OUTLINE

SERVICE SPECIFICATION

FOR THE PURCHASE OF

Community Mental Health and Wellbeing Service

This document defines the Community Mental Health and Wellbeing Service
To commence on 1st April 2016

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### 1.0 Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Table of contents</td>
<td>2</td>
</tr>
<tr>
<td>2.0 Introduction</td>
<td>3</td>
</tr>
<tr>
<td>3.0 The Vision for the Service</td>
<td>4</td>
</tr>
<tr>
<td>4.0 Alignment to Strategic Priorities</td>
<td>5</td>
</tr>
<tr>
<td>5.0 The Approach of the Service</td>
<td>5</td>
</tr>
<tr>
<td>6.0 The Model</td>
<td>7</td>
</tr>
<tr>
<td>7.0 Support Principles</td>
<td>9</td>
</tr>
<tr>
<td>8.0 Service Expectations</td>
<td>10</td>
</tr>
<tr>
<td>9.0 Outcomes</td>
<td>11</td>
</tr>
<tr>
<td>10. Service Specific Models</td>
<td>12</td>
</tr>
<tr>
<td>11. Service Outcome Performance Indicators</td>
<td>13</td>
</tr>
<tr>
<td>12. Useful Documents</td>
<td>18</td>
</tr>
<tr>
<td>13. References</td>
<td>20</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>21</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>22</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>24</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>25</td>
</tr>
<tr>
<td>Appendix 5</td>
<td>27</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>28</td>
</tr>
</tbody>
</table>
2.0 Introduction

Kent County Council (KCC) in conjunction with the Clinical Commissioning Groups (CCG’s) are responsible for providing prevention, early intervention and recovery services. The Community Mental Health and Wellbeing Service will help prevent entry into formal social care and health systems, reduce suicide and prevent negative health outcomes associated with poor mental health. The service will be based on recovery and social inclusion principles and designed to be accessible to anyone needing mental health and wellbeing support in Primary Care, including those people who fall through the gaps between services.

There are an estimated 205,000 people living with common and severe mental illness in Kent. There are two groups of beneficiaries of this service, the first are approximately 5,000 to 7,000 adults in Kent with stable serious mental health problems and they need a clearly defined care programme of support to avoid relapse and promote recovery. The second group with common mental health problems will need variable, lower intensity support to stop them reaching a crisis point and unnecessarily entering into health and social care systems.

The new Community Mental Health and Wellbeing Service will support recovery and provide a consistent offer of person centred support through services which champion mental wellbeing within communities. It will form a key part of an integrated pathway across the voluntary sector, primary care mental health and social care and include public health initiatives to ensure there is appropriate, equitable, timely and cost effective interventions for vulnerable people in the community.

This service will support:

- Delivery of the Better Care Fund
- NHS Five Year Forward View
- No Health Without Mental Health – a cross Government mental health outcomes strategy for people of all ages
- Parity of Esteem

What is Mental Health?

- **Mental health** is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO 2003)\(^1\)

There are Two Main Categories of Mental illness:
Delivery Network Specification

- **Common mental illness.** It is estimated that 1 in 4 people will experience ‘common mental illness’ (depression or anxiety) at some point in their life. (National Adult Psychiatric Morbidity Survey, Meltzer 2001).
- **Severe mental illness.** It is estimated that three people in every 1000 will experience ‘severe and enduring mental illness’ (schizophrenia, psychosis and bi-polar disorder) (Oxford Textbook of Psychiatry).

Mental health and wellbeing is experienced by each of us as individuals and located within a web of interactions and relationships with others. These experiential processes are central to individual and community resilience. We need to maintain and grow the gifts and strengths or assets of individuals and communities to support those interactions which help us adapt and self-manage in the face of social, physical and emotional challenges.

This specification is for the provision of a service for people with mental health needs in Kent to enable people to stay well and recover. The ways in which people are supported can be flexible, person centred and can help people to make the best use of their community. Organisations who provide services should note that they should help connect and empower communities as there is extensive evidence that connected communities are healthier communities.

2

### 3.0 The Vision for the Service

The vision for the new service is to provide a holistic offer of support for individuals living with mental health and wellbeing needs in Kent and to deliver support in line with national and local guidance and protocols.

**People said during the public consultation:**

“At the moment, the help available is disjointed and I think people could benefit from a better integrated service.”

“There is a need for services to be better aligned and centrally coordinated.”

“More joined up and consistent approach to services regardless of where you live in Kent”

“If it means a more co-ordinated use of resources and the avoidance of overlapping then it would be good thing.”

“I would hope that a more joined up process which has clear outcomes and measures will be more effective in meeting people’s needs, reduce bureaucracy and red tape and make best use of available money.”
4.0 Alignment to Strategic Priorities

The specification will provide a platform for KCC to meet a number of its supporting outcomes set out in the KCC’s Strategic Statement and Outcomes Framework.

- People with mental health issues are assessed and treated earlier and are supported to live well
- Kent residents enjoy a good quality of life, and more people benefit from greater social, cultural and sporting opportunities

The service will contribute to achievement of Public Health outcomes set out in the Public Health England’s (PHE) vision - to improve and protect the nation’s health and wellbeing, tackle stigma and improve the health of the poorest, fastest through the following two key outcomes:

PHE Outcome 1: Increased healthy life expectancy - taking account of the health quality as well as the length of life

PHE Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities through greater improvements in more disadvantaged communities

This specification will provide a platform for health and social care to meet a number of strategic outcomes:

- Kent communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life.
- Older and vulnerable residents are safe and supported with choices to live independently

5.0 The Approach of the Service

The service should be person centred, holistic and non-stigmatising to all users.

The approach will be underpinned by the philosophies of recovery and social inclusion with no wrong door. We want those with mental illness to be fully supported on their personalised recovery journey when supported in primary care. Everyone who experiences mental health needs has the right to individually tailored one-to-one support to engage in mainstream social, leisure, educational, and cultural activities, in ordinary settings, alongside other members of the community who are not using the service.
Community Focused

Each member of staff or volunteer in every organisation who provides services should understand the support available from their local community. People will be supported by the service to access the range of support on offer to help them stay well in terms of community activity and opportunities to connect with and contribute to their local community. This may require co-working and co-location with community based services. Staff and volunteers should also understand the support from secondary community mental health services by clear onward referral protocols between mental health & wellbeing providers.

Improving Wellbeing

The service will need to promote wellbeing as a unifying concept behind which individuals can stay well and recover well, supporting communities to align their assets and efforts, ensuring that local policies, programmes and interventions support wellbeing through tackling stigma, being inclusive throughout; underpinned by the Six Ways to Wellbeing and Think Local Act Personal (TLAP) “I” Statements.

Maximise Service Impact

The service should maximise the impact by working with range of other commissioned/community services and encourage activities that promote a healthy lifestyle. The Five Year Forward Plan (2014) outlines the importance of opportunistic prevention and making every contact count.

The Service will support the implementation of the NHS guidance on ‘Making Every Contact Count’. The service will ensure that contact and discussions with people who use the service includes contributory health behaviours (e.g. smoking, excess weight, physical inactivity and alcohol). The service will offer brief advice on contributory health behaviours to reduce the risk of exacerbating poor health outcomes and make referrals to relevant support services.

There may be free training available which the Delivery Network can access and/or it would be expected that the Strategic Partner source appropriate training to maximise impact and upskill the workforce. The Public Health commissioning lead will be able to signpost to relevant training opportunities.

Prevention

In line with the ‘Five Year Forward View’ and the ‘Care Act’ the service should put an emphasis on prevention and aim to intervene early to stop escalation of need.

Targeted and Focused on Health Inequalities

Health inequalities are avoidable variations in health status of groups and individuals and is a complex issue. One of the success factors for improving
the public's health for Local Authorities and Clinical Commissioning Groups will be assessed on how well they are reducing health inequalities in their area. This service should aim to contribute towards the reduction of health inequalities and take a targeted approach to work with vulnerable and at risk groups. An annual EqIA will be undertaken by the Strategic Partner.

**Evidence Based**

The service should deliver interventions that are built on a strong evidence base approaches and examples of good practice, including National Institute of Clinical Excellence (NICE) guidance/Public Health England. This should not stop innovation and creativity to meet the specified outcomes.

**Maximise social value from the services we commission**

KCC services have a social purpose and therefore KCC will require that services become smarter at determining social value working within the commissioning process. This will be through improving the economic, social and environmental wellbeing of Kent.

**6.0 The Model**

Delivery of this service is through a Strategic Partner model with a network of providers (Delivery Network). The intention is to design a flexible contract which will allow for further investment over the life of the contract.

There will be four separate contracts covering the following areas:

- Dartford, Gravesham, Swanley and Swale Clinical Commissioning Groups Area
- West Kent Clinical Commissioning Group Area
- Ashford and Canterbury & Coastal Clinical Commissioning Groups Area
- South Kent Coast and Thanet Clinical Commissioning Groups Area

**The Strategic Partner**

The Strategic Partner will hold the contract with Kent County Council /Clinical Commissioning Groups and will be ultimately responsible for the delivery of the whole Community Mental Health and Wellbeing Service through the implementation and development of a sustainable Delivery Network. The Strategic Partner will be permitted to deliver some of the services but will need to demonstrate their commitment to building a Delivery Network though Delivery Partners as defined in the Delivery Partner role below.

The Strategic Partner will be responsible for the overall performance of the contract and any incentivisation targets. They will need to collate and analyse the performance information and will be required to monitor the delivery of all...
outcomes identified within the contract. They will also need to demonstrate their ability to manage the Network and ensure a proportionate approach to risk management and incentivisation payments.

KCC envisages that a sustainable relationship is fostered throughout the contract period, which meets the expectations of both the Strategic Partner and the Delivery Network, according to the position established at the inception of the contract. In entering into contractual agreements between the Strategic Partner and Delivery Partners, there should be an understanding of what is important and this should go onto form part of the contractual agreements. This will be reviewed throughout the contract term to ensure that the whole networks expectations are being met.

Key requirements of the Strategic Partner will include:

- Strategic Leadership
- Managing the Delivery Network
- Operational Management
- Communication
- Quality assurance and performance management
- Ensuring delivery of service outcomes and outputs
- Resource mapping, planning effectively for future need
- Market Stewardship
- Safeguarding
- Risk Management
- Grant Scheme

This role is specified in appendix 1

The Strategic Partner will ensure links are made with both Residential Care and Supported Accommodation provision within their CCG area (please refer to Appendix 6 for a list of mental health specific residential care and supported accommodation providers).

The Delivery Network

The network may change over time to meet the needs of the population, any changes to the network would need to be discussed and agreed with the commissioning leads before any changes are made. An agreed notice period will be given to those in the Delivery Network surrounding any changes, e.g. funding so they are not destabilised as an organisation. The Strategic Partner must ensure there is continuity in the delivery network at all times and reduce disruption for people who use the service through effective and timely communication.

A Partnering Agreement and contract should set out the principles, ethos and standards which both the Strategic Partner and Delivery Network must adhere to when working together. The Strategic Partner should work in a way that is sensitive to the different needs and requirements of providers in the Delivery
Network and must ensure their approach to contract management is proportionate.

The service will be focused on the delivery of outcomes and we are keen to see a diverse range of providers in the Delivery Network. This may include providers who have not traditionally delivered mental health and wellbeing services.

This is likely to include but not be limited to the following;

- Organisations who have experience of delivering employment outcomes
- Organisations who have experience of delivering time limited interventions including housing related support
- Organisations who have experience of supporting individuals to become more empowered and to live independently
- Organisations which link people into their communities
- Organisations offering art and cultural activities
- Sports and leisure organisations
- Organisations that use the natural environment to improve wellbeing e.g. greencare, nature projects, horticultural therapy, forestry etc.

7.0 Support Principles

We want Strategic Partners and the Delivery Networks to support people to be able to make a positive contribution to their communities and to increase their positive relationships and to become healthier both mentally and physically by ensuring the model of support provides:

- A ‘Circle of Support’ - no wrong door model
- Designed to promote independence, recovery and resilience
- Builds on principles of community development and community capacity - ensuring that community activities start where people are and engages people as equals.
- Tackling health inequalities
- Tackling gaps in provision and quality
- Growing the resilience of individuals and communities and especially of young people in transition and their families.
- Aiding community empowerment by supporting the development of locally responsive strategies to help individuals and communities not only to take control of local assets and also gain the knowledge, skills and influence to grow their impact
- Working alongside communities to grow resilience, in partnership with Local Authorities in Kent to improve mental wellbeing.
- Identifying winnable and specific targets or change that unify and build community strength. Outputs could include growing or creating assets.
in partnership with communities such as a Kent Time-Bank which will enable people across Kent to exchange skills, time and other assets to increase self-esteem, confidence and enable people to feel part of their community

• Activities to support wellbeing or encouraging engagement with environmental initiatives, this could include investing in creative art interventions or community exercise space and green spaces. The link below focuses on children but is relevant to all age groups. http://www.artswork.org.uk/programmes/south-east-bridge/what-are-the-quality-principles/

• Ensuring that the service meets the needs of the Care Act.
• Inspiring hope and helping people to develop personalised strategies to keep well and support their recovery.
• Supporting vulnerable people who fall through the gaps between services.

8.0 Service Expectations

We want Strategic Partners and the Delivery Network to:

• Identify and work with local groups including community assets
• Ensure sustainability – Kent County Council expects that the service will become more sustainable and not reliant on one funding stream.
• The aspiration over the life of the contract is to move to position where the KCC funding is no more than 40% of the total funding, through the network accessing a range of other funding opportunities (this will not be relevant for Clinical Commissioning Groups funded services, i.e. IAPT or Primary Care Specialist)
• Ensure an appropriately trained workforce with the required skills
• Work in partnership with the new Primary Care Social Care work force which will be co-located in this service
• Provide evening and weekend services in line with people’s needs
• Develop proactive links with the Primary Care Mental Health Specialists and Improving Access Psychological Therapy providers to deliver a whole systems approach
• Ensure that social and health opportunities are not limited to providers of mental health services but are available from local community assets which will increase overall community participation and facilitate the destigmatisation of mental health.
• Promote recovery based approaches which take a more holistic approach to mental wellbeing and mental health improvement
• Demonstrate an understanding of the local population needs within which they will work and adapt services appropriate to local need.
9.0 Outcomes

This section sets out the outcomes for this service which are based on System Outcomes and individual Personal Outcomes, and essential requirements or standards. Outcomes can be defined as the intended impact or consequence or result of a service on the lives of individuals and communities and based on co-production.

“Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families, carers and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.”

*The Challenge of Co-production (2009)*

**System Outcomes**

By working with health and social care partners the service will:

- Reduce the number of people entering hospital in crisis and residential care admissions
- Reduce the numbers entering secondary mental health care
- Increase the numbers of people being transferred from secondary services to primary care
- Increase numbers of people accessing support including information, advice and signposting
- Increase number of people self-caring following period of enablement through the support time and recovery service
- Increase access to early intervention services
- Improve transition from children and young people services to adult mental health
- More people in employment
- More people in stable housing and managing their tenancies
- More people supported to achieve emotional wellbeing
- Reduce stigma and discrimination
- Increase awareness raising of mental health in the workplace to reduce barriers to employment
- Support co-working and collaboration between primary care services, health and social care to meet the totality of individual and family needs
- Increase levels and models of mutual/peer support
- Improve outcomes for carers through signposting/referral
- Reduce suicides

**Personal Outcomes**

As a direct result of the service more people will:

- Connect to their communities and feel less lonely and socially isolated
Delivery Network Specification

- Have choice, control, and feel empowered
- Report and optimise physical and emotional wellbeing
- Live safely and independently and optimise recovery
- Be in stable accommodation and managing their life
- Achieve economic wellbeing - ensuring people’s income is maximised, debts are managed and where appropriate applicable welfare benefits are accessed
- Feel satisfied with service delivery and service outcomes
- Be involved in service design, service offer and availability
- Access a wide range of opportunities to support their personal recovery which include (but are not exclusively limited to): lifelong learning, employment and volunteering, social and leisure, healthy living support including local opportunities to get fitter and make better lifestyle choices regarding food, smoking, alcohol and harm minimisation.
- Stay in or enter employment
- Be supported to be independent and manage their long term conditions
- Have increased social skills
- Be appropriately supported to manage their recovery

10. Service Specific Models

This service specification is based on outcomes, but there are certain service specific models which must be incorporated into the service delivery model. These are:

- Employment Model
- Primary Care Community Link Worker Model
- Housing Related Support
- IAPT (for Dartford, Gravesham and Swanley CCG and Swale CCG)
## 11. Service Outcome Performance Indicators

The Key Performance Indicators (KPI's) and suggested ways to measure and will be further developed through the competitive dialogue process.

<table>
<thead>
<tr>
<th>Description of Outcome</th>
<th>Requirements/ service standards/Outputs</th>
<th>KPI</th>
<th>Suggested ways to measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>People connected to their communities and feel less lonely and socially isolated</td>
<td>Office of National Statistics(ONS) isolation statement Health and Social Care Measure</td>
<td>95% of all people who use the service report an improvement</td>
<td>E.g. Recovery and Outcome star</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>The number of new</strong> groups of people working together on projects and attending community based activities</td>
<td><strong>Number</strong> of new groups and community activities</td>
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<td></td>
<td></td>
<td><strong>Numbers</strong> of people reporting an improvement in the size and range of their social networks</td>
<td></td>
</tr>
<tr>
<td>People have choice and control and feel empowered</td>
<td>People have actively engaged in their wellbeing plan</td>
<td><strong>Wellbeing</strong> plans in place within one month (95%)</td>
<td><strong>Wellbeing</strong> plans audited Measured taken at start of intervention and measure taken at exit</td>
</tr>
<tr>
<td>‘When I need support for my mental health, people work together, respecting my culture, my goals and my experience, to deliver fast access, peer support and flexible, responsive care for my physical and mental health needs at the same time’, (TLAP) ‘I’ Statement</td>
<td>Who I am What is important to me How I wish to be supported How people behave with me</td>
<td><strong>Think Local Act Personal</strong> (TLAP) ‘I’ statements incorporated into Wellbeing Plans (100%)</td>
<td>Data capture and reporting – consistent data format presented</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Increase</strong> in voting and membership of local community groups</td>
<td>Set trajectory</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Increase</strong> in voting and membership of local community groups</td>
<td>Self- reported through people who use the service</td>
</tr>
</tbody>
</table>
| Report and optimise physical and emotional wellbeing and reduce health inequalities including healthy living support by providing local opportunities to get fitter and make better lifestyle choices regarding food, smoking, alcohol and harm minimisation | **Every** contact counts approach **Areas** to improve physical and emotional wellbeing                  | Documented in **Wellbeing Plans** (100%) **Wellbeing** improved Self- reported less GP visits Self- reported change in behaviour                                       | **WEMWBS** (Warwick Edinburgh Wellbeing Scale) 

**Outcome** Star or exit interview                                                                                                                                                                                                 |
|                                                                                       |                                                                                                        | **Wellbeing** improved Self- reported less GP visits Self- reported change in behaviour **Number** of people increased ability to manage their own mental wellbeing **Number** of people reporting increased ability to manage mental health | Data capture and reporting – consistent data format presented                                                                                                                                                           |
| People in stable accommodation and managing their life | Referral systems in place for housing related support  
Single referral point  
Links to residential care and supported accommodation providers as well as attendance at appropriate housing forums in locality | Number of referrals for housing related support  
Length of waiting time  
Duration of support provided  
National Indictor the number of people in settled accommodation under the Care Programme Approach 75%  
Links made to providers  
Attendance at local housing forums | Data capture and reporting – consistent data format presented  
Set trajectory |
|---|---|---|---|
| People achieve economic wellbeing – ensure people's income is maximised, debts are managed and where appropriate applicable welfare benefits are accessed | People have access to information, advice and support  
People signposted/referred to organisations who deliver these types of services | Number of people entering employment or self-employment  
Number of people under Care Programme Approach supported in employment for 16 hrs plus a week for 13 weeks or more  
Number of people in primary care supported in employment for 16 hrs plus a week for 13 weeks or more  
Number of people supported to stay/remain in work  
Number of people accessing debt of benefits | Data capture and reporting – consistent data format presented  
Case Studies  
Set trajectory |
| People feel satisfaction with service delivery and service outcomes | Complaints and compliments 75% satisfaction rate | Self-reported through people who use the service surveys | Reported through friends, carers and family test |
| People involved in service design, service offer and availability | Co-production, including mutual and peer support | Evidence of people participation in the planning, delivery, monitoring and evaluation of the service | Data capture and reporting – consistent data format presented |
| | | | Case Studies |
| People access a wide range of opportunities to support their personal recovery which include (but are not exclusively limited to): lifelong learning, employment and volunteering, social and leisure activities | Identified in wellbeing plans | Number of people reporting improvement in size/range of social networks. 75% of people reporting an improvement | Data capture and reporting – consistent data format presented |
| | | Number of people supported to access mainstream sport/leisure/green spaces/green spaces groups/facilities. | Self-reporting |
### Delivery Network Specification

<table>
<thead>
<tr>
<th>Description of Outcome</th>
<th>Requirements/service standards/Outputs</th>
<th>KPI</th>
<th>Suggested ways to measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>People with long term conditions supported to be independent and manage their conditions</strong></td>
<td>People recovering from mental illness need to be appropriately supported</td>
<td><strong>Number</strong> of people supported to access mainstream arts or cultural groups/activities. <strong>Number</strong> of people supported to access other mainstream opportunities. <strong>90%</strong> of people supported to access one of the above</td>
<td><strong>Wemwbs</strong> (Warwick Edinburgh Scale) <strong>Outcome</strong> Star or exit interview Case Studies Self-Reported</td>
</tr>
<tr>
<td><strong>Social Value Maximised</strong></td>
<td><strong>Local Employment</strong>: Creation of local employment, volunteering and training opportunities</td>
<td>Evidence of social value in policies i.e. employment policy</td>
<td><strong>Number</strong> of opportunities reported with evidence of employment opportunities</td>
</tr>
<tr>
<td><strong>Buy Kent First</strong></td>
<td>Buying locally where possible to reduce unemployment and raise local skills</td>
<td><strong>Number</strong> of Kent purchases reported</td>
<td>Data capture and reporting – consistent data format presented</td>
</tr>
<tr>
<td><strong>Community Development</strong>: Development of a resilient local community and community support organisations, especially in those areas and communities with greatest need</td>
<td>Equalities Policy demonstrated across the Delivery Network Opportunities provided for all members of the community, particularly those groups that are under-represented, for example BME, homeless people</td>
<td><strong>Equalities data (Protected Characteristics) recorded (100%)</strong> <strong>Increased</strong> number of people participating in local community activities</td>
<td>Equalities information to be reported 6 monthly Annual EqIA Data capture and reporting – consistent data format presented</td>
</tr>
<tr>
<td><strong>Good Employer within the Delivery Network</strong>: Support for staff development and welfare</td>
<td>Staff surveys through Delivery Partners Self-reported through Delivery Partners</td>
<td><strong>Annual reporting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Green and Sustainable</strong>: Protecting the environment, minimising waste and energy consumption and using other resources efficiently</td>
<td>Delivery Partner self-reporting</td>
<td>Part of annual reporting</td>
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**Kent Environment Strategy**: Living ‘Well’ within our environmental limits: Leading Kent towards consuming resources more efficiently, eliminating waste and maximising the opportunities for the green economy
<table>
<thead>
<tr>
<th>Rising to the climate change challenge - working towards a low carbon Kent that is prepared for, and resilient to, the impacts of climate change</th>
<th>Environmental Policy <strong>More</strong> people cycle, walk, use public transport or shop locally, including staff and volunteers and people who use the service</th>
<th>Change in behaviour 10% increase per annum (baseline agreed through competitive dialogue)</th>
<th>Self-Reported in first year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage Kent communities and businesses to act to reduce their carbon footprint and increase their resilience to climate change;</td>
<td>Environmental Policy Decrease the amount of waste due to the service activity in the wider community</td>
<td>Change in behaviour 10% increase per annum Reduction in mileage Decrease in printing (baseline agreed through competitive dialogue)</td>
<td>Self-Reporting in first year</td>
</tr>
<tr>
<td>Kent businesses to take advantage of opportunities arising from climate change and environmental technologies;</td>
<td>Environmental Policy The Strategic Partner and organisations within the Delivery Network to Increase percentage of recycling</td>
<td>Change in behaviour 10% increase per annum (baseline agreed through competitive dialogue)</td>
<td>Self-Reported in first year</td>
</tr>
<tr>
<td>Promote opportunities to support communities in Kent to find local solutions that benefit local people and the environment.</td>
<td>Environmental Policy</td>
<td>Change in behaviour 10% increase per annum (baseline agreed through competitive dialogue)</td>
<td>Self-Reported in first year</td>
</tr>
</tbody>
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12. Useful documents:

This publication sets out the asset based approach noting how it is geared towards accentuating positive capabilities and activating solutions for health promotion action. Professional staff and practitioners are encouraged to embrace positive approaches to health and importantly focus on health and wellbeing rather than ill health and disease.

The Marmot Review sets out compelling epidemiological evidence that social and economic inequality is damaging to mental and physical health through a life course approach.

Mental Health, Resilience and Inequalities Dr Lynne Friedli (WHO 2009)
Lynne Friedli sets out how resilient communities have lower levels of crime and violence and higher levels of pro-social behaviour and social integration. Resilient individuals are shown to have more fulfilling relationships, lower prevalence of physical as well as mental illness, and higher educational achievement, employability, productivity and earnings.

Public Health England’s guide shares extensive evidence that connected and empowered communities are healthy communities.

The NHS Five Year Forward View (2014)
http://www.england.nhs.uk/ourwork/futurenhs/
NHS England CEO, Simon Stevens, sets out how our health services need to change and argues for a new relationship with patients and communities.

From Evidence Into Action PHE (2015)
PHE’s strategy - From Evidence into Action calls for place-based approaches that develop local solutions, drawing on all the assets and resources of an area; integrating public services and also building resilience of communities in order to improve health and wellbeing for all and to reduce health inequalities

The Care Act
The 2014 Act introduces a general duty on local authorities to promote an individual’s ‘wellbeing’. This means that we should always have a person’s wellbeing in mind and when making decisions about them or planning services.

Wellbeing can relate to:
- Personal dignity (including treatment of the individual with respect)
- Physical and mental health and emotional wellbeing
Delivery Network Specification

- Protection from abuse and neglect
- Control by the individual over day-to-day life (including over care and support)
- Participation in work, education, training or recreation
- Social and economic wellbeing
- Domestic, family and personal relationships
- Suitability of living accommodation
- The individual's contribution to society
 references


2 Kent County Council Strategic Statement – Increasing Opportunities, Improving Outcomes 2015 – 2020

3 No Health without Mental Health, A cross-government mental health outcomes strategy for people of all ages (DH 2011)

4 Live It Well Strategy. www.liveitwell.org.uk


6 Suicide prevention: second annual report Department of Health 2015


8 NICE guidance on Depression http://www.nice.org.uk/guidance/cg90

9 Kent and Medway Joint Working Protocol for Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) 2013

10 www.liveitwell.org.uk

11 Boyle D and Harris M. The Challenge of Co-production Nesta 2009

The Outcomes Star – see
   http://www.homelessoutcomes.org.uk/resources/1/OutcomesStar/OutcomesStar.pdf - will be used as a core measurement tool as part of this contract to capture progress of the service user towards greater independence and social inclusion. Please detail any other tool or method you would use to demonstrate change relevant to the indicators you have listed.

Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) this is a prototype measure developed (Tennant et al. 2007). It focuses on the positive aspects of mental health. It is short and easily understood as an instrument of mental wellbeing by the public and can be seen as an intervention in its own right. http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/
Appendix 1: Strategic Partner Specification

To be inserted
Appendix 2:

Primary Care Community Link Worker Service Objectives

- Provide a primary care community link worker service which offers individually tailored, one-to-one and time limited support (up to 8 weeks) for people with a common mental health issue to engage in and sustain mainstream activities, in ordinary community settings, alongside members of the community who do not use services.

- To work in partnership with the full range of agencies and groups in the community, including GPs, Gateways and Improving Access to Psychological Therapies (IAPT), to develop opportunities for people who use the service to participate in mainstream activities.

- Promote recovery and community participation of people who experience common mental health issues by enabling them to proactively apply the ‘six ways to wellbeing’ recommended on the Live It Well website for Kent and Medway - www.liveitwell.org.uk

- To assist people to achieve their personal goals by offering support to develop their skills in line with their interests and through their participation in the design and running of activities in the Primary Care Community Link Worker Service.

- Ensure link workers have a comprehensive knowledge of the challenges and support needs of people with Mental Health needs.

- This service will also provide support to the Margate Central and Cliftonville West wards of Thanet. The service will ensure a more appropriate use of social care services, enabling people to access the most appropriate services to meet their needs. People will be provided with the right information and support to ensure they access the right service at the right time. The service will need to deliver an enhanced signposting and support service to meet the needs of Thanet residents which reflect the diversity and needs. The service will need to be responsive to the issues identified below. (Margate Central and Cliftonville West Thanet Needs Assessment)

Margate Central and Clintonville West Wards Needs Assessment

- Thanet has the second highest population density of the Kent districts. Population projections from the Office for National Statistics (ONS) show a rise in all age groups over the next five years with the largest
percentage rise occurring in the 65-84 age group. This is predicted to increase by 15.99% in 2019. Thanet has the widest gap of life expectancy at birth between wards compared to any other district in Kent. The gap is 16.8 years between the lowest (Margate Central) and highest (Kingsgate) Crime in Thanet is high compared to other districts with burglaries, anti-social behaviour, criminal damage, domestic abuse and substance misuse being of particular concern. A high proportion of crimes are carried out within Margate Central and Cliftonville West. Levels of skills and qualifications in Thanet are lower than the Kent averages;

- 21.7% of local people consider themselves to have a limiting long term illness. This is above the Kent average of 16.5% and the national average at 17.6%;

- Thanet has the highest rate of teenage pregnancy in Kent

- Hospital admissions for alcohol related harm in Thanet are significantly higher than the Kent and the national averages. There is considerable variation within Thanet with the rate being 35 times higher between the highest and lowest wards (Kingsgate and Cliftonville West)

- The health of people in Thanet is worse than other districts in the South East

- Adult participation in sport in Thanet is lower than the Kent average;

- The population of Thanet is becoming more diverse with an increased number of people from minority ethnic groups settled in the area.

- Satisfaction with the area as a place to live is low compared to other parts of the country;

- 55% of local people feel no strong sense of belonging to the area
Appendix 3

Employment Model

The employment model should be based on the Individual Placement and Support (IPS) approach which meets the following:

- Eligibility is based on individual choice with no exclusion criteria
- Supported employment is integrated with clinical treatment
- Competitive employment is the primary goal
- Job search is rapid (begins within 4 weeks)
- Job finding, and all assistance, is individualised
- Employers are approached with the needs of individuals in mind
- Follow-along support is continuous
- Financial planning is provided
Support to Enable People to Secure or Retain Accommodation – Housing Related Support

Service Objectives:

- To provide an outcomes focused, individually tailored accommodation support service to support people with both common mental health and severe mental health issues to secure or sustain accommodation

- To develop the capacity of people to live independently following a time-limited programme of support

- To raise awareness of tenancy and occupancy obligations such as rent and services charges/mortgage conditions/appropriate behaviours in order to retain housing situation

- To enable and facilitate people to address offending behaviour that may jeopardise their housing situation, e.g. anti-social behaviour

- To offer advice about maintaining safety and security of home and the equipment required to maintain safety and security

- To enable and facilitate people who use the service to deal with official correspondence

- To signpost/refer onto to appropriate services which enable people to retain their housing situation

- To provide time limited support, up to duration of 1 year for an average of 2 hours per household unit per week. In certain circumstances support may be provided to a person for longer than 1 year up to a maximum of 2 years but continuation of service must be agreed with the Strategic Partner and Commissioners

- To provide a single referral point – referrals will come from various sources e.g., District and Borough Councils, Local Authority, social and private housing providers, mental health professionals and self-referrals. It is anticipated that an open and easily accessible referral application procedure will need to be made available to all referrers

- To work in partnership with the full range of agencies and groups in the community, including District and Borough Councils, Citizen Advice Bureaux, CMHTs, Gateways to aid referrals into the service and for onward referrals
• It is not anticipated that a person using the service will already be in receipt of accommodation support services unless as part of an agreed handover period.
Appendix 5

Residential and Supported Accommodation Providers List

[PDF]
Accommodation Appendix.pdf
Appendix 6

Dartford, Gavesham and Swanley CCG and Swale CCG Specifications