across some tiers and age groups there is evidence of clustering of external services (within additional and intensive for ages 5 – 25).

For the EHPS external offer; based upon the original contracts awarded to these services, performance has been either 'good' or 'acceptable'. It is recommended that for future EHPS commissioned services outcome focused, impact evaluations, where appropriate, are conducted which feed into an overarching evaluation framework.

Individual 'costs to service' are available for some commissioned services, but not all of those within scope. Due to the recent changes as a result of transformation there has been a short term negative impact on performance which has begun to improve.

The internal and commissioned services currently being offered by EHPS are shown below.

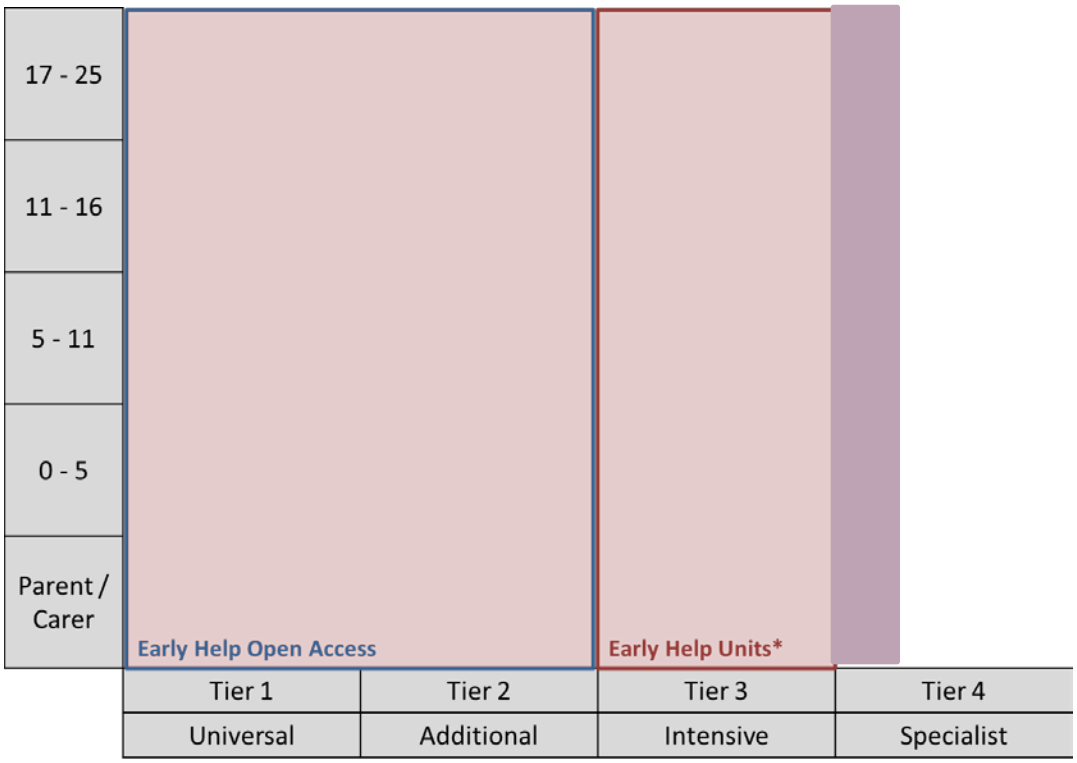


Figure 20: EHPS internal services

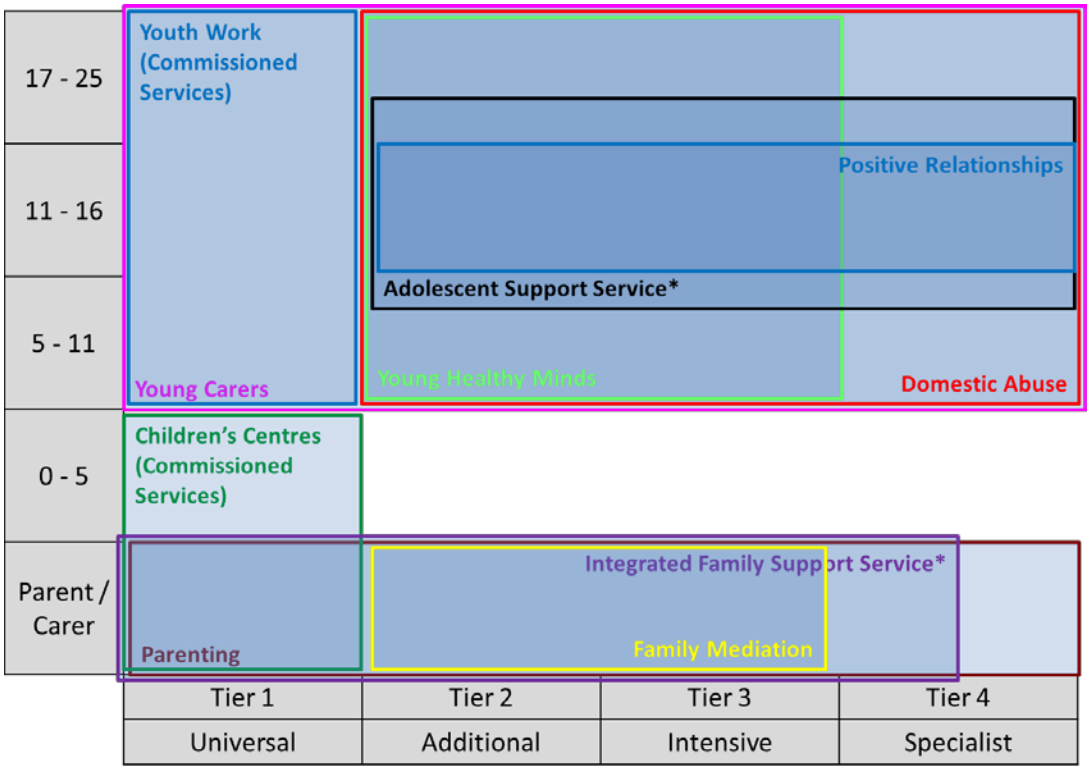


Figure 21: EHPS commissioned services

The following can be derived from the figures above:

- The EHPS internal services, open access support and case holding units and specialist interventions, (post transformation) provide a broad coverage of tiers and ages;
- A large range of internal and commissioned EHPS services are currently available;

For the services shown below, when available, the lead organisation, average duration, average unit cost and waiting list are shown.

Service	Average Duration	Average Unit Cost
Children's Centres (Commissioned Services)	Not Available	
Youth Work (Commissioned Services)		
Adolescent Support Services	29 weeks	£1,111
Family Mediation	6 weeks	£578.14
Family Intervention Projects, Integrated Family Support Service, Family Support	21 Weeks	£1,322
Domestic Abuse Support	7 weeks	£430
Young Healthy Minds	Not Available	
Young Carers	ongoing	£197
Positive Relationships	15 Weeks	£717.72
Parenting programmes	12 Weeks	Varies according to Programme

Figure 22: EHPS commissioned service information

7.2 Market position

Internally EHPS is currently undergoing transformation, and the new systems, practices, and processes are bedding-in. The model requires staff to work systemically with the range of issues a family presents. This is to reduce duplication of work and to ensure as few professionals as possible are involved with a family, there of course, will be some occasions where complementary services, programmes or activities are required to assist vulnerable children and families.

Externally, over the last three years some providers have started to work more collaboratively and in partnership and may be well placed to meet new procurement challenges and models such as larger contracts or consortium arrangements with a greater range of partners involved. However, there are still a range of micro and small organisations that have yet to respond effectively to the changing landscape and have the potential to be put at risk through the lack of infrastructure and experience of competing for larger scale contracts. Any commissioning intentions will need to reflect both the need for efficient procurement and localised opportunities to sustain and build upon the current good practice undertaken by the micro and small VCS providers. While some providers are well placed, others (micro and small VCS in particular) have yet to respond effectively. Local research has shown that over 5 a year period smaller VCS organisations were at increased risk of ceasing to exist.

Early findings from a current research project focused on VCS organisations who were working with children and young people in universal and early intervention (then under the banner of reducing social exclusion) services are shown below: 41

Size	% Increased	% Decreased	% Ceased	% Merged	% Total
Micro < £10,000	5.1	35.9	56.4	2.6	16.9
Small £10,001 - £100,000	18.7	26.7	49.3	5.3	32.5
Medium £100,001 - £1m	46.5	33.8	16.9	2.8	30.7
Large £1m - £10m	67.9	25.0	0.0	7.1	12.1
Major >£10m	55.6	38.9	5.6	0.0	7.8
Total	33.8	31.2	31.2	3.9	100.0

Figure 23: VCS organisation outcomes in Kent 2008 – 2013 (this information should not published or further cited without author consent)[41]

[41] Alison Body, Research Associate, University of Kent

The sample is based upon tracking the trajectory of 231 organisations registered with Kent Children's Fund in 2008 (not necessarily funded by but identified as working with children in Kent).

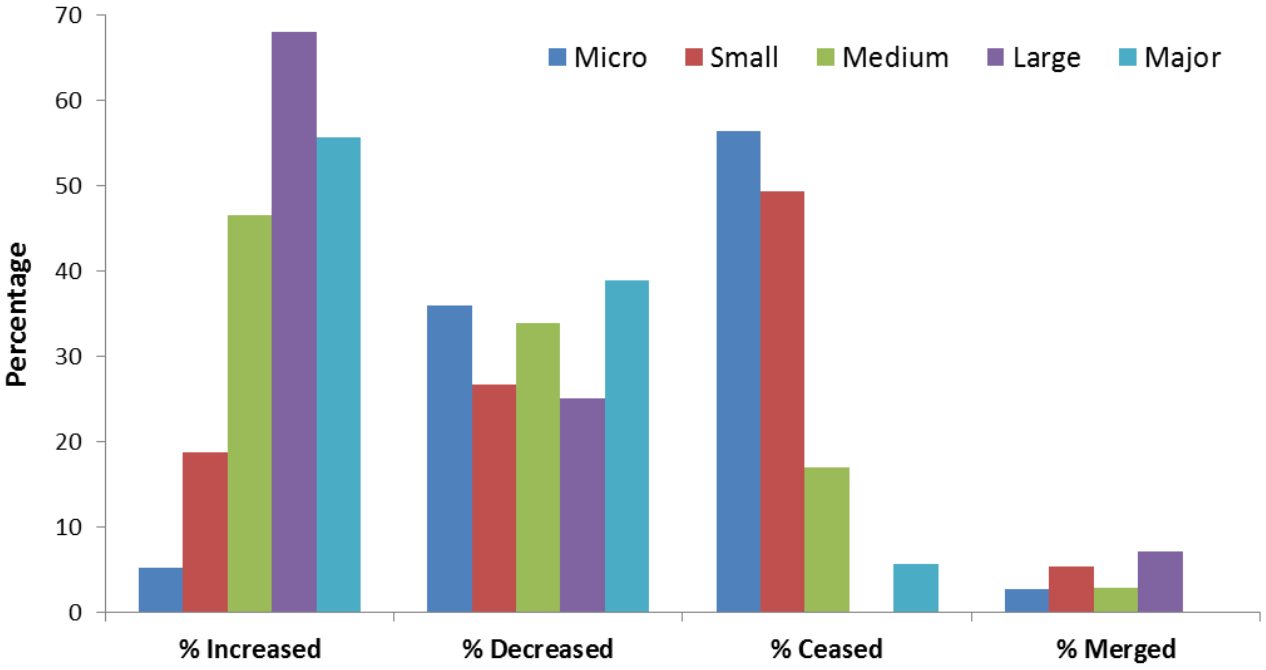


Figure 24: VCS organisation outcomes in Kent 2008 – 2013 (this information should not be published or further cited without author consent)

The findings show that there is a fairly even trend in organisations which have increased, decreased, or ceased overall. However, but when broken down to size category the figures demonstrate the increased risked to smaller organisations.

7.3 Integrating and aligning resources to maximise impact

The EHPS commissioning process is approaching joined up working with other partners through several different mechanisms in order to strengthen our offer across the key agendas of education, health and social care. By commissioning at a local District level, this will allow:

- Engagement with and encouraging the growth of small / micro businesses and the voluntary and community sector, e.g. within arts and culture.
- Increased involvement of District councils, parish councils, police, CCGs etc.
- Complementing existing funding steams to open up local funding for local innovation. For example, a local grant creating opportunities for joint funding at a local level.
- The recent integration of Public Health to into local authorities provides opportunities to jointly plan and commission across EHPS and Public Health. Key discussions currently involve how to complement and align:
    - The School Nursing service for secondary schools with EHPS adolescent support
    - The Emotional Wellbeing and CAMHS model and EHPS role
    - The future of Health Visiting
- Within the Troubled Families programme and Youth work KCC and District Councils are working collaboratively to ensure that vulnerable adolescents and their families lives can be improved. This includes sharing use of buildings and delivery hubs, staff and resource to achieve the required outcomes.
- Internally linking to the appropriate cross partnership bodies will ensure that dialogue takes place around the joining up of resources and activities e.g. Kent Health and Wellbeing Board, Children's Health and Wellbeing Board, Multi-Agency Data and Information Group and Kent Safeguarding Children's Board.
- Maximising KCC's investment through commissioning, including using EHPS monies to pump prime other projects in localities and to use as joint investment in innovative programmes. In addition, it is critical to recognise that a small contribution to the VCS can often lever in greater amounts of investment of funding to the county.

7.4 Late Intervention Spend

The Early Intervention Foundation (EIF) compiled a report detailing estimates of how much the KCC public sector spends annually (2014-15) on Late Intervention affecting children and young people, based on their national model.

1Local government spends the most on late intervention (£151 million) - approximately the same amount in late intervention as the NHS, Police, Justice and Education combined.

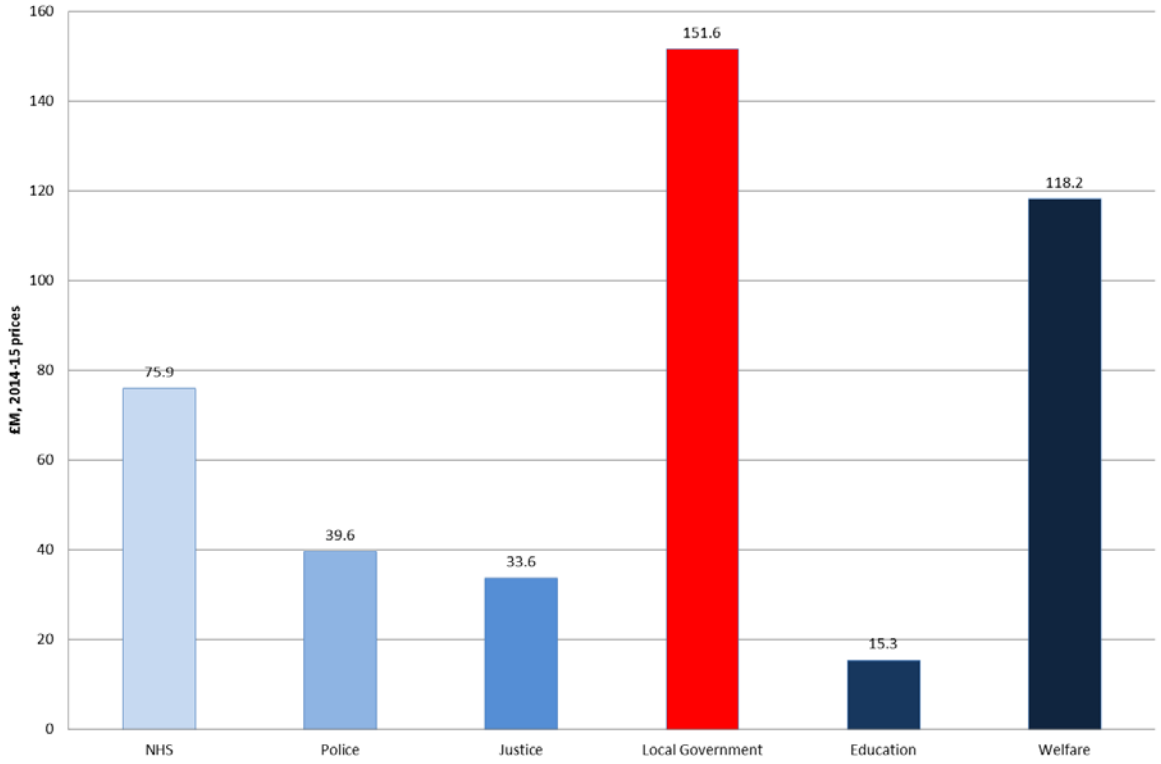


Figure 25: Late Intervention spend by organisation (£m, 2014–15 prices)[42]

The EIF has also estimated how much of the total Kent and England and Wales budget is currently spent on a number of key outcomes for children.

[42] Information provided by the Early Intervention Foundation, 21 May 2015

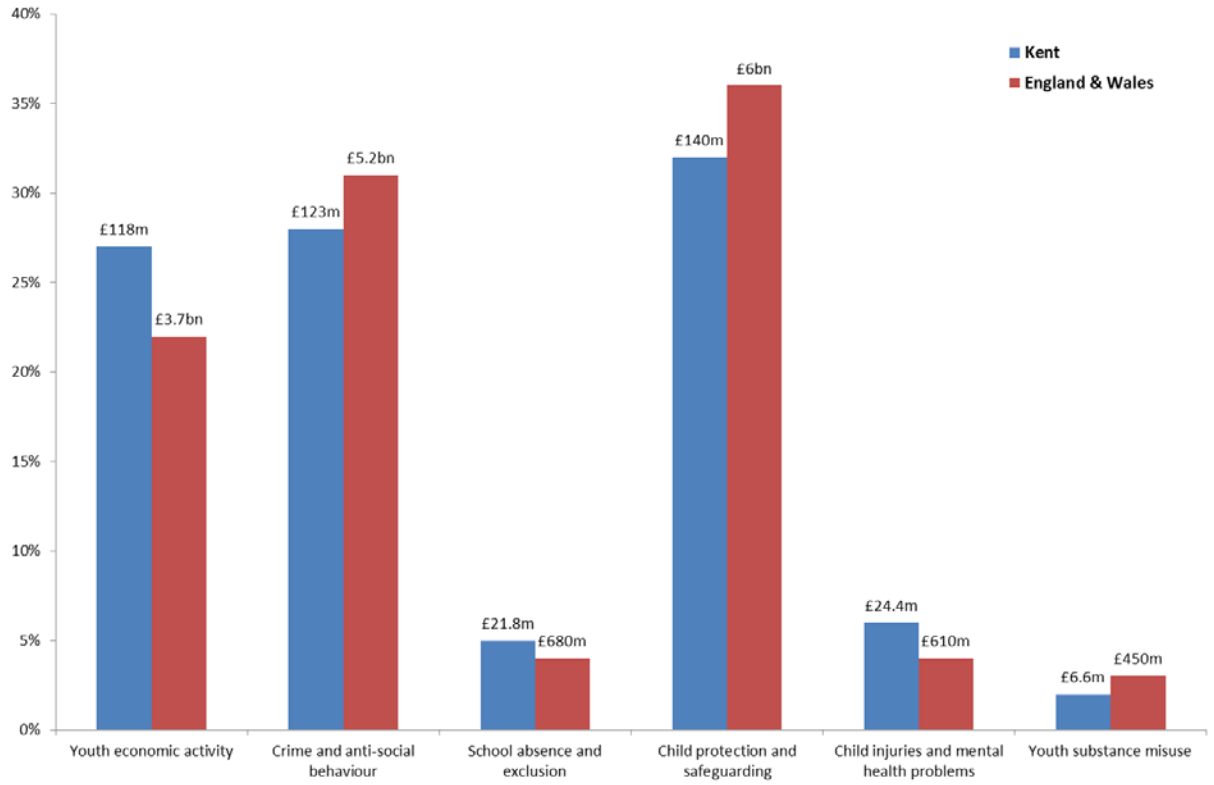


Figure 26: Late Intervention spend by outcome in Kent and England and Wales (£m, 2014–15 prices)

The most significant areas of late intervention spend in Kent are youth economic inactivity (including NEETs), child protection and safeguarding, and crime and anti-social behaviour.

It is noted that proportionally Kent spends more than England and Wales in the following areas; youth economic inactivity (including NEETs), school absence and exclusion (contributing to NEETs) and child injuries and mental health problems.

As previously shown, in Kent, the populations making up these cohorts are largely from the same population segments and related to communities of deprivation.[43]

[43] KCC (2015) Children's Risk Model (Presented by Business Intelligence)

8. Conclusions

The identification of need in the community supports and is consistent with the current approach in EHPS to adopt a whole family approach to working with children, young people and their families. The findings suggest that a partnership approach is considered in commissioning external services, such as Public Health and Adult Social Care – e.g. School Nursing, Health Visitors.

Localised community capacity and engagement can enable communities in creating positive outcomes. Local knowledge can inform local solutions. It suggests that local, smaller scale resources offering social value be considered in the commissioning of external services, such as through a localised commissioning approach.

Complexity in demand provides the motivation for externally commissioned services to be able to respond flexibly. It suggests that the approach to commissioning external services should be reviewed regularly to ensure flexibility and thus remain complementary to the new EHPS local authority delivered services including specialist children's social care services. The importance of measuring success supports the implementation of a Performance and Evaluation Framework as part of the Three Year Plan as a basis for appropriate referral, monitoring and review. The performance measures and indicators will be reflected in service outcomes once agreed in the Plan. Key Performance Indicators (KPIs) and indicators in line with such a framework be relevant to the level of service – whether universal additional, intensive or specialist .

Early Help & Preventative Services (EHPS) Commissioning

Analyse Phase: Glossary, References and Appendices

July 2015

Kent County Council
kent.gov.uk

Glossary, References and Appendices

9. Glossary of Terms

Black or Minority Ethnic / BME	The terminology normally used in the UK to describe people of non-white descent.
CAMHS	CAMHS stands for Child and Adolescent Mental Health Services. CAMHS are specialist NHS services. They offer assessment and treatment when children and young people have emotional, behavioral or mental health difficulties
Child in Need / CiN	A Child in Need is a child who is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority, whose health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services or whose is a Disabled Child.
Child Protection Plan / CP	A child protection plan should assess the likelihood of the child suffering harm and look at ways that the child can be protected, decide upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare, clarify people's responsibilities and actions to be taken, outline ways of monitoring and evaluating progress.
Clinical Commissioning Group / CCG	Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed, and ensuring that they are provided.
Common Assessment Framework / CAF	The common assessment framework is a way of working out what extra support a child may need and how best to provide it.
Domestic Abuse Notifications / DANs	When the police are called to an incident of domestic violence where children are present, the police are required to send a referral to children and families social services.
Early Help and Preventative Services / EHPS	Early Help reflects the widespread recognition that it is better to identify and deal with problems early rather than respond when difficulties have emerged and intervention can be less effective and often more expensive.
Early Help Notification / EHN	A form which referrers complete about a family/child detailing background, reason for referral, etc. which is then sent by the Triage team to the relevant Provider for intervention/support.
Early Help Unit model	Details of the Unit model are shown on page 17
Family Intervention Project workers / FIP Light	FIP and FIP Light workers are attached to Troubled Families teams in each District of Kent, working directly with families
Free School Meals / FSM	Some children are eligible to receive free school meals subject to criteria relating to receipt of certain benefits – please see https://www.gov.uk/apply-free-school-meals
Indices of Multiple Deprivation / IMD 2010	The English Indices of Deprivation measures relative levels of deprivation in small of England called Lower layer Super Output Areas (LSOAs)
Joint Strategic Needs Assessment / JSNA	Primary Care Trusts and local authorities are required to produce a JSNA of the health and well-being of their local community. This is a requirement of The Local Government and Public Involvement in Health Act 2007.

Kent Family Support Framework / KFSF	The Kent Family Support Framework is a streamlined process which aims to provide support and replaced Assessment (CAF)
Key Performance Indicator / KPI	Key Performance Indicator. Key Performance Indicators, also known as KPI or Key Success Indicators (KSI), help an organization define and measure progress toward organizational goals.
LGBT	LGBT stands for Lesbian/Gay/Bisexual/Transgender
Mosaic Groups	Mosaic means you can start treating them as an individual. It gives you the intelligence you need to reach the right people with the right message at the right time – every time
NEETs	A NEET is a young person who is "Not in Education, Employment, or Training"
Specialist Children's Services / SCS	A team that deal with the specialised needs of a child which require specific help from a specific service.
Statement of Special Educational Needs / SEN	A Statement is a document which sets out a child's SEN and any additional help that the child should receive. The aim of the Statement is to make sure that the child gets the right support to enable them to make progress in school. A Statement is normally made when all the educational provision required to meet a child's needs cannot reasonably be met by the resources within a child's school at School Action or School Action Plus (known as Early Years Action or Early Years Action Plus in Early Years Settings).
Step up / Step down	Refers to the transition into higher level or lower level services in order to help the child or families better.
Tier 1 / Level 1 services	Universal, open access services
Tier 2 / Level 2 services	Additional and targeted services
Tier 3 / Level 3 services	Intensive services
Tier 4 / Level 4 services	Specialist services
Troubled Families	Troubled families are defined as those who are involved in youth crime or anti-social behavior, have children who are excluded from school or regularly truanting, have an adult on out-of-work benefits cost the public sector large sums in responding to their problems
Voluntary and Community Sector / VCS	The voluntary sector or community sector (also non-profit sector or "not-for-profit" sector) is the duty of social activity undertaken by organizations that are not for-profit. https://en.wikipedia.org/wiki/Voluntary_sector - cite_note-1 and non-governmental
Young Carers	Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult.

10. References

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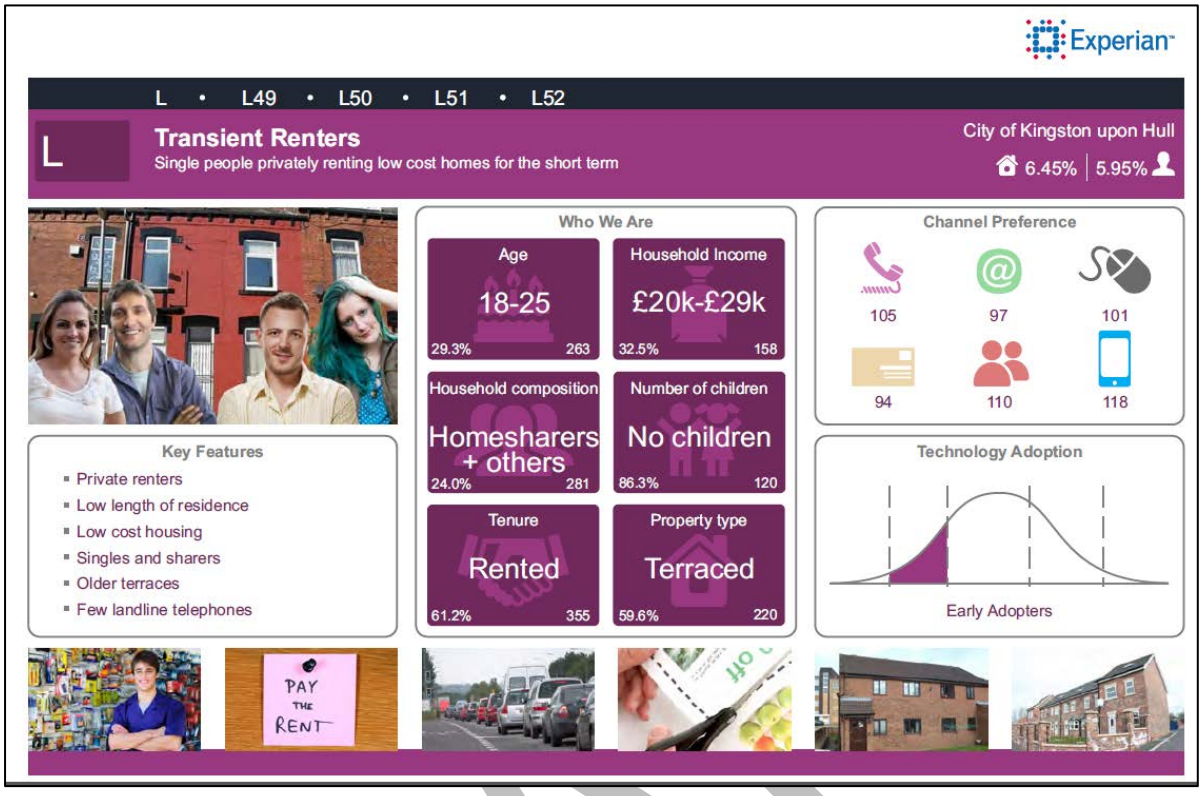
Appendix 1: Questions which should be answered

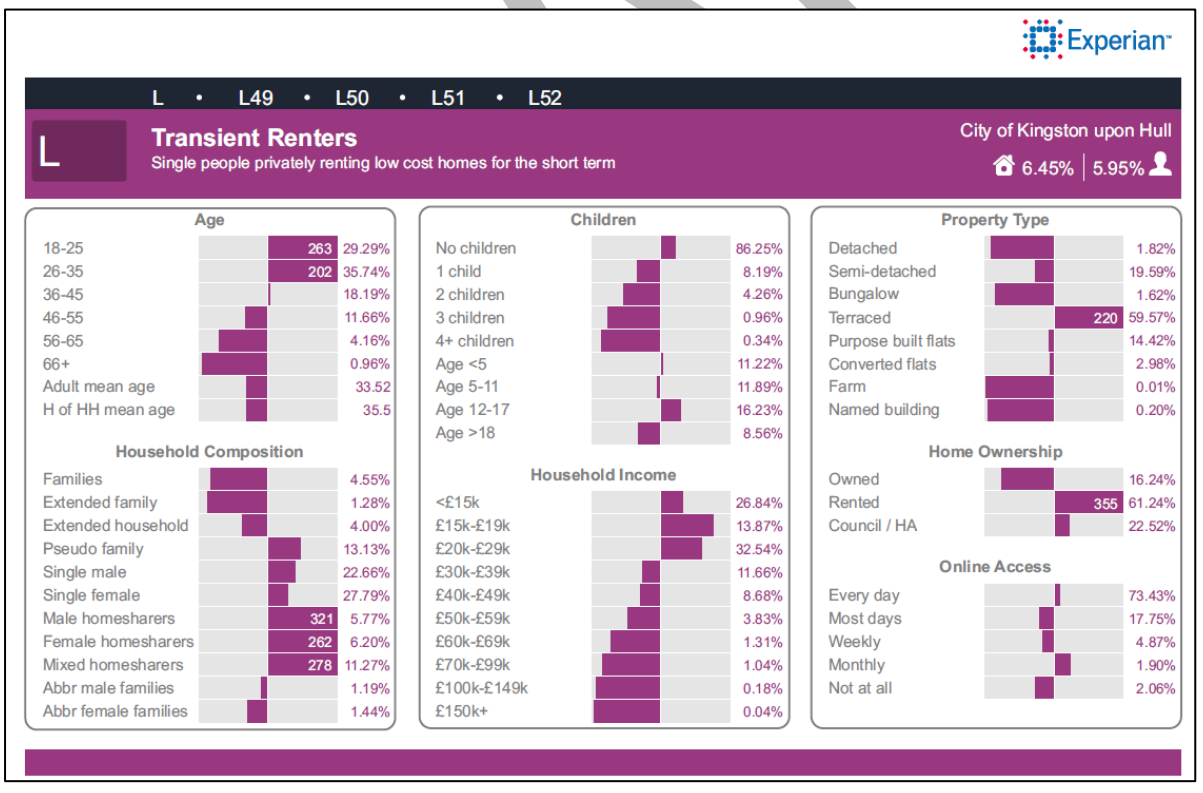
All questions below have been extracted from Kent County Council (2015) *A commissioning framework for Kent County Council: Delivering better outcomes for Kent residents through improved commissioning*

ANALYSE: Questions the Diagnostic report should answer	
A1	What are the challenges we are seeking to address?
A2	What are the needs of our residents and/or service users and how are these likely to change?
A3	What are practitioners and service users telling us?
A4	What other resources are being used to tackle similar issues and outcomes?
A5	What is driving demand for these services and what is our evidence for this?
A6	How is demand for these services likely to change and what will be the impact?
A7	How effective are the services currently being delivered and what is the current cost?
A8	What is the state of the current market and how is this likely to change?
A9	Is KCC the best placed organisation to provide services to support this outcome?
A10	How can we join up resources and activities with other partners to maximise our impact?
A11	What are the outcomes we are seeking to achieve through this new commissioning exercise?
A12	What will success look like?

Table 7: Questions the Diagnostic report should answer

Appendix 2: Mosaic L, M. N, O profile summaries





Experian

M • M53 • M54 • M55 • M56

M Family Basics

Families with limited resources who have to budget to make ends meet

Sandwell

7.22% | 8.74%

Who We Are

Age	Household Income
31-35	<£15k
14.8% 165	29.3% 143

Household composition	Number of children
Family + other adults	3 children
33.9% 171	14.2% 332

Tenure	Property type
Council / HA	Terraced
55.5% 302	51.8% 191

Channel Preference

110	102	95
86	103	118

Key Features

- Families with children
- Aged 25 to 40
- Limited resources
- Some own low cost homes
- Some rent from social landlords
- Squeezed budgets

Technology Adoption

Early Adopters





Experian

M • M53 • M54 • M55 • M56

M Family Basics

Families with limited resources who have to budget to make ends meet

Sandwell

7.22% | 8.74%

Age

18-25		17.53%
26-35		28.34%
36-45		30.62%
46-55		19.69%
56-65		3.06%
66+		0.76%
Adult mean age		36.61
H of HH mean age		39.87

Household Composition

Families		23.12%
Extended family		15.75%
Extended household	218	13.82%
Pseudo family		15.56%
Single male		3.31%
Single female		14.73%
Male homesharers		0.75%
Female homesharers		3.21%
Mixed homesharers		5.35%
Abbr male families		0.89%
Abbr female families		3.44%

Children

No children		11.74%
1 child	289	35.86%
2 children	300	27.63%
3 children	332	14.21%
4+ children	487	10.57%
Age <5	235	25.50%
Age 5-11	243	30.28%
Age 12-17		22.44%
Age >18		10.23%

Household Income

<£15k		29.27%
£15k-£19k		8.84%
£20k-£29k		26.58%
£30k-£39k		17.32%
£40k-£49k		11.34%
£50k-£59k		4.71%
£60k-£69k		1.23%
£70k-£99k		0.62%
£100k-£149k		0.08%
£150k+		0.01%

Property Type

Detached		1.90%
Semi-detached		35.43%
Bungalow		2.91%
Terraced		51.85%
Purpose built flats		7.37%
Converted flats		0.54%
Farm		0.01%
Named building		0.11%

Home Ownership

Owned		36.61%
Rented		7.86%
Council / HA	302	55.53%

Online Access

Every day		71.08%
Most days		20.42%
Weekly		4.07%
Monthly		1.28%
Not at all		3.14%

Experian

N • N57 • N58 • N59 • N60 • N61

N Vintage Value

Elderly people reliant on support to meet financial or practical needs

South Tyneside
6.82% | 4.73%

Who We Are

Age	Household Income
76-80	<£15k
17.7% 418	59.4% 291

Household composition	Number of children
Single	No children
71.7% 189	98.9% 137

Tenure	Property type
Council / HA	Purpose built flats
54.9% 298	34.5% 222

Channel Preference

115 88 83
112 109 71

Key Features

- Elderly
- Living alone
- Low income
- Small houses and flats
- Need support
- Low technology use

Technology Adoption

Late Majority






Experian

N • N57 • N58 • N59 • N60 • N61

N Vintage Value

Elderly people reliant on support to meet financial or practical needs

South Tyneside
6.82% | 4.73%

Age

18-25		0.89%
26-35		1.33%
36-45		2.44%
46-55		5.29%
56-65		12.87%
66+	365	77.18%
Adult mean age		71.87
H of HH mean age		74.29

Household Composition

Families		13.69%
Extended family		3.28%
Extended household		1.44%
Pseudo family		2.56%
Single male		24.32%
Single female	219	47.41%
Male homesharers		0.80%
Female homesharers		1.95%
Mixed homesharers		0.63%
Abbr male families		1.30%
Abbr female families		2.62%

Children

No children		98.85%
1 child		0.75%
2 children		0.30%
3 children		0.07%
4+ children		0.02%
Age <5		2.02%
Age 5-11		2.74%
Age 12-17		4.36%
Age >18		11.88%

Household Income

<£15k	291	59.35%
£15k-£19k		14.77%
£20k-£29k		18.43%
£30k-£39k		4.67%
£40k-£49k		1.46%
£50k-£59k		0.54%
£60k-£69k		0.27%
£70k-£99k		0.37%
£100k-£149k		0.10%
£150k+		0.02%

Property Type

Detached		1.24%
Semi-detached		17.46%
Bungalow		13.90%
Terraced		31.03%
Purpose built flats	222	34.50%
Converted flats		1.86%
Farm		0.01%
Named building		0.22%

Home Ownership

Owned		35.09%
Rented		10.03%
Council / HA	298	54.87%

Online Access

Every day		63.60%
Most days		22.58%
Weekly		7.95%
Monthly		2.67%
Not at all		3.20%

Experian

O • O62 • O63 • O64 • O65 • O66

O Municipal Challenge

Urban renters of social housing facing an array of challenges

Hackney

6.46% | 5.69%

Who We Are

Age	Household Income
56-60	<£15k
11.5% 159	43.9% 215

Household composition	Number of children
Single	No children
53.1% 140	81.3% 113

Tenure	Property type
Council / HA	Purpose built flats
81.7% 444	58.7% 378

Channel Preference

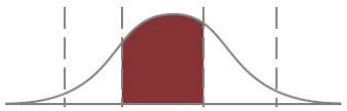
99 98 89

115 103 105

Key Features

- Social renters
- Low cost housing
- Challenged neighbourhoods
- Few employment options
- Low income
- Mobile phones

Technology Adoption



Early Majority

Experian

O • O62 • O63 • O64 • O65 • O66

O Municipal Challenge

Urban renters of social housing facing an array of challenges

Hackney

6.46% | 5.69%

Age

18-25	9.22%
26-35	18.19%
36-45	19.15%
46-55	24.01%
56-65	20.62%
66+	8.81%
Adult mean age	46.3
H of HH mean age	49.38

Household Composition

Families	10.84%
Extended family	5.21%
Extended household	4.74%
Pseudo family	8.63%
Single male	27.56%
Single female	25.56%
Male homesharers	2.85%
Female homesharers	4.25%
Mixed homesharers	5.21%
Abbr male families	2.09%
Abbr female families	2.87%

Children

No children	81.29%
1 child	7.29%
2 children	6.14%
3 children	3.43%
4+ children	1.85%
Age <5	7.82%
Age 5-11	9.85%
Age 12-17	12.75%
Age >18	12.42%

Household Income

<£15k	215 43.95%
£15k-£19k	12.73%
£20k-£29k	22.72%
£30k-£39k	11.65%
£40k-£49k	4.79%
£50k-£59k	1.69%
£60k-£69k	1.36%
£70k-£99k	1.02%
£100k-£149k	0.10%
£150k+	0.01%

Property Type

Detached	0.65%
Semi-detached	12.80%
Bungalow	2.76%
Terraced	22.14%
Purpose built flats	378 58.73%
Converted flats	2.92%
Farm	0.00%
Named building	0.04%

Home Ownership

Owned	10.34%
Rented	7.94%
Council / HA	444 81.72%

Online Access

Every day	67.04%
Most days	23.11%
Weekly	5.43%
Monthly	1.60%
Not at all	2.82%

Appendix 3: External services referrals - EHN categories

	Adolescent Support Workers	Domestic Abuse	Domestic Abuse	Family Mediation	Intensive Family Support	Intensive Family Support	Positive Relationships	Positive Relationships	Parenting	Young Carers
		North South	East West		East South	North West	North, East & West	South		
Cases Referred in 14/15 (whole year)	1377	385	196	419	522	320	218	67		1660
Methodology	1:1 case work with some supporting group work	Group work	1:1 work	Family based work with some 1:1 work when needed to support the whole family approac	Mainly in the home family based work – FIP type model of working	Mainly in the home family based work – FIP type model of working	Group work	Group work	Classroom based learning for parents	Group work through 'Chill Clubs' 1:1 support depended on need of Young Ca
ASD/ADHD	17				4		2		4	
Anger Man.	47	9			4		2		2	
Anxiety/stress/panic	29			1	3		11			
Autism/ Aspersers spectrum					2				1	
Behaviour	65	16		2	53	9	19		39	
Boundary setting	32				45		17		20	
Bullying	15						6			
Child Mental Health	13				18	3				
Child Substance Misuse	8					1				
Communication				34	8	5				
Debt and Money management	1				14	18				
Domestic Abuse (Experiencing)	8				8	24	26		4	
Domestic Abuse (Witnessing)	12		100		6			80		
Engagement with Ed. (Child)	58				25	27				
Exclusion/ missing from education	32						4			
Family events (divorce/separation etc.	54	5		1	4	29	7		9	
Family events (divorce/separation)		7			4	21	6			
Gender Identity - Child	6									
Gender Identity - Adult										
Involved in abusive/coercive relationship (Young Person)	1				10		15			
Improving social networks	46				12		7			
Keeping your child safe	12				7		7		7	
Learning Disabilities (Child)	1				1			20	2	
Loss and Bereavement	10				2					
Low educational attainment due to conduct	37						4			
Low Self Esteem/ Confidence	63			1	7	42	11			
Maintaining a family routine	23			5	21				7	
Meeting emotional needs	44			4	26	62	4			
Parenting				7	1	2				
Other Learning Disabilities					18	13			1	
Parental Mental Health	7				13	31				
Promoting good health	6				7	51				
Providing a stable home environment	5			3	23	9				
Speech and Language Difficulties										
Sexuality (LGBT) - Child	2									
Sexuality (LGBT) - Adult										
Substance Misuse (adult)					1	9				
Supporting learning (adult)					1				1	
Young Parent										
Young Carer									71	100
Other	4			44		8				

Kent	Dartford / Gravesham / Sevenoaks / Tonbridge & Malling / Tunbridge Wells / Maidstone	Canterbury / Swale / Thanet / Dover	Ashford / Shepway
SEN (pre-statement/assessment)	Family support (families in crisis)	Family support (in home lower need)	Family support (holistic)
EHWB (lower level counselling, active listening)	EHWB (lower level counselling, active listening)	Link to adult mental health	Consistent approach (1 worker)
SLC development	Resources (for families e.g. loanable DVDs)	Parenting (IY babies parenting programmes)	Family support (Peer mentoring, family to family support, transition work, child development)
EHWB (pre-CAHMS level e.g. phobia, OCD)	Mental health (not meeting needs of teenagers and YP)	SEN (Family support ASD/ADHD i.e. Early Bird)	Links with VCS/community
Family trauma (bereavement, separation)	Family trauma (bereavement)	Family support (teenagers)	Family trauma (bereavement)
Think Family approach	Education and attendance (ELS children and families support - interpreters)	EHWB (boys)	Lack of aspiration
Resources (for FIPs)	Gambling support	Child sexual abuse support	Needs based data (Local approaches)
Parenting (flexible support)	Pre-CAF flexible support (CAF notification and refusers)	Pre-CAF flexible support	Step down/exit strategies (closure summaries)
DA (family DA services)	EHWB (pre-CAHMS level e.g. phobia, OCD)	Domestic abuse	Needs-based model (local data linked to issues and needs, local champion model)
DA (aimed at perpetrators)	Education and Attendance (School refusers)	Mental Health	Needs based data - Long-term outcomes tracking (EYFS to KS2)
			Needs based data - Consistent paperwork and data collection

Appendix 5: Thematic analysis

Early years open access and targeted support

- Resources
  - Access to systems
  - Play equipment
  - Funds for engagement e.g. coffee
- Supervision
  - Receive good quality supervision and support

Approaches
  - Holistic/whole family
  - Non-judgemental
  - Non-authoritarian
  - Strength-focussed
  - Knowledge-based
    - Realises impact of trauma on brain development

Engagement
  - Must be flexible - Longer/shorter engagement plans

Location
  - Multiple areas
    - Home
    - Community/children's centres
    - Telephone

Skills
  - Active listening
  - Ability to model behaviours
  - Positive role modelling
  - Time management
  - Play/development
  - Poverty alleviation
  - Debt management
  - Employability support

Collaborative working
  - With existing local partners and able to refer to them
  - Health services e.g. mental health, breastfeeding, smoking
  - Adult education e.g. literacy and numeracy
  - Uses volunteers to engage families, act as mentors and build capacity

Information
  - Must be shared between partners

5-11 Open access and targeted support

- Approaches
  - Safe and confidential
  - Everyday approach
  - Communicate well – shows we value people
  - Restorative
- Engagement
  - Multiple areas
    - Social media
    - Virtual groups
    - Real relationships
  - Rapid – no waiting list
  - Must be timely
  - Flexible
  - Consistent presence
  - Utilise community assets
- Location
  - Based locally in community, not office i.e. youth centre, supermarket, children's centre
- Skills
  - Self-awareness
  - Focus on emotional need
  - Active listening
  - Conflict resolution

12+ Open access and targeted support

- Resources
  - Requires filtered information on issues/needs from scorecards
  - Needs information from workforce
    - Must be able to cross-reference datasets and capture gaps in the workforce
  - Requires service-level agreements to set expectations
- Supervision
  - Key to role
  - Can be used to capture workforce intelligence
- Approaches
  - Evidence-based/guided by intelligence
- Engagement
  - Must be proactive between services and interventions
  - Be responsive
  - Flexibility
  - Must be based on local gaps/needs (District and sub level)
- Collaborative working (with partners)
- Information
  - Needs information sharing protocol
  - Services must be tested/evaluable
  - Services must be testable
  - WEMWBS to track outcomes

Substance misuse

- Approaches
  - Holistic/whole family
  - Child-based
- Engagement
  - Needs to work with a “light touch”
  - Can’t work with people under the influence – how can this be safely overcome?
- Location
  - Uses multiple areas
    - Children’s centre
    - Schools
    - Youth centres
    - “Busses and marquees”
- Collaborative working
  - Primary MH
  - Schools (FLOs, SENCOs)
  - CSA
  - Police
  - Health (midwives, health visitors, school nurses)

Housing/Financial

- Approaches
  - Needs-based
    - Harness local knowledge
  - Co-designed (within community)
  - Sustainable
  - Mindful
  - Range of delivery models
- Engagement
  - Flexible model (to adapt if not working)
  - Engage community at every stage
  - Consistency of presence
  - Approach and programme should grow organically
- Location
  - Multiple areas
    - Wherever community is
    - Range of public spaces
- Collaborative with partners
  - Housing providers
  - Voluntary sector
  - Workers with expertise and local knowledge
  - Volunteers, befrienders, mentors, influential community members
  - Key community members
  - Arts and cultural organisations and individuals

Family and parenting

- Engagement
  - One-offs don't work very well
  - Be consistent, not just stops
  - Uses volunteers
    - Up-front investment in infrastructure for volunteers can save money over time
    - Must ensure enough volunteers as not enough are available
  - Use mentors/champions who have already been through the programme
  - Must engage families in rural areas as well as population centres
  - Flexible
    - Shorter engagements as 12 weeks is a long commitment (could offer 6 week focussed courses
    - Across age ranges
  - Could offer food incentives to families to complete courses
  - Open every day including Saturday and Sunday.
  - Remain open past 16:30 as some families can only access after this time
- Approach
  - Non-stigmatising
  - No logos
  - Needs identified based on consultation with users
- Location
  - Must be suitable
  - Offer an outreach to hard to reach families
- Collaborative working
  - Colocation at sites with other partners
  - Midwives
  - Health visitors
  - Children's Centres
  - GPs
  - VCS – through libraries, arts and culture

Emotional/mental health

- Approach
  - Use of creative approaches e.g. artistic facilitation, mirroring, modelling
  - Focus on change and prevention not just on diagnosis
  - Gardening i.e. allotments
- Engagement
  - Use champions
  - "Train the trainers" approach to engage community
- Location
  - Tailored environment
  - Shared spaces e.g. eating, experiences
- Collaborative working
  - VCS e.g. Youngminds, MIND, Children's Society, NCVS
  - Libraries, pubs, community centres, cafes, wellbeing centres

- Social services and early help practitioners (especially around vulnerable groups)

Skills
- CBT
- Art therapy
- Practical interventions e.g. sport and physical activity
- Diet

Information
- Must be evidence-based
- Must show what works
- Gather evidence of impact

<u>Domestic Violence</u>

Approaches
- Identify trigger points within families i.e. financial pressures
- Whole family, holistic
- Includes educational, social and emotional elements
- Sensitivity to individual needs
- Include restorative processes

Engagement
- Should not drop-off after engagement
- Continuum of services
- Promotional materials e.g. leaflets, posters, digital media, word of mouth
- Flexible, with county offer and rapid response, bespoke targeted service component.
- Appropriate to the level of need

Location
- In home
- Place where service user is safe/comfortable

Skills
- Community development
- Promote internal learning
- Supervision
- Drama/music/art workshops in schools

Collaborative working
- Clear communication with partners
- Children's centres
- Youth hubs
- Schools
- Housing providers
- Voluntary sector

Information
- Must be evidence-based
- Includes training on why we collect data and understanding of local intelligence and its use.

Appendix 6: EHPS Indicators

EHPS One Year Plan 2014-2015 (July 2014) – Performance Indicators and Targets

Indicator	Performance Target		Target
	Kent 2014	National 2014	2015
Reduce referrals to Specialist Children's Services by 15%	19741		16779
Reduce re-referrals to Specialist Children's Services by 6%	26.6%		25%
Increase step downs from statutory Social Care to Early Help by 30%	1145		1490
Reduce step ups from Early Help to statutory Social Care by 25%	600		450
Early Help Assessments completed per 10,000 per age group, 0-4	86		103
Early Help Assessments completed per 10,000 per age group, 5-11	132		154
Early Help Assessments completed per 10,000 per age group, 11-16	117		136
Early Help Assessments completed per 10,000 per age group, 16-19	48		57
Increase the percentage of CAFs and TAFs closed with a measurable positive outcome by 25%	66%		83%
Reduce the number of primary fixed term exclusions by 10%	1107		1000
Reduce the number of primary permanent exclusions by 10%	26		23
Reduce the level of persistent absence in the primary sector	3.1%		2.8%
Reduce the number of secondary fixed term exclusions	6783		5625
Reduce the number of secondary permanent exclusions	76		39
Reduce the level of persistent absence in the secondary sector	6.7%		5.5%
Troubled Families: percentage of phase 1 cohort identified and worked with	84%	NA	95%
Troubled Families: percentage of phase 1 cohort turned around	30%	NA	70%
Reduce the percentage of NEETs overall	5.9%		2.4%
Reduce the number of NEETS coming from vulnerable groups	1142		890
Reduce the percentage of young women who become pregnant (per 1000 women aged 15-17)	25	26	23
Increase the percentage of Children's Centres receiving a judgement of good or better following Ofsted inspection	72%		75%
Increase the percentage of DWP identified 2 year olds taking up free entitlement	79%		83%
Percentage of funded 2 year olds in good or outstanding settings	85%		86%
Increase the percentage of children taking up 'free for two'	61%		80%
Reduce the number of first time entrants to the Youth Justice System by 10%	698	NA	628
Reduce the rate of re-offending by young people	33.4%	35.3%	31%
Reduce custodial sentences as a percentage of court disposals	4.3%		3.5%
Reduce the number of Children in Care on the Youth Justice caseload (snapshot at end of each Quarter)	52	NA	47
Increase the percentage of families with children under 5 living in poverty who are registered with a Children's Centre	TBA		TBA
Increase the percentage of priority families with children under 5 living in the area who have sustained contact with a Children's Centre	TBA		TBA
Increase the percentage of children with FSM achieving good levels of development in the Early Years Foundation Stage	48%	36%	50%
Increase the percentage of parents from target groups completing parenting or other programmes	50%		60%
Increase the percentage of children being breastfed at six to eight weeks and sustained over time	36%		40%
Reduce the percentage of babies born to mothers who still smoke at the end of pregnancy by 10%	10%	13.1%	11.8%
Increase the number of vulnerable learners on apprenticeships	173		200
Increase the percentage of Children Missing Education offered suitable education within 30 days of becoming known	56%		70%
Number of families electing to educate at home who receive a visit by the LA	618		700
Reduce CAMHS caseload, for patients open at end of the month (May 2014)	8949		8000
Reduce the number waiting for routine treatment after assessment by CAMHS	484		350

Table 8: EHPS performance indicators and targets (one year plan)

EHPS Prospectus (May 2014) – Performance Indicators 0-11 year olds

Priorities for 0-11 year olds	Key Performance Measures
We will keep vulnerable and disadvantaged children safe without the need of specialist children's services	Number of CAFs completed per 10,000 population for 0-4 year olds and 5-11 year olds
	% and number of TAFs closed because the case has escalated to Children's Social Services for 0-4 year olds and 5-11 year olds
	% and number of SCS cases closed that have been stepped down to CAF/Preventative Services for 0-4 year olds and 5-11 year olds
	% and number of TAF's open for 3 months or less when outcomes were achieved for 0-4 year olds and 5-11 year olds
	% and number of TAF's open for 6 months or less when outcomes were achieved for 0-4 year olds and 5-11 year olds
	% and number of TAF's open for 12 months or less when outcomes were achieved for 0-4 year olds and 5-11 year olds
	% and number of referrals with a previous referral within 12 months for 0-4 year olds and 5-11 year olds
We will reduce health inequalities in the early years and during childhood and ensure we improve physical and mental health outcomes	% of mothers breastfeeding at 6-8 weeks from birth
	Obesity1 % of obese children in Reception and Year 6
	% Prevalence of smoking during pregnancy
	Number of A&E attendances for 0-4 year olds and 5-11 year olds
	Number of teenage mothers
	Number of children supported by CAMHS with a positive outcome
	Reduction in the number of children referred to CAMHS
	Reduction in waiting and treatment times for CAMHS
We will ensure vulnerable and disadvantaged children access and participate in good quality childcare and education and achieve good	% and number of fixed term exclusions at primary school
	% and number of permanent exclusions at primary school
	% and number of persistent absentees receiving early help
	% and number of take up of EYFE for two year olds, and
	three and four year olds
	% of pupils at EYFS achieving a Good Level of Development2
	% of pupils at KS1 achieving L2B+ in Reading, Writing and Mathematics 3
	% of pupils at KS2 achieving L4+ in Reading, Writing and Mathematics4
	% reduction in attainment gaps for pupil premium pupils at EYFS, KS1 And KS2
We will ensure early help services support children and families to be resilient and overcome barriers to achieving their potential	Number of families who receive early help support who report a positive outcome in helping them to move on
	% of families contacted within 8 weeks of child being born - Children's Centre
	Number of families supported through the Troubled Families Programme that achieve good outcomes and are turned around (with child under 11)
	% and number of families in each reach area who engage with Children's Centres
	% of families with children living in poverty under 11 who access employment and who take up maximum benefits

Table 9: EHPS performance indicators 0-11 (prospectus)

EHPS Prospectus (May 2014) – Performance Indicators 12-1- year olds

Priorities for 12-19 year olds	Key Performance Measures
We will ensure that more young people receive help earlier so that their needs do not escalate and require support from specialist provision	Number of CAFs completed per 10,000 population for 12-16 year olds and post 16 year olds
	% and number of TAFs closed because the case has escalated to Children's Social Services for 12-16 year olds and post 16 year olds
	% and number of SCS cases closed that have been stepped down to CAF/Preventative Services for 12-16 year olds and post 16 year olds
	% and number of TAF's open for 3 months or less when outcomes were achieved for 12-16 year olds and post 16 year olds
	% and number of TAF's open for 6 months or less when outcomes were achieved for 12-16 year olds and post 16 year olds
	% and number of TAF's open for 12 months or less when outcomes were achieved for 12-16 year olds and post 16 year olds
	% and number of referrals with a previous referral within 12 months 12-16 year olds and post 16 year olds
We will ensure young people are helped to avoid harm from substance misuse and risky behaviours and they benefit from improvements in support for mental health and wellbeing	Number of young people supported by CAMHS with a
	positive outcome
	Reduction in the number of young people referred to CAMHS
	Reduction in waiting and treatment times for CAMHS
	Number and % of teenage pregnancies and single mothers aged under 20
	Self-reported use of drugs and alcohol and reduction in drug misuse
	Attendance by young people at A&E for deliberate or unintentional harm
	Chlamydia rates for 15-24 year olds
We will ensure that all young people aged 11-19 are positively participating in EET, and achieving and progressing well to employment or higher learning	Percentage of persistent absenteeism by young people receiving early help
	Percentage of NEETs
	Percentage and number of fixed term exclusions for young people receiving early help
	Percentage and number of permanent exclusions for young people receiving early help
	Percentage and number of young people attending PRUs or alternative provision who achieve a good outcome at age 16 and have a positive destination to college or employment with training
	% young people achieving 5 good GCSEs with English and maths at age 16
	% young people achieving level 2 and 3 qualifications at age 19
	% reduction in attainment gaps for disadvantaged young people at ages 16 and 19
	Number of apprenticeships started and completed by vulnerable and disadvantaged young people receiving early help
We will ensure that young people are resilient, able to make positive informed choices and become active and responsible citizens with strong personal networks	Percentage and number of targeted young people aged 16-17 engaged in social action and volunteering
	Unemployment numbers for vulnerable 17-19 year olds
	Number of families with adolescent members supported through the Troubled Families Programme that achieve good outcomes and are turned around
	Number of young people receiving custodial sentences
	Numbers of young people first time entrants (FTE) into the criminal justice system
	Rate and number of re-offending by young offenders

Table 10: EHPS performance indicators 12-19 (prospectus)