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AGENDA

SWALE HEALTH AND WELLBEING BOARD MEETING

Date: Wednesday, 19 November 2014
Time: 9.30 am
Venue: Committee Room - Swale House

Membership:

Councillors

Quorum = 3

Issued on Date Not Specified

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Swale Health and Wellbeing Board

Public Meeting

Wednesday 19 November 2014, 9.30am – 11.30am

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

AGENDA

Item	Time	Item	Lead
1	9.30	Introductions and apologies for absence	Chair
2	9.35	Minutes of last meeting*	Chair
3	9.40	KMPT MH Quality Review	Nicola Jones, Swale CCG & TBC, KMPT
4	10.00	MH Crisis Provision*	Alan Heyes and Steve Furber, Swale MHAG
5	10.20	Draft Children and Young People's Emotional Health and Wellbeing Strategy*	KCC - TBC
6	10.35	Health and Wellbeing Board Prioritisation*	ALL
7	10.50	Integrated Commissioning Group Update	Paula Parker, KCC
8	11.05	Better Care Fund	Tristan Godfrey, KCC
9	11.10	Kent Health and Wellbeing Board: https://democracy.kent.gov.uk/ieListDocuments.aspx?MId=5469&x=1&	ALL
10	11.20	Partners Update/AOB	ALL
		Dates of future meetings: 28 January 2015 18 March 2015 20 May 2015 15 July 2015 16 September 2015 18 November 2015	

* Papers attached

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Health and Wellbeing Board – Fourth Formal Meeting

Meeting held on Wednesday 17 September 2014 at 09:30am

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

Present	**Cllr Andrew Bowles (AB), *Leader, SBC (Chair)***	**Abdool Kara (AK), *Chief Executive, SBC***
	Cllr Ken Pugh (KP), *Cabinet Member for Health, SBC*	**Paula Parker (PP), *Commissioning Manager, KCC***
	Cllr John Wright (JW), *Cabinet Member for Housing and Lead Member for Health, SBC*	**Alan Heyes (AH), *Community Engagement Lead, Mental Health Matters***
	Amber Christou (AC), *Head of Housing, SBC*	**Tristan Godfrey (TG), *Policy Manager, KCC***
	Patricia Davies (PD), *Accountable Officer, Swale CCG*	**Terry Hall (TH), *Public Health, KCC***
	Ally Hiscox (AH), *Deputy Chief Operating Officer, Swale CCG*	**Jo Purvis (JP), *Strategic Housing and Health Manager, SBC***
	Dr Fiona Armstrong (FA), *Chair, Swale CCG*	**Dr Phil Barnes (PB), *Acting Chief Executive, Medway Foundation Trust***
	Su Xavier (SX), *Swale CCG*	**Linda Smith (LS), *Public Health, KCC***
	Cllr Chris Smith (CS), *Deputy Cabinet Member Adult Social Care & Public Health, KCC*	**Tracey Schneider (TS), *Project Manager, KCC***
	Jo Pannell (JoP), *Kent Healthwatch*	**Gill Harris (GH), *Planning Manager, SBC***
		Katie Matson (KM), *Systems and Performance Officer, SBC*
Apologies	**Debbie Stock, *Chief Operating Officer, Swale CCG***	**Lyn Gallimore, *Kent Healthwatch***
	Bill Ronan, *Community Engagement Manager, KCC*	**Penny Southern, *Director Learning Disability and Mental Health, KCC***
	Sarah Williams, *Assistant Director, Swale CVS*	**Mark Lemon, *Strategic Business Advisor, KCC***

NO	ITEM	ACTION
1.	**Introductions**	
1.1	AB welcomed attendees to the meeting.	
1.2	All attendees introduced themselves and apologies were noted.	
1.3	JP informed the Board that Lyn Gallimore was retiring from Healthwatch, and therefore the Board, due to health issues. AB wished Lyn well and recorded his thanks for her work with the Board. AB to send a note of thanks to Lyn as well.	**AB**
2.	**Minutes from Last Meeting**	
2.1	The minutes from the previous meeting were approved.	

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2.2	Matters arising: § p.1, 2.2: meeting between SBC, KCC and Swale CCG been arranged to discuss priorities; § p.1, 2.2: JSNA local assurance framework for Swale has been completed and will be circulated with the minutes; § p.3, 3.2: JP to provide the Board with information regarding GPs and housing interventions; and § p.4, 6.2: JP to contact Alison Davies about a future presentation to the HWB on Integrated Discharge Teams.	 **JP** **JP** **JP/AD**
3.	**Medway Foundation Trust Review**	
3.1	PB gave an update on Medway Foundation Trust (MFT). The key points were: § MFT was rated overall as inadequate by CQC following full inspection at the end of April, and remains in special measures; § some individual units were rated as good – children's, intensive care and dementia, with the neo-natal unit rated as top five within the country for outcomes. The hospital was also rated good overall for caring; § concerns were raised by CQC around use and reliability of data and management of surgical pathway, (not the clinical ability of surgical staff); § patient flow through the hospital needs improving. Need to reduce delays in discharge to free up bed capacity and prevent hospital getting congested and patients getting stuck in A&E as nowhere to move onto; § A&E needs improving – it is overcrowded and is not being used efficiently, particularly the Vanguard Unit which was meant to be used for triage but because of hospital congestion was getting blocked by patients they couldn't move on. The Vanguard unit is being removed. § MFT are trying to move away from the Monday-to-Friday culture, i.e. having consultant/surgeon ward rounds at the weekends so people can be discharged, which will help with the flow of patients within the hospital; § MFT are undertaking work alongside University Hospitals Birmingham Foundation Trust to make improvements; looking at structures, operations, comms, data and IT; and § MFT are also making the management structure leaner and are currently out to recruit a new CEO and COO.	
3.2	Points made in the discussion included: § culture change is difficult and MFT need to get the clinicians to buy into the vision and for all staff to commit to owning the current problems and working towards resolving them. The main focus is on having a high quality emergency and clinical pathway, but there is a need to still ensure support for other good functioning units;	

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	§ attracting and retaining good quality staff is also a challenge but MFT is committed to ensuring that the standard of recruitment is not lowered. Some clinicians will be attracted by the challenge of working at MFT and working to help bring about improvement; § MFT remain committed to the model of seven day working and has been chosen as an early adopter in December 2013; and § the Board were pleased with the proposed changes and are happy to support MFT with the implementation.	
4.	**Alcohol Strategy for Kent 2014-16**	
4.1	LS introduced the Kent Alcohol Strategy. The key points were: § there is a nationwide rise in liver deaths and alcohol-related harms. Huge cost to the public purse, around £3.5b annual cost to the NHS. Kent has the largest alcohol-related costs to the NHS within the South East; § the new strategy is focusing on prevention and stopping people with lower levels of alcohol consumptions from progressing to acute harm; § trying to implement a behavior/culture change amongst people, particularly the middle classes, who do not necessarily think that their alcohol consumption is too high. Would like to get to the same place in relation to alcohol as now are on smoking; § looking to try to identify people who are at risk of alcohol-related harm earlier and target them with appropriate interventions/messages. Working with GPs and pharmacies, running pilots in A&E, and developing scratch-cards to give to people to self-identify; § KPH have developed an Integrated Care Pathway tool for services to use to help refer people on to appropriate interventions, including advice, local services, and specialist treatments. This has been piloted in South Kent Coast CCG area and KPH are now looking to roll this out in Swale. Workshop on 29 September will look at this in more detail; § also looking to improve the quality of treatment for people coming through specialist treatment. Better working needed with mental health services. Looking at including something around dual diagnosis in future GP contracts; and § the education of young people around these risks is very important. KPH has the Risk It Programme, going into schools to raise awareness. Also looking at how they can link in with Troubled Families.	
4.2	Points made in the discussion included: § need to get the message into secondary schools - not just a one-off talk, but ensure the message is promoted all the time. Could look at training champions within schools; § this is a big issue for housing and SBC are keen to ensure that frontline staff are aware of and can deal with people with alcohol problems. Have had AA in before to train staff and will do so again;	

	§ need to also look at how to link alcohol harm and mental health better, and how those with dual diagnosis can be better helped; § the focus can't just be on alcoholism, we also need to target prevention amongst those who are not at that stage but do drink more than recommended. particularly those who think that they do not have a problem; § campaigns and communications will be aimed at the mass population to hit those groups, and KPH is undertaking work with GPs to proactively identify patients on their registers who may be at risk, so they can receive more targeted intervention; § KPH will also be including in their new contracts the need to have a workforce trained in alcohol awareness; § also need to consider raising awareness amongst our own workforces. SBC happy to do this for their staff, and to encourage Public Service Board partners to do the same; and § need to use the workshop on 29 September to design a framework for the pathway and interventions, and to set local priorities.	
5.	**Swale Borough Council Local Plan**	
5.1	GH provided an update to the Board on the progress of SBC's emerging Local Plan (LP). The key points were: § health and wellbeing are embedded within the LP, and there is a core strategy policy on health and wellbeing; § SBC need to ensure that they create space in the plan for health provision and identify the necessary infrastructure required. Work has been undertaken with NHS Estates to map and identify existing health provision and capacity and the potential future need; and § the NHS have already indicated that it might be difficult to meet requirements without developer contributions. A draft of the LP will be available on the SBC website towards the end of October, with a formal consultation expected to start just before Christmas. JP to circulate link to the Board when available.	**JP**
5.2	Points made in the discussion included: § the need to ensure that the CCG plans reflect the LP projections for future development, expected increases in population, and local capacity. PD stated that the CCG are working with NHS England around primary care capacity and future requirements. In Swale there are particular issues around a population shift and growth in numbers of older people, and also an ageing GP population; and § the lack of viability of new development in some parts of the Borough will mean that it will be difficult to raise the necessary developer contributions to deliver all the required infrastructure, including health.	
6.	**Dementia Action Alliance**	
6.1	TS explained about the Kent Dementia Action Alliance and the work that has	

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	been undertaken in Sittingbourne and Sheppey so far. The key points were: § aiming to build dementia-friendly communities (DFCs) within Kent, to reduce the stigma of dementia and aid community cohesion; § the Kent-wide Dementia Action Alliance feeds into the Kent HWB. Some areas, such as Swale, have their own local action alliances; § in Swale there are two distinct communities, Sittingbourne and Sheppey, and each has their own alliance. So far, a few meetings have been held in each area; § work that has come out of that includes organising dementia friend awareness raising sessions. A couple have been held at the Oasis Academy on Sheppey, and sessions are being set-up for SBC frontline staff and Members; and § looking to set-up public engagement events to raise awareness of services available to people with dementia and their families and trying to encourage people to have as active a life as possible. Points made in the discussion included: § the Joint Policy and Planning Board and Kent Housing Group have developed a 'Dementia Action Alliance' for Kent housing organisations. Work is going to be undertaken to train housing officers from AmicusHorizon in how to spot the early signs of dementia when they are doing home visits; and § support needs to be offered to carers as well as sufferers from dementia. People do not always know what services are out there, eg carer crisis/respite services. PP to share list of services that are operating locally.	**PP**
7.	**Better Care Fund**	
7.1	TG updated the Board that the latest BCF submission was due to be submitted to DOH on 19 September, subject to the agreement of the Kent HWB.	
7.2	PD stated that the North Kent BCF Plan had been sent to the assessors for comment, and had received positive feedback.	
8.	**Kent Health and Wellbeing Board**	
8.1	The agenda for the Kent HWB was noted with no comments.	
9.	**Forward Plan**	
9.1	KMPT Review has been put back to the November meeting.	
9.2	Local assurance framework to be added to the Forward Plan.	
10.	**Partners' Update/AOB**	
10.1	**Swale CCG** § Swale CCG are continuing to support MFT as they try to improve. § The CCG Performance Report was noted by the Board as being very	

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	helpful.	
10.2	**KCC** § KCC's efficiency partners will be looking at how to work better with health services to reduce the numbers of people going into hospital. § Due to changes to be implemented through the Care Act, the numbers of people who will be able to access a social care assessment are expected to increase from April 2015. This could put additional strain on services. CS suggested that we have a briefing on the Care Act at a future Board.	**JP**
	§ Social care are looking at how they can work better with the VCS and what services the VCS can offer.	
10.3	**Kent Public Health** § The Board noted the Healthy Living Pharmacy update paper. AB thought that there is a pharmacy at Teynham Street, which wasn't listed in the paper. TH to check.	**TH**
	§ KCC Members briefing on health inequalities to be held on 15 Oct at 2pm.	
10.4	**Mental Health Matters** § MHM have started offering telephone counselling services to those with mental health issues.	
	§ The proposed Live It Well Hub at the Gateway has been put on hold	
	§ A Crisis Café is due to be opened in Medway to prevent people going to A&E in the evenings if they just need some time out or someone to talk to.	
10.5	**SBC** § SBC have finalised their budget proposals, with papers available on this in late November. There will be no frontline cuts.	
	§ Proposals for the regeneration of Sittingbourne Town Centre have been developed, and a planning application is expected in October.	
	§ Andrew Ervine, a former employee of SBC, is undertaking a PhD into partnerships and would like to use the partnerships of Swale, including the Board, to inform his research. The Board agreed to this. Members of the Board will shortly receive an email questionnaire from AE to complete.	

Next meeting date: **Wednesday 19 November 2014***

Time: **9.30am – 11.30am**

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

***This meeting will be in public**

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

28 January 2015

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18 March 2015

20 May 2015

15 July 2015

16 September 2015

18 November 2015

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From: Alan Heyes, Community Engagement Lead, Mental Health Matters
Steve Furber, Chair, Swale Mental Health Action Group

To: Swale Health and Wellbeing Board – 19 November 2014

Subject: **Mental Health Crisis Provision in Swale**

Classification: Unrestricted

Summary:

This report sets out proposals for a mental health crisis cafe to provide access to out of hours support for people within Swale experiencing a mental health crisis.

Recommendations:

The Health and Wellbeing Board is asked to note the contents of the report and support the

1. Introduction

1.1. In April 2014, Swale Borough Council's Policy Overview Committee undertook a review of mental health services across Swale. The Committee proposed a series of recommendations, which were presented to the Swale Health and Wellbeing Board on 16th July 2014.

1.2. One of the recommendations concerned the provision of accommodation for people experiencing some form of mental health crisis. Following discussions with KMPT and KCC it was felt that more effective help for those experiencing crisis could be delivered by a community out of hours service, based in an informal setting such as a cafe.

1.3. Following work that Mental Health Matters have been undertaking with Medway, options are now being explored for the provision of a mental health crisis cafe service within the Swale CCG area. Due to the natural boundary between Sittingbourne and the Isle of Sheppey and the lack of late night public transport running between the two, options for a crisis cafe service in both Sittingbourne and Sheerness are being considered.

2. Background

2.1. There have been a number of drivers, both at a national and a local level that support the rationale for the design of community-based out of hours mental health services. In 2011, Mind commissioned an independent inquiry (Listening to Experience, 2011) into acute and Crisis mental health services. People said they wanted:

- To be treated in a warm, caring and respectful way.
- A reduction in the medical emphasis in acute care and recognition of the benefits of peer support and other third sector providers, in helping manage a crisis.
- Services to respond quickly to prevent further escalation of the crisis.
- A place to go for safety and respite.

2.2. To set the scene here is a short film about the Safe Haven Project, a pilot project funded by the North East Hampshire and Farnham Clinical Commissioning Group:
http://www.youtube.com/watch?v=BTfN_vopEAU

Following on from the "Safe Haven Project" ideas were developed within the Mental Health Action Groups (MHAGs) to establish a crisis cafe similar to a pilot model in Hampshire. The idea was to offer something out of hours for people at those vulnerable times at the weekend when apart from the Mental Health Matters Helpline and community based mental health Home Treatment teams on call out little or no service provision is currently made.

Mental Health Matters approached Medway CCG to see if NHS winter pressures money could be funded in the belief that if we could provide a safe place and holding environment fewer people would attend A&E to get out of hours mental health support.

A consultation to look at the feasibility of similar projects across Kent and Medway was conducted between the Mental Health Action Group and the Medway Clinical Commissioning Group. This consultation involved key stakeholders including service users, carers, statutory, primary care and third sector providers.

The main theme was to establish why people use A&E for their mental health needs. It concluded people wanted a physical place to go, out of hours, where they could get support and advice. People said that they wanted a safe environment for people to have access to mental health support when they need it. The crisis cafe would meet this need.

3. Implementation

3.1. The cafe would be staffed by a multi-agency team from Primary and Secondary care and third sector organisations working in a client focussed and collaborative way who would bring a wide range of skills and qualifications to the mix. Something of a one stop shop. Staff would listen without judgement; offer respect, and support those in crisis. People would not need an appointment to attend and our protocol would be to signpost rather than refer them. The cafe would offer an open door policy and everyone would be welcome.

3.2. The cafe would work with other agencies (e.g. local GPs, police, local authority housing teams, Community Mental Health Teams and the helpline) to identify frequent attendees at A&E and frequent callers to help relieve the pressure on A&E and prevent Section 136s. People would have access to a range of community information on mental health and wellbeing as well as invaluable peer support which promotes integration into the community.

3.3. The cafe could offer clinical interventions and in Medway we have agreed with our KMPT colleagues to provide Support Time Recovery Workers (STR workers) and after

evaluation we would look possibly to have a Community Psychiatric Nurse (CPN) or Occupational Therapist (OT) on site. The rationale would be self-harm reduction, socialising, activity and diversionary work as well as having a calm and friendly environment for secondary mental health interventions.

4. Outcome measures and evaluation

Qualitative and quantitative tools will be used to evaluate the project. These would include:

- A count of the number of people who attended the cafe and the reason for their attendances.
- Feedback about the service from those that attended the cafe.
- Feedback from external agencies.
- Use of CORE GAD or PHQ9 scoring to ascertain improvements around client's wellbeing.

5. Delivery in Swale

5.1. The environment and location of any cafe is important. Mental Health Matters are looking at sites where there are sympathetic organisations with appropriate facilities that are accessible. To ensure the greatest amount of access for people living across the Swale CCG area, provision of two cafes, one in Sittingbourne and one in Sheerness, are being considered.

5.2. Meetings at The Quays and the Pulse Café in Sittingbourne and the Healthy Living Centre at Sheerness have been arranged and verbal feedback on these early discussions will be provided to the Board on 19th November.

5.3. A funding bid has been submitted to Swale CCG and Naomi Hamilton, Mental Health Commissioning Manager, has been very supportive of the plans. The success of the bid should be known shortly and verbal feedback will be given at the Board meeting on 19th November.

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Report Subject: Swale Health and Wellbeing Board – Assurance Framework

Date: September 2014

Summary:

The Kent Health and Wellbeing Board (KHWB) has developed an assurance framework that includes a range of activity and outcome indicators from across the health and social care system in Kent. This report presents a specific Swale overview of these indicators.

Recommendations:

The Swale Health and Wellbeing Board is asked to:

- Note the contents of the report and seek assurance from relevant committees for actions plan to address areas that require further attention.
- Approve ownership of the framework for regular monitoring of the agreed indicators.

1. Introduction

This report aims to provide the Swale Health and Wellbeing Board with an overview of a range of activity and outcomes indicators based on Kent's Health and Wellbeing Strategy and a series of other stress indicators.

As agreed at the KHWB, the indicators have been drawn from a number of existing frameworks and responsible agencies across Kent and England:

- Kent Public Health and the Public Health Outcomes Framework (PHOF)
- NHS Outcome Framework
- KCC Social Care
- Adult Social Care Outcome Framework
- NHS England South Escalation Framework

2. Background to the report

The Kent Health and Wellbeing Board Assurance Framework was developed to provide the Board with an overview of activity and outcomes across the Kent Health and Social Care System.

Many of the indicators in the framework have been included in the revised draft Health and Wellbeing Strategy and will be used to assess progress and impact of the strategy. Others have been derived from the NHS England South Escalation Framework to provide assurance or highlight potentially unsustainable pressures in the component sectors.

The framework aims to provide updates on a regular basis to highlight whether indicators are progressing in the right direction. At the February KHWB meeting, members recommended that the assurance framework should be replicated for local Health and Wellbeing Boards.

The KHWB meeting held in November 2013 decided that the assurance framework should:

- Contain national metrics stated in the Better Care fund; in most cases these metrics were already present in the framework. Metrics on avoidable emergency admissions and patient/service user experience are to be defined and developed in future reporting.

- Add indicators to reflect the evolution of local and national data sets. These are highlighted within the report.

- Following discussions with the Area Team (NHS England) reflect stress indicators across the different components of the system – Public Health, Acute/Urgent, GP and Social Care. Work is on-going to ensure the most appropriate indicators have been identified.

Key to KPI Ratings used

GREEN	Better than Kent Status
AMBER	Similar to Kent Status
RED	Worse than Kent Status
æ	Performance has increased relative to previous levels (not related to target)
	Performance has decreased relative to previous levels (not related to target)
	Performance has remained the same relative to previous levels (not related to target)

Data quality note: All data is categorised as management information. All results may be subject to later change.

Report Prepared by

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3. Strategy Indicators

The following tables provide an overview of the indicators outcome group in the Kent Health and Wellbeing Strategy. The direction of travel refers to the movement from the last time period. The RAG rating relates to the comparison with the overall Kent value.

Due to geographical boundaries where district only is indicated this relates to the area covered within Swale District Council. As more data becomes available at CCG level, district only data will be replaced.

A breakdown of the indicator values for each local health and wellbeing board area in Kent is included at Appendix A.

Outcome 1: Every child has the best start in life

Indicator	Kent Status	Swale Status	DoT	Time Period
1.1 Increasing breastfeeding initiation rates (PHOF)	72.1%	not currently available	-	2012/13
1.2 Increasing breastfeeding continuation 6-8 weeks (PHOF)	40.8%	not currently available	-	2012/13
1.3 Improve MMR vaccination update - two doses 5 years old, (PHOF)	92.2%	not currently available	-	2012/13
1.4 Reduction in the number of pregnant women with a smoking status at the time of delivery (KMPHO)	13.1%	20.6%	-	2013/14
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	14.6	16.3	æ	2013/14
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	7.3	10.2		2013/14
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000, KMPHO)	8.8	13.6		2013/14
1.8 Reduction in conception rates for young women aged under 18 years old (rate per 1,000, PHOF)	25.9	35.6 district only	æ	2012
1.9 Decrease the proportion of 4-5 year olds with excess weight (PHOF)	21.7%	23.2% district only		2012/13
1.10 Decrease the proportion of 10-11 year olds with excess weight (PHOF)	32.7%	33.2% district only		2012/13 rag changed

Exception items:

- For 2013/14 Swale has the highest proportion of women with a smoking status at time of delivery across all areas in Kent; at 20.6% it is significantly higher than Kent as a whole at 13.1%, Thanet is the 2nd highest at 17.0%. it should be noted that Swale had the lowest number of maternities in 2013/14.
- Although the unplanned hospitalisation rate for asthma in under 19 years old for Swale is above Kent for 2013/14 at 16.3 per 10,000 compared to 14.6, the Swale rate has decreased since 2010/11 from having the highest rate across the CCGs to the 3rd highest in 2013/14; This was a decrease from 29.1 per 10,000 to 16.3 per 10,000.
- Swale district experienced a decrease in the under 18 conception rate from 2011 at 41.2 per 1,000 to 35.6 per 1,000 in 2012, with an overall decrease since 2005. However Swale District remains above the Kent average and have the 2nd highest rate in Kent.

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

Indicator	Kent Status	Swale Status	DoT	Time Period
2.1 Reduction in the under-75 mortality rate from cancer (rate per 100,000, KMPHO)	135.5	133.8	æ	2012
2.2 Reduction in the under-75 mortality rate from respiratory disease (ASR per 100,000, KMPHO)	30.7	23.6	æ	2012
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited (where GP Practice can be linked, Public Health)	36.1%	28.3%	-	2013/14
2.4 Increase in the number of people quitting smoking via smoking cessation services (Subject to amendment, Public Health)	5254	518	-	2013/14
2.5 Reduction in the number of hip fractures for people aged 65 and over (ASR per 100,000, KMPHO)	480.5	559.6	æ	2013/14
2.6 Reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000, KMPHO)	295.5	334.9	æ	2010-12
2.7 Decrease the proportion of adults with excess weight (PHOF)	64.6%	68.8% district only	-	2012
2.8 Increase the Percentage of physically active clients (PHOF)	57.2%	52.6% district only	-	2012

Exception items:

- The Swale rate of hip fractures in those aged over 65 years has fluctuated since 2008/09, and experienced a reduction from 770.8 per 100,000 in 2012/13 to 559.6 in 2013/14.

- Although the Swale rate of deaths attributable to smoking (aged 35+) has been reducing since 2008-10, it is the highest rate in Kent.

Outcome 3: The quality of life for people with long term conditions is enhanced and they have access to good quality care and support

Indicator	Kent Status	Swale Status	DoT	Time Period
3.1 Clients with community based services who receive a personal budget and/or direct budget	67%	not currently available	-	February 2014
3.2 Increase in the number of people using telecare and telehealth technology	2,992	not currently available	-	February 2014

Exception items:

- There has been a further drop in the proportion of people receiving a personal budget and/or direct budget, this is due to more people receiving a short term service such as enablement or telecare and would not therefore be eligible for a personal budget or direct payment.

- There have been further increases in the number of people using telecare and telehealth technology and to February there were 2,992 clients, this far exceeds the target of 2,125.

- Local health and wellbeing board area figures on both metrics will be available for the next report.

Outcome 4: People with mental health issues are supported to "live well"

Indicator	Kent Status	Swale Status	DoT	Time Period
4.1 Reduction in the number of suicides (ASR per 100,000, KMPHO)	5.31	4.56	æ	2011-13
4.2 Increased employment rate among people with mental illness/those in contact with secondary mental health services (ASCOF)	7.4%	not currently available	-	2012/13
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent (KMCS)	73.5%	86.0%	æ	Q3 2013/14
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours (KMCS)	100%	100%		Q3 2013/14
4.5 Number of adults receiving treatment for drug misuse (primary substance) number (KDAAT)	to be presented in next report			
4.6 Number of adults receiving treatment for alcohol misuse (primary substance) number (KDAAT)	to be presented in next report			
4.7 Increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment (PHOF)	10.9%	not currently available		2012
4.8 Decrease the number of people entering prison with substance dependence issues who are previously not known to community treatment (PHOF)	Awaiting indicator development and reporting from PHE			

Exception items:

- Further work is needed on the substance misuse metrics (4.5, 4.6, 4.7 and 4.8) with the aim to provide figures for the next report.

Outcome 5: People with dementia are assessed and treated earlier

Indicator	Kent Status	Swale Status	DoT	Time Period
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence (KMCS)	41.5%	44.8%	æ	2012/13
5.2 Rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000, KMCS)	25.1	21.3		2013/14
5.3 Rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000, KMCS)	50.5	48.7		2013/14
5.4 Total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	225.7	257.4		2013/14
5.5 Total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	452.5	573.1		2013/14

Indicator	D&G NHS Trust	EKHUFT	MTW	MFT	Time Period
5.6 The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:					
(a) identified as potentially having dementia	92%	100% æ	99%	78% æ	Q4 2013/14
(b) who are appropriately assessed	100%	94%	99%	88%	Q4 2013/14
(c) and, where appropriate, referred on to specialist services in England	100% æ	100%	100%	91% æ	Q4 2013/14

Exception items:

- The total number of bed-days in hospital for patients older than 64 years old and 74 years old of patients with a secondary diagnosis of dementia is increasing for Swale and continues to be higher than Kent; the aim is for a decrease in the number of bed-days.

4. Stress Indicators

Children's Services

Indicator	Kent Status	Swale Status	DoT	Time Period
6.1 Decrease the number waiting for routine treatment after assessment – CAMHS (KMCS)	565	69	æ	April 2014 rag removed
6.2 CAMHS Caseload, for patients open at any point during the month (excluding Medway and Out of Area, KMCS)	8,523	531	-	April 2014
6.3 Increase proportion of SEN assessments within 26 weeks (MIU KCC)	94.5%	93.2% district only	æ	March 2014 rag changed
6.4 SEN Kent children placed in independent or out of county schools (number, MIU KCC)	583	67 district only		March 2014

Exception items:

- Swale district has increasing proportions of SEN assessments within 26 weeks and is now just below Kent levels.

Public Health

Indicator	Kent Status	Swale Status	DoT	Time Period
6.5 Population vaccination coverage – Flu (aged 65+, PHOF) Target: 75%	71.4%	not currently available	-	2012/13
6.6 Population vaccination coverage – Flu (at risk individuals, PHOF) Target: 75%	48.7%	not currently available	-	2012/13

Exception items:

- Currently metrics on Flu vaccinations are not available at CCG level, work is ongoing between Kent Public Health and the Area Team (NHS England) on future provision.

Acute/Urgent and Primary Care

Indicator	D&G NHS Trust	EKHUFT	MTW	MFT	Time Period
6.7 Bed Occupancy Rates (overnight)	96.7%	92.3%	93.6%	94.3%	Q4 2013/14
6.8 A&E Attendances within 4 hours (all) from arrival to admission, transfer or discharge	97.9%	93.5%	96.9%	83.2%	Week ending 25/05/2014
6.9 Number of emergency admissions	To be further discussed and developed with NHS England				
6.10 GP Attendances	Awaiting information from NHS England and indicator development				
6.11 Out of Hours activity	Awaiting information from KMCS and indicator development				
6.12 111 NHS Service	Work ongoing with KMCS to shape and define				

Exception items:

- Overnight bed occupancy rates for Q4 2013/14 vary between 92.3% at EKHUFT to 96.7% at Dartford and Gravesham (D&G) NHS Trust.

- A&E attendances within 4 hours from arrival also varies from 83.2% in Medway NHS Foundation Trust to 97.9% in D&G NHS Trust. These figures relate to the week ending 25/05/2014.

- Work is ongoing to either define or find suitable current metrics for those listed above; monthly data meetings are held that include KMCS and NHS colleagues where discussions are ongoing.

Social care / Community care

Indicator	Kent Status	Swale Status	DoT	Time Period
6.13 The proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services **BCF**	Under review by Adult Social Care			
6.14 Number of delayed days, acute and non-acute for Kent **BCF**	2170 days	Not currently available	-	April 2014
6.15 Infection control rates	Work ongoing with NHS England to shape and define			
6.16 Percentage of people with short term intervention that had no further service	Under further development with Adult Social Care			
6.17 Admissions to permanent residential care for older people (number). **BCF**	100	not currently available	-	April 2014

Exception items:

- There was a reduction in the number of admissions to permanent residential care for older people in April 2014 of 100 people from 127 people in March and is now below the 130 target (maximum number). This metric will be presented at local health and wellbeing board level in the next report following work by Adult Social Care.

Appendix A: Local area indicators

Outcome 1: Every child has the best start in life									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
1.4 Reduction in the number of pregnant women with a smoking status at the time of delivery	2013/14	13.1%	10.9%	12.8%	12.9%	16.5%	20.6%	17.0%	9.4%
1.5 Unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	14.6	16.6	11.5	16.5	18.0	16.3	14.8	12.3
1.6 Unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	7.3	4.7	7.9	6.2	9.6	10.2	11.9	5.5
1.7 Unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 10,000)	2013/14	8.8	8.1	8.2	9.9	6.4	13.6	15.7	6.5

Outcome 2: Effective prevention of ill health by people taking greater responsibility for their health and wellbeing									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
2.1 Reduction in the under 75 mortality rate from cancer (rate per 100,000)	2012	135.5	111.4	121.0	128.5	147.9	133.8	140.0	145.2
2.2 Reduction in the under 75 mortality rate from respiratory disease (rate per 100,000)	2012	30.7	28.1	26.8	30.1	34.8	23.6	40.2	30.0
2.3 Increase in the proportion of people receiving NHS Health Checks of the target number to be invited	2013/14	36.1%	38.7%	40.1%	15.9%	33.6%	28.3%	29.2%	27.8%
2.4 Increase in the number of people quitting smoking via smoking cessation services	2013/14	5254	420	630	834	957	518	930	965
2.5 Reduction in the number of hip fractures for people aged 65 and over (rate per 10,000)	2013/14	480.5	459.7	562.5	554.9	431.5	559.6	540.9	397.7
2.6 Reduction in the rates of the deaths attributable to smoking persons aged 35+ (rate per 100,000)	2010-12	295.5	245.3	270.4	287.7	301.7	334.8	333.9	299.2

Outcome 4: People with mental health issues are supported to 'live well'									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
4.3 Increased crisis response of A&E liaison within 2 hours – Urgent	Q3 2013/14	73.5%	**65.4%**	**67.6%**	**90.8%**	**57.5%**	**86.0%**	**80.9%**	**81.0%**
4.4 Increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours	Q3 2013/14	100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Outcome 5: People with dementia are assessed and treated earlier									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**West Kent**
5.1 Increase in the reported number of dementia patients on GP registers as a percentage of estimated prevalence	2012/13	**41.5**	**43.0**	**43.2**	**44.2**	**38.7**	**44.8**	**34.6**	**42.6**
5.2 Rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**25.1**	**20.5**	**28.8**	**27.0**	**25.1**	**21.3**	**26.1**	**24.1**
5.3 Rate of admissions to hospital for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**50.5**	**43.3**	**56.6**	**53.3**	**50.3**	**48.7**	**50.2**	**48.5**
5.4 Total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia (rate per 1000)	2013/14	**225.7**	**187.6**	**168.1**	**342.8**	**183.0**	**257.4**	**193.0**	**231.4**
5.5 Total bed-days in hospital per population for patients older than 74 years with a secondary diagnosis of dementia (rate per 1000)	2013/14	**452.5**	**382.4**	**327.1**	**673.0**	**363.9**	**573.1**	**383.1**	**467.7**
Trust Level Data									
	Time Period	**D&G NHS Trust**		**EKHUFT**		**MTW**		**Medway**	
5.6 The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have been:									
(a) identified as potentially having dementia	Q4 2013/14	**92%**		**100%**		**99%**		**78%**	
(b) who are appropriately assessed		**100%**		**94%**		**99%**		**88%**	
(c) and, where appropriate, referred on to specialist services in England		**100%**		**100%**		**100%**		**91%**	

Stress Indicators									
Indicator	**Time Period**	**Kent**	**Ashford**	**Canterbury**	**DGS**	**SKC**	**Swale**	**Thanet**	**WK**
Children's Services									
Decrease the number waiting for routine treatment after assessment – CAMHS	April 2014	**565**	**16**	**0**	**216**	**120**	**69**	**49**	**95**
CAMHS Caseload, for patients open at any point during the month (excluding Medway and Out of Area)	April 2014	**8523**	**724**	**1206**	**1432**	**1347**	**531**	**1250**	**2033**

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September 2014

The way ahead

Kent's Emotional Wellbeing Strategy

for children, young people and young adults

DRAFT

Part one: Strategic Framework

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

Kent County Council kent.gov.uk

Part one: Strategic Framework

The way ahead

Kent's Emotional Wellbeing Strategy

for children, young people and young adults

This publication is available in other formats and can be explained in a range of languages.
Please email: fsccommissioningadmin@kent.gov.uk

Contents

Foreword

Emotional wellbeing is a vital factor in each of our lives, shaping the way in which we understand ourselves and one another, and influencing a range of long-term outcomes.

In the journey from childhood to adolescence and early adulthood, it becomes even more vital. Enjoying positive ***emotional wellbeing*** (which includes mental health) opens the door to improved physical and cognitive development, better relationships with family members and peers, and a smoother transition to independence.

As partners in Kent, we want to support children, young people, young adults and their families as they make this journey, and work together in helping them respond to and overcome specific challenges that they may face.

This first part of our strategy describes the ***principles*** we will follow to do this, and lays the foundation for part two: a multi-agency delivery plan (expected in January 2015).

Why now?

Emotional wellbeing is an area of both national and local concern, with studies suggesting a marked decline in children and young people's satisfaction with their lives within the last five years[1]. The Good Childhood Report (2013) found that around 20% of children now experience below average levels of wellbeing, and 10% will have a diagnosable mental health condition: that translates to around three children in every class.

The case for change is both moral, and economic.
We know that the long-term consequences of inadequate support for children and young people with emotional difficulties can be enormous: one study suggests that half of all adults with mental health problems were diagnosed in childhood – but less than half were treated appropriately at the time[2], leaving them at an increased risk of disengagement from school, poor employment prospects and reduced physical health[3]. Until we have effective support embedded at an early stage, we will continue to see specialist mental health services across the country overwhelmed by demand, and children exposed to these poor outcomes.

In Kent, we are also responding to a real ***call to action*** at this time from children, young people, families, professionals and politicians to focus our attention on securing ***a comprehensive Emotional Wellbeing offer*** for children, young people (up to 25) and their families. We have made significant progress in recent years, but we know that more is needed if we are to fully respond to the needs of our families in Kent: and the solution is far bigger than any individual organisation.

1 Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A. and Main, G. (2013) *The Good Childhood Report 2013*, The Children's Society, London.

2 Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder. Archives of general psychiatry*, Vol 60, pp.709-717.

3 Richards (2009): Sainsbury Centre for Mental Health: *Childhood Mental Health and Life Chances in post-war Britain*.

What is our vision for Emotional Wellbeing in Kent?

This strategy focuses on the groundwork needed to envision and establish a '***whole-system***' of support for children, young people and young adults experiencing emotional and mental health difficulties - because we simply can't meet all of the needs from individual commissioned services.

In the first instance we depend hugely upon ***skilled and supportive professionals*** working with children, young people/ adults and families in schools, community groups, health settings and beyond. However, these people also have a wider day-job to perform, and there is a need to build capacity, knowledge and confidence among those who work with children and young people every day, ***promoting and protecting emotional wellbeing.***

Confidence, in particular, will also rest upon knowing that there are ***effective services*** available to offer extra support to those children and young people who have a higher level of need. We need much greater collaboration in designing and resourcing Emotional Wellbeing services to ensure that what we put in place meets need ***swiftly, flexibly and effectively*** – and that it will be understood and valued by those professionals referring to it.

In partnership with children, young people, young adults and families, we need to define what a 'good' system of Emotional Wellbeing support would look like – and this strategy is the first step.

We've been listening to children, young people and families over the last few months and they have given us some clear messages about the way that they want to see – and experience – support being delivered. They aren't necessarily surprising, but we underestimate their importance at our peril.

This strategy is therefore:

*i. **Purposefully focussed*** on the messages we have been given by members of the public and professionals, responding to the issues raised and improving the overall experience for children, young people and families who are seeking support;

*ii. **Mindful*** of the journey that we have been on in recent years as professionals aiming to improve our local offer: the progress we have made, the areas where improvement is still needed, and the learning we have gained about the best ways to target our efforts;

iii. Committed to a partnership-approach: overcoming organisational boundaries and individual agendas to articulate and bring to life our vision of a 'good' system of emotional wellbeing support for 0 – 25 year olds in Kent.

As partners on the Children's Health and Wellbeing Board, we will work together in implementing this strategy, and the four key principles which follow, through service re-design and commissioning to take place from 2014/15 onwards. Success will depend upon leadership and commitment from a wide range of agencies, and on our continuing dialogue with the children, young people, young adults and families that we seek to support.

Andrew Ireland,
Corporate Director, Health and Social Care
Chair of Kent Children's Health and Wellbeing Board

September 2014

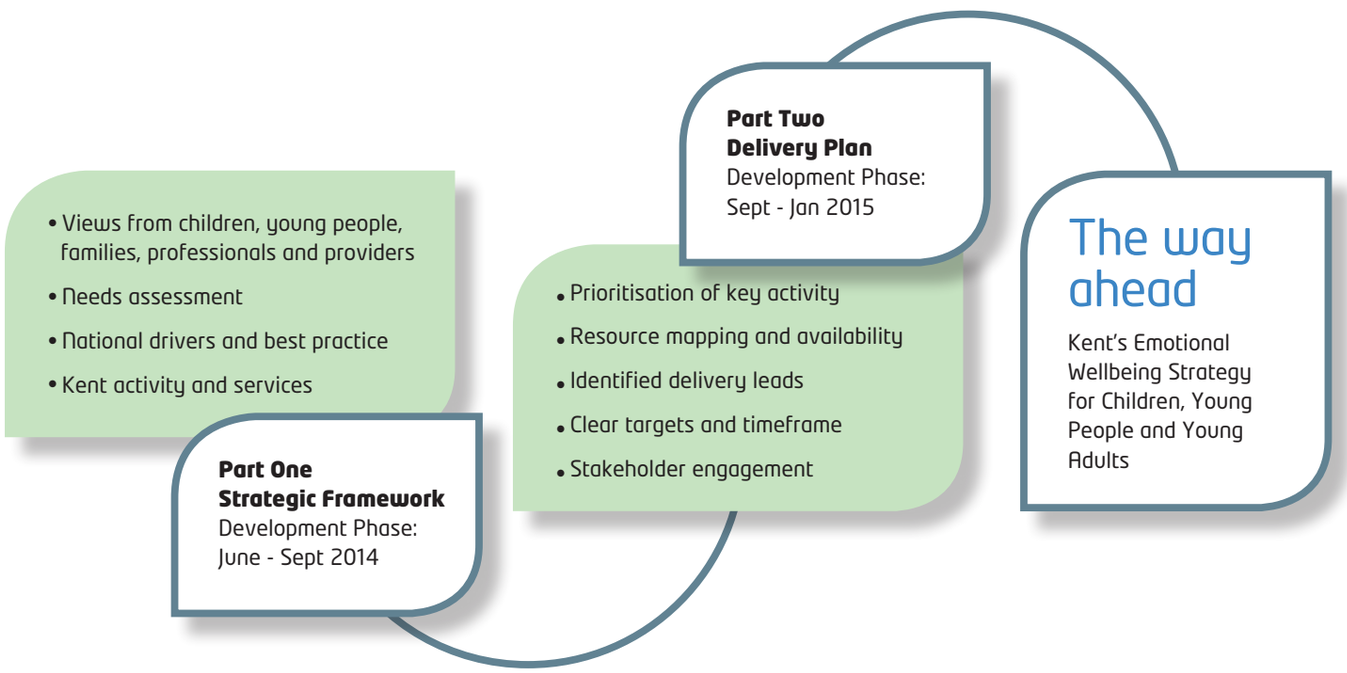
What is 'The way ahead'?

This is the first of two documents which together will form our vision as Kent partners for improving the emotional wellbeing of our children and young people.

Part One, outlined in this document, articulates the ***outcomes that we are seeking and the principles we will follow*** to achieve them. These outcomes respond directly to views expressed by children, young people, families, professionals, and providers, as well as the findings of local and national data and best practice.

Part Two will translate these outcomes and principles into ***a practical, multi-agency delivery plan***. This will identify key performance measures, delivery leads, resources and timeframes within which actions will be implemented.

The complete Strategy, comprising both elements, is expected to be presented to the Children's Health and Wellbeing Board in February 2015.



Where have we come from?

Although there is still work to do, we've made significant progress in the last few years.

Since the Child & Adolescent Mental Health Services (CAMHS) National Support Team visited Kent in 2010, we've put in place a number of key recommendations which have led to:

- The introduction of a county-wide Emotional Wellbeing Service for children and young people aged 4-18. This has enabled us to respond earlier to emerging emotional health needs and deliver complementary support to families and frontline professionals.
- The development of a broader, countywide Early Help offer to support children, young people and families who are at risk of experiencing poor outcomes;
- A single service and service provider in place to deliver Tier 2 and 3 mental health services, offering more unified and consistent approach across the county.
- A reduction in waiting times for assessment and treatment from mental health services – but we know there is still more to do.
- An improved partnership between Health and Kent County Council around emotional wellbeing, which has enabled greater sharing of skills and knowledge: to the extent that we are now ready to plan and commission the next generation of these services from a shared viewpoint, together with our wider partners.

We know there is still improvement needed to achieve the ambitions we set ourselves in 2010, and our strengthened partnership now puts us in the right place to do this. This strategy will identify some of the key priorities that we will address together over the coming years.

What do we know?

The following summary is based upon emerging priorities from the Joint Strategic Needs Assessment in Kent, led by KCC's Public Health Department. The full needs assessment will be available from November 2014.

> "Emotional wellbeing is defined as a positive state of mind and body: feeling safe and able to cope, with a sense of connection with people, communities and the wider environment."
>
> ***World Health Organisation, 2004***

Emotional wellbeing fluctuates, often rapidly for children and young people, in response to life events – and their ability to overcome these challenges without long-term harm is determined by the interplay of ***risk and protective factors*** available to them. As professionals working in children's services, we have a unique opportunity to influence this balance.

- ***Universal settings, particularly schools, play a crucial role*** in supporting children and young people to be resilient and emotionally healthy, identifying children or young people who show early signs of difficulty, and knowing when and how to request additional support - as recognised in the recent 'Mental Health and Behaviour in Schools' guidance (DfE, 2014). Many schools in Kent place real emphasis on whole-school approaches to emotional wellbeing, and offer additional pastoral support, counselling, or therapeutic services. ***We need to support these efforts and continue building capacity and skill, as well as knowledge of what is available locally and how to access it, among the children's workforce.***
- ***The vast majority of children, young people and young adults will not need any additional support*** beyond the reach of universal services – however, it is estimated that approximately 15% (approximately

34,000) in Kent will display a higher level of need. Many of these can be supported with some additional '***early help***': an evidence-based approach[4] which seeks to minimise the risks of problems occurring (particularly among at-risk groups) and to act quickly to improve outcomes where there are signs of difficulty. The success of these approaches, particularly around emotional well-being, often depends upon ***working in partnership with families*** –recognised in KCC's recent Early Help Prospectus (2014).

- However, some young people will remain at particularly ***high risk of emotional ill-health due to on-going circumstances*** in their lives, including children in care, those with learning difficulties or disabilities, children of parents with mental health or substance misuse problems, and young carers. Of these groups, statistics indicate that in Kent, we particularly need ***to secure more support for children in care/care leavers and young offenders.***

- ***Specialist services*** exist to meet the needs of children, young people and young adults experiencing acute or prolonged periods of complex emotional, behavioural or relationship difficulties. ***Our local needs assessment in Kent suggests that we particularly need to place more focus on the following groups:***

  - Presentation of self-harm at A&E among the 16-24 year old group
  - The high predicted number of children with Autistic Spectrum Disorder (ASD).
  - Children of parents, particularly mothers, who have mental health problems (among whom there is a 37% higher incidence of developing problems themselves)
  - Young people and young adults who have a 'dual diagnosis' and need support with substance misuse and emotional wellbeing difficulties.

We also know that emotional wellbeing difficulties present as the most common health issue among young people from 16 to 25 – but traditionally services have been divided into a 'child' and 'adult' offer at age 18, with differing resources available. This can cause real difficulty and distress for young people and their families who need consistency at a key point of transition. Research suggests that we need instead ***an integrated offer and pathway that extends from birth to age 25*** [5].

Levels of need [6]

1% Severe – of children and young people will experience episodes of being seriously mentally ill requiring intensive support from specialist services and potentially inpatient care.

9% Complex – of children and young people will experience significant emotional and behavioural difficulties which are complex and / or enduring, and will require support from specialist services. Signs may include anxiety, conduct or behavioural problems, attachment issues and eating disorders.

15% Early Help – of children, young people and young adults may need some additional help from services. Indicators may include responses to bullying, low mood, behavioural problems, relationship difficulties and school non-attendance.

75% Prevention – of children, young people and young adults will not need any additional support from emotional wellbeing services. This doesn't mean that they won't experience periods of emotional instability - but that they will receive sufficient support from their families, peers, schools, and the wider children's workforce to overcome challenges that they face.

4 See *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer* 2012.

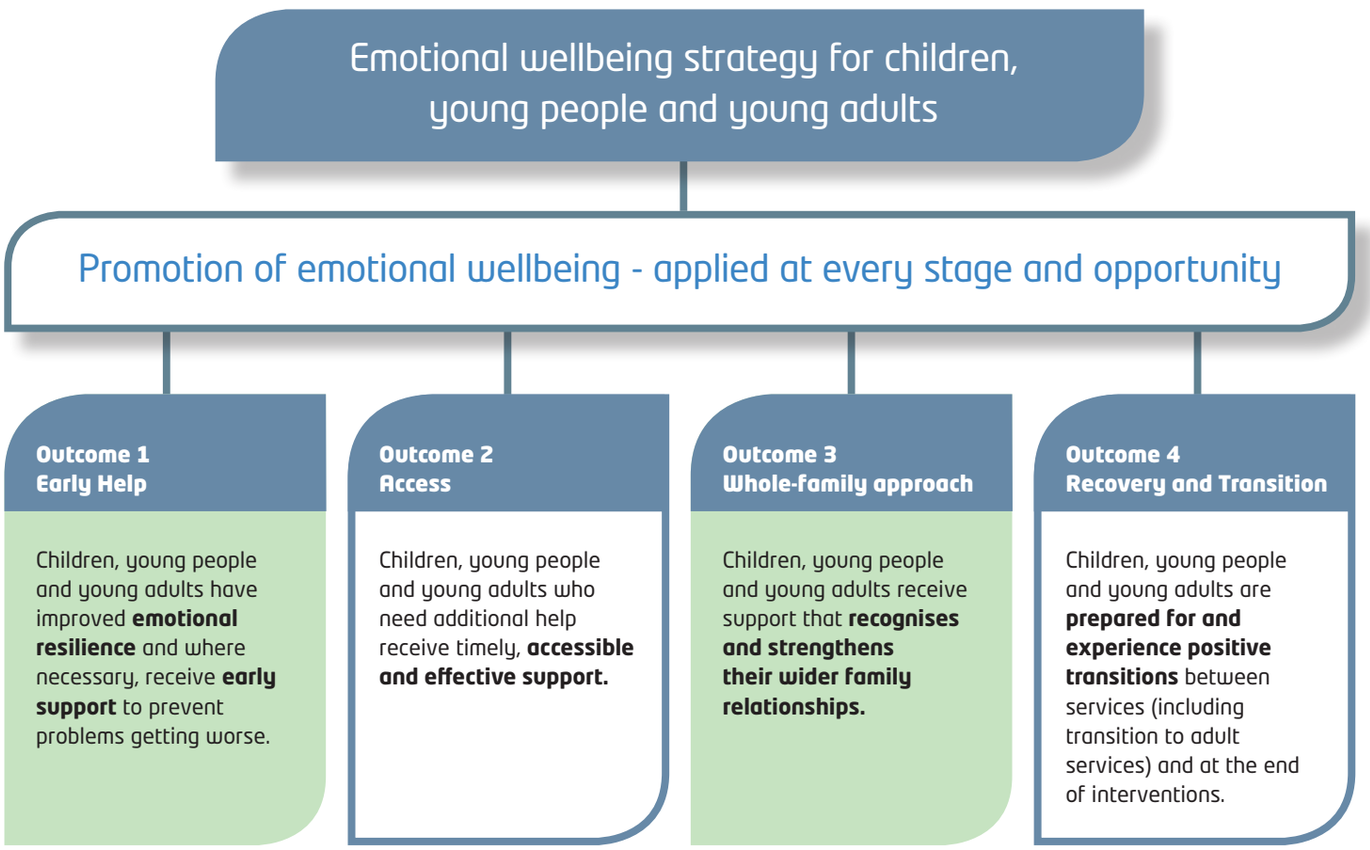
5 Supporting Young People's Mental Health: *Eight Points for Action: A Policy Briefing from the Mental Health Foundation* (2007) and International Association for Youth Mental Health: *International Declaration on Youth Mental Health* (2013)

6 Diagram based on Health & Social Care Advisory Service (HASCAS) model; all percentages approximate.

What do children, young people and families think a 'good' system would look like?

This strategy has been designed in response to the messages we have heard from children, young people, young adults and their families about the principles that matter most to them about the ways in which they are supported, whether in universal settings or from targeted and specialist services.

Over 200 responses have been gathered between May – July 2014 through surveys, focus groups and interviews, with a further 50 frontline professionals offering the benefit of their experience. The feedback has been analysed and grouped into priorities that fall within ***four overarching outcomes,*** which will form the basis of our strategy and the guiding principles for future service design. These outcomes are shown in the following diagram and discussed in more detail over the next few pages.



Outcome 1: Early help

*Children, young people and young adults have improved **emotional resilience** and where necessary receive **early support** to prevent problems getting worse.*

Early Help means doing all we can to prevent or minimise the risk of problems arising, and responding early if difficulties do emerge.

This is the definition at the heart of KCC's recent Early Help and Preventative Services Prospectus: a document which sets out the broader offer of preventative support available to children, young people and families where there are risks of poor outcomes.

Efforts to improve emotional wellbeing are a vital part of this offer, and so the two strategies are intrinsically linked, and we will specifically share the following aims:

- To ***develop self-esteem and resilience among children and young people***, particularly those who are most at risk of poor outcomes due to circumstances in their lives.
- To ***support schools and early years settings*** in improving the emotional resilience of children and young people.
- To ***support parents who are experiencing mental health issues.***

In addition, we want to respond to the following priorities identified by children, young people, young adults and families:

1 To support children, young people, young adults and families in ***developing and securing their own emotional wellbeing,*** and where necessary, in navigating and negotiating access to support that meets their needs.

2 To ***improve skills and confidence among staff in the children's workforce at all levels,*** through training in identifying and responding to the needs of children and young people who have emotional wellbeing difficulties.

3 To build upon our work to date in ***developing a high-quality, flexible and visible Emotional Wellbeing offer*** within schools and community settings, linked to the broader suite of Early Help support.

"We need more 'drop-in' provision available locally, where we can access help quickly, preferably without an appointment."

"Parents/carers, teachers, and other front-line professionals need more support to identify and work with children and young people who have emotional wellbeing difficulties."

Outcome 2: Access

Children, young people and young adults who need additional help receive ***timely, accessible and effective support.***

Effective support for emotional wellbeing isn't just about the quality of the service offered.

It is about how easy it is to ask for help; how it feels to have your needs assessed; and (where necessary) how simple and responsive the pathway to getting the right kind of treatment in place. These experiential factors play a determining role in how successful the eventual intervention can actually be - and so they are a priority for us as we think about designing a 'whole system' approach.

In aiming to improve this overall experience, there are a number of priorities which we will need to address and which have been highlighted by children, young people, young adults and their families:

1. A range of options about the ways in which support can be delivered, whether face-to-face, over the phone or virtually.

2. A more flexible approach to service delivery, with more visible local facilities and (where appropriate) the potential for a 'drop in' offer available within the community.

3. Better understanding by professionals (including teachers and GPs) of the kind of support available locally – and a simpler process to access it.

In addition, our needs assessment and feedback underlines the need to:

4. Improve our specialist pathways, particularly for children and young people with Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum Conditions (ASC0) and families.

5. Improve our targeted outreach to the most vulnerable groups, particularly young offenders, children in care, and care leavers.

"The adults working with us (teachers, GPs etc) need to understand the total offer of support available to meet our needs locally - and we need a simple process to access it."

"We need a range of different ways to access support: in person, peer-to-peer, in safe online spaces (including social media) and via text or telephone."

Outcome 3: Whole family approaches

There is a broad consensus of evidence to suggest that professionals and services make most impact on the lives of children, young people and young adults when they work in partnership with the wider family [7].

Parents/carers have a unique and critical opportunity to influence the emotional wellbeing of their children, and often understand their needs best. With this in mind, our priorities will be to:

1. Improve the ways in which services ***work alongside and in partnership with parents/carers*** and the wider family to manage their own risk and resilience (as far as this is safe to do and, particularly where young adults are involved, consent is given).

2. ***Promote the importance of maintaining positive family relationships***, where this is appropriate, and encourage good communication within families.

3. Ensure that where interventions are offered to a child or young person, their parents and carers are engaged as much as possible in ***understanding the work being done and what they can do to support it***. Within this, we will link to local parenting support opportunities where appropriate.

4. Finally, to pay particular attention to whether there are on-going support needs among families at the point at which services begin to ***step back*** – recognising that this can be a time of real pressure.

"Our wider families need support too: to understand what is happening to us, what work is being done, and how they can best help."

"Stick with our families after the point of 'stepping down' – this is often when we (and they) need most help."

7 See *Think Family Toolkit: Improving Support for Families at Risk – strategic overview*. Department for Children, Schools and Families (2009).

Outcome 4: Recovery and transition

*Children, young people and young adults are **prepared for and experience positive transitions** between services (including transition to adult services) and at the end of interventions.*

The process of ending support from a service, whether goals have been achieved or needs have changed, is every bit as important as the beginning.

If successful progress is to be sustained, then the partnership with children, young people, parents/carers, families, and schools is vital – and these key 'partners' need to be supported too, and prepared for the next step. In some cases, this may mean a more gradual 'stepping down' process – and a clear plan needs to be agreed, with routes 'back in' if concerns re-emerge.

When it becomes necessary to change the kind of support that is offered, then this too needs to be a carefully managed process, with children, young people and young adults involved wherever possible in decisions about how best their needs can be met: an overwhelming call from the young correspondents to our surveys [8].

Through designing a 'whole system' offer that meets needs across a continuum from birth to 25, we will aim to ensure that support is no longer shaped by a watershed at age 18, but that it responds instead to the individual needs of a young person as they follow their own unique path into adulthood [9].

Our priorities are therefore:

1. To work *in close partnership with children, young people, parents/carers and families, as far as possible, in preparing for and implementing transitions* whether at the end of an intervention or when another service becomes involved.

2. To set out *clear lines of communication and 'routes back'* if concerns re-emerge.

3. To design an extended offer that is led by the needs of young people as they approach and enter adulthood, with *consistency and continuity of support available post-18.*

"Make sure that there is a clear plan and clear communication between the different people working with us, especially when we need to move between services."

"Young people who are approaching 18 must be able to access the same level of support from adult services if they need it, and experience a smoother transition."

[8] See also *Report of the Children and Young People's Health Outcomes Forum 2013/14*

[9] A priority within: *Closing the gap: priorities for essential change in mental health* (Department of Health, 2014).

Where next?

This document sets out a framework of four key outcomes which will form the cornerstones of our vision to improve emotional wellbeing for all children, young people and young adults in Kent.

The next stage of activity, to take place from September 2014 – January 2015, will involve wider engagement with the public, partners and professionals around the design of Part 2 – The Delivery Plan. This process will define the key actions needed to achieve our four outcomes, including service design, commissioning intentions, performance measures and resources.

The Children's Health and Wellbeing Board will continue to oversee this work and hold responsibility for ensuring that both elements of this strategy are widely understood and committed to by partners.

For further information and updates on this work, please visit xxxxxxxxx (TBC).

Strategic links:

The Way Ahead: Kent's Emotional Wellbeing Strategy for Children, Young People and Young Adults has been written in reference to the following key local strategies:

Kent Joint Health and Wellbeing Strategy (Kent Health and Wellbeing Board, 2014).

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

Social Care, Health and Wellbeing Directorate: 2014/2015 Strategic Priorities Statement (see p.23). Kent County Council (2014).

Education and Young People's Services Directorate: 2014/2015 Strategic Priorities Statement (p.14-16) (Kent County Council, 2014).

Early Help and Preventative Services Prospectus (Kent County Council, 2014)

Joint Strategic Needs Assessment for Children in Kent 2011 (Kent Public Health, 2011)

References:

Rees, G., Goswami, H., Pople, L., Bradshaw, J., Keung, A. and Main, G. (2013): *The Good Childhood Report 2013.*

Kim-Cohen, J., Caspi, A., Moffitt, TE., et al (2003): *Prior juvenile diagnoses in adults with mental disorder.*

Richards (2009): *Sainsbury Centre for Mental Health Childhood Mental Health and Life Chances in post-war Britain.*

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

Fraser, M., Blishen, S. (2007): *Supporting Young People's Mental Health: Eight Points for Action: A Policy Briefing from the Mental Health Foundation.*

International Association for Youth Mental Health (2013): *International Declaration on Youth Mental Health*

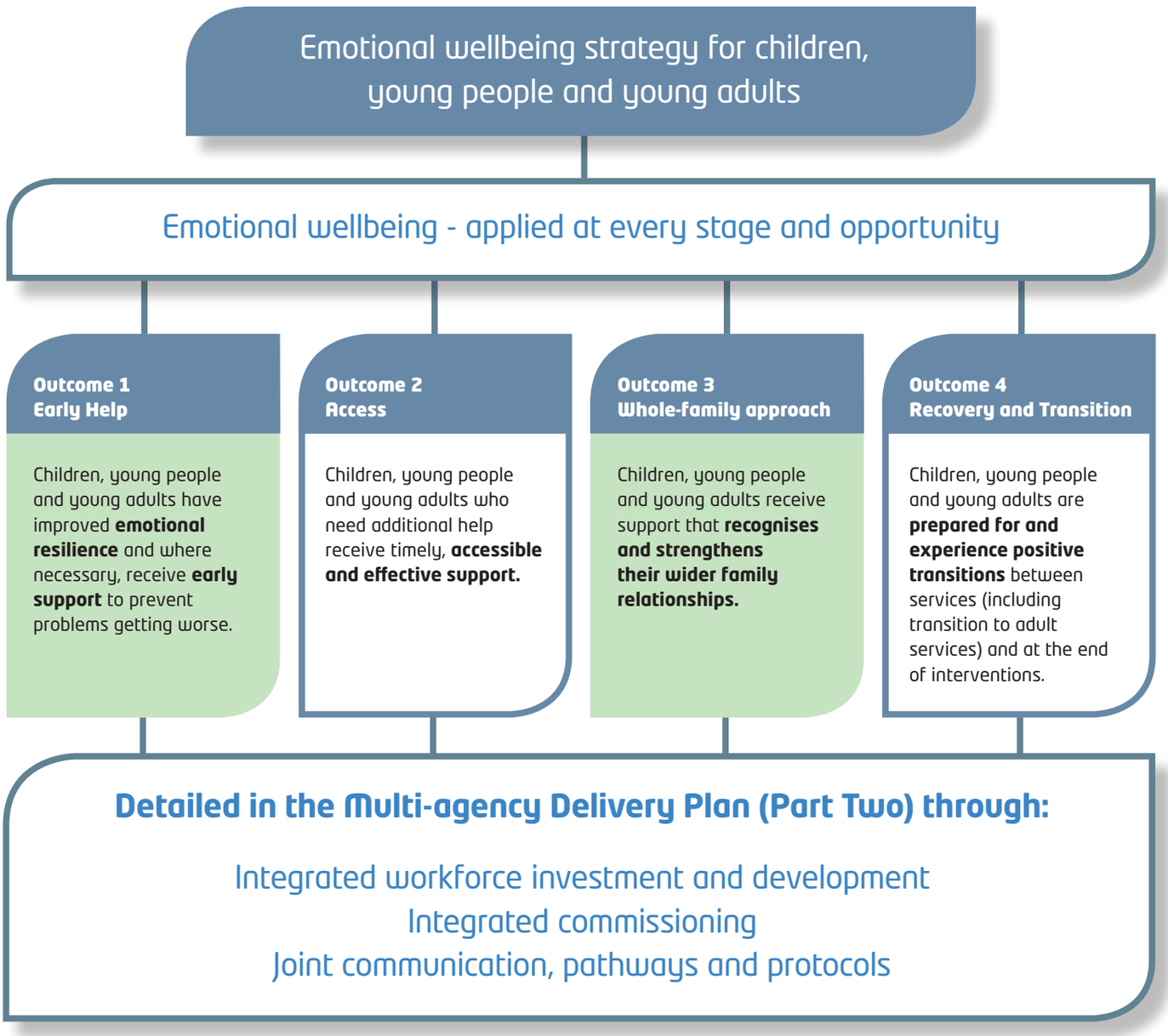
Department for Children, Schools and Families (2009): *Think Family Toolkit: Improving Support for Families at Risk – strategic overview.*

Department of Health (2013): *Report of the Children and Young People's Health Outcomes Forum 2013/14*

Department of Health (2014): *Closing the gap: priorities for essential change in mental health.*

Department for Education (2014): *Mental Health and behaviour in schools: Departmental Advice for School Staff.*

Quick reference: Outcomes Framework



Notes

Part one: Strategic Framework

The way ahead

Kent's Emotional Wellbeing Strategy

for children, young people and young adults

This publication is available in other formats and can be explained in a range of languages.
Please email: fsccommissioningadmin@kent.gov.uk

From: Jo Purvis, Strategic Housing and Health Manager, Swale Borough Council

To: Swale Health and Wellbeing Board – 19th November 2014

Subject: **Swale Health and Wellbeing Board Priorities**

Classification: Unrestricted

Summary:

This report sets out suggested local health and wellbeing priorities for the Swale Health and Wellbeing Board for 2015.

Recommendations:

The Health and Wellbeing Board is asked to:

1) Agree to the priorities outlined in this report; and

2) Agree to the Health Improvement Partnership developing an action plan to deliver these

1. Introduction

1.1. In July 2014, the Kent Health and Wellbeing Board tasked local Health and Wellbeing Boards with developing local action plans to implement the Joint Health and Wellbeing Strategy.

1.2. Representatives from Swale Borough Council, Swale CCG and Kent Public Health met in October to discuss potential health and wellbeing priorities for the Board to focus on and drive delivery towards.

2. Background

2.1. The suggested health and wellbeing priorities are based on the outcomes set out in the Joint Health and Wellbeing Strategy. However, it has a wider remit and also considers the priorities and outcomes of other key strategic health documents including CCG commissioning plans, Mind the Gap the Kent Health Inequalities Action Plan and Think Housing First, the Kent Housing and Health Inequalities Plan.

2.3. Data provided by the Joint Strategic Needs Assessment local assurance framework for Swale was used to identify areas where Swale is under-performing compared to Kent and/or national averages. Relevant indicators will be taken from this and other existing performance monitoring data i.e. housing falls prevention data, to monitor progress against the priorities. Where indicators do not currently exist, these will be developed by the Health Improvement Partnership in consultation with relevant partners.

3. Priorities

3.1. Suggested priorities have been developed based around the themes of the Joint Health and Wellbeing Strategy, but also include the key cross-cutting issue of housing. Priorities will be reviewed at the end of the year and may be revised depending on the progress made.

3.2. The suggested priorities for the Board for 2015 are:

1) Improve child and maternal health
- Reduce the number of pregnant women with a smoking status at the time of delivery
- Increase breastfeeding initiation rates and continuation at 6-8 weeks
- Decrease levels of childhood obesity
- Reduce under-18 conception rates

2) Reduce health inequalities
- Reduce rates of premature mortality
- Increase the level of NHS Health Check take-up
- Decrease the proportion of adults with excess weight
- Increase the proportion of physically active adults

3) Support people with mental health issues, including dementia, to "live well"
- Reduce stigma surrounding mental health issues, including dementia, amongst local businesses and communities
- Improve emotional resilience and wellbeing amongst children and young people
- Reduce the numbers of people attending A&E for mental health crisis support
- Reduce the time spent in hospital for patients with a diagnosis of dementia

4) Reduce the impact of housing on health
- Improve access to GP services for homeless households in temporary accommodation
- Improve identification of people in housing need who have mental health issues
- Reduce the number of falls within the home amongst people over-65
- Reduce the number of excess winter deaths

4. Next steps

4.1. The first meeting of the Health Improvement Partnership (HIP) is due to take place in December. Subject to the Board's agreement, the HIP will develop an action plan to deliver the agreed priorities and set baselines for indicators as necessary. This will be brought back to the Board in January.

4.2. Following agreement to the action plan, progress against the actions and the agreed indicators will be monitored by the Board on a quarterly basis. Priorities will be reviewed at the end of the year and revised as necessary.