AGENDA

ADULT SOCIAL SERVICES POLICY OVERVIEW COMMITTEE

Tuesday 1st April 2008 at 10.00 am
Council Chamber, Sessions House
County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone: **(01622) 694277**

Tea/Coffee will be available 30 minutes before the meeting outside the Chamber

Membership (15)

Conservative (10): Mr J B O Fullarton (Chairman), Mrs A D Allen, Mr M J Angell, Mr J Curwood, Mr C Hibberd, Mr D A Hirst, Mr R E King, Mr P W A Lake, Mr M J Northey and Dr T R Robinson

Labour (4): Ms C J Cribbon (Vice-Chairman), Mr G Cowan, Mrs E Green and Mrs M Newell

Liberal Democrat (1): Mr S J G Koowaree

UNRESTRICTED ITEMS

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

The Committee has the option of breaking for lunch and continuing its business afterwards, if the weight of business dictates. The timing of the meeting will be determined on the day by the Chairman. All timings shown on this agenda are approximate.

A. COMMITTEE BUSINESS

A1 Substitutes

A2 Declarations of Members' Interest relating to items on today's agenda

A3 Minutes of the meeting held on 29 January 2008 (Pages 1 - 26)

A4 Chairman's Announcements

Presentation

New Performance Framework

B. ITEMS FOR CONSIDERATION

B1 Putting People First (Pages 27 - 64)

B2 Kent's Strategy for Later Life (Pages 65 - 80)

B3 Carers in Kent Report Recommendations - Implementation Plan (Pages 81 - 90)

B4 National Framework for NHS Continuing Healthcare (Pages 91 - 98)

B5 Adult Social Services Budget Monitoring 2007/08 (Pages 99 - 118)

B6 Equality Impact Assessments (Pages 119 - 126)

C. SELECT COMMITTEE WORK

C1 Select Committee - update (Pages 127 - 130)

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

Thursday, 20 March 2008

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

ADULT SOCIAL SERVICES POLICY OVERVIEW COMMITTEE

MINUTES of a meeting of the Adult Social Services Policy Overview Committee held at Sessions House, County Hall, Maidstone on Tuesday, 29 January 2008.
PRESENT: Mr J B O Fullarton (Chairman), Ms C J Cribbon (Vice-Chairman), Mrs A D Allen, Mr M J Angell, Mr G Cowan, Mr J Curwood, Mrs E Green, Mr C Hibberd, Mr R E King, Mr S J G Koowaree, Mrs M Newell, Mr M J Northey and Dr T R Robinson.

OTHER MEMBERS PRESENT: Mr N J D Chard (Cabinet Member for Finance), Mr L Christie, Mr M J Fittock, Mr K G Lynes (Cabinet Member for Adult Social Services) and Mr R J E Parker.

IN ATTENDANCE: Mr O Mills, Managing Director, Kent Adult Social Services; Mr S Leidecker, Director of Operations, Kent Adult Social Services; and Miss T A Grayell, Democratic Services Officer.

UNRESTRICTED ITEMS

1. Minutes of the Meeting held on 16 November 2007
(Item A3)

RESOLVED that the Minutes of the meeting held on 16 November 2007 are correctly recorded and they be signed by the Chairman. There were no matters arising.

2. Chairman's Announcements
(Item A4)

The Chairman congratulated the Managing Director of KASS and his team on the quality of the reports placed in front of the Committee.

3. Director's Update (Oral)

(1) Mr Mills reported that CSCI's annual report had been published that morning. This would comment on the eligibility criteria used by local authorities, mostly above 'moderate', and would be likely to use Kent as an example of good practice as we had kept our eligibility criteria as 'moderate'.

(2) He added that a Concordat had been published by the Department of Health in December 2007 to set out how the Department of Health and KCC, amongst other partners, would deliver the 'Putting People First' initiative. He undertook to send every Member a copy of the Concordat.

(3) In response to a question about self funders, Mr Mills explained that all applicants for care packages would have an assessment but had a choice of route thereafter, depending on the services required and their level of savings. If entering a home and having savings above £21,000, a service user would have to pay for themselves, but if accessing domiciliary care in the community, the KCC could arrange services for recipients to pay for themselves. He emphasised that, whatever support they were

ultimately entitled to, and however it was to be delivered, everyone should receive good information and be confident of the quality of the service being delivered.

(4) The Chairman announced that an oral update on the Queen Elizabeth Foundation Centre in Dartford would be made at the end of the meeting to allow local Members to attend and have an opportunity to ask questions.

4. Description of the Budget Setting Process

(Presentation by Mr S Leidecker, Director of Operations, and Miss M Goldsmith, Directorate Finance Manager)
(Mr N J D Chard, Cabinet Member for Finance, was present for this item).
(Miss M Goldsmith, Directorate Finance Manager, was in attendance for this and the following two items)

(1) Mr Leidecker and Miss Goldsmith introduced a series of slides which set out the timetable and process for setting and monitoring the KASS budget. *(The slides used in this presentation are attached to these Minutes as Appendix 1).* Mr Lynes, Mr Chard and Mr Mills also responded to questions from Members. Arising from the presentation, and in response to questions put by Members, the following points were highlighted:-

(a) The Budget Book had been presented in a different way from previous years. Specific grants, of which there were now very few, were shown differently. More detail on services was presented this year than in previous years, which meant that the changes in spending which would inevitably emerge over the year would also have to be shown and explained in ongoing monitoring.

(b) Area Based Grants would ceased to be ring-fenced, so there was no guarantee they would keep pace with inflation. Under Local Area Agreements (LAAs) agencies would work together to achieve better outcomes from the money invested. KCC was the accountable body for the allocation of funds. Services being delivered under Area Based Grants must be assumed to continue but there was no guarantee that they would all be able to be funded in the future. The majority of grants related to the delivery of key indicators for KASS.

(c) Members expressed the concern that continued “movement of the goalposts” meant that it was very difficult to compare like with like with each year’s budget. Changes this year reflected questions raised in previous years, but there were also changes this year in the way grants were allocated. KASS tried to present its budget consistently as far as possible but this year was the first year of three year comprehensive spending review. Monitoring of the budget was done month by month by cross checking forecasts against activity, and needed to keep step with the corporate financial timetable.

(d) KASS had to balance service needs with a very limited budget and faced some stark choices – limit the number of service recipients, change the method of service delivery or reduce the quality of service delivered. This choice presented an ongoing challenge.

(e) Under year one of the LAA, KASS was confident there would still be some level of flexibility to offset any underspends against overspends. There would always be a need for flexibility to make the most sensible use of the funds available and to minimise risk. Funding under the area based grant system was already mostly committed.

(f) A good workforce was vital for good service delivery, especially with the move towards personalised services. KCC would always prioritise the provision of a

quality workforce out of the money available, and impress upon other partners in the LAA the need to do the same.

(g) KASS operated a complex, well-tested and generally very accurate forecast and allocation process in its Business Plan. It was always difficult to predict expenditure over a long period of time, so changes in spend patterns, in response to changing needs, would inevitably emerge as the year progressed. The Committee would be kept updated on variances in spending against forecast by means of the quarterly budget monitoring report.

(2) Mr Chard added that officers had done an outstanding job this year in controlling and monitoring the budget. Other local authorities had not contained their Adult Social Services budgets half as well as Kent had. Mr Lynes emphasised that the CSCI annual report had highlighted that other local authorities had raised their eligibility criteria while Kent had maintained theirs as moderate. Kent Adult Social Services had an excellent staff team, which is why it performed so well and on budget. However, so much of future demand for service simply could not be predicted, and in addition to this, funding mechanisms were also changing year on year.

(3) RESOLVED that the presentation on the budget setting process be noted, with thanks.

5. Adult Social Services Budget Monitoring 2007/08
(Item B1 – Report by Managing Director, KASS)

(1) Mr Mills and Miss Goldsmith introduced the report and answered questions from Members. Points highlighted were as follows:-

(a) "Management action" covered a range of measures and included an assessment of staffing levels using the 'traffic' light system (red being critical), ongoing review of care provision via care packages to ensure best value for money and optimum use of resources, good housekeeping and minimising administration costs wherever possible. KASS had an ongoing culture of reviewing to optimise performance and minimise waste.

(b) Any adjustment proposed to a client's care package would only be made after consultation with the client, and with their consent. KASS ran a robust complaints procedure but officers were not aware of any complaints arising from such a review.

(2) RESOLVED that the projected outturn figures for the Directorate for the second quarter (to October 2007) be noted.

6. Budget 2008/09 and Medium Term Plan 2008/09 to 2010/11
(Item B2 – Report by Managing Director, KASS)

(1) Mr Lynes praised the excellent work of the KASS staff at headquarters and the frontline over the past year and said how proud he was of them and their work. He emphasised that, despite the £6m efficiency savings the Directorate had had to identify in the Budget report, at a time of great and increasing demand, both he and KASS remained passionate about service delivery and customer care and Members needed to enable them to carry on delivering an excellent service.

(2) Mr Lynes highlighted the achievements of the Directorate over the last year. Kent Adult Social Services was one of only four local authority Adult Social Services Directorates to retain 3-star status every year since the star ratings began, and had retained 'moderate' eligibility criteria for another year when most other authorities had not. Part of Kent's success was its excellent working relationships with partners in Health and the private and voluntary sectors and the joint working initiatives which were in place. KCC had been successful in a number of bids – the Urgent Care Demonstrator, Brighter Futures, POPPs and the Whole System Demonstrator – but it was important to bear in mind that money won via bids was time-limited. He expressed grave concern about the sustainability of these excellent schemes and initiatives once funding for the pilot schemes came to an end. The POC had also commissioned two Select Committees – Transitional Arrangements and Carers in Kent – whose excellent reports would guide and shape future service delivery.

(3) *Staffing Levels*
In response to a question put by Mrs Green, and concerns raised by Mrs Green and Mrs Newell, Mr Leidecker explained that it was difficult to give a detailed account of all staff vacancies being held across the County at any one time. Staffing situations in the districts varied, but he assured Members that no one district or team would be holding more than one or two care management vacancies at any one time. The Directorate operated a monthly traffic light system to monitor vacancies and sickness levels within each team. These are assessed by senior managers and used to inform recruitment decisions, with 'red' seen as critical. Mr Mills added that, to ensure maximum capacity, the four acute hospitals in the county, at which KASS care managers were employed in-house, were excluded from any management action.

(4) *Legal Costs of PFI arrangements*
In response to a question from Mrs Newell, Mr Lynes explained that KCC was working together with district councils on a PFI Initiative 'Better Homes, Active Lives'. As the time had approached for the final PFI agreement to be signed, some districts had become reluctant to share in the unknown level of risk ahead and so, to avoid jeopardising the future of the project, KCC had taken on a greater share of the risk.

(5) *Maximising Benefits*
In response to a question from Mrs Newell, Mr Leidecker explained that the likely savings to the KCC arising from maximising benefits for Kent residents was very difficult to estimate. KCC and its partners had initiatives in place to support Kent residents to claim maximum benefits available; Age Concern, for example, had started clinics to give benefit advice. Miss Goldsmith added that the Internal Audit were due to start an audit on maximisation of benefits. It was anticipated that this would evidence the effectiveness of the work being undertaken on this, and would also show up the effectiveness of the KCC's message. Pilot schemes between KCC and the Department of Work and Pensions (DWP) were in place, using DWP staff seconded to KCC. The problems of identifying and maximising benefits were attached only to existing service users. New service users would have their benefits maximised from the start of their involvement.

(6) *Domiciliary Care Charging*
In response to a question from Mrs Newell, Mr Mills explained that, once the new domiciliary care charges had been in place for a whole financial year, they would show up as part of the regular base budget and not as a "change".

(7) RESOLVED that the Budget proposals for the Directorate be noted and agreed, and Members' concerns (on staffing levels) expressed in paragraph (3) above be taken into account when preparing the final Budget for ratification by the County Council.

7. Six Monthly Performance Update and Annual Performance Review Report for Adult Social Care

(Item B3 – Report by Managing Director, KASS)

(Ms D Exall, Head of Performance and Planning, was in attendance for this and the following two items)

(1) Ms Exall introduced the report and emphasised that the Directorate was on good track, considering the budget pressures it was under. It was important for the public to be able to see clearly how well the Directorate was doing, so an easy-read larger type version of the star rating letter had been prepared, and emphasis had, as always, been placed on the clarity of the information presented. Points highlighted were as follows:-

(a) Members welcomed the announcement of the retained Three Star rating and congratulated officers on this achievement

(b) Kent would be in the highest band for the uptake of Direct Payments but would need to protect service users from being pressurised into using Direct Payments under personalised budget arrangements, and this view should be expressly robustly in Kent's response to the consultation. "Putting People First" offered maximum options with the aim of maximising control.

(c) Of the "Key areas for improvement", delayed transfers of care would be addressed by working with the PCTs and Acute Trusts, and the number of drug misusers sustained in treatment would be addressed via KCC's involvement in KDAAT, using information from partners such as the police. A recent change in the treatment route via the NHS and Mental Health Trust would help increase the number of misusers receiving treatment.

(d) With the publication of the Carers in Kent Select Committee report, this was a good time to develop a Carers' Strategy, and information on performance would make a valuable contribution to this.

(2) RESOLVED that the progress on performance to date be noted, and that the easy-read 'Key Messages' document be welcomed.

8. Active Lives

(Item B4 – Report by Managing Director, KASS)

(1) Ms Exall introduced the final version of the Active Lives document, which was being presented for the Committee's approval prior to ratification by the full Council.

(2) Ms Exall received Members' congratulations on the well-produced document, and commented that District Councils would need to pay attention to it as part of LAA arrangements, and it could be used to draw attention to Local Strategic Partnerships.

(3) One thing was highlighted which was not mentioned in the Active Lives document; continuing education. Education was a vital part of social development and so was of enormous value. Ms Exall agreed that this was a good point.

(4) RESOLVED that the final version of the Active Lives document be approved, to replace the previous Active Lives document in the Policy Framework, subject to it being ratified by the full County Council

9. Joint Strategic Needs Assessment (Adults)
(Item B5 – Report by Managing Director, KASS)

(1) Ms Exall introduced the report and explained that it was now a statutory requirement to undertake a JSNA, but Kent had already done some considerable work which was already influencing the Directorate's budget setting and strategic planning for next year. However, there was still plenty to do. A report would be published in April summarising the key issues arising from the data analysis, but the JSNA was really a process rather than a product. Modelling would be done district by district as social care needs varied greatly across geographical regions. Information used as the basis for an assessment was gathered from census returns and current activity levels, so was reliable, although any forecast or projection would have some margin of error. Modelling would therefore seek to estimate best and worst cases. In response to questions raised by Members, the following points were highlighted:-

(a) Members welcomed the JSNA, as changing lifestyles and care needs had received much coverage in the national media.
(b) Preventative work was vital and the population needed to be well educated on the need to take responsibility to look after themselves and protect their own health as well as how to access services when needed.
(c) Choice, independence and flexibility were to be applauded but inevitably carried a cost. Much of the current elderly population came from a generation that did not want to "make a fuss", but future generations would be more willing to make a fuss and demand a choice of service.
(d) The JSNA would have to have sufficient teeth to impact on PCTs' local development plans and the allocation of health funding.
(e) The Active Lives process had been vital in identifying issues which had then fed into the JSNA. Transport was a big issue, as people expected to maintain an active lifestyle way beyond their ability to drive themselves. There was a need to close the gap in provision between commercial providers, who necessarily concentrated on the most economically viable service provision, and actual needs. A strategy was in place to address all issues around maintaining independence, including transport.
(f) Inequalities in health care were still a major issue which would not necessarily be altered by the JSNA.

(2) RESOLVED that the information set out in the report be noted, with thanks.

10. Day Services for Adults with a Learning Disability – Value for Money Review
(Item B6 – Report by Managing Director, KASS)
(Mr D Watson, Business Change Manager, and Mrs M Howard, Director, Provision and Commissioning, were in attendance for this and the following items)

(1) Mrs Howard introduced the Value for Money report, which had been prepared by PriceWaterhouse Coopers, and highlighted its key findings, recommendations and the patterns of use it had shown up. The report had shown that Kent provided services for more service users than other local authorities but at a lower unit cost, and PriceWaterhouse Coopers were pleased with Kent's modernisation agenda. In

discussion, and in response to questions from Members, the following points were highlighted:-

(a) Members congratulated the Directorate on receiving a generally good appraisal, but some Members expressed the view that the comments made by PriceWaterhouse Coopers lacked the compassion with which service delivery of this type should be associated.
(b) Clients with learning disabilities placed in Kent by other local authorities were charged for service provision by Kent so did not draw services or funding away from Kent clients.
(c) The transition period between young people and adults was a key area to be addressed, as young people had higher expectations of service provision than did older people.

(2) RESOLVED that the Value for Money report on day services for people with learning disabilities, its key findings and progress, be noted.

11. Valuing People Now – From Progress to Transformation
(Item B7 – Report by Managing Director, KASS)
(Mr D Sowerby, Joint Director, Learning Disability, and Ms S Gratton, Head of Learning Disability Commissioning, Eastern and Coastal Kent PCT, were in attendance for this and the following items)

(1) Mr Sowerby and Mr Mills introduced the report and explained that Kent had the opportunity, until the end of March 2008, to comment on the Valuing People Now (VPN) proposals. Mr Sowerby set out how service provision for people with learning disabilities had changed through the 20th century, arriving at the production of the Valuing People strategy in 1999. VPN would now build on and develop further the Valuing People strategy, setting out four key priorities for action on which consultees were able to comment. Mr Sowerby said that, in his view, Kent's two key issues were leadership and accountability and organisational change. A presentation on these key issues would be made to the Cabinet in March at which people with learning disabilities would attend to speak to Members.

(2) Arising from the presentation, and in response to questions raised by Members, the following points were highlighted:-

(a) Mr Sowerby gave a definition of "learning disability" as severely impaired social functioning and severe intellectual impairment (e.g., the ability to handle new information or change) which developed before adulthood. This distinguished those with learning disabilities from people who had suffered similar impairments as a result of a car accident, for example, in adulthood.
(b) It was vital to encourage people with learning disabilities to engage with work as far as possible to develop their work skills and help them avoid the 'benefit trap'.
(c) A strategic board had been set up to look at the transfer of resources for people with LD from the NHS to the KCC, led by Miss C Highwood, KASS Director of Resources, and included the Directors of Finance from the two PCTs and Ms Gratton.
(d) Kent had placed 200 of its own people with learning disabilities out of the county, and 1,500 had been placed in Kent by other local authorities, for whom funding did not follow. Approximately 900 out of the 1,500 incomers were placed in Thanet, giving it a disproportionately high percentage.

(e) Members expressed the concern that the VPN strategy did not include any reference to education amongst its four top priorities, although good education facilities for people with learning disabilities were vital as they learn for longer. There had been more educational opportunities for people with learning disabilities years ago than there were now! Changes being made now should have happened years ago.

(f) In recent years, society seemed to have made very little progress in enabling people with learning disabilities to play a part in the community.

(g) Area Partnership Boards (examples quoted were Dartford and Maidstone) did engage with people with learning disabilities and had been addressing the issue of integration, and such a link could also usefully be included when drafting the Terms of Reference of the Accessing Democracy Select Committee. All Members could be informed of the arrangements for their Local Area Partnership Boards so they could access them and become involved.

(h) It was important to allow people with learning disabilities to lead change and for KCC to fit around their agenda, rather than the other way around.

(i) Work linked to "Learning Disability Awareness Week" in 2007 had highlighted that some people's attitudes to learning disabilities were very out of date.

(j) Sevenoaks Town Council was currently running a good initiative wherein local shop keepers who were willing to welcome and act as champions to people with learning disabilities would display a badge in their shop windows. People with learning disabilities who experienced problems or became distressed while out in the town centre knew they could go to a shop displaying the badge to receive support and understanding.

(k) There were a number of things KCC could and should do; address the transport issue by liaising with commercial bus providers, and establish a Kent Employability Forum to support potential employees with learning disabilities and employers seeking to take them.

(3) RESOLVED that the consultation process be noted and Members' comments and suggestions, listed above, be included in KCC's response to the VPN consultation.

12. What Makes A Good Day? – A Plan to Improve Days for People with a Learning Disability in Kent – Consultation Update
(Item B8 – Report by Managing Director, KASS)

(1) Mr Watson and Mrs Howard presented a series of slides and some short films, and outlined the consultation process and timetable. Arising from the presentation, and in response to comments and questions raised by Members, the following points were highlighted:-

(a) Members expressed concern about there being sufficient alternative options for activities for people with learning disabilities if a centre were to close under the modernisation programme. It might have been more helpful had the consultation asked "what stops us having a good day?"

(b) Service users and their families were understandably concerned about losing services when the present arrangements ended. Often any change was seen as being necessarily detrimental.

(c) Parents did not necessarily know what their children wanted and it was important to ensure that service users had the chance to put their own views as well.

(d) Change in service provision was an issue being experienced by all local authorities around the country. A major exercise to identify what service users want had been needed for a long time.
(e) There would need to be a range of options to allow choice. Some activities might only appeal to a small number of participants.
(f) Members found the answers received to the questions listed in the report were very moving. The KCC had let down previous generations, and must not let down them or others in the future once it have taken the time to ask their views.

(2) RESOLVED that the consultation process and responses to it, listed in the report, be noted.

13. Re-provision of NHS Accommodation in Kent
(Item B9 – Report by Managing Director, KASS)

(1) Ms Gratton introduced the report and explained there was a group of 170 people who had left long-stay hospital years ago to be accommodated in various provisions (e.g., group homes) in the community, supported by NHS staff. This NHS staff support would not continue beyond 2010 so alternative support provision needed to be found. New provision would make use of Valuing People Now and other initiatives for people with learning disabilities that Members had heard about in previous reports.

(2) New capital of £175m was being made available over the three years by the Department of Health to meet bids for funding made by PCTs. The schemes bid for under this funding would address updating of housing stock which no longer met residents' needs and the provision of new types of accommodation to meet identified needs. The contracts for new support arrangements would transfer from the NHS to the KCC.

(3) In discussion, and in response to questions raised by Members, the following points were highlighted:-

(a) Services currently involved in the change were mostly not registered with CSCI, so would need to register and meet CSCI standards, even if they would transfer to a new status in two years' time. The PCTs had been asked in their operational plans to make contingencies to cover possible additional costs incurred in meeting registration requirements.
(b) Bids had been prepared for a variety of types of accommodation. A housing assessment of the needs and wishes of the residents concerned had been undertaken to see if they preferred to move to rural or urban locations, nearer to their families, etc. The types of accommodation proposed in the bids would seek to match these needs as closely as possible.
(c) The group of 170 service users ranged in age from the 30s to the 90s but mostly were in the 40 to 60 age group. It was a finite group; no new service users would now join.
(d) Residents in the group concerned had different levels of involvement in their community. Some areas of the county had developed their residents' skills more effectively than others and given them more opportunities to integrate, while in other areas homes were more self-contained.
(e) Local authorities would take the lead for the future commissioning arrangements for all the group except those few who may have very specialised medical needs which the NHS would continue to meet.

(4) RESOLVED that the information on the commissioning plan contained in the report, and information given in answer to questions, be noted, with thanks.

14. Update on Select Committee Work
(Item C1 – Report by Overview and Scrutiny Manager)

(1) Mr Mills and Mr M J Angell introduced the proposal being put forward by the Directorate for a Select Committee to look into Autistic Spectrum Disorder. Such a Committee would be ground breaking as no other local authority had undertaken such a piece of work.

(2) RESOLVED that:-

(a) the successful completion of the work of the Carers in Kent and Gypsies and Traveller Sites Select Committees be noted;
(b) the work of the Transitional Arrangements IMG be reported to a future meeting of the of the Committee; and
(c) the proposal for a Select Committee Topic Review to cover Autistic Spectrum Disorder be supported and recommended to the Policy Overview Co-ordinating Committee on 14 February 2008 as this Committee's contribution to the ongoing Select Committee work programme.

15. Director's Update
(Mr L Christie, Mr M J Fittock and Mr R J E Parker were present for this item)

(1) At the end of the formal part of the meeting, Mr Mills and Mrs Howard gave an oral update on developments relating to the Queen Elizabeth Foundation Day Centre (QEFDC) in Dartford, and answered a number of questions put by the Committee and local Members who had attended for this item.

(2) Mr Mills explained that services at QEFDC were provided under contract to KCC. Under its modernisation programme, KCC was now aiming to provide more person-centred services. The proposals were currently at the consultation stage.

(3) Mrs Howard added that proposals for change had been put together with QEFDC staff to provide a range of alternatives. Proposals included the establishment of social network sites locally, accessible services in Dartford, Gravesham and Swanley, and relocation of gym equipment in a community centre so it would be accessible for all to use. Consultation with service users and centre staff to assess users' aspirations, needs and wants was ongoing, alongside an assessment of their eligibility to use Direct Payments to purchase services.

(4) Local Members reported a number of rumours, misleading and late information which had emerged locally, fuelling the anxiety of service users and their families, who were already fearful of the changes proposed.

(5) Responding to questions put to them by Members, Mr Mills and Mrs Howard explained the following:-

(a) As services at the Centre were not provided by the KCC, they were not subject to the County Council's established protocol for "closure or change of use of

premises". However, changes to the services would follow the spirit of this protocol, with extensive consultation taking place.

(b) What was proposed would give a wider range of services than was available at present. Although the building would eventually close, service provision and the funding which covered it would continue. The changes being made were a re-commissioning exercise, not a reduction in service.

(c) Results of the extensive of consultation through Active Lives For Adults had shown that many people had expressed a wish to be integrated in the community and to have a job, not to be segregated. Although the original aim of the Centre was to integrate its service users, for most this had simply not happened.

(d) KCC have made a commitment that all Centre users would be offered alternative services. It was possible that some may not meet the eligibility criteria which would be applied to the re-provision of services and would not qualify to use Direct Payments, but KCC had given a commitment that those that did not prove eligible would be able to access other parts of service in the community by other means. It was KCC's aim that no-one should be left without services. It was important that all organisations met their obligations under the Disability Discrimination Act and ensure disabled people had access to generic services. Although it could seek to influence the provision of services by others, KCC was not ultimately responsible for the delivery of services provided by other agencies.

(e) KCC had a responsibility to achieve best value for public money by making sure it benefited the greatest range of service users possible.

(f) The premises had not been sold, as had been reported in the local media.

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Budget Presentation – ASSPOC – 29th January 2008

Budget Setting Process 2008-09 to 2010-11

- Indicative budgets for all directorates 08-09 & 09-10 at County Council February 07
- During summer 2007, pressures are reviewed, and some budget alignments between directorates for staff transfers etc. made.
- Directorates work up savings options in order to balance to the indicative allocations already set.

Budget Setting Process2008-09 to 2010-11

- November 2007, POC asked to consider options for delivery of 3% efficiency savings.
- December 2007, provisional local government settlement received.
- January 2008, Draft budget proposals published.
- Late January - POC Papers.
- Early February - Cabinet Scrutiny

Budget Setting Process 2008-09 to 2010-11

- 6th February - Cabinet propose budget for County Council
- County Council – 19th Feb

KASS – Budget Setting Process 2008-09

- Feb 2007 – we had indicative budget allocations for 2008-09 and 2009-10.
- Spring/Summer 2007 – we reviewed the demographic growth calculations that were included in the earlier assumptions.
- Looked back at trends, and worked with planning and policy teams to estimate future growth.
- Areas and centrally run services also highlighted local pressures.

KASS – Budget Process 2008-09

- Pricing strategies worked on.
- September – Pressures were finalised (although small changes were made during subsequent months).
- November Savings plans were worked on in order to reflect efficiencies, and also to produce balanced budget against the indicative allocations we had.
- January – We are allocated our draft final budgets subject to County Council.

What happens next

- Finance work with SMT to consider allocation of growth (demography monies) across the services and geographical areas.
- Likewise savings will be allocated
- SMT agree final allocations – February.
- Local finance teams then work with area and service management teams to ensure that budgets are allocated by 1st April.

Historic Basis for budget allocation

- Zero based budget exercise undertaken in 1997-98 at LGR – was on commitment basis at geographical/district level.
- Incremental allocations made since, normally on a commitment basis.
- Analysis carried out to try and apply government formula at district level - this was applied over a 3 year period to the Older People's budgets, which primarily transferred budgets from West Kent to East Kent.

Historic Basis for budget allocation

- It was not possible to apply this for younger adults because the government funding formula did not really take into account disability related factors, but just population and benefits data that could be applicable for all adults under the age of 65.

Format of KASS Budget Book

- For 2008-09 the budget book is amended to include more detail, hence why the monitoring report for 2007-08 is different to the Budget Book.
- For that reason I will focus on explaining the new format.

Gross & Net Budget

- The Gross budget for KASS for 2008-09 is £448m.
- This budget is funded as follows:
  - Government formula funding £ 97m
  - Council Tax £ 202m
  - Area based grants £ 25m
  - Ringfenced specific grants £ 34m
  - Client charges £ 62m
  - Health Income £ 19m
  - Other income £ 9m
  - Total £ 448m

'Budget Book' explanation

- The budget book for 2008-09 is broken down into the 4 main client groups:
  - Older People
  - Learning Disability
  - Physical Disability
  - Mental Health

‘Budget Book’ explanation

- Under each client group, the following services are shown:
  - Residential
  - Nursing (Older People only)
  - Domiciliary
  - Direct payments
  - Supported Accommodation
  - Other services – which includes services such as daycare, transport, meals, OT Equipment

‘Budget Book’ explanation

- Other headings on budget book include:
  - Assessment & Related Services
  - Supporting People
  - Gypsy & Traveller Unit
  - People with no recourse to public funds
  - Strategic Management
  - Performance, Policy & Quality Assurance
  - Resources
  - Specific Grant Income

Gross / Income

- Within the budget book, the gross figures relate to the amount that we are actually spending to purchase services.
- The income figures relate to the external income that we are receiving, which is mainly as follows:
  - Client charges
  - Health Service funding
  - Other local authorities
  - Other government bodies (but not specific grants)

Gross Expenditure

- Approximately 85% of spend on services is purchased through external market and is driven by demand.
- Because of this, there has to be some flexibility around budget allocation against individual service lines as costs differ, and patterns of demand change.
- It will therefore be necessary during the year to vire (transfer) service budgets between service lines to reflect changing demands .
- Transfers do not usually take place between geographical areas after the budget has been set.

Client Charging

- Client charging is made for the following services:
  - Residential and Nursing Care
    - Clients are 'means tested' against legislation – 'Charging for Residential Guidance'
  - Domiciliary Care
    - Clients are 'means tested' against fairer charging guidance, and Kent's policy on charging is applied

Health Funding

- KASS receive approximately £19M of income from the Health Service in Kent:
- Joint funded services through a Section 31 Pooled arrangement such as intermediate care, integrated care centres, community equipment, RNCC etc.
- Individual clients who are either 100% health responsibility but whom we place on their behalf or clients who are joint funded, mainly learning disability clients.

Gross / Income

- Because of all of the complexities of demand and market driven services, and changing needs and complexities of individual care packages - alongside charging policies which are individually calculated this means that the gross and income budgets cannot be fully correlated. Virement between gross and income may be therefore needed.

Other Local Authority Income

- Although relatively small, this relates mainly to:
  - Cross boundary services to Medway following LGR
  - Other authority clients placed in our in-house homes

Other Government Income

- This includes government funding that does not traditionally come under the remit of a specific grant, but is usually through a bidding mechanism.
- Examples include:
  - Whole Systems Demonstrator
  - Brighter Futures
  - POPPS

Specific Grant Income

- In previous years specific grant income was shown against the budget book service line for which the money was spent against.
- In 08-09, any specific grant income is shown against a separate line within the budget book
- In 07-08 a number of specific grants were received. The majority will be funded as Area Based Grants or as formula funding through base.
- In both instances the income is no longer included within KASS budget.

Specific Grant Income

- The grants affected are:
  - Now transferred to base through formula
    - Delayed Discharges (Reimbursement) - £ 2.5M
    - Access & Systems Capacity - £13.4M
  - Remaining as specific grants
    - Social Care Reform (new 08-09) - £ 2.0M
    - HIV/Aids (08-09 figure awaited)
    - Supporting People - £32.0M
    - (this transfers to ABG in 09-10)

Specific Grant Income

  - Area Based Grants
    - Adult Social Care Workforce - £ 3.2M
    - Carers - £ 4.3M
    - Learning Disability Dev. Fund - £ 1.0M
    - Mental Capacity Act - £ 0.6M
    - Mental Health - £ 3.2M
    - Preserved Rights - £11.7M
    - Supporting People Admin - £ 0.9M

Preserved Rights

- This relates to those clients who were placed in residential care prior to 1993.
- At that time they were in receipt of a benefit - Preserved Income Support.
- Many of these clients were not known to Social Services, as they placed themselves, and their benefits covered the cost of their care.
- The exception to this was in respect of some Learning Disability clients, whereby Social Services were ‘topping-up’ the benefits due to the complex needs of the clients.

Preserved Rights

- In 2002 government ceased the benefit - preserved income support and transferred the funds via specific grant to local authorities.
- Each year the grant has reduced due to an element being rolled into base formula funding and assumed attrition
- We currently have approximately 1,000 clients under the category of Preserved Rights, of which are 700 are with learning disabilities.

KASS Monitoring Processes

- Although the Corporate monitoring requirement is that of a full report on a quarterly basis, we have continued to do full monitoring monthly.
- Reason – volatile demand led budgets – a lot can change in 3 months!

KASS Monitoring Processes

- Forecasts are undertaken at team/district level.
- Aggregated at area then directorate level
- Formal monthly budget monitoring meetings including finance and activity.

By: Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Services Policy Overview Committee – 1 April 2008

Subject: **PUTTING PEOPLE FIRST**

Classification: Unrestricted

Summary: Informs Members of this shared vision and commitment to the transformation of adult social care.

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1. Introduction

1. (1) 'Putting People First' is a landmark concordat between six Government departments, the Local Government Association, the Association of Directors of Adult Social Services, the NHS, representatives of provider organisations, the Commission for Social Care Inspection, and other partners. It was published in December 2007 and is attached at Annex 1.

(2) It sets out a shared vision for the transformation of social care, which is needed to cope with the demographic and other changes facing the nation, which ASSPOC has considered in the past.

2. Context

2. (1) 'Putting People First' builds upon the transformation of social care which was first signalled in the Green Paper 'Independence, Wellbeing and Choice (2005)', then strengthened in the White Paper 'Our Health Our Care Our Say (2006)'. It thus confirms the direction of travel, rather than breaking new ground. However, it is unique in having such breadth of sign-up, and this level of consensus over the vision for social care in the future is to be welcomed.

3. Key Points

- Development of a new personalised adult care system
- Reinforces the commitment to independent living for all people
- Collaborative approach
- Empowering people
- Need to win hearts and minds of all stakeholders
- Social Care Reform Grant to support system wide transformation
- Adult Social Care to take a leadership role
- Transformation will be delivered through the new performance framework (this is a separate item on the agenda)
- Universal information, advice and advocacy service
- Common assessment process with emphasis on self assessment
- Person centred planning and self-directed support mainstreamed

- Family and carers seen as experts and should be supported to develop their skills and confidence
- Workforce – new skills academy to support world class commissioning
- SCIE to promote, identify and disseminate best practice and innovation

4. Next Steps

4. (1) The government has also recently (January 2008) published a Local Authority Circular 'Transforming Social Care' which provides more details about how the transformation is to be achieved, including the provision of the Social Care Reform Grant. Parts 1 and 2 are attached as Annex 2. In Kent, the vision is already well understood – Active Lives is consistent with 'Putting People First'. We are already well advanced in planning how to deliver this transformation through the Active Lives for Adults (ALfA) change programme, the modernisation of in-house services, the Valuing People partnership groups, and so on.

5. Recommendations

5. (1) Members are asked to NOTE the content of "Putting People First".

Debra Exall
Head of Performance & Planning
Kent Adult Social Services
Tel: 01622 6115

HM Government

Putting People First

A shared vision and commitment to the transformation of Adult Social Care

Local Government Association

adass

NHS

Putting People First

A shared vision and commitment to the transformation of Adult Social Care

Introduction

The Our health, our care, our say White Paper and statements in the 2007 budget report and Comprehensive Spending Review announcement outlined the key elements of a reformed adult social care system in England; a system able to respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives.

Demography means an increasing number of people are living longer, but with more complex conditions such as dementia and chronic illnesses. By 2022, 20% of the English population will be over 65. By 2027, the number of over 85 year-olds will have increased by 60 %. People want, and have a right to expect, services with dignity and respect at their heart. Older people, disabled people and people with mental health problems demand equality of citizenship in every aspect of their lives, from housing to employment to leisure. The vast majority of people want to live in their own homes for as long as possible.

In the context of changing family structures, caring responsibilities will impact on an increasing number of citizens. Examples include an eighty-year-old woman having to cope with her husband's dementia, a young mum pursuing a career and bringing up a family while looking after her elderly parent, a business executive working overseas whose widowed mother is hospitalised overnight following a stroke and older parents seeking for the right support to ensure their adult son with a learning disability can live independently.

We agree that there is a need to explore options for the long term funding of the care and support system, to ensure that it is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual. As stated in the Comprehensive Spending Review (CSR) announcement 2007, the Government will produce a Green Paper following extensive public consultation setting out the key issues and options for reform. Notwithstanding the Green Paper on longer-term reform of the funding system and following the recent CSR settlement, there is now an urgent need to begin the development of a new adult care system. A personalised system which can meet the challenges described earlier and is on the side of the people needing services and their carers. While acknowledging the Community Care legislation of the 1990s was well intentioned, it has led to a system which can be over complex and too often fails to respond to people's needs and expectations.

This landmark protocol seeks to set out and support the Government's commitment to independent living for all adults. It also outlines the shared aims and values, which will guide the transformation of adult social care. It is unique in establishing a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. It seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage. It recognises that sustainable and meaningful change depends significantly on our capacity to empower people who use services and to win the hearts and minds of all stakeholders', especially front line staff. Local government will need to spend some existing resources differently and the Government will provide specific funding to support system-wide transformation through the Social Care Reform Grant, in line with agreements on new burdens.

We do not seek to prescribe uniform systems and structures in every part of the country. However, access to high quality support should be universal and available in every community. Some of these reforms can be made within the parameters of the local adult social care policies. Others require adult social care to take a leadership role within local authorities, across public services and in local communities.

Ultimately, every locality should seek to have a single community based support system focussed on the health and wellbeing of the local population. Binding together local Government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training.

This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens. The new local performance framework, which covers the delivery of all services by local government working alone or in partnership, will help to create an improved approach to local partnership, enabling local authorities and partners to work together to lead their area and better meet the public's needs. The transformation of adult social care will be delivered through the new performance framework, and will draw on new mechanisms within the framework, such as the new statutory requirement on local authorities and PCTs to undertake a Joint Strategic Needs Assessment, to ensure that the transformation process really delivers on the challenges for each local area.

In future organisations will be expected to put citizens at the heart of a reformed system. Incentives will include the new focus of the local performance framework, guidance on commissioning for health and wellbeing, Human Rights legislation, and any international obligations such as the new UN Convention on the Rights of Persons with Disabilities.

2 Values

Ensuring older people, people with chronic conditions, disabled people and people with mental health problems have the best possible quality of life and the equality of independent living is fundamental to a socially just society.

For many, social care is the support which helps to make this a reality and may either be the only non-family intervention or one element of a wider support package.

The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services. In the future, we want people to have maximum choice, control and power over the support services they receive.

We will always fulfil our responsibility to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. However, the right to self-determination will be at the heart of a reformed system only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse.

Over time, people who use social care services and their families will increasingly shape and commission their own services. Personal Budgets will ensure people receiving public funding use available resources to choose their own support services – a right previously available only to self-funders. The state and statutory agencies will have a different not lesser role – more active and enabling, less controlling.

3 A personalised Adult Social Care System

The key elements will be:

3.1 **Local authority leadership accompanied by authentic partnership working with the local NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.**

The current Darzi review of the NHS has recognised the relationship between health, social care and wider community services will be integral to the creation of a truly personalised care system.

3.2 **Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:**

- live independently;
- stay healthy and recover quickly from illness;
- exercise maximum control over their own life and where appropriate the lives of their family members;
- sustain a family unit which avoids children being required to take on inappropriate caring roles;
- participate as active and equal citizens, both economically and socially;

- have the best possible quality of life, irrespective of illness or disability;
- retain maximum dignity and respect.

3.3 System-wide transformation, developed and owned by local partners covering the following objectives:

- A joint strategic needs assessment undertaken by local authorities, relevant PCT and NHS providers. This should be undertaken in conjunction with other local needs assessments and plans (for example, local housing strategies). The joint strategic needs assessment and these other plans will inform the Sustainable Community Strategy. It will also be accompanied by an integrated approach with local NHS commissioners and providers to achieve specific outcomes on issues including:
  - relevant preventative public health policies, e.g. infection control and fall reduction strategies;
  - hospital discharge arrangements;
  - the provision of adequate intermediate care;
  - the management of long term conditions;
  - packages of support with a health and/or nursing care element;
  - co-located services, bringing together social care; primary care and other relevant professionals;
  - community equipment services;
  - universal information, advice and advocacy;
  - carer support and public/patient involvement;
  - complaints systems.

  The full range of relevant local statutory, voluntary and private sector organisations need to be fully engaged. Where appropriate, Local Area Agreements will be the vehicle to bring together national policy with local priorities, informed by the vision developed by local partners. This will mean organisations being willing to allocate funding to others, if this will have greater impact on shared outcomes. The NHS Operating Framework will reflect a new shared responsibility for the health and wellbeing of citizens, families and communities.
- Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users. Supports third/private sector innovation, including social enterprise and where appropriate is undertaken jointly with the NHS and other statutory agencies eg Learning and Skills Council, employment services, and Housing Authorities. This must be shaped by the Joint Strategic Needs Assessment.
- A locally agreed approach, which informs the Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm. Supporting people to remain in their own homes for as long as possible. The alleviation of loneliness and isolation to be a major priority. Citizens live independently but are not independent; they are interdependent on family members, work colleagues, friends and social networks.
- A universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding. A 'first shop stop', which could be accessed by phone, letter, e-mail, internet or at accessible community locations. Key strategic partners to be the Pensions Agency and relevant voluntary organisations. The LinkAge Plus pilots are providing strong evidence of the benefits for older people of this approach. Personal advocates to be available in the absence of a carer or in circumstances where people require support to articulate their needs and/or utilise the personal budget.
- A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
- Person centred planning and self directed support to become mainstream and define individually tailored support packages. Telecare to be viewed as integral not marginal.
- Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision. Lord Darzi's recent NHS next stage review interim report suggested that in the future personal budgets for people with long-term conditions could include NHS resources.

- Direct payments utilised by increasing numbers of people, as defined by locally set targets in LAAs.
- Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
- A transformed community equipment service, consistent with the retail market model.
- Systems which support integrated working with children's services, including transition planning and parent carers, and identifying and addressing concerns about children's welfare.
- Support for at least one local user led organisation and mainstream mechanisms to develop networks which ensure people using services and their families have a collective voice, influencing policy and provision.
- Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.
- Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors. Strategies to be co-produced, co-developed and co-evaluated with the private and voluntary sectors.

Adult social care will also take responsibility for championing the rights and needs of older people, disabled people, people with mental health needs and carers within the local authority, across public services and in the wider community. Early priorities will be intergenerational programmes involving older people as active citizens, integrated policy development which supports independent living (housing, access to work, education/training and leisure) including transition planning for young disabled people and local action to tackle the stigma faced by people with mental health problems.

4 Support for Reform

The Department of Health will provide funding over the next three years to support system-wide transformation in every local authority. Local authorities and their partners will agree together how this funding will be spent to develop the personalised system described in Section 3.

A detailed prospectus consistent with our core principles will be published in December.

In line with the soon to be published National Improvement and Efficiency Strategy (NIES), Department of Health (DH), will refocus the relevant activities of Care Services Efficiency Delivery Programme (CSED) and Care Services Improvement Partnership (CSIP) and seek partnerships with Regional Improvement and Efficiency Partnerships, local consortia, In Control and other 'change agents' to ensure every local authority has access to high quality support for the necessary change programme.

DH, and where appropriate, other Government Departments, will ensure new capital investment supports a more integrated approach to health and wellbeing in every community.

DH will lead a new cross-ministerial group including the Treasury, Department for Communities and Local Government (CLG), Department for Work and Pensions (DWP), Department for Innovation, Universities and Skills (DIUS) and Department for Children, Schools and Families to ensure a joined-up approach to adult social care transformation and the review of long-term funding. The need for legislative and regulatory changes will be considered in consultation with local Government, providers and other stakeholders.

A new skills academy is being developed with partners to support world class commissioning and leadership in social care. Skills for Care and the General Social Care Council (GSCC) will provide leadership to ensure entry level training, continued professional development and workforce registration to reflect the new skills required in a personalised system. In taking this forward, we will ensure that opportunities for co-ordination and joint capacity building are exploited with the World Class Commissioning programme for PCTs and those programmes in Children's services and the rest of local government. DH will also work with CLG and the Local Government Association (LGA) to consider how best to take this forward in the context of the NIES.

Social Care Institute for Excellence (SCIE) will be expected to promote, identify, and disseminate best practice and innovation, acting as a catalyst for system-wide transformation. Commission for Social Care Inspection (CSCI) and their successor regulator will align their approach to inspection and regulation with the reform agenda, in the context of the Comprehensive Area Assessment (CAA).

5 Timescale

Every local transformation process will include clear benchmarks, timescales and designated delivery responsibilities.

By the end of the CSR period in March 2011, we expect people who use services and their carers as well as front line staff and providers to experience significant progress in all local authority areas. Incremental progress should be evident over a shorter period of time.

6 Engagement/ Consultation

If we are to win the hearts and minds of all stakeholders, especially frontline staff, it is essential that they are participants in the change programme from the design stage onwards.

It is hoped that every local authority will create forums, networks and task groups which involve staff across all sectors, people who use services and carers as active participants in the change process.

7 Conclusion

We recognise that organisations such as In Control, other voluntary organisations and some local authorities have been at the cutting edge of innovation in adult social care for some time. The Individual Budget, Partnerships for Older People and LinkAge Plus pilots have begun to demonstrate what works as well as identifying barriers to progress.

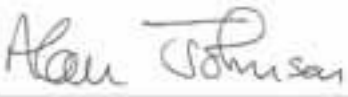
However, national and local leadership is now essential if we are to achieve system-wide transformation. This is necessary because of demographic realities, but driven by a shared commitment to social justice.

This protocol seeks to be a catalyst – not a straightjacket – for innovation and is the first stage in a unique attempt to co-produce, co-develop and co-evaluate a major public service reform.

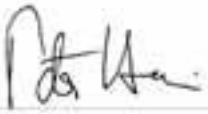
We will judge our success through the views and experiences of those who use the social care system, progress in supporting adults to live independently, objective measures of performance, and the job satisfaction of those working at all levels of the system.

In the future, adult social care will touch the lives of an increasing number of families.

By signing this historic protocol, we accept our shared responsibility to create a high quality, personalised system which offers people the highest standards of professional expertise, care, dignity, maximum control and self determination.

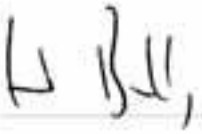


Secretary of State for Health



Secretary of State for Work and Pensions

Secretary of State for Communities and Local Government



Secretary of State for Children, Schools and Families

Chief Secretary to the Treasury

Secretary of State for Innovation, Universities and Skills

Chief Executive, NHS

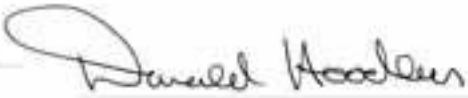
Chief Executive, NHS Confederation

Chair, Society of Local Authority Chief Executives

Chair, Commission for Social Care Inspection

Chair, Social Care Institute for Excellence

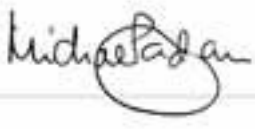
Chair General Social Care Council



Chair Skills for Care

English Community Care Association

National Care Association



UK Home Care Association

Executive Director, National Care Forum


NHS services available here
NHS

Local Authority Circular **LAC (DH) (2008) 1**

To: The Chief Executive
County Councils)
Metropolitan District Councils) England
Shire Unitary Councils)
London Borough Councils
Common Council of the City of London
Council of the Isles of Scilly
Director of Adult Social Services
Councils with Social Service Responsibilities in England

Copied to: Chief Executive – Strategic Health Authorities
Chief Executive – Primary Care Trust
Regional Directors of Public Health
Government Office Directors
Regional Directors, CSIP RDCs

Date: 17 January 2008

Gateway Reference: 9337

TRANSFORMING SOCIAL CARE

1. This Local Authority Circular sets out information to support the transformation of social care signalled in the Department of Health's social care Green Paper, *Independence, Well-being and Choice* (2005) and reinforced in the White Paper, *Our health, our care, our say: a new direction for community services* in 2006. The approach was confirmed in the landmark '*Putting People First'* Concordat[1] between six Government Departments, the Local Government Association, the Association of Directors of Adult Social Services, the NHS, representatives of independent sector providers, the Commission for Social Care Inspection and other partners, published in December 2007. There are four sections to this circular:

   - **Part 1:** (Pages 2-8) looks at what needs to be done, the vision for development of a personalised approach to the delivery of adult social care, the history and the context in which this policy is grounded.

   - **Part 2:** (Pages 9-15) sets out how the Department of Health (DH) and sector leaders propose to develop a sector led programme to support councils with social service responsibilities in delivering this modernisation agenda.

   - **Annex A:** (Pages 16-26) is a copy of the Social Care Reform Grant Determination. It sets out the details of the new ring-fenced grant to help councils to redesign and reshape their systems over the next 3 years.

   - **Annex B:** (Page 27) Is a list of useful websites.

[1] *Putting People First: a shared vision and commitment to the transformation of Adult Social Care,* HMG, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

PART 1: A PERSONALISED APPROACH

Introduction

2. Consultation responses to the White Paper[2] confirmed that people want access to support when they need it and they expect it to be available to them quickly, easily and fit into their lives. They also want adult social care services to make provision for a range of needs with a greater focus on using preventative approaches to promote people's independence and wellbeing. The emphasis should be on enablement and early intervention to promote independence rather than involvement at the point of crisis, within the framework of Fair Access to Care Services.

3. To make this happen the sector needs a shared vision. The direction is clear: to make personalisation, including a strategic shift towards early intervention and prevention, the cornerstone of public services. In social care, this means every person across the spectrum of need, having choice and control over the shape of his or her support, in the most appropriate setting. For some, exercising choice and control will require a significant level of assistance either through professionals or through independent advocates.

4. This is a challenging agenda, which cannot be delivered by social care alone. To achieve this sort of transformation will mean working across the boundaries of social care such as housing, benefits, leisure and transport and health. It will mean working across the sector with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services. This will range from support for those with emerging needs, to enabling people to maintain their independence and to supporting those with high-level complex needs. When considering transformation partners should look at resources spent through mainstream services, the NHS, housing and other relevant statutory agencies, the voluntary and private sectors, and not just those resources spent via the adult social services department.

5. The new Local Performance Framework will be of fundamental importance in supporting this to happen. Primary Care Trusts and Local Authorities are working in the Local Strategic Partnerships (LSPs) to agree new Joint Strategic Needs Assessments. Joint Strategic Needs Assessments (JSNAs) will provide the foundation for health and wellbeing outcomes within each new Local Area Agreement (LAA). Our ambitions for modernising social care sit entirely within this Framework.

6. The importance of this holistic approach is recognised and underpinned by '*Putting People First: A shared vision and commitment to the transformation of Adult Social Care',* a concordat that establishes a collaborative approach between central and local Government, the sector's professional leadership, providers and the regulator. It sets out the shared aims and values, which will guide the transformation of adult social care.

7. Across Government, the shared ambition is to meet the aspiration to put people first through a radical reform of public services. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity. Local priority setting will be focused on meeting local needs and playing a leading role in

[2] *Our health, our care, our say: a new direction for community services*, Department of Health (2006)

shaping strong and cohesive local communities[3]. This document sets out the contribution of social services, working in partnership across Local Strategic Partnerships, to support local leaders and their partners to make this happen.

Context: Why change is needed

8. Advances in public health, healthcare and changes in society mean that we are living longer, and as communities become more diverse, the challenges of supporting that diversity becomes more apparent. People have higher expectations of what they need to meet their own particular circumstances, wanting greater control over their lives and the risks they take. They want dignity and respect to be at the heart of any interaction, so that they can access high-quality services and support closer to home at the right time, enabling them and their supporters to maintain or improve their wellbeing and independence rather than relying on intervention at the point of crisis. Social care cannot meet these challenges without radical change in how services are delivered.

9. The change in the structure of our population is one of the most significant challenges we face in the 21st century. Life expectancy has increased considerably with a doubling of the number of older people since 1931[4]. Between 2006 and 2036, the number of people over 85 in England will rise from 1.055 to 2.959 million[5], an increase of approximately 180%. This trend will continue (eg the numbers of people with dementia in England, around 560,000[6] in 2007, is expected to double in the next 30 years) and with it, demand for support across the continuum of need will increase. In addition, the numbers of people aged 50 and over with learning disabilities are projected to rise by 53% between 2001 and 2021[7]. And, thanks to advances in medicine, more children with complex needs are surviving into adulthood. We need to recognise their aspirations and their desire to live life as fully as possible.

10. More people are being supported to live independently at home, but at the same time resouces are increasingly targeted at those with the greatest need[8][9][10]. This is despite emerging evidence from the Partnership for Older People Projects (POPPs) which indicates that earlier interventions before people reach high levels of need may be more cost-effective for the heath and social care system and provide better outcomes for individuals. This is also reflected in the Office for Disability Issues report '*Better outcomes, lower costs'* into housing adaptations[11].

11. Supported by the DH's efficiency programme, councils have increasing shown how developing homecare re-ablement services can support independent living and deliver value for money. Assistive technology such as telecare and minor adaptations, like fitting a handrail, can also enable people with support needs to continue to live in their own homes. The commitment to develop a National Dementia Strategy recognises the importance of people receiving an early diagnosis and being offered appropriate choices, rather than at a time of crisis.

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[3] *Strong and Prosperous Communities: The Local Government White Paper,* Department for Communities and Local Government (2006)
[4] Royal Commission on Long-term Care for the Elderly (1999)
[5] *2006-based principal population projections* , Office for National Statistics (October 2007)
[6] *Dementia UK: Report to the Alzheimer's Society,* Knapp et al, Kings College & London School of Economics & Political Science (2007)
[7] *Estimating future need/demand for support for adults with learning disabilities in England,* Emerson & Hatton (2004)
[8] *State of Social Care in England 2005-06,* Commission for Social Care Inspection (2006)
[9] *Time to care? An overview of home care services for older people in England,* Commission for Social Care Inspection (2006)
[10] Council Self Assessment Surveys, Commission for Social Care Inspection (July 2007)
[11] *Better outcomes, lower costs: implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence,* Heywood and Turner, Office for Disability Issues (2007)

12. Demographic changes will also have an impact on the number of people able to care and support family members, which will in turn influence the wider provision of care. The role of carers was highlighted in *Our health, our care, our say*[12], and the issues it raised are now subject to a wide-ranging consultation with the Government committed to publish a new Prime Ministers Strategy for Carers in spring 2008.

13. All this indicates that, faced with long-term demographic change, the current system of social care delivery will need to fundamentally re-engineer and modernise to respond to the pressures on the system, the increased expectations placed upon it and tackle substantial culture change. It will also need to be set in the context of the recognition of the need to explore options for the long term funding of the care and support system. The Government has announced its intention to produce a Green Paper in 2008, to identify the major challenges, the key issues and setting out options for reform, to ensure any new system is fair, sustainable and unambiguous about the respective responsibilities of the state, family and individual.

14. However, many councils find it difficult to invest in approaches aimed at promoting independence such as prevention, early intervention or re-ablement programmes, which are necessary to promote well-being and meet the population challenges. Social care and wider local government services need to work with the NHS, the voluntary, community and independent sector to harness the capacity of the whole system. It needs to shift the focus of care and support, across the spectrum of need, away from intervention at the point of crisis to a more pro-active and preventative model centred on improved wellbeing, with greater choice and control for individuals.

The Vision – what reforming social care means

15. The wider government approach to personalisation can be summarised as "*the way in which services are tailored to the needs and preferences of citizens. The overall vision is that the state should empower citizens to shape their own lives and the services they receive*"[13]. It forms one element of wider cross-government strategy on independent living, to be published early next year.

16. If personalisation is a cornerstone of the modernisation of public services, what does it mean for social care? What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.

17. To do this will require a common assessment of individual social care needs, emphasising the importance of self-assessment. The role of social workers will be focused on advocacy and brokerage, rather than assessment and gate keeping. This move is from the model of care, where an individual receives the care determined by a professional, to one that has person centred planning at its heart, with the individual firmly at the centre in identifying what is personally important to deliver his or her outcomes. With self-directed support, people are able to design the support or care arrangements that best suit their specific needs. It puts people in the centre of the planning process, and recognises that they are best placed to understand their own

[12] *Our health, our care, our say: a new direction for community services*, Department of Health, 2006
[13] *Building on Progress: Public Services*, HM government Policy Review, Prime Minister's Strategy Unit, London (2007)

needs and how to meet them. They will be able to control or direct the flexible use of resources (where they wish to), building on the support of technology (eg telecare), family, friends and the wider community to enable them to enjoy their position as citizens within their communities.

18. Direct payments and individual budgets (currently being evaluated) are an existing way to foster this transformation in the community. Individual budgets (IBs) build on what works with direct payments and, like direct payments, they give people more choice and control. IBs can bring a number of income streams together to give the individual a more joined-up package of support. Critically they allow the person to plan how to achieve outcomes, which meet their needs within a clear allocation of resources.

19. In the future, all individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being. Having an understanding of what is available will enable people to use resources flexibly and innovatively, no longer simply choosing from an existing menu, but shaping their own menu of support. A person will be able to take all or part of their personal budget as a direct payment, to pay for their own support either by employing individuals themselves or for purchasing support through an agency. Others may wish, once they have decided on their preferred care package, to have the council continue to pay for this directly. The approach, which may be a combination of both, will depend on what works best for them. The term personal budget will describe this transparent allocation of resources.

20. Importantly, the ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings.

Making personalisation a reality for the 21st century

21. Reforming social care to achieve personalisation for all will require a huge cultural, transformational and transactional change in all parts of the system, not just in social care, but also for services across the whole of local government and the wider public sector. The scale and purpose of this ambition should not be underestimated. The experience with direct payments makes this clear. For the past ten years, direct payments have successfully given some people the ability to design the services they want but their impact has been very limited. The latest figures show that about 54,000 people out of a potential million recipients receive support through a direct payment[14]. Evidence shows major variations in take up across the country, with success determined less by the characteristics of people who use services or the features of direct payments themselves, than by local leadership, professional culture and the availability of support.

22. The challenge will be to translate the vision into practical change on the ground to make a real difference to the way individuals engage with services and support and, in so doing, make a real difference to their lives. It will also mean changes in how professionals engage and work to support people's needs. Personalisation is about **whole system change**, not about change at the margins. It will require strong local leadership to convey the vision and the values, which underpin it and to reach beyond

[14] Council Self Assessment Surveys, Commission for Social Care Inspection (July 2007)

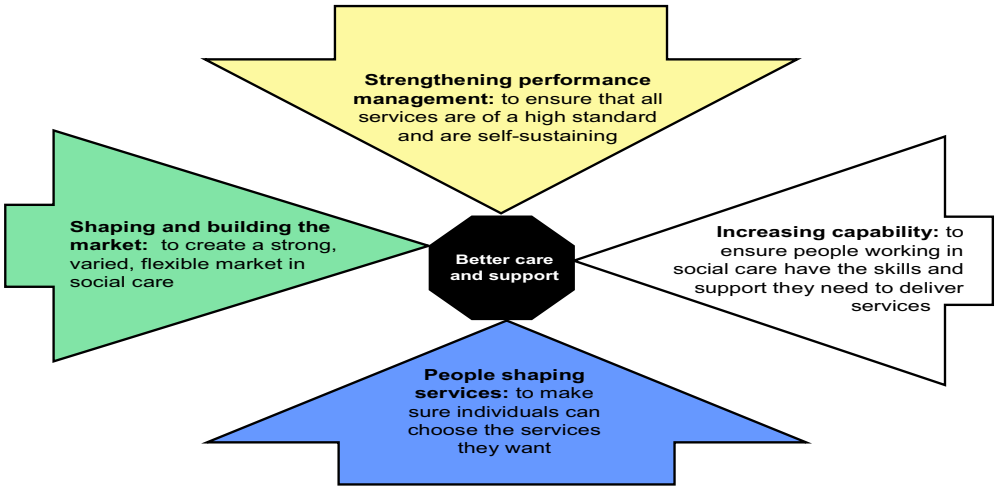
the confines of social care. It is essentially about a significant cultural shift and management of change for the wider social care and local government sectors. To achieve this, all stakeholders will need to work in partnership to construct a comprehensive delivery model, which works across social care and touches on the wider reforms within the NHS and in local government.

23. It will take time. There are significant cultural and organisational barriers to overcome and it cannot be driven from the top down. Ultimately, it will be for those at local level to deliver the change and the Government will need to work with its partners in the wider social care and local government world to support the right environment for this to happen.

24. With the increasing demand on resources, it is essential that councils work the with the NHS, other statutory agencies, the third and private sectors and their local communities to ensure a strategic balance of investment in prevention and approaches to promote independence and providing intensive care and support for those with high-level complex needs. Pooled budgets and integrated funding between health and social care can provide the flexibility for funds to be invested in early intervention and preventative approaches. Local commissioners working with local partners, in particular the NHS, should consider how resources may be released from across the whole system and redirected to enable investment in early intervention and prevention for all levels of need.

25. All participants across the sector will need to engage to bring about both the transformational culture change and the systems change needed to deliver personalisation. The reform model (below) identifies the four domains the Government and its partners must address in order to reform social care, not just in a sustainable manner, but also in a way that improves the quality of people's experience.

26. The purpose of this reform is to ensure people have choice and control over the support they need to live the lives they want. It is necessary to tackle all four together to deliver the Government's aims of better health and better care for people who need treatment and support, as well as better value for taxpayers.



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[15] '**Better care and support'** at the centre of the diagram is a proxy for the seven outcomes for social care as set out in *Our health, our care, our say* (2006): improved health and emotional wellbeing; improved quality of life, making a positive contribution, choice and control, freedom from discrimination, economic wellbeing and personal dignity.

Achieving Personalisation: where are we now, and what will the new system look like?

27. In the future, the social care system will allow individuals to make real choices, and take control, with appropriate support whatever their level of need. Everyone, with support if necessary, will be able to design services around their own needs, within a clear personal financial allocation. For those funding their own support and care it will mean that there are clear information points, and support and brokerage services that enable them or their supporters to navigate the system, access qualified and appropriate advice and purchase quality services or support which meets their needs.

28. It will also mean a very different relationship between national and local government, one that follows a participative model of service transformation. DH will work with partners, including users and carers, local government, the NHS, and local third and independent sector organisations to develop the mechanisms and strategies to achieve personalisation at a local level.

29. Different councils are at different points in this process; transition cannot and will not happen overnight. Councils should consider setting clear benchmarks, timescales and designated delivery responsibilities to ensure tangible short-term progress, and by March 2011, significant moves towards fundamental system-wide change. Councils will also need to talk directly to disabled people and their organisations. What is clear is that doing nothing is not an option.

30. However, this transformation is not starting from zero; a number of building blocks are already in place. There has been significant investment in tools and technologies to support change and this will continue over the next three years with further dissemination of the learning and experience from the DH efficiency and personalisation programmes, the POPPs pilots, the Department for Work and Pensions LinkAge Plus pilots, Individual Budget pilots and the work of In Control. Councils should be working to develop and embed these into their systems and cultures over the next spending period in order to deliver the ambitions of personalisation.

Challenges

Resources

31. The aspirations for the modernisation of social care through personalisation, choice and control must be set in the context of the existing resources and be sustainable in the longer term. However, transformation is about looking at the full range of services commissioned and provided to ensure that they all pull together towards the same objective of improved outcomes for individuals.

32. Personalisation must be delivered in a cost effective way. It is important to recognise that personalisation, early intervention and efficiency are not contradictory but will need to be more strongly aligned in the future. If delivered effectively personalised support can be a route to efficient use of resources, offering people a way to identify their own priorities, and co-design and focus the support they need. There is already some evidence that this can be made a reality. Emerson et al[16] undertook a longitudinal evaluation of the impact and cost of person centred planning and concluded that the

[16] *The impact of person centred planning,* Emerson et al, Institute for Health Research, Lancaster University, 2005

introduction of more personalised support had a positive benefit on the life experiences of people with learning disabilities. Importantly this benefit had been achieved without additional service costs once initial training costs were taken into account.

33. In Control[17] work has begun to show that self-directed support does not have to cost more than traditional services when based on an effective resource allocation system. In the pilots, individual satisfaction levels increased very significantly. In addition, evidence emerging from the POPPs pilots indicates that a shift to early intervention and re-ablement allows money to be spent in a more cost effective way.

34. In the wider context, the Government will be developing a reform strategy for the long-term funding for people in need of care and support. The plan is to spend the next period in conversation with the public, private and third sectors. Early in 2008, DH will set out a process, which will involve extensive public engagement and will lead to a Green Paper, which will identify the scale of the challenge, key issues, and give options for reform.

Workforce

35. The vision for a personalised approach to adult social care has huge implications for the workforce of the future[18]. It is clear that, given population and workforce demographics as well as rising expectations of people who use services, the current and future workforce need to change radically to meet the challenges it will face.

36. Sustainable and meaningful change depends on the capacity to empower people who use services and to do this we need to win the hearts and minds of frontline staff, from all sectors. It is vital that local workforce development strategies are co-produced, co-developed, co-provided and co-evaluated with private and voluntary sector partners, as well as users and carers, with a focus on raising skill levels and providing career development opportunities.

37. In response to this, DH is working with its key delivery partners to develop an Adult Workforce Strategy. This will address and plan for the key workforce priorities in the short and longer term to underpin and enable delivery of the personalisation agenda. In particular, it will recognise that in developing a personalised approach, **it is essential that frontline staff, managers and other members of the workforce recognise the value of these changes, are actively engaged in designing and developing how it happens, and have the skills to deliver it.**

38. It is recognised that a key component of the reform of social care will be effective leadership, management and commissioning skills. Work is underway to develop a Social Care Skills Academy to develop these skills.

39. In addition, to help meet the costs of training staff in social care, DH has issued a number of grants in 2007/08. The majority of the funding is to develop National Vocational Qualifications to ensure a better-trained and qualified workforce to raise the quality of social care services in both the statutory and independent sectors. Money has also been provided to support councils in developing their human resource capacity and capabilities, which will begin to equip the workforce for the opportunities of personalisation.

[17] *A report on in Control's first phase 2003-2005*, Carl Poll et al, In Control, 2006
[18] *Independence, wellbeing and choice: Our vision for the future of social care for adults in England*, Department of Health, 2005

Part 2: Developing a Sector Support Programme for the Transformation of Adult Social Care

Overall aim of the Programme

40. The Department of Health (DH) and its partners want to achieve the transformation of social care to deliver support tailored to individuals and local populations irrespective of their circumstances or level of need. The Department will work collaboratively, with partners, including disabled people and their organisations, to develop, produce and evaluate the programme of implementation work ahead and support capacity building at a local level. This is a major programme of change to achieve and one which will require different approaches and ways of working from all those involved with social care.

41. Driving change on the ground in a top-down Whitehall-led model is not the answer. Therefore, the approach deliberately focuses on building the strengths and capacity of individual councils to make local decisions on priorities reflected though improvement targets in LAAs. The success of this whole-system change is predicated on engagement with communities and their ownership of the agenda at a local level. The new Public Service Agreements (PSAs), the Local Government National Indicator Set (NIS) and LAAs provide the incentives and framework to make local delivery a reality[19].

42. The Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and the Improvement and Development Agency (IDeA) are in a unique position in terms of raising awareness and engaging with local government leaders at all levels. The skills, knowledge and attitude of the leaders will be critical to delivery of the programme.

43. There is a clear role to provide both strategic leadership and also to develop and increase leadership capacity and capability across councils. Personalisation and early intervention are issues for the whole of local government, not just for directors of social services. The links to delivery of the corporate agenda must be explicit to gain local buy-in. Shared purpose is required if the political and managerial leaders in councils are to promote the investment in preventative services and the devolution of control and the integration of wider objectives are needed to make personalisation a reality.

44. The establishment over the past year of Joint Improvement Partnerships (JIPs) in each region provides a strong foundation to build on. The national programme will work to integrate the JIPs in each region into the work and governance structures of the Regional Improvement and Efficiency Partnerships (RIEPs). This will ensure a more coherent, joined-up approach, and will emphasise that system reform on this scale cannot be achieved by focusing solely on adult social care.

45. ADASS, LGA and IDeA will work together as a sector-led 'consortium' at national level to support the change agenda. At a regional level, the RIEPs will work with the JIPs, to facilitate regional implementation and local activity, and provide local leadership.

[19] *The New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators*, Department for Communities and Local Government, 2007

46. This will support the goals of our framework for the *National Improvement and Efficiency Strategy*[20] (NIES).

47. Councils will be supported to make substantial progress on transforming their services over the next three years, with performance across health and social care measured against relevant indicators in the National Indicator Set (and any relevant LAA improvement targets). This information will inform the joint performance assessment across health and social care undertaken by the new joint inspectorate, the Care Quality Commission, and the Comprehensive Area Assessment (CAA). The prize is huge, transforming the areas in which we live, the lives of our citizens and creating self-improving public services, which can provide personalised support to all.

48. For its part, DH, jointly with the national consortium, will work on facilitating a range of national tools to assist reform at a local level and on policy and statutory issues that require a cross-government approach. This will include, for example, the development of tools and technologies, guidance for professionals and leadership development.

What are we doing to help?

Core funding

49. Over the Comprehensive Spending Review 2007 (CSR07) period, provision for social care will benefit from the real terms increase in Revenue Support Grant (RSG) to local government. This includes support for PFI projects and represents an increase by an average of 1% a year in real terms over the next three years. This is worth £2.6 billion more by 2010/11. Direct DH funding for grants, including those for carers, mental health and the social care workforce, will also increase by an average 2.3% real per year, worth £190 million by 2010/11. In addition, resources spent by PCTs on social care for Adults with learning disabilities will be transferred to local authorities from 2009/10.

50. Alongside this additional investment, councils will be expected to spend some of their existing resources differently, utilising mainstream services to ensure the health and wellbeing of their communities and working in a genuinely collaborative way with third and private sector agencies.

Social Care Reform Grant

51. In addition to local partners using some existing resources across the health and well-being system differently, DH will be making over half a billion pounds available as a ring-fenced grant to local councils over the next 3 years. The new Social Care Reform Grant is worth £85 million in 2008/09, £195 million in 2009/10 and £240 million in 2010/11. This includes money from resources secured in CSR07 for the NHS and recognises the positive impact investing in social care can have on people's health and the demand for healthcare. The grant determination for 2008/09 is attached as an Annex A to this Circular (pages 17-27), in addition to details of allocations and conditions.

52. The objectives of the Social Care Reform Grant will directly inform each DH regional business plan to ensure our priorities are informed by local strategies. Each of DH's new Regional Deputy Directors for Social Care and Local Partnerships will be a key

[20] http://www.communities.gov.uk/localgovernment/performanceframeworkpartnerships/lpffaqs/efficiencystrategy/efficiencystrategy/

member of the regions JIPs. The RIEP and the JIP will need to work together to agree the priorities for regional facilitation. Every local transformation process will need to include clear benchmarks, timescales and designated delivery responsibilities.

53. To support this, the Department will provide some additional funding to support and facilitate local activity. This will ensure the best value for money through local collaboration to deliver the aims of the transformation programme in partnership with the RIEPs. This is described in more detail in paragraphs 58-60. DH's Efficiency Programme will also be working to align its support with the RIEPs to ensure an effective and joined-up approach to support transformational change.

Implementing change at a Local Level

54. Using the total resources provided through CSR07 (including the Social Care Reform Grant) and through ensuring improved value for money, we are confident that each council is in a position to make real and measurable progress to achieve the systems changes that will deliver the transformation of social care for their local populations over the next three years. For most councils, this will require investment in system change tailored to their needs and they will need to work either individually or collaboratively as part of a wider group with common areas for development.

55. Councils are in different places on this journey. There will be differences in terms of local priorities but the overall direction and strategic goals are clear. In order to do this effectively, councils will need to develop their own transition strategies. They will need to assess where they are, using a range of diagnostic tools to ensure that their plans are feasible and sustainable and that they focus resources on their own core priorities.

56. Some tools are already available (see Annex B for links); others will need to be developed. In particular, a means to capture how the wider contribution of local government services, such as housing, leisure, adult education, transport, and environmental services, can support personalisation. DH and the consortium will work together to commission and develop these tools to assist councils and their partners in identifying local priorities for improvement, drawing on information gathered through Joint Strategic Needs Assessments, and making decisions to feed into LAAs. This will also help ensure support and available resources, at both regional and national levels, are focused on the identified priorities.

57. Whilst there will be some local variation in the process of reform, there are core elements which councils will need to develop to ensure they have the capability and capacity to respond flexibly and responsively to the demands placed on them. These are listed in more detail in Annex A of this document (Appendix B).

At a Regional Level – Sector-led Support

58. Though the national consortium will not provide 'hands-on' change management support, it will develop a mechanism to facilitate the sharing of information across the regions, to maximise the learning from any local and regional investment.

59. To support this regional facilitation role, DH will expect its Regional Deputy Directors for Social Care and Local Partnerships to agree priorities for a £2million top-slice of the Social Care Reform Grant to be spent on regional improvement initiatives in

consultation with the RIEP and JIP. DH will look at how, from 2009/10 this resource might be transferred to the RIEPs, in line with the principles of the NIES.

60. This £2million top-sliced money will be in addition to existing resources in the system for implementation and improvement activity, to support a coherent regional strategy for transformation. It is anticipated that, taking account of local priorities, all councils in each region will be supported to ensure there is:

- Close working with DH's regional teams in each Government Office to align and join up policy delivery.

- Dissemination of tools and technologies to support excellence in delivery and transformational change, such as implementing the new operating system being developed by the IB pilot sites (learning from the evaluation), disseminating the early learning from the POPP pilots and the wider prevention agenda (including signposting of individuals who do not currently access statutory services) and DH efficiency and re-ablement work.

- Work to shape and develop local and regional markets with the capacity and the variety to offer the range of options the population demands. This will include a mixed economy of care providing a range of services delivered by organisations across all sectors and sustainable advocacy and brokerage organisations that are accessible to both those entitled to public support and self-funders.

- Support for local leadership, for example through IDeA programmes on peer review and mentoring, for both elected members and directors.

- Facilitation of information exchange and improvement work, bringing together "clusters" of councils and their partners where shared priorities have been identified.

- An agreed strategy for the commissioning of specific regional support and facilitation, such as building workforce capacity and capability to use the tools of personalisation (eg resource allocation systems) or managing change through project management, business case development and benefits realisation.

- A joined-up approach with the work of the DH efficiency programme which will also be working to align its support with the RIEPs.

- Support for councils in developing performance management systems to measure the outcome benefits for people and communities of personalisation and early intervention and collect other types of robust evidence, which can be used for performance assessment processes, to inform commissioning without requiring extra work.

- Proactive identification of under performers to engage them in developing strategies and key areas for investment (eg change management) either individually or at a regional level.

At a National Level

61. DH is committed to developing a real and meaningful partnership with the consortium and other key stakeholders to take the transformation agenda forward. This means the Department will work strategically with the consortium, In Control and other partners to jointly commission or undertake activities to facilitate reform where it is best placed to do so.

62. An additional £1m top-slice from the Social Care Reform Grant will be used to enable DH and the implementation board (paragraph 63) to:

- Commission and develop key tools and technologies, which will be required by all councils, although dissemination will be facilitated at the regional level. This will include the development of key components of the new social care system, eg a Common Assessment Framework, charging guidance and workforce development. Identifying the need for new universal tools will be done in partnership with the consortium and will reflect their regional intelligence.

- Facilitate a range of national mechanisms to support implementation, in particular the interface of policy and statutory issues and cross-government agenda. This will include working through the Innovation, Capacity, Efficiency Programme Board facilitated by the Department for Communities and Local Government.

- Provide strategic advice, in particular on the four key areas identified to deliver public sector reform, people shaping services, increasing capability, shaping and building the market and strengthening performance management.

- Establish jointly with the consortium, a national information network for facilitation at the regional level with an information loop back from all nine regions on good practice for national dissemination. This will include the learning coming out of key pilot programmes such as POPPs and IBs.

- Work with the Social Care Institute for Excellence to establish a good and emerging practice library to support the role out of the transformation agenda

- Work with the consortium to develop the capacity to commission support services from a range of suppliers including accredited independent consultancy companies (eg with a framework agreement to ensure rapid call-off of support).

- Work with the regulators (the new Care Quality Commission and the General Social Care Council) to ensure their roles and functions support the transformation agenda.

63. Recognising that the principle of sector leadership of the programme applies equally at national as well as regional level, DH will work with the consortium to second a programme director from the sector to drive forward this challenging agenda. An implementation board will oversee the programme, which will include senior representatives of the consortium (ADASS, IDeA, and LGA) and DH, and representatives from the RIEPs and the Society of Local Authority Chief Executives.

Outcomes Expected

64. From April 2008, the new local performance framework for local government working alone or in partnership, will be introduced. The health and adult social care priorities for places will be drawn from the National Indicator Set[21], which cover those aspects of DH's Public Service Agreements (PSAs) and Departmental Strategic Objectives (DSOs) that are delivered in partnership.

65. DH has three DSOs (*Better health and well-being for all; Better care for all and Better Value for all*) from which our two PSAs (*to promote better health & well-being for all and to ensure better care for all*) naturally fall. These cover a range of health and social care priorities, which specifically include:

Better health and well-being through:

- Improving people's health and emotional wellbeing by enabling them to live as independently as suits them.
- Designing systems that build on the capacity of individuals and their communities to manage their own lives, confident that they have access to the right information and interventions at the right time should they need more support.
- Focusing on prevention, early intervention and enablement, rather than crisis management, to bring long-term benefits to individuals' health and wellbeing.

Better care through:

- Strategic working with NHS partners to enable people with long-term conditions to manage their health and wellbeing more effectively.
- Ensuring information is available and accessible for all to support decision-making and access to care services, irrespective of people's social circumstances and eligibility for statutory services.
- Supporting people to maintain or improve their wellbeing and independence within their own homes and local communities and through avoiding unnecessary admission to hospital.
- Enabling people to make choices and be in control of their care to deliver successful outcomes first time. Promoting shared decision making to encourage ownership.
- Providing quality care that promotes dignity, and is safe, effective and available when and where people need it.

66. DH's third Strategic Objective – **Better Value for All** - is also key in delivering the best outcomes for communities in the most cost effective way. Councils, working with local partners, will have their own ideas of how to deliver better value at a local level. One example of a way for councils to deliver this locally might be by harnessing resources from across the whole system to shift the focus of care and support away from intervention at the point of crisis to a more pro-active, early intervention model. This can deliver long-term benefits to individuals and the system in terms of improved outcomes and more cost-effective use of resources.

[21] *The New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators*, Department for Communities and Local Government (2007)

67. These objectives support the shared outcomes set out in '*Putting People First*'[22]. These are that all signatories should ensure people, irrespective of illness or disability, are supported to:

- live independently
- stay healthy and recover quickly from illness
- exercise maximum control over their own life and, where appropriate the lives of their family members
- sustain a family unit which avoids children being required to take on inappropriate caring roles
- participate as active and equal citizens, both economically and socially
- have the best possible quality of life, irrespective of illness or disability and
- retain maximum dignity and respect.

Measuring Success

68. Independent annual assessment of performance has proved a good incentive for improvement across both health and social care. Commissioners will be assessed by the regulator on their performance against the outcome-focused metrics set out in the National Indicator Set. The new Care Quality Commission's performance assessment will contribute to the Comprehensive Area Assessment (CAA).

69. Councils will need to develop their own monitoring systems to understand how the change is experienced by the population. This diagnostic data will need to look at not only efficiency, but also take into account quality assurance and customer satisfaction. Councils will be able to use this information to develop coherent support plans for delivery of personalisation, as well as to identify additional needs and priorities. These should directly inform their Joint Strategic Needs Assessment and local commissioning strategies.

Cancellation of this circular

1. This circular should be cancelled on 1st April 2009.

Enquiries

2. Any queries about this document should be addressed to Helen Tomkys, Department of Health, Social Care Policy and Innovation Team, Wellington House, 133-155 Waterloo Road, London SE1 8UG. You can email: Helen.Tomkys@dh.gsi.gov.uk

3. This Circular may be freely reproduced and can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/DH_081934.

4. Current circulars are now listed on the Department of Health website on the internet at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/index.htm.

[22] *Putting People First: a shared vision and commitment to the transformation of Adult Social Care,* HMG, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118

ANNEX A: DETERMINATION UNDER SECTION 31 OF THE LOCAL GOVERNMENT ACT 2003 OF THE SOCIAL CARE REFORM GRANT FOR 2008/2009

Introduction

1. This Determination is made by the Secretary of State for Health ("the Secretary of State") under section 31 of the Local Government Act 2003[23] ("the 2003 Act"). It specifies grants that the Secretary of State proposes to pay to certain local authorities in England.

2. Before making this Determination, the Secretary of State obtained the consent of the Treasury in accordance with section 31(6) of the 2003 Act.

Amounts payable to authorities

3. Pursuant to section 31(3) of the Act the Secretary of State hereby determines that the local authorities to which grants are to be paid, and the amount of each grant, are the local authorities listed in column 1 of Appendix A and the corresponding amounts set out in column 2 of that Appendix.

Purpose of the grant

4. (a) Pursuant to section 31 of the 2003 Act, the Secretary of State hereby determines that the grants shall be paid towards revenue or capital expenditure incurred or to be incurred by local authorities in the financial year 2008/2009 for the purpose of social care modernisation and reform as described in Appendix B;

   (b) "Capital expenditure" has the same meaning as specified in section 16(1) of the 2003 Act.

Payment

5. The grants shall be payable to local authorities in one instalment on or before 30th April 2008. Local authorities must be able to identify expenditure against the grant monies for the purposes set out in Appendix B, paragraphs 8-11 if required by the Secretary of State to do so.

Grant conditions

6. The Secretary of State may request the repayment of the whole or any part of the grant monies to the extent that they are not used for the purposes for which they are given as set out in Appendix B, paragraphs 8-11.

Signed by authority of the Secretary of State
17 January 2008

[23]. 2003 c.26

Appendix A

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Principal Metropolitan Cities	6.611	15.367	18.823
Other Metropolitan Districts	13.985	32.670	40.218
Metropolitan Sub Total	20.596	48.037	59.041
Inner London	5.524	12.845	15.753
Outer London	7.253	16.864	20.680
London Sub total	12.777	29.709	36.433
Shire Counties	35.149	82.738	102.652
Shire Unitary Authorities	13.477	31.516	38.874
Shire sub total	48.627	114.254	141.526
England Total	82.000	192.000	237.000

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Principal Metropolitan Cities			
Birmingham	1.973	4.584	5.609
Leeds	1.175	2.740	3.367
Liverpool	1.035	2.397	2.922
Manchester	0.942	2.194	2.691
Newcastle upon Tyne	0.516	1.193	1.455
Sheffield	0.970	2.260	2.778
Sub-Total	6.611	15.367	18.823
Other Metropolitan Districts			
Barnsley	0.437	1.027	1.272
Bolton	0.482	1.130	1.393
Bradford	0.808	1.890	2.329
Bury	0.288	0.674	0.832
Calderdale	0.320	0.751	0.928
Coventry	0.534	1.243	1.524
Doncaster	0.521	1.221	1.506
Dudley	0.540	1.265	1.559
Gateshead	0.384	0.891	1.093
Kirklees	0.638	1.498	1.853
Knowsley	0.343	0.799	0.979
North Tyneside	0.362	0.844	1.039
Oldham	0.398	0.929	1.143
Rochdale	0.378	0.885	1.092
Rotherham	0.470	1.102	1.366
Salford	0.464	1.077	1.317
Sandwell	0.629	1.463	1.791
Sefton	0.544	1.269	1.558
Solihull	0.280	0.658	0.813
South Tyneside	0.314	0.728	0.890
St Helens	0.339	0.793	0.977
Stockport	0.437	1.018	1.252
Sunderland	0.554	1.288	1.580
Tameside	0.407	0.952	1.174
Trafford	0.331	0.771	0.946
Wakefield	0.593	1.391	1.721
Walsall	0.491	1.145	1.406
Wigan	0.561	1.318	1.634
Wirral	0.651	1.520	1.870
Wolverhampton	0.486	1.131	1.383
Sub-Total	13.985	32.670	40.218
Metropolitan Sub-total	20.596	48.037	59.041

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Inner London			
City of London	0.018	0.043	0.053
Camden	0.471	1.107	1.371
Greenwich	0.471	1.095	1.345
Hackney	0.490	1.133	1.381
Hammersmith and Fulham	0.333	0.773	0.946
Islington	0.430	0.996	1.217
Kensington and Chelsea	0.366	0.866	1.082
Lambeth	0.498	1.150	1.399
Lewisham	0.470	1.085	1.322
Southwark	0.524	1.211	1.478
Tower Hamlets	0.491	1.135	1.383
Wandsworth	0.455	1.051	1.281
Westminster	0.508	1.200	1.494
Sub-total	5.524	12.845	15.753
Outer London			
Barking and Dagenham	0.327	0.752	0.916
Barnet	0.505	1.179	1.452
Bexley	0.303	0.708	0.871
Brent	0.460	1.069	1.309
Bromley	0.400	0.932	1.145
Croydon	0.457	1.068	1.313
Ealing	0.478	1.107	1.353
Enfield	0.449	1.047	1.285
Haringey	0.374	0.867	1.060
Harrow	0.336	0.783	0.962
Havering	0.336	0.783	0.961
Hillingdon	0.350	0.815	1.001
Hounslow	0.316	0.733	0.897
Kingston upon Thames	0.188	0.439	0.540
Merton	0.259	0.602	0.737
Newham	0.485	1.121	1.368
Redbridge	0.381	0.887	1.090
Richmond upon Thames	0.220	0.515	0.635
Sutton	0.253	0.589	0.725
Waltham Forest	0.375	0.868	1.060
Sub-total	7.253	16.864	20.680
London Sub-total	12.777	29.709	36.433

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Counties			
Bedfordshire	0.503	1.189	1.480
Buckinghamshire	0.568	1.334	1.651
Cambridgeshire	0.788	1.863	2.323
Cheshire	0.985	2.317	2.872
Cornwall	0.961	2.271	2.829
Cumbria	0.882	2.072	2.563
Derbyshire	1.279	3.015	3.744
Devon	1.230	2.898	3.604
Dorset	0.642	1.509	1.874
Durham	0.966	2.259	2.789
East Sussex	0.861	2.021	2.502
Essex	2.000	4.710	5.845
Gloucestershire	0.847	1.989	2.461
Hampshire	1.537	3.618	4.490
Hertfordshire	1.414	3.309	4.085
Kent	1.980	4.655	5.770
Lancashire	1.908	4.481	5.547
Leicestershire	0.798	1.886	2.346
Lincolnshire	1.136	2.694	3.364
Norfolk	1.418	3.340	4.149
North Yorkshire	0.835	1.969	2.448
Northamptonshire	0.896	2.119	2.638
Northumberland	0.528	1.239	1.533
Nottinghamshire	1.195	2.813	3.489
Oxfordshire	0.788	1.853	2.295
Shropshire	0.468	1.106	1.376
Somerset	0.836	1.970	2.450
Staffordshire	1.211	2.857	3.549
Suffolk	1.093	2.576	3.201
Surrey	1.336	3.128	3.858
Warwickshire	0.759	1.792	2.228
West Sussex	1.092	2.558	3.162
Wiltshire	0.602	1.421	1.766
Worcestershire	0.808	1.907	2.369
Sub-total	35.149	82.738	102.652

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Unitary Authorities			
Bath & North East Somerset	0.252	0.589	0.727
Blackburn with Darwen	0.261	0.609	0.748
Blackpool	0.318	0.743	0.914
Bournemouth	0.294	0.682	0.836
Bracknell Forest	0.119	0.279	0.346
Brighton & Hove	0.414	0.956	1.167
Bristol	0.677	1.576	1.931
Darlington	0.168	0.392	0.484
Derby	0.401	0.939	1.159
East Riding of Yorkshire	0.504	1.193	1.488
Halton	0.220	0.514	0.633
Hartlepool	0.175	0.408	0.503
Herefordshire	0.301	0.712	0.886
Isle of Wight Council	0.269	0.635	0.790
Isles of Scilly	0.010	0.010	0.010
Kingston upon Hull	0.507	1.178	1.443
Leicester	0.523	1.213	1.483
Luton	0.264	0.617	0.760
Medway	0.310	0.730	0.905
Middlesbrough	0.258	0.597	0.728
Milton Keynes	0.285	0.677	0.847
North East Lincolnshire	0.273	0.638	0.786
North Lincolnshire	0.254	0.600	0.745
North Somerset	0.309	0.731	0.911
Nottingham	0.530	1.230	1.504
Peterborough	0.261	0.612	0.757

Local Authority	Social Care Reform Grant		
	2008-09	2009-10	2010-11
Shire Unitary Authorities			
Plymouth	0.430	1.007	1.243
Poole	0.211	0.493	0.607
Portsmouth	0.296	0.688	0.847
Reading	0.188	0.436	0.533
Redcar and Cleveland	0.250	0.584	0.720
Rutland	0.045	0.106	0.133
Slough	0.170	0.395	0.482
South Gloucestershire	0.308	0.728	0.907
Southampton	0.371	0.864	1.063
Southend-on-Sea	0.287	0.669	0.824
Stockton-on-Tees	0.289	0.677	0.838
Stoke-on-Trent	0.483	1.126	1.381
Swindon	0.241	0.565	0.698
Telford and The Wrekin	0.259	0.613	0.763
Thurrock	0.219	0.514	0.637
Torbay	0.300	0.706	0.877
Warrington	0.281	0.659	0.816
West Berkshire	0.166	0.390	0.484
Windsor and Maidenhead	0.154	0.360	0.443
Wokingham	0.130	0.307	0.382
York	0.245	0.573	0.709
Sub -total	13.477	31.516	38.874
Shires Sub-total	48.627	114.254	141.526

Appendix B

THE SOCIAL CARE REFORM GRANT 2008/09

Summary

5. The White Paper[24] set out the role adult social care services should play in increasing people's independence and promoting inclusion in communities through preventative approaches and the promotion of well-being, rather than intervention at the point of crisis.

6. To meet this goal, the system will need to undergo significant reform and redesign to ensure people have access to early interventions and to exercise choice and control over the services and support they need. It will also require investment in training and support for the workforce to enable them to meet the challenges of this new way of working.

7. This transformation will take place within the new local performance arrangements and in partnership with the full range of local statutory, voluntary and private sector organisations. Councils will need to work with health partners in their Local Strategic Partnerships to undertake Joint Strategic Needs Assessments (JSNAs), which will in turn be informed by, and support other needs assessments and plans (eg the Sustainable Community Strategy and local housing strategies). This reflects the shared responsibilities for health and wellbeing of citizens, families and communities as set out in the NHS Operating Framework[25].

8. Appendix A of this document sets out the resources available for the year 2008/09 for undertaking this redesign of systems, processes and transactions to transform delivery. The allocations are made on the basis of the Adult Social Care Relative Needs Formula. The Grant will continue over the three years of the CSR07 settlement and indicative allocations for 2009/10 and 2010/11 are included for planning purposes.

Purpose of the monies

9. The Department of Health (DH) is making available, through the Social Care Reform Grant, monies to support councils in this transformation. It is in addition to the monies provided through the Personal Social Services funding and is specifically for the range of process reengineering, capability and capacity building activities required to design the entire system including work to:

    (i) Change the social care system away from the traditional service provision with its emphasis on inputs and processes towards a more flexible, efficient approach, which delivers the outcomes people want and need and promotes their independence, well-being and dignity.

    (ii) Create a strategic shift in resources and culture from intervention at the point of crisis towards early intervention focused on promoting independence and improved wellbeing in line with the needs of the local population, reaching out to those at risk of poor outcomes.

[24] *Our health, our care, our say: a new direction for community services*, Department of Health (2006)
[25] The Operating Framework for the NHS in England 2008/09, pp25
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

(iii) Ensure that people are much more involved in the design, commissioning and evaluation of services and how their needs are met. This choice and control should extend to individuals in every setting and at every stage; ranging from advocacy and advice services, prevention and self-management to complex situations where solutions are developed in partnership with professionals.

(iv) Remodel systems and processes so they are not only efficient and equitable but also recognise the ability of individuals to identify cost effective, personalised solutions through wider community networks and innovation.

(v) Join up services to provide easy to recognise access points, which coordinate or facilitate partner organisations to meet the needs of individuals. Systems should be put in place to identify hard to reach people and strategies developed to meet their needs.

(vi) Raise the skills of the workforce to deliver the new system, through strengthening commissioning capability, promoting new ways of working and new types of worker and remodelling the social care workforce.

(vii) Develop leadership at all levels of local government and communities to enable this change to happen.

10. In practice, what this means is that by 2011 all 150 councils will be expected to have made significant steps towards redesign and reshaping their adult social care services (in the light of their JSNAs), having most of the core components outlined below in place:

- An integrated approach to working with the NHS and wider local government partners. Moving to harness resources from across the whole system, with a strategic shift in the focus of care and support away from intervention at the point of crisis to a more holistic, pro-active and preventative model centred on improved well-being. This might include focus on specific outcomes such as hospital discharge, intermediate care, transition to adulthood and co-location of services.

- A commissioning strategy which includes incentives to stimulate development of high quality services that treat people with dignity and maximise choice and control as well as balancing investment in prevention, early intervention/re-ablement and providing intensive care and support for those with high-level complex needs. This should have the capacity to support third/private sector innovation, including social enterprise and where appropriate undertaken jointly with the NHS and other statutory agencies such as the Learning and Skills Council.

- Universal, joined-up information and advice available for <u>all</u> individuals and carers, including those who self-assess and fund. Enabling people to access information from all strategic partners (eg third sector organisations, LinkAge Plus, Pensions Agency). Councils could do this using the 'first stop shop' model. Links to advocacy and support services will need to be considered where individuals do not have a carer or in circumstances where they require support to articulate their needs and/or utilise the personal budget.

- A framework for proportionate contact and social care needs assessment to deliver more effective, joined-up processes. Greater emphasis on self-assessment, enabling social workers to spend less time on assessment and more on support, brokerage and advocacy to ensure users experience a 'no wrong door' service.

- Person centred planning and self-directed support to become mainstream, with individuals having choice and control over how best to meet their needs, including through routine access to telecare.

- A simple, straightforward personal budget system, which will lead to maximum choice and control being in the hands of people who use services as well as support to increase the uptake of direct payments.

- Mechanisms to involve family members and other carers as care partners, with appropriate training to enable carers to develop their skills and confidence.

- An enabling framework to ensure people can exercise choice and control with accessible advocacy, peer support and brokerage systems with strong links to user led organisations. Where ULOs do not exist, a strategy to foster, stimulate and develop user led organisations locally.

- An effective and established mechanism to enable people to make supported decisions built on appropriate safeguarding arrangements, eg risk boards and corporate approaches to supporting individual choice. Supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.

- Active membership of the local/regional personalisation networks to ensure access to the latest information, advice and support. Effective local information systems to capture inputs/outputs and outcomes for individuals to support local quality assurance.

11. Councils will also be expected to have started, either locally or in their regions, to develop:

    - A market development and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes. This may include a transformed community equipment service, consistent with the retail model.

    - A workforce with the capacity and capability to deliver choice and support control, staff who are appropriately trained and empowered to be able to work with people to enable them to manage risks and resources.

12. In summary, in the longer term, all 150 councils with social services responsibilities should be transformed to deliver personalised services, which enable individuals or groups to develop solutions, which work for them. Key components should include:

    - Everyone eligible for statutory support, should have a personal budget, a clear and transparent allocation of resources, with many more people having the opportunity to take all or part of this budget as a direct payment.

- A strategic balance of investment between enablement, early intervention and prevention, providing intensive care and support for those with high-level complex needs.

- A Common Assessment Framework in place across health and social care to deliver a more diverse range of local services and solutions.

- An established mechanism to ensure that views and experiences of users, carers and other stakeholders is central to every aspect of the reform programme.

Actions

13. Councils will be expected to:

    (i) work with regional consortia and improvement agencies to start to develop and identify local actions needed for service transformation.
    (ii) engage with other partners, including disabled people and their organisations to ensure this priority contributes to and is properly represented in discussions on Local Area Agreements.

14. DH will work with partners in Government and across the sector to develop and improve outcome-based indicators around prevention and early intervention informed by the evaluation of the POPPs pilots and provide tools, technologies and approaches flowing from the learning from the IB pilots and related initiatives.

ANNEX B - Useful web-links

Dementia Tool-kit - Strengthening the Involvement of People with Dementia
http://www.olderpeoplesmentalhealth.csip.org.uk/service-user-and-carer-engagement-tool/download-the-toolkit.html

Care Services Efficiency Delivery (CSED) Programme
http://www.csed.csip.org.uk/

Partnerships for Older People Projects
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/DH_080122

Promoting Independence toolkit – The Long Marathon to achieving choice and control for older people
http://www.changeagentteam.org.uk/index.cfm?pid=597

Self-Directed Support Network
http://kc.csip.org.uk/about.php?grp=36

Individual Budgets
http://individualbudgets.csip.org.uk/index.jsp

Increasing the Uptake of Direct Payments - Solution Set
http://kc.csip.org.uk/solutionset.php?grp=601

CSIP Networks
http://www.integratedcarenetwork.gov.uk/index.cfm?pid=5

National Service Framework and System Reform for Older People
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Olderpeople/DH_079331

Valuing People Support Team
http://valuingpeople.gov.uk/index.jsp

New Deal for Carers
http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/Carers/NewDealforCarers/index.htm

Our Health, Our Care, Our Say: A New Direction for Community Services
http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/index.htm

Commissioning Framework for Health and Well-Being
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604

Local Government White Paper: Strong and Prosperous Communities
http://www.communities.gov.uk/localgovernment/currentagenda/strongprosperous/

LinkAge Plus evaluation
http//www.dwp.gov.uk/asd/asd5/WP42.pdf

Creating Strong, Safe and Prosperous Communities [draft statutory guidance on Local Area Agreements, the duty to co-operate and commissioning]
www.communities.gov.uk/publications/localgovernment/statutoryguidance

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Item No. B2

By: Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Services Policy Overview Committee – 1 April 2008

Subject: **KENT'S STRATEGY FOR LATER LIFE**

Classification: Unrestricted

Summary: A Kent Strategy for Later Life is being developed. This paper introduces the current draft, informs Members of next steps and seeks input into the final version.

Background – Why Now?

1. (1) In the past, the County Council has shied away from having an "older people's strategy". As part of the development of Towards 2010, a holistic older people's theme was seriously considered, but on balance it was felt that all the themes should apply to all age groups. Equally, Active Lives is structured in a generic way, rather than focussing on the specific needs of different age groups.

(2) However, the benefits of having a Children and Young People's Plan and a Children's Trust became increasingly apparent, and there are lessons that can be applied to older people. Whilst "older people" (however defined!) are an extremely diverse group, there are issues that do particularly resonate with senior citizens. Of course KCC and its partners have been supporting older people in many ways for many years, but over the last year there does seem to be a consensus that it is time for the different partners in Kent to have a mechanism to ensure that older people's needs and interests are being met and are seen to be met.

(3) KASS therefore led a number of workshops to which a wide range of representatives were invited, from older members of the public through to District and Borough Council representatives, Police, Health, the voluntary sector, BME community representatives, and so on. At those workshops, people were presented with the seven dimensions of independence, and the Vision for Kent themes, and asked to identify their priorities for action.

(4) Although KASS has led this work, this is on behalf of the Kent Partnership as the strategy is about identifying issues and action needed in relation to older people as a whole. The actions required will cut across not only the County Council Directorates but other public, private and voluntary organisations.

Key themes emerging from the initial consultation

2. (1) There was vigorous debate at the workshops, and a considerable degree of consensus about the main issues that needed addressing, although the solutions were not always obvious. The emerging themes were:

i) **Valuing Later Life:** perhaps surprisingly this "need for a cultural change" came out very strongly in all the workshops.
ii) **Planning for a secure old age** (ie for financial security and physical health)
iii) **Healthy Communities** (ie good & accessible transport, decent homes, community safety, social activities)
iv) **Learning** and being well informed - getting information you need when you need it
v) **Independent Living**

(2) There was little appetite for a lengthy strategy document, but people did feel it would be useful to have a short overarching statement highlighting the priorities for action and acting as a signpost to where people could find further information (including older people's strategies for specific services or geographical areas where these exist). Based on the consultation, the attached draft (Appendix 1) was written to summarise the issues raised.

Next Steps

3. (1) There is a Members' Conference on Ageing and the Economy on 2 May 2008 which will be very useful in helping to shape priorities for action. It is hoped to widely promulgate the content of this conference to stimulate further discussion, including amongst older people's forums and the Active Retirement Association for example. The draft strategy will go on the KCC website, and we will encourage as many people as possible to give us their views.

(2) In June I will be holding two further multi-agency events (East and West) also involving older people to finalise the issues and action to be included in the overarching strategy (which will remain short and snappy).

(3) I will then establish an editorial panel of older people to draft the final version (a model that worked really well for Active Lives). We will aim to produce the final version in the autumn.

Recommendations

4. (1) Members are asked note the contents and comment on the attached draft strategy.

Debra Exall
Head of Performance & Planning
Kent Adult Social Services

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Active Ageing

Kent's Strategy for Later Life

This document summarises how people in Kent want to live their later lives, and what they want from public and community services and facilities. It is based upon discussions with people from all walks of life, and with representatives of all the major service providers. It also builds upon the Vision for Kent, Kent's Community Strategy, taking the themes identified there and scrutinising them from the perspective of older people. People said to us that they didn't think another detailed strategy document was needed, and indeed we have many plans in Kent already, some of them specifically targeted at older people. This paper is therefore an over-arching summary of the issues that are important to people in Kent, and highlights action planned or being taken. The aim is to help to focus agencies' attention on the cross-cutting issues, with older people themselves, and ultimately to provide a monitoring tool to enable people to hold agencies to account for achieving these collective objectives.

Because of the importance of planning ahead for health, fitness and economic wellbeing in old age, some of the issues raised are relevant to people in their fifties and sixties, or younger, none of whom would consider themselves to be an "older person". Many people in their seventies and eighties are active and enthusiastically involved in community life. Some people, particularly those in their nineties or older, but sometimes younger, need support or care in order to maintain their quality of life. Kent is a particularly diverse county, containing some of the most affluent and some of the most deprived wards in the country. The growing population of people in Kent aged 50 or older thus uses virtually all public and community services in Kent, directly or indirectly. Older people as a group are also incredibly diverse, with very different needs depending on personal circumstances. Nonetheless there are some clear common themes which emerge.

This strategy therefore aims to address those issues which older people currently face, but also to support younger people to plan and prepare for their ageing.

What do older people in Kent want?

Public services in Kent have ongoing engagement with local residents, particularly in connection with Community Strategies, so have built up a picture of the views of older residents. To supplement this, several workshops were held specifically on developing a Kent strategy for later life. These involved the public, the voluntary and community sector, representatives of BME communities, residential and domiciliary care providers, Saga, Health, Police, Fire, District and Borough Councils and KCC Directorates. This first draft reflects those discussions. It has also built on research from elsewhere, including the World Health Organization's work on Global Age-friendly Cities, and the work of the Better Government for Older People Network.

The key themes to emerge during the Kent discussions were:

1. **Valuing Later Life:** many people felt that the needs and perspectives of the older generations were sometimes overlooked, and that society as a whole did not always appreciate the many benefits that older people bring. The balance should be redressed. Those who run public services must ensure that older people's voices influence strategic planning decisions. Perhaps we should create a Kent Senior Citizens' Parliament? More widely, are there ways in which collectively we can promote positive images of later life, prevent discrimination on the grounds of age, and thus help society to value older people more?

2. **Planning for a secure old age** means individual planning for future financial security, continuing to have the opportunity of paid employment for those who want it, and ensuring that those who are entitled to benefits take them up. It also means taking action to keep fit and healthy as far as possible.

3. **Healthy Communities** are important for all age groups, but there are particular issues that are more likely to impact on older people (e.g. public transport, decent homes that are suitable as people become progressively more frail, safety in the home and on the street, accessibility of facilities, tackling social isolation, and so on.)

4. **Learning** is an essential part of adapting to the challenges that life brings at different stages, and lifelong learning was a key theme. People need excellent information to enable them to live their life as they want – stay healthy, get involved in community life, get the support they need, and so on. New technology provides particular opportunities here.

5. **Independent Living** is what everyone wants – to exercise choice and control over their everyday life. For most of us it is not an issue. But for disabled people, including frail older people, there are many ways in which the community and environment can support independent living. Good health care, housing, social services and access to transport underpin this.

ACTION PLAN

Theme 1: Valuing older people

Respect
People should have respect for each other – older people also recognised that they needed to respect young people. Part of respect is treating people as individuals, not a homogenous group, and this is an inherent part of treating people with dignity. Dignity in care was a strong theme.

Positive images of old age
In the media, all too often old people are either invisible and overlooked, or portrayed negatively. Whilst old age can bring disability and poverty, the balance needs to shift. Older people contribute a vast amount to the communities in Kent – most volunteering and unpaid caring is carried out by older people. Many people felt that in Kent we don't make the most of the wealth of experience and knowledge available amongst older people.

Towards a more caring and compassionate society
People need companionship and friendship, and communities need to tackle social isolation (which can affect all age groups, but particularly very old people). People need to be educated to look out for each other. They also need to be educated about ageing – if younger people had a better understanding of ageing perhaps they would be more tolerant, considerate and respectful of older people.

Ensuring people retain self-sufficiency and self-confidence
Part of enabling people to take responsibility for their lives, and exercise choice and control, is to ensure they have the confidence to carry it through.

Actions: Addressing and changing the nature of the society within which we live will inevitably be a slow process, and some of the issues above are very fundamental. There are actions, however, that can have a positive impact. The anti-ageism legislation is already making people think more about whether they are inadvertently discriminating against older people. Specific actions could include:

- All Kent public services, and their contractors, should reinforce the message that their staff must treat people with dignity and respect.
- Engage in a media campaign to raise the profile of older people in Kent, and have more positive images of ageing. Kent TV could be particularly useful here.
- Develop a discussion about how to create a more caring and compassionate society, greater understanding of the impact of ageing and thus empathy with older people, and how to equip people to retain their self-sufficiency and self-confidence as they age.

- Develop more schemes that enable youngsters to learn from older people's skills and experience, particularly in fields where there are skills shortages.
- Create a Kent Council or Parliament for Senior Citizens?

Theme 2: Preparation for a healthy, financially secure old age:

This needs to be a lifetime quest for people. However, it becomes particularly important that people in their middle years or beyond are planning for their future if they have not already started to do so.

Good health

During the consultation, the majority of people commented on how important it was to have good health. Whilst some poor health cannot be avoided, there is a lot that individuals can do themselves to stay healthy. Health promotion was therefore seen as very important, as was access to healthy activities such as sports facilities, walking, dances and so on. It was also seen as important to provide support and services for people that prevented further deterioration of existing conditions, and enabled them to remain independent for longer.

Prevention

The saying ' prevention is better than cure' is just as valid today as it was a hundred years ago. The drive to promote good health as a way to prevent avoidable ill health problems in later life needs to be a major priority. We need to build upon and use the experiences of successful smoking cessation initiatives to begin tackling other issues such as obesity and diabetes. We need to ensure that those people who do have long term conditions are prevented from being admitted to hospital or residential care unnecessarily. For example harnessing the benefits of new technology to support people in their homes is increasing through such schemes as Tele-heath and Tele-care.

Actions:

- The Kent Public Health Strategy sets out priorities for improving public health.
- The Annual Public Health Report has a specific chapter relating to older people, with priorities for action.
- The Kent Local Transport Plan has specific targets to improve access to hospitals and GP surgeries.
- Negotiate with leisure centres to provide free (or very cheap) access to leisure facilities at off peak times?! NB strategic discussions are already underway on this, led by Peter Gilroy
- Ensure leisure centres and other healthy activities have good public transport links.
- Learn from the Sure Start model (for children and families), and develop prevention/health promotion strategies across health services and adult services that are delivered very locally.

Enough money
Although the proportion of pensioners in poverty has fallen, economic wellbeing was a major concern of people in the consultation, who thought it important for people to plan ahead for their financial security in later life. Some thought the basic state pension should be increased so that it is sufficient to enable people to have a good quality of life so that other forms of subsidy would not be necessary. Some thought that more services should be means-tested, so that wealthier pensioners should be expected to pay for services they could afford in order to provide greater subsidy for those who could not afford to pay. The proportion of income which had to be spent on care needs, for those people who needed support, was felt to be too high, leaving them very little money to spend on anything else. Fuel poverty is a particular issue.

Actions:

- Ensure that people claim the benefits to which they are entitled and provide incentives for long-term financial planning with the correct advice. KCC's Towards 2010 document already includes a target on benefits maximisation for older people.
- Some people will choose to continue in paid work, part-time if not full–time, past state retirement age. It is important that those who do want to have paid work are not discriminated against in finding suitable employment. Ensure age discrimination legislation is applied in spirit and practice.
- Lobbying to remove the disincentives to working which exist within the benefits system.
- Develop accredited financial and insurance products specifically to benefit older people.
- Action to reduce fuel poverty.

Theme 3: Healthy Communities (Infrastructure that promotes independence and choice):

Transport and Accessibility
These two issues can have a huge impact on people's lives, and came out strongly in the consultation as an area for improvement. Issues raised included:

- Timings of buses/trains – to ensure they enable people to access particular facilities (eg theatres/cinemas – so people don't have to leave before the end of the show)
- Transport after hospital discharge was a particular issue highlighted
- Need for more flexible solutions – dial-a-ride schemes, taxi vouchers – with vehicles that can cope with wheelchairs.
- Can we negotiate for free bus passes to be used on trains?

- In order to effect any significant change we need to break through some of the complexity which surrounds public transport. This matter needs to be pursued with Central Government.

The accessibility and availability of public transport is critically important because many older people are more reliant than the majority of working-age people on public transport. Local authorities are required by the Transport Act 2000 to produce a Local Transport Plan considering how the transport needs of various groups will be addressed. The current Local Transport Plan (2006-2011) addresses the issue of accessibility and particularly social exclusion and its impact on quality of life.

About 80% of bus services in Kent are provided by private, commercial bus companies, for example Arriva and Stagecoach. Kent County Council spends around £7 million a year from the transport budget to offer the remaining 20% of bus services that are not "commercially viable", in other words services where the running costs are more than the money received from passengers fares. A large amount of these resources pay for rural bus services in the County, which provide links to villages and country areas. Without this funding these services would not exist. This budget also provides journeys that are early morning, late evening and at weekends. Priority for funding socially necessary bus services in Kent is based upon the Government's social inclusion model using access to health care, food shopping, learning and employment as the key considerations.

Only 17 per cent of disabled people are born with a disability, therefore the majority of people develop a disability later on in life, many of whom are older people. Accessibility must therefore be a key issue when considering the needs of older people. This is not only good practice, but is a requirement under the Disability Discrimination Acts 1995 and 2005. Service providers such as local authorities, shops, cafes and leisure centres have a duty not to discriminate against disabled people. Where physical features make it impossible or unreasonably difficult for disabled people to make use of a service, the service provider must either remove the feature or alter it so that the disabled person can make use of it. Examples might be ticket machines at stations, a step leading up to a shop or a toilet that isn't wide enough to manoeuvre a wheelchair into.

Transport providers such as those who run buses and trains are also required to ensure that they do not discriminate against disabled people. This could be by ensuring staff are trained in disability awareness, as well as ensuring that new vehicles are made fully accessible, and that existing vehicles are amended to ensure they are accessible for disabled people. Making a vehicle accessible means things like step free access, colour contrast within the vehicle and audible/visual information systems which can assist many older people who might not be registered disabled but nonetheless have restricted mobility or sight and hearing difficulties.

Actions:

- Identify the accessibility needs of older people in the County particularly focussing on the targets highlighted in the Accessibility Strategy for Kent (eg pedestrian access to town centres, percentage of buses with low floor access, access to fresh food etc).
- Ensure that older people continue to be a focus when improving access to key facilities such as healthcare and social opportunities.

Decent homes

KCC's recognition of the importance of decent housing in improving community well being and the quality of living is established in the 'Vision for Kent'. The provision of high quality homes is one of the Vision's nine themes. For the 50+ population, it is particularly important to plan for future housing needs, in relation to both economic wellbeing and independent living. For frail older people, the nature of their housing can have a significant impact on their degree of independence and thus quality of life.

Adapting a person's existing property to make it more suitable for them can be hugely expensive – for the individual or the state. It is also therefore very important that new housing is built to "lifetime homes" standards, making it easier to adapt, and for people to plan ahead where possible. Older people who were home owners were keen to have accredited companies to do home maintenance, because they were worried about "cowboys". Affording house maintenance and home improvements was also an issue – people were not generally aware of the schemes promoted by the Kent Housing Group which include the ten Home Improvement Agencies across the County. The Kent Handyvan scheme was greatly valued, and people also made the connection to feeling safer in their homes (in terms of accidents and crime).

Actions:

- Greater promotion and marketing of schemes that already exist to support older people in house maintenance, home improvement, gardening and so on, including Home Improvement Agencies, the 'Warm Front' scheme, and schemes that quality assure traders (need references/contacts).
- Ensure older people's needs are fully reflected in plans for new communities and developments (sustainable communities agenda).
- See also reference to community volunteering schemes later.
- Safety in the home (eg fire prevention – a key priority for the Kent Fire & Rescue Service)
- Handyvans – further expansion? More publicity?

Perceptions of crime
Although, perhaps surprisingly, this was not a major theme that emerged during the consultation, we know from national and local research that fear of crime can prevent people from accessing social activities, and contribute towards the creation of social isolation and loneliness.

Actions:
- Refer to crime prevention initiatives for older people.
- Role of Community Wardens – any further action needed?
- Perhaps a Kent "Be Smart Be Safe" handbook, with information, advice and contact details, would address a number of issues across the themes raised, not only in relation to safety.

A broad range of activities geared for older people
To increase people's participation in community life, social inclusion and the contribution they make to society, it is important to ensure that communities have a broad range of activities geared towards older people. It is essential that such people are involved in the planning of such activities. In some cases, older people themselves run activities specifically for older people – for example, over 50s clubs, Pensioner Forums, the Active Retirement Association, and so on. The World Health Organization's work on Age-friendly Cities has emphasised the importance of older people meeting with their peers and supporting each other. But in addition to this, people also want to mix with different generations and have social activities that are geared to all age groups. We must ensure that older people shape and influence the development of community activities in general, or there is a danger that their particular interests, needs and expertise could be overlooked.

Actions:
- Develop a process by which older people are involved in strategic planning for community infrastructure (if a Kent Council for Senior Citizens is created, this could be one mechanism)
- Improve access to leisure facilities by public transport and walking
- Access to support/advice to set up local activities or events – local communities taking the lead
- More publicity of existing schemes? (eg Adult Education's programmes for older people; District & Borough targeted activities, Sports Development Unit work)

Volunteering
The majority of volunteers (and those caring for people who need support) in Kent are older people. Voluntary work is important in its own right, providing community support and activities that would otherwise be unaffordable, and enabling knowledge, experience and expertise to be put to good use. There are also benefits for the volunteers in terms of the "feel good" factor from contributing to community life, which brings good self-esteem and mental wellbeing.

In Kent we are fortunate to have a thriving voluntary and community sector. Central government and local public services alike see the need to expand and enhance the "third sector". Voluntary agencies were keen to emphasise that a strategic approach is needed to ensure their sustainability and to enable them to maintain their ethos, which is distinct from that of the public sector. Considerable action is already underway, including:

- the development of a Kent-wide Voluntary Sector Compact (setting out the relationship between the public and voluntary sectors in Kent)
- targets to increase volunteering in both Towards 2010 and Kent Agreement 2 (the new Local Area Agreement, starting April 2008).
- Other action needed??

Theme 4: Learning

Innovations

The pace at which new ideas and technologies come on stream seems to get faster all the time. A number of older people were anxious about new technology and felt left behind and excluded. There are courses specifically targeted at older people, but perhaps even more are needed. Is there a market here that the private sector could fill, leaving the public sector to focus on the more socially excluded older people? There is a potential virtuous circle, because the more confident older people become with new technology, the easier it is for them to access information, support and social interaction, and there is a positive impact on their health and wellbeing. Webcams, telecare and telehealth are not a complete substitute for personal contact, but can be a tremendous supplement to it, enabling people to have virtual face-to-face contact with relatives, friends and professionals on a regular basis and as needed.

Information

At all the workshops this was discussed – people feel that they don't know how to find information about services, facilities or support at the point they need it. How do we enable people to be well informed without bombarding them with information when they don't need it? So much effort has already gone into this, so it is disappointing that it is still passing some people by. For example, Kent's Library Service is now so much broader than simply book lending. The "Ask a Librarian" scheme is fantastic and could be more widely used. Many Kent Libraries have free internet access so people without their own computer can access the web from their library. GP surgeries also need to be information hubs – people expect a great deal from their GPs, and don't always get it, and perhaps don't use their pharmacist as much as they could. As more new Gateways open (and they will be based in retail centres where people frequently visit), they will be a valuable source of information for people, as will Kent TV.

Actions:

- Greater publicity, targeted at older people, about the different ways in which people can find out information - face-to-face, by phone, or on the internet.

- Investigate the implications of providing subsidised or free broadband connections for socially isolated or vulnerable people? Could the benefits justify "investing to save"?
- Something specific on adult education?

Theme 5: Independent Living

People want to retain their independence for as long as possible, and need the community to support them in doing so. This is the major objective in 'Active Lives', KCC's ten year vision for adult social care, which sets out a number of commitments for KCC and its partners to deliver.

Person-centred approach
Increasingly people have moved away from the 'one size fits all' model of service delivery. Today people rightly expect services to be flexible and targeted at their individual needs rather than expecting people to fit around the service. Over time this is becoming more of a reality thorough such mechanisms as:

- Direct control of resources – direct payments and individualised budgets for social care
- Involving people directly in the planning and development of future services
- Planning support in a way which focuses on the needs of people

The challenge is to enable the person-centred approach to become universal, and to be applied across different agencies.

Reduce isolation*:*
The demographic projections for the future strongly indicate that there will be a far greater percentage of people living alone in later life than there has ever been in the past. What action can/should be taken to reduce social isolation? This is a community responsibility. There is plenty of evidence to show that social isolation leads to poor mental health, physical deterioration and generally a poorer quality of life and prognosis for the future. People have a fundamental need to be engaged in society.

Actions:

- How can we create more attractive housing options (across all types of tenure) for older people, which better meet their needs, reduce social isolation, and could also free up more 'family homes' for new families?
- How can we encourage more "befriending" voluntary activity?
- Develop more imaginative and available respite for people caring for friends and relatives (including respite in people's own homes, and holidays for the person being cared for)

- Increase advocacy for vulnerable groups, including people with dementia and people in residential and nursing care, to ensure that their voices are heard.
- Commission more 'intermediate care' (a half-way house for people leaving hospital) to help prevent people from moving into residential care.
- Implement "Active Lives" (the 10 year vision for social care in Kent), which includes the above actions, and more.

TAKING FORWARD THE STRATEGY

Older people were keen to know the process by which decisions were made about planning future services. They understood that resources are finite and difficult decisions have to be made about priorities, but wanted the decision-making process to be transparent so that they knew how to influence and were confident that decisions were based on a good understanding of the issues.

Once there is agreement about the priorities for action within this strategy, what mechanisms do we need to deliver the outcomes and monitor progress?

- How should we ensure that we have a mechanism for capturing older people's input into strategic service development?
- Do we need an 'older people' equivalent of the Children's Trust – ie a Management Board where older people's issues are brought together?
- Do we need a Kent Older People's Council/Parliament?

NB To secure discussion and 'sign up' to this strategy, need to develop a timetable of discussion with relevant groups/agencies/boards.

Probably need a page of reference documents, and/or glossary e.g.

1. *A Sure Start to Later Life (Dept Communities and Local Government, 2006)*
2. *Our Health Our Care Our Say (Dept Health, 2006)*
3. *Travel, Access and Older People - A review of local transport accessibility planning (Help the Aged, 2006)*
4. *Towards Lifetime Neighbourhoods (Dept Communities & Local Government, Nov 2007)*
5. *Global Age-friendly Cities: A Guide (World Health Organization, 2007)*
6. *Active Lives, the 10 year vision for social care in Kent (KCC, 2007)*
7. *Local Transport Plan (2006-2011) (KCC, 2006)*
8. *Accessibility Strategy*
9. *Communities Vision (KCC, 2007)*
10. *Regeneration Strategy (KCC 2008, in draft)*
11. *Etc…*

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Item No. B3

By:	Oliver Mills, Managing Director Kent, Adult Social Services
To:	Adult Social Services Policy Overview Committee – 1 April 2008
Subject:	**CARERS IN KENT REPORT RECOMMENDATIONS – IMPLEMENTATION PLAN**
Classification:	Unrestricted

Summary: This paper sets out the work programme put in place to take forward recommendations of the Carers in Kent Select Committee Report. The purpose of this paper is to report on the action plan arising from the recommendations of the Carers in Kent Report.

Introduction

1. (1) The Carers in Kent Select Committee report that was published on 25 January 2008 would have a major impact on the work of Kent Adult Social Services (KASS). KASS is committed to implementing the recommendations of the Select Committee Report in partnership with Children, Families and Education Directorate, Communities Directorate, Carers Support Organisations, Primary Care Trust, Independent Providers and Partner Agencies delivering Every Child Matters Outcomes.

(2) A copy of the report was sent to Ivan Lewis, Minister for Care Services on 13 February 2008 as it was agreed at the County Council Meeting on 13 December 2007[1].

(3) The implementation of the recommendations of the Select Committee report will be influenced by two key national strategies on Carers and Dementia Services. The Government is expected to launch both of these strategies later in 2008. The former may be published in June 2008.

(4) A Carers Advisory Group has been established in partnership between KASS and carers support organisations. The main purpose of the group is to represent the voice of carers and inform on service development priorities and the commissioning intention of social services and health. The group will also play an important role in the development of the multi-agency adult carers strategy and policy development. The terms of reference, which have been agreed by the Carers Advisory Group, together with the results of the local service gap analysis will be presented at a stakeholder event which is planned for June 2008.

[1] See Appendix 1 : Letter to Ivan Lewis

(5) The purpose of this paper is to report on the action plan arising from the recommendations of the Carers in Kent Report.

Implementation Plan

2. (1) Actions planned to progress the implementation of the recommendations of the report have to be prioritised to ensure that Carers and the people they care for obtain the maximum benefit.

(2) Detailed Implementation Plan for each of the recommendations is attached to this report [2]. The work programme shows the key areas where progress has been made in the first three months.

Recommendations

3. (1) Members of the Policy Overview Committee are asked to note and comment on the contents of this report.

Background documents:
a) Carers in Kent Report, 2007

Michael Thomas-Sam
Head of Policy and Service Development
6 March 2008
Tel: 7000 4843

[2] See Appendix 2 Implementation Plan

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Kent County Council
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email Michael.thomas-sam@kent.gov.uk
Your ref: Carers/L/2/08
Our ref: OM/KW
Date: 13 February 2008

Ivan Lewis
Minister for Care Services
Department of Health
79 Whitehall
LONDON SW1A 2NH

Dear Minister,

I have great pleasure in enclosing a copy of the 'Carers in Kent' report by Kent County Council Member's Select Committee on Carers. The report was presented to KCC's Cabinet at its meeting on 3rd December 2007 and the full Council subsequently debated the report and the recommendations on the 13th December 2007.

The report highlights a number of key issues, some of which are particular to Kent, but there are other issues identified in the report that have national resonance. That is why the full council agreed that I should submit the report to the review of the Prime Minister's 1999 Carers Strategy.

I hope very much that this will make an important contribution to the national strategy, together with the views of carers themselves, their support organisations and other statutory agencies.

Yours sincerely

Oliver Mills
Managing Director
Kent Adult Social Services

cc: Linda Doherty, Association of Directors of Adult Social Services
Kevin Lynes, Cabinet Member, Kent Adult Social Services
Les Christie, Chairman, Select Committee on Carers, KCC
Angela Evans, Overview and Scrutiny, KCC
George Koowaree, County Councillor, Ashford East

Appendix 2

CARERS IN KENT - REPORT RECOMMENDATIONS
IMPLEMENTATION PLAN – 10th MARCH 2008

No.	Recommendation	Agency	Action	Timeframe	Status
1	Raise awareness and profile of carers and carers support services and make information available out of standard hours	KASS/ CFE	• Develop Kent wide Young Carer Leaflet and make available to all agencies/organisations • Improve links between the County Duty Service and the Contact Centre • Support carers week events in Kent • Update carers information on the adult carers website • Update carers information fact sheets • Consider impact of transport on carers sustainability in the Kent Strategy for Later Life • Identify how carers can inform the Local Involvement Network(LINK) • Identify ways to involve carers in the recruitment process • Continue to work with partners to enable carers to access benefits and other money advice • Develop plans to involve carers in training on carers awareness • Progress the expansion of the “Learning for Living” programme for adult carers	June 2008 Ongoing June 2008 April 2008 July 2008 March 2008 Ongoing Ongoing Ongoing July 2008 March 2009	On course On course On course On course On course Completed On course On course On course On course On course

2	Promote Single point of Contact for carers	KASS/ CFE	• Explore how a national information line can link to local carers information sources • Work with partners to ensure information formats are accessible to all carers • Develop Kent-wide single point of contact via the KCC Contact Centre	November 2008 Ongoing September 08	On course On course On course
3	Involvement of the carer support organisations at assessment and subject to carers consent, sharing the statutory assessment should be considered	KASS	• KASS Commissioners to consider as part of the commissioning requirements for 2008/09 • Ensure policy on confidentiality is not used to exclude carers inappropriately	June 2008 Ongoing	On course On course
4	Reviews or contact from Care Managers should be regular with annual as a minimum	KASS	• Ensure that KASS Policy is consistent with DH Guidance • Monitor operational teams performance against the policy • Include information in the planned carers annual report • Ensure carers know about who and how to contact key staff in KASS and providers	January 2008 Ongoing November 08 Ongoing	Completed On course On course On course

5	District Social Services Teams to address and overcome issues around call management	KASS	• Heads of Services to have systems in place • Monitor the issue over time	March 2008 On-going	Completed On course
6	Emergency Card Schemes backed up by emergency plans and response teams should be expanded and developed Kent-wide if the pilot is successful	KASS	• Evaluate the emergency card scheme • Commission and design emergency card with carers input • Commission carers emergency cover services • KASS to continue to provide a range of short breaks • Publicise emergency card scheme and roll-out County-wide	May 2008 September 08 September 08 Ongoing September 08	On course On course On course On course On course
7	KCC with Health and VCO's need to ensure that provision of respite/breaks is flexible, of the right type and that the provision meets the needs of carers as well as for the cared-for person	KCC/Health	• Work with provider/Carer Support Organisations to be able to better respond • Enhance Commissioning of Services for Carers with Disabled Children • Ensure young carers can access respite through provider groups • Work with health to support carers in delivering the requirements of the NHS Operating Framework, ensuring impact on carers health is understood; carers issues are addressed at the point of hospital discharge	Ongoing March 2008 Ongoing Ongoing	On course On course On course On course

8	Multi-Agency Adult Carers strategy to be progressed as a priority	KASS	• Establish a multi-agency group to plan, develop and implement multi-agency Kent Adult Carers Strategy (informed by the revised National Carers Strategy, when published) • Develop draft strategy • Consult on draft strategy • Develop implementation plan • Establish Carers Advisory Group • Conduct Gap analysis • Identify priorities for service development	June 2008 November 08 January 09 February 09 February 08 March 2008 April 2008	On course On course On course On course Completed On course On course
9	Need to ensure that awareness is raised within schools to increase the understanding of what is meant by a "young carer", find ways to identify and support young carers. Ensure that actions to support "young carers" within schools are identified and put in place	CFE	• Guidance for schools on how to support young carers has been developed • Develop governor training pack • Repeat survey of schools to identify the number of young carers • Raise awareness with schools staff through a variety of media and events • Develop Kent wide Young Carer Leaflet and make available to all agencies/organisations	February 2008 December 08 December 08 Ongoing June 2008	Completed On course On course On course Completed

10	Consider the need for a clearly identified "Lead" for young carers on CSS operational front and education, alongside those for policy/strategy	CFE	• Lead for Children, Families and Education in place • Implement the Common Assessment Framework (CAF)	September 07 Ongoing	Completed On course
11	Need to ensure clear responsibilities and referral pathway for young carers between Kent Adult Social Services, CFE and other agencies. Protocols between KASS and CFE to be developed.	CFE/KASS	• Develop protocols to clarify roles and information sharing • Key CFE documents on KASS Website for access by Staff • KASS agreed Policy Statement on duty to safeguard and promote the welfare of children in place	May 2008 February 08 February 08	On course Completed Completed
12	Invisible people – the multi-agency young carers strategy and accompanying commissioning strategy should be implemented urgently and monitored to ensure objectives in targets are met.	CFE/Health	• Seek approval from the Kent Children's Trust County Board • Seek KCC Member approval • Launch strategy and associated documents • Produce annual report on delivery	January 2008 May 2008 July 2008 Ongoing	Completed On course On course On course

13	KCC in partnership with Health and the VCO's need to improve understanding and sign posting from Health sector to available help and support for carers in the county.	KCC/Health	• Work with health to support carers in delivering the requirements of the NHS Operating Framework • Develop Kent wide Young Carer Leaflet and make available to all agencies/organisations • Improve links between the County Duty Service and the Contact Centre	Ongoing June 08 Ongoing	On course Completed On course
14	KCC to pursue with Health, the need to consider how carers of Mental Health patients (and service users) can be better supported, particularly at times of crisis and out of hours.	KCC/Health	• Work with Kent and Medway PCT's to ensure that commissioning of services considers how carers or people with Mental Health needs are supported • Ensure policy on confidentiality is not used to exclude carers inappropriately	Ongoing Ongoing	On course On course

Item No. B4

By:	Oliver Mills, Managing Director, Kent Adult Social Services
To:	Adult Social Services Policy Overview Committee - 1 April 2008
Subject:	**NATIONAL FRAMEWORK FOR NHS CONTINUING HEALTHCARE**
Classification:	Unrestricted

Summary: This paper sets out the essential summary of the National Framework for NHS continuing healthcare. The purpose of this report is to update Members on the implementation of the National Framework. Specifically on the local application process, appeal mechanism for individuals and the procedure for resolving disputes between the NHS and Kent Adult Social Services (KASS).

Introduction

1. (1) **'NHS continuing healthcare'** is the term used to describe a package of services for people either in care homes or their own homes which is arranged and funded solely by the NHS. NHS services are free unlike services arranged or provided by adult social services, which may be subject to a charge.

(2) The Department of Health (DH) published the *'National Framework for NHS continuing healthcare and NHS-funded nursing care'* on 26 June 2007, with an **implementation date** of 1 October 2007. The Association of Directors of Adult Social Services (ADSS) and the Local Government Association (LGA) have also published a *'Commentary and Advice for Local Authorities'* document that provides local authorities with advice on how to interpret the DH National Framework.

(3) Copies of the *'Public information booklet'* have been placed in the Member Library. The booklet is accessible via the following link: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079515. The full list of the associated documents is shown at the end of this report.

(4) Ivan Lewis, Minster for Care Services, provided information about the number of people receiving NHS continuing healthcare in each Primary Care Trust (PCT) area for 2007, in a parliamentary answer on 22 February 2008. The comparative information in the South East Coast Strategic Health Authority area and also in the Kent Local Authority comparator areas is set out in Appendix 1.

Essential Summary of the Policy

2. (1) The introduction of the National Framework, which only applies in England, removed the need for each of the 10 Strategic Health Authorities to have their own rules for deciding who qualifies for NHS continuing healthcare. The eligibility 'test' is based on a person having a **'Primary Health Need'** (PHN). PHN is determined by decisions about the:

- **Nature -** the type of needs, and the overall effect of those needs on the individual, including the type ("quality") of interventions required to manage them;
- **Intensity -** both the extent ("quantity") and severity (degree) of the needs, including the need for sustained care ("continuity");
- **Complexity** - how the needs arise and interact to increase the skill needed to monitor and manage the care;
- **Unpredictability** the degree to which needs fluctuate creating difficulty in managing needs; and the level of risk to the person's health if adequate and timely care is not provided.

(2) Any one of these factors may, alone or in combination, indicate PHN. The eligibility for NHS continuing healthcare is not decided nor influenced by the setting of where the care is provided or by the characteristics of the person who delivers the care.

(3) A local authority will be acting unlawfully in funding people with needs above the level that it has a legal duty to provide, that is, individuals with PHN. There is a **legal upper limit** to the nursing and healthcare that a local authority can provide whilst there is **no legal lower limit** to what the NHS can provide. This means those occasions where gaps arise between the local authority provision and NHS continuing healthcare entitlement, a pragmatic solution such as a **joint package of care** is the sensible way forward, provided that both bodies agree the an individual does not have a PHN.

(4) The Secretary of State for Health has issued statutory instructions *(The NHS Continuing Healthcare [Responsibilities] Directions)* under the powers of the National Health Service Act 2006 and of the Local Authority Social Services Act 1970. These define the duties of the Primary Care Trust in determining eligibility for NHS continuing healthcare. The **Directions** also place a requirement on the NHS and Councils to resolve any dispute in accordance with a dispute resolution procedure agreed between the two bodies.

(5) The Government replaced the three Registered Nursing Care Contribution bands (High, medium and low) with a single rate of £101.00 for 2007/08. As yet, no decision has been made on adjusting the rate for 2008/09.

Local Implementation Arrangements

3. (1) Kent and Medway PCTs, Kent County Council and Medway Council have developed **operational protocols** that set out the roles and responsibilities for key health and social care staff. The protocols take staff through a step-by-step process with defined timescales for the completion of work.

(2) The **application process** starts with the completion of an assessment of a person's health and care needs, by a multi-disciplinary team (at least two professionals from the NHS and social services). If appropriate, the team makes a recommendation for NHS continuing healthcare. The Primary Care Trust Continuing Care Co-ordinator completes a Decision Support Tool for the PCT Panel to make its decision.

(3) Key frontline staff from both health and social services have been **trained** and have the requisite knowledge to apply the new policy.

(4) A person has a **right to appeal** against a decision by the PCT if he or she is not happy with the outcome of the assessment. It is the PCT's responsibility to inform the person that they may apply for a review of the decision. This is known as the Independent Review Panel (IRP). The purpose of the panel is to check that proper procedures have been followed in reaching a decision about eligibility. The review process does not apply where individuals or their families and any carers wish to challenge:

- content of the eligibility criteria;
- type and location of any offer of NHS funded continuing care services;
- the contents of any alternative care package which may be offered;
- their treatment or any other aspect of the services they are receiving or have received.

(5) There are separate procedures for **resolving disputes** between the NHS and KASS. Both bodies have agreed that whilst this process is on-going, the care of the individual should not be compromised or delayed. The PCTs and the KASS have agreed to adopt a **"Without Prejudice"** approach to such situations whereby the final outcome of the dispute will be backdated to the time of the original funding request. People in their homes or care homes funded by the local authority will continue to be supported by the Council. Similarly, anyone in hospital or funded by the PCT will remain funded by the NHS until the dispute is resolved. If the Council continued to fund the care that consequently is decided to have been the responsibility of the NHS, the PCT will backdate the repayment to the Council. Likewise, where the PCT continued to pay for a service that later is decided to have been the responsibility of the local authority, the Council will backdate the reimbursement to the PCT.

(6) It is important to evidence fairness and equal treatment, we have therefore put performance monitoring systems in place to assess the consistency of PCT decision-making.

Recommendations

5 (1) Members of the Policy Overview Committee are asked to note and comment on the contents of this report.

Background documents:

a) National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

b) NHS-funded Nursing Care Practice Guide

c) Final versions of National Framework Decision Support Tools

d) The NHS (Nursing Care in Residential Accommodation) (England) Directions 2007

e) The Delayed Discharges (Continuing Care) Directions 2007

f) The NHS Continuing Healthcare (Responsibilities) Directions 2007

g) NHS Continuing Healthcare and NHS-funded Nursing Care – Public Information Leaflet

h) The NHS Continuing Healthcare Frequently Asked Questions (FAQ)

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Head of Policy and Service Development
6 March 2008
Tel: 7000 4843

Appendix 1

NUMBER OF PEOPLE RECEIVING NHS CONTINUING HEALTHCARE
IN THE SOUTH EAST COAST HEALTH AUTHORITY AREA

	No of People Receiving Continuing Care				No of People per 50,000 Population			
	Q4 2006-07	Q1 2007-08	Q2 2007-08	Q3 2007-08	Q4 2006-07	Q1 2007-08	Q2 2007-08	Q3 2007-08
England	30,975	24,952	27,619	29,092	30.51	24.68	27.32	28.78
Brighton & Hove PCT **(5LQ)**	246	156	135	1112	48.92	30.34	26.26	21.79
East Sussex Downs and Weald PCT **(5P7)**	211	181	151	151	31.96	27.82	23.21	23.21
Eastern and Coastal Kent PCT **(5QA)**	692	329	304	319	48.02	23.17	21.41	22.47
Surrey PCT **(5P5)**	355	388	582	513	16.54	18.30	27.45	24.19
West Kent PCT **(5P9)**	152	305	278	318	11.47	23.23	21.17	24.22
West Sussex PCT **(5P6)**	687	365	494	293	44.57	23.74	32.14	19.06
Medway PCT **(5L3)**	81	117	155	149	16.09	22.11	29.29	28.16

NUMBER OF PEOPLE RECEIVING NHS CONTINUING HEALTHCARE
IN THE KENT LOCAL AUTHORITY COMPARATOR AREAS

	No. of People Receiving Continuing Care				Number of People per 50,000 Population			
	Q4 2006-07	Q1 2007-08	Q2 2007-08	Q3 2007-08	Q4 2006-07	Q1 2007-08	Q2 2007-08	Q3 2007-08
England	30,975	24,952	27,619	29,092	30.51	24.68	27.32	28.78
Bedfordshire PCT **(5P2)**	159	172	163	170	19.68	21.13	20.02	20.88
Bristol PCT **(5QJ)**	127	86	123	110	15.47	10.18	14.56	13.02
Central and Eastern Cheshire PCT **(5NP)**	163	100	169	188	18.07	11.27	19.04	21.19
Central Lancashire PCT **(5NG)**	192	206	214	224	21.25	23.50	24.41	25.56
East and North Hertfordshire PCT **(5P3)**	362	285	244	250	34.29	26.11	22.35	22.90
East Lancashire PCT **(5NH)**	130	116	117	135	16.89	15.51	15.64	18.05
East Sussex Downs and Weald PCT **(5P7)**	211	181	151	151	31.96	27.82	23.21	23.21

Gloucestershire PCT **(5QH)**	68	61	62	65	5.88	5.30	5.39	5.65
Mid-Essex PCT **(5PX)**	918	273	94	94	126.92	38.70	13.33	13.33
North East Essex PCT **(5PW)**	54	56	63	89	8.56	8.98	10.10	14.27
Norfolk PCT **(5PQ)**	269	233	262	301	18.20	16.30	18.32	21.05
Oxfordshire PCT **(5QE)**	193	145	224	205	15.89	11.91	18.40	16.84
South East Essex PCT **(5P1)**	298	111	169	174	45.21	16.84	25.63	26.39
South Gloucestershire PCT **(5A3)**	168	77	98	91	33.02	16.04	20.41	18.95
South West Essex PCT **(5PY)**	142	67	132	128	18.28	8.50	16.74	16.23
Southampton City PCT **(5L1)**	275	275	275	220	60.14	56.55	56.55	45.24
Suffolk PCT **(5PT)**	57	49	64	94	4.87	4.21	5.50	8.08
Surrey PCT **(5P5)**	355	388	582	513	16.54	18.30	27.45	24.19
West Essex PCT **(5PV)**	86	90	95	74	15.64	17.32	18.29	14.24
West Hertfordshire PCT **(5P4)**	333	290	238	265	31.37	27.20	22.33	24.86
West Sussex PCT **(5P6)**	687	365	494	293	44.57	23.74	32.14	19.06
West Cheshire PCT **(5NN)**	133	93	94	90	28.27	19.00	19.21	18.39

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Item No. B5

By:	Oliver Mills, Managing Director Adult Social Services
To:	Adult Social Services Policy Overview Committee – 1 April 2008
Subject:	**ADULT SERVICES BUDGET MONITORING 2007/08**
Classification:	Unrestricted

Summary: A report on the forecast outturn against budget for the third quarter for Kent Adult Social Services.

Introduction

1. (1) This report is the third of what will be a regular report to this Committee on the forecast outturn against budget for the Adult Social Services Department.

Background

2. (1) Policy Overview Committees consider the draft Medium Term Financial Plan at their November and January meetings. To enable a more informed discussion, three reports will be presented to the Committee on a regular basis:

a) **Budget Monitoring reports**
A detailed quarterly budget monitoring report is presented to Cabinet, usually in September, December and March, and a draft final outturn report in June. A report for each directorate is annexed to the summary report, and the annex for the Adult Social Services Directorate will be presented to this Committee at the meetings following those Cabinet meetings. This will help inform this POC about current trends, pressures and management actions in advance of the next year's budget setting

b) **Performance data**
This will be reported at least half-yearly to this Committee.

c) **Outturn report**
Effectively an amalgam of the above two, the outturn report will summarise both the financial and performance information for the whole of the preceding year

(2) Informed by these reports, the POCs will be in a stronger position to question and comment on the future budget and medium term proposals, as they will be asked to do at the November and January meetings.

Third Quarter monitoring report

3. (1) The monitoring report for the third quarter for Adult Services is attached (Appendix 1) and this indicates an overall revenue pressure of £2,853k for the Directorate. This is a decrease on the previous pressure of £4,109k as reported to POC in January. The reduction in part results from the impact of management actions imposed to bring the Directorate back to a balanced position, and primarily relate to decreases in Older People, Mental Health and Other Services. The reduction also results from additional funding secured from the Eastern and Coastal Kent PCT in respect of intermediate care and services for patients leaving hospital and requiring social care. This funding recognises the growing pressures that have been seen within our financial forecast on services for older people, and also enables us to work jointly to extend the strategy for intermediate care across the East Kent area for 2008-09. The income and any associated costs have now been included within the forecast.

(2) Although a range of management actions remains in place, the amount of financial savings generated have, to some extent, been offset by increased demand for services. It is therefore considered prudent to forecast a year end pressure, after Management Action, of £1,915k.

(3) The main areas to note within the third quarter's position are:

- Older People -£193k – on-going demographic pressures remain on domiciliary care, particularly where used as an alternative to residential placements. It has also proved difficult to evidence a switch in activity from other services to Direct Payments, even though budgets have been adjusted for this. However there have been reductions in the number of nursing and residential primarily as a result of higher than expected attrition. The funding secured from the Eastern & Coastal Kent PCT has also helped to allay some of the pressures within Older People;
- People with Learning Disabilities +£4,781k – this is due to on-going demographic and price pressures within all main areas of expenditure, including residential, direct payments, daycare, domiciliary and supported and other accommodation;
- People with Physical Disabilities +£1,492k – as with Leaning Disabilities, there are significant pressures across all services, but primarily direct payments, where increases are not matched by decreases elsewhere, and supported and other accommodation;
- Assessment & Related -£939k – the increased underspend results from on-going management of vacancies and planned slippage of costs to try to reduce budget pressures in commissioning. The funding secured from the Eastern & Coastal Kent PCT has also helped to allay some of the pressure within the hospital care management team;
- Older People Direct Services Unit +£260k – although significant pressure relating to utility and staffing costs remain;
- Adult Services Provider Unit -£121k – the underspend results from vacancy management, some additional rent for group homes and the decision to close some respite units over the Christmas period, which was not previously anticipated.

- Occupational Therapy Bureau -£167k – this results from absorbing pressures to fund replacement of hoists rather than using the provision created in the previous year, together with some slippage against planned recruitment;
- Mental Health -£110k – Mental Health is now forecasting an underspend as a result of implementing management actions, primarily reductions and delays in planned residential placements which has brought the forecast down by £90K in recent weeks, together with vacancy management;
- Other -£2,150k – this results from both management action around staffing vacancies as well as some specific savings. These include: £525k in training; £468k provision for System Renewal Programme costs not now required; £122k part year savings on the establishment of a systems support team; and £278k underspend on facilities budgets within the Directorate. There are also £336K savings within Area business units, and £207K savings within Performance, Planning and Contracting, both as a result of vacancy management.

Recommendations

4. (1) Members of the Policy Overview Committee are asked to note the projected outturn figures for the directorate as at the third quarter

Michelle Goldsmith
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KENT ADULT SOCIAL SERVICES DIRECTORATE SUMMARY JANUARY 2007-08 FULL MONITORING REPORT

1. FINANCE

1.1 REVENUE

1.1.1 All changes to cash limits are in accordance with the virement rules contained within the constitution, with the exception of those cash limit adjustments which are considered "technical adjustments" i.e. where there is no change in policy, including:

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits have been adjusted since the last full monitoring report to reflect a number of technical adjustments to budget.

1.1.2 **Table 1** below details the revenue position by Service Unit:

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Adult Services portfolio							
Older People	167,460	-68,849	98,611	1,246	-1,439	-193	Demographic and placement pressures
People with a Learning Difficulty	72,939	-20,502	52,437	4,267	514	4,781	Demographic and placement pressures
People with a Physical Disability	26,089	-5,558	20,531	1,454	38	1,492	Demographic and placement pressures
Adults Assessment & Related	29,559	-4,357	25,202	-730	-209	-939	Management action around staffing
Older Persons Direct Service Unit	24,273	-3,712	20,561	275	-15	260	Staffing & utility costs
Adult Service Provider Unit	13,868	-780	13,088	-128	7	-121	Management action
SESEU	1,876	-436	1,440	14	10	24	
Occupational Therapy Bureau	9,055	-2,885	6,170	670	-837	-167	Release of provision for replacement hoists
Mental Health Service	23,323	-7,275	16,048	-216	106	-110	Management action around residential placements and staffing
Supporting People	33,006	-33,006	0	-20	0	-20	
Gypsy Unit	625	-280	345	-9	6	-3	
Asylum All Appeal Rights Exhausted	100	0	100	-20	0	-20	
Strategic & Area Management	649	-3	646	21	3	24	
Performance, Contracting & Planning	7,331	-1,784	5,547	-696	-147	-843	Management action around staffing
Training, Duty & Support	15,248	-4,110	11,138	-1,245	-67	-1,312	Staff savings, training budget and facilities
Total Adult Services controllable	**425,401**	**-153,537**	**271,864**	**4,883**	**-2,030**	**2,853**	
Assumed Management Action				**-1,227**	**289**	**-938**	
Forecast after Mgmt Action				**3,656**	**-1,741**	**1,915**	

1.1.3 **Major Reasons for Variance**:

Table 2, at the end of this section, details all forecast revenue variances over £100k. Each of these variances is explained further below:

1.1.3.1 General Comment

KASS continues to face significant budget pressures in common with many other local authorities. These primarily relate to demographic and price pressures within services for People with Learning Disabilities.

Contributions to KASS from the Eastern & Coastal Kent PCT

Over recent weeks, we have reached a successful agreement with the Eastern & Coastal Kent PCT in respect of intermediate care proposals and services for patients leaving hospital and requiring social care. We have secured funding from the PCT, which both recognises the growing pressures that have been seen within our financial forecast on services for older people, but also allows us to start working jointly on a strategy for intermediate care across the East Kent area for 2008-09. The income and any associated costs have now been included within the forecast

1.1.3.2 Older People (-£193k)

The number of permanent residential placements continues to fall, both as result of higher than expected attrition, together with the implementation of management actions. The number of placements remains at a level well below target and this has resulted in a significant underspend of £703k. Although the number of permanent nursing placements has fallen since a high of 1,433 in September, the number remains at a level in excess of target and this has resulted in a forecast overspend of £242k. Despite the on-going demand for beds for transfers from hospitals, as with residential, there has been a higher than expected level of attrition in nursing placements. The Directorate also continues to benefit from the Preserved Rights Specific Grant as attrition remains higher than allowed for in the grant allocation. The current underspend against this line is £556k.

Expenditure on domiciliary care remains the most significant pressure within Older People. The reduced rate of residential placements continues to impact on this line as domiciliary care is often seen as the alternative to seeking a permanent placement. From Section 2 of this report it can be seen that although both the number of clients and the amount of hours provided have dropped slightly in Quarter 3, the actual average hours provided to each client has increased. This reflects the increasing level of support that is required to enable those clients, who would otherwise be in residential care, to remain in their own homes. As a result there is an increasing number of cases where two care workers are required to meet the needs of the client leading to increased costs overall. This, together with on-going demographic pressures, and the transfer of budget to Direct Payments without evidence of a corresponding reduction in activity as clients switch to Direct Payments, have all contributed to the forecast overspend of £1,630k.

The forecasts also include the impact of the Ombudsman decision in relation to our practices on charging for domiciliary care, specifically that we backdate charges to the date that a service starts and not to the date of notification of the charge to the client. This has resulted in a reduction in income of £225k. However there have been increases in income of £525k across a number of other budget lines as a result of increased activity.

Following review it has been identified that both the gross and income forecasts relating to the Partnerships for Older People Projects (POPPS) – Independence through the Voluntary Action of Kent's Elders (INVOKE) project in East Kent were incorrectly included against Assessment & Related. Although there has been no impact on the net position this has resulted in a transfer of forecast of £454k gross and income to Older People. The project will be run by a number of partners including KASS, the Eastern & Coastal Kent PCT, Voluntary Sector Providers and Community Action groups. Its objectives include reducing inappropriate hospital admissions and long term placements, creating community services that focus on prevention of ill health and promotion of wellbeing, and involving the public, patients, and other members of the community in the redesign of services and service delivery.

As indicated above funding has been secured from the Eastern & Coastal Kent PCT to allay some of the pressures within Older People and to date some £550k of additional income has been factored into the forecast.

1.1.3.3 People with Learning Disabilities (+£4,781k)

Services for this client group remain under extreme pressure as a result of both demographic and placement price pressures. As a result there continue to be significant forecast overspends against the main budget lines – residential, direct payments and supported accommodation/independent living, day care and domiciliary. Part of the pressure relates to the impact of young adults transferring from Children's Services, many of whom have very complex needs and require a much higher level of support. Alongside these so-called "transitional" placements is the increasing number of older learning disabled clients who are currently cared for at home by ageing parents who will begin to require more support. There are also more cases of clients becoming "ordinarily resident" in Kent. This is the term used to describe people deemed to be living in the county and therefore the responsibility of KCC, rather than just receiving care in a residential or nursing placement. A client would become "ordinarily resident" following de-registration of a residential home and conversion to supported accommodation, something which is starting to happen more frequently.

In December the Directorate reached agreement with Health over a number of jointly funded residential placements, the responsibility for whom had been in dispute for several years. These clients were jointly assessed as having social care needs rather than health, with the result that the Directorate has had to write off over £300k of invoices that had been raised. Although these invoices had been 100% provided for in previous years, the action of writing off a debt reduces the income reported for the current year.

1.1.3.4 People with Physical Disabilities (+£1,492k)

There are similar pressures here to those for services for People with Learning Disabilities – an increase in direct payments, without a corresponding reduction in domiciliary and other costs, together with demand and demographic pressures against residential care budgets, day-care and supported accommodation.

1.1.3.5 Assessment & Related (-£939k)

The underspend results from management action around staffing vacancies. There is planned slippage across all areas including the Policy team, Direct Payments Advisory service and Exchequer services (Specialist Finance Teams).

Also within this position is £200k of income from the Eastern & Coastal Kent PCT which in part is being used to offset staffing pressures within the hospital care management team. These relate to posts that could not be held vacant and could therefore not form part of the Directorate's Management Actions.

1.1.3.6 Older People Direct Services Unit (+£260k)

The overspend is a combination of higher than anticipated utility costs, together the continuing need to cover sickness and other absence with agency staff in order to meet care standards set by the regulator (Commission for Social Care Inspection).

1.1.3.7 Adult Services Provider Unit (-121K)

The underspend relates to vacancy management, some additional rent for group homes and the decision to close some respite units over the Christmas period, which was not previously anticipated.

1.1.3.8 Occupational Therapy Bureau (-£167k)

This underspend has arisen for two reasons. Firstly, although a provision of £100K was set up last year to fund the bulk replacement of hoists on health and safety grounds, the OTB has been able to absorb these costs within existing budgets'. This allows the full amount of the provision to be released as an underspend. Secondly there is also some slippage against planned recruitment.

1.1.3.9 Mental Health (-£110k)

The underspend within Mental Health relates to Management Actions, primarily reductions and delays in planned residential placements which has brought the forecast down by £90K in recent months, together with vacancy management.

1.1.3.10 Other (-£2,150k)

Principally relates to management action around staffing vacancies, but there are some specific savings including:

- -£525k – management action against training.
- -£468k – provision for risks in SRP costs not now required
- -£122k – delay in recruitment of the systems support team.
- -£278k – management action in facilities.
- -£336k – management of vacancies in area business units.
- -£207k – Performance, Planning & Contracting – management of vacancies
- -£89k – management of vacancies in Finance.
- -£20k – Asylum All Appeal Rights Exhausted – underspend
- -£326k – management action – Resources
- -£20k – Supporting People Admin underspend

Alongside these savings are several areas of budget pressure:

- +£15k – pressure on Personnel.
- +£80k – pressure on legal costs of Housing PFI
- +£50k – pressure on legal services SLA
- +£79k – pressure on enhanced pensions

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
KASS	Older People Domiciliary expenditure	+1,630	KASS	Eastern & Coastal Kent PCT income	-750
KASS	Learning Disability Residential	+1,059	KASS	Assessment & Related - Management action around staffing	-739
KASS	Learning Disability Supported Accommodation	+1,012	KASS	Older People Residential	-703
KASS	Learning Disability Independent Living Schemes & Group Homes	+1,002	KASS	Older People Preserved Rights	-556
KASS	Learning Disability Direct Payments	+839	KASS	Management Action on Training	-525
KASS	Physical Disability Direct Payments	+769	KASS	Older People income	-525
KASS	Learning Disability Domiciliary expenditure	+348	KASS	Provision for risk within SRP expenditure not now required	-468
KASS	Learning Disability Day Care/Day Opportunies	+346	KASS	Area Contracts & planning Teams - management action around staffing	-336
KASS	Learning Disability Impact of review of joint funded placements with Health	+306	KASS	Management Action - Resources	-326
KASS	Physical Disability Supported Accommodation	+268	KASS	Mental Health Assessment & Related - vacancy management	-292
KASS	Older Persons Direct Services Unit (staffing costs)	+247	KASS	Management Action in Facilities	-278
KASS	Older People Nursing (excl Pres Rights)	+242	KASS	HQ Policy & Performance - management action around staffing	-207

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
KASS	Physical Disability Day Care Exp.	+226	KASS	Part year saving on establishment of SRP Systems Support Team	-122
KASS	Part year impact of 'fairer charging' decision by Ombudsman	+225	KASS	Occupational Therapy Bureau - Provision for Replacement Hoists	-100
KASS	Mental Health Residential Care exp.	+151			
		+8,670			-5,927

1.1.4 **Actions required to achieve this position**:

Management Action plans were finalised in August which, at the time, were anticipated to bring us back to a breakeven position. Whilst there has been some progress in Management Actions within the Area commissioning budgets, doubts remain about achieving the full amount required to bring the Directorate back to a balanced position. It is therefore considered prudent to continue to forecast a year end pressure, after Management Action, of £1,915k.

It should be noted that the management actions that KASS has implemented, were considered to be within existing policy and targeted across all expenditure lines. The main elements were:

- Higher level of scrutiny through panel process on new placements of residential and nursing.
- Review all domiciliary care packages to maximise throughput, reduce long term dependency & increase recovery / rehabilitation.
- Invest to Save Scheme for LD Residential Change to reduce residential placements in favour of supported living arrangements.
- Continue to pursue large health debt cases for specific clients.

- Recruit only to posts in care management where the traffic light system indicated as essential.
- Reduce use of agency staff and other costs across the non-direct service lines.

However as a result of discussion in November with the Leader and Chief Executive a number of those actions which potentially impacted on transfers of care and hospital staffing were relaxed.

We do feel that management actions have been achieved in the following areas:

- Older People Residential & Nursing Care – a net reduction of approximately 130 permanent clients, this has however been offset by some increases in non-permanent and intermediate care placements. This has been partly achieved by the joint working with the NHS in respect of their contribution to hospital transfers and the setting up of intermediate care schemes.
- Less clients are now in receipt of domiciliary care, however those new clients now requiring services, generally have more complex needs and therefore the hours being provided have increased, and hence costs have not reduced significantly.
- In the past 5 months there has been no net increase to the number of learning disabled clients in residential care, and there have been significant increases in clients being placed in supported living arrangements. It should be noted however that those clients who are requiring residential care, have far more complex needs and their costs are significantly more than those who are able to move into community type placements.
- The Mental Health service has achieved some £400K of management action in the past 5 months which has been across a number of services.
- Successful negotiation has been reached with the Eastern & Coastal Kent PCT regarding all aged debts, and this has allowed us to release some £300K of our bad debt provision back to revenue.
- We have achieved approximately £200K of savings in Assessment and Related services in recent months.
- A further £200K of savings has been achieved across the non-direct service lines since August.

1.1.5 **Implications for MTFP**:

The 2008-11 Medium Term Plan fully reflects the underlying pressure the directorate faces.

1.1.6 **Details of re-phasing of revenue projects**:

No revenue projects have been re-phased.

1.1.7 **Details & impact of proposals for residual variance**:

The roll forward of the £1.915m residual variance to 2008-09 will be considered at year end in the light of the overall outturn position for the Authority.

1.2 CAPITAL

1.2.1 All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader or relevant delegated authority.

Cash limits have been adjusted since the last full monitoring report to reflect:

	2007-08	2008-09	2009-10	Future Years
	£000s	£000s	£000s	£000s
▪ Re-phasing per 2008-11 MTP	-5,771	155	2,438	2,053
▪ External funding and revenue funding	10			

for Gypsy Sites
- Reversal of previous virement to CF&EA portfolio in respect of Improving Information Management grant 40

1.2.2 **Table 3** below provides a portfolio overview of the latest capital monitoring position.

	Prev Yrs Exp £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	Future Yrs £000s	TOTAL £000s
Kent Adult Social Services portfolio						
Revised Budget per Dec Cabinet	16,764	11,023	5,786	1,794	4,687	40,054
Adjustments:						
- Re-phasing per 2008-11 MTP		-5,771	155	2,438	2,053	-1,125
- Gypsy Sites		10				10
- virement from CF&EA portfolio		40				40
						0
Revised Budget	16,764	5,302	5,941	4,232	6,740	38,979
Variance		-795	795	0	0	0
split:						
- real variance		0				0
- re-phasing		-795	+795			0

Real Variance		**0**	**0**	**0**	**0**	**0**
Re-phasing		**-795**	**+795**	**0**	**0**	**0**

1.2.3 Main Reasons for Variance

Table 4 below, details all forecast capital variances over £250k in 2007-08 and identifies these between projects which are:
- part of our year on year rolling programmes e.g. maintenance and modernisation;
- projects which have received approval to spend and are underway;
- projects which are only at the approval to plan stage and
- projects at preliminary planning stage.

The variances are also identified as being either a real variance i.e. real under or overspending which has resourcing implications, or a phasing issue i.e. simply down to a difference in timing compared to the budget assumption.

Each of the variances in excess of £1m which is due to phasing of the project, excluding those projects identified as only being at the preliminary planning stage, is explained further in section 1.2.4 below.

All real variances are explained in section 1.2.5, together with the resourcing implications.

Even though table 3 above shows re-phasing of £0.795m into 2008-09, table 4 and section 1.2.4 below, contain no detail of forecast capital variances over £250k, and slippage in excess of £1m in 2007-08 respectively, as the individual projects affected fall below these amounts now that the capital cash limits have been adjusted for the re-phasing reflected in the 2008-11 MTP.

Table 4: CAPITAL VARIANCES OVER £250K IN SIZE ORDER

			Project Status			
portfolio	Project	real/ phasing	Rolling Programme	Approval to Spend	Approval to Plan	Preliminary Planning Stage
			£'000s	£'000s	£'000s	£'000s
Overspends/Projects ahead of schedule						
	None					
			0	**0**	**0**	**0**
Underspends/Projects behind schedule						
	None					
			0	**0**	**0**	**0**
			0	**0**	**0**	**0**

1.2.4 **Projects re-phasing by over £1m**:

None

1.2.5 **Projects with real variances, including resourcing implications:**

KASS are currently not forecasting any real variances within its capital programme.

1.2.6 **General Overview of capital programme**

(a) Risks

The majority of the directorate's capital programme comprises 'back-to-back' schemes predicated on generating capital receipts. There is a risk around the valuations of the identified capital receipts.

(b) Details on action being taken to alleviate risks

Schemes reliant on capital receipts are being reviewed regularly with our Corporate Property colleagues.

1.2.7 **PFI projects**

- PFI Housing

The £72.489m investment in the PFI Housing project represents investment by a third party. No payment is made by KCC for the new/refurbished assets until the asset are ready for use and this is by way of an annual unitary charge to the revenue budget, to be funded from the PFI credits.

	Previous	**2007-08**	**2008-09**	**2009-10**	**TOTAL**

	years				
	£000s	£000s	£000s	£000s	£000s
Budget	-	8,892	51,818	11,779	72,489
Forecast	-	8,892	51,818	11,779	72,489
Variance	-	-	-	-	0

(a) **Progress and details of whether costings are still as planned (for the 3rd party)**

Overall costings are still as planned.

(b) **Implications for KCC of details reported in (a) i.e. could an increase in the cost result in a change to the unitary charge?**

The unitary charge is not subject to indexation as the contractor has agreed to a fixed price for the duration of the contract. Deductions will be made during the contract period if performance falls below the standards agreed or if the facilities are unavailable for use.

During the contract period if one of the partners proposes a change that either results in increased costs or a change in the balance of risk this must be taken to the Project Board for agreement. Each partner has a vote and any decision resulting in a change to the costs or risks would need unanimous approval.

(c) **Reason for Variance/Rephasing**

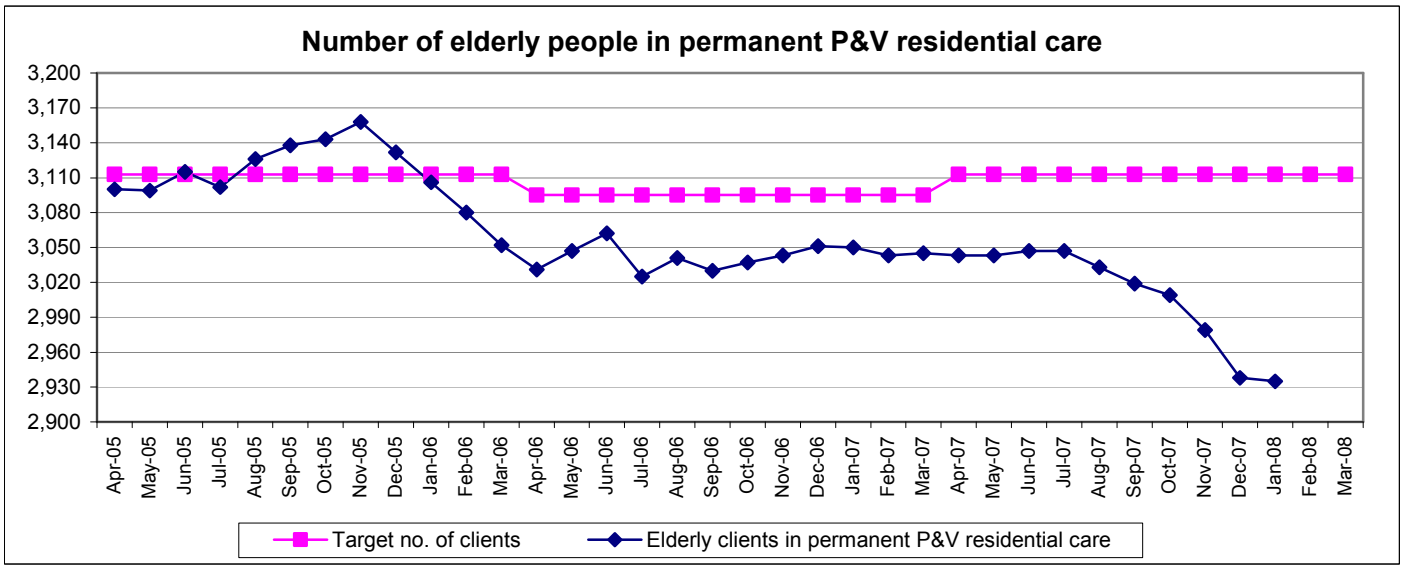
The forecast reflects the anticipated capital expenditure by the contractor in the PFI contract. The contract was signed on 5th October and any figures prior to this were estimated.

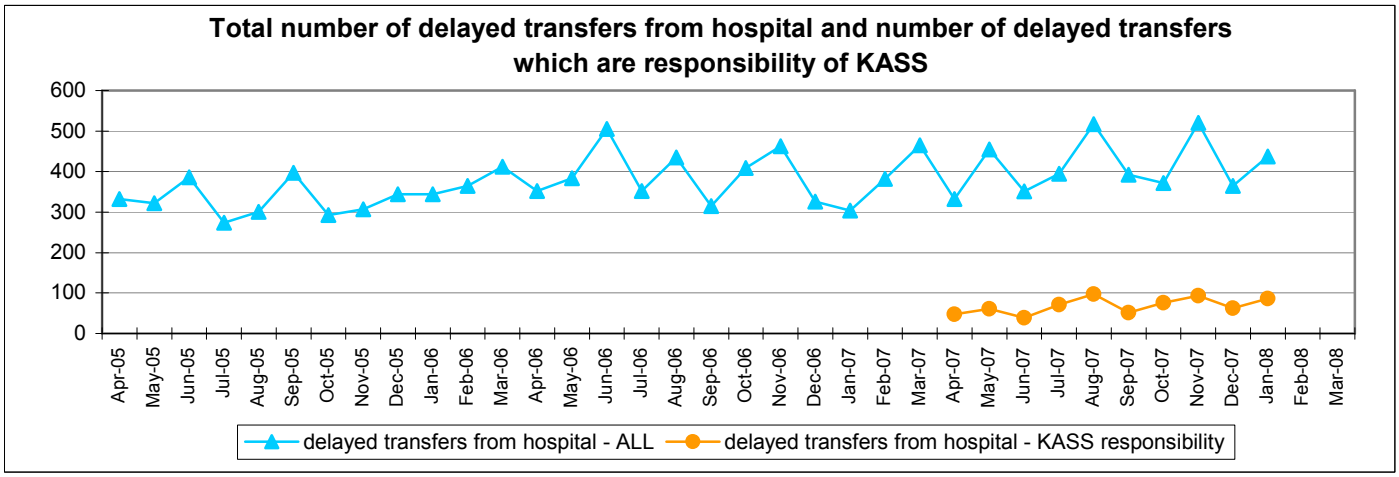
2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

Owing to delays in implementing SWIFT (client activity system), the activity data for the period August 2006 to March 2007 has been reliant on local records and manual counts.

2.1.1 **Numbers of elderly people in permanent P&V residential care, including indicators on delayed transfers**:

	2005-06			2006-07			2007-08			
	Target	Elderly clients in permanent P&V residential care	Delayed transfers from hospital	Target	Elderly clients in permanent P&V residential care	Delayed transfers from hospital	Target	Elderly clients in permanent P&V residential care	Delayed transfers from hospital (DTCs)	
									All	KASS
April	3,113	3,100	332	3,095	3,031	352	3,113	3,043	332	47
May	3,113	3,099	322	3,095	3,047	384	3,113	3,043	455	61
June	3,113	3,115	386	3,095	3,062	505	3,113	3,047	351	39
July	3,113	3,102	274	3,095	3,025	352	3,113	3,047	395	71
August	3,113	3,126	301	3,095	3,041	435	3,113	3,033	517	97
September	3,113	3,138	397	3,095	3,030	315	3,113	3,019	392	51
October	3,113	3,143	293	3,095	3,037	409	3,113	3,009	372	76
November	3,113	3,158	307	3,095	3,043	463	3,113	2,979	520	93
December	3,113	3,132	344	3,095	3,051	326	3,113	2,938	365	62
January	3,113	3,106	344	3,095	3,050	304	3,113	2,935	437	86
February	3,113	3,080	365	3,095	3,043	382	3,113			
March	3,113	3,052	412	3,095	3,045	465	3,113			



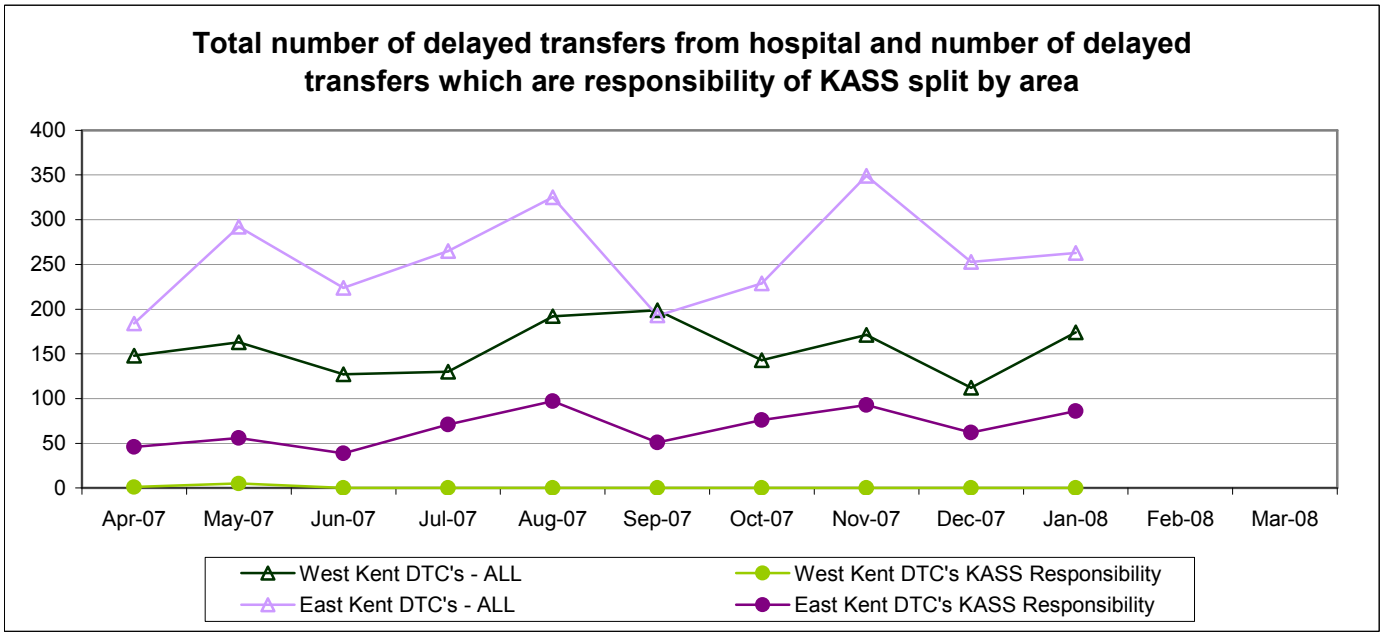


Comments:

- The Delayed Transfers of Care (DTCs) show the numbers of people whose movement from an acute hospital has been delayed. Typically this may be because they are waiting for an assessment to be completed, they are choosing a residential or nursing home placement, or waiting for a vacancy to become available. This figure shows all delays, but those attributable to Adult Social Services, and therefore subject to the reimbursement regime, are a minority and these are also now shown on the graph. There are many reasons for fluctuations in the number of DTCs which result from the interaction of various different factors within a highly complex system over which we have very little influence. It should also be noted that each third month is a five-week month.

2.1.2 **Indicators on delayed transfers, split between East and West Kent**

2007-08						
	Delayed transfers from hospital (DTCs)					
	West Kent		East Kent		TOTAL	
	ALL	KASS	ALL	KASS	ALL	KASS
April	148	1	184	46	332	47
May	163	5	292	56	455	61
June	127	0	224	39	351	39
July	130	0	265	71	395	71
August	192	0	325	97	517	97
September	199	0	193	51	392	51
October	143	0	229	76	372	76
November	171	0	349	93	520	93
December	112	0	253	62	365	62
January	174	0	263	86	437	86
February						
March						

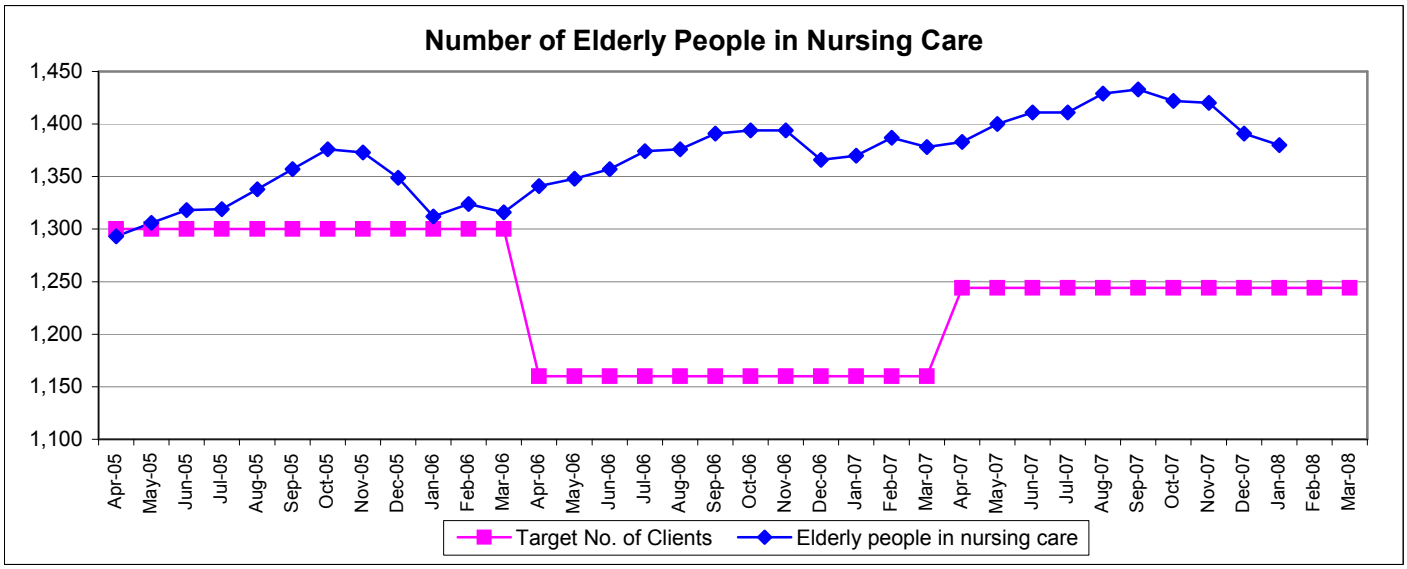


Comments:

- This graph analyses the data by KASS Area in order to reflect the differences in both the finances and performance of the East Kent and West Kent PCTs.

2.2 **Numbers of elderly people in nursing care:**

	2005-06		2006-07		2007-08	
	Target	**Elderly people in nursing care**	**Target**	**Elderly people in nursing care**	**Target**	**Elderly people in nursing care**
April	1,300	1,293	1,160	1,341	1,244	1,383
May	1,300	1,306	1,160	1,348	1,244	1,400
June	1,300	1,318	1,160	1,357	1,244	1,411
July	1,300	1,319	1,160	1,374	1,244	1,411
August	1,300	1,338	1,160	1,376	1,244	1,429
September	1,300	1,357	1,160	1,391	1,244	1,433
October	1,300	1,376	1,160	1,394	1,244	1,422
November	1,300	1,373	1,160	1,394	1,244	1,420
December	1,300	1,349	1,160	1,366	1,244	1,391
January	1,300	1,312	1,160	1,370	1,244	1,380
February	1,300	1,324	1,160	1,387	1,244	
March	1,300	1,316	1,160	1,378	1,244	

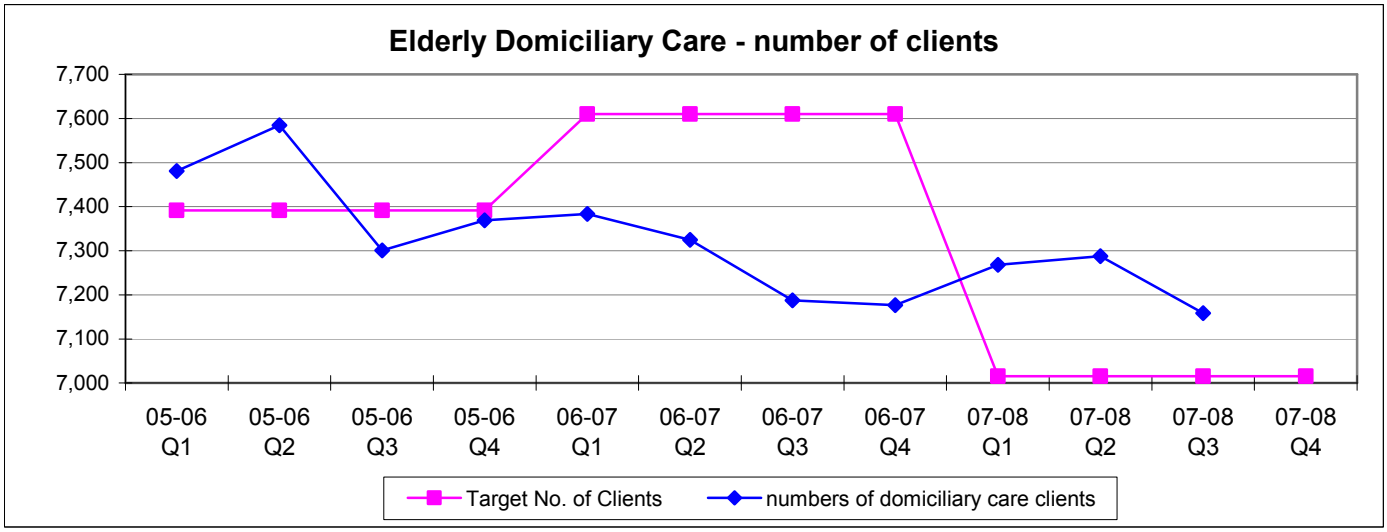


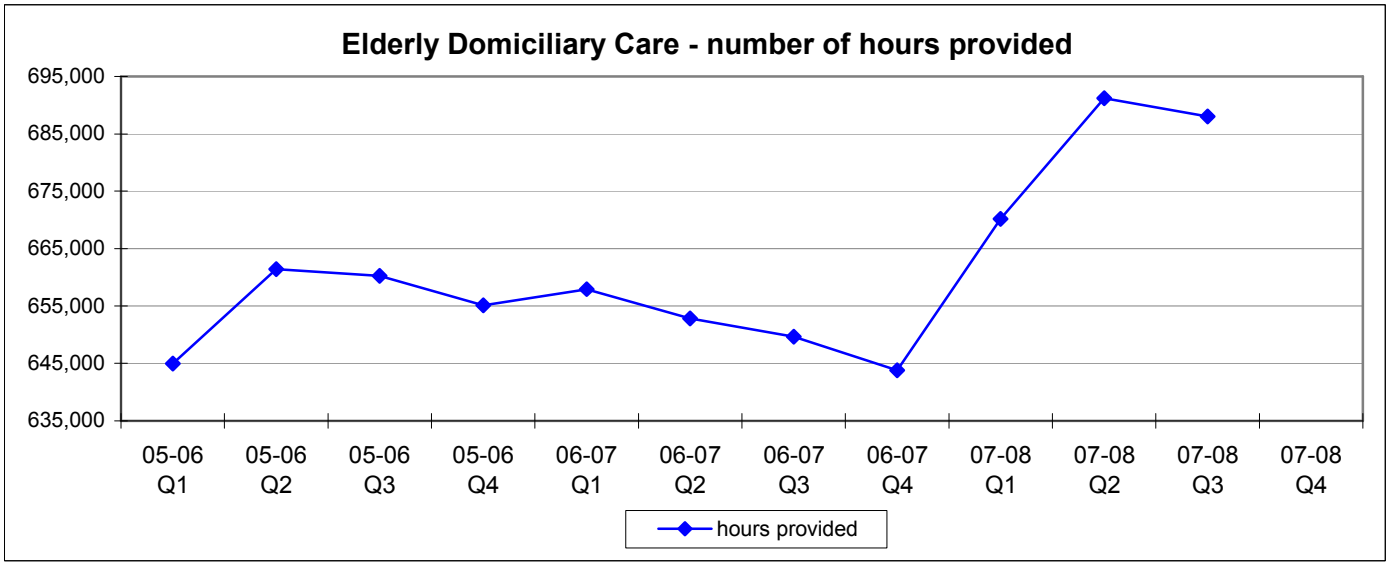
Comment:

- Increases in permanent nursing care may happen for many reasons. The main influences over the last year have been the closure of hospital beds in the East of the County. The knock on effect of minimising delayed transfers of care has resulted in an increase in the number of older people being admitted to nursing care. Demographic changes – increasing numbers of older people with long term illnesses – also means that there is an underlying trend of growing numbers of people needing more intense nursing care. The recent downturn in placements is the result of higher than expected attrition.

2.3 **Elderly domiciliary care – numbers of clients and hours provided**:

	2005-06			2006-07			2007-08		
	Target	numbers of domiciliary care clients	hours provided	Target	numbers of domiciliary care clients	hours provided	Target	numbers of domiciliary care clients	hours provided
Apr - Jun	7,391	7,481	644,944	7,610	7,383	657,948	7,015	7,268	670,203
Jul - Sep	7,391	7,585	661,415	7,610	7,325	652,789	7,015	7,288	691,231
Oct - Dec	7,391	7,301	660,282	7,610	7,188	649,624	7,015	7,159	688,032
Jan - Mar	7,391	7,369	655,071	7,610	7,177	643,777	7,015		



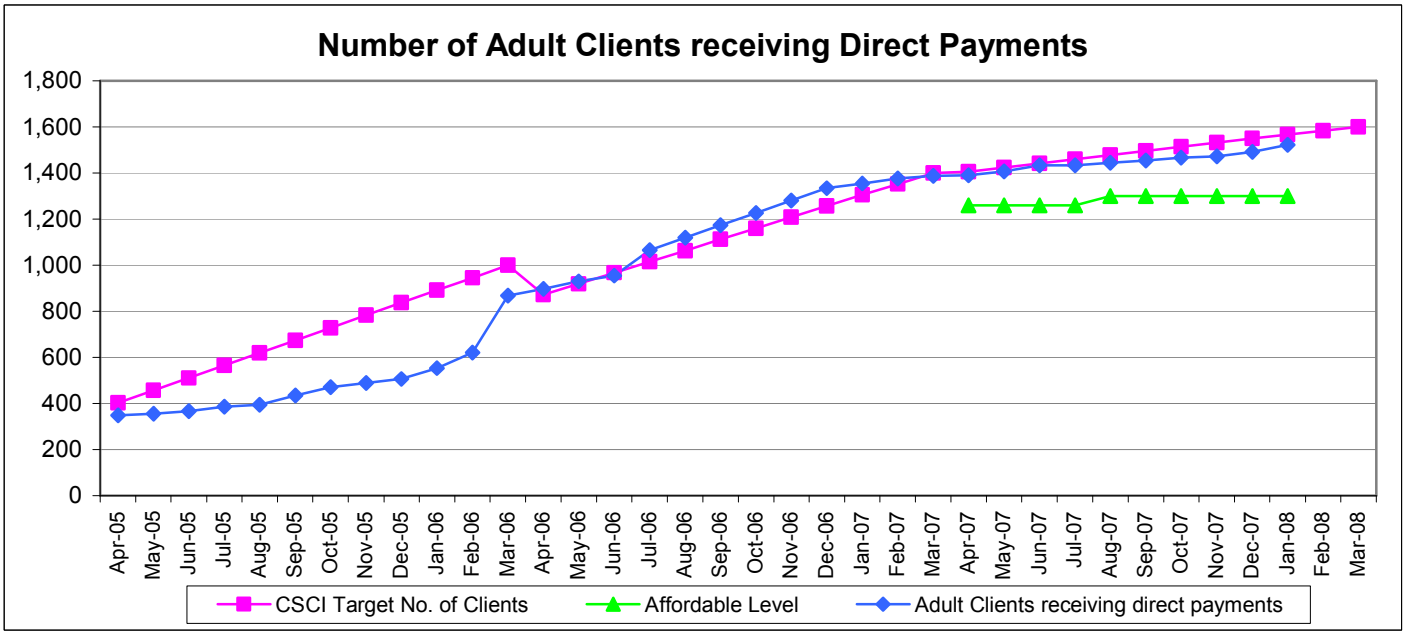


Comment:

- Although the number of people receiving domiciliary care, together with the number of hours provided, has decreased in Quarter 3, the average number of hours provided per client has increased slightly. Indeed the average has been higher than in previous years and reflects the increasing number of clients who require a higher level of support to enable them to remain within their own homes. Often this support could be through two care workers rather than one. As indicated earlier in the report the reduction in residential placements has also had an impact on activity, as this is often the alternative to seeking a permanent placement. Data quality issues in Swift make comparison with last year more difficult which might also explain the significant increase in clients.

2.4 **Direct Payments – Number of Adult Social Services Clients receiving Direct Payments:**

	2005-06		2006-07		2007-08		
	CSCI Target	Adult Clients receiving Direct Payments	CSCI Target	Adult Clients receiving Direct Payments	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments
April	403	349	871	896	1,406	1,259	1,390
May	457	355	919	930	1,424	1,259	1,407
June	511	366	967	954	1,442	1,259	1,434
July	566	386	1,015	1,065	1,460	1,259	1,434
August	620	395	1,063	1,119	1,478	1,299	1,444
September	674	434	1,112	1,173	1,496	1,299	1,454
October	728	470	1,160	1,226	1,514	1,299	1,467
November	783	489	1,208	1,280	1,532	1,299	1,472
December	837	507	1,256	1,334	1,549	1,299	1,491
January	891	553	1,304	1,355	1,566	1,299	1,522
February	945	621	1,352	1,376	1,583		
March	1,000	868	1,400	1,388	1,600		



Comments:

- Direct payments are increasing, however a body of evidence is growing which suggests that the introduction of direct payments is identifying some previously unmet demand/need. Work is ongoing to track all new direct payment clients to prove /disprove this belief.

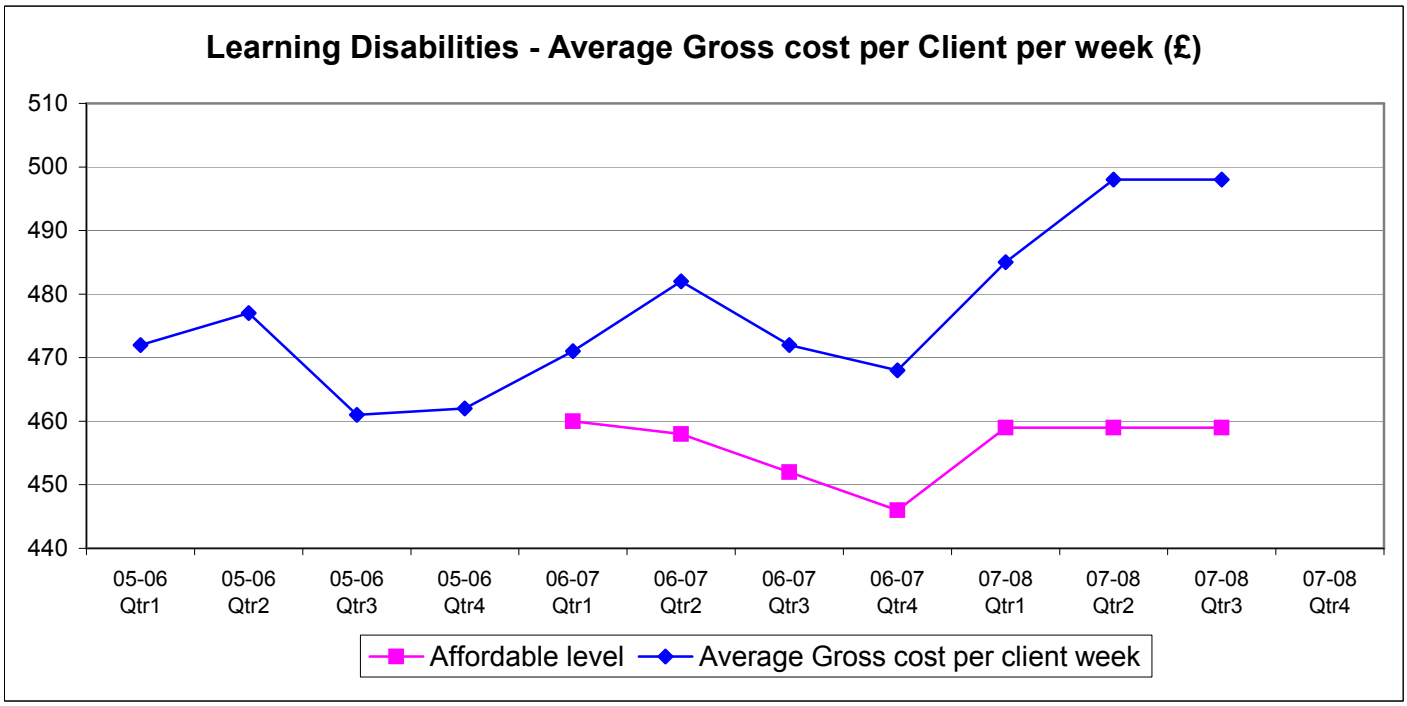
- It should be noted that the affordable level is 1,299, which relates to the budgets that are currently set for direct payments. This level has been increased since July to reflect budgets vired from other service lines, such as domiciliary and day-care, to recognise the move away from traditional services into self directed support.

- The financial forecast and variances being reported cover the ongoing costs of the 1,491 direct payment users we currently have.

- The original target of 1,662 clients was a self-reported target to the Commission for Social Care Inspection (CSCI). Following review the Directorate has now decided to assume a target of 1,600 clients by year-end which would still leave us in the top band.

2.5 **Learning Disabilities – Average Gross Cost per Client per Week:**

	2005-06	2006-07		2007-08	
	Average Gross cost per client £	Affordable level £	Average Gross cost per client £	Affordable level £	Average Gross cost per client £
April - June	472	460	471	459	485
July - September	477	458	482	459	498
October - December	461	452	472	459	498
January - March	462	446	468		



Comments:

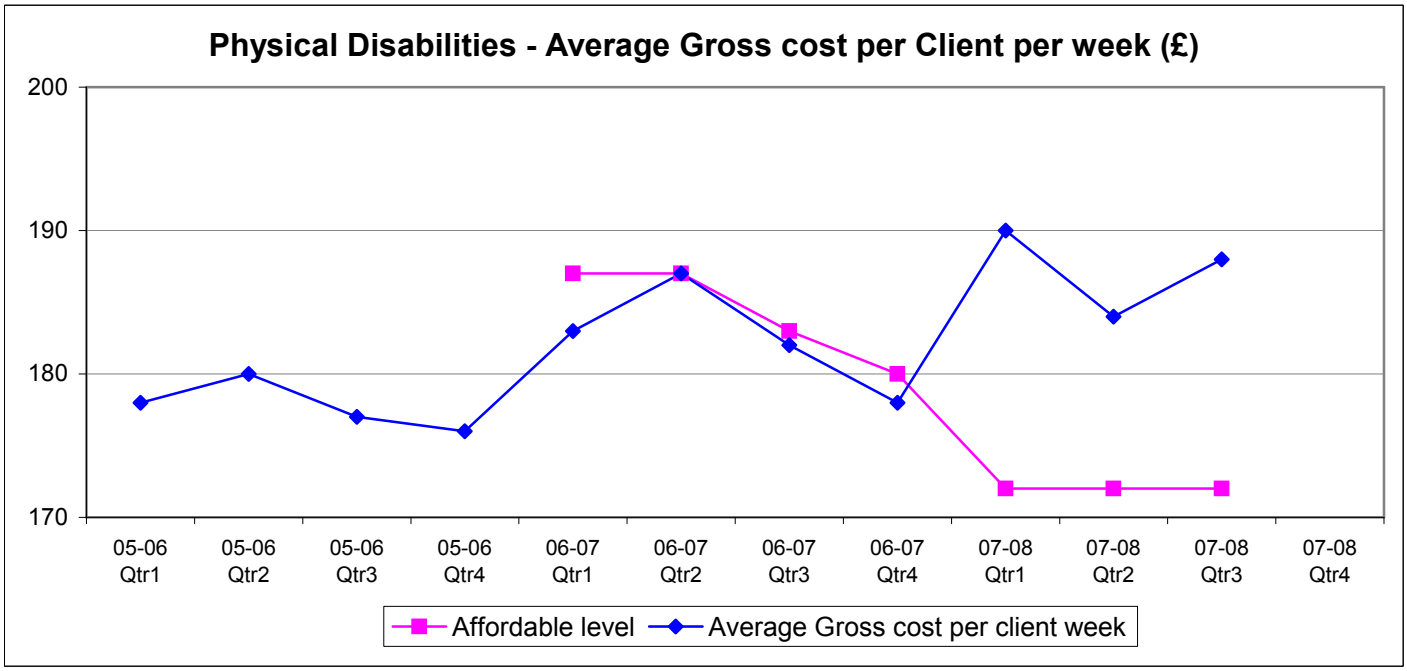
- Targets did not exist prior to 2006-07 as this average cost is not a real performance indicator. It is merely intended to demonstrate the general upward trend in the cost of supporting clients with Learning Disabilities.

- This graph reflects the average cost per client week across all Learning Disability services, including those with the lowest levels of need.

- The basis for calculation has changed from last year in order to include both the costs of services provided by the private and voluntary sector and in-house service provision. The previous years' figures have been adjusted accordingly.

2.6 **Physical Disabilities – Average Gross Cost per Client per Week:**

	2005-06	2006-07		2007-08	
	Average Gross cost per client £	Affordable level £	Average Gross cost per client £	Affordable level £	Average Gross cost per client £
April - June	178	187	183	172	190
July - September	180	187	187	172	184
October - December	177	183	182	172	188
January - March	176	180	178		



Comments:

- Targets did not exist prior to 2006-07 as this average cost is not a real performance indicator. It merely attempts to demonstrate the general upward trend in the cost of supporting clients with Physical Disabilities.

- This graph reflects the average cost per client week across all Physical Disability services, including those with the lowest levels of need.

- The basis for calculation has changed from last year in order to include both the costs of services provided by the private and voluntary sector and in-house service provision. The previous years' figures have been adjusted accordingly.

Item No. B6

By: Oliver Mills, Managing Director, Kent Adult Social Services

To: Adult Social Services Policy Overview Committee – 1 April 2008

Subject: **EQUALITY IMPACT ASSESSMENTS**

Classification: Unrestricted

Summary: This report provides Members with key messages and a progress report from the process of undertaking Equality Impact Assessments on all Directorate policies, practices and procedures. This is a legal requirement under Equalities legislation and is central to the Equality Standard for Local Government assessment and KCC's Equality Strategy.

Introduction

1. (1) Equality Impact Assessments (EIAs) are a statutory responsibility to assess all policies, practices and procedures to check if:

a) there are any unwitting adverse impacts on Kent residents on the grounds of age, disability, gender, race, religion and belief, sexuality or factors of social inclusion.

b) we are missing any opportunities to make our services more inclusive and accessible.

(2) There are two types of Equality Impact Assessments:

Stage 1: INITIAL SCREENING ASSESSMENTS
on all existing and new policies, practices and procedures

Stage 2: FULL EQUALITY IMPACT ASSESSMENTS
on any policies where there might be evidence or a possibility of 'adverse impact';
or where we are planning a significant new public service and are testing out how best to be inclusive and accessible, eg Telehealth and Telecare.

(3) All Directorates have been conducting EIAs and these formed key evidence for KCC's external assessment under the Equality Standard for Local Government (which took place on 18-19 March 2008).

Initial Screening

2. (1) Screenings have been carried out on all 243 Directorate policies, practices and procedures. These are conducted by the 'Policy Owner' – the

manager who has day to day responsibility for implementation, together with a 'Critical Friend', who asks challenging questions about how the policy could be more inclusive and accessible. The Directorate's Equalities Manager or an Equality Champion (a member of staff who advises on a particular strand of equality – age, disability, gender, race, religion or belief, sexuality or social inclusion) has fulfilled this role.

(2) A common format was used across KCC which questions:

- is this a new or existing policy, practice or procedure?
- what are its aims, what partner agencies are involved, and who will benefit?
- what are the monitoring arrangements?
- what consultation has there been in the past two years, who was involved and what were the findings?
- does the policy affect particular groups differently and if so can this be legally justified?
- have we missed any opportunities to promote disability, gender or racial equality?
- is there a need to gather more information to assess its impact?
- is it easy to modify the policy, procedure or practice?

(3) This screening determines whether the policy, procedure or practice is of 'Low Adverse Impact' or needs to be referred for a Full Equality Impact Assessment. The vast majority (235) were assessed as being of Low Adverse Impact, and in those cases the manager concerned undertook to make small but significant changes to increase inclusivity and accessibility. Improvement Plans have been drawn up and progress on these will be checked in October 2008.

EXAMPLES OF CHANGES AS A RESULT OF EIA SCREENING

Accessibility/ Usability of KASS Web Sites

3. (1) Increasingly, information and access to services can be achieved online. KASS Web Team are at the forefront of such development nationally with 60 service based web sites. User friendly access and giving full consideration to the needs of these whose first language is not English in key in the design and updating of these sites. Many are interactive and all use 'Plain English'.

- in September 2007, KASS commissioned an external 'Usability Study' on all KCC websites.

- In November 2007, an 'Accessibility Study' was commissioned to consider any access improvements for those who are visually impaired, have cognitive impairment, hearing impairment and those who may have keyboard manual dexterity difficulties. These have been reported and an Action Plan to make necessary improvements is being drawn up. This demonstrates KCC's continuing commitment towards usability and accessibility, and KASS has lead responsibility for KCC.

- The KCC website has been amended to provide a simple explanation of how to access service information in British Sign Language (BSL), in alternative formats and in 10 community languages. Recently video clips have been added of interpreters explaining this in Bengali, Cantonese, Czech, Lithuanian, Mandarin, Polish, Punjabi, Russian, Slovakian and Turkish. There are plans to add a further 10 languages shortly.

District Plans

4. (1) The Screening Assessment of the Directorate's District Plans identified that they could be stronger at identifying the diversity of need within the District and projecting this forward. District Managers have made a commitment to develop information and contacts with BME groups in their districts and where contacts don't exist to start to engage with them. This will also focus on the 'new communities' who have settled in Kent more recently.

(2) This process will be informed by 2005 Ethnic Population Estimates (Office of National Statistics, November 2007) which identifies 73,200 people (5.3%) classified as Black Minority Ethnic (BME) in the KCC area in 2005. In 2001, the proportion was 3.1%.

(3) Between 2001 and 2005, the BME population in the KCC area has increased by 76.3% (an additional 31,700 people). Whilst still being a small proportion of the total population, we need to take into consideration that these changes are reflected across all Kent districts, eg Sevenoaks 143% increase (2,200 to 5,400 people), Tonbridge & Malling 130% increase, Swale +118%, Canterbury +107%, Thanet +106%, Ashford +100% and Dover +97%.

(4) These new communities are contributing greatly to Kent's economy, but we need to take a more informed view of how we can engage with them and ensure their specific needs are being met.

Procurement

5. (1) The Directorate has devised a thorough system of procurement which has equalities as a key component – from Good Care Guides, service specifications, tendering and contracting and contract monitoring. KASS contracts 85% of its services with the private and voluntary sector. This has a value which equates to 42% of all KCC procurement business.

(2) Thirty four Contracts Unit policies were examined and were assessed as being good practice examples. However, the screening has prompted a re-emphasis of promoting anti-discriminatory practice by featuring equalities much more prominently in their contract Quality Assurance Monitoring Document.

(3) Residential Homes for example are assessed on how each resident's individual needs (which could involve their disabilities, gender, religion and belief, sexuality or social interests) are understood and catered for and that any harassment or discrimination is properly addressed.

(4) The Contracts Unit has also subsequently devised an excellent 'easy read' Service User form inviting them to provide a confidential, positive or negative reference on their residential home.

Kent Home Care

6. (1) KASS has been exploring issues of impact assessments for some time now, although this particular process is a new one. A couple of years ago our in-house home care service examined their practices in relation to recruiting Domicilliary Care Workers in Gravesham, where 12.1% of the population are from BME communities. They examined the ethnicity of their workforce, which revealed very small numbers of BME staff and only 3 with the Asian languages and cultural understanding that are most relevant to the communities they serve. This meant that Care Managers had difficulty in offering culturally appropriate care packages.

(2) It was discovered that the existing predominantly white workforce were alerting their friends to vacancies and supporting them in their applications.

Improvement Plan:

- Kent Home Care linked with the Directorate's Equal Care Project to attract BME candidates who had undertaken 'An introduction to care work' training.
- KHC now send job details to BME groups in the recruitment district. This is being applied countywide and for example, we hope to attract partners of Gurkha soldiers to vacancies in Folkestone.

'Reality Checking' Screened Assessments

7. (1) A proportion of the 235 screened policies assessed as being of 'Low' adverse impact have been 'reality checked' to quality assure these assessments.

- briefings were held for Diversity staff groups

- 3 Reality Checking workshops were held, where 18 staff drawn from equality champions, diversity staff groups, trade unions (UNISON and GMB) and equalities group members commented on 35 assessments selected by participants

- 2 other workshops involving 25 members of Disability and BME groups commented on 4 policies

- A further peer review workshop, involving 50 East Kent Managers commented on 6 policies

(2) Each Directorate was asked to 'Reality Check' 10% of those screened policies rated as being of Low adverse impact. This gave a target of 24 checks. KASS 'reality checked' 45 screened assessments.

(3) KCC's former Inclusive Services Policy Manager sought advice from DIALOG, the Employers Association and they regarded KCC's screening process as being 'very robust'.

Full Equality Impact Assessments

8. (1) Eight policies are subject to a Full EIA. Seven have been completed as at 1.4.08.

a) Staffing Policies

- Personal Action Plans/ Personal Development Plans/ End of Year Appraisals
- Core Supervision Policy for Social Care Staff

b) Service Policies

- Telehealth
- Telecare
- Carers Policy (Adults)
- Domiciliary Charging
- Modernisation proposals for Queen Elizabeth Foundation for the Disabled
- 1995 Gypsy/ Traveller Policy Document is to be revised and updated. This is awaiting legislative changes expected around June 2008 and will be completed after that.

<u>Telehealth and Telecare</u>

(2) Full Equality Impact Assessments have been conducted on Telehealth and Telecare initiatives. These have involved ongoing dialogues with large numbers of disabled people and people from BME groups to trial and influence the development of equipment and how these new services are communicated and operated.

<u>Domiciliary Charging</u>

(3) Over 8,000 domiciliary service users, carers groups and Kent residents were consulted through use of a questionnaire on proposed charging increases. Three public meetings were also held county-wide to consider views. The assessment judged that these increases were implemented in a manner that did not treat those from equality groups worse than others. It also acknowledged that Heads of Service can and do use discretion to ameliorate any negative impact on particular service users, for example, extra arrangements are made to meet additional complex needs/ cultural provision.

<u>Carers Policy (Adults)</u>

(4) The screenings identified the need to better reflect diversity in carers' individual service plans and assessments. The Directorate has subsequently

worked with 70 carers support organisations to increase the awareness of carers' right to assessment and services. A Carers Advisory Network is being established to inform and shape policies and service development.

(5) KCC Cabinet has prioritised "strengthening the support provided to people caring for relatives and friends" as part of its strategic objectives in 'Towards 2010'. A key aspect is to consult with carers on the quality of services and outcomes that are important to them. This will also contribute to a national DOH Carers Survey in 2010. As part of this, we intend to undertake 1:1 interviews with BME carers which will be completed by May 2008.

(6) A representative group of 50 carers are meeting in a focus group (Feb – April 2008). They will identify key issues and recommend future action.

(7) A Select Committee of KCC Members carried out a review of carers services and an Implementation Plan is being developed to progress actions identified. The report was debated by KCC on 13 December 2007 and sent to the Minister for Social Care as KCC's contribution to the Prime Minister's Review of the 1999 Carers Strategy. Item No. B2 on today's agenda sets out the work programme put in place to take forward the recommendations of the Carers in Kent Select Committee Report.

<u>Modernisation proposals for Queen Elizabeth Foundation Resource Centre</u>

(8) Members are aware that these proposals represent the implementation of KCC's Active Lives Policy to support the people of Kent to live independently in their local communities. This is in line with the Social Model of Disability and the development of person-centred individual services. It is intended to also extend opportunities to people from BME communities and to younger disabled people who do not currently access the existing service.

(9) The Directorate feels that new service proposals will be more extensive and inclusive, but this has not been welcomed by some existing service users.

(10) A consultation process has taken place over recent months. Service users indicated that they would prefer to retain the current service provision. They fear that funding is to be withdrawn and that future arrangements might not suit them. They are used to accessing the day service in one place and as a large group and are suspicious of the concept of individual services that make more use of mainstream facilities. These concerns have been shared with the Council verbally, through letters and emails and also by Service Users contacting press and other media to raise these issues.

(11) Service users have been actively involved in the work of the North West Kent Service Review Project Board, as members and in individual and group meetings, and the proposals have evolved as a result of their feedback. A series of meetings have been held with service users and carers and a working group with service users to look at how individual budgets will work for them. In addition, each existing service user has received an individual assessment to determine their needs and aspirations.

(12) The Equality Impact Assessment included breaking down service user responses and complaint issues and encouraging the managers concerned to respond to each of these. The needs of disabled people in the area who currently don't access QEFD were also considered.

(13) KASS is to ask an independent equalities consultant to review this Equality Impact Assessment, to comment on the fairness of procedures and make any recommendations for further action.

New Policies and Next Steps

9. (1) Reports being considered by the KASS Strategic Management Team now always ask if an Equality Impact Assessment has been conducted.

(2) We have plans to carry out EIAs on each of the Active Lives for Adults (ALFA) work streams.

(3) This whole Equality Impact Assessment Process has been valuable in fine-tuning what we do to ensure that our policies, practices and procedures are as inclusive and as accessible as is possible.

(4) KCC is currently gathering good practice examples from other authorities on how practically to share this information with the public of Kent.

(5) In conclusion, Equalities are a key mainstream issue for Kent Adult Social Services. The Equality Impact Assessment process has demonstrated that we have many good practice examples to showcase. As the Commission for Social Care Inspectorate said: "Kent Adult Social Services serves most people well but also understands what it needs to do better and has plans to improve."

Recommendations

10 (1) Members are asked to note and comment on the Directorate's achievement in conducting Equality Impact Assessments on all of its policies, practices and procedures.

Keith Wyncoll
Equalities Manager
Kent Adult Social Services

KW/AM
11.03.08

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Item C1

By:	Overview and Scrutiny Manager
To:	Adult Social Services Policy Overview Committee – 1 April 2008
Subject:	**UPDATE ON SELECT COMMITTEE WORK**
Classification:	Unrestricted

Summary: This report updates Members on future Select Committee work.

Select Committee: Transitional Arrangements

1. (1) This Select Committee will be reconvened in May 2008 to receive a report on progress against its recommendations, one year on from the publication of its report. The minutes of this meeting will be submitted to the next meeting of this Committee.

(2) The Informal Member Group convened to undertake a piece of focused work around some of the key issues raised by the Select Committee has been delayed in moving ahead with its work, and its progress will be reported to a future meeting of this Committee.

Select Committee: Autistic Spectrum Disorder

2. (1) The Policy Overview Co-ordinating Committee (POCC) met on 14 February 2008 to consider the Select Committee Topic Review work programme and bids for resources for various pieces of work. After considerable deliberation, the POCC decided that the next review to be carried out should be on Autistic Spectrum Disorder (ASD), which had been enthusiastically promoted by this Committee.

(2) During the discussion of this item, Mr Mills offered to meet reasonable costs for a professional adviser to the Select Committee. This person will be independent of the Directorate.

(3) The Membership of the SC is Mrs A D Allen, Mr G Cowan, Mrs E Green, Mr S J G Koowaree, Mr M J Northey, Mr R A Pascoe, Dr T R Robinson and Mr J D Simmonds, with Mr Simmonds being the Chairman Designate. Work on this review will commence shortly.

Retrospective Monitoring of past Select Committee Recommendations

3. (1) The POCC considered a report which set out the progress which had been made against all Select Committee recommendations since 2001. The Committee expressed its appreciation of this major piece of information gathering, and acknowledged that it had been prepared at very short notice. However, it expressed a desire to see more extensive monitoring of the topic reviews which were completed before the current monitoring arrangements were introduced, and resolved that these be systematically reviewed by the parent Policy Overview Committees.

(2) For this Committee, this means going back to the three major reviews of Nursing, Domiciliary and Residential Care, completed in February 2002, March 2003 and December 2003, respectively. The POCC appreciated that this work was undertaken several years ago, and much of what was recommended then has since been overtaken by more recent developments in policy and practice. The Committee was also mindful that retrospective monitoring will add a workload on top of the ongoing monitoring work. It did not impose a deadline but implied that it would like to see something coming to POCs in response to this request in the next few months or so.

Building Capacity for Policy Overview Committees

4. (1) At the meeting of the POCC on 14 February, Members also received a report on building capacity of Policy Overview Committees. The comments made at that meeting will be referred to the Chief Officers Group and then to Cabinet for their consideration of how best to build capacity for POCs. Initial feedback from the Comprehensive Performance Assessment inspection recommended strengthening the Overview and Scrutiny function. All Policy Overview Committees and the Policy Overview Co-ordinating Committee will be kept informed as work progresses to improve the operation and effectiveness of the Policy Overview Committees.

Recommendations

5. (1) Members are asked to note:-

(a) that the Transitional Arrangements Select Committee will meet in May 2008 to review progress against its recommendations, one year on from the publication of its report;
(b) that a Select Committee Topic Review on Autistic Spectrum Disorder (ASD) will commence shortly;
(c) that the Policy Overview Co-ordinating Committee has directed that topic reviews which were completed before the current monitoring arrangements were introduced be systematically reviewed by their parent Policy Overview Committees; and
(d) The Policy Overview Co-ordinating Committee's views on Building Capacity for Policy Overview Committees, in response to the outcome of the Comprehensive Performance Assessment.

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Background Information: *Nil*

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