

Here for you, how did we do?

Local account for Kent Adult Social Care



April 2016 - March 2017

Report highlighting the achievements, improvements and challenges of Kent County Council Adult Social Care during the past year and our vision for the future.

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Foreword

By: Graham Gibbens, Cabinet Member for Adult Social Care and Anu Singh, Corporate Director of Adult Social Care and Health.



Graham Gibbens



Anu Singh

We are pleased to publish, "Here for you, how did we do?" the Local Account for Kent County Council Adult Social Care for April 2016 – March 2017.

This Local Account describes the achievements, improvements and challenges of KCC Adult Social Care in the past year and sets out our vision for the future.

There continue to be big challenges ahead in Adult Social Care, we are changing the way in which we deliver our services so we can continue to offer quality care and value for money for the future. We are also committed to improving social care outcomes within the constraints of a challenging financial climate.

We have already made essential savings and we are working to become even more efficient. We are doing this through reducing paperwork, simplifying processes and cutting red tape, as well as looking at the way we commission services to get better value for you and the council.

At the same time, we are making significant investment in vital support services, which will help people, stay independent for longer, offer greater support for carers and reduce avoidable hospital admissions. We are also working more closely with our partners in the NHS to integrate Health and Social Care.

The people of Kent have told us they want real choice in their care, they want personalised care which suits them and they want to stay independent for as long as possible.

We know that quality care matters to people and we will continue to work to find innovative and efficient ways to deliver these services.

In 2016-17, we strived to:

- keep vulnerable adults safe
- support people to live independently in their own home
- increase investment in enablement services (see glossary) and Telecare (see glossary) provision to enable people to regain their independence and remain at home
- reduce the number of permanent admissions to residential care
- support more people through a person-centred process and to receive a personal budget (see glossary)
- support more people with a learning disability into employment
- use surveys and other feedback to look at what we are doing well and what needs improving
- work with Health to plan and provide joint services.

Many people, including those who use our services, their carers and voluntary organisations were crucial in putting this Local Account together and we would like to thank all those who contributed. We will continue to listen to and work with people in Kent to build a sustainable service for the future.

Introduction

Welcome to this year's annual report for Adult Social Care in Kent - '**Here for you, how did we do?**' April 2016 - March 2017 which describes the achievements, improvements and challenges faced by Kent Adult Social Care during the past year as we have continued to transform our services. It also sets out our vision for the future.

In the past, the Care Quality Commission (see glossary) used to assess how well Local Authorities were performing in Adult Social Care. They no longer do this, and as part of national changes, all Local Authorities are now asked to produce a document in partnership with their residents to enable them to hold the authority to account. As a result '**Here for you, how did we do?**' has been produced.

The Local Account is an important way in which people can challenge and hold us to account and this is the sixth year that it has been developed in partnership with people who use our services, their carers, voluntary organisations and service providers as well as members, district councils and staff.

Throughout this document, we will provide updates on the key issues you have told us are important to you and we will also tell you about the new things we have been developing and are working on.

Feedback from you is enormously important and many people played a crucial role in putting this Local Account together either through providing us with feedback or taking part in meetings to let us know the areas that were important to you.

You told us that you would like to know:

- How to access our services (page 11)
- How we spend money (page 15)
- How we do things differently (page 20)
- How we support carers (page 47).

We will continue to listen to and work with people in Kent to build a sustainable Adult Social Care Service for the future and we will continue to distribute the Local Account as widely as possible to give everyone the chance to read it, challenge our approach, ask questions and feedback their views.

If you have not had the opportunity to contribute to the Local Account or have been involved in the past and would like to continue to help us shape how the Local Account looks and what it includes going forward, please email us at: kentlocalaccount@kent.gov.uk letting us know how you would like to be involved.

If you have any questions regarding the content of this report or you would like to submit your comments, please complete our feedback form online. The feedback form only takes five minutes to complete and we would love to hear from you.

We also have a paper feedback form which you will find in the centre of the booklet. Please contact us if it isn't included and we can arrange for a copy to be sent to you.

Further copies of the Local Account can be downloaded directly from our website at: www.kent.gov.uk/localaccount where you can also find plain text and easy read versions as well. Alternatively, please contact us and we can arrange for further copies to be sent to you.

Symbols used in this report



Refers to what is new this year.



Refers to an update on last year.

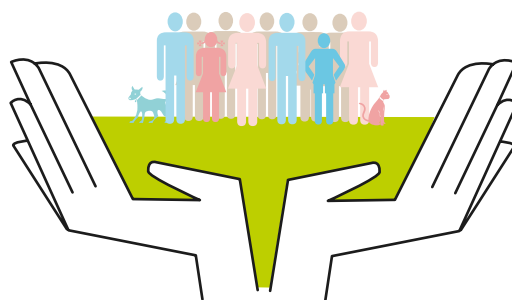
Kent and its people

At Kent County Council (KCC) we recognise the diverse needs of our community. We value and celebrate diversity and believe it is essential to provide services which work well for all our customers and staff. The different ideas and perspectives that come from diversity will help the council to deliver better services as well as making Kent a great county in which to live and work.

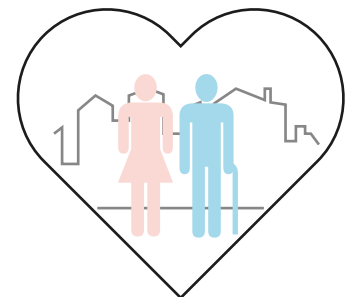
Further information on the council's objectives for equality and diversity can be found at: www.kent.gov.uk/diversity



14,286 people aged between 18-64 are supported by Adult Social Care

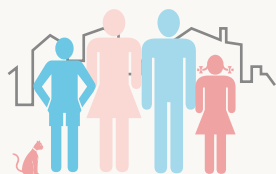


34,641 people in Kent are supported by Adult Social Care

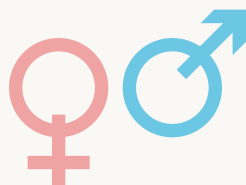


20,355 people supported by Adult Social Care are over the age of 65

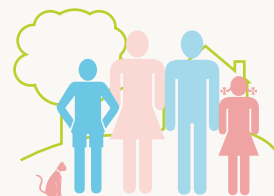
Facts and figures about Kent



74% of the Kent population live in urban areas



51% of the population is female and 49% male



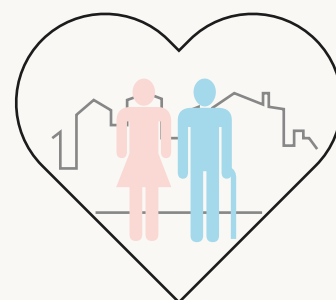
26% of the Kent population live in rural areas



17.6% of the Kent population have an activity limiting illness or condition (257,000 people)



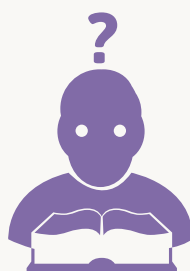
46% people in Kent supported by Adult Social Care are over the age of 85



57.5% forecast increase in over 65 year olds between 2015 and 2035



5,370 people (18-64) supported by KCC Adult Social Care have a physical disability



4,720 people (18-64) supported by KCC Adult Social Care have a learning disability



4,863 people (18-64) supported by KCC Adult Social Care have mental health issues

Further facts and figures about Kent can be found at www.kent.gov.uk/about-the-council/information-and-data

What does Kent Adult Social Care do?

'Together, we want to make sure people are at the heart of joined up service planning and feel empowered to make choices about how they are supported.'



What Statutory Responsibilities do we have?

KCC Adult Social Care has a statutory responsibility for:

- assessing your needs
- planning your support
- arranging your services, where appropriate
- providing community care services for adults living in Kent who qualify for social care support.

Who do we support?

Kent Adult Social Care support:

- older people
- adults with physical disabilities
- adults with sensory disabilities including dual sensory impairment and autism
- adults with learning disabilities and disabled children
- adults with mental health issues
- adults moving from children's services to adult services
- adults who give voluntary care to family members or friends.

What is our purpose?

Our principal purpose is to work with people who need care and support and who may need any of the services we arrange or provide. We do this by working with people to understand their personal needs, helping them to build on their strengths and abilities wherever possible. We always aim to promote people's independence and wellbeing, helping them to achieve outcomes that are important to them.

What is our aim?

Our aim is to make sure Kent's population of older people, people with physical disabilities, people with learning disabilities and people with mental health issues live healthy, fulfilled, independent lives and that people feel socially and economically included in the community.

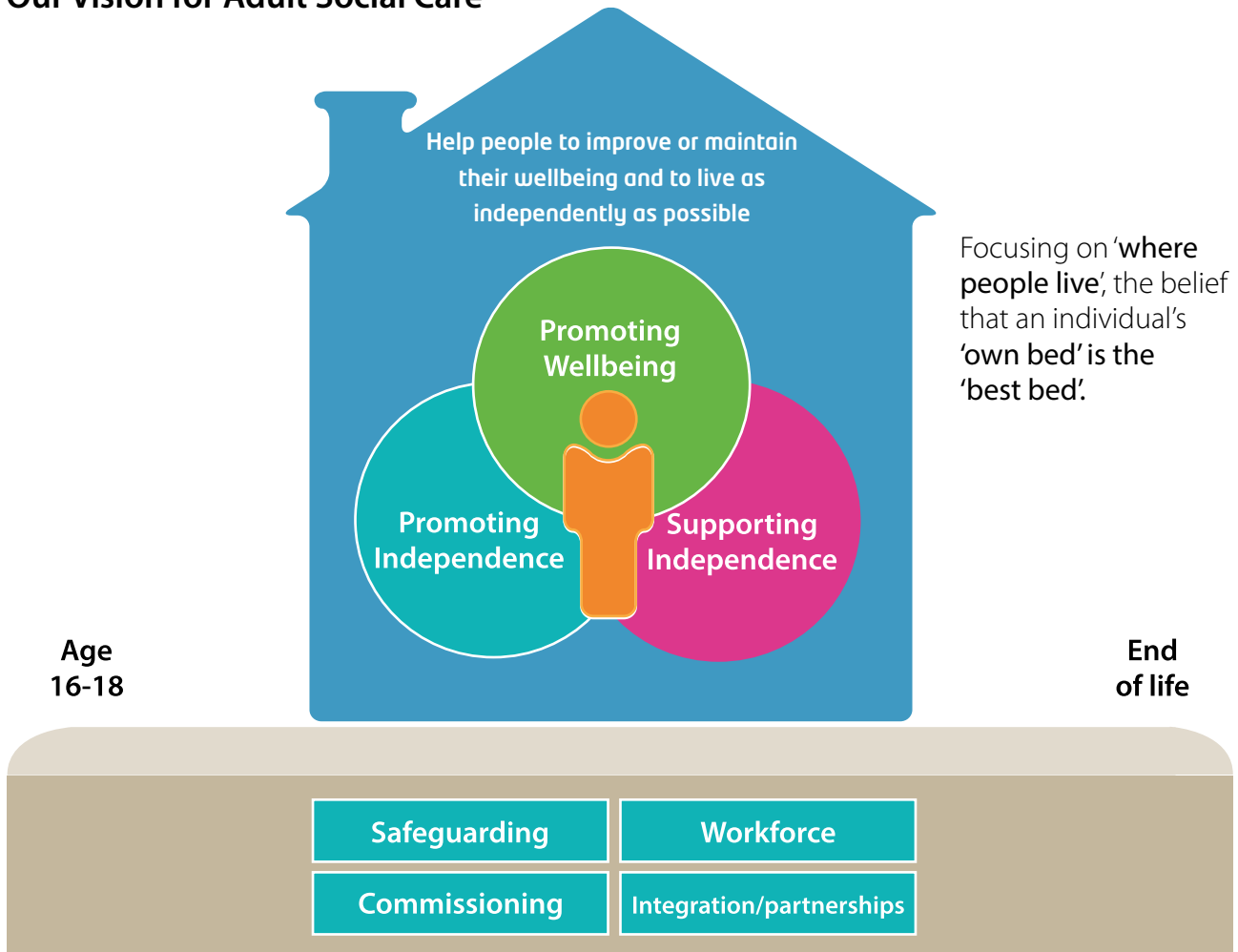
We're also aiming to drive, promote and support transformational change through commissioning high quality, cost effective, outcome based social care services to ensure that the right level of support is provided at the right time, right place and at the right cost for vulnerable adults, children and young people, their families and carers in Kent.

'A life not a service'

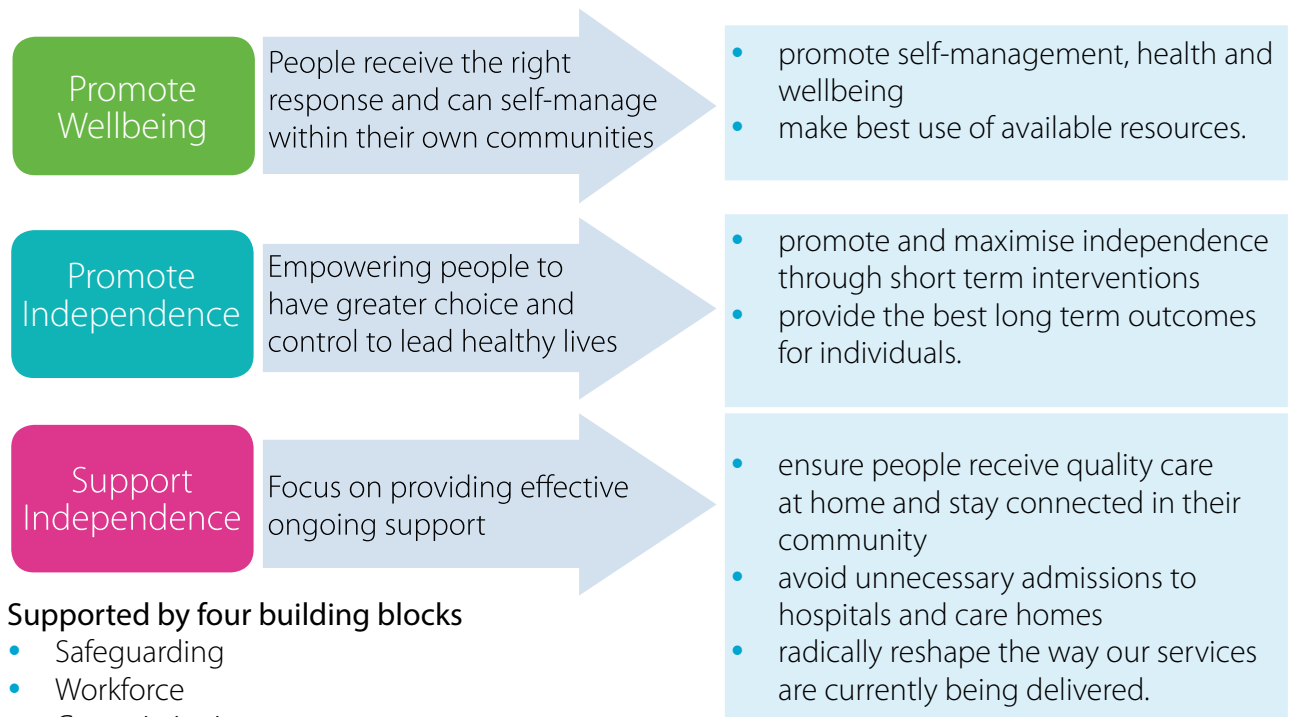
This builds on **supporting older and vulnerable adults to live independently** and it supports KCC's vision to focus on improving lives by ensuring every pound spent delivers better outcomes for residents, communities and businesses.

Our vision for Adult Social Care is centred around the individual being at the heart of everything we do. More information on, 'Your life, your wellbeing' - our vision and strategy for adult social care 2016 -2021 can be found at www.kent.gov.uk/careandsupport.

Our Vision for Adult Social Care



How will we deliver our Vision for Adult Social Care? We will:

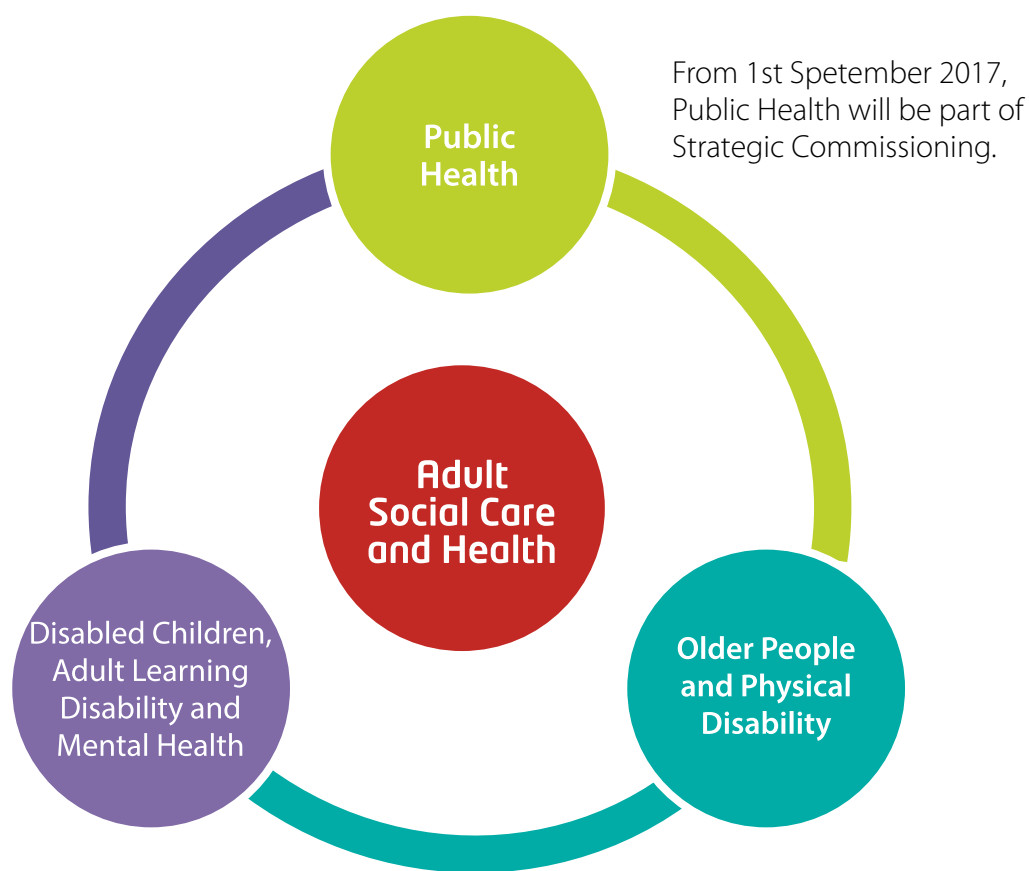


Through transition on an all age pathway.

How Adult Social Care in Kent is structured

The Adult Social Care and Health Directorate is made up of three Divisions which work together to meet the statutory responsibilities for social care and public health that Kent County Council is obliged to fulfil.

- Older People and Physical Disability
- Disabled Children, Adult Learning Disability and Mental Health
- Public Health



Older People and Physical Disability (OPPD) commissions and provides a range of services to improve outcomes for older people and physically disabled adults and their carers.

- **The purpose of the Division** is to support older and vulnerable adults wherever they live in our community to improve or maintain their wellbeing and live as independently as possible.
- **Key business areas** – Area Referral Management Service, Adults Central Referral Unit, Adult Community Teams, Kent Enablement at Home, Sensory and Autism Services, Integrated/Registered Care Centres, Day Centres, and the Health and Social Care Integration Team.



Disabled Children, Adult Learning Disability and Mental Health commissions and provides a range of services for children, young people and adults with disabilities and people with mental health issues.

- **The purpose of the Division** is to support vulnerable adults and children to live independently by promoting their wellbeing and supporting their independence.
- **Key business areas** – Disabled Children and Young People Teams, Community Learning Disability Teams, In-House Provision, Mental Health Services and the Operational Support Unit.

The services for adult mental health and learning disability already work in integrated teams with NHS colleagues. One of the priorities for the year ahead is to implement a lifespan pathway for our service users to ensure continuity of support as soon as people enter our services, through transition to adulthood and throughout their lives.

Public Health commissions and provides a range of services that aim to improve and protect the health of the population and provides advice and guidance to the wider Health and Social Care system.

- **The purpose of the Division** is to understand and highlight the factors that affect peoples' health, helping people to stay healthy and preventing illness. With our partners we seek to promote and deliver actions to improve the overall health and wellbeing of residents and to reduce inequalities in health.
- **Key business areas** - Children and Young People, Health Improvement Services, Kent Public Health Observatory, Health Protection and Sexual Health, Mental Health and Community Wellbeing and Health and Social Care Integration, Health Inequalities and Business and Operational Management.

Additional information about the business areas of Adult Social Care and the Social Care, Health and Wellbeing directorate can be found in the Annual Business Plan at www.kent.gov.uk and search Business Plans.

Your journey with Adult Social Care

Getting the right care and support is important and you need to take time to consider all the options and information available. Many people will manage their support needs themselves, often with help from family and friends. Some people are not able to do this and need help from Kent Adult Social Care.

Care and support is the term used to describe the help some adults need to live as well as possible with any illness or disability they may have. It can include help with things like; getting out of bed, washing, dressing, getting to work, cooking meals, eating, seeing friends, caring for families and being part of the community.

If you think you have care and support needs, you are entitled to a needs assessment or if you are a carer and you need some support, you are entitled to have a carer's assessment.

The assessment is about you and we will make sure that you are able to be involved. A family member, neighbour, friend or carer can help and represent you and if you don't have someone who you can ask, and you have a lot of difficulty being involved in the assessment yourself, we will find an independent advocate to help you.



Contact

If you feel you have care and support needs, you need to contact us and we will start an assessment of your needs based on what you tell us. A relative, GP, neighbour, friend or carer can also contact us on your behalf. See page 60 for our contact details.



Your Needs Assessment:

- is an opportunity for you to tell us about your situation and discuss your care needs to help us to understand things from your point of view
- will happen over the telephone or face to face and will help us to see if you are eligible for care and support services
- will look at how your needs impact on your wellbeing and what you would like to achieve in your daily life.

We will assess your care and support needs with you, and decide if they are at the level where you need help. If you have eligible needs, we will discuss with you how you would like these met based on the information you gave us during your assessment and we will work with you to develop a care and support plan. If you do not have needs that are eligible, we will give you information and advice about what care and support is available to help you locally. This could include help from a local charity or voluntary organisation.



Planning your Support (your Care and Support Plan)

- This will set out how your eligible needs will be met and we will support you to organise the right balance of care and support services to achieve the goals in your plan.
- You can put the plan together on your own, with the help of your family and friends or with our help.



Supporting you to be Independent

- Where we can, we will aim to support you to stay in your own home and live independently, maybe by providing you with simple equipment to make life easier such as a grab rail for the bath or adapted cutlery and non-spill cups.
- By helping you to do more for yourself, we aim to improve your quality of life and wellbeing.
- If you pay for some or all of your care, doing more for yourself may help reduce the cost of your care and support.
- If you receive a service that is time limited, we will reassess you when it ends to see whether you still need our support or service.



Paying for your care and support

- We will assess how much you need to pay towards your care and support by carrying out a financial assessment.
- This looks at your capital (savings and investments) and your weekly income (which includes most pensions and benefits) to see how much you will need to pay towards the cost of your support.
- We may contribute to the cost of your care but this depends on the financial assessment.



Arranging your Support

- Once we have agreed with you how your needs will be met, you can choose to use the care services we provide and arrange or you can make your own care arrangements with a direct payment.
- This gives you greater choice and control over the care you receive.
- A direct payment is the money we will pay toward the cost of your care. We pay this onto a Kent Card.



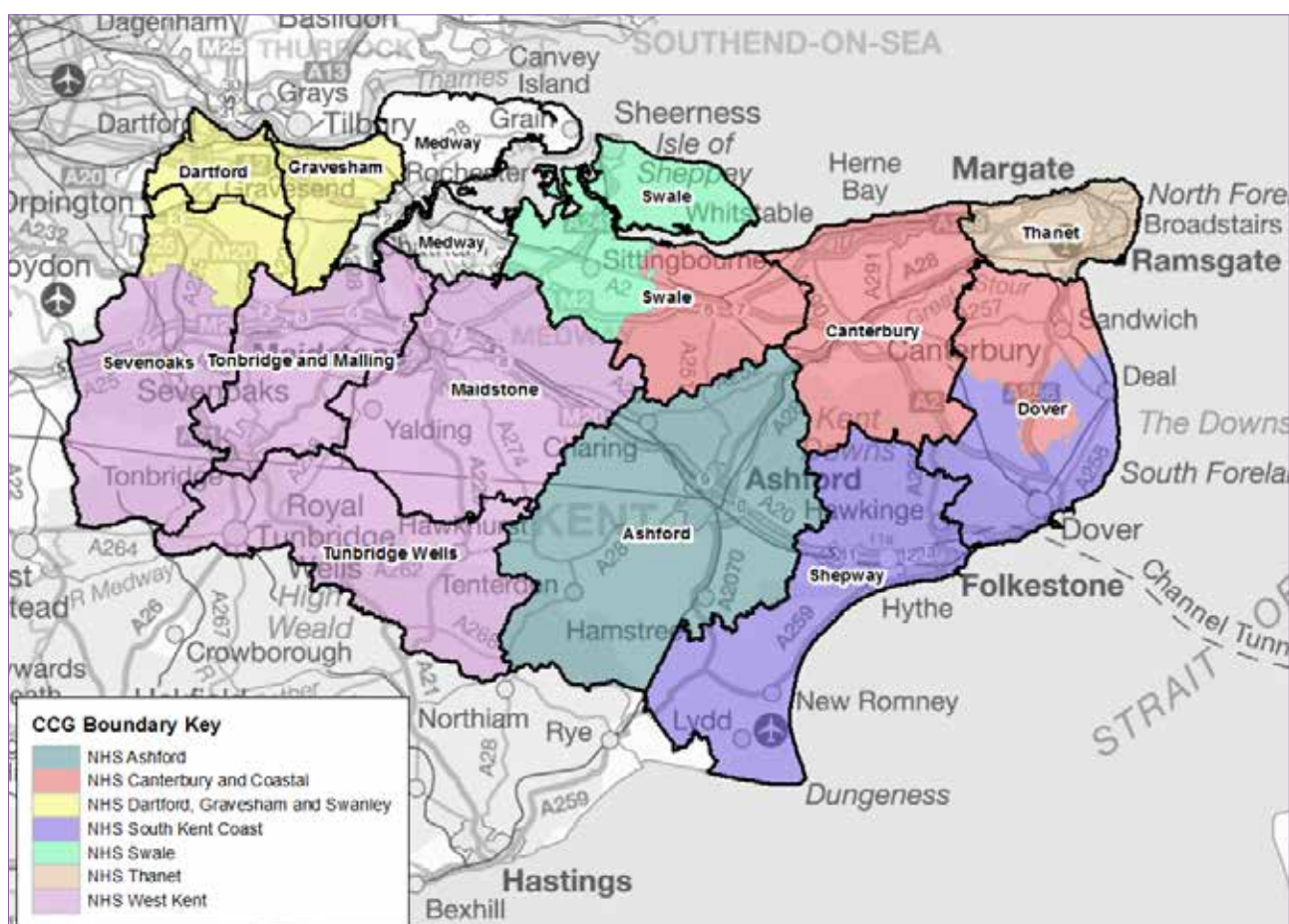
Reviewing your care and support

- We will contact you to check that your care and support is going well and that you are happy with what is being provided.
- This will happen within eight weeks of starting your care and support and then at least every year.
- We will also review your care and support if you or your carer contact us to let us know that your care is not working for you or if your circumstances have changed.

Sometimes things will improve so much that you may no longer need our services or you may need different help from someone else. We will help you with any advice you need about other organisations which might be able to support you.

All our employees wear name badges at all times so you can clearly identify them as KCC employees.

Clinical Commissioning Groups - CCGs



*Please note the coloured areas detail the CCG boundaries, the outlined areas are the district boundaries, resulting in some overlap. Map also highlights Medway CCG.

This map shows the district boundaries for Adult Social Care in Kent, which are now aligned with the Clinical Commissioning Groups (see glossary) to make it easier to provide joint Health and Social Care Services to residents. There are seven CCGs across Kent as well as Medway CCG.

CCGs organise the delivery of NHS services in their area and work closely with patients, healthcare professionals and in partnership with local communities and Kent County Council.

West Kent CCG is the largest CCG. It has the biggest overall population and the highest number of people aged 16-64, over 65+ and aged over 85+. Thanet CCG is the most densely populated CCG with 13.4 people per hectare followed by Dartford, Gravesham and Swanley CCG at 9.5.

The total Kent population is expected to be 1.58 million by 2020. Ashford CCG and Dartford, Gravesham and Swanley CCG have the highest predicted population change from 2013 to 2020 by 7% to 8%. Swale CCG, Thanet CCG and West Kent CCG have the lowest population increase from 4% to 5%.

Of the 12 local authority districts within the Kent County Council area, Maidstone Borough is the most populated with 166,400 people. Dartford Borough is the least populated with 105,500 people.

Further information on how Kent County Council is working with your local Clinical Commissioning Group (CCG) and how health services are being delivered in your area can be found at www.kent.gov.uk and search **Kent Integration Pioneer** (see glossary).

Challenges facing Adult Social Care Services

Adult Social Care Services across Kent continue to face four huge challenges:

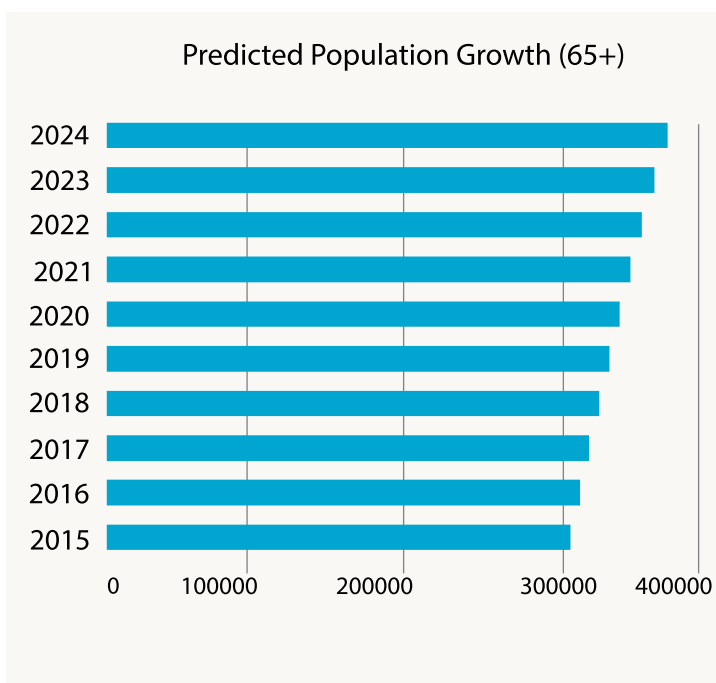
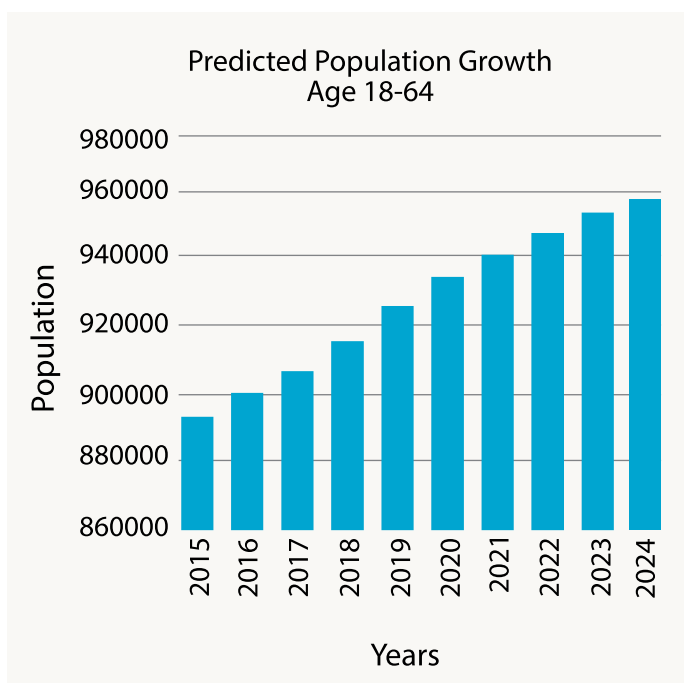
- people want better quality and choice in the services they use
- the population is living longer with complex needs putting further demand on social care
- the financial climate is imposing massive constraints on local authorities
- we need to deliver joint services with the NHS and other partners.

As the population of Kent and demand on services increases, we need to ensure that we continue to deliver cost effective Adult Social Care Services where people remain at the centre of the care they receive.

Predicted Kent population growth (excluding Medway) 2015 – 2024

Age Band	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
18-64	892,800	899,700	906,000	914,700	924,800	933,200	939,700	945,900	951,900	957,900
65+	300,500	307,000	312,800	319,400	326,100	332,600	339,600	347,100	355,100	363,700
Total	1,193,300	1,206,600	1,218,800	1,234,100	1,250,900	1,265,900	1,279,200	1,293,000	1,307,000	1,321,600

Source: KCC Housing Led forecast (Oct 2015), Strategic Business Development & Intelligence, KCC.



Additional facts and figures about Kent and the predicted population growth can be found at: www.kent.gov.uk/about-the-council/information-and-data

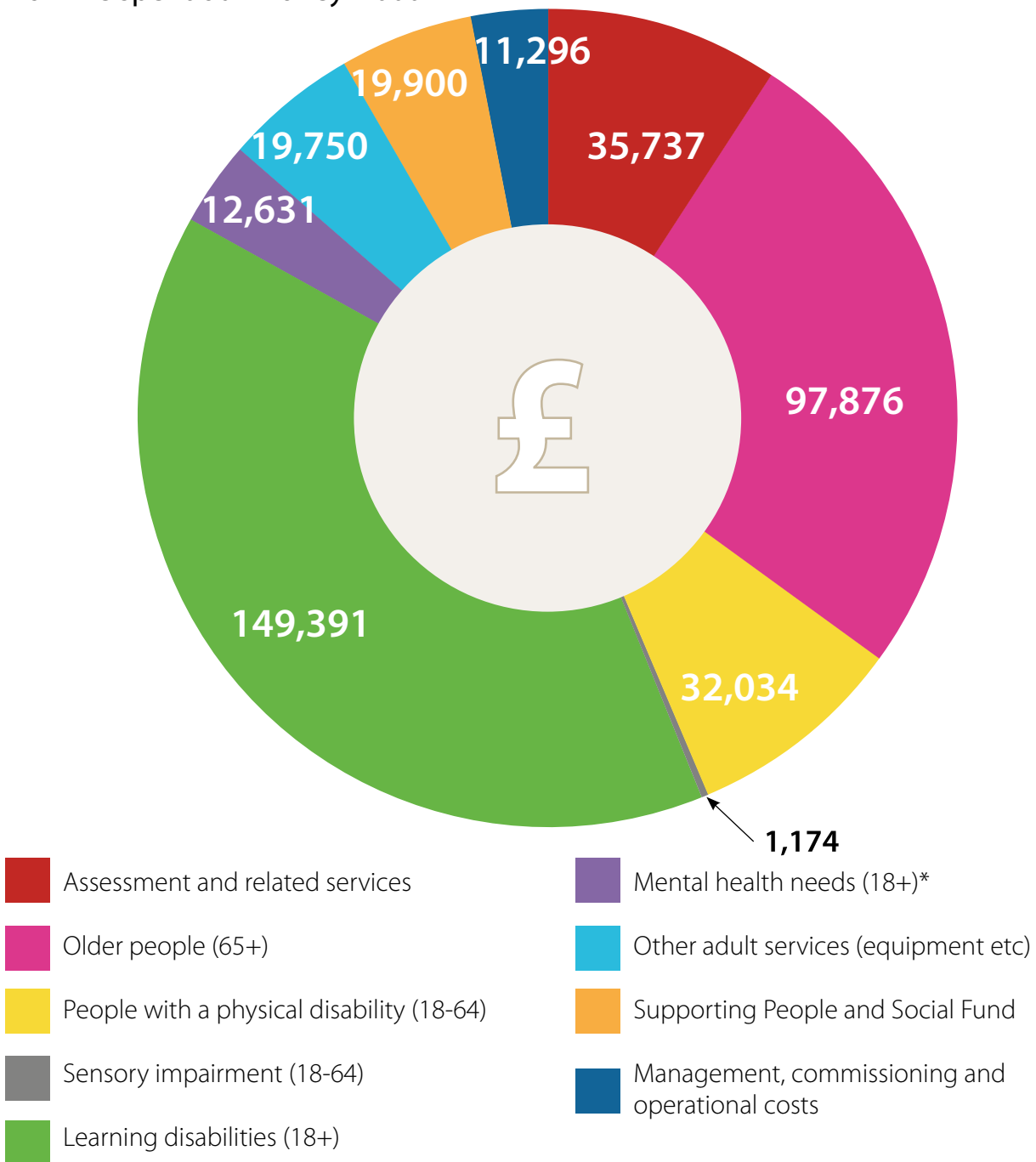
How we spend our money

KCC's net expenditure is £1.834 billion per annum and the budget is split into three areas:

- direct services to the public - £1.62 billion
- financing items - £125 million (authority wide costs that are not service specific)
- management, support services and overheads - £93 million.

The Adult Social Care net budget is £379,789 million per annum, below is an illustration of how this is spent across all our client groups. For more detailed information go to: www.kent.gov.uk/budget

How we spent our money £'000



* Mental health services are also funded and provided by Kent and Medway Partnership Trust (KMPT) who work in partnership with KCC.

How we spend our money

Service	Net (£'000s) 2016-17	Percentage of Budget
Assessment - staff costs for carrying out community care assessments, support plans and reviews	42,459	11.2%
Residential care and nursing care including non-permanent care such as respite	160,561	42.3%
Domiciliary Care services provided to individuals in their own homes and those within extra care housing	33,575	8.8%
Direct payments - money which is passed directly to individuals so they can purchase and manage services to meet their eligible needs	47,662	12.5%
Supported Living and Supported Accommodation arrangements	58,596	15.4%
Day Care, Community Support Services and Meals	20,073	5.3%
Non-residential client charging – client contributions towards community based services	-14,901	-3.9%
Enablement - intensive short term support which encourages people to be as independent as possible	8,220	2.2%
Advanced Assistive Technology	4,627	1.2%
Voluntary organisations contributions for social support related services	18,175	4.8%
Support for Vulnerable People - Supporting People and Social Fund	19,900	5.2%
Better Care Fund income	-31,819	-8.4%
Management, commissioning and operational costs	12,661	3.3%
Total adult spend	379,789	

Additional Social Care Grant



In the Chancellor's 2017 Spring Budget, the government announced that an additional £2 billion will be given to councils in England over the next three years for Adult Social Care.

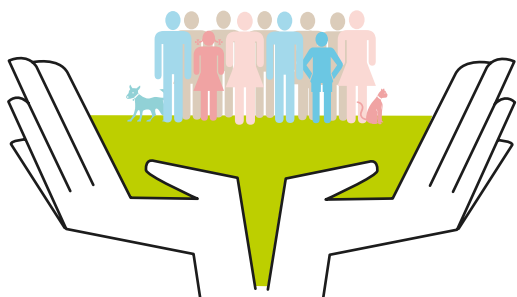
From this additional Social Care Grant, Kent County Council will receive additional funding of £52.282 million towards social care spending over the three year period 2017-20 (£26.091m in 2017-18). This equates to approx. 2.6% of the total additional funding nationally.

There are three purposes for the grant. These are:

- meeting adult social care needs
- reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- ensuring that the local social care provider market is supported.

We are developing a strategy and plans to enable this resource to be used in those areas where it will be most effective and where people remain at the centre of the care they receive whilst we continue to deliver cost effective Adult Social Care Services.

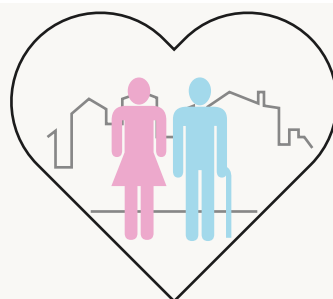
Headline figures



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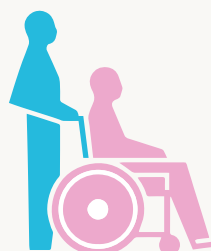


20,355 people supported by Adult Social Care are over the age of 65

Assessments



33,966 people received an assessment of their needs



8,263 assessments were completed that took account of carers' needs.

Personal Budgets

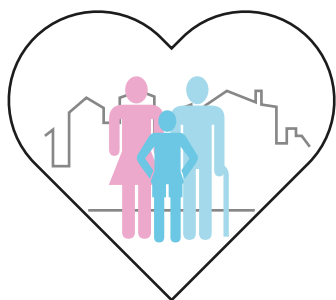


12,055 people had a Personal Budget

5,408 people decided to take their Personal Budget as a Direct Payment

2,113 people received their Direct Payment through a Kent Card

Services in the community



5,879 people received a home care support service so they could stay in their home

7,706 people received an enablement service

81% of people could return home due to an enablement service

2,411 people received a day care service

1,244 supported living placements were made

Residential and nursing care



4,302 people in permanent residential placements

1,229 older people were resident in nursing care homes

1,102 residential placements were made for people with learning disabilities

588 suppliers provided services in relation to permanent residential placements

112 suppliers provide services in relation to nursing care homes

Carers



899 carers received a 'something for me' payment

Reviews



17,693 people received a review of their needs



Transformation programme



To meet the challenges facing Adult Social Care services across Kent, we have been transforming our existing services to deliver better outcomes for people building on people’s strengths and capabilities, promoting their independence and improving their health and wellbeing.

Initial planning for this began in 2012 and we have been driving forward three stages of transformation. We have been working closely with people who use our services, their carers, the public, our staff, the NHS, the voluntary and community sector and other organisations to help us achieve our desired outcomes and deliver savings.

The first two stages of our transformation programme are complete and already we’ve achieved significant savings and discovered far more efficient ways to deliver our services:

What a difference our Transformation has made so far!

Our transformation programme has enabled outcomes for thousands of older and vulnerable people across Kent to be improved.

- ✓ developments in Kent Pathways Service, Shared Lives, Your Life Your Home, Learning Disability Integrated Commissioning, Kent Enablement & Recovery Service and Live Well Kent have been implemented
- ✓ improved ways of working has meant that 3,500 more people every year are benefiting from our Enablement service
- ✓ additional 2,000 people each year are accessing telecare
- ✓ additional 3,600 people each year are receiving Promoting Independence Reviews
- ✓ effective enablement has meant the average package size for people receiving care after enablement has reduced by 55 minutes per week
- ✓ additional 350 people per year going home when discharged from hospital
- ✓ enablement teams have support from a Senior Occupational Therapist who provides clinical support and advice to help people reach the most independent outcome
- ✓ simplified and structured paperwork to ensure the right support is provided at the right time
- ✓ Care Navigators in GP practices in North Kent has resulted in a 90% reduction in the need for GP appointments for people who are frequent attenders to surgery.

What’s different about phase three?



The third stage of our transformation programme is being delivered in line with our new strategy for Adult Social Care **“Your Life, Your Wellbeing”** and is focused on delivering a sustainable social care service for the future, while supporting and enabling integration.

Having completed our first two successful programmes of transformation, phase three is more complex and requires more involvement of other agencies.

We are focusing on services and pathways that involve interaction with partners in Health and other services and identifying innovative approaches that require the development and implementation of new models of delivery.

Phase three builds on the success of the first stages of our transformation and we have reflected on what worked well and what could have been better to inform our planning going forward.

Ongoing Challenges in our transformation – ‘A life, not a service’

One of our biggest challenges is to ensure people are at the centre of their care and live as independent a life as is possible given their needs and circumstances.

Although we have achieved significant savings and implemented more efficient ways to deliver our Adult Social Care services, we are not complacent and continue to face significant challenges as we move forward.

Through our transformation programme, we recognise that we need to continue to:

- ensure we are paying a fair and affordable price for our services and that we are confident about how we agree prices to keep people supported effectively across both residential and community services
- ensure our workforce is supported with the culture change needed to deliver transformation, maintaining high morale and minimising staff turnover
- work closely with the NHS to co-ordinate joint priorities, planning and sharing of data
- work with our homecare providers to ensure that there is sufficient capacity to deal with demand and to ensure that it doesn't compromise the effectiveness of enablement.

This will ensure we continue to deliver quality care that offers value for money for the future, that we improve social care outcomes within the constraints of a challenging financial climate and that our social care practitioners are supported by efficient and effective functions.

Kent's Sustainability and Transformation Plan (STP) - transforming Health and Social Care in Kent and Medway



We published our draft Health and Social Care Sustainability and Transformation Plan (STP) on 23 November 2016. The draft sets out in broad terms what we need to do to bring about better Health and Wellbeing, better standards of care, and better use of staff and funds, to meet the changing needs of local people for decades to come.

The STP has been developed jointly with the NHS, Social Care and Public Health leaders in Kent and Medway. It is the first time we have all worked together in this way and it gives us a unique opportunity to bring about positive and genuine improvement in Health and Social Care delivery over the next five years.

The draft plan builds on conversations held over several years with local people about the care they want and need, and has the patient at its heart.

However, it is work in progress - we are not putting forward concrete proposals at this stage. Instead, we are sharing our ambition for the future and our thinking on where we need to focus.

We will only be able to decide on and implement any changes following a period of engagement and consultation with local communities in Kent and Medway.

Health and Social Care Integration



‘Many people who need social care support also need health support. By working more closely together, people can get more seamless services, have better outcomes and we can help reduce costs.’

The number of people living with multiple, long-term health conditions is increasing. This is a challenge to Health and Social Care both locally and nationally, but also an opportunity for us to deliver services in a way that:

- improves outcomes
- improves experience of care
- makes best use of resources.

What is the Integrated Care Pioneer programme?

Kent’s Integrated Care Pioneer programme is a partnership including Kent’s seven CCGs, Adult Social Care, Kent Community Health Foundation Trust, Kent and Medway Partnership Trust for Mental Health, Hospital Trusts in Kent and

district councils. The partnership also includes the independent and voluntary sector and Healthwatch Kent.

The aim of the Integrated Care Pioneer programme is to make Health and Social Care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes

The programme has been running since 2013 and there are twenty five pioneer sites across England, all working on developing and testing new and innovative ways of joining up Health and Social Care to provide support and earlier treatment for people in their own home and communities.

In the last year the Pioneer Programme has achieved and focused on the following:



Design and Learning Centre for Clinical and Social Innovation

'Making out of hospital care safer for both citizens and the professionals.'

The Design and Learning Centre for Clinical and Social Innovation has been set up by the Kent and Medway Integration Care Pioneer Team in partnership with the NHS and Social Care to support how we transform and integrate Health and Social Care services across Kent and Medway.

The main focus of the Design and Learning Centre is to reduce frailty, develop safe new services and transform the Health and Social Care workforce by promoting independence and self-care, exploring digital technology and sharing innovative ideas and best practice.

Innovations are developed in partnership with clinicians, care professionals, residents, industry, innovators, local academic institutions and extensive international collaborators who include Denmark, Sweden, Holland, Scotland, USA and Japan.

The aim is to develop innovative solutions, at the right time to support people to live independently and meet local community challenges. This will help to create safer **'out of hospital'** solutions to reduce the pressure on both Health and Social Care services.

Where is the Centre based?

The Design and Learning Centre has a modern office at Discovery Park in Sandwich set up with technology to enable virtual working and networking across local NHS and Social Care sites rather than in isolation.

The Centre sets out to enable new ways of working by co-designing and evaluating sustainable solutions to meet the changing needs of a growing population, incorporating the new models of care such as vanguards and GP federations.

The projects that the Design and Learning Centre is leading or supporting:

Impact Framework for Preventative Services

This involves the development of an outcome framework for voluntary sector preventative services through an online database. This is a unique model for voluntary sector services.

Microsystems Leadership

Clinical microsystem aims to improve the quality and value of care provided in primary care in the West Kent system through the development of team coaching with patients. This builds improvement capability at the front line with knowledge, processes and tools which the team learn and can re-use.

Integrated Community Healthcare Centre

This prototype will enable people to have their acute clinical care met in the community, reducing the need for acute hospital beds whilst making local primary care more sustainable. This prototype provides an environment where patients would choose to have their acute clinical needs met that feels like an extension of their home rather than a hospital – **"Home from Home"**

Push Project

This is a resuscitation aid developed by the Kyoto European Centre, London. We are looking at rolling this out with Kent schools.



International Collaboration

The Design and Learning Centre has formed international collaborations and submitted a range of bids:

- 2 Seas Buurtzorg bid – This bid has been successful and the program of work will start in October 2017
- European Partnership Active Healthy Ageing – B3 action group integrated care
- MOUs Scotland, South Denmark, Jonkoping
- Kyoto University
- 2 Seas bid: Innovation Labs and Community Engagement with Belgium, Netherlands and France.

The Esther model - Learning from Health and Social Care in Sweden

What is the Esther model and who is Esther?

The Esther model, which originated in Sweden, is inspired from one patient's experience (Esther) and was developed by Health and Social Care staff who work with people who need care and attention from more than one Health Care provider.

Esther was a real person who became unwell with serious heart failure and was admitted to hospital. There were delays in diagnosis, treatment and care planning. Overall the experience that Esther had was not good and the staff involved in her care recognised that there was a different way of doing things that would lead to better outcomes, higher quality care and efficiency.

Supporting the Esther principles

'Every person that works in Health and Social Care is important to the ESTHER experience, from care workers, cleaners, nurses to social workers.'

Esther could be a female or male, old or young; Esther is simply a person who needs care and attention from more than one Health Care provider.

The ESTHER principles are about asking **'what matters to ESTHER?'** instead of **'what is the matter with ESTHER?'** ESTHER Coaches are specially trained members of staff, known as 'Esther Improvement Coaches' who help to develop the quality approach that underpins these principles and they share knowledge and tools within their teams. To date we have trained 32 coaches.

What is ESTHER to me?

"ESTHER is "one" and not one size fits all"
Jacqui Cole, ESTHER Coach, KCC

In Thanet, twenty people from different care organisations completed ESTHER coach training to gain a deeper knowledge about improvement work and they were able to implement practical improvements, either within their own team or across Health and Social Care organisations. Examples included having a plan for hair care for a bedbound lady to ensure 'ESTHER'S wellbeing' and identifying the 'correct care placement for ESTHER' with her care-coordinators so she didn't bounce around the system from one service to another.

"ESTHER is quality care that starts with the question "what changes do you want?"
Sarah Mitchell, ESTHER Coach, Kent Community Health Foundation Trust

Training is underway for our fourth cohort of ESTHER coaches and we are currently focusing on the team linked to the pathway from hospital discharge to Broadmeadow Registered Care Centre and then home or community support within the home.



We are asking ESTHERS and staff to share their own experiences of moving through the pathway now and will highlight the improvements made to the pathway once the ESTHER training has ended and the coaches have the knowledge of the tools to continue implementing the ESTHER principles within the pathway and their own teams and organisations.

To support the roll out of ESTHER, Roadshows were held across East Kent where ESTHER Coach Trainers visited a range of sites including care homes, hospitals and offices to raise awareness and to identify ESTHER Ambassadors. Following the roadshows, there are now 92 ESTHER Ambassadors.

Four ESTHER cafes have been held so far. The cafes give people the opportunity to hear about the experiences of ESTHER's with services in their areas including access and signposting.

Planning is underway to hold future ESTHER cafés with ESTHERs invited to join a range of Health and Social Care professionals to share their stories and experience of care with the aim of working together to improve experiences in the future.

Buurtzorg

Buurtzorg is a model of care that was founded in the Netherlands by Jos de Blok in 2006, the literal translation of Buurtzorg is "neighbourhood care". The core principle of the Buurtzorg model is that nursing teams are autonomous and self-managing, teams are intentionally small with each team having a maximum number of 12 nurses and they work with a smaller number of patients than UK community nursing teams. This model has expanded over the globe with teams forming in Sweden, Japan, the USA and UK.

A pilot project is underway to implement the Buurtzorg Model in West Kent around the College Road GP Practice. The aim of the Buurtzorg model is to change and improve the delivery and quality of home health care through leadership and collaboration with the community nurses. The nurses in the Buurtzorg teams are responsible for delivering both nursing and care, to support nurses in their observations and to work in a preventative way.

The nursing team in West Kent known as the "One Care" team have been recruited and have started to see patients and build their case load. As part of this pilot, a small Social Care element has been included to make it an integrated team.

Shared learning from the pilot project will help us understand how the model works in practice and lessons learnt will help inform future work linked to the Buurtzorg model.

Extensive partnership working has been ongoing for several months with a range of people from various organisations across Kent and Medway and with European partners to work on Interreg 2 seas bid based on the Buurtzorg model.

We have been successful in obtaining the bid and the focus of this programme of work is "*Transforming Integrated Care in the Community*"

This is providing us with the opportunity to explore the Buurtzorg model in more detail and for implementation projects to be tested against the agreed blueprint.

Medication management

This is the first challenge to the Design and Learning centre via the Design and Learning Centre Advisory Board and will be the first project to go through the Design and Learning Centre methodology.

Room for Life and Home for Life

Both the Room for Life and Home for Life projects were established under the Pioneer Programme and the Design and Learning Centre.

Following positive feedback and outcomes provided by the volunteers, further work to combine the outcomes and learning from the projects is underway and may support the future redesign of services.

Case Study

Sue and Bill's Story – being a volunteer for 'Home for Life'



Sue was one of our first volunteers for 'Home for Life' alongside her husband Bill and she described taking part as too good an opportunity to miss. Sue felt being involved was a good way to understand what is offered in terms of services and how these could meet her needs (as a carer) and Bill's as a user of Health and Social Care services.

Sue wanted to take part in the project to help identify and make improvements where things did not go well for them following Bill needing to access a range of services during a period when he was unwell.

After taking part, Sue felt she had achieved what she set out to do; she now feels more knowledgeable of the services that are available to her and Bill and she is in contact with people who can help them. However, Sue does feel it will be a challenge on both sides keeping information up to date.

Sue found having regular contact with a Personalisation Development Officer throughout the project to be the most beneficial as it provided her with support and reassurance; Sue felt she had someone on her side while navigating through the Health and Social Care system. Sue was also able to increase her knowledge and understanding of the services available to her and Bill using the menu of services and she found this to be invaluable.

Sue described the Personalisation Development Officer role as "**professional, helpful, empathetic and willing to support us**" at a time when it felt as though the world had put them on the side burner.

Sue described her experience taking part in 'Home for Life' as edifying and well worth looking into and she would definitely recommend it to others.

The key thing Sue took away from the experience was that no information is wasted and if she were to access services in the future, she would like to see a more personalised and individual approach especially in relation to questions that are posed to clients, carers and their families.

When asked to describe the experience of taking part in 'Home for Life', Sue defined it as 'useful, educational and empowering'.

Case Study

Muriel - experiencing the 'Room for Life'

Our latest volunteer, Muriel found her experience in the 'Room for Life' interesting and stimulating.

She liked being able to try out the different technologies and provide feedback on the flat, equipment and activities, all of which will inform the project moving forward. Being in the flat also gave Muriel time to reflect on her life and motivated her to think about changes she might make to improve her quality of life.

Although Muriel does a number of activities, she felt that she was 'stuck in a rut' and was keen to extend her social circle and mix with people with a broader age range.

Muriel is now considering joining a reading group and is also looking into doing some sort of voluntary work, possibly with the Cats Rescue or Dogs Trust as she likes animals. Muriel also attends the Falls Clinic which she has found very beneficial but staying in the Room for Life has motivated her to think about joining an exercise class once the Falls programme comes to an end.

During her stay, Muriel took the opportunity to look through the Directory of Services, and came across a number of organisations she thought could support her and people she knew to remain in their own homes as they got older. Muriel was particularly interested in Family Mosaic's Handyperson service as she was struggling with the steep step outside her front door and was also looking for someone to do some decorating.

The Directory of Services significantly increased Muriel's knowledge of community services and she felt 'it was great to have all the information in one place'. The project has benefitted greatly from Muriel's involvement and her valuable and constructive feedback will continue to help to shape the project.

Integrated Personal Budgets and the Kent Card

We continue to work in partnership with CCGs on integrated personal budgets as these are a useful way of giving people more ownership and control over their ongoing healthcare (as they get older or their needs become more complex). Recent figures show there were 76 active adult Personal Health Budgets in place for patients agreed continuing health care.

For further information on the integration of Health and Social Care in Kent and the work of the Integrated Care Pioneer Team, please visit www.kent.gov.uk and search Kent Integration Pioneer.



Access to Independence

Kent Enablement at Home (KEaH) and Access to Independence Project

What is Kent Enablement at Home?

Kent Enablement at Home or KEaH is a short term service which supports people to do more for themselves at home, by learning or re-learning skills to make an individual feel safe and happy in their own home. The service offers support that aims to encourage and enable people to lead as independent and fulfilling a life as they can, in the way that they want.

How does it work?

KEaH is not about doing things for people, it is about giving people the skills and confidence to complete daily living tasks for themselves.

Support may include help getting in or out of bed, washing, dressing, getting to work or being part of the community, providing Fast Track Equipment (basic pieces of equipment to make daily tasks around the home easier or the provision of Telecare – personal and environmental sensors in the home that provide 24-hour monitoring.

The KEaH Team have three key priorities:

- everyone should get the best chance to be independent through structured delivery of enablement
- everyone who can benefit from the service should have access to it. We should try our best to never turn someone away
- to deliver the support service users need efficiently and we should adjust our operational practices to best meet this need.



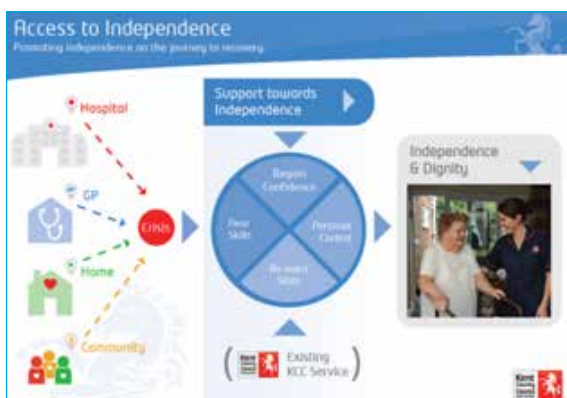
These priorities are met by:

- ✓ sharing best practices and knowledge between teams, introducing input from Occupational therapy, Case Managers and Purchasing Officer to help achieve best outcomes
- ✓ setting enablement goals which aim for the greatest level of independence possible for a service user
- ✓ actively managing the visit time with service users, ensuring they are working towards the end goal of enablement in a structured way
- ✓ providing visibility of visit lengths to enable the team to make more informed scheduling decisions
- ✓ reducing unnecessary service user visits by mapping and tracking a clear end goal to enablement and by managing the transition to increased independence for those whom have met their enablement goals
- ✓ providing visibility of service users progress
- ✓ highlighting and learning from the reasons why outcomes have not been achieved.

The success of the KEaH service in Kent has been recently noted in the latest national report issued by the Royal College of Occupational Therapists, "Living, not Existing: Putting prevention at the heart of care for older people", endorsing the value Occupational Therapists can bring to a variety of teams and projects across Health and Social care.

What is the Access to Independence Project?

The Access to Independence project, which was one of our key projects in phase two of our Transformation Programme, aims to give more time back to the KEaH teams, so they can provide more support to more service users - **promoting independence on the journey to recovery.**



Enablement is a key factor in maximising independence for the ever increasing number of service users who are able to benefit from its provision.

The project has focused on gaining a better understanding of how to improve outcomes for service users and increase their level of independence, through improving efficiencies in the way the service is delivered.

This has been achieved by ensuring that everyone makes effective use of all the tools available to them, enabling people to have the right support at the right time.

As part of the project, tools have been developed to assist in the allocation of

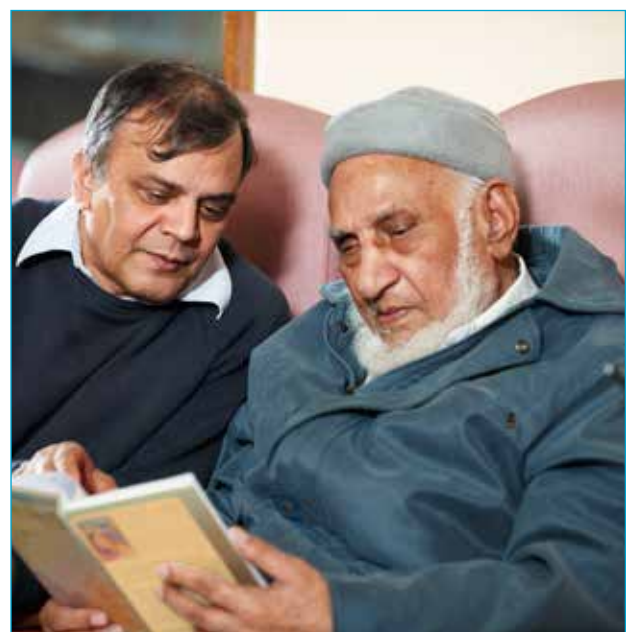
Enablement Support Workers and this has enabled resources to be more aligned to levels of demand, which has reduced the numbers of people who were not provided with enablement. This directly benefits a much higher number of service users across Kent.

Achievements

- At the start of the project, KEaH started an average of 172 individual per week. With improved efficiency, we now start an average of 196 individuals per week.
- 63% of individuals who are supported by KEaH achieve full independence, an increase from 50% prior to the project starting.
- Individuals who do require homecare support following KEaH need, on average just over 30 minutes of homecare per week compared to an average 1.6hrs of homecare support at the start of the project.



This has been achieved through improving practice within the service and effective joint working between KEaH, Case Management and Occupational Therapists who assess and work with individuals who use our services.





Outcome Based Care

During the Summer of 2016, a 12 week assessment was undertaken with practitioners and Home Care providers to better understand if different approaches and interventions could improve a person's outcomes and experience and help maintain their level of independence. We found around 61% of people (approximately 2,600 of our current home care users) could have benefited from professional led, outcomes focused care.

We have been working with a design team since February 2017 to co-design different parts of the pathway a person receiving homecare experiences.

What is the Outcome Based Care project?

The Outcome Based Care pilot started on 5 June 2017 with one of our current homecare providers; 121 Care and Mobility, who are delivering care within the Canterbury CCG. A Kent Enablement at Home (KEaH) supervisor and Occupational Therapist have been working with 121 Care and Mobility to identify whether people could benefit from a more enabling approach to home care. The pilot team are focusing on how they can support people to do things for themselves to help maintain and improve their levels of independence.

What progress have we made?

To date, the Outcome Based Care team have reviewed a third of the total number of people we will be working with during the pilot. We have identified that over 50% of the people reviewed could benefit from a different outcome and/or intervention. We will continue to work with people receiving care and support from 121 Care and Mobility moving towards outcome goals and identify barriers to achieving these.



What have we learnt so far?

We have identified:

- people are still coming into Social Care from a number of different routes, such as hospital, KEaH etc
- for some people, if outcome goals were met and sustained, social care involvement could reduce or end leaving a health only need e.g. input from pharmacy or district nurses
- there are opportunities to improve review processes between KCC and 121 Care and Mobility. This will help to improve decision making and reduce duplication
- some people could have their needs met by a voluntary agency instead of through home care
- multiple new referrals have been made to services such as Care Navigators, Multi-Disciplinary Health Teams, Equipment and Mental Health to support the delivery of outcomes
- for some people, we are working on wellbeing goals with the aim to improve the quality of care they receive.



What feedback have we received?

“I want to work with my care worker in this way to identify things I can do independently”

Person receiving a service from 121 Care and Mobility


“I like that you are helping Dad to make a sandwich for himself”

Family member of person receiving a service from 121 Care and Mobility

“When I see my client now he has a really sparkle in his eyes.... what an achievement!”

Member of staff employed by 121 Care and Mobility

Integrated Rehabilitation

 Clients who had received a service from KEaH and finished with a long-term Homecare package were reviewed to understand if anything could have been done to support these individuals to achieve more independent outcomes. The reviews were undertaken with Health and Social Care professionals including therapists and nurses.

The assessment found that opportunities to improve a person's outcomes could be achieved if Health and Social Care staff worked more closely together to improve the quality of short-term interventions and service delivery. The review found that:

- 16% of ongoing homecare hours could have been avoided through improved short-term interventions
- For 16-30% of people, there is an overlap in tasks delivered by both KEaH and Health's Intermediate Care Teams (ICT).

What is the Integrated Rehabilitation project?

The Integrated Rehabilitation project is exploring ways to bring KEaH and Intermediate Care Teams (ICT) together to create an integrated model of care and pathway. The project aims to:

- improve a person's experience of a consistent pathway and seamless, person centred rehabilitation service
- improve a person's outcomes and reduce their requirement for ongoing care by delivering a more effective enabling service
- minimise duplication of activity and effort between different professionals and services providing rehabilitation.

An integrated Rehabilitation pilot started on 5 June 2017 between KEaH and ICT in Ashford.

What have we learnt so far?

We have identified:

- 13% of people who are referred to KEaH or ICT are referred to both services
- most people who require input from both KEaH and ICT are referred to KEaH for managing their personal needs and to ICT for physio input
- the two services deliver similar rehab and reablement tasks, however there are also some specialist services such as processing Disability Facility Grants and Speech and Language Therapy.

Case Study



Canterbury resident Betty* had been in hospital for 4 months following a series of illnesses. At the end of her stay in hospital, she was weak and had lost confidence in her ability to live independently at home. Her family were anxious about her leaving hospital and going home where she would not have a full medical team around her.

However, Betty was supported by our enablement service and was able to go home and receive several calls a day offering her the support she needed.

Betty was determined to become independent again and be able to live a fulfilling lifestyle. The team worked closely with her to help her re-gain her confidence and re-familiarise herself with independent living. An enablement supervisor and occupational therapist created a support plan with Betty to help identify key goals that mattered to her to allow her to get back to where she was before hospitalisation.

With this structured work, she was confident in gradually reducing her calls from 4 to just 1 a day.

After 3 weeks with the enablement service, Betty achieved all her goals and left the service, completely independent.

*Name, details and image have been changed to protect identity

Promoting well-being

Promoting independence

Supporting independence

Sensory and Autism Services

Kent Adult Social Care has its own specialist unit for sensory impaired people (d/Deaf, sight impaired, deafblind) and individuals with an autistic spectrum condition. The unit comprises both in-house teams and voluntary organisations: Hi Kent (see Glossary) the Royal Association for Deaf people (RAD - see Glossary), Kent Association for the Blind (KAB - see Glossary) and Advocacy for All (see Glossary).

Specialist teams for d/Deaf and deafblind people merged in April 2015 to provide one county-wide Sensory Services team, based alongside a county-wide Autism team in Ashford. These specialist teams provide a number of services including information and advice, assessments, short term enabling help, safeguarding, personal budgets and equipment.

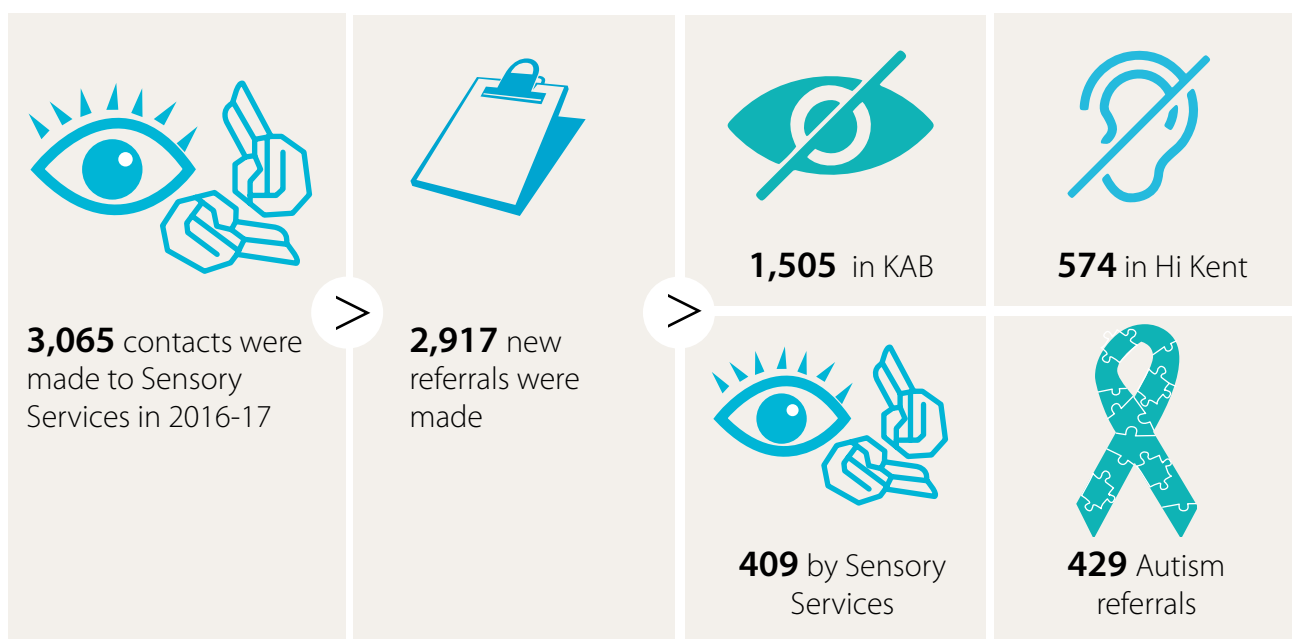
Hi Kent provides equipment assessment and provision for older people and a hearing aid maintenance service and has resource centres in Maidstone and Canterbury.

Kent Association for the Blind (KAB) provides assessments, rehabilitation training (mobility, daily living and communication skills training), registration as sight impaired and has resource centres in Maidstone and Canterbury. KAB also provides a Guide Communicator service – a specialist one to one support service for deafblind people.

The Royal Association for Deaf People (RAD) provides interpreting services for d/Deaf and deafblind people. The Unit manages this contract on behalf of a number of public agencies in Kent .

Advocacy for All provides 11 peer support groups for people with an autistic spectrum condition across Kent. People with autism come together regularly to help and support each other and the groups organise activities and speakers.

Headline figures





Developments in Autism

Strategy for Adults with Autism in Kent

The Strategy for Adults with Autism in Kent has been developed by the Kent Autism Collaborative taking into account the views of people with autism, their families and carers, professionals and voluntary organisations who work with people who have autism. A three month public consultation period was held and the strategy changed in the light of the feedback received.

Our vision is for people with autism to receive the right support at the right time, to be enabled to develop to their full potential and to be active and accepted members of their communities. At the core of this strategy is the desire to create an autism friendly society in its widest sense.

The strategy sets out the direction we are going to follow over the next five years to achieve this vision. It will form the basis from which more detailed plans will be developed.

KCC is committed to working in partnership with the CCGs to help improve services for people with autism and to take forward the implementation of the strategy. The top priority for 2017/18 is to address the need for a multidisciplinary diagnostic and assessment service and related specialist interventions and support services.

Public Health have also carried out some detailed work to understand the numbers and needs of children and adults with autism in Kent. This analysis will help inform the future planning of services.

The Strategy for Adults with Autism in Kent and the Autistic Spectrum Conditions Joint Needs Assessment are published on the kent.gov.uk website.

All Age Neurodevelopmental Pathway

KCC has carried out a project to consider the needs of children and adults with autism and developed an all age Neurodevelopmental pathway. The project involved survey work by the Tizard Centre with young people with autism and their families, mapping of current services, the identification of issues and gaps in services and developing plans to improve the current situation.

One clear issue that was identified was the lack of awareness of the help that was available. Two pathways have now been developed and published which describe the services and resources available for people with autism and their families. (These are published on the Kent.gov.uk website).

Two further projects are now planned to give detailed consideration to how best to address the social care needs of children and to review and redesign the team for adults with autistic spectrum conditions.

The Autistic Spectrum Conditions Enablement project

Kent's Specialist ASC Enablement intervention was granted social care research status from July 2015 to September 2016, and has been nationally accredited as good practice. The enablement intervention is an intensive, short term, targeted intervention which assists service users to regain, maintain or develop daily living skills and provide them with the confidence to carry these out to the best of their ability.

Specialist enablement takes place over a twelve week period and involves working one-to-one with service users on agreed meaningful goals, as identified by them.

The research project has been completed and the results analysed. There have been some life-changing results for some, especially around their increase in daily living skills, self-management, confidence, quality of life and self-esteem. There have also been benefits in the reduced costs of care and support packages.

This innovative project is proving to be of national interest and the team have written a book on their work shortly to be published by Jessica Kingsley (November 2017)

We have received lots of positive feedback from our Enablement interventions:

"It's all making me feel good about myself and not feeling such a mess or failure, it's helping me to function better with my life and this will most definitely benefit my family too."

"You cannot imagine the difference you have made to my son's daily life, I can't begin to say how much we appreciate it."

An Enablement case study

Jenny had a diagnosis of Asperger's Syndrome, and had recently recovered from a period of psychosis. Jenny had young children – one child being on the spectrum themselves and she was also a single parent.

She could be physically exhausted much of the time, due to disturbed nights from caring for the children and running a family home. This was additionally compounded by her sensory difficulties which she said made her feel agitated on a daily basis. Jenny also struggled with sequencing and planning tasks in her family routine.

Within her overall enablement intervention, Jenny was one of the first people in the UK to trial an interactive home white board, which allowed her to visually see time periods counting down throughout the day and allowed her to plan time and activities.

This aid helped Jenny to provide structure, increased her confidence and improved her concept of the passage of time, benefitting the whole family; indeed, Jenny states that her young son on the spectrum used to come down at night and not go back to bed – now he sees the Board's light is blue and goes back upstairs as blue means 'Night'. He sleeps better as a result and also checks the Board throughout the day to see how long he has to wait until an activity starts, improving his overall behaviour as he can predict upcoming events.

At the end of the enablement period, Jenny felt that she could cope without an ongoing support package.



Sensory Services

Development of an all age Sensory Pathway

In April 2016, the Children's Sensory team joined the unit. The children's team work with deaf, visually impaired and deaf/blind children and young people until they are 18 years old. Social workers with specialist knowledge and skills, including British Sign Language carry out a children and families assessment. A multi-agency care plan is then developed which identifies the needs and support required.

If the child/young person has complex disabilities including deafness, visual impairment or deaf/blindness, the team can offer specialist support and advice to families and other professionals.

Deaf Wellbeing and Access Project

People who are born Deaf or become Deaf during their early childhood are most likely to use British Sign Language (BSL) as their first language. The Deaf community has a strong and unique culture based around their language and identity as Deaf people.

Typically, Deaf BSL users have a marked reduction of opportunity to access services. To reduce the gap in equality between Deaf people and the hearing world, KCC Sensory Services have appointed a dedicated Deaf Community Worker for a one year pilot, working in the Thanet area.

Our Deaf Community Worker has been engaging with service providers to improve community access and is working hard to make a difference to BSL users in Thanet. It is expected that this exciting and pioneering approach will yield some excellent results, empowering the Deaf community to become more independent and reduce inequalities.

Sensory Services also has a dedicated Facebook page to help engage effectively with the Deaf community by various methods, including sign-language videos.

We are now developing an all age Sensory pathway, aligned with the changes taking place within the Lifespan Pathway project. We are working to improve young people's experience of transitioning from Children's to Adult services and to ensure better partnership working with agencies such as Education and Health

Case Study

Sarah who is deaf, was referred to Sensory C&F team when she was 13 years old due to concerns from her teacher. She had poor attendance at school, there were signs of self-harming and she was described as "not seeming herself, quite withdrawn, grubby and pale." Sarah was making no effort to engage in support services being offered at school.

Following a Children and Families assessment by a Social Worker in the Sensory team, she was identified as a Child in Need. Further direct work was undertaken with Sarah to explore her wishes and feelings about herself, home life, school and her identity as a deaf person.

A referral was made to Deaf CAMHS which resulted in a further diagnosis of autism which gave professionals a better understanding of the support Sarah needed.

Her mother had been struggling with parenting a teenager and was provided with support to understand her daughter's needs and provide the care Sarah required.

The result was that Sarah's relationship with her family improved and with a more positive self-esteem, the self-harming stopped. Sarah became more confident and started to attend school again. She attained the appropriate grades to transfer to college to study the Hair and Beauty course she wanted to do.

Promoting well-being

Promoting independence

Supporting independence

Integrated Community Equipment Service and Technology Enabled Care Services



Integrated Community Equipment Service (ICES)

ICES play a crucial role in helping us to support the most vulnerable people in Kent to remain in their own home. Through the provision of equipment, people are enabled to carry out everyday activities independently or are provided with equipment which supports them to be cared for at home.

We updated you in the last edition of the Local Account that we had commissioning a new service that would be more responsive to service users' needs and make the best use of our financial resources and a new contract started in November 2015. This was awarded to Nottingham Rehab Limited (trading as NRS Healthcare). The contract has been let in partnership with KCC and the seven NHS CCGs in Kent.

We also commissioned a new contract for a Digital Care and Telecare service that has brought together telecare installation and monitoring, service user support and staff

training under the responsibility of a single provider. This was awarded to Invicta Telecare Limited (trading as Centra Pulse and Connect) and is a KCC contract. Centra Pulse have been contracted to supply, install, maintain and monitor telecare alarms.

Both services reduce care home/foster care and hospital admissions and assists with timely discharge from hospital.

In 2016/17

- **92,761** service users were seen by the Integrated Community Equipment Service
- **164,133** items of equipment were provided to support the most vulnerable people in Kent to remain in their own home.

Our Kent Enablement at Home (KEaH) service has made good use of both services and the Occupational Therapists working in KEaH teams have been able to support better outcomes by assessing quicker and providing a wider range of specialist equipment to support our service users.

Update

584 people in Kent have received additional specialist equipment while they were being supported by the KEaH service. Clients have had the opportunity to practise and gain confidence in using the equipment with enablement support workers enabling people to continue to live independently at home for longer.

new

Safe and Well

Safe and Well is a service provided by NRS Healthcare which enables people who aren't eligible for social care to find out about getting personal equipment to support their independent living. The service includes free online self-assessment, local demonstration and telephone advice, links to Centra services (technology and Telecare), occupational therapist visits (fee charged) and a directory of trusted local suppliers

Further information on Safe and Well can be found at www.safeandwell.co.uk

County Technician Service

The team provide minor adaptations to the homes of adults and children across Kent ranging from simple grab rails to more complex ramping and other access solutions. The service is fully mobile and out about within the county with simple, minor adaptations provided within seven days with more complex work requiring further time to complete.

In the last 12 months the service provided 12,921 adaptations/ equipment to 8200 people. This work also included completing 1092 bathing assessments.

The Kent Blue Badge Service

Between April 2016 and March 2017, we received 29,671 Blue Badge applications and issued 28,019 badges - the highest ever number issued in a year.



Bob's story

"Bob* has a degenerative condition that affects the nervous system, this affects his co-ordination, mobility and more recently the ability to use his hands to grip/ pick up items; Bob is unable to use a telephone to call for help.

Bob is unable to transfer independently; he is a wheelchair user and has had recent falls when attempting to self-propel in his wheelchair. The provision of Telecare equipment has meant that Bob's wife can now go to the shops knowing that if he has a fall, she will be notified. Prior to the provision of Telecare, Bob's wife would 'time' herself at the shops and admitted to completing her weekly food shopping in 30 minutes.

Since the provision of Telecare she has stayed out for a couple of hours secure in the knowledge that she will be notified if there is an incident. The provision of Telecare has reduced carer anxiety and the risks associated with Bob having a fall when alone. Equipment provided has included a smoke detector, Reach, Key safe, wrist worn IV intelligent, Touch Pendant aid (easy press)."

**Name, image and details have been changed to protect identity.*



Peter's story

"We love it here by the sea. Being able to watch the sun rise and set is so peaceful and reminds you to appreciate everything you have."

Peter had a Centra telecare alarm installed at home to provide his family with peace of mind. He has a history of strokes and his wife Lee lives with a physical disability. They recently moved away from friends and family so Centra's services are more important than ever to the couple.

"After some encouragement from my family, I agreed that it would be wise to have some sort of personal alarm at home. We recently moved to Deal from Maidstone and knew that help from our family wouldn't be so readily available if anything was to happen to either of us.

It turns out that the decision to get a Centra Pulse alarm would save my life. In January 2013, I suffered a fall at home and couldn't get to my feet. I blacked out and don't remember a thing. Lee was unable to get me up. Luckily she could raise the alarm via the telecare pendant on my wrist which connects to the Centra Pulse call centre and they arranged urgent medical attention.

I was taken to hospital in a semi-coma and transferred to the renal unit after a few days where I remained for nearly three weeks. I was then moved to the rehab ward for 11 weeks while I learnt to walk again.



The doctor explained that I had been paralysed with myelitis which affected all my muscles and caused my kidneys to fail completely. The consultant told me that if I'd remained on the floor without medical attention for as little as 30 minutes more that would have been it, good night Irene!

Up until then, I had only worn my pendant when Lee left the house. Now I wear it all the time except in bed as recommended. Had it not been for the alarm I would have died that day. Lee goes on two holidays abroad and a long weekend away each year. Knowing I have my alarm, she can go away with complete confidence with the knowledge that help is there for me if I need it."



Shared Lives



We are always looking at different ways we can provide support and the Shared Lives scheme is just one example of how we're transforming the lives of Kent residents.

Shared Lives offers eligible people over the age of 16, placements within a Shared Lives family home for:-

- long term – living with a Shared Lives family on a long term/permanent basis where this is the person's main home
- short breaks – staying for a couple of days, a week at a time or longer if required
- day support – one session is up to 5 hours and can be any time during the week at the Shared Lives Host's home.

Shared Lives is about opening the door to choice, satisfying experiences and a sense of belonging whilst enabling people to keep their own independence.

As well as offering an excellent form of quality care and support, Shared Lives saves, on average around £26,000 per year, per individual, against the cost of residential care.

How does Shared Lives work?

Shared Lives is available to individuals with a wide range of care and support needs, such as older people, people with learning and physical disabilities, people with mental health issues, people on the autistic spectrum, people living with dementia and people with a sensory impairment.

Our experienced team work with the individual to match them with a suitable household. We match the person with a family who have the right skills and characteristics to give the care and support needed.

Shared Lives hosts could be a single person, a couple, friends or a whole family. Our hosts will also be that all important link to wider social experiences and the local community. Our hosts are thoroughly assessed, trained and monitored throughout their time with Shared Lives.

Over 220 people have accessed our Shared Lives service and we have many individuals in placements with hosts and their families.

We have also continued to recruit new hosts in all areas of Kent and the service now has nearly 170 hosts and their families for people that wish to consider Shared Lives as an alternative to living in a residential service or using other day services or short breaks units.

Further information on Shared Lives can be found on our website at www.kent.gov.uk/sharedlives, phone: 03000 412 400 or email: sharedlives@kent.gov.uk.



Case Study



Fred's story - Shared Lives and Telecare coming together!

Fred* was in a long term Shared Lives placement. He had been experiencing changes in his behaviour and it was necessary to consider creative solutions to help him and his Shared Lives hosts. Fred was becoming disorientated at night and this was having an impact on his hosts who were unable to get a good night's sleep and finding it hard to provide care and support the next day.

Telecare provided a solution with the installation of a bed sensor which connected to a lamp switch, helped him get out of bed safely, find the bedroom door and go to the toilet during the night. Once Fred had been to the toilet, there were concerns that he'd become disorientated and be at risk of falling.

A passive infra-red sensor was installed close to a base monitor and set to a constant beam. When the sensor was activated, it would link to a voice recording of one of the hosts who reassured him to return to bed. In the instance that Fred did not return to bed, the sensor would alert the host, waking them up via Care Assist, a bleep alert, so they could support Fred when he needed it most.

These installations helped Fred remain independent at night and meant his hosts could get a good night's sleep, helping them to maintain the quality of support provided during the day.

A pilot study was completed with other Shared Lives placements and it was found that within one year the use of Telecare demonstrated a cost saving on average of £46,798pa compared to adults with the same support needs living in residential care settings. In addition the placements that had Telecare equipment installed were sustained going forward to help with overcoming disturbed nights.

**Name, details and image have been changed to protect identity.*

Douglas's story

Douglas was 52 and living with his elderly father. Douglas had put on weight, due to lack of exercise and rarely left the house.

His family initially decided that he would be moved to a residential home. However someone mentioned that he may be suitable for Shared Lives and he was referred across. His brother initially was not happy with the idea that he would move in with another family but met the host family and decided to give it a go.

Douglas moved in with Rod and Lee and has been living with them for 2 years, along with another Shared Lives user called Noel. Over this time, he has lost 5 stone, has developed a love of walking the dog, is often out of the house and uses the bus system all on his own.

Douglas is now involved in trampolining, cricket, he works at the local stables and has been on holiday for the first time in 20 years. With Rod and Lee's consistent and continuous support, he has transformed into a more independent and crucially a happier person.



Douglas's brother now thinks that Shared Lives is the best thing that could ever possibly have happened to him. By sharing their life, Rod and Lee have radically change Douglas's life for the better.

Promoting well-being

Promoting independence

Supporting independence

Your life Your home - supporting people to choose their home



In 2016 there were just over 1200 adults with a learning disability in residential care across Kent and a significant number of these adults could lead more fulfilling independent lives by moving from Residential Care to Supported Living.

Supported Living that may be more suitable is a flat with shared communal areas with other service users, shared housing or shared living with a family.

'Your Life Your Home'

The 'Your Life, Your Home' project was implemented in early 2016 and will run for a period of three years, with the aim of supporting both existing and future adults with learning disabilities to live in the way they want through:

- expanding the options for increased independent living available to Adults with Learning Disabilities through Supported Living and Shared Lives placements, and reducing the number of residential placements

- enabling people to have more control and lead a more independent life if they choose to, in line with government legislation as set out in Valuing People Now
- designing a sustainable set of processes and tools to facilitate moving Adults with Learning Disabilities who would benefit from moving from Residential Care to Supported Living.

Our aim is to provide the opportunity for people with Learning Disabilities to access new housing and support. Transfers are done slowly to minimise disruption and make sure the right housing is available.

What have we done so far?

Working with a 'Your Life Your Home' project team, we have rolled 'Your Life Your Home' out to all localities across Kent

We are engaging with people in residential homes and their care managers, to understand whether they would benefit from a move to Supported Living or Shared Lives.



133 people have already moved out of residential care through the Your Life, Your Home Project.

Supported Living accommodation is advertised on the Accommodation Register that has been developed as part of the project.

People that have moved, and their families and carers have fed back that their lives have improved and they are enjoying doing different things.

We are working with residential providers, housing providers and community support providers to understand future plans for new supported living accommodation, and inform providers of likely demand to stimulate new development.



Mental Health (MH) Your Life Your Home Pilot



Learning from the 'Your Life Your Home' project currently being delivered by the Learning Disabilities teams, we are working to support individuals with mental health issues currently in a residential care placement to live more independently.

This work is based on an assessment which took place at the end of 2016, which found there are a significant number of people who could be better supported in a community setting.

Working closely with practitioners from the Community Mental Health teams, Primary Care Social Work team and representatives from Policy, Performance and Finance teams, the existing process has been further developed in order to deliver the right outcomes for individuals being supported in a Mental Health residential placement.

A team of Social Workers and Social Work Assistants from both Primary and Secondary Care teams across the county is being brought together to deliver the project. They have started the reviews with individuals to work with those who are able to move into a community based service.

The project is due to be delivered over one year, supporting individuals who are able to be more independent and increase their wellbeing. In this time, we are also working with accommodation providers, as in Learning Disability Your Life Your Home, to develop the market for the future.

Promoting well-being

Promoting independence

Supporting independence

Kent Pathway Service



Enabling people with a learning disability to be more independent.

The Kent Pathways Service (KPS) supports young people and adults with a learning disability to become more independent by supporting them to develop their skills so they can do more for themselves.

The support provided (up to twelve weeks), is intensive and task specific for people to learn and develop skills at home and in the community such as daily living skills, community safety, learning to travel independently, preparing for work, college and finding daily and social activities.

The Service was originally designed and developed as a six month pilot in the locality office of Dover and Thanet. This was successful and KPS has now been implemented across Kent since April 2016.

From April 2016 to June 2017, 632 successful referrals have been completed increasing peoples skills and independence. This also has an impact on people's confidence and their willingness to try other new things.

How Kent Pathways Supports Individuals:

- to ensure continuity and build a successful working relationship, Individuals will work exclusively with a single Support Worker during their programme
- Kent Pathways programmes are bespoke and the frequency and timing of support will be flexible so that they best meet the individuals needs and Outcomes
- the rate of progression is individual to each person. Some will spend the first couple of weeks simply building a relationship with their Support Worker
- individuals and their Support Workers work in partnership to come up with **SMART** objectives so that they have realistic goals to work towards
- every three weeks, an informal review is held with the individual to assess progress towards the goals and to make any alterations to the support that may be required
- feedback is always requested after support finishes to continuously improve the service
- Care Managers and Social Workers are encouraged to consider the suitability of a referral to Kent Pathways Service at every assessment and review. They are closely involved in the entire process and regular feedback is provided by the Support Worker.

People really appreciate this service:

"I would tell other people to use the Kent Pathways Service!" Paul F.

Success stories:

Alan wanted to find voluntary work. After using the service he now works at Community Grow near Maidstone. Alan says, "I'm so exited about my job!"

Aaron wanted to be more independent on public transport. He can now do a whole journey on his own, Aaron says, "I'm very happy."

Supporting Mental Health and Wellbeing -Live Well Kent

Mental health problems can affect any of us at any time in our lives. For most people with mental health needs, the first place to get help is your doctor, who can often refer you to other professionals.

Some people need more intensive support. Most of these services are provided by Kent and Medway NHS and Social Care Partnership Trust (KMPT). Other services are provided by independent providers, voluntary organisations and others.

We have taken a proactive approach to improving the mental health and wellbeing of people of Kent.



Live It Well is a website that is designed to promote better wellbeing and mental health for all of the residents in Kent and Medway and to help people connect with support in their local communities. The vision for Live Well Kent is to keep people well and provide a holistic offer of support for individuals living with both common mental illness and severe and enduring mental health diagnosis.

The approach puts a greater focus on outcomes and engages people in innovative ways to achieve these outcomes, based on recovery and social inclusion principles. It offers a **“Life not a service ethos”** and builds resilience in communities through asset based approaches to community development.

Mental Health Facts

- One in four adults will experience a mental health problem at some point in their lives and one in six adults has a mental health problem at any one time. (*‘No Health without Mental Health’, Mental Health Strategy for England, February 2011*)
- Mental health is the largest single cause of disability in the UK.
- Mental illness is the largest single cause of disability and represents 23% of the national disease burden in the UK. It is the leading cause of sickness absence. (*Chief Medical Officer (CMO) annual report: public mental health, 2013*)
- Adults with mental health problems are one of the most socially excluded groups in society.

Key aims of the Live Well Kent Service are to:

- aid recovery and prevent relapse, improve health and social care outcomes for individuals with poor mental health and wellbeing
- reduce the stigma associated with mental illness
- connect people with their communities, ensuring they have access to the widest possible range of community support and services to meet their particular needs.

6,533 people have been referred to the Live Well Service since it was launched in April 2016.



“I didn’t think I’d ever leave my flat again”

For nearly a year, Nick (54) didn’t leave his home or speak to anyone. He’d been diagnosed with depression and had also developed agoraphobia.

“I went into a deep depression and never thought I’d leave my flat again,” he recalls.

Things began improving when Live Well Kent got involved. They put Nick in touch with Porchlight’s community inclusion service and

he began meeting regularly with a support worker called Gill. “I can honestly say Gill saved my life,” he says.

“She helped me build the confidence to go back outside for short periods. She was willing to sit and talk me through what I’d be doing which made it a lot less daunting. It was also nice having somebody to talk with again – it gave me back a sense of normality.”

Now, Nick attends a weekly coffee meet-up with people in similar situations. He also goes for a regular walks with Porchlight volunteer Rose.

“My confidence is coming back and the future is looking good. I still have bad days but I can always call Gill and she’ll help me.”

“If someone needs help, I’d tell them not to hesitate getting in touch with Live Well Kent,” says Nick. “It’s the best thing you could do.”

Mental Health in Kent

In Kent and Medway at any one time, there are around:

- 163,000 - 190,000 people with common mental health problems, such as anxiety and depression
- 60,000 people with severe mental illness, such as severe depression or post traumatic stress disorder
- 12,000 people with severe mental illness and longer-term needs, such as schizophrenia and bipolar disorder.

(Source: Kent and Medway Joint Strategic Needs Assessment for Mental Health, April 2009)

Further information can be found on the Live Well website at www.livewellkent.org.uk to make a referral please call 0800 567 7699 or email: info@livewellkent.org.uk

Carers in Kent

Carers Assessments

If you provide care and support to an adult friend or family member, you may be able to get more help to carry on caring and to look after your own wellbeing.

If you give unpaid care to someone who is over the age of 18, you can ask for a carer's assessment.

'Caring' for someone covers lots of different things, including:

- helping with their washing, dressing or eating
- taking them to regular appointments
- keeping them company when they feel lonely or anxious.

If this sounds like you, you are a 'carer'.

You can have a carer's assessment even if the person you care for does not get any help from the council, and they will not need to be assessed. You also don't need the permission of the person you are caring for to request a carer's assessment. You are entitled to ask for one in your own right.

However, you can request a combined assessment - where you will be assessed at the same time as the person you care for has their needs assessment.

The Kent Carer's Emergency Card

The Kent Carer's Emergency Card is a credit sized card to carry with you at all times if you have caring responsibilities. The card has a unique registration number on it and a telephone number for our 24-hour service. If you are suddenly taken ill or have an accident, anyone with you can call the number on the card and our staff will use the registration number to carry out a pre-arranged emergency plan.

Headline figures



152,000 people (10.4%) of Kent's total population estimate they provide unpaid care.

64% of all unpaid carers in Kent estimate they provide less than 30 hours of unpaid care a week.

24% of Kent's residents who provide unpaid care estimate that they provide care for 50 hours or more a week.

You can apply for the card if you live in Kent, are over 18 and care for someone else. The card is free of charge.

A break from caring

Being a carer can be physically and emotionally challenging and it's important you have the opportunity to take a break from your caring role.

There are lots of ways you can take what we call a 'short break' from caring. This could be for a few hours, overnight, a weekend or longer. The person you care for will be looked after in a supportive, safe environment and perhaps enjoy new activities while you take some time for yourself.

There are different kinds of short breaks available, depending on the sort of needs the person you're caring for has.

Crossroads care can provide you with a break from caring if you are providing care or support to a family member or friend who is ill, elderly or has a physical or learning disability.

Volcare provide a respite service between 1 day and 2 weeks for carers who provide full time care to relatives in their own home. This service is available in Canterbury, Thanet and Dover districts.

Local carer organisations

If you give unpaid care to someone who is over the age of 18, you can get in touch with your local carer organisation for support.

Local carer organisations can offer you help, advice, training and support in your role as a carer. They can talk to you about your needs as well as the needs of the person you care for, and then let you know how they can help.

Our local carer services are run by different organisations for each area of Kent.

Case Study

Joan's story



Joan* is 70 years old and cares for her husband, Sid*, who has Parkinson's disease. Joan's grand-daughter takes her shopping twice a month and this is often the only time Joan has to herself, away from the home.

Joan had no other support and was struggling to cope.

She said ***"I feel angry. I want to be able to cry but the tears won't come, so I just get even angrier. I am stressed and not sure how much more I can take. I feel I want to walk out of the door and not come back."***

Joan's case manager explained that she was entitled to support and that she could have a carers assessment and referred Joan to Involve Carers. During the visit from Involve, Joan explained her sleep is continually broken by Sid. When Sid has a fall, she struggles to help him back up, putting strain on her back.

Joan said she would love to spend a few days visiting her brothers in Nottingham, but can't leave Sid. One of her passions is gardening, but as Sid doesn't like Joan to leave him, she is

rarely able to do this and said the garden is so overgrown she would need some help to make it manageable.

Since Involve's visit, Joan has been referred to Crossroads Crisis service and agreed 3 3-hour visits per week, plus an overnight sitting service once a fortnight.

She's been put in touch with Maisie, through the Involve Keeping in Touch service and been referred for a volunteer to help with her garden. She has been given advice on what to do if Sid falls to protect both of them and been issued with a Kent Carer's Emergency for peace of mind should she be unable to care for Sid in an emergency situation. The Involve team have also liaised with Sid's case manager regarding respite so Joan can spend a few days visiting her brothers.

Two months on, Joan's reported feeling much more relaxed and calm. Her emotional well-being has improved - she is feeling less stressed, more able to cope and has also noticed Sid seems happier too. Joan said the Crossroads Carer in Crisis service had been a "Godsend" and being able to talk with Maisie every couple of weeks is "so reassuring - I don't feel so alone in my caring role anymore."

**Names, details and image have been changed to protect identities.*

Adult Safeguarding Unit

'It is everyone's right to live in a safe environment, free from harm. Adult safeguarding is about keeping people safe and protecting them from abuse and neglect wherever possible.'

What is safeguarding?

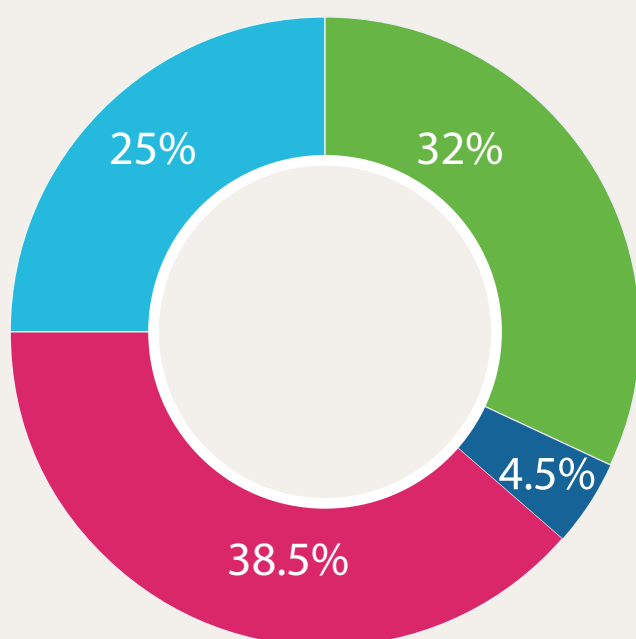
"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." Care Act (2014).

Abuse is a breach of a person's rights and may be a single act or happen repeatedly over a period of time. Abuse may be deliberate, but may also happen as a result of poor care practices or ignorance. It can happen anywhere.

Facts and figures

We have seen a significant increase in the number of Safeguarding Concerns received.

5,715 Safeguarding Enquiries were received during 2016/17 compared to 2015/16 when there were 3,906 (an increase of 46% when compared to the previous year). This is due to increased awareness of safeguarding and more robust reporting following the implementation of the Care Act 2014).



- 32% of Enquiries were not evaluated as abuse or discounted.
- 4.5% of Enquiries received ceased at the individual's request.
- 38.5% of the Enquiries had abuse confirmed or partially confirmed.
- 25% of the Enquiries investigated had insufficient evidence to confirm or discount them*. This is an increase from 2014/2015, where the percentage was 14%.

*This does not mean that no action was taken, but people were supported in other ways.



What should you do if you suspect or have witnessed an adult at risk being abused?

You should contact Adult Social Care on 03000 41 61 61 (social.services@kent.gov.uk) for Kent and 01634 33 44 66 (ss.accessandinfo@medway.gov.uk) for Medway. We advise against approaching the person directly.

If you wish to discuss your concerns outside normal office hours, you can contact the Out of Hours Team on 03000 41 91 91 for Kent and Medway.

If you think that someone may be at immediate risk of harm, you should contact the Police by calling 999.

Abuse or neglect can take many forms. The Care Act lists the following types of abuse and neglect.



The Kent and Medway Safeguarding Adults Board (see glossary) is a statutory service which exists to make sure that all member agencies are working together to help keep Kent and Medway’s adults safe from harm and protect their rights. The Board is chaired by an Independent Chair and meets 4 times a year.

The implementation of the Care Act places safeguarding adults on a statutory footing. Making Safeguarding Personal is an essential part of all our work as we always put the victim at the centre of the Enquiry.

Extensive work has been undertaken by KCC and multi-agency partners, many of them being led by the Kent and Medway Safeguarding Adults Board.

More information and the Kent and Medway Safeguarding Adults Board Annual Report can be found at: www.kent.gov.uk/social-care-and-health/information-for-professionals/adult-protection/kent-and-medway-safeguarding-adults-board

Comments, compliments and complaints



We welcome feedback on the services that we provide and on the services we arrange for people but might be provided by another care provider. Hearing people's views on the services helps us to identify where improvements are required as well as where things are going well.

We aim to provide a complaints service that is accessible and fair and we try to ensure the response to the complaint is proportionate to the issues being raised. A key part of the complaint process is to find a resolution to the issue giving rise to the complaint and provide an explanation if the service has not been to the standard we would expect.

Each year we analyse the complaints and enquiries that we have received to identify any lessons we need to learn and need to communicate to staff.

In 2016-17 we received:

- 649 Complaints
- 362 Enquiries
- 430 Compliments.

Of the Complaints:

- 181 were not upheld
- 198 were partially upheld
- 199 were upheld
- 33 were withdrawn
- 19 were passed to other teams
- 15 other.

Some of the main reasons for complaints included:

- Communication issues
- Disputed decisions
- Delays
- Charging disputes
- Quality of Care issues.

The key themes and issues arising from complaints are anonymised and discussed at management meetings and at the Quality and Practice meetings for practitioners. Some of the topics covered in 2016/17 included:

- A number of complaints included reference to the difficulties some service users experienced in communication with the service. There was a reminder to staff of the need to keep service users, and where appropriate the relatives/family members informed of any key changes (for example following a review or a reassessment). Some of the complaints related to safeguarding where families did not feel they were kept sufficiently informed. The national "Making Safeguarding Personal" initiative has helped to address this, along with the production of Kent specific information leaflets for individuals affected by safeguarding.
- Charging for services also gave rise to some complaints. There is a charge for many of the care and support services provided and financial assessments are completed to determine how much someone will have to pay, if anything, towards the cost. In the past, there have been complaints that some people were unaware that they would be

charged or how much the charge would be. A charging booklet has been produced with information about charging (one booklet for care in the home and another booklet for residential and nursing home care). In addition to the booklets, a letter is often provided with further information about the charging arrangements.

- A complaint about "Protection of Property" led to an update to the Protection of Property policy. Protection of Property is relevant when a service user moves into accommodation such as a care home and they are unable to deal with their own property and there is no one else to do it on their behalf.
- Some of the complaints received were from, or on behalf of, individuals complaining about the quality of care provided by care providers. These complaints are shared with the commissioning service so that they can be taken into account as part of contract monitoring visits to address any concerns that have been raised.

Feedback from service users and carers helps us to improve our services and people are entitled to complain if they are not happy with the service they have received. A person can complain on their own behalf or with the help of someone else such as a relative, carer, friend or advocate. We may need to seek consent from an individual if someone is making a complaint on their behalf. A member of our complaints team can assist if help is needed in making a complaint or if an advocate is needed.

The Kent Adult Social Care "Have Your Say" leaflet provides more information about the Adult Social Care complaints procedure and further information can be found on the Kent County Council website.

Compliments

We also welcome compliments when people make contact to commend the service or the work of an individual. Set out below are a few examples of the compliments we have received over the past year.

"Thank you simply isn't enough to say how much we appreciate the care and kindness you have shown our mum."

"I am writing to thank you for the dedicated care your team gave mum when she was desperately ill recently. The care your team gave our mum was just incredible; we do not believe she would have survived and be alive today without your teams."

"We would like to thank everyone for their assistance and great service."

"I am completely satisfied with the support and help that we got from the direct payments worker. She is very good at her job, is very knowledgeable about helping and knows how to put you at ease."

"We are extremely pleased with the grab rail and half step completed yesterday, not only by the quality of the work but also with the short time frame in which the work was completed."

New

Learning Disability Alliance Arrangements



Building on the strong history of collaborative working in the Adult Community Learning Disability services, KCC is now working in a formal Alliance Arrangement with its partners, Kent and Medway NHS Partnership Trust (KMPT) and the Kent Community Health NHS Foundation Trust (KCHFT).

The providers of the community Learning Disability services and the integrated commissioning team for Learning Disability are working together to achieve the following outcomes:

- improved quality of life through increased choice and control, greater independence and living free from abuse;
- increased life expectancy through reduction of health inequalities, better preventative care and avoidance of crisis escalation and parity of services;
- better patient/client experience through reasonable adjustments, person-centred practice and a skilled, competent workforce;
- increased support for the whole system development through ensuring a sustainable integrated service which will work with other providers to help shape the “market” of support available to people with a learning disability.

The work streams and projects that will contribute to these outcomes are set out in the three-year Joint Commissioning Plan, which has been agreed by KCC.

The Alliance Arrangement will help to strengthen partnership working for the future, and together with the integrated commissioning arrangement between KCC and the CCGs will help to ensure a legacy of integration across the system.

Home Care Services

Home care services are provided by care workers to people in their own home, so they can be supported to live independently and can manage activities of daily living. Home care services are delivered by home care agencies on our behalf and are arranged through the Kent County Council Home Care contract.

The current home care contracts commenced on 3 July 2017 and will run for a two year period.

Strategic Commissioning manage the home care contracts, in close liaison with Adult Social Care and specifically Area Support Managers. We use intelligence gathered from teams, the home care specification and key performance indicators to manage home care agencies to deliver improving home care services.

Glossary

Assistive Technology: These technologies help you to maintain independence. Telehealth provides equipment and devices used to remotely monitor aspects of a person's health in their own home. Telecare can be a combination of remotely monitored passive alarms and sensors to maintain independence at home.

ASC (Kent Autistic Spectrum Conditions Team): This integrated specialist team aims to address the unmet needs of adults with autism, including those with Asperger's Syndrome, who do not meet the eligibility of Learning Disability services. The service is jointly commissioned by Kent County Council (KCC) and Kent and Medway NHS and Social Care Partnership Trust.

Audits: Regular audits will be undertaken by the police, Adult Social Care and Health, to determine where improvements can be made and ensure that policies and procedures are being followed.

Autism Collaborative: The collaborative is a collection of stakeholders including clients and carer representation, the local authority, Health and all the main voluntary and charitable organisations. The aim of the group is to examine services and ensure that they are meeting the needs of adults with autism. If not how the group might plan to meet any gaps in services. The Collaborative will draw together various pieces of work from all sectors in order to fully complete the Kent Autism Strategy.

Better Care Fund (BCF): The BCF, worth £3.8 billion, was announced by the Government in the June 2013 spending review. It is designed to support the transformation and integration of Health and Social Care Services, to ensure local people receive better care.

BME: Black minority ethnic residents in Kent.

Care Quality Commission (CQC): The CQC is responsible for the inspection and registration of services including care homes, independent Health Care establishments and the Shared Lives Scheme.

Clinical Commissioning Groups (CCG): This is the name for the new health commissioning organisation which replaced Primary Care Trusts in April 2013. CCGs make it easier for us to work directly with our partner organisations and make the best use of resources.

Countywide Safeguarding Group: This is a meeting for senior managers within Kent County Council chaired by the Director of Commissioning for Social Care, Health and Wellbeing. The group reviews safeguarding activity across the county to ensure that robust systems are in place to provide appropriate support to individuals who raise allegations or concerns about adult abuse.

Dementia Care Mapping (DCM): A set of observational tools designed to evaluate quality of care from the perspective of the person living with dementia.

Department of Health (DH): They lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, delivered with the compassion, respect and dignity they deserve.

Deprivation of Liberty Safeguards: Aim to prevent the unlawful detention of adults in hospitals and care settings who lack capacity to choose where they live and/or to consent to care and treatment.

Direct Payment: Cash payments to individuals who have been assessed as having eligible social care needs. The amount paid is less any contribution that is required by the individual following a financial assessment.

Domiciliary Care: These services can help people with personal care and with some practical household tasks to help them to stay at home and live independently.

Enablement: This is a short term, intensive service that can help you remain in your own home or regain independence if you have been ill or in hospital.

Good Day Programme: This programme enables people with learning disabilities in Kent to choose what they want to do during the day, evenings and weekends, have support when and where they need it, and be an equal citizen of their local community.

Hi Kent: A registered charity for deaf and hard of hearing people, who work in partnership with Kent County Council. Hi Kent carry out assessments of need for people aged over 65 years old, provide advice and a range of equipment.

KAB: A rehabilitation service for people who are blind or partially sighted in Kent. KAB aim to provide a quality service sensitive to the individual's needs to help them attain the highest levels of independence.

Kent Card: A secure way of receiving Direct Payments without the need to open a separate bank account. The card is a chip and pin visa card and works in the same way as a visa debit card. It can be used to pay a Personal Assistant (PA), makes record keeping easier and reduces paperwork.

Kent Health and Wellbeing Board (HWB): The Board lead and advise on work to improve the health and wellbeing of people in Kent. It does this through joined up engagement across the NHS, Social Care, Public Health and other services that the Board agrees are directly related. The Board aims to reduce health inequalities and ensure better quality of care for all patients and care users.

Kent Integration Pioneers: Aim to drive forward innovative ways of creating change in the Health Service which the Government and national partners want to see spread across the country. Kent is an integration pioneer.

Kent Wide Carers' Publication: An information booklet for carers about the range of support services available in the local area.

Mutli-Disciplinary Teams (MDTs): Joint teams between Social Care and Health that aim to minimise duplicate referrals.

National Transforming Care Programme: A programme of work led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH) to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition.

Occupational Therapy: This service provides assessment, advice, equipment and adaptations for disabled people living in their own homes.

Personal Budget: Money paid by Kent Adult Social Care to you so that you can arrange your own care and support services.

Promoting Independence Reviews: These assess your abilities and difficulties with managing every day activities. We will work with you to identify what you are able to do and what you hope to be able to achieve, in order to continue to live independently. The Promoting Independence Service helps you to maximise how much you can do for yourself, and regain or learn new skills before any decisions are made about your ongoing support needs.

The Royal Association for Deaf (RAD): A British charitable organisation who promote the welfare and interests of Deaf people. RAD provide employment and legal advice, host

activities and support groups for families with parents and/or children who are deaf or hard of hearing and also offer an interpreting service.

Safeguarding: Safeguarding is about protecting children, young people and vulnerable adults from abuse or neglect. The policy aims to tackle how adult abuse can be prevented through community cohesion, communication, good practice and to ensure that everyone is treated with dignity and respect.

Safeguarding Adults Board: The Board consists of representation by senior management from the council, CCGs, Police, carers, voluntary and private sector representatives. A range of these partners may be involved in an investigation/ Social Care enquiry regarding suspected abuse or neglect.

The Board also arrange serious case reviews (which became Safeguarding Adults Reviews under the Care Act) where there is concern that safeguarding arrangements could have been more effective.

Self-Neglect: This is described as “the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and wellbeing of those who Self-Neglect and perhaps to their community”.

Shared Lives: This scheme helps vulnerable adults who want to live as part of a family or household find somewhere suitable. It is similar to fostering, but for adults rather than children. Placements can either be on a short or long term basis or act as a stepping stone towards independent living.
www.kent.gov.uk/sharedlives

Telecare: Any service that brings Health and Social Care directly to a user (generally in their homes). It enables people, especially older and more vulnerable individuals, to live independently and securely in their own home by providing them with personal and environmental sensors in the home. These

remotely monitor over a 24 hour period and should something happen like you have a fall, a warning is sent to a response centre and the required help is sent to assist you.

Telehealth: is part of Telecare, but relates specifically to remote monitoring of a person's vital signs, including blood pressure, weight and blood glucose.

Transformation: Over the next four years KCC will be looking at how their existing services currently operate, the difference they make, and if there's a better way to do things. We will also bring services together to avoid duplication and improve efficiency, shaping them around people and place. This is known as Transformation.

Data Sources

- ONS mid-year estimates 2012
- PCIS population June 2014
- Health and Social Care Information Centre (HSCIC) website
- Office of National Statistics (ONS) website
- Direct Payment services report
- Residential Monitoring and Non Residential Monitoring services report
- KCC Annual return reports



Getting in Touch

There are several ways for you to contact us.

Telephone our contact centre

For non-urgent telephone calls, please contact us Monday to Friday between 8.30am and 5.00pm.

The contact centre is based in Maidstone and is open for business 24 hours a day, 7 days a week.

Telephone: 03000 41 61 61

Text relay

A text relay service is available for Deaf, hard of hearing and speech impaired customers and is available 24 hours a day, 7 days a week.

Text Relay: 18001 03000 41 61 61

Out of hours service

Not every crisis occurs during office hours. Kent and Medway Social Services provide for these times with our out of hours service that can offer advice, support and help to ensure that vulnerable people are not left at risk.

Telephone 03000 41 91 91

Calls from landlines are typically charged between 2p and 10p per minute; calls from mobile typically cost between 10p and 40p per minute.

Email and website

You can email us with queries or questions about any of our services or information.

Email: social.services@kent.gov.uk or see our website at: www.kent.gov.uk/careandsupport

For more information on the Local Account email: kentlocalaccount@kent.gov.uk www.kent.gov.uk and search 'local account'

This document is available in alternative formats and languages. Please call: 03000 421553 Text relay: 18001 03000 421553 for details or email alternativeformats@kent.gov.uk

