ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 30 March, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 30 March 2010 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

Membership (13)

Conservative (11): Mr P W A Lake (Chairman), Mr K Pugh (Vice-Chairman), Mrs A D Allen, Mr R Brookbank, Mrs P T Cole, Mr N J Collor, Mr J Cubitt, Mr D A Hirst, Mr M J Jarvis, Mr J E Scholes and Mr C P Smith

Labour (1): Mr L Christie

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.

Item No

A.COMMITTEE BUSINESS

A1 Substitutes

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

A3 Minutes of the meeting held on 13 January 2010 (Pages 1 - 18)

A4 Chairman's Announcements

A5 Cabinet Member's and Director's Update (oral)

PRESENTATION - Safeguarding

B. ITEMS FOR SCRUTINY

B1a Safeguarding Adults Annual Report 2008/09 (Pages 19 - 76)

B1b Care Quality Commission - Annual Performance Assessment Report for Adult Social Care (Pages 77 - 92)

B2 Kent Adult Social Services Debt Position, February 2010 (Pages 93 - 100)

C. ITEMS FOR CONSIDERATION

C1 'Live it Well' - Mental Health Strategy for the Next Five Years (Pages 101 - 144)

C2 Adult Social Services Budget Out-turn Report 2009/10 for the Third Quarter (Pages 145 - 176)

D. OFFICER DECISIONS FOR SCRUTINY

E. ITEMS PLACED ON THE AGENDA BY MEMBERS

F. SELECT COMMITTEE WORK

F1 Update on Select Committee Work (Pages 177 - 178)

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

Monday, 22 March 2010

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

KENT COUNTY COUNCIL

ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Adult Social Services Policy Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 13 January 2010.

PRESENT: Mr P W A Lake (Chairman), Mr K Pugh (Vice-Chairman), Mrs A D Allen, Mr L Christie, Mrs P T Cole, Mr N J Collor, Mr J Cubitt, Mr D A Hirst, Mr M J Jarvis and Mr S J G Koowaree

ALSO PRESENT: Mr G K Gibbens and Mr M J Angell

IN ATTENDANCE: Mr O Mills (Managing Director - Adult Social Services), Mr S Leidecker (Director of Operations) and Miss T Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

37. Minutes of the meeting held on 17 November 2009
(Item A3)

RESOLVED that the minutes of the meeting held on 17 November 2009 are correctly recorded and that they be signed by the Chairman. There were no matters arising.

38. Chairman's Announcements
(Item A4)

The Chairman paid tribute to all KASS staff who had maintained services to look after elderly and dependent residents across Kent in the recent severe winter weather and said how much he admired their efforts.

39. Cabinet Member's and Director's Update (oral)
(Item A5)

Severe Weather Conditions

1) Mr Gibbens supported the Chairman's comments about KASS staff, as well as partners in the independent sector and the Army with whom they had worked, and were still working, in the continuing severe weather. He asked that his appreciation and thanks be passed to the staff concerned.

2) Mr Mills added that KASS had relied partly on the willingness of communities to look out for and help elderly and vulnerable neighbours with daily support and general care as well as meals to supplement the Community Meals service run by apetito and delivered with the help of the Army. Help had also been given by the 4x4 Users South East Response Service, a group of owners of 4x4 vehicles who offer to help in accessing remote areas.

3) Mr Mills said he had been struck by the resourcefulness of domicilliary care workers and agencies in delivering services. All domicilliary care providers had business continuity plans for such circumstances. The Emergency Planning Unit also had well tested plans and had been resourceful and flexible in giving a first class service, along with the initiative and hard work of in house KASS staff. Use of technology such as telecare and telehealth and the BT MeetMe service had come into their own for maintaining contact with clients and allowing links between managers across the county to co-ordinate support services.

In response to a questions, Mr Mills explained that, although KASS was not formally involved in decisions on which areas should be prioritised for gritting, they would have the chance to give a view as part of a debrief. Miss Highwood added that, in cases where KASS was aware of a particular risk, eg a steep entrance to a care home, it would direct help.

Cow Lane Learning Disability Centre, Canterbury

4) Mr Gibbens confirmed that he had taken the decision to close the centre on the proviso that alternative facilities are put in place first. Consultation and work with users and carers had been going on for two years to prepare for the change. The changes would improve services for clients in Canterbury with Learning Disability needs.

KASS Strategy

5) The KASS Strategy, on which the POSC had commented at its November meeting, would be considered/approved by the full County Council on 1 April.

Queen Elizabeth Foundation Day Centre, Dartford

6) Since the closure of the centre, KASS had run services under the Active Lives Network. It had always been intended that a third sector provider would take on this service provision, and in 2009 the contract had been let via a tendering process to the Inspire Community Trust of Bexley, which would start service delivery on 25 January. This Trust was committed to promoting independent living for clients with LD needs. An update on this issue had been sent to all local KCC Members on 6 January and would be sent to all POSC Members today.

Age Concern Funding

Mrs A D Allen declared a non-pecuniary interest in this item as a Chairman of Dartford Age Concern Committee, and Mr S J G Koowaree declared a non-pecuniary interest as he was related to recipients of care services delivered via Age Concern.

7) An update paper was tabled, and Mr Gibbens explained that he would shortly be meeting all the Chairmen of all Age Concern Committees in Kent in the spring of 2010 and Mr Mills would be meeting all Chief Executives for a second meeting. Mr Gibbens and Mr Mills answered questions from Members on this issue, explaining the following:-

a) it was up to each Age Concern who would take part in the meetings, but Mr Mills undertook to find out how each area Age Concern proposed to approach and advise Mr Christie;

b) The deadline for completion of the reorganisation of services was July 2010;

c) Mr Mills said he was not aware of any impact of the funding changes upon the relationship between Age Concern and Help the Aged nationally;

d) Mr Gibbens emphasised that service providers would not be affected by the reorganisation, and that no cut in service would result from it;

e) the consultants proposed to be used to advise on the change would be independent experts in providing elderly support;

f) although it was up to each local Age Concern Committee how much it charged for services, KCC would help them to make best use of their funds, and any change in service provision would be preceded by consultation with the client concerned. Mr Gibbens undertook to emphasise these reassurances when meeting with the Age Concern committees.

Swine Flu

8) Mr Mills said that preparation for a potential pandemic including vaccinating every health professional and care home worker, and the Department of Health had made £70,000 of additional funding available to meet the cost of vaccinating social care staff in Kent.

Retirements

9) Mr Mills reported that Janet Hughes, Director of Provision and Commissioning in East Kent, had left the Directorate at the end of December. He said Janet had been an excellent advocate for vulnerable people in the county and was well know and respected by elected Members. Anne Tidmarsh had been appointed to fill the post. Members added their appreciation of Janet's work and their best wishes for her retirement, and congratulations to Anne on being appointed.

10) Steve Leidecker, Director of Operations, would be retiring on 1 April 2010. No-one had yet been appointed to fill the post, but Members were reassured that the post was being held and not deleted. Mr Gibbens added that he was concerned that the post had not been able to be filled and said he would ensure that he was kept aware of any problems in covering the role in the meantime.

40. Presentation - The Personal Care at Home Bill

Miss C Highwood, Director, Strategic Business Support, was in attendance for this item, with Mr A Webb, Policy Officer.

1) Miss Highwood presented a series of slides which set out the timetable of Bill, summarised its content and implications for KCC. *Slides are appended to these Minutes as Appendix 1.* She and Mr Mills answered questions of detail put by Members, explaining the following:-

a) Miss Highwood had been working closely with the Department of Health to clarify the impact of the Bill on Kent and to test on what assumptions the provisions of the Bill had been based. Via this close working, she had been able to make the Department of Health aware of Kent's views

and concerns in advance of it sending its formal response to the consultation;

b) the Department of Health had asked for early outline responses by 26 January, although the statutory deadline for responses was 23 February. Members' views expressed in today's meeting would be included in the draft response, which would be debated by Cabinet on 1 February;

c) a major complication of the new proposals was the large number of unknowns, and complications to the way KCC assessed services, e.g., it would need to predetermine which services received by a client were to be charged and which not charged before it could set that client's personal budget;

d) in considering and responding to the proposals, Members would be given KASS guidance and support to ensure that they understood the context of them and their implications for Kent, and what efficiency savings would be needed to compensate for the financial implications of delivering the new provision;

e) as much of the new provision was based on personal choice, it was simply not possible to predict how clients or their families might choose to change what services they used or how they accessed those services; and

f) the government's intention was to review the situation in 18 months' time, due to the large areas of implications which were unknown for all Local Authorities in the UK.

2) In discussion, Members expressed views and concerns on the Bill's content, and these are summarised in Appendix 2 to these Minutes.

3) In addition, the Cabinet Member Mr Gibbens said that his role was to listen to Members' concerns prior to the issue being discussed at Cabinet, and added his personal views: in an ideal world it would be good to be able to offer free care to all, but this was simply not realistic, development of the Bill seemed rushed, with not much opportunity to challenge the calculations on which it was based, he could not see how the numbers would work, he thought the Bill was unaffordable, and suspected that it could only be paid for by cuts in the NHS and increased Council Tax.

4) The Chairman summed up and set out the next steps. A draft KCC response would be prepared, which would include the views and concerns expressed by Members today. He undertook to discuss with the Cabinet Member the feasibility of POSC Members having a further discussion once the draft response was ready, to add or strengthen any points, if necessary. The draft response would then be discussed by Cabinet on 1 February and submitted to the Department of Health by the deadline of 23 February.

5) RESOLVED that:-

a) the presentation be welcomed, with thanks;

b) Members' views and concerns expressed in discussion, and set out in Appendix s to these Minutes, be built into the draft KCC response to the Department of Health;

c) the Chairman and Cabinet Member discuss the feasibility of POSC Members having a further opportunity to consider the draft response and add or strengthen any points if necessary; and

d) the KCC draft response be discussed by Cabinet on 1 February and then submitted to the Department of Health by 23 February.

41. Adult Social Services Budget Outturn Report 2009/2010, for the second quarter
(Item B1)

Miss M Goldsmith, Directorate Financer Manager, was in attendance for this and the following item.

1) Mr Leidecker introduced the report and said that the latest monitoring had forecast a reduced overspend, and that he was confident that the Directorate would achive a balanced budget at the year end. The Directorate was making ongoing savings and efficiencies. Mr Leidecker and Miss Goldsmith answered questions of detail from Members, as follows; -

a) the number of clients receiving in house domicilliary care services showed a higher turnover because more clients were moving to enabling services rather than staying on domicilliary care for any length of time;

b) none of the Directorate's contingency fund was allocated *per se*, but it had all been used to suppress or offset budget pressures;

c) KASS vacancy rates and staff turnover remained very low compared to the average rates for the rest of the KCC;

d) although numbers of delayed transfers had increased in East Kent, the percentage for which KASS was responsible had shown no appreciable increase; and

e) in response to a question about KASS's robust monitoring and budget management, Mr Leidecker confirmed that much time and effort was spent on monthly monitoring and forecasting, and the exercise was complex. Although it was expected that the overspend of £770,000 would be cleared by the year end, if it was reduced to £500,000, this amount would represent only 0.1% of the Directorate's overall budget. This illustrated the tight margins within which this demand-led budget was managed. Events like severe weather conditions always added demand to the budget.

2) In discussion, one Member expressed concern about the level of client debt and how this was monitored and dealt with. Key concerns were that increasing debt year on year was unsatisfactory and debt should not be allowed to drift, assessment of a client's ability to repay debt must be fair and compassionate, and controls must be effective. He sought a statement of management action being taken to address and contain debt.

3) Mr Mills assured Members that the Directorate's Senior Management Team was rigorous in monitoring levels of debt each month and offered to share the new action plan, which had been started in October 2009 to address debt, which Members welcomed. He added that KASS always took action if the level of debt became unreasonable, having pursued court proceedings in past cases, and should not be seen as 'a soft touch'. Bailiffs would ever be used in extreme cases. A new debt recovery team, as part of the new action plan, would make recovery easier by starting action earlier.

4) RESOLVED that:-

a) the report, and Members' comments ion it, be noted; and

b) a further report on client debt be submitted to a future meeting of the POSC, to allow Members to take a closer look at the issue.

42. Budget 2010/2011 and Medium Term Financial Plan 2010 - 2013
(Item B2)

1) Mr Mills introduced the report and highlighted the priorities and risks in the Medium Term Plan. These will be set out in the KASS Strategy which will be reported to Cabinet and discussed at the County Council. The Directorate's draft budget included a 0% pay increase for staff in 2010/11 but also a 0% price increase for providers. Mr Mills emphasised that there should be no reduction in staff numbers in 2010/11. Mr Mills and Miss Goldsmith answered questions of detail from Members, as follows:-

a) the budget figures for the next three years showed a 0% pay increase for staff across all three years, as all Directorates had been asked to set their budgets making the same assumption;

b) £32 million had passed from the KASS budget to the Communities budget to reflect the move of the Supporting People function to Communities; and

c) Mr Christie asked what percentage of KASS staff was eligible to receive 'Total Contribution Pay' (TCP) progressions, and Mr Leidecker undertook to find out and advise Mr Christie of the figure.

2) In discussion, Members made the following comments:-

a) the clarity of the report and the information set out in it was welcomed, and KASS finance staff congratulated on their work in preparing it;

b) the increase of 1.29% in the KASS budget was welcomed; and

c) Members expressed differing views on whether or not staff pay increases for each of the three years should be included in the budget projection. Medium Term Plans had always previously included an estimate of staff pay increases for future years in the same way as price increases for each of the three years had been estimated and included.

3) RESOLVED that:-

a) the report be noted and the staff involved in its preparation be congratulated on its clarity; and

b) Members' views, set out in paragraph 2) above, be taken into account when finalising the KASS budget and Medium Term Plan.

43. Half-Yearly Monitoring of the Annual Operating Business Plans, 2009/2010
(Item B3)

Mr N Sherlock, Head of Planning and Public involvement, was in attendance for this and the following item.

1) Mr Sherlock introduced the report and answered questions of detail from Members, as follows:-

a) KASS continued to lobby the CQC about some indicators which it saw as being flawed, having written to CQC again very recently;

b) although progress would be easier to see if a target was presented alongside performance information, no target could be set until end of 2009/10 year, as this would provide the baseline;

c) hypothecated grants are an area of particular risk for all local authorities, as they are fixed term and could be changed or discontinued by any change in government after the general election; and

d) Members asked to be told what evidence would be supplied to the Care Quality Commission to demonstrate progress against NI 130. POSC Members would be sent this information when it was reported to Cabinet at the end of the financial year.

2) Mr Gibbens added his compliments to officers on the ongoing success of the WSD project, which he said had been massively challenging but a real achievement for Kent. He asked that his thanks and compliments be passed to all staff concerned.

3) RESOLVED that the information given in the report and in response to Members' questions be noted, with thanks.

44. Risk Management - Revised Directorate Risk Register
(Item B4)

1) Mr Sherlock introduced the report and explained that all Directorates' Risk Registers fed into the Corporate Risk Register. In discussion, and in response to Members' questions, the following points were highlighted:-

a) the Personal Care at Home Bill was not currently listed on the risk register but would have a high rating due to the financial risks it brought to the KCC;

b) the present template that Directorates were required to use to evaluate and report risks was flawed, eg there was no way of recording the effects of a risk, and there was no scope to state a target by which a risk could be lowered in next year's register. Officers agreed this would be a useful tool and undertook to look into it for the future. A new Head of Audit and Risk for the whole KCC had recently been appointed to address the way in which risk assessed and managed;

c) Members were assured that risks being assessed received very robust discussion at all levels of Management;

d) each Directorate was required to list its top 10 risks, hence all those listed in the report were rated 'High'; and

e) although Human Resource was listed as one of KASS's top risks, the officer team set out the following points:-

1) its vacancy rate was 4.5% and its turnover 1.7% - both very low;

2) there were no particular problems recruiting to safeguarding teams, and staff tended to stay long term, but there were some problems in recruiting Mental health Social Workers;

3) succession planning remained a high priority for the Directorate;

4) the present rating of 'High' for Human Resource had been assessed during a period of extensive reorganisation, and it was hoped that this risk would be rated lower in next year's register; and

5) an interpreter scheme was well established in KASS to help clients for whom English was not their first language, and in areas with a prevalent BME community, much effort was made to employ staff from that community.

2) RESOLVED that the information set out in the report and given in response to Members' questions be noted, with thanks.

45. Update on Select Committee Work
(Item C1)

RESOLVED that the information in the report be noted.

Personal Care at Home Bill

Implications for Kent County Council

Background

- Introduced in Queen's Speech 18 Nov 09
- Bill and Consultation published 25 Nov 09
- Consultation ends 23 Feb (26 Jan)
- Proposed implementation 1 October 2010

Summary

- Bill makes statutory provisions for free *personal* care **at home**
- Consultation outlines proposed implementation:
- Proposes free personal care for those with ‘highest needs’
- ‘Highest needs’ defined as Critical (FACS) with 4+ ADLs
- To include those currently self-funding their care

Activities of Daily Living

Activities of Daily Living (ADLs)

There are six basic categories of ADLs:

- personal toilet (washing, bathing, personal presentation, dressing and undressing and skin care);
- eating and drinking (as opposed to obtaining and preparing food and drink);
- managing urinary and bowel functions (including maintaining continence and managing incontinence);
- managing problems associated with immobility;
- management of prescribed treatment (e.g. administration and monitoring medication),
- behaviour management and ensuring personal safety (for example, for those with cognitive impairment - minimising stress and risk)

Source: p.15, Personal Care at Home Bill, *A consultation on proposals for regulations and guidance*, Department of Health (2009)

Case study 1

- Mrs W is 87 and suffers from short term memory loss and Parkinson's and is unsteady on her feet. *She lives with her daughter* who works full time. She requires help with toileting, prompting to take medication, support with eating & drinking and mobility.
- Receives:
  - 20 x ½ hour sessions per week
  - Daycare 3 days per week
  - Respite 4 weeks per year
- Weekly cost (inc. respite) = £307.47

Case study 2

- Miss C is 50 and has Cerebral Palsy and is a wheelchair user at all times. *She lives with her brother in law* who carries out all domestic tasks. She requires help with washing and dressing, transferring to and from wheelchair, using a commode and almost constant accompaniment to ensure her safety.
- Receives:
  - 7 x 1 hour sessions per week with 2 staff
  - 20 x ½ hour sessions per week with 2 staff
  - 1 x 1 hour session with 1 staff
  - Independent Living Fund provides funding for someone to take Miss C out
- Weekly cost (exc. ILF) = £489.40

Implications

Are varied and far reaching, and include:

- Loss of income from existing service users
- Requirement to provide for self – funders who qualify
- Increased transactional costs
- Higher expectations
- Possible disputes (cf. Continuing Care)
- Changes to SWIFT client information system

Financial impact

- Kent to receive grant of **£5-6M**
- Expected to find **£3.3M** in efficiencies
- Takes little account of younger adults
- No. of self – funders difficult to estimate
- Govt costings based on 6.54 hrs per week
- Independent research shows 4+ ADLs should be met by **15.6 hrs per week**

Appendix 2 to Minutes

ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE, 13 JANUARY 2010

Members' views and concerns expressed during debate of the Personal Care at Home Bill (Minute 40)

Points are recorded as they were expressed, and listed in the order in which they arose.

1. Wouldn't it help to aim for one streamlined assessment process? Currently, clients could undergo three separate assessments – for acute care, primary care and social care.
2. There has already been much change in social care (e.g., personal budgets) which is still bedding in, and this Bill brings more difficulties and requires more efficiencies. If this goes through, and I think it probably will, we could have a crisis in handling the admin for all these changes. It seems that greater use of Kent Card would be needed, as well as further modernisation of service delivery, and these changes would need to be made urgently.
3. I see many problems in this. I hope the quality of care will be the same when it starts to be given free to a client, having previously been paid for, or will corners start to be cut?
4. As in the NHS, where someone could choose to pay to receive faster treatment, would some people be able to get a better service by opting to pay for it?
5. I find it difficult to follow all the arguments around free and charged care. Some people who pay now might still want to do so! Some people who already have free care might worry that they will receive the same quality of care under the new arrangements. I hope we will have some control over the quality of service delivered.
6. I am concerned about the level of input Members are able to have on Government consultations, and the POSC's chance to see the draft response to which it has contributed. When consulting on major Bills, we need a system to allow the POSC further input at the draft response stage.
7. I question that we can afford the proposals in this Bill.
8. Funding is based on a client receiving 6½ hours of care a week. Is it possible to have/does Kent have the scope to have a flexible system of care in which a client can have 6½ hours of free care per week and then pay for anything above that?
9. There are many things that we simply can't forecast, e.g., people currently funding their own residential care might opt to move out and receive care at home instead as this care would be free.
10. We could sum this up as having three major aspects; the concept, which seems sound; the cost and the financial implications – the government seems to be proposing to underfund it and make others fill the gap; and the staffing resources to deliver it.

11. I agree that there are many areas of cost which we cannot predict. Many families would like to support their elderly relatives themselves, but we don't know how many people might have asked previously for a contribution towards the cost of doing this and not been given it.
12. We have to take account of, and respond to, the demographic patterns of which we are aware; more people are living beyond 85 and will seek more care as they grow older, and by the end of 2011, 50% of the population will be over 60. These demographic pressures will be very difficult to fund, and we can't control them.
13. In choosing what services they access, there is nothing to stop clients taking advantage of free care provision first and then choosing what other care they wish to pay for.
14. It is vital to get the initial care assessment right but, once that is done, there is still much to cope with. The Kent Card should be used more.

By:	Graham Gibbens, Cabinet Member, Adult Social Services Oliver Mills, Managing Director, Kent Adult Social Services
To:	Adult Social Services Policy Overview and Scrutiny Committee – 30 March 2010
Subject:	**SAFEGUARDING ADULTS ANNUAL REPORT 2008/2009**
Classification:	Unrestricted

Summary:	This report presents the Multi-agency Safeguarding Adults Annual Report for 2008-2009

Introduction

1 (1) This multi agency safeguarding report summarises the work undertaken by partner agencies in the year leading up to the Commission for Social Care Inspectorates Safeguarding themed inspection of Kent Adult Social Services which took place in March 2009. Some additional monitoring data from Medway Council is awaited and will be amalgamated with the Kent data prior to publication.

Summary of Safeguarding Issues emerging in 2009/2010

2 (1) Following the CSCI inspection report KASS has developed and worked on its post inspection action plan. Our multi agency partners supported the inspection process and are supporting activities e.g. further development of the publicity and awareness strategy which will include by holding a safeguarding week in June 2010.

(2) Working with partner agencies to address the issues raised by the bringing together of adults with a range of social problems and risky behaviour in bed and breakfast accommodation in Thanet, ensuring that KASS does not support placements in multi-occupancy accommodation for any vulnerable adults without careful planning. This will be tackled through the Margate Task Force theme in Kent's Total Place report.

(3) Maintaining a close working relationship with Supporting People (SP) whenever safeguarding concerns arise in services with a SP contract.

(4) The publication of the Leicestershire Serious Case Review (SCR) for Fiona Pilkington and her 18 year old daughter was discussed at the Safeguarding adults' board and committee. This SCR greatly raised the profile of Hate Crime and the multi agency safeguarding policy and protocols have been revised to include vulnerable people who are victims of Hate Crime. Kent Police established in April 2009 Hate Crime units across the county. They are ensuring that any incidents involving vulnerable adults are discussed with the specialist adult abuse officers who will raise a safeguarding alert which will ensure a multi agency response to these concerns.

(5) In July 2009 the DH published the report following the consultation on the review of No Secrets. To date there has not been a full response to the report from the government and this is not now expected before the general election. However NHS Care Service Minister Phil Hope did state that 'we are going to make it law that every local area must have a Safeguarding Adults Board'. He also announced a new Ministerial group to oversee the safeguarding of vulnerable adults.

(6) On 24 February the Law Commission published consultation paper 192 encompassing all aspects of Adult Social Care. The consultation closes on 1 July 2010. Part 12 of the consultation paper relates to safeguarding adults at risk. The proposals include:

- *A duty on the local authority to make enquiries and investigate allegations of abuse and take actions within its power to safeguarding persons from harm*
- *To replace the term Vulnerable Adults to Adults at Risk. It will include anyone with social care needs who is or maybe at risk of harm*
- *To consider if emergency powers are needed to protect adults at risk*
- *To place in statute the duty on each social services authority to establish an adult safeguarding board with specified functions and membership and a requirement to share information and contribute to serious case reviews.*
- *An enhanced duty to cooperate in safeguarding adults from abuse and neglect.*
- *That the successor to No Secrets should be linked to a local authorities statutory function to safeguarding adults from abuse and neglect.*

Recommendation

3. (1) Members are asked to NOTE and COMMENT on the contents of the report.

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Background documents
Multi agency annual report 2007/2008

Kent and Medway Safeguarding Vulnerable Adults

Annual Report
April 2008 – March 2009

Contents

Foreword

Welcome from the Chair of the Kent and Medway Safeguarding Vulnerable Adults Board and Committee

I am delighted to introduce the second Kent and Medway Safeguarding Vulnerable Adults Annual Report for 2008 – 2009. The report is published on behalf of the Kent and Medway Safeguarding Vulnerable Adults Board and contains contributions from partner agencies who are members of the board, committee and various sub groups.

Kent and Medway have developed robust policies, procedures and protocols for safeguarding vulnerable adults and these are implemented through strong collaborative working relationships between the agencies.

We continue to meet the range of challenges arising from the safeguarding agenda particularly the debate on the relationship between personalisation and safeguarding vulnerable adults. In March 2009 Kent Adult Social Services was the subject of a safeguarding inspection by the Commission for Social Care Inspection. Our next annual report for 2009 - 2010 will provide the details of the recommendations arising from the inspection and how Kent Adult Social Services, along with its partners involved in safeguarding vulnerable adults, and the action plan developed form the inspection report.

All those involved in this multi agency work show a high level of commitment to safeguarding vulnerable adults living in Kent and Medway. I would like to take the opportunity to thank them for their contributions to the work of the board, committee and sub groups in the last year.

Oliver Mills
Managing Director, Kent Adult Social Services
Chair of the Kent and Medway Safeguarding Vulnerable Adults Board and Committee

Executive summary

This annual report summarises the structure of the Kent and Medway Safeguarding Vulnerable Adults Board, Committee and sub groups.

Both national and local developments influence and direct the safeguarding agenda in Kent and Medway and these are outlined in this report.

Multi agency training is a key activity in Kent and Medway and the report provides an overview of the training undertaken and further work being developed.

There is a strong multi agency approach to safeguarding vulnerable adults in Kent and Medway and the main partner organisations have each given an overview of their activities during 2008 - 2009.

The report also provides a breakdown of the safeguarding activities from April 2008 - March 2009. The section covers the rates of referrals, the age, gender, ethnicity and client category of alleged victims, the sources of adult protection alerts, the location of abuse, the alleged care home incidents by area, the categories of abuse and the breakdown of decisions.

Section 1. Introduction

In 2000 the Government published 'No Secrets' which required local authorities to set up a multi agency framework to ensure not only a coherent policy for the protection of vulnerable adults at risk of abuse but also a consistent and effective response to circumstances that gave grounds for concern. It gave local authorities a role in co-ordinating safeguarding activities. The definitions outlined below have been adopted in the Kent and Medway safeguarding vulnerable adults policy, protocols and guidance.

A vulnerable adult is defined in the 'No Secrets' guidance as a person aged 18 years;

"Who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

Abuse is defined as;

"A violation of an individual's human or civil rights by any other person or persons".

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable adult is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person.

The main forms of abuse are;

- Physical abuse including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- Sexual abuse including rape and sexual assault or acts to which the vulnerable adult has not consented, or could not consent or was pressurised into consenting
- Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks
- Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- Neglect or acts of omission, including medical or physical care needs, failure to provide access to appropriate health, social care of educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Discriminatory abuse, including racist, sexist, that is based on a person's disability, and other forms of harassment, slurs or similar treatment.

Abuse can happen anywhere and take place in any context, for example; in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations.

Vulnerable adults may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

Section 2. Kent and Medway Safeguarding Vulnerable Adults structure

Following the publication of the 'No Secrets' guidance Kent and Medway developed its first multi agency policy, protocols and guidance in August 2000. They were revised in 2005 and since then have been reviewed on a six monthly basis.

The Kent and Medway Safeguarding Vulnerable Adults Board is chaired by the Managing Director of Kent Adult Social Services with the Vice Chair being the Assistant Director for Social Care in Medway Council. Other members of the Board include senior representatives from the three health trusts in West Kent, East Kent and Medway and from Kent Police. The members of the board contribute to funding a training consultant and two administration officer posts.

The board takes a strategic lead on safeguarding matters, directing and delegating areas of work to the Kent and Medway Safeguarding Vulnerable Adults Committee. The committee is also chaired by the Managing Director of Kent Adult Social Services with the Assistant Director for Social Care for Medway Council as Vice Chair. Other members of the committee come from the lead agencies and services involved in safeguarding vulnerable adults. The committee ensures effective communication between the various agencies as well as overseeing the work of the sub groups.

The aim of the board is to;

- Safeguard vulnerable adults living in Kent and Medway through a multi agency approach ensuring their safety, independence and well being
- Be accountable for the safeguarding vulnerable adults agenda in Kent and Medway, specifically at a strategic level for priorities, resources and performance
- Provide a strategic direction to all partner agencies involved in safeguarding activities
- Effectively co-ordinate the safeguarding activities of partner agencies.

The aim of the committee is to;

- Commission the development and review of policies, protocols and guidance in the area of safeguarding vulnerable adults
- Commission panels to carry out multi agency audits and serious case reviews
- Ensure the structure and practices adopted in Kent and Medway uphold the adult protection principles contained in 'No Secrets' and the standards within the Safeguarding Adults National Framework of Standard.

(Appendix 1 shows The Kent and Medway Safeguarding Vulnerable Adults Structure)

The work of the Kent and Medway Safeguarding Vulnerable Adults partnership is underpinned by the following principles and values;

- It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity
- All agencies and services should ensure that their own policies and procedures make it clear that they have a zero tolerance of abuse
- Priority will be given to the prevention of abuse by raising the awareness of adult protection issues and by fostering a culture of good practice through support and care provision, commissioning and contracting
- Vulnerable adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services. All agencies will respond to adult protection concerns with prompt, timely and appropriate action in line with agreed protocols
- These principles are applicable to all adults whether living in a domestic setting, care home, social services or health setting or any community setting
- Protection of vulnerable adults is a multi-agency responsibility and all agencies and services should actively work together to address the abuse of vulnerable adults
- Interventions should be based on the concept of empowerment and participation of the vulnerable individual
- These principles should constitute an integral part of the philosophy and working practices of all agencies involved with vulnerable adults and should not be seen in isolation
- It is the responsibility of all agencies to take steps to ensure that vulnerable adults are discharged from their care to a safe and appropriate setting
- The need to provide support for the carers must be taken into account when planning services for vulnerable adults and a carer's assessment should be offered
- These principles are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation.

Section 3. National context

A number of national developments influence and direct the safeguarding agenda in Kent and Medway. These include:-

3.1 The Mental Capacity Act 2005 (Deprivation of Liberty Safeguards)

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The act's starting point is to confirm in legislation the presumption of capacity - that it should be assumed that an adult has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. The act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process. Any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests, under the statutory framework, and the least restrictive option must always be considered. But the act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves. Professionals are protected from liability where capacity assessment and best interests' decision making is undertaken under the statutory framework, and restraint is used under the legal criteria as defined by the act.

The act also introduces new roles under the Court of Protection, court appointed deputies and Lasting Powers of Attorney. There are statutory criteria for instructing an Independent Mental Capacity Advocate for people lacking in capacity, where important decisions about serious medical treatment and changes of accommodation have to be made, and who have no family or friends that it would be appropriate to consult about those decisions. Independent Mental Capacity Advocates can also be instructed for vulnerable people in cases of safeguarding and care reviews, on a discretionary basis. The act introduces new criminal offences, under Section 44, of ill treatment or wilful neglect of a person who lacks capacity to make relevant decisions.

The Mental Capacity Act Deprivation of Liberty Safeguards, which came into force in England on 1 April 2009, provides a legal framework to prevent unlawful deprivation of liberty occurring. They protect vulnerable people in hospitals or care homes who lack the capacity to consent to the arrangements made for their care and/or treatment but who need to be deprived of their liberty in their own best interest to protect them from harm.

3.2 Safeguarding Vulnerable Groups Act 2006

The Safeguarding Vulnerable Groups Act is designed to solve the failures identified by the 2004 Bichard Inquiry arising from the Soham murders. From April 2008 the Independent Safeguarding Authority (ISA) was created and began work to transfer information from the existing Protection of Vulnerable Adults (POVA) Register to a new and wider ranging vetting and barring scheme. The Independent Safeguarding Authority Vetting and Barring Scheme introduced new arrangements requiring those who wish to work with children or vulnerable adults to be registered. It will;

- Make all decisions about who should be barred from working with children and vulnerable adults
- Deal with both paid and unpaid work activities that are classified 'regulated' or 'controlled'

- operate two barred lists (one for those barred from working with children and one for those working with vulnerable adults).

The new arrangements will be implemented in phases with the ISA taking responsibility for barring decisions from January 2009. When fully implemented (from October 2010) any person working in these areas will be required to register with the ISA. The scheme will extend to include all staff in social care and health as well as volunteers working with vulnerable adults or children and will work alongside the existing Criminal Records Bureau checks.

3.3 Care Quality Commission

In April 2009 the Commission for Social Care Inspection, Health Care Commission and Mental Health Commission will merge to form the Care Quality Commission (CQC). The Commission will be an independent regulator of health and social care in England and responsible for monitoring and regulating the standards of social and health care services. It will develop a single set of standards covering social care and health services with a new approach to how the standards expected of these services will be monitored and regulated.

3.4 The review of 'No Secrets'

In the summer of 2007 the Minister for Care Services announced that 'No Secrets' (published in 2000) was to be reviewed. This decision followed the publication of the first ever study into the prevalence of abuse in people's own homes (by the Department of Health and Comic Relief). The review reflected the need to change and develop safeguarding policy in the light of the Government's wider policy goals of;

- Choice, control and promoting independence
- Making community empowerment and lifetime housing a reality for everyone
- Increasing access to criminal justice for everyone including vulnerable people.

In October 2008 the Department of Health published 'Safeguarding Adults - A Consultation on the Review of the No Secrets Guidance'. The focus of the consultation was about how people are empowered to identify and manage risk. The consultation period opened in October 2008 and the deadline for responses was the end of January 2009. The consultation questions covered the themes of;

- Leadership
- Prevention
- Outcomes
- Managing risks
- Managing choice
- Health services and safeguarding
- Safeguarding, housing and community empowerment
- Access to the criminal justice system
- Guidance and legislation
- Definitions.

3.5 'Safeguarding Adults: a study of the effectiveness of arrangements to safeguard adults from abuse' - Commission for Social Care Inspection report (November 2008)

This study focussed on the effectiveness of safeguarding arrangements across the country analysing evidence from a range of regulatory and inspection functions across councils, care homes, home care agencies and other social care services. It confirmed the rising profile of work to safeguard vulnerable adults and also highlighted the variability in the quality of support provided to individuals who experience abuse across council areas.

3.6 'Personalisation and Safeguarding' - Association of Directors of Adult Social Services (ADASS) (October 2008)

This paper aimed to clarify a number of options open to the Association of Directors of Adult Social Services for promoting a framework for adult social care services that would help local authorities ensure that vulnerable people were safeguarded. As people begin to have a wider choice and take greater control over their care services as outlined in 'Putting People First' (which set the direction for adult social care over the next 10 years), the debate on the relationship between safeguarding and personalisation became prominent. 'Putting People First' (published in December 2007) encouraged greater personalisation, individualised budgets and an increased use of personal assistants by people eligible for local authority social care.

3.7 'Living well with dementia: A National Dementia Strategy' (February 2009)

The aim of this national strategy is to ensure that significant improvements are made to dementia services across three key areas for example improved awareness, earlier diagnosis and intervention and a higher quality of care. The strategy identifies a number of key objectives aimed at improving the quality of services provided to people with dementia and promoting a greater understanding of the causes and consequences of dementia. The strategy provides a framework within which local services can;

- Deliver quality improvements to dementia services and address health inequalities relating to dementia
- Provide advice and guidance and support for health and social care commissioners and providers in the planning, development and monitoring of services
- Provide a guide to the content of high quality services for dementia.

3.8 'Transforming Adult Social Care' Department of Health Circular (March 2009)

This circular was published to help local authorities and their partners in the ongoing transformation of adult social care, first set out in 'Putting People First'. It highlighted that with advances in public health, healthcare and changes in society people are living longer and as communities become more diverse the challenges of supporting the increased demand and diversity become more apparent. It is anticipated that social care will not be able to meet these challenges without a change in how services are delivered.

3.9 National Carers Strategy (June 2008)

In June 2008 the Department of Health published the National Carers Strategy 'Carers at the heart of 21st century families and communities'. It is evident that people are living longer and many have rising aspirations in terms of maintaining maximum independence and control over their own lives. As a result of these changes more people are taking on a caring role. Many people are balancing work, childcare and caring for an ageing parent. The shift to independent living and care at home will result in a greater contribution from carers. The strategy recognised that over the next ten years carers must be elevated to the centre of family policy.

Section 4. Local context

4.1 Consultation event on 'No Secrets'

On 7 January 2009 Kent Adult Social Services hosted a Kent and Medway multi agency consultation event to help inform the Kent and Medway Safeguarding Vulnerable Adults Committee's response to the review of the 'No Secrets' guidance. Over 150 people from a range of statutory agencies, voluntary and community groups, care home providers, domiciliary care providers along with service users and carers attended the event. Workshops were held focussing on the themes of:-

- Leadership
- Empowerment
- Prevention and response
- Safeguarding, guidance and legislation.

The key messages arising from the event and detailed in the Kent and Medway response to the Department of Health were;

- The need for legislation to protect of vulnerable adults
- The need for multi agency safeguarding boards and committees to have a statutory basis
- The need for agencies to work together and share information
- The need to revise the definition of vulnerable adults
- The need for a national framework of standards for safeguarding adults
- The need to empower victims and have greater access to advocates.

4.2 Kent and Medway Safeguarding Vulnerable Adults Board's strategy

Over the last 18 months there have been many changes both nationally and locally in the safeguarding arena and against this back drop of change and challenges the Kent and Medway Safeguarding Vulnerable Adults Board recognised that a more strategic approach to safeguarding was required across the county. As a result a successful workshop was held in October 2008 with senior managers, users and carers involved in the safeguarding partnership.

A draft three year strategy was developed to span the broad range of safeguarding activities from awareness raising and prevention through to adult protection interventions and justice. The strategy is built around six overarching objectives that will drive and underpin the three year strategy. They include;

- Robust governance arrangements that will be fit for purpose promote the safeguarding of vulnerable adults and ensure accountability for performance
- A performance management framework that ensures the robust application of the multi agency policy and guidelines, supports continuous improvements in safeguarding and assures quality
- Awareness raising and publicity which contributes towards prevention and the promotion of wellbeing
- A range of preventative activities that reduce the incident of harm, abuse and exploitation
- A framework that addresses the interface between personalisation and safeguarding and the associated workforce implications
- Measures to promote access to justice and support for the victims of abuse.

Although these objectives are at a high level an annual business plan will sit alongside the strategy setting out the detailed actions needed to progress the six objectives. The board will receive an annual report on the progress against the plan.

Following the workshop the board considered the increasing multi agency safeguarding agenda as a result of legislation, guidance and the safeguarding national standards framework. At its November 2008 meeting the board agreed to appoint a Safeguarding Adults Board Manager to formulate and direct the work of the Kent and Medway Safeguarding Vulnerable Adults Board, Committee and sub groups. At the same time the board also considered the need for, and agreed to appoint an additional training consultant to help meet the current demand for training across the agencies.

4.3 Kent Adult Carers' Strategy

This was published in 2008 having been developed in collaboration with carers and a range of statutory and voluntary sector partners. The strategy sets out the vision Kent Adult Social Services and its partners plan to take forward through a partnership approach across the county. The strategy uses the framework set out in the National Carers' Strategy and commits to deliver the national strategy in five years rather than ten years. It emphasises the multi agency co-operation required across health, social care and the private and voluntary sector in meeting the needs of adult carers.

4.4 Commission for Social Care Inspection - Inspection of Kent Adult Social Services

In March 2009 a team of inspectors from the Commission for Social Care Inspection visited Kent Adult Social Services to find out how well the council was safeguarding vulnerable adults. The results of the inspection will be available in the Kent and Medway Safeguarding Vulnerable Adults Annual Report for 2009 - 2010.

Section 5. Review and achievements 2007 - 2008

The Kent and Medway Safeguarding Vulnerable Adults Annual Report 2007 – 2009 identified a number of developments for 2008 – 2009. The following lists the achievements made during the year;

- The Kent and Medway Safeguarding Vulnerable Adults Board developed its draft three year strategy for the partnership and work is continuing to refine the strategy and develop an associated action plan
- The Kent Carers Strategy was developed, aiming to deliver the National Carers Strategy in five rather than ten years
- The multi agency competency framework has been further developed and will be finalised during 2009 – 2010
- Medway Council increased its capacity for level 1 training as well as delivering specific training sessions for different groups of staff
- The quality of care model was piloted in the Canterbury district in East Kent and there are now plans to extend the practice to other districts in the area
- The Kent and Medway Safeguarding Adults Board agreed to fund a Safeguarding Adults Board Manager and an additional training consultant
- The various groups in the Kent and Medway safeguarding partnership continued to meet on a regular basis.

Section 6. Multi agency safeguarding training

Training to enable staff in all agencies to undertake safeguarding actions in accordance with the multi agency policy and protocols continues to receive a high degree of support from the Kent and Medway Safeguarding Vulnerable Adults Board and Committee. The training strategy and provision are designed to meet the standards set out in the Association of Directors of Adult Social Services 'National Framework of Standards for Good Practice and Outcome in Adult Protection Work'.

The Safeguarding Vulnerable Adults Training Group comprises of representatives from all the key agencies. Its terms of reference are 'to identify, develop and maintain adult protection training programmes for both the statutory and private and voluntary sector.' The group meets quarterly to monitor and evaluate existing training provision and also plan future developments.

The current strategy aims to equip all agencies in taking responsibility for the delivery of awareness training to all their staff in their organisations. Awareness training is mandatory in the majority of key agencies. Training for staff in the private and voluntary sector can be accessed in two ways. It can be accessed through Kent Adult Social Services Learning Resource Team's contract with a local care training college or by direct access to a course to enable that sector to take control for direct delivery of training to its own staff. All other training is provided by the multi agency funded training consultant in collaboration with senior/experienced practitioners, specialist trainers within partner agencies and academics with a proven track record of research interest in this topic.

Work has been completed in partnership with an 'e-learning' provider to create a safeguarding vulnerable adults awareness e learning package. This has been made available for use by all key agencies, the private and voluntary sector and higher education institutes across Kent and Medway.

The current training programme is differentiated into six levels and delivered to multi agency groups (Appendix two). The levels of training reflect the roles and responsibilities of staff under the multi agency policy, protocols and procedures (Appendix three). The programme is a core training structure based on common tasks reflected in the multi agency policy, protocols and guidance which maximises its relevance and relates the training directly to the work staff undertake. It also ensures staff build on their existing knowledge and skills by adopting a sequential learning approach. It is designed to reflect core and complimentary knowledge and skills within the multi agency context of safeguarding work.

The demand for training consistently outstrips the training consultant's capacity to supply. The year 2008 - 2009 was no exception and a number of additional courses were delivered throughout the year in an attempt to address the waiting list, for example the number of level 2 courses delivered has increased from 10 to 17.

The table below outlines the number of courses provided during 2008 - 2009 along with the planned provision for 2009 – 2010.

Courses	Existing Provision 2008 - 2009	Number of staff trained	Planned provision 2009 - 2010
Train the Trainer	6	111	5
Level 2	17	275	16
Level 3	7	153	6
Level 4	2	30	2
Level 5	3	48	4
Level 6	2	25	2

All course participants complete a course reaction form to capture their evaluation of the course relevance, the value and quality of the content and what was most or least helpful. These comments are summarised and suggestions for improvement considered and are fed back to the Training Group.

The training has consistently received positive evaluations from course participants and some constructive criticism. A sample summary from one course is illustrated in the table below;

Level 5 Training – 3 courses from April 2008 - March 2009, number of attendees - 48

Pre-Course Information	Poor	Satisfactory	Excellent
Joining instructions/ map	6%	35%	59%
Course	**Poor**	**Satisfactory**	**Excellent**
Venue/facilities		53%	47%
Course content		12%	88%
Pace of the course		20%	80%
Length of course		23%	77%
Refreshments/breaks		36%	64%
Your Trainer(s)	**Poor**	**Satisfactory**	**Excellent**
Level of knowledge			100%
Value of practical work/exercises		6%	94%
Trainer's overall presentation, i.e. use of visual aids, practical exercises, scenarios etc		6%	94%

The training consultant is currently working with the customer focus group, existing advocacy services and a direct service provider to design a strategy and package of resources to support the raising the awareness of service users and the general public. Our aim is to enable service users and others to exercise more choice and control in their lives to minimise the risk of abuse. The Tizard Centre has agreed to work with us in evaluating a pilot project to inform future development of the work.

Work is also underway with higher education Institutes across the Kent and Medway to encourage the inclusion of teaching on adult protection within their pre registration curriculum for health and social care professionals. Awareness training is now being incorporated in Kent Police probationer training.

Further work is planned to gain academic accreditation of the training programme by existing academic partners to enable practitioners across all disciplines to gain recognition of the learning they have undertaken within their existing post qualifying award frameworks.

A multi agency competency framework for all practitioners with responsibilities for safeguarding vulnerable adults has been drafted. A further work plan to develop this framework will be presented to the training group and the finished document circulated for wider consultation before a recommended model can be made to the committee.

In an attempt to encourage learning within the workplace the training consultant offers to facilitate practice reflection workshops when requested. This is offered either single or multiple agency and targeted at the type of case that offers the opportunity for significant learning but would not meet the criteria for reference to the Serious Case Review panel.

Refresher training to maintain knowledge skills and commitment to process is required by all agencies. Further to this the training consultant is in the process of developing an awareness update/refresher resource manual for all awareness course trainers. This will be based on the format and content of the existing ‘Train the Trainer’ recall days run twice a year.

Section 7. Multi agency approach to safeguarding vulnerable adults in Kent and Medway

This section of the annual report contains updates on activities by key partners in the safeguarding partnership during 2008 - 2009.

7.1 Medway Council

We are continuing to work in partnership with NHS Medway to deliver Level 1 training. The table below shows that during 2008 – 2009 we increased the capacity for Level 1 training and trained an extra 60 people. The Safeguarding Adult Co-ordinator has also delivered specific sessions for Members and Housing Department staff.

2007 - 2008						
Number of Medway Council staff attended	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	96	20	6	2	6	5
2008 - 2009						
Number of Medway Council staff attended	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	156	29	20	2	7	8

All staff within the council have access to the newly launched e-learning package. The priority for the next year is to increase awareness and highlight staff responsibilities across directorates and divisions within Medway Council, with those staff who have face to face contact with our most vulnerable citizens e.g. adult learning tutors, community safety wardens and environmental health staff.

In May 2008 the Safeguarding Adults Co-ordinator along with staff from the Adult Social Care Commissioning Team launched the Action on Elder Abuse and UK Homecare Associated Limited ‘Adult Protection Toolkit for Domiciliary Agencies’ with all of our contracted homecare providers. This had led to improved awareness amongst this group of staff and the importance of reporting concerns at an early stage.

In December 2008 and January 2009, as part of the ‘No Secrets’ (2000) consultation the Safeguarding Adults Co-ordinator successfully bid for funding from the Department of Health to consult with hard to reach groups within Medway. As a result, two groups, which included carers and service users with physical disabilities, were able to respond to the questions directly relating to them, within the review. This was significant, as this further raised awareness of safeguarding amongst these hard to reach groups.

In January 2009 the Adult Social Care In House Services for Older People started a project in collaboration with staff from the Medway NHS Foundation Trust in order to apply our work on the prevention of abuse. The scope of the project was to translate the Department of Health, Essence

of Care benchmarks for Privacy and Dignity into our residential in house services. The team managers have now agreed on the benchmarks and these are being used as an inspection tool for our Care Standards Act (2000) Regulation 26 audits.

To coincide with World Elder Abuse Day on 15 June 2008, 50 people attended a multi agency workshop, in which all services and agencies across Medway were invited. The objective of the workshop was to raise awareness of the Dignity in Care Campaign and the role of the Independent Safeguarding Authority.

During 2009 – 2010 we shall be continuing to promote the message that safeguarding is 'everyone's responsibility' by working with the Medway Adult Community Learning Service in developing training, policy and guidance for all of their staff and tutors.

We will also be developing and delivering a safeguarding vulnerable adults awareness programme specifically for our front line staff which includes Community Safety Wardens and Environmental Health staff.

We will significantly improve our data collection to meet the requirements of National Data Collection on the abuse of vulnerable adults.

We shall be working closely with the board to improve public awareness of how to report concerns and how the citizens of Medway can protect themselves from abuse.

7.2 Kent Adult Social Services

In 2008 Kent Adult Social Services was advised that we were to be the subject of a Commission for Social Care Inspection Safeguarding Adults themed inspection in March 2009. We were supported by partner agencies and services in preparing for the inspection. Additional training and update training was highlighted and a case file audit tool was introduced to be used by managers to ensure that all aspects of a safeguarding case had been addressed prior to agreeing to a safeguarding case closure.

With the planned restructuring of Kent Adult Social Services in readiness for delivering the personalisation agenda, an audit of training needs was undertaken to ensure that safeguarding issues would be well managed within the changes proposed. An increase in the number of safeguarding coordinators to 11 was agreed with two co-ordinators specialising in addressing concerns related to people with a learning disability who had previously been supported by the NHS.

We contributed a full response to the consultation on the review of 'No Secrets'. We also supported the multi agency event that took place on 7 January 2008 to complete a multi agency response. This event included representatives from all our partner agencies, councillors, users of services, carers and many service providers. Both responses supported the need for specific safeguarding adults' legislation and the need to place safeguarding adult's boards on a statutory basis.

Kent Adult Social Services supported the development of the national data set and all councils were advised of the need to collect and report the agreed information from October 2009.

Our practitioners are continuing to support research being lead by Brunel University in collaboration with four other universities into the detection and prevention of the financial abuse of older people. The aim is to examine the decision making by managers in health, social care and banking.

Kent Adult Social Services and multi agency colleagues contributed a number of articles to the February 2008 Journal of Adult Protection which was focussed on Kent. These included an article about the development of safeguarding adults work in Kent and the challenges to come along with an article focussing on the development of a Quality Assurance Framework used with weak care services aimed at improving the provision of care and reducing instances of abuse.

We continue to support the Serious Case Review process and executive summaries of all the cases are now published on the committee website www.kent.gov.uk/adultprotectioncommittee. The recommendations from all of the cases are monitored and reviewed annually at the request of the committee. The review is aimed at ensuring that current practice takes account of recommendations relevant to current casework. One Serious Case Review was started in the year.

Kent Adult Social Services staff and managers have attended a range of training opportunities to support the effective implementation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and to ensure that these are integrated within safeguarding adults practice. This has ensured that mental capacity is always considered in relation to victims of abuse especially where lack of understanding has led to the victim being unable to protect themselves from those who abuse. There is also a need in some cases to assess the mental capacity of the abuser especially where the abuser lives with the victim. It is important to engage the support of a range of other agencies and services where adult abuse occurs within domestic settings. This may mean that a victim will be the subject of a multi agency risk assessment conference which can pull together resources to reduce identified risks.

An extensive programme of events and regular communication took place with managing authorities (care homes and hospitals) to prepare them for the implementation of the Deprivation of Liberty Safeguards in April 2009. These safeguards are aimed at preventing the unauthorised deprivation of liberty of people who lack capacity and avoids safeguarding concerns arising.

Kent Adult Social Services worked closely with the Community Safety Partnership, the county Domestic Abuse Group and the multi agency public protection arrangements to promote the profile and interests of safeguarding adults and ensure that their needs are included in planning.

Safeguarding adults now has a significant profile within the Kent County Council Communities Directorate and a lead representative from the directorate now sits on the Kent and Medway Safeguarding Vulnerable Adults Committee. Collaborative work is progressing to ensure that work undertaken through the Communities Directorate to promote community safety includes consideration of all aspects of the needs of vulnerable adults. This includes direct presentations from Trading Standards to the service users and carers forums to raise awareness of rogue traders, bogus callers and more recently illegal loan sharks. The KCC Handy Van Scheme also supports older and disabled adults by carrying out work within family homes to improve safety and security. The vulnerability of older and disabled people is a factor when the Communities Directorate engages with the police in relation to anti social behaviour and especially when the targeting of hate crime effects vulnerable adults.

At the beginning of 2009 a significant number of fire deaths of older and disabled people occurred. Kent Adult Social Services staff are supporting the auditing of several cases to establish an effective way to ensure that where appropriate Kent Adult Social Services or NHS staff can make a referral to Kent Fire and Rescue Service for a home safety check. This will enable advice and resources to be provided to reduce the risk of fire.

Kent Adult Social Services is represented on the Kent Safeguarding Children Board and this ensures that within the transition from children's services to adult social care safeguarding concerns are addressed to maintain continuity of support. It also enables the vulnerability of parents with special needs to be considered when child protection concerns are raised.

7.3 Kent Police

Kent Police continues to see the amount of cases of adult abuse increase. This is in line with an ageing population, increased awareness of adult abuse due to internal and external campaigns and strengthening relationships with partner agencies. This increase is also set against the backdrop of changes in law and policy for the handling and management of vulnerable people in our society. With the introduction of greater freedom for vulnerable adults to choose how and who provides their care, with less supervision from local authority comes greater opportunity to potentially exploit these freedoms. Kent Police are committed to ensuring that vulnerable adults are safeguarded against exploitation and able to enjoy the freedom of choice that these policy changes are aimed at.

In the Adult Protection Performance Report in September 2009, the figures reflect that in the year April 2007 to March 2008, there were 1616 adult protection alerts across Kent. In the past year, this figure has grown to 2052, an increase of 27.0%.

Kent Police have recognised that the arena of adult protection is one that demands special attention. A Public Protection Board scrutinises operational performance, utilising the Adult Abuse Quarterly Assessment. This process of review and analysis provides information of repeat locations, offenders and types of offences. This information, once assessed, is allocated to either the co-ordinator or a specified officer from the area, for action to be carried out.

This information is also used within the framework of staff focus groups. The aim of the groups is to facilitate communication force wide, encouraging best practice, learning lessons and a corporate approach to both process and investigation. It is also designed to consult with each Business Command Unit (BCU), regarding future Home Office guidance and/or initiatives. This also allows for BCU good practice to be identified and included into Force Policy. The focus groups are now supported by a fully functional web page containing all the required information about adult abuse, including details of training, and it is updated on a regular basis. The information is open to all officers and staff across the force and is helping Kent Police internally raise the profile of adult protection.

The Mental Capacity Act has led to a number of new work streams coming online. As with any new legislation it is often poses difficulties of interpretation. The close joint working between the Headquarters Public Protection Unit and the Crown Prosecution Service (CPS) has demonstrated its value in this area. A recent query by a reviewing lawyer over the charging remit of Section 44 was raised and due to the partnership approach to prosecuting cases in Kent a course was mapped out that will lead to national guidance being provided throughout the CPS to ensure clarity for all its prosecutors.

Other work is being undertaken by Kent Police, Kent County Council and the South East Coastal Ambulance Service in producing joint protocols for dealing with people lacking capacity especially with regards to best interests decisions and the use of restraint where deemed necessary. Legal guidance will be published by the National Policing Improvement Agency, in the intervening time Kent Police have been proactive in seeking and interim guidance to aid front line officers.

Work is also currently being undertaken with officers and staff from Kent Police College as to how this important training can best be delivered across the force, utilising the expertise of trainers not just from Kent Police but also from our multi agency partners.

The year 2009 started with high hopes with the 'No Secrets' review and all the consultations that went on both countywide and nationally. Kent Police were heavily involved in the consultation process not only through the Association of Chief Police Officers (ACPO) Group, but also within the local framework of the Kent and Medway Safeguarding Vulnerable Adults Committee and Operational Group. The local consultation sessions were always fully subscribed to and many useful ideas and views were recorded.

2009 to 2010 will prove to be a busy time for safeguarding as it is clear from all parties including ACPO that for safeguarding vulnerable adults to move forward, there needs to be legislation. A response from the Minister of State for Care Services is currently awaited.

The Action on Elder Abuse conference held in Nottingham in March 2009, attended by Kent Police and 25 Police Officers from 12 different forces highlighted the potential for the safeguarding role to be held in a state of limbo due to the Government issuing neither guidance nor legislation.

Kent Police feel strongly that they are in a good position to continue the great work conducted by all agencies and whilst additional guidance and legislation will prove ultimately helpful the delay will not affect the level of safeguarding provided to the residents of Kent.

The Adult Abuse Co-ordinator for all adult abuse issues across the county continues to represent Kent Police on the Safeguarding Vulnerable Adults Committee and Operational Group, as well as the Local Implementation Network Group. The latter has been fundamental in looking at the issues being raised both in Kent and other forces about the use of the Mental Capacity Act and the review of training that needs to be put in place for all Police officers and staff and other agencies.

Other regular commitments include the Disability Action Group, the Safeguarding Committee for the Maidstone and Tunbridge Wells Hospital Trust, the Mental Health Steering Group and Safer Recruitment group meetings. All these groups add to the safety net for vulnerable adults in Kent.

This year saw an article, produced by the Headquarters Public Protection Unit, published in the Journal of Adult Protection. The article provided readers with an overview of what Kent Police have sought to do with implementing changes within the Public Protection Unit and a review of a successful case that not also involved safeguarding but also the Violent and Sexual Offenders Register Management Team. Given the wide circulation of this report, we received contacts from other forces such as the Grampian Police asking for information about how things are done here in Kent. The Journal also went on to show the nature of the way the agencies work together.

Kent Police continue to review and develop our practice with new force policy being published. The policy will ensure greater corporacy across the county in the way that the investigations into

safeguarding alerts are carried out, as well as highlighting certain issues such as consideration for welfare and counselling not only for suspects in custody but also those spoken to at home.

Other recent inclusions in the policy are items such as Hate Crime and the Mental Capacity Act. The former was deemed to be under reported across the county. Analysis has identified that issues dealt with under safeguarding could also be categorised as Hate Crime. A joint process of investigation has been agreed and implemented in the policy. It is hoped that this will not only increase the confidence of the victims when reporting crime but also ensure all appropriate angles are looked at when officers investigate crime.

The future is now looking good, despite the news earlier regarding the 'No Secrets' review. More people across the county have an awareness of the role of safeguarding and how they can report things when they are concerned.

7.4 NHS West Kent

NHS West Kent continues to be a committed partner in the Kent and Medway safeguarding partnership. During 2008 - 2009 a Safeguarding Vulnerable Adults Policy and Procedure was developed and agreed by the Clinical and Corporate Governance Committee. The policy sets out the responsibilities of all staff that work, or have contact with vulnerable adults, to provide health services within a safeguarding framework. It also reflects the aims of the Kent and Medway multi agency policy, protocols and guidance.

The key aims of the policy are: -

- Improve the identification of adult abuse
- Improve the organisation's response to adult abuse
- Seek to prevent vulnerable adults from being abused
- Promote the Kent and Medway Multi-Agency Adult Protection Policy
- Develop training to raise awareness of safeguarding vulnerable adults
- Ensure all staff that come into contact with vulnerable adults receive adult protection awareness training
- Cascade information on adult protection through a network of trainers
- Support staff involved in adult protection procedures
- Engage in multi agency policy development and audit activities.

Briefings were written on the Mental Capacity Act and the Deprivation of Liberty Standards and widely communicated to staff in the trust. A range of training programmes were also developed including safeguarding induction sessions, adult protection awareness training and non clinical statutory and mandatory training.

7.5 NHS Eastern and Coastal Kent

The Safeguarding Vulnerable Adults Team mission statement is;

'To safeguard vulnerable adults from risk and harm by promoting good practice and quality care through education and effective working processes within a multi agency framework'

The Safeguarding Vulnerable Adults Team provides expert adult protection advice, training, support and supervision to all NHS Eastern and Coastal Kent Community Services staff. We are

a team of experienced senior nurses working across East Kent and support, integrate and provide expert clinical knowledge when concerns about community health are raised within the wider multi agency adult protection arena. We are fully involved in the development of multi agency adult protection policy, training and evidence based practice.

Adult protection training is mandatory for all staff in Community Services via the Adult Protection DVD. The DVD is seen by all staff, included in corporate induction and determines what safeguarding and adult protection are and what the staff members' responsibility is towards safeguarding adults whatever their role. All clinical staff attend further essential adult protection awareness training for clinicians.

Adult protection update training has been developed to explore in-depth understanding in relation to the reporting of adult protection and go through the adult protection process with staff with practice scenarios and write a required chronology. This will be rolled out from April 2010.

Adult protection awareness training for staff working with Children and Families continues to be delivered to those specific staff and specific bespoke training is delivered from lessons learnt following an adult protection alert. 'e-learning' is available to staff for updating and refreshing knowledge.

The Trust continues to hold a database on the number of alerts raised to the Safeguarding Vulnerable Adults Team and continue to strive to interlink with internal incident reporting systems, with commissioning and with local Kent County Council data. Since 1 April there have been 215 adult protection alerts into our service. To date, 74% of referrals into the service come from staff within our community services with 26% coming externally from KCC colleagues and the wider health economy

Specialist adult protection advice sought from the nursing team is an hourly occurrence and originates from staff, other professionals and the public. The main request is usually in the form of a question about a concern, something someone has witnessed, has heard or has continual niggles about.

All members of the Safeguarding Vulnerable Adults Nursing Team have attended a five day debrief supervision course facilitated by a supervision consultant. We have developed a framework to provide specific adult protection supervision for staff involved in the process. This will enable a formalised, safe, supportive and professional process for staff following an alert being raised and will allow staff to look at the lessons learned.

The Mental Capacity Act and Deprivation of Liberty Safeguards Consultant Nurse is an integral member of the safeguarding team and the principles of the Mental Capacity Act are absorbed into all safeguarding issues. The training, advice, supervision and support includes these principles and is provided by the team whose understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards is expert, up to date and applicable to practice. The team has been involved in setting up, taking part and advising on Best Interest meetings, consistently questioning and maintaining a focus around decision making and best interests.

The team has developed its own safeguarding team leaflets with contact details and where to get further information. As processes develop within Community Services a new web-page will be developed with the communications team. This will enable people to access information via the Community Services web site.

At present four of the nurses in the safeguarding team are undertaking the Best Interests Assessors course at Masters Level at Canterbury Christ Church University. This will enable a highly trained nursing resource to ensure all safeguards are in place to comply with the Mental Capacity Act 2005 and Mental Health Act 2007.

Work is underway to standardise an evidence based investigation pack for the team to provide the most effective framework to support the adult protection process within Community Services.

The team continues to initiate developments within the wider multi agency adult protection process working with other health colleagues, Social Services and the Police with continual input into the independent and private and voluntary sectors.

7.6 NHS Medway - Medway Community Healthcare

Medway Community Healthcare is firmly committed to raising awareness of safeguarding adult issues and reducing adult abuse. The Safeguarding Adults Team has evolved in the past year and now consists of a Lead for Safeguarding, a Mental Capacity Act Manager, a Safeguarding Adults Advisor and a Safeguarding Adults Facilitator. Recruitment is underway to employ a further member of staff by the end of 2009. The team has secretarial support.

National guidance issued by the Department of Health ('No Secrets' 2000) supports the safeguarding adults arena and is in the process of being reviewed. Medway Community Healthcare promotes multi-agency working and adheres to the Kent and Medway multi agency Adult Protection Policy, Protocols and Guidance.

The Mental Capacity Act (2005) includes Deprivation of Liberty Safeguards and has been phased in since April 2007. Medway Community Healthcare is robustly represented at Kent and Medway multi agency Implementation Networks.

Corporate induction training for both safeguarding adults and the Mental Capacity Act are mandatory for all staff. Level 1 Basic Awareness Safeguarding Adults and Mental Capacity Act training is mandatory for all staff for whom it is applicable. This strategy is supported by an action plan which is a live document and will be adjusted in response to new information or policies.

The Safeguarding Adults Team has employed three new members of staff over the past year. The service is managed by the Lead for Safeguarding Adults and Mental Capacity Act who has been in post since April 2007. In June 2008 the Mental Capacity Act Manager commenced. This role was to ensure that the organisation was compliant with the Mental Capacity Act and to improve staff awareness. In August 2008 the Safeguarding Vulnerable Adults Named Nurse was employed. Part of this role is to manage the increasing number of safeguarding cases, which have resulted from improved awareness of safeguarding issues by staff. In March 2009 a further team member was recruited who had responsibility for staff training in both safeguarding adults and the Mental Capacity Act, both of which are mandatory for staff. The training programme will be redesigned to reflect the needs of individual services.

There are 6 levels of safeguarding vulnerable adults training. Levels two to six are delivered by the multi agency funded training consultant on behalf of all the statutory agencies in Kent and Medway. Level one is facilitated jointly with Medway Council. This level of training is mandatory for all staff who have face to face contact with clients. Induction training runs monthly and is facilitated with the Safeguarding Children's Team.

As more services are becoming aware of the various levels of training, it has been identified that the training will need to be adapted to individual services.

With the employment of another member of staff who has responsibility for training, a strategy will be written detailing the future redesign of safeguarding adults training.

Administrative arrangements for training have been jointly managed by Medway Council Learning and Development Department. Procedures are in place for Medway Community Healthcare Learning and Development Department to commence collation and administration of safeguarding training to enhance easy access to data.

There are presently four levels of training for the Mental Capacity Act which are hosted on behalf of Medway Community Healthcare by Kent County Council.

Level one is mandatory for Medway Community Healthcare staff who have face to face contact with clients.

Medway Community Healthcare adheres to the Kent and Medway multi agency Adult Protection Policy, Protocols and Guidance. Medway Community Healthcare policies have been developed for both safeguarding vulnerable adults and the Mental Capacity Act (2005). As safeguarding adults and the Mental Capacity Act are relevant to many policies, both have been included in several other policies as they have been reviewed. These include the Consent Policy, Serious Untoward Incidents Policy, Transfer of Care Policy and Incident Reporting Policy.

Safeguarding Links have been requested in all service areas to raise awareness with staff and to offer a minimal level of support. Links take the responsibility for ensuring that safeguarding and the Mental Capacity Act are included into regular team meetings, promoting awareness. All Safeguarding Links are invited to attend regular meetings with both the Leads for Safeguarding Adults and Safeguarding Children. Both safeguarding teams offer individual support to the Links.

Clinical supervision has been identified as essential for staff who are involved in or have been involved in safeguarding adults investigations. Individual and team supervision is offered by members of the Safeguarding Adults Team, all of whom are trained supervisors. On one occasion in 2008, an independent supervisor was employed to talk with staff over several sessions regarding an in-depth safeguarding adult's investigation. Level 6 Safeguarding Adults Post Abuse training is offered to all staff who identifies a need. Two members of the team have attended this training. Bi-monthly group Mental Capacity Act supervision commenced in January 2009.

The Lead for Safeguarding Adults and the Safeguarding Adults Named Nurse have both been trained at all 6 levels of safeguarding training. The Lead and the Mental Capacity Act Manager have also completed all levels of training.

All team members regularly attend both local and national conferences to up date knowledge. The lead commenced an MSc in Interprofessional practice in Health and Social Care in September 2008. The Mental Capacity Act Manager will commence a stand-alone MSc module on Law and Ethics in September 2009.

The Department of Health document 'No Secrets' (2000) was under consultation from October 2008 to January 2009. Several sessions were organised so that a Medway Community Healthcare response could be collated. All staff were invited to attend to give their views. A joint response

from Medway Community Healthcare and Medway Council was sent to the Department of Health in January 2009.

All staff are supported through safeguarding adults incidents and encouraged to attend case conferences as necessary. There has been a considerable increase in alerts during 2008 to 2009 and a database was developed in January 2009 to collate statistics. Alerts range from minor involvement to more complex involvement. The level of involvement is determined by the lead agency for safeguarding, Social Services. To date there have been 90 alerts. Audits will show trends and themes which will assist with service provision. Serious Cases Reviews are multi agency and independently chaired. Lessons learned from the Serious Case Reviews are cascaded to all statutory agencies with feedback going back through the Safeguarding Adults multi agency committee and board. Action plans highlighting the lessons learned from internal investigations are cascaded to staff through the Quality Board.

Deprivation of Liberty Safeguards came into force as an addendum to the Mental Capacity Act (2005) in April 2009. In preparation for this, during 2008 and the beginning of 2009, work was done identifying Medway Community Healthcare as a Managing Authority for the specific in patient areas of St Bart's Hospital, Darland House and the Wisdom Hospice. Staff in these areas were identified as authorisees and trained appropriately. All the documentation to make an authorisation has been made available to the three in patient areas and is also on the intranet to download. The Mental Capacity Act Manager has been actively involved in developing multi agency documentation to support an authorisation, including a capacity assessment form.

There are a number of challenges for 2009 - 2010. These include;

- Key performance indicators will include training compliance and amount/trends of alerts
- Continuing to raise awareness with staff, stakeholders and the public
- Embedding the Mental Capacity Act and safeguarding into services and to assist with improvement of documentation to reflect this
- Identifying requirements following the publication of the outcome of the No Secrets consultation review
- Identifying robust service specification provision of commissioner requirements
- Continual redesign of service to identify needs of staff, public and organisation
- Extending networking and multi agency involvement to ensure safe patient experience
- The Safeguarding Adults Team will support the Human Resources department to ensure vetting and barring legislation is implemented, resulting in safer recruitment
- Ensure the Safeguarding Adults Team is supported by a team strategy as required by the Standards for Better Health and is compliant with all aspects of core standard C7e
- Working towards clinical supervision being mandatory for all staff who have been involved in a safeguarding adult/Mental Capacity Act investigation.

7.7 Kent and Medway NHS and Social Care Trust

The trust, in line with its statutory partners in Kent and Medway continues to maintain and promote its commitment to the county wide policy at all times. The trust has maintained its representation at the joint Kent and Medway Safeguarding Vulnerable Adults Committee throughout the year, as well as holding a quarterly forum where all operational directorates are represented, to discuss activity and plan developments.

In late 2008 the safeguarding co-ordinator post (subsequently evolving to become the Head of Safeguarding) for the trust was appointed to, and the post holder will commence full time with effect from mid April 2009. From November 2008 the post holder actively led the trust preparation for the Commission for Social Care Inspection's inspection of Kent's Adult Social Services in early 2009.

The process of preparation for the inspection was, of necessity, very focussed and comprehensive for both the trust and all other partner agencies. The work to ensure that the trust's systems and individual staff were fully prepared was supported by key Kent Adult Social Services staff and key individuals from across the trust. The safeguarding preparation encompassed the preparation and production of a list of 800 case files, for the Inspector to randomly select a number to review in detail. Two cases were selected from the trust's services. The two individual practitioners, their supervisors and their line managers were then involved in processes of reviewing and managerially critiquing their cases for written presentation to the Inspector. This was successfully actioned and completed.

As always, the training of staff has continued to be a key area. We are nearing completion of a centralised data base to enhance our skill base, planning and developments across our county wide services, for all staff, professional and vocational. The trust has several trainers in key service areas and they have met increasing demand, but further, and continuing, reviews of how best to meet capacity demands will be monitored, and maintained, through the trust's safeguarding operational groups. Additionally, we are now establishing, in partnership with our Learning and Development Team a training needs matrix to ensure that all levels of staff are guided to, and receive, the appropriate levels of training and regular updates.

As noted in the data from Kent there appears to have been a reduction in the reporting by the trust services. It is also noted that the "not recorded" level has increased, although this is not specific to the trust. This report is currently undergoing comparison with the unrefined baseline figures that the Trust holds. For April 2009 onwards the trust is implementing a data collection process to enable a more effective review of centralised data for the trust's Executive and its' partners. This will enable us to evidence if there has been an actual reduction in the reporting, or recognition, of areas of adult protection. This will be reporting into the Annual Report for 2009/10.

In common with other mental health trusts there continues to be a debate as to how and where safeguarding concerns are reported/recorded. The links between safeguarding and the Serious Untoward Incident processes are now being strengthened by reciprocal representation at the formal trust meetings; to clearly demonstrate learning needs and actions from concerns (actual or potential) relating to safeguarding. To further strengthen this, a specific safeguarding governance reporting structure is to be established in the next six months.

The requirements of the Mental Capacity Act (2005) and 'Deprivation of Liberty' are clearly a key development across the operational directorates; a lead has been taken, and maintained, by Older People Services in the trust. This will continue to be expanded into safeguarding processes and policies over the course of the next twelve months.

The trust, in conjunction with partner agencies, develops enhanced professional practices as a direct response to Serious Case Review recommendations. During the time span of this annual report there are two (D-2003 and S-2005) Serious Case Reviews in Kent that have a level of trust involvement. We review the progress of any recommendations (trust or other agencies) from the Serious Case Review and update the action plans accordingly. This year, we have achieved

progress against the identified recommendations relating to;

- Training staff re the Mental Capacity Act
- Improving record keeping
- Training for staff in dealing with situations of conflict.

Trust personnel were consulted with to provide professional contributions to the national 'No Secrets' consultation, via the county-wide response led by the Kent and Medway policy manager.

The trust's focus on safeguarding continues for the next twelve months on maintaining safest practices and responses for all of its service users, whilst preparing itself, and its staff, for achieving Care Quality Commission requirements for April 2010 onwards.

7.8 Maidstone and Tunbridge Wells NHS Trust

From July 2008 the Maidstone & Tunbridge Wells NHS Trust has recruited a matron for safeguarding vulnerable adults to work strategically across the trust ensuring that the Safeguarding processes and ideals are embraced by all members of staff. Although work has already been completed in some areas there is also a number of areas where work is planned.

An annual update of safeguarding activity, achievements and challenges is presented to the Trust Board annually. The first of which was submitted to the trust board October 2008.

The Trust Board has received a safeguarding presentation from the child protection nurse lead and matron for safeguarding vulnerable adults with regards to the trust agenda for safeguarding children and adults. This highlighted to the Trust Board the busy safeguarding agendas and promoted an open and honest reporting culture to be facilitated.

The Safeguarding Vulnerable Adults Policy and Procedure has been updated to include recent updates from the national and local safeguarding agenda. The final policy will be taken to the Committee in June 2009 for approval.

As part of the Safeguarding Policy and Procedure the Matron for Safeguarding Vulnerable Adults will be requesting nominations for Safeguarding Champions to be given for each area and intends to underpin their work with 3 days additional training each year. This will include heavy references to the Dignity in Care Challenge and the 10 key points of the challenge.

Each safeguarding champion will be urged to sign up to be a dignity in care champion.

The Trust Mental Capacity Act (MCA) policy and procedures have been re-drafted to ensure that they reflect changes in legislation. The Deprivation of Liberty Safeguards processes have also been included in this redraft.

Draft formats in relation to documenting the assessment of mental capacity, best interest decision making and best interest meetings have been developed and circulated for use to gain feedback from practitioners. Feedback to date has been positive and so these formats have been included in the redrafted MCA policy and procedure.

A programme of MCA Basic Awareness Training has been developed and is now delivered to all staff who are potentially assessing mental capacity and/or are decision makers. This is a two

hour session and is complemented by the matron for safeguarding vulnerable adults and the two Patient Experience Matrons visiting staff who raise concerns about their knowledge and ability to assess capacity whereby one-one information sharing is offered in this sometimes complex area of work. From January 2009 – March 2009 218 staff have participated in the Basic Awareness MCA seminars.

Bespoke training for different areas has been offered and well received. This affords staff to learn about safeguarding processes and the application of the Mental Capacity Act in smaller groups and to discuss cases relevant to their areas of practice

The Kent MCA programme of Basic Awareness in the Mental Capacity Act is in place from basic awareness Level 1 to Level 3 training. This is advertised to all clinical staff to access accordingly.

To enable the trust to gain effective feedback from patients whilst they are in hospital, we have developed a Patient Experience Questionnaire using hand held personal computers. This is a bespoke designed handheld computer system and the questionnaire can be altered as the need arises. It has also been designed to give us real time feedback with regards to the experience that patients have when they stay with us. This will automatically be downloaded onto our Key Performance Indicator (KPI) Dashboard and the outcomes will be discussed weekly amongst ward managers, matrons and ADNS' at our KPI meetings.

Episodes of violence and aggression towards staff and patients are discussed weekly at the KPI meetings whereby best practice and solutions can be shared to enable practitioners to learn from events. The Trust Local Security Management Service delivers Conflict Resolution training to staff with regards to dealing and managing violence and aggression.

Matrons and ward managers, with advice from the Local Security Management Service, will assess (with regard to the level of Incident Reports from each area) whether there is a need to develop further de-escalation and conflict resolution training. Allied Health Professionals who work in identified high-risk areas will be offered this further training, if it is assessed as being required.

Further work is required to identify areas that may require more in depth training with regards to managing challenging behaviour that is unexpected or to manage environments and people more effectively when likely challenges are known.

The trust has access to an 'e-learning' package from the University of Greenwich with regards to increasing staff knowledge in relation to people with a learning disability. The safeguarding champions will be expected to complete this interactive, six week course as part of their development in the first year of being safeguarding champions. With leadership from the matron for safeguarding vulnerable adults it is hoped that the knowledge gained from this course will be cascaded to all members of staff. As a result they will have more understanding of some of the challenges facing people with a learning disability and more knowledge in how to work collaboratively with our multi agency partners.

Posters that clearly identify where the definition of a vulnerable adult can be found and who to contact given a certain set of circumstances have been developed and laminated for all clinical areas. Contact details for the matron for safeguarding vulnerable adults are clearly advertised on this poster, for use by ward staff.

The definition of a vulnerable adult, what needs to be reported, and to whom have been clarified

for staff with our published KPI definitions. This has been circulated to all Matrons and Ward Managers and will be placed on the KPI Clinical Dashboard. Pocket information cards will be printed and circulated to all clinical staff and staffs who have direct patient contact including porters, domestics and ward clerks.

In the Maidstone and Tunbridge Wells NHS Trust there are two patient experience matrons. One is based at the Kent and Sussex Hospital (also covering Pembury) and the other is based at Maidstone Hospital. Both have, as part of their role, a responsibility to ensure that all reported vulnerable adults or safeguarding issues are responded to appropriately.

Each directorate matron has a responsibility for the care of patients in their designated wards and have been responsible for ensuring robust investigations and action plans are competed and developed in relation to any issues of concern that are raised. This is a developing area of work and the matrons are encouraged to take up the opportunities afforded by the multi agency safeguarding training on offer. All matrons and ward managers have been given the opportunity to access Mental Capacity Act basic awareness and Level 2 Safeguarding training and are encouraged to access the Kent and Medway multi agency training.

One multi agency training session has been delivered to a group of regional doctors.

The Trust provides the venue for the KCC hosted Residential Forum for Safeguarding. This needs to be more widely publicised for attendance from Trust staff so that they can understand more clearly what is required from them with regards to discharges back to residential homes.

Appropriate ward staff and matrons are involved in all safeguarding alerts and investigations within their areas. It is an expectation of the Trust that all medical staff will share the responsibility for the safeguarding vulnerable adult's agenda in their divisions. This responsibility has been included in all medics job descriptions.

Both safeguarding and MCA basic awareness training has been developed for medical staff to be able to understand, identify, report and investigate abuse. There is an emphasis on the multi agency requirements in relation to safeguarding vulnerable adults. Proposals have been presented to the Chief Medical Director and it is recognised that all medical staff need safeguarding and MCA training. It has been agreed that the MCA training needs to be delivered via the Medical Clinical Governance programme.

Through training, posters and referral processes we are ensuring that staff feel confident to report out into the multi agency arena any concerns in relation to the abuse of vulnerable adults. The safeguarding presentation to board members was delivered with an emphasis on developing an open and honest culture within the organisation. It was well received. More staff appear to be aware of the importance of reporting concerns with regards to adult abuse and there is evidence of staff showing a willingness to refer their concerns. Evidence is that 34 referrals have been raised by Trust staff from beginning October 2008 to the end of Sept 2009.

A local multi agency communications group has been convened to share good practice, processes, concerns and knowledge, in order that local resolution can be sought with regards to how we communicate effectively in multi agency processes.

The matron for safeguarding vulnerable adults, patient experience matrons and trust medical leads for safeguarding attend, on a regular basis, multi agency meetings to promote developments

in the Trust and to discuss concerns and solutions with our partner agencies. These include:-

- Kent and Medway Safeguarding Adults Committee Meeting and sub-groups
- Kent and Medway Operational Group
- Local Implementation Network meeting for MCA and various sub groups
- Kent and Medway Health Leads Business Meeting and clinical supervision.

Trust staff are encouraged to use the Serious Untoward Incident Reporting Mechanisms already in place. This takes into account safeguarding issues where vulnerable adults have been involved.

The trust populates and responds to the multi agency serious case review processes. These processes are discussed at the trust's Safeguarding Committee and methods of developing good practice are discussed as a result.

The CRB policy is in place across the trust. All staff and volunteers who have access to areas where a vulnerable adult may be located will have a CRB check completed either retrospectively or as they join the trust. Some will be required to have enhanced disclosures dependent upon their roles and responsibilities. A new policy and procedure has been implemented for volunteers and work experience placements.

There have been numerous improvements within the Maidstone and Tunbridge Wells NHS Trust with regard to working in the safeguarding multi agency arena. However it acknowledged that this is a fast moving agenda and as such the trust is prepared to ensure that the safeguarding of vulnerable adults is paramount in all the work that it does. With clarity of reporting mechanisms, policies and procedures and training delivery the safeguarding processes will continue to be publicised throughout its staff group so that responses are effective and timely in relation to safeguarding concerns.

7.9 Dartford and Gravesham NHS Trust

Dartford and Gravesham NHS Trust now have an additional member of staff working in an operational role and recently we presented the importance of adult protection to the Trust Board which has been fully supported and endorsed. The raised profile of adult protection has resulted in a rise in reporting concerns although this has not, so far this year, led to an increase in confirmed cases of abuse.

Excellent working relationships have been developed with Kent Police and Kent Adult Social Services and a joint 'lessons learned' meeting has been set up to discuss individual cases and create action plans for issues that may arise and may need development.
Along with the trust's policy and guidance on adult and child protection issues each ward and department now has a 'quick guide' to the process of raising a concerns to completing the CM31 and other documentation.

Whilst recognising there is much work to be done relating to safeguarding vulnerable adults it is felt that in the last year alone substantial progress has been made. Training in adult protection and Mental Capacity Act awareness, staff and the programmes for 2010 have been set. A number of senior staff who are awaiting Levels 1 and 2 training have been identified. These people, once trained, will be identified as adult protection champions for their areas.

7.10 Medway NHS Foundation Trust

This section highlights the safeguarding activity conducted by the Medway NHS Foundation Trust (MFT) from 1 April 2008 to the 31 March 2009.

The investigation of adult protection alerts is undertaken following the principles of the Kent and Medway multi agency adult protection policy and protocols. The relevant social services department (Kent or Medway) still retains the statutory responsibility for managing adult protection issues. Where incidents happen within the trust, social services delegates the responsibility for the investigation of the incident to the trust. Following investigation the report is presented to the appropriate social services for signing off, quality assurance and data collection.

The term protection relates to the need to actively protect a vulnerable adult at risk of/or suffering abuse. The term safeguarding relates to proactive activities that minimise/or prevent incidents of abuse.

There were 22 episodes of protection that necessitated raising an alert to protect a vulnerable adult.

13 referrals were made regarding incidents that had taken place within the premises of MFT, of the 12 incidents 10 were alleged to have been perpetrated by trust staff. One was by a family member whilst the patient was on a ward managed by MFT and the last case was perpetrated by a fellow patient

Eight incidents happened in the community, which necessitated MFT staff raising an alert when the patient was admitted into the care of MFT.

One case was a shared case with issues in both MFT and Kent Adult Social Services.

Of the 13 cases attributed to trust staff nine were related to omissions in care, two were alleged physical abuse, one was alleged sexual abuse perpetrated by a fellow patient and one was alleged mental abuse perpetrated by a family member.

The omissions in care were broken down into;

- Non management of bowels - one
- Acquisition of a grade three pressure ulcer - two
- Patient left in urine - two
- Discharged whilst at risk of urinary retention - one
- Inappropriate surgical management - one
- Poor provision of basic care of a person with learning disability - one
- Inappropriate referral - one.

The one incidence of alleged sexual abuse was perpetrated by a fellow patient who was also a vulnerable adult.

One alleged physical abuse was impossible to understand as the vulnerable person was unable to describe what had happened to her and there was no evidence of assault or damage to the lady. The AP1 did not describe the concern and there were no further clues when the notes were reviewed. The other physical abuse related to a staff member who claimed to have seen another staff member roughly handle a patient.

The shared case with Kent Adult Social Services related to a lady who was allegedly discharged from MFT at 22.00 hours via a taxi to a residential home. This was latter withdrawn as staff at the home confirmed the lady arrived by ambulance.

The patient who received inappropriate surgical management was investigated externally. MFT were asked to undertake a serious untoward incident investigation this has been completed and an action plan is being implemented.

Of the 13 allegations of abuse raised against MFT staff the investigation;
- Confirmed - five
- Discounted - four
- Found insufficient information to make a decision in two
- Referred one case to social care (issue found to be in community)
- Continues to investigate in one case.

In 47 weeks activity there were 88 episodes of safeguarding. The vulnerability of the individuals reviewed were as follows;
- Elderly care - 29
- Vulnerable person - 28
- Person with a learning disability - 16
- Physical disability - nine
- Mental health sufferer - four
- Victim of domestic violence - one
- Inappropriate referral (i.e. not vulnerable) - one.

The safeguarding activities were broken down as:
- Review for potential adult protection referral - 31
- Care concern - 14
- Request for information from external agencies - 13
- Reviews that led to adult protection alerts being raised - eight
- People with learning disability review - seven
- Transfer of care concern - five
- Best Interest decision facilitation - three
- Capacity assessment - two
- Behavioural management - two
- Malicious referrals - two
- Place of safety admission - one.

There were only four recorded episodes of safeguarding relating to MCA issues, this was due to MCA not being a field on the safeguarding database. This has since been rectified.

In March 2009 the trust introduced reviews for people with learning disability - the review is carried out within 24 to 48 hours of admission. The aim is to engage both the individual and their carers at the earliest opportunity so as to provide a personalised plan of care and to ensure that services reflect their often complex needs.

With the increased awareness of the needs of patients with a learning disability it became clear that the trust needed a learning disability liaison nurse (LDL Nurse). During 2008 to 2009 funding was secured from one of the commissioning PCTs and the post was advertised three times before the successful applicant was selected. They take up post in January 2010.

There have been notable developments in practice following episodes of safeguarding. The first was the introduction of the non-verbal pain assessment tool to all wards and departments, which is evidenced based and originates from Australian dementia research. The tool allows staff to evidence pain levels and the effectiveness of analgesia in the non-verbal patients. The tool can be used for patients with learning disabilities, dementia patients and patients who do not have the ability to speak due to surgical procedures. This development was written up and published in the July 2008 issue of the Nursing Times and has also been the focus of workshops throughout East Kent.

The second development of practice was the introduction of a protocol to allow both trust staff and carers to support patients with learning disabilities whilst they were in-patients on the ward. The protocol identifies the specific needs of the patients whilst they are in a foreign environment, who is best placed to meet those needs and how many hours (if at all) supplementary care needs to be purchased by the trust to facilitate carers to support them. This commitment by the trust to improve the experience of patients with learning disabilities has been welcomed by both.

Safeguarding vulnerable adults awareness sessions remained non mandatory for the year however the trust committed to making the training mandatory from April 1 2009.

To accommodate mandatory status a training needs analysis for all staff needing to undertake the training was commissioned. The analysis identified that all staff with face to face contact with vulnerable persons needed to do the trust's four hourly session, those with limited contact would do e-learning and those with no contact need not undertake the training.

Safeguarding awareness sessions have been increased to 18 per year to meet the needs of trust staff.

Mental Capacity Act (MCA) Level 1 training was introduced with sessions running on site every month aimed at front line staff who have contact with persons lacking the ability to make a decision. Also the external MCA levels two and three sessions were circulated to the appropriate persons.

Protection work remains the most time consuming aspect of operational safeguarding, however there are fewer contacts recorded than safeguarding but those contacts are more time intensive.

The most common alert raised against trust staff is neglect by omission - the focus for these omissions pertains to basic nursing care delivery.
Of the 13 alleged abuses by trust staff only five were proven.

Safeguarding contacts are more frequent than protection contacts, the most common contact is a request to consider if an issue merits the raising of a concern.

The requests from external agencies for information to support investigations is growing, it is now the third highest safeguarding activity.

Training capacity must expand to meet the requirements of mandatory status, therefore alternate methods of training need to be explored such as DVD and 'e-learning'.

The Mental Capacity Act will have a significant impact on the operational and educational resources of safeguarding.

7.11 East Kent Hospital University NHS Foundation Trust

Safeguarding adults is the recognition of potentially vulnerable adults within the trust including patients, relatives and members of staff. The trust adopted the Multi agency Adult Protection Policy, Protocols and Guidance for Kent and Medway 2005 which were produced in line with the Department of Health guidance document 'No Secrets' (2000). During 2009, the trust's risk management governance group was asked to ratify the East Kent Trust Safeguarding Adults Policy 2009. The policy was updated and further enhanced to enable full relevance for healthcare workers. The statutory requirement of individuals Human and Civil Rights not to be violated will be paramount in all considerations, included in this is the Mental Capacity Act 2007 and the Deprivation of Liberties Legislation 2009.

The updated Safeguarding Vulnerable Adults Policy 2009 was submitted to the Risk Management and Governance Group. The enhancements included the Mental Capacity Act 2007 and the Deprivation of Liberties Legislation 2009 guidelines for all healthcare workers and Trust employees. Consideration was given to, and guidelines produced, of the need for the monitoring and reporting, in line with the NHSLA requirements.

The safeguarding of vulnerable people has been recognised as being a priority of both the trust and the Directorate of Clinical Quality and Patient Safety. Within the mission statement of the trust the needs of vulnerable adults has been highlighted. To that end, the leads of services within the trust who have a direct influence over the safeguarding adults have been invited to join the trust wide safeguarding group.

Within the remit of the trust wide safeguarding group a process has been agreed and ratified for the monitoring and reporting of ongoing cases of vulnerable people within the trust. A regular agenda item and time has been allocated so that group members can highlight and record data which in turn will make the basis of a quarterly report to the Risk Management Governance Group. This report will emphasise the type of safeguarding concerns, trends, numbers and resolutions of the concerns. Further to this, recommendations will be made by the leads to the Risk Management Governance Group to ensure that the needs to continue safeguarding of vulnerable people are a paramount priority for the trust.

The programme of mandatory training of basic awareness was made available to be delivered to all directorates and departments trust wide. The programme is delivered at present by the Lead for Safeguarding Vulnerable People. This training is multidisciplinary and has been developed in conjunction with the basic awareness training delivered by Social Services. To date there has been considerable uptake of the basic awareness training with all disciplines represented. The training is delivered in a two hour session. Induction programmes also have safeguarding vulnerable adult input.

Specific training was delivered for specific Matrons to reinforce their knowledge regarding the Mental Capacity Act and information supplied for the Deprivation of Liberties legislation to enable correct processes when alerts are raised and due processes are followed.

There had been a collective realisation that the agenda for the safeguarding of vulnerable adults has increased substantively over the last few years. This agenda has further been burdened by the needs of expert knowledge and training with regard to the increased safeguarding adults national agenda, Mental Capacity Act 2007 and Deprivation of Liberties Legislation 2009. A

proposal was therefore been made to increase the level of safeguarding staff.

To date there has been one Serious Case Reviews in Kent and Medway involving the Kent and Medway Partnership Trust. The East Kent Hospital University NHS Foundation Trust submitted an action plan in response to the request of the Safeguarding Vulnerable Adults Committee.

7.12 Customer forum

The forum continues to be well attended with service users still coming from all over the county to the meetings held at Aylesford Priory. The meeting format has matured over the years, and each forum meeting now has two speakers, followed by a question and answer session. There is also a general discussion and information section, from which comes suggested topics for the next meeting. The question and answer sessions have often resulted in useful feedback to the speakers.

In 2008/2009 the forum had an enthusiastic speaker who managed to make the implications of the new Mental Capacity Act interesting. There was also a presentation by two newly appointed NHS matrons appointed to look after vulnerable adults in hospital. They both took away information to help their strategies from the forum members fielding a series of personal experiences. A second meeting received a presentation from Trading Standards on the current “scams” along with a description of the actual court procedures and penalties involved when proceedings are taken against alleged wrongdoers.

Members of the forum continue to serve on the Kent and Medway Safeguarding Vulnerable Adults Committee, and the Policy, Protocols and Guidance sub group and were called upon for information in the recent Commission for Social Care Inspection.

7.13 Carers forum

The forum continued to meet in 2008/2009 with two meetings at Aylesford Priory in April and October. It is difficult getting carers to attend the meetings, but those who do, go away refreshed and better informed. This year there were presentations about Links, Patient Advice and Liaison Services (PALS), Self Directed Support, the Advocacy Service and Independent Mental Capacity Advocacy Service.

Issues of particular interest at the Kent and Medway Safeguarding Vulnerable Adults Committee meetings included the involvement of carers and users in training programmes. Many carers have little idea of the safeguarding projects that are available to them. One of the forum members was invited to give a brief presentation to the Safeguarding Vulnerable Adults Operational Group about free home safety checks, message in a bottle and ICE phone numbers. These have since been promoted more widely, although there is still room for improvement in raising awareness of these safety measures.

Carers groups continue to be concerned about the lack of training for carers, that the knowledge and expertise of carers is often disregarded and the fact that carers themselves are often vulnerable adults whose stress and health needs are often overlooked.

Section 8. Safeguarding Activity 2008 - 2009

The following section summarises safeguarding activities from April 2008 to March 2009 and makes reference to three elements of data i.e;

- Alert – this refers to an individual reporting a suspected instance of abuse
- Incident – this refers to a suspected case of abuse that is being investigated
- Involvement – this refers to an agency involved in the investigation.

Rates of referrals – changes between 2007 - 2008 and 2008 - 2009

During 2007 - 2008 1848 alerts were recorded with 2201 being recorded for 2008 - 2009. There is a general increase of 19% in the referral rate over the two periods.

	April 2007 to March 2008	**April 2008 to March 2009**	**% change between periods**
East Kent Total	1019	1224	20.1%
West Kent Total	480	656	36.7%
Medway	230	142	-38.3%
Headquarters	1	2	100.0%
Mental Health	83	74	-10.8%
Not Recorded	35	103	194.3%
County Total	**1848**	**2201**	**19.1%**

Table 1: Adult protection alerts recorded in Kent between April 2007 and March 2009

The not recorded category has increased significantly by 194% having risen in number from 35 between April 2007 and March 2008, to 103 between April 2008 and March 2009.

Age of alleged victims

Of the 2059 alleged victims during the period April 2008 to March 2009 there has been no significant variation in the percentages in each age band to the last report (39% are aged 18 - 64, 11% aged 65 - 74, 22% aged 75 - 84 and 27% are aged 85 and over). (*This excludes Medway data)

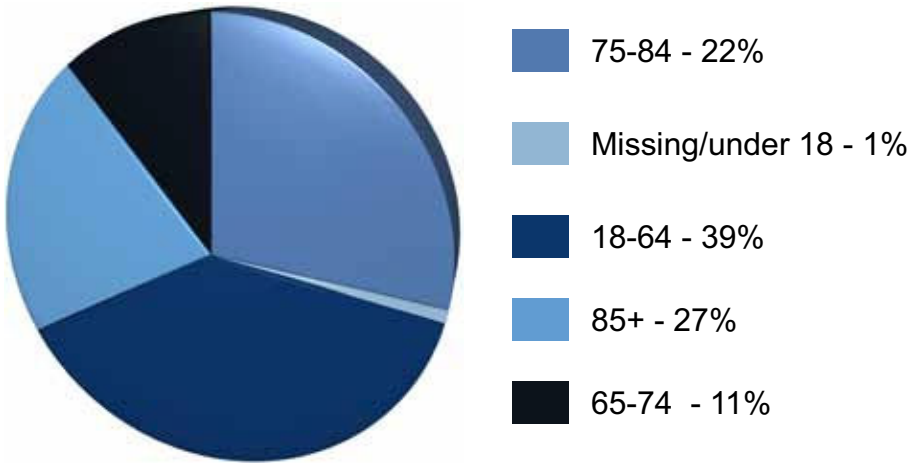


Figure 1: Adult protection alerts recorded in Kent between April 2007 and March 2009 by age. (*This excludes Medway data)

Gender of alleged victims

Of the 2059 alerts recorded during the period April 2008 to March 2009, 1295 (63%) of the alleged victims were female and 760 (37%) were male with 4 not being recorded. There was no significant variation in the proportions in this report compared to previous reports. (*This excludes Medway data)

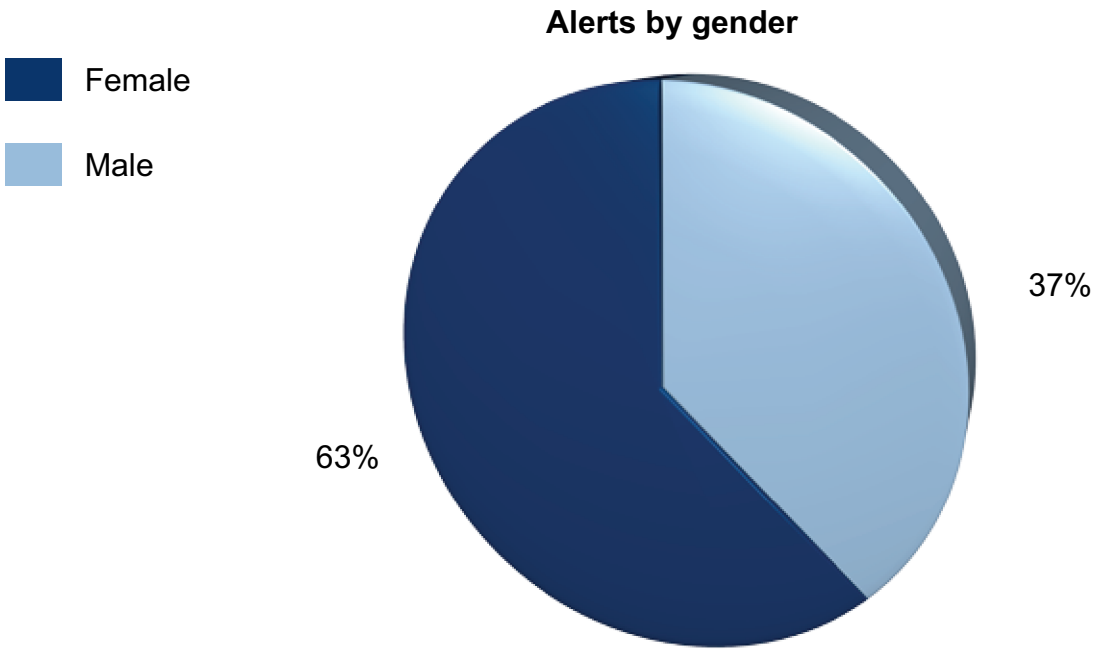


Figure 2: Adult protection alerts recorded in Kent between April 2008 and March 2009 by gender (*This excludes Medway data)

Gender in the 18 - 64 age group in Kent is split more evenly with 389 males and 412 females, as shown in Figure 3 below.

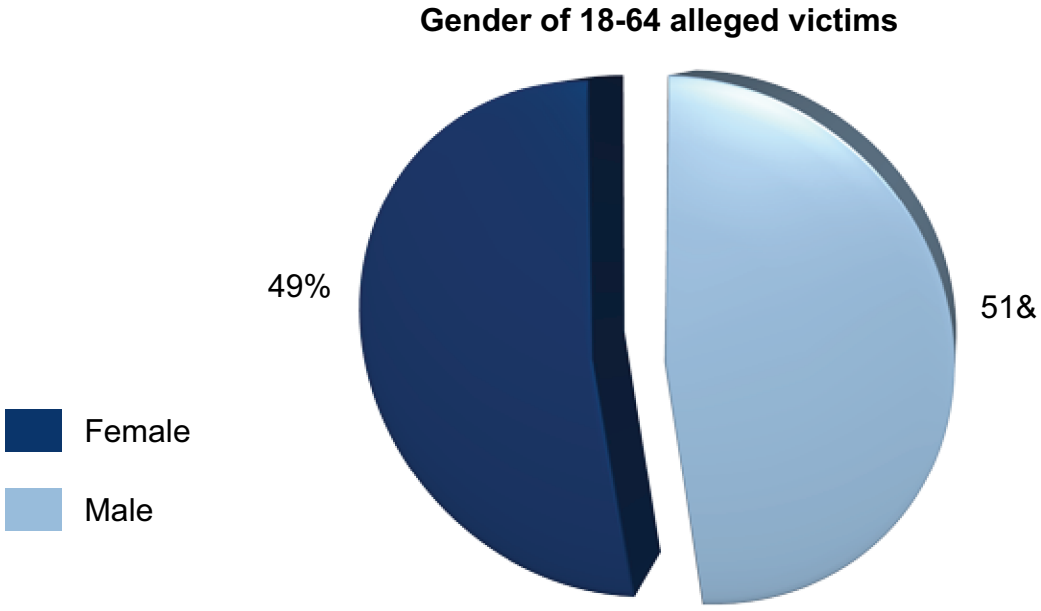


Figure 3: Adult protection alerts recorded for the 18 - 64 age group in Kent between April 2008 and March 2009 by gender (*This excludes Medway data)

However, differences in the numbers of alerts for the 65 + age group are more significant. There are 873 females and 363 males, as shown in figure 4.

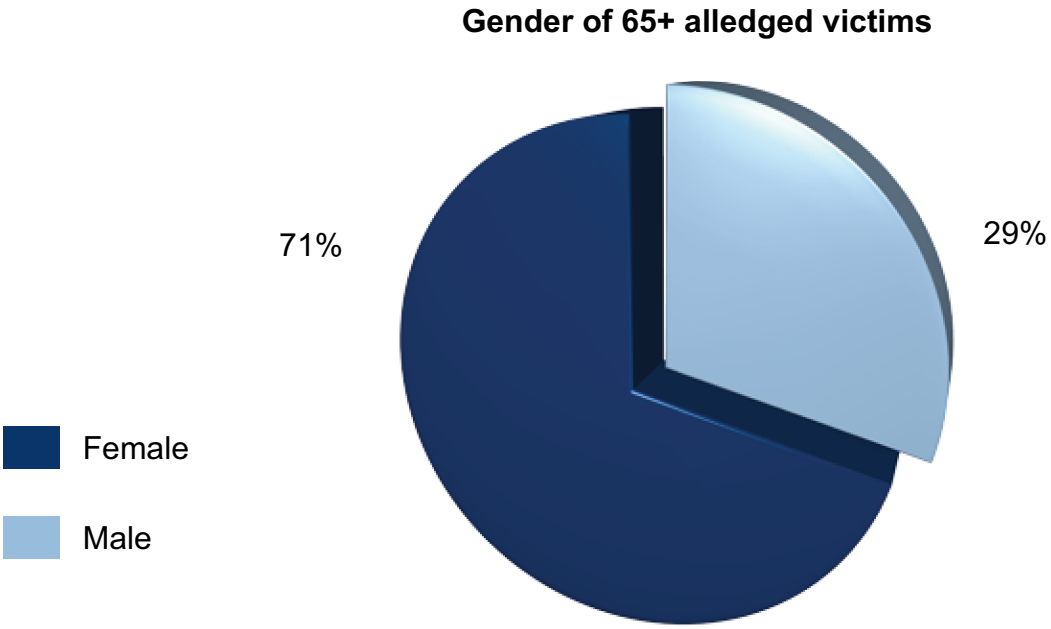


Figure 4: Adult protection alerts recorded for the 65 + age group in Kent between April 2008 and March 2009 by gender (*This excludes Medway data)

Ethnicity of alleged victims

The ethnicity of the 3677 alleged victims in Kent is broken down into three categories, White, Black and Minority Ethnic and unknown (which includes not recorded). There is almost no variation in the proportions between the two periods. These figures are displayed in table 2 below. (*This excludes Medway data).

	Apr 2007 to Mar 2008	Apr 2008 to Mar 2009	Total	Total Proportion
White	1470	1863	3333	90.6%
BME	34	38	72	2.0%
Unknown	114	158	272	7.4%
Total	**1618**	**2059**	**3677**	

Table 2: Adult protection alerts recorded in Kent April 2007 and March 2009 – by ethnicity (*This excludes Medway data)

The highest percentage of alerts is for the White ethnic group, which includes White British, White Irish and White Other. The alerts for those who have no ethnic origin entered is 8%, and the number of alerts from BME backgrounds is 2% compared with a BME population for Kent of 6%. These proportions vary very little.

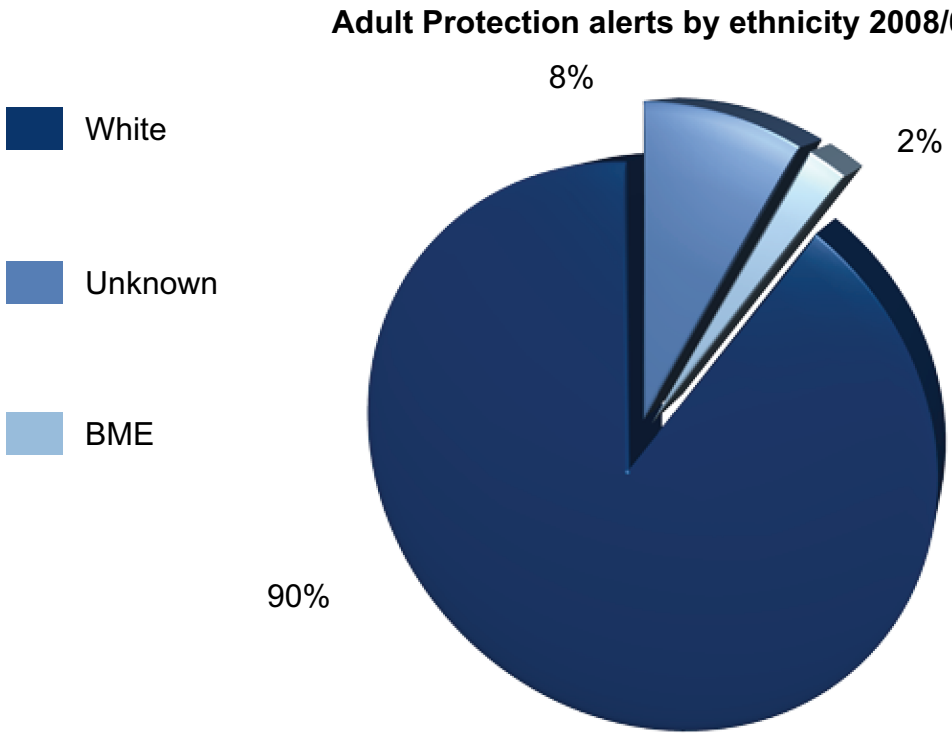


Figure 5: Adult protection alerts recorded in Kent between April 2008 and March 2009 by ethnicity (*This excludes Medway data)

Client category of alleged victims

Over half, 61%, of the 3677 alleged victims are in the Older Person category. The next highest category is Learning Disability 16%. The Not Recorded category is relatively low at 2%.

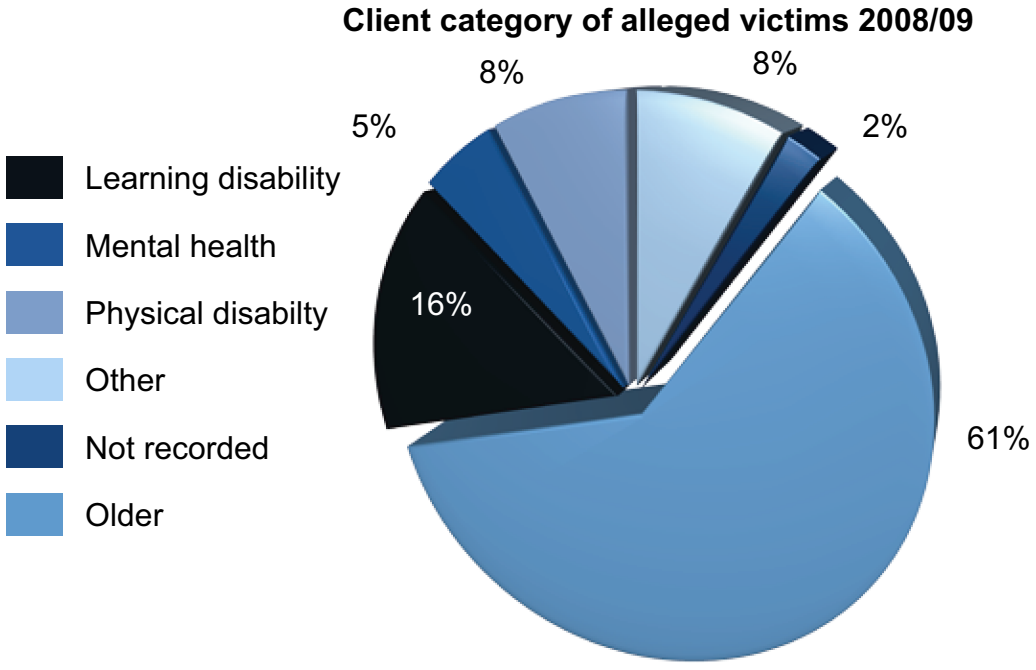


Figure 6: Adult protection alerts recorded in Kent between April 2008 and March 2009 by client category (*This excludes Medway data)

Sources of adult protection alerts

The sources of adult protection alerts are shown in table 3 for the period April 2007 to March 2009. There are also figures for the percentage change of the source between the two periods and the proportion of total alerts in 2008 - 2009 for each source group. The 'other' category includes carer, Independent non statutory/voluntary agencies, anonymous, legal (including solicitors), other local authority, probation and stranger.

Table three shows that the largest source of alerts is social care staff accounting for 39.8% of total alerts in 2008 - 2009. Education/workplace, family member, regulators and not recorded all had a decrease in numbers. The percentage change compares the alert figures excluding Medway data, however Medway data is included in the total proportion 2008 - 2009.

	April 2007 to March 2008	**April 2008 to March 2009**	**Medway April 2008 to March 2009**	**Percentage change between 2007 -2008 and 2008 - 2009**	**Proportion 2008 -2009**
Education / workplace	19	10	0	-47.4%	0.4%
Family member	195	177	33	-9.2%	9.2%
Friend / neighbour	39	40	1	2.6%	1.8%
Housing	12	34	3	183.3%	1.6%
Primary Health	141	227	16	61.0%	10.6%
Secondary Health	97	164	4	69.1%	7.3%
Not recorded	194	161	0	-17.0%	7.0%
Other	168	220	28	31.0%	10.8%
Police	86	141	3	64.0%	6.3%
Regulators	45	41	7	-8.9%	2.1%
Self referral	64	66	2	3.1%	3.0%
Social care staff	558	778	132	39.4%	39.8%
Total	**1618**	**2059**	**229**	**27.3%**	

Table 3: Adult protection alerts recorded in Kent April 2007 and March 2009 by the source

Location of abuse

During the period April 2007 to March 2009 there were 2986 adult protection incidents recorded in Kent. As shown in Table four below the number of incidents increased by 14.5% between the two periods. The proportion 2008 - 2009 contains Medway data whilst the change between the two periods excludes Medway data.

	April 2007 to March 2008	April 2008 to March 2009	Medway April 2008 to March 2009	Proportion of 2008 - 2009	Change between the two periods
Alleged perpetrators home	0	8	0	0.4%	
Another person's home	12	14	2	0.8%	16.7%
Care home	443	596	56	30.7%	34.5%
Care home with nursing	258	237	25	12.3%	-8.1%
Day centre	26	30	42	3.4%	15.4%
Educational / training Workplace establishment	14	3	0	0.1%	-78.6%
Hospital	27	66	7	3.4%	144.4%
Not recorded	13	26	0	1.2%	100.0%
Other	51	46	2	2.3%	-9.8%
Other health setting	17	25	0	1.2%	47.1%
Own home	507	709	79	37.1%	39.8%
Public place	43	50	8	2.7%	16.3%
Respite/short-term break home	17	22	0	1.0%	29.4%
Supported accommodation	27	45	10	2.6%	66.7%
Voluntary work place	1	0	0	0.0%	-100.0%
Unknown	36	18	0	0.8%	-50.0%
Total	**1492**	**1895**	**231**		**27.0%**

Table 4: Location of alleged abuse 2007 - 2009

Alleged care home incidents by area

The table below shows the number of incidents recorded and focuses on the location of care homes.

	Alleged incident location - Care Home 2008 - 2009	Total Number of Incidents 2008 - 2009	Proportion
East Kent Total	455	918	49.56%
West Kent Total	163	490	33.27%
Medway	81	231	35.06%
Headquarters	0	2	0.00%
Mental Health	8	69	11.59%
Not recorded	207	416	49.76%
County Total	**914**	**2126**	**42.99%**

Table 5: Alleged care home incidents by district 2008 – 2009

Categories of abuse

The table below shows the categories of abuse as a percentage for the period April 2007 to March 2009 and data for Medway in the period 2008 - 2009. The dominant category during both periods in Kent is physical abuse. In Medway financial abuse is the slightly more dominant category.

Psychological abuse has noticeably increased by 3.9% across the two periods and is significantly more dominant in Medway. Institutional abuse has decreased over the two periods, and is also low in Medway.

Type of Abuse	April 2007 to March 2008	April 2008 to March 2009	Medway April 2008 to March 2009
Discrimination	0.9%	0.5%	0.6%
Financial	24.1%	22.7%	25.8%
Institutional	13.4%	8.0%	7.5%
Neglect	22.1%	22.4%	15.4%
No Category	5.9%	4.9%	3.5%
Physical	26.7%	27.7%	24.2%
Psychological	12.8%	16.4%	20.1%
Sexual	6.1%	4.7%	2.8%

Table 6: Percentage types of abuse by period

Percentage of incidents of abuse categories by area 2008 - 2009

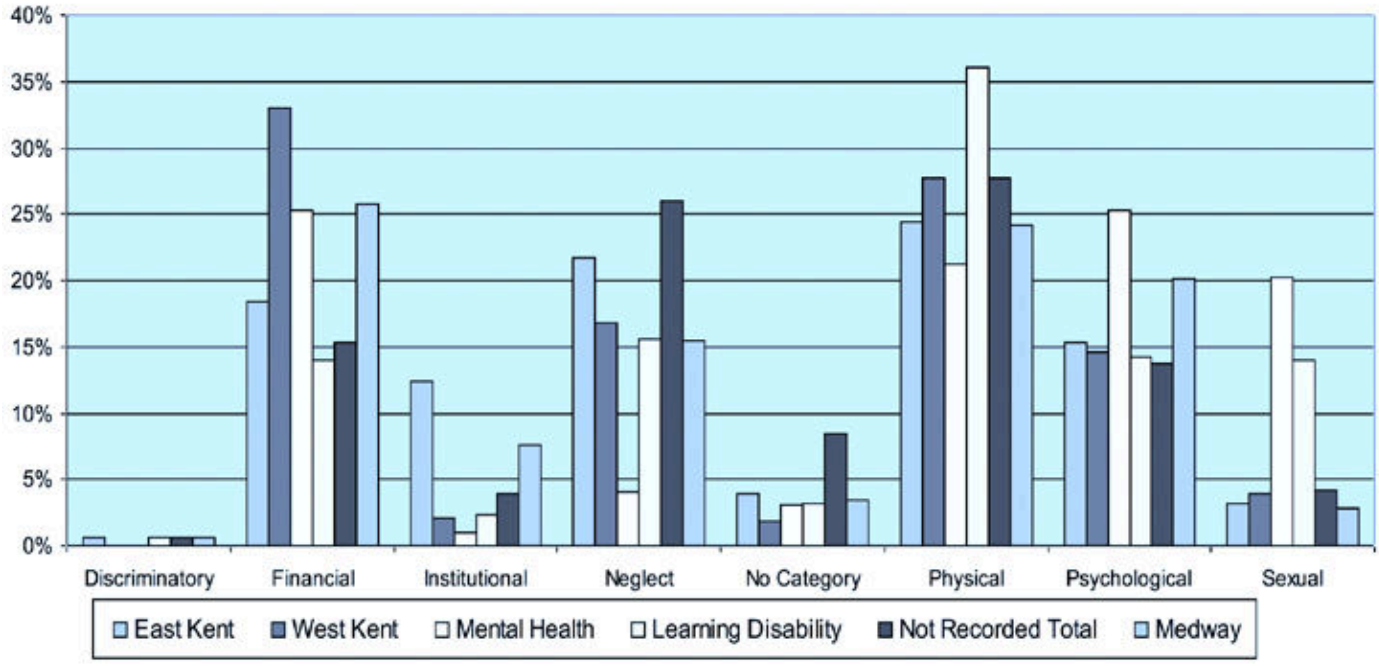


Figure 7: Percentage of incidents of abuse categories by area 2008 - 2009

This graph shows the percentages of alerts by category of abuse and area for April 2008 to September 2009. Mental health has a significantly higher percentage of psychological and sexual abuse than the other areas. East Kent has a significantly higher percentage of institutional abuse, where as West Kent has a higher percentage of financial abuse. Learning disability has the highest percentage of physical abuse compared to the other areas. The proportions where no district is recorded could change these comparisons.

Breakdown of decisions

Figure 8 opposite shows the percentage investigation outcomes for closed alerts 2008 - 2009. The two largest proportions are not determined / inconclusive and not substantiated (28%), although 'substantiated' is only 2% smaller.

'Substantiated' means that the allegations were confirmed whilst 'partly substantiated' means that some aspects of the allegation were confirmed.

'Unsubstantiated' means that the allegations were discounted and 'inconclusive' means that despite investigation and assessment there was insufficient evidence to determine if the abuse happened or not. Other refers to cases where the outcome was not entered.

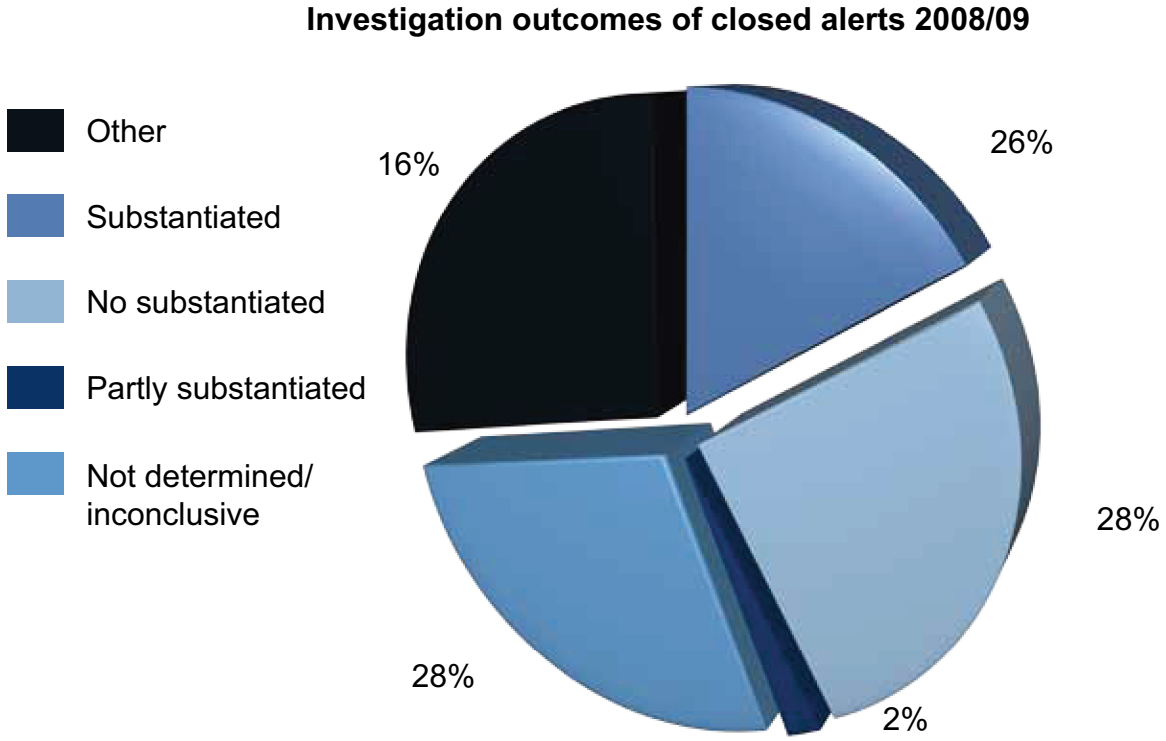


Figure 8: Decisions of Investigations recorded between April 2008 and March 2009

Investigation/assessment involvement

Table seven below provides details of the investigation/assessment involvement. Social Services has the highest proportion of 100%. Figure 12 below illustrates the proportions. Figures for 2007 - 2008 were obtained from figures previously reported.

	April 2007 to March 2008	April 2008 to March 2009	Proportion 2007 -2008	Proportion 2008 -2009
Social Services	875	1049	100%	98.3%
Police	412	484	49.4%	45.4%
Health	144	228	17.3%	21.4%
Regulatory Body	373	280	44.7%	26.2%
Not Recorded	148	216	17.7%	20.2%
Service Provider	81	122	9.7%	11.4%
Voluntary Organisation	26	46	3.1%	4.3%
Housing	9	18	1.1%	1.7%
Total	**2068**	**2443**		

Table 7: Involvement of agencies in investigations of abuse in Kent 2007 - 2009

Section 9. Development Plan 2009 - 2010

A number of key activities have been identified by the Kent and Medway Safeguarding Adults Board for 2009 - 2010 including;

- Further developing the three year strategy and associated business plan (for 2009 - 2010)
- Recruiting a Safeguarding Adults Board Manager
- Recruiting an additional training consultant
- Developing an action plan to respond to the recommendations from the Commission for Social Care Inspection following the safeguarding adults inspection in Kent Adult Social Services
- Responding to any requirements/recommendations from the outcome of the review of the 'No Secrets' guidance
- Reviewing the governance arrangements for the Kent and Medway safeguarding partnership
- Developing a safeguarding awareness raising strategy across Kent and Medway
- Finalising the multi agency competency based framework and implementing across all agencies
- Agencies considering the 2008 - 2009 activities to identify any learning points.

Progress on these activities will be reported in the Kent and Medway Safeguarding Vulnerable Adults Annual Report 2009 - 2010.

Apendices

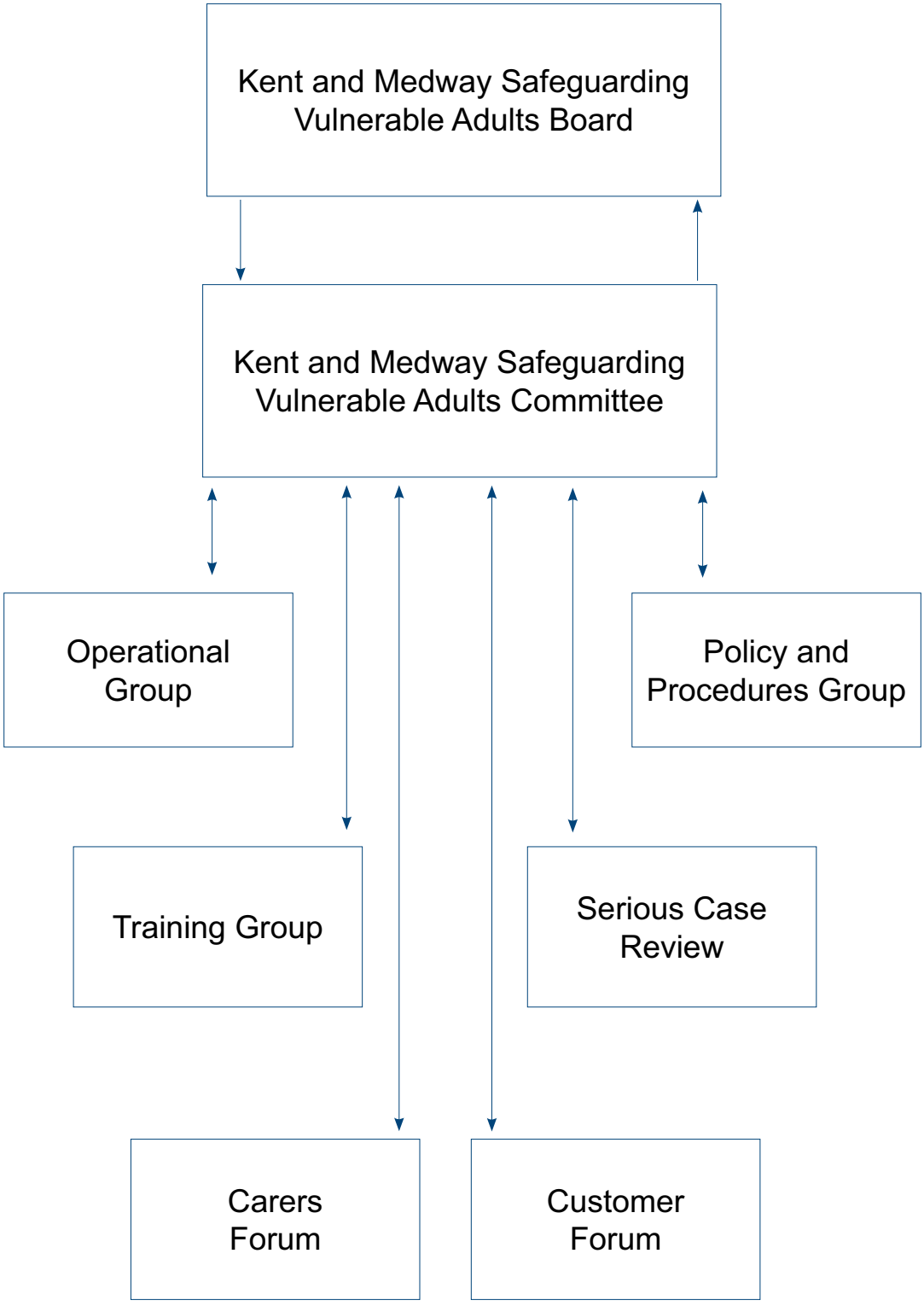
1. Kent and Medway Safeguarding Vulnerable Adults Structure

2. Kent and Medway Safeguarding Vulnerable Adults Adult Protection Training Structure

3. Adult Protection Training Target Group

Appendix 1

Kent and Medway Safeguarding Vulnerable Adults Structure



Appendix 2

Kent and Medway Safeguarding Vulnerable Adults
Adult Protection Training Structure

Level 1:
Awareness
Developing a shared understanding about what constitutes abuse and the definition of what is a vulnerable adult? An understanding of the signs and symptoms of abuse. Also what to do if you witness abuse or are told about it.

Level 2:
The Practitioners Role
Dealing with disclosures for those who need to complete the alert form as part of their professional role. Determining risk, vulnerability and seriousness. Examining the implications of the three 'C's – capacity, consent and confidentiality.

Level 3:
The Investigators Guide
Knowledge and skills required in planning and undertaking a protective and/or detective investigation either within a single agency or jointly with colleagues from other agencies. Examining elements of good practice in gathering evidence.

Level 4:
Joint Working in Criminal Investigations
Developing mutual understanding of the complimentary and supportive roles of the police, social services and other agencies when a potential crime has been committed. This will include an overview of the 'Achieving Best Evidence' model of interviewing.

Level 5:
Decision Making and Accountability
This course is directed at those who will be involved in the conclusion decision making processes (such as care conferences and planning meetings) and have responsibility for these under the current policy and procedures. Evaluating the evidence and implementing protection planning.

Level 6:
Post Abuse
Who are the stakeholders in protection planning? Providing for the post-abuse support needs of the vulnerable adult and their support networks – a strengths and needs model.

It is recommended that the adult protection training programme be approached in a systematic manner.

For more information on each course please consult the Adult Protection web site: www.kent.gov.uk/adultprotectioncommittee or training brochure.

We are committed to integrating an equalities perspective into all our work.

Appendix 3

Adult Protection Training Target Group

Multi-agency Adult Protection Committee and Training Consultant

Private and Voluntary sector	Police	Social Services
Train the Trainer Unit managers, senior staff in residential and domiciliary services, home owners	**Train the Trainer** Training school staff Area Training Officers	**Train the Trainer** Experienced or Senior Practitioners in Adults & Specialist Services
LEVEL 1 Adult Protection 'Awareness' All staff especially for NVQ in care and support staff i.e. office/admin, domestics, cooks, gardeners	**LEVEL 1** Adult Protection 'Awareness' All Police constables, rural wardens, N.W.L.O, call centre staff	**LEVEL 1** Adult Protection 'Awareness' OPSDU, LDAF, ASPU, Mental Health community support workers
LEVEL 2 The Practitioners Role Senior Community Support Worker (domiciliary), unit managers (residential)	**LEVEL 2** The Practitioners Role Patrol sergeants, Public Protection Unit (PPU) officers	**LEVEL 2** The Practitioners Role Care managers, care manager assistants, social workers, senior practitioners, team leaders, district managers, professionally qualified staff from health integrated teams/ partnership trusts
LEVEL 3 Investigators Guide Senior Community Support Worker (domiciliary), unit managers (residential)	**LEVEL 3** Investigators Guide PPU	**LEVEL 3** Investigators Guide Care managers, social workers, senior practitioners, professionally qualified staff from health integrated teams/partnership trusts
	LEVEL 4 Working With The Police PPU officers	**LEVEL 4** Working With The Police Care managers, social workers, senior practitioners
		LEVEL 5 Decision Making & Accountability District managers, team leaders, senior practitioners, managers of staff in integrated teams (MH/LD)
LEVEL 6 Post Abuse Support Senior Community Support Worker (domiciliary), unit managers (residential) and train with registered managers in SSD provision and senior staff in community services	**LEVEL 6** Post Abuse Support Patrol sergeants, PPU officers, PPU and supervisory staff of above.	**LEVEL 6** Post Abuse Support Care managers, care manager assistants, social workers, senior practitioners, team leaders, district managers, professionally qualified staff from health integrated teams/ partnership trusts, managers of OPDSU, LDAF, ASPU and P&V

Health	Benefits Agency	Housing
Train the Trainer Professionally qualified staff with interest in area of practice	**Train the Trainer**	**Train the Trainer** Professionally qualified staff with an interest in this area of practice
LEVEL 1 Adult Protection 'Awareness' All staff both in community and in-patient and support services; managers/professionally qualified/ support staff	**LEVEL 1** Adult Protection 'Awareness'	**LEVEL 1** Adult Protection 'Awareness' All staff including private sector staff and control room
LEVEL 2 The Practitioners Role District nurses, allied professionals in community health, managers of above, ward managers, in-patient staff, grade nurses	**LEVEL 2** The Practitioners Role	**LEVEL 2** The Practitioners Role Housing officers, homelessness/ housing needs/advice, Sheltered scheme & mobile wardens
LEVEL 3 Investigators Guide District nurses, allied professionals in community health, managers of above, ward managers, in-patient staff grade nurses, optional for managers	**LEVEL 3** Investigators Guide	**LEVEL 3** Investigators Guide
LEVEL 4 Working With The Police		
LEVEL 5 Decision Making & Accountability Managers and complaints handling staff if investigation is single agency?		
LEVEL 6 Post Abuse Support District nurses, allied professionals in community health, managers of above, health visitors, hard managers, in-patient staff grade nurses, complaints handling staff if investigation is single agency, managers	**LEVEL 6** Post Abuse Support	**LEVEL 6** Post Abuse Support `Housing officers, homelessness/ housing needs/advice, Sheltered scheme & mobile wardens

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Version number: CM,PJ,AC 17/03/2010

By:	Graham Gibbens, Cabinet Member for Adult Social Services Oliver Mills, Managing Director, Kent Adult Social Services
To:	Adult Social Services Policy Overview and Scrutiny Committee – 30 March 2010
Subject:	**CARE QUALITY COMMISSION – ANNUAL PERFORMANCE ASSESSMENT REPORT FOR ADULT SOCIAL CARE**
Classification:	Unrestricted

Summary:	This report provides an update following the Routine Business Meeting with the Care Quality Commission on 15 December 2009.

Introduction

1. (1) On 15 December 2009, Kent Adult Social Service's Routine Business Meeting with the Care Quality Commission (CQC) took place to audit performance for the year 2009/10. This was the first business meeting for the performance year 2009/10.

Policy Context

2. (1) The major agenda item for the meeting was the Inspection Action Plan. It has been monitored closely by the Strategic Management Team (SMT), Area Management Teams (AMT's) and the Inspection Steering Group. The discussion was led by Silu Pascoe (Lead Inspector CQC). The general impression of the meeting was that CQC are satisfied with the progress but it will be reviewed again at the next meeting on 15 March 2010.

(2) Briefings were provided for CQC on the other areas of improvement and these were only touched on. However, CQC have since come back with questions / actions regarding these for which we have provided responses.

(3) A report went to Cabinet on 1 February 2010, regarding the Annual Performance Assessment of Kent Adult Social Services by CQC.

(4) The outcome of the performance analysis of Kent Adult Social Services for 2008-09 was announced on 3 December 2009. Instead of the annual star ratings of KASS, in which we have been awarded three stars in the last seven years, Kent Adult Social Services was awarded *'Excellent'* in three of the seven outcomes:

- Improved Quality of Life
- Making a Positive Contribution
- Economic Well-being

and was judged as *'performing well'* in the other four outcomes.

(5) This is a further improvement on last year's performance where we were judged as *'excellent'* on achieving two outcomes and *'good'* on the five others.

(6) This performance assessment is taken with the judgements reached in the Independence, Wellbeing and Choice inspection in March 2009, which rated Kent Adult Social Services as follows;

- Safeguarding adults *Good*
- Delivering preventative services (focussed on older people) *Excellent*
- Capacity to improve *Excellent*

Recommendations

3. (1) Members are asked to NOTE and COMMENT on this report.

Nick Sherlock
Planning and Public Involvement Manager
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Katherine Stephens
Senior Planning Officer
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Attached documents:
Appendix 1: Inspection Action Plan Update Sheets.

CQC Inspection Action Plan: Recommendation 1

The council and its partners should develop a communications and engagement strategy that ensures people who use services, carers and members of the public know how to report abuse and know how to keep themselves safe.

Activity to Date

1. Strategic Overview

This action sheet and those which follows focus on the KASS activity. However it is to be noted that much of this activity is being co-ordinated with other partners on the Safeguards Board. This is being overseen by a group set up by the Board to monitor progress on the implementation of the Inspection Action Plan.

Within KASS the Steering Group originally set up prepare for the Inspection has continued to meet and monitor the implementation of the action plan. SMT and AMT's are updated regularly on progress and both Areas have groups in place to ensure the recommendations are being implemented locally. Progress on the Action Plan has been reported to members through our internal core monitoring processes which are reported regularly to Cabinet and to the Overview and Scrutiny Committee.

2. Public Involvement Strategy

The Public Involvement Strategy is being developed with the public. We have seen the development of this action in 3 stages:

1. Scoping the strategy with the public and key partners
2. Drafting the plan
3. Sign off and implementation

To date much of the activity has been focused on stage 1 of the plan which has included:

- A wide programme of meetings to involve the public. This has involved an extensive schedule of meetings with a range of groups across age / gender / disability and ethnic origin. It has also featured as a key part of the carers action plan
- Working with partners – for example the multi agency group set up by the Safeguarding Board to deliver the action plan
- We are also using other methods of communication such as articles in our Step By Step publication, public involvement web page and articles.

The sessions with groups are planned individually to meet the needs of the groups but do have the following elements in them.

- How do people want to work with us
- Safeguarding
- Information – Right Time, Right Place, Right Method.
- Self Directed Support.

3. Information – how people get information about safeguarding, our services and how to be involved with KASS is a key factor in the delivery of this recommendation – this is covered in more detail in the update on Recommendation 6.

Further work planned

- Drafting of the strategy with an editorial group of members of the public - followed by further consultation
- Implementation and monitoring the impact / outcomes of the strategy
- A Safeguarding Awareness week – to raise the profile of safeguarding with the people of Kent
- Ensuring strategy is linked into core business
- Review plan for the strategy with the public
- SCRG – monies from this grant will used to stimulate community engagement with a focus on BME and hard to reach communities
- The Kent Total Place pilot is focused on improving services to the customer, reducing duplication and improving efficiency across the public sector.

CQC Inspection Action Plan: Recommendation 2

The council and its partners should develop an adult safeguarding workforce development strategy that includes a competency-based framework.

Activity to Date

- Competency-based framework drafted - all partner agencies involved in its development and are committed to making it a part of their workforce strategy
- Safeguarding is a key element in the KASS workforce development strategy
- BME issues embedded in safeguarding training
- Safeguarding issues are embedded into Self Directed Support training

Outcomes

- BME issues are embedded in safeguarding training
- Safeguarding issues are embedded into Self Directed Support training
- Each agency has its own workforce development strategy which has a safeguarding section, which is competency-based
- Draft competency-based framework has been developed with partners

Further work planned

- Comments from partners regarding the competency-based framework will be incorporated into the final document
- Competency-based framework will be finalised and published – timescales to be agreed by the safeguarding adults sub-group
- Safeguarding Board will put together a multi-agency workforce development strategy
- Safeguarding Board will ensure that the overarching strategy has robust links to safeguarding

- Kent Integrated Local Area Workforce Strategy (InLAWS) - an overarching workforce strategy is being developed which will incorporate safeguarding, quality and regulation as Section 6

CQC Inspection Action Plan: Recommendation 3

The council and its partners should analyse the high number of inconclusive outcomes of safeguarding alerts in order to inform future practice.

Activity to Date

- Audit 28th September analysed cases on spreadsheet presented to CSCI/ CQC for inspection which identified inconclusive outcomes
- Report compiled regarding the outcome of the audit and recommendations made regarding the terminology used when recording outcomes of cases
- Findings discussed by the Area Management Teams and a multi-agency group. Agreed measures to inform future practice are in place
- Data Quality reports being used in supervisions to review outcomes and the level of data quality
- Personnel and Development Review Board – meeting on 25 November discussed the process for updating the overarching KASS supervision policy as well as the need to review underlying policies. A timetable will be established for this piece of work
- Outcomes of the work have been shared with the Safeguarding Board to embed learning points from this exercise

Outcomes

- Following the audit, a report was compiled which made recommendations that the terminology used to record outcomes be changed. These changes can be easily converted back to DH terminology
- Better understanding of the reasons for the number of inconclusive cases
- Follow up investigations have been carried out on individual cases
- Partners are better informed as a result of the lessons learnt
- Safeguarding training information has been and will continue to reinforce the message as a result of the analysis
- Management oversight and practice monitoring systems are in place including supervision, peer reviews and Good Practice Groups
- The overarching KASS supervision policy is being updated and will include Self Directed Support and safeguarding

Further work planned

- A programme of audits will take place to ensure consistency of recording outcomes
- Data Quality indicators will continue to be developed
- KASS supervision policy will be updated and will include safeguarding and Self Directed Support
- Multi-agency policies will continue to be reviewed

CQC Inspection Action Plan: Recommendation 4

The council should review both the need for and the capacity of advocacy organisations to support and empower people through safeguarding processes, especially during the investigative process or where support needs are long term.

Activity to Date

- Advocacy captured within SDS Project Plan as a workstream
- Mapped advocacy services in the County. This will be followed up with a plan for ensuring that services to support those engaged in safeguarding are available, accessible and of good quality
- Following this mapping, there will be a pilot project in East Kent with a focus on safeguarding in Ashford in partnership with an advocacy service
- Developing a proposal to commission Advocacy Services for people with Dementia
- East Kent have developed a series of recommendations, including identifying longer term support for individuals following completion of safeguarding concerns and to gain feedback from clients expressing their views on the need for advocacy in safeguarding
- Undertaken a mapping exercise linked to the renewal of voluntary organisation agreements. Proposals will be brought to the Commissioning Board
- Co-ordinated Advocacy services for people with learning disabilities in place Kent wide, contract cover support in and around safeguarding. Commissioned by LDDF
- Mental Health have undertaken a mapping exercise
- Built-in support through the Independent Mental Capacity Advocate (IMCA) provision for certain people in some safeguarding cases

Outcome

- Mapping exercises have been undertaken across Kent – which are being used to evaluate the level of advocacy in Kent
- Voluntary organisation agreements have been revised following mapping exercises
- LDDF has commissioned co-ordinated advocacy services for people with learning disabilities across Kent
- Vulnerable adults going through the safeguarding process can have an independent advocate to represent them

Further work planned

- Outcomes of mapping exercises will inform future commissioning across Kent
- Money has been allocated within SCRG to increase capacity for advocacy with a focus on safeguarding during 2010/11
- As part of the allocation of SCRG monies, advocacy services for people with Dementia will be commissioned

CQC Inspection Action Plan: Recommendation 5

The council should work with family carers to develop better access to appropriate information, advice and services to support them in their caring role.

Activity to Date

- A Carers Action Plan has been developed to address this recommendation. Plan will be reviewed every six months
- Events list to be published on Kent Carers website
- Gateways are used as places where people can access information
- Carers development programme commissioned from Foundation for People with Learning Disabilities will support Family Carers to work closer with KASS
- Kent Carers Emergency Card - just over 1000 carers have registered with contingency support plans in place
- Deaf Carers project. Royal Association of Deaf People have been commissioned to undertake a Carers Project with the Local Deaf Community

Outcomes

- Carers Action Plan developed to address this recommendation
- Carers Policy promoted via 'floor walk' exercises across Localities
- Information published on carers website
- Carers are able to activate contingency plans when crisis develops via the Kent Carers Emergency Card
- Voice of carers informs commissioning of carers services

Further work planned

- Review Carers Action Plan every six months
- Information will continue to be provided in Gateways and other key locations
- Information will be published on Twitter and Facebook sites
- Documents on carers website will be translated into BSL
- Proposal to introduce Carers Support Planning Policy and Carers Outcome Focused Review Policy
- Conduct the next series of carers survey (2010) to inform trends
- Publish Carers Annual Report
- Inform the work of West Kent NHS on their NHS Support for Carer Demonstrator pilot
- Link with the work on the Kent Dementia Demonstrator pilot
- Evaluation of carers assessment pilot sites – a report will be taken to KASS SMT in January 2010
- Carers User Experience Survey

CQC Inspection Action Plan: Recommendation 6

The council should implement a clear public information strategy that includes information distribution and improved signposting by staff to ensure that people are made aware of the range of preventative services available.

Activity to Date

Print

- Draft directorate communications strategy presented to SMT mid November will help achieve a more controlled and consistent approach to directorate communications
- Reviewing printed publications. Considering audiences and formats in which they prefer to receive their information – this enables us to be better equipped to take decisions regarding platforms, formats and volumes
- Not allowing any re-prints of existing materials without full justification

Information, Advice and Guidance

- Policy published in September 2009. Written with involvement of members of the public, service users, carers and representatives from voluntary organisations

Web

- Work on a new website for KCC is now at an advanced stage.
- Programme to review all KASS entries on website
- Kent Learning Disability Partnership Board has an independent website linking across 12 Districts and includes signposting

Other projects include:

- County Show – communications survey
- KASS Strategy feedback
- "Signpost Kent" – Consortium of Mental Health providers have developed an information resource
- East Kent and West Kent hard copy directories
- 'Around the World in Ashford' Event
- Gateways
- *Gateways Satisfaction:* National One Stop Shop Benchmarking Group Survey in April 2009.
  Maidstone – 99% satisfaction
  Tenterden – 97% satisfaction
- A consistent Customer Satisfaction Survey was conducted across the Gateway Network in October 2009. These results are currently being collated and will be available shortly

We continue to look at a range of methods to enable people to have information about available support and social services and safeguarding. These include the work of Care Navigators and Community Information and Liaison Assistants (CILA)

- **Care Navigators** provide a brokerage service that supports people to select the most appropriate service to meet their needs ensuring they can access information on different services available
- **Community Information and Liaison Assistants** (CILA) support the availability of information resources within the community as well as the facilitation of ad-hoc groups to support independence and wellbeing

Care Navigator - Changes in 09/10

- Now extended from 6 to 12 staff with all Care Navigators (CN) trained to support brokerage via National Development Team (NDT)
- Role extended to enable persons over 50 who are not eligible for KCC services to be assisted, using brokerage, to purchase services using funds other than a personal budgets (KCC assessed funding allocation). This for example could be the direct purchase of a service through their private funds
- Extension of the scope and life of the contract has enabled direct access to persons regardless of their status

Community Information and Liaison Assistants

- Extension of scope and life of the contract post POPPs funding (DH pilot) to March 2011
- Role has been extended to support electronic mapping to better support future commissioning decisions and provide direct access to existing services for community residents and service providers
- Electronic mapping will also support Total Place
- Continual development of communities via partnership working.

<u>Outcomes</u>

- Information, Advice and Guidance policy published
- Draft directorate communications strategy has been developed
- Printed publications have been reviewed
- New website developed to ensure easier access to information.
- Hard copy directories have been produced by East Kent and West Kent
- Kent Learning Disability Partnership Board independent website includes signposting
- County Show was used to conduct a communications survey and was also an opportunity to provide information to members of the public
- Through Community Information and Liaison Assistants (CILA), delivery of health promotion activities that has extended to support one to one cooking aimed at marginalised communities or targeted at specific clients such as widowers

<u>Further work planned</u>

- Public involvement sessions
- Out and About project
- KASS Strategy will be developed and published
- Move away from service orientated content and instead focus on collating relevant and related information based on audiences and life events

- Information will continue to be provided in Gateways and other key locations
- Carers information and forums on the internet – carers website, Twitter site and Facebook site will be kept up to date with latest events and communications for carers
- CILAs are doing 2 pieces of work that directly support the Information/Advice element of their service. These are:
  a) compilation and production of service directories (available electronically and in hard copy)
  b) mapping provision of services in localities to extend information in above.
- CILA's are meeting in January 2010 to ensure that they have universal information about services, as well as share any new information that they become aware of
- CN/CILA's integrated with SDS developments, including via Kent Contact Assessment Service (KCAS).

CQC Inspection Action Plan: Recommendation 7

The council should ensure that it monitors the outcomes for people signposted on to other services to inform commissioning plans.

Activity to Date

- For people signposted to other services, name/address/reason for contact and action taken are recorded on KCAS duty log
- KCAS have determined how outcomes can be monitored for people signposted to other services. A survey will be undertaken by KCAS in February with people signposted to other services to establish the outcomes of signposting. The outcomes of this will be fed directly into commissioning and business planning in the Localities
- KASS has a system in place for recording personal outcomes, through assessment and support planning processes. This information enables us to develop preventative services in the voluntary sector based on what we know is working well for service users
- Outcome focused review policy developed
- We are working with the voluntary sector and providers to have a better understanding of outcomes of their services, particularly those non care managed services
- We have worked with Age Concerns and LINKs to identify quality of care and outcomes as determined by service users through individual focus groups
- Swanley Development Programme has reported back findings of a programme of Person Centred Planning and signposting towards mainstream services for people with learning disabilities
- We have undertaken mystery shopping exercises and CILAs and Care Navigators follow up with written questionnaires. This will give us a clear understanding of people's experiences of these services to inform the development of current and future services
- Learning Disability service users are also engaging in mystery shopping of community facilities and services

- QAF been developed and is public facing on the Online Directory – first release tested with dates being established for further enhancement

Outcomes

- Quality of care and outcomes as determined by service users have fed into the new specification with voluntary organizations
- Working more closely with LINKS to identify quality of care and outcomes through a range of methods including the feedback LINKS receive and individual focus groups with service users
- KASS will be able to learn from the outcome focused review policy which elements could be used to measure outcomes for people who are signposted to other services. Links to work in progress to develop an outcomes based strategic commissioning model

Further work planned

- Outcomes based strategic commissioning model will continue to be developed, involving the public, especially the people who take up the support we offer
- Continue to encourage voluntary sector to work more closely with social care providers
- Continue to engage with LINKS in order to work together to gain feedback from people about their experiences
- Continue to engage in mystery shopping and follow up with written questionnaires

CQC Inspection Action Plan: Recommendation 8

The council should ensure that its diverse communities are effectively involved in commissioning processes so that services are sensitive to their needs.

Activity to Date

- BME Summit (WK). Joint working with NHS West Kent. Purpose of Summit is to engage the BME sector directly in order to identify the extent to which current services meet the needs of the BME population, provide information on safeguarding, to find out the effectiveness of this communication for them, provide information on available services and determine their needs and engage them in service design
- As part of developing a new public involvement strategy a range of meetings are being held with key ethnic minority groups and organisations across the County - part of this work is to involve them in commissioning processes
- Equalities and Diversity issues has been identified as key priority of SDS delivery in both East & West Kent
- The Performance group and SDS are developing an outcome based strategic commissioning model. The development of this model will include active involvement of citizens and those from diverse communities will be a key feature of this model
- Mapping is taking place to pull together information on population and BME communities

- Further work is in hand to map Social Enterprises in Kent and Medway and part of this to identify those who particularly support the BME sector
- Mental Health Community Development Workers engagement with BME communities
- Specific LDDF commissioned advocacy development post for BME communities for people with learning disabilities and their families
- Directorate Equalities Group taking a key role in supporting the delivery of this recommendation
- Deaf Carers project. Royal Association of Deaf People have been commissioned to undertake a Carers Project with the Local Deaf Community
- Redrafting of Culturally Competent Care to ensure that it is relevant to SDS and the current position of social care
- Good Care Guide being developed for LGBT
- Programme of customer impact assessments for all new policies, guidance and tools which support the implementation of SDS

<u>Outcomes</u>
- Mental Health Community Development Workers engage with BME communities
- Continue to work with BME groups to assist Ashford International Association and develop community lunches
- Continue to support Diversity House
- Specific LDDF commissioned advocacy development post - developing better links with Sikh and Bangladeshi communities, linking them with both statutory and voluntary sector organizations

<u>Further work planned</u>
- An outcome based strategic commissioning model will be developed, which will include the active involvement of the public, including those from diverse communities
- Public involvement sessions with diverse communities will continue to take place to discuss the Public Involvement Strategy and this will feed into commissioning processes
- Stakeholders will be actively engaged in reviewing and updating Kent Equalities Strategy
- Locality Managers will continue to engage with BME communities in their area in liaison with Health and District Councils
- Ensuring that people have access to culturally appropriate brokerage services
- Following the BME Summit, a report will be written pulling together the outcomes which will directly inform strategic and locality commissioning
- Specific LDDF commissioned advocacy development post - further work is planned, mainly within the North West of Kent, to see how links can be created between strong local groups and decision makers/influencing groups (KASS / District Partnership Groups / Partnership Board)

CQC Inspection Action Plan: Recommendation 9

The council should ensure its partner agencies have a clearer understanding of the new self-directed support approach and build their capacity to flexibly respond to people's individual needs.

Activity to Date

- Bulletins updating partners of developments with regards to Self Directed Support – also sent to District Councils and Health
- Appointment of area specific project managers to support work with partners
- Area Directors have written to all Chief Executives of the District Councils and NHS partners to advise of the change in working practice. Private and voluntary sector have also been written to
- Meet monthly with local partners, including representatives from the Kent Community Care Association, Kent Centre for Independent Living (a ULO) and other stakeholders
- Engaged with a number of domiciliary care organisations across Kent, who provide new enablement services. Provided free training for domiciliary care staff to deliver the new Enablement contract and continue to meet with and support them
- Active engagement with voluntary sector organisations to ensure they understand personalisation and the required changes to their businesses
- Presentations being delivered to District Councils and voluntary sector forums regarding personalisation
- East Kent brokerage pilots and bulletin for all staff – recent award ceremony for trained brokers. Brokers have attended EK management exchange to talk to staff
- Significant investment from LDDF in Community Capacity Building projects in Tunbridge Wells, Sevenoaks, Tonbridge and Malling, and Swale
- Investment of LDDF in the creation of Community Interest Company to engage with brokerage and support individuals to maintain personal budgets
- Development project in conjunction with DH and SHA to increase and co-ordinate the social enterprise sector in Health and Social Care. Life Challenge - project managed by Kent and Medway Social Enterprise Network
- A number of short films have been produced, focusing on the Kent Card, Direct Payments, Equipment and the Enablement Service – these are being used in the broader context of promoting Self Directed Support including meetings with partners
- A great deal of work is underway with Age Concerns as part of a directorate process led by Oliver Mills, Managing Director
- Meeting with voluntary sector on 14 December to discuss personalisation and this will lead into a review and renewal of service/grant agreements

Outcomes

- All brokers receive safeguarding training
- All brokers have been CRB checked

- Bulletins updating partners of developments with regards to Self Directed Support have been produced. These have also been sent to District Councils and Health
- Partners advised of the change in working practice
- Area specific project managers have increased capacity to deliver key messages around Self Directed Support
- Training delivered to domiciliary care staff to enable them to deliver new contract
- Community Capacity work well advanced now in Sevenoaks with good in-roads being made with many small community organisations as well as with larger, more public/community organisations – Sensio, BT, Libraries, District Council, VAWK etc
- Tunbridge Wells, Tonbridge and Swale - good local steering groups formed and beginning to show gains with smaller community organisations such as churches and local interest groups. District councils engaged throughout
- Ashford LD Community Interest Company has begun to work very clearly on brokerage and is currently supporting 20+ people with person centred planning towards the development of Support Plans. This is closely linked to both the Good Day Programme and to the Brokerage Pilots in East Kent. The Community Interest Company now has an established base with a library and information point, plus meeting rooms and facilities. The Community Interest Company is also providing low levels of paid work for 10+ people with learning disabilities
- Life Challenge Project was recently launched by partner agencies and celebrated the opening of an Enterprise Hub in Herne. The project has mapped Social Enterprise activity across the Health and Social Care sector in Kent and revealed a very active sector in Kent; 400+ social enterprises are currently operating in Kent

<u>Further work planned</u>

- Short film clips to be incorporated into a DVD for Kent TV and for use at partner/public facing events
- Bulletins will continue to be produced to keep partners informed of developments with regards to Self Directed Support
- Meetings with stakeholders will continue at a locality level and will develop into part of a market development system
- Self Directed Support Strategy for Mental Health services will be developed
- Work continues with both Health and Social Care Commissioners to look at the use of Social Enterprise to gain increased and demonstrated Social Return on Investment
- Development of a strategic commissioning model to include market development, community capacity, public involvement, quality management and service development led by needs and preference
- Work is planned to bring providers and service users together in meetings to seek to inform future service development and a consistent dialogue, capture of information and responsive market

- We are revising and implementing new provider forums with the help of Kent and Medway Care Alliance. These will be largely self-managing groups but we will support them
- Where these currently exist, Self Directed Support is consistently on the agenda and District forums have had specialist Self Directed Support presentations
- Contracting and Heads of Service ensure that provider visits include an update of Self Directed Support and there are many visits taking place as part of the inductions for Heads of Service new in post to their localities and, for instance, the new dementia strategy is being developed

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By: Graham Gibbens, Cabinet Member Adult Social Services
Oliver Mills, Managing Director Kent Adult Social Services

To: Adult Social Services Policy Overview & Scrutiny Committee - 30 March 2010

Subject: **KASS DEBT POSITION FEBRUARY 2010**

Classification: Unrestricted

Summary: A report on the current position relating to KASS debt

Introduction

1. (1) At the Adult Social Services Policy Overview & Scrutiny Committee on 13 January 2010, it was agreed that a further report be presented at this Committee on KASS Debt.

Summary Position

2. (1) The overall debt for KASS as at February is £21,031K, of which £5,977K is not yet due for payment, leaving the amount due for payment £15,054K.

(2) There are two types of invoicing arrangements used by KASS, both of which are through Oracle Accounts Receivables. This report will primarily deal with the client related debt, but will give a general overview of the other debt.

(3) The sundry debt due for payment is:

Health	£2,162K
Sundry	£ 359K
Total	£2,521K

(It should be noted that the £1,021K owed by health is secured by a legal agreement.)

(4) The client billing debt is currently £16,789K, of which £12,533K is due for payment.

(5) Attached at Appendix 1 is an analysis of how debt has changed over the main categories for each year since 2005/06.

Client Charging

3. (1) Clients are financially assessed to determine their contribution toward either their residential or domiciliary care costs.

(2) Residential Charging - this charging is distinct from non-residential (domiciliary) charging in that councils have a duty to charge for services under section 22 of the National Assistance Act 1948. Councils have no discretion in how they charge individuals, and all councils are required to do so.

(3) Non-Residential Charging – Section 17 of the Health and Social Security and Social Services Adjudication Act 1983 gives councils the power to charge a person for non-residential services no more than it appears reasonable for them to pay. This means that each council has discretion in how they charge individuals for certain services and how much an individual has to contribute to the costs. In Kent we only charge for domiciliary type care.

(4) In 2008-09 the total amount of income charged to clients was as follows:

Residential	£42,581K
Domiciliary	£ 9,449K
Total	£50,030K

Analysis of Client Related Debt

4. (1) The £16,789K client related debt, the debt can be broken down as follows:

Residential	£13,680K
Domiciliary	£ 2,253K
Health Contributions	£ 856K
Total	£16,789K

(2) Of the £16,789K only £12,533K is actually due for payment, invoices had only just been dispatched for the remaining £4,256K. Clients and health have 28 days to pay their invoices.

(3) The £12,533K can be broken down between secured and unsecured debt as follows:

• Unsecured – ongoing clients	£5,658K
• Unsecured – terminated/ deceased clients	£ 1,153K
Total Unsecured	£6,811K
• Secured with legal charges	£4,906K
• Health contributions	£ 816K
Overall Total of due debt	£12,533K

Aged Analysis of Unsecured Debt

5. (1)

	Under 6 months	Over 6 months	Over 1 year	Total
Unsecured – ongoing client debt	£3,503K	£918K	£1,237K	**£5,658K**
Unsecured deceased/terminated Client debt	£243K	£242K	£668K	**£1,153K**
Total unsecured client debt	**£3,746K**	**£1,160K**	**£1,905K**	**£6,811K**

Numbers of Unsecured Debts

6. (1)

	Numbers
Unsecured – ongoing clients with debts	4,218
Unsecured deceased/terminated clients with debts	518
Total Unsecured Debts	4,736

Secured Debt

7. (1) During 2009 we have carried out a full review of all of the debts that we have secured by legal charges on clients houses. This review has ensured that the estimated valuation of the properties are not less than the value of the deferred debts, and if so 100% provision has been allowed for.

Bad Debt Provision

8. (1) The total bad debt provision that exists for client related debt is £3,599K. This is calculated by looking at the value of all of the debts under various debt categories of those secured and unsecured. It also takes into account the age of the debt.

(2) Generally the percentages for the main categories used are as follows:

Unsecured - ongoing (under 6 months) - 5%
Unsecured - ongoing (over 6 months) - 60%
Unsecured - terminated (under 6 months) - 33%
Unsecured – terminated (over 6 months) - 75%

(3) The general provision is £1,953K. This covers all debts, secured, unsecured and health. This provision is re-calculated on a monthly basis, and any required changes are forecast within the revenue monitoring.

(4) In addition to the general provision that is calculated as described above we have allowed for an additional £1,646K of specific provisions. These relate to individual named clients for which we believe there is a high risk of the debt not being paid. This is reviewed during the course of the year to see if any payments have been made.

Write Off's

9. (1) In 2008-09 £362K of client related debt was written off. The trend has been similar to previous years. For 2009-10 to February £375K has been formally written off.

Reasons for Debt

10. (1) Many of the clients who we are charging do not actually manage their own financial affairs, especially those in residential and nursing care. It is likely that a family member is managing their affairs on their behalf. However the debt must remain the responsibility of the client, and we can take not specific debt recovery action against the family member, only the client. In many debt cases, the client is not even aware that their relative is not paying the monies due. This makes debt recovery against vulnerable people very difficult.

(2) When we are made aware that others may be misappropriating a client's finances, we can approach the Pension Service and ask that KCC becomes appointee for the client's benefit. This can be a complicated and lengthy process, and depends entirely on whether the client has mental capacity, and if so whether they agree to us becoming responsible for their finances. In cases such as this it is likely that any debt that has accrued before we take on appointeeship, will never be paid, and will probably end up being written off.

Debt Recovery Structure

11. (1) From October 2009 we have restructured and the debt recovery staff are now within KASS, they were previously within CED. As part of the restructure we have placed a debt recovery officer within each of the new localities within the KASS operational structure. They are however managed by the Area Finance Managers.

(2) In total we have 6 Debt Recovery Officers, and 2 Senior Debt Recovery Officers. The posts have now all been recruited to.

(3) The new posts will be situated alongside the Finance & Benefit Assessment Officers. We have changed the emphasis of their roles to ensure that they follow up all financial assessments they undertake to ensure that the debt does not accrue at the outset, as we believe that a high proportion of the debt we end up writing off is due to it growing at an early stage. It will only be after their input that the debt is passed to the Debt Recovery Officers.

(4) We believe that this approach will reduce new debt accruing, however as can be seen from the figures above, we have a significant amount of debt that is over a year old, which needs to be investigated. Although a significant amount of this is covered by the bad debt provision, we feel that some of these should continue to be pursued if necessary through Legal Services.

(5) We have agreed to continue to employ 2 additional temporary staff members till September 2010 to focus purely on reducing the level of aged debt, so that our newly appointed debt recovery staff are able to focus more on new debts and the prevention strategy.

Recommendation

12. (1) Members are asked to **NOTE** and **COMMENT** on the content of the report.

Michelle Goldsmith
Directorate Finance & e-Commerce Manager
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(VPN: 7000 1770)

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Total KASS Debt 2005-06 -2009-10 £000

	Secured - Client	Unsecured - Client	Unsecured - Sundry	Health - Secure	Health - Unsecure	Total
2005-06	2,901.0	7,599.3	1,405.5	2,683.2	5,798.3	20,387.3
2006-07	3,353.6	8,008.6	395.5	83.1	8,683.9	20,524.8
% Movement (05/06 to 06/07)	**+16%**	**+5%**	**-72%**	**-97%**	**+50%**	**+1%**
2007-08	3,598.3	7,861.9	450.0	2,770.5	3,846.8	18,527.6
% Movement (06/07 to 07/08)	**+7%**	**-2%**	**+14%**	**+3,234%**	**-56%**	**-10%**
2008-09	4,607.8	9,677.7	933.6	4,743.6	2,901.1	22,863.8
% Movement (07/08 to 08/09)	**+28%**	**+23%**	**+107%**	**+71%**	**-25%**	**+23%**
2009-10 (Feb)	5,088.4	10,844.6	547.2	1,798.6	2,752.1	21,031.0
% Movement (08/09 to current)	**+10%**	**+12%**	**-41%**	**-62%**	**-5%**	**-8%**
% Movement (05/06 to current)	**+75%**	**+43%**	**-61%**	**-33%**	**-53%**	**+3%**

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By:	Graham Gibbens, Cabinet Member, Adult Social Services Oliver Mills, Managing Director, Kent Adult Social Services
To:	Adult Social Services Policy Overview and Scrutiny Committee – 30 March 2010
Subject:	**LIVE IT WELL – MENTAL HEALTH STRATEGY FOR THE NEXT 5 YEARS**
Classification:	Unrestricted

Summary:	To inform Members of the 5 year strategy being developed by the lead Primary Care Trust (PCT) commissioning team for mental health; in collaboration with Kent Adult Social Services (KASS) and to invite comments.

Introduction

1. (1) This initiative sets out the strategy for delivering Kent's mental health services for the next 5 years. It is a more personalised approach which focuses on prevention, health and wellbeing and improving access and reducing discrimination and stigma.

(2) Preparatory work for this strategy has been taking place over the last 2 years.

- It is based on what service users and carers say they need. There was an extensive public consultation, as outlined below.
- It is based on what is known about local need, through a comprehensive Joint Strategic Needs Assessment.
- It is a statement of the vision for the next five years which was developed with service-users, carers, and health and social care professionals.
- It contains 10 key commitments to improve services and the actions that will be carried out to achieve them.

(3) Live it Well has the aim of creating a single identity for the transformation in mental health, both in PCT commissioned services and those commissioned by KASS. This complements both Active Lives in KASS and the wider Strategic Health Authority commitments in "Healthier People, Excellent Care". Its focus on outcomes also complements the developing approach from the Care Quality Commission (CQC) and is consistent with "New Horizons".

Policy Context

2. (1) The 10 year National Service Framework for mental health has just come to an end and will be replaced by "New Horizons" which is a less target-driven, more holistic vision for mental health. Statutory bodies are required to refresh their overall spending strategic commissioning programmes and this is an opportunity to ensure that a clear and forward looking mental health programme is included , which puts far greater emphasis on helping people to stay well, as well as making substantial improvements to the support and treatment they receive when they are ill.

Rationale

3. (1) The key messages from the extensive consultation exercise were that service users and carers want services to be locally delivered in community settings where possible; timely, without long waits; personalised, with alternatives to medication and the right to arrange care themselves; and in ways that are non stigmatising.

(2) The Joint Strategic Needs Assessment identified that in Kent, as elsewhere, there is a strong correlation between deprivation and poor mental health and that more emphasis needed to be placed on building social capital and promoting healthy lifestyles in planning for mental health services.

(3) As a result of these clear messages, 10 commitments to transform services have been created. These aim to develop a mental health system that:

- Promotes positive mental health and well-being,
- Intervenes early,
- Provides personal care, and
- Focuses on helping people to recover.

(4) This strategy is closely linked to the performance management framework that has been developed by NHS Medway (the lead PCT) in conjunction with the Kent & Medway NHS and Social Care Partnership Trust (KMPT). Performance indicators are related to key aspects of the strategy, which has also been reflected in the outcome measures incorporated in the KASS service agreements with independent providers.

Other Considerations

4. (1) The broad financial position for public services is well known and the strategy will have to be met within existing budgets. It will facilitate greater coherence between the resources from KASS the expenditure of PCTs. In line with “Total Place”, KASS are working with the PCTs to identify opportunities for sharing accessible premises.

(2) This strategy will improve equality of access to services. There has been substantial involvement with service users, carers and the public and professional, throughout 2008 and 2009 to produce the current strategy.

(3) KASS and the PCTs have developed services targeted to BME communities and other hard to reach groups such as deaf mental health service users; and their experiences have also contributed to the proposals for improving access to services in this strategy.

Implementation Proposals

5. (1) There has been close liaison between KASS and the PCT lead commissioning team for mental health team in developing this strategy. Implementation is likely to see more collaboration and joint commissioning.

(2) KMPT, the major provider of mental health services in Kent, are also developing new ways of working based on the values in “New Horizons”. KASS and the PCT lead commissioning team have worked closely with key staff from KMPT, through the joint commissioning arrangements for mental health, to ensure that the KMPT redesign of services fits well with the strategy.

(3) Following extensive public consultation the strategy is now in a late draft version. The next few weeks will provide the final opportunity to comment and to seek amendments, where these are needed. Organisations will then endorse the final strategy which is expected to be published by July 2010.

(4) The Strategic Management Team for KASS has already made a number of points to include in the final version. This will be in the areas of housing support and accommodation: employment initiatives; strong and direct links with Children & Adult Mental Health Services (CAMHS) commissioners to ensure better transitional arrangements; and more emphasis on the use of innovative technology as outlined in "New Horizons".

Recommendations

6. (1) Members are asked to NOTE the attached draft strategy and to CONSIDER any further comments to be made before publication.

Lead Officers:

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Live It Well

(Draft)

A strategy for improving the mental health and wellbeing of people in Kent and Medway

DRAFT

Vision statement

"With our partners we will co-create a mental health system that makes mental health everybody's business. The system will address the varied needs of the people living in Kent and Medway. It will deliver a range of activities to promote positive mental health and wellbeing in the community, it will lessen the prevalence of common mental health problems, and it will lessen stigma and discrimination. We will ensure that prevention is targeted at those at higher risk. Service responses will intervene early when people develop problems, and will enhance the inclusion, physical health and optimal functioning of people who have severe mental health problems. Service providers will deliver a personalised service for all service users. Wherever possible, services will be community-based. They will work in equal partnership with service users and their families, and will facilitate recovery and reintegration through the provision not only of best practice care but of accessible, supportive and empowering relationships."

Contents

DRAFT

Foreword

Who might we get to write this?
e.g. a combined statement from the two DPHs? A local 'celebrity'? A comment from Re-Think?

Executive Summary

1. Overview

Now is a very opportune time to develop a vision and a strategy for improving the mental health and wellbeing of people living in Kent and Medway.

Firstly, because of recent consultation and listening exercises locally and with the development of our joint strategic needs assessment (JSNA) (1.), we have never been better informed about the mental health needs of the population of Kent and Medway. Secondly, the 10 year *National Service Framework for Mental Health* (2.) and its implementation have come to an end. The NSF very largely set the direction for commissioning mental health services locally but now we need to move forward and consider what further improvements we need and how best to commission for them, and to use world-class commissioning approaches to achieve that.

With good timing the Department of Health has recently launched its consultation document *New Horizons: A shared vision for mental health* (3.), with a clear vision over the next ten years. It states with much ambition that by 2020 we will raise the importance of mental wellbeing to the same priority as physical health, we will deliver more prevention, we will improve the quality and outcomes of care, we will deliver more personalised services, we will address inequality in access and experience of care, we will reduce stigma, and we will improve the physical health of those with significant mental health problems.

New Horizons captures some clear shifts in thinking that we have to make locally - both about the importance of mental health and wellbeing for a population and about how mental health is delivered in any population. In our vision and strategy we have to consider many challenges - how we shift much more towards public health approaches to promote, achieve and sustain people's mental health, how we support individuals to make lifestyle choices that will improve their mental wellbeing as well as their physical health, how we engage the widest coalition of resources to

improve mental health and wellbeing, and how we deliver services in the most innovative ways.

Lastly we must note some contextual issues. Even without a recession the Government has set some markers for improvement across Government services – higher quality, more innovation, greater productivity, more prevention (often referred to as the QIPP agenda). The global financial crisis will mean that the funding environment in Kent and Medway for health and social care will be much more challenging over the next five years than it has been over the last five. Recovery from recession is predicted to be hesitant, and high unemployment will impact on the mental health of Kent and Medway residents.

(see Appendix 1 for financial summary)

So, just delivering more of the same types of services cannot and will not be our agenda. Our vision, from now until 2015, is shaped by what we have heard from those who use services and by our clear understanding of need, but also by recognition of some fundamental shifts needed, and by focused thinking on a few absolute priorities. We will deliver improved service quality by continued development of Commissioning for Quality Incentives (CQUINs), and encouraging quality in primary care via the Quality and Outcomes Framework (QOF scheme). We will also deliver improved quality and efficiency by a specific focus on the 10 High Impact Changes for Mental Health (4.)

(see Appendix 2 for the key performance indicators, or KPIs, that will be used to monitor the implementation of this strategy)

(see Appendix 3 for full list of 10 High Impact Changes for Mental Health.)

It is important to note that there are separate strategies for dementia care and services, for child and adolescent mental health services, and for drug and alcohol services, and therefore these are not covered here.

2. What service users and carers say services should be like

Local

- they should fit in with where we live
- in the community as far as possible, rather than health locations
- in places where everyone else also uses resources to get on with life

Personalised

- a single point of contact for service users
- alternatives to medication, increased access to talking treatments
- better signposting to resources and services so we can arrange support for ourselves with a personal budget

Timely

- services should be when we want them (which is usually early on)
- better out of hours support with 24 hour support for people in crisis
- a proper procedure when police detain people with mental health problems

Non stigmatising

- service users should be empowered, not disempowered, by mental health services
- challenge stigma, not identifying service users as separate from the rest of society
- personalised relationships with people we know

*sources include
Canterbury and District Mental Health Forum August 2009
West Kent PCT Listening Exercise 2008
Four specific workshops to develop the vision held across Kent and Medway in June 2009

3. What we know about local needs

The **prevalence** and **impact** of mental health problems on society is poorly appreciated:

- The proportion of the population surveyed in England meeting the criteria for one common mental disorder (such as anxiety or depression) rose from 15.5% in 1993 to 17.6% in 2007 (5.). A quarter (24%) of people with a common mental disorder were receiving treatment for an emotional or mental health problem, mostly in the form of medication (5.)

- Nearly one third of those going to GPs have a mental health problem (6.)

- The wider cost of mental health problems to the country (estimated at £77billion in 2005/06) exceeds Treasury spending on the NHS as a whole at £76 billion (6.)

- Mental health problems are estimated to be the commonest cause of premature death and years of life lost with a disability – 23 per cent of the burden of disease in high income countries and 40 per cent of years lived with a disability (quoting World Health Organisation reports) (6.). The average life expectancy of people with schizophrenia is 10 to 12 years less than those without, due to increased physical health problems and a higher suicide rate.

- One third of people think that people with mental health problems should not have the same rights to a job as everyone else (5.).

The **Mental Health Joint Strategic Needs Assessment** for Kent and Medway (1.) estimates that there are:

- 163,00 to 190,000 people with common mental health problem(s) at any one time, of whom 25% need treatment
- More than 60,000 people are estimated to have severe mental illness, and around 12,000 people are estimated to have severe and enduring mental illness

Mid 2008 estimates put the **population** of Kent and Medway combined at 1.66 million. The population of Kent is expected to increase by 10% (138,000) between 2006 and 2021, and in Medway by just over 2% (5,800 people). Across Kent and

Medway the population over 65 is expected to increase by about 15% between 2008 to 2013, and by about 40% over the period 2008 to 2023. This growth will be more marked in Eastern and Coastal Kent. There will be a consequent increase of and strain upon informal carers.

Significant **determinants** of mental ill health are:

- Deprivation is strongly correlated with mental ill health – and is concentrated in the coastal towns. This would encompass poverty, low income, debt, unemployment, poor housing, and poor physical health. It has recently been suggested that debt is a stronger risk factor for mental ill health than low income (7.)

- Social capital – the strength that individuals draw from their interactions with others - is weaker in some parts of Kent than others. This is more the case where deprivation is greatest, and for specific groups such as carers and older adults

- Healthy lifestyles – exercise and healthy eating can reduce risks of depression. Alcohol dependence in particular is more common among people with mental health problems than the rest of the population.

4. Our Commitments

Our vision for improving the mental health and wellbeing of people in Kent and Medway is crafted from the analysis we have made from all the sources described above. Given this analysis our efforts will be targeted in 10 discrete areas – which we have set down below as our commitments.

By 2015 we will have:

i. Built coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing

ii. Lessened the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services

iii. Reduced the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic communities, and those who are seldom heard

iv. Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions

v. Reduced the number of suicides

vi. Ensured that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs - and that service contact points are more local

vii. Ensured that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is

viii. Delivered better recovery outcomes for more people using services, and in the most appropriate setting for them

ix. Ensured that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service

x. Delivered effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems

In pursuing these commitments we will be guided by four key principles – to deliver improved health outcomes, to improve all aspects of quality, to seek innovative improvements to service and system performance, and to deliver value for money.

5. Our Commitments:

- **why have we chosen these**
- **where we are now with each commitment**
- **the actions we are going to take to meet each commitment**

In this section we will explain why we have chosen these commitments, give an outline of where we are now (the JSNA may have more detail), and list the actions we will take to meet each commitment in a prioritised order.

i. We will build coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing.

The NHS has a core responsibility for providing a comprehensive service, based on need, for anyone presenting with a mental health problem. However, if we are to lessen the occurrence of mental health problems among the people of Kent and Medway, we will have to engage all relevant agencies in that endeavour. The significant determinants of poor mental health have much in common with those of poor physical health – deprivation, unemployment, debt, stress, poor physical health, poor housing, lack of social networks, and so on. The work to raise awareness of these issues, to recognise people at risk, to signpost people to support or services, to offer 'first aid' support, to enable people to develop more resilience, to reduce stigma, to make mental health everybody's business, cannot be just 'government' work. In particular, it cannot be the work of government agencies working in silos.

We believe it can only be planned and initiated if we collaborate across all stakeholder agencies and develop innovative and enterprising ways to alleviate some of these problems.

Currently we have a Strategic Commissioning Board for Mental Health, covering all of Kent and Medway, and three Joint Commissioning Boards (JCBs) for Mental Health, one each for Eastern and Coastal Kent, for Medway and for West Kent. There is Primary Care Trust and Local Authority Social Services representation on all of these, and there are mechanisms in place to ensure JCBs have service user and carer views. Our strategy addresses how we will widen engagement.

In the autumn of 2009 the terms of reference for the three JCBs were significantly revised, and they adopted a much strengthened stance on commissioning.

Comments from the four stakeholder workshops held in June 2009 included:

- wellbeing also had a community dimension – strong, safe and sustainable communities promoted mental wellbeing, while a sense of community was felt to be good for an individual's wellbeing.

- the voluntary sector has a large role to play, particularly in working with people from BME communities;

- schools need education around mental health. Mental health promotion and prevention work is important to raise public awareness of the need to look after our mental health and wellbeing, and to be aware of the early signs that something is wrong;

- link in with some of the Regeneration projects that are taking place in certain areas of Kent? SEEDA would be the agency here. Projects mostly happen at district level, e.g. around old coal fields, and various housing initiatives, "Community Cohesion" sites.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will consistently ensure over the next five years that the importance of improving mental health and wellbeing and that the importance of all agencies collaborating on this goal together are widely accepted – by using such channels as influencing Local Strategic Partnerships and their Health and Wellbeing subgroups, by influencing Crime and Disorder Reduction Partnerships, and by strengthening Local Planning and Management Groups (LPMGs). We will ensure the widest circulation of the Joint Strategic Needs Assessment in support of this commitment. We will encourage all three PCTs to achieve collaboration on this goal by fully exercising their World Class Commissioning leadership competence on the mental health and wellbeing agenda.

- We will engage all mental health service providers with the broader vision for mental health and wellbeing development and encourage them to develop initiatives to raise awareness and to collaborate together in such initiatives.

- We will instigate the development of a Kent and Medway-wide mental health

promotion network. Among other objectives the network will develop training strategies aimed at both non-health professionals – i.e. those that could recognise people at risk in the workplace – and for health professionals; both strategies will be aimed at raising awareness, identifying risk, offering initial support, and signposting people to more comprehensive support.

And, *over the next five years:*

- We will ensure that key agencies are as aware of the economic and social return benefits of a mental health and wellbeing strategy and initiatives as they are of the benefits to individuals.

- We will continue to develop the commissioning strengths and influence of the Strategic Commissioning Board for Mental Health across Kent and Medway, and of the three constituent Joint Commissioning Boards.

- We will continue to encourage user and carer engagement and develop more effective user and carer engagement processes.

- We will improve advice and signposting about mental health and wellbeing support at council gateway sites.

- We will be open to all proposals from any source, including potential providers as well as existing providers, which will enhance our success on delivering this agenda.

- We will support and encourage new partnerships at the local level within towns, villages, streets and any other relevant locality where such collaboration will increase our ability to deliver this mental health and wellbeing agenda.

*HIC refers to High Impact Changes for Mental Health (4.) – see Appendix 3.

ii. We will lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services

Stigma is an unnecessary burden carried by mental health service users, and it also deters people from seeking help in the first place. Almost nine out of ten people with mental health problems (87%) reported the negative impact of stigma and discrimination on their lives in the Stigma Shout survey (5.). The fear of stigma and discrimination may deter relatives or friends seeking help for others too. Further, 69% of service users said they had been treated differently (in a negative way) because of their mental health problem, and 71% said stigma and discrimination had stopped them doing the things they want to do.

In the Stigma Shout survey employers were the second highest-scoring group from which those with mental health problems personally experienced most stigma and discrimination (35%), with only their immediate family higher (36%). The ability to work, and to derive both income and self-esteem from that, is of profound importance in many people's lives.

Offenders, too, do not want to be labelled with a mental health diagnosis because of the stigma and discrimination this brings with it.

Time to Change has identified that movies are the main source of information that reinforces negative stereotypes of mental illness above and beyond any other form of media.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.) – to campaign to overcome discrimination against people with mental health problems. A further pledge made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' is to work with employers to maintain employment for those with mental health problems.

Comments from the four stakeholder workshops held in June included:

- early recognition of symptoms was important so that people could take time off rather than struggle to manage and become more ill – the stigma surrounding mental illness needed to be addressed and removed;

- help with mental health issues should be provided in 'ordinary settings' without being labelled 'mental health' and where a range of appropriate help and support is provided for several different issues so the setting is anonymous;

- Resource centre in community for social activity and activities of normal living, creative workshops, cooking, walking, health centre, swimming;

- the Third Sector will be essential to provide a real mixed economy of help and support with a wide variety of possible access routes in discrete locations not labelled 'MENTAL HEALTH'.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will encourage employers to pay at least as much attention to mental health discrimination as any other form. We will persuade more employers to sign up to the 'Mindful Employer' initiative, and persuade more to commit to the national 'Time to Change' initiative. . We will achieve this through the commissioning of employment services.

  'Lack of mental well being in the workplace is costing the UK £25.9billion per annum in terms of sickness absence, presenteeism and turnover, and an additional nearly £5b in terms of incapacity benefits. It is not only economically costly but also costly to the health and wellbeing of individuals and their families. Initiatives like MINDFUL EMPLOYER energize employers to do something about the wellbeing of their employees and is of vital importance to the health of the nation.'
  Cary L Cooper CBE, Distinguished Professor of Organizational Psychology and Health, Lancaster University

  (www.mindfulemployer.net)

- We will encourage NHS employer organisations to become exemplar

employers in managing staff wellbeing, as recommended in the NHS Health and Wellbeing Independent Report by Professor Boorman (9.).

- We will commission for community mental health services to be available in more community settings and support providers to achieve this, and to change signs and signposting to be less labelling of service users.

And, *over the next five years:*

- We will sustain a positive communication plan about mental health and raise awareness of the harm caused by stigmatising and unhelpful labelling of those people with mental health issues. We will speak out about negative or inaccurate media portrayal of mental health issues and the use of perjorative terms to describe those with mental ill health.

- We will ensure more employers are aware of the NICE guidance 'Promoting mental wellbeing through productive and healthy working conditions: guidance for employers' (10.) launched in November 2009 which advises employers:

    - to adopt a business-wide and integrated approach to improving mental health management. This should take into account the nature of the work, the workforce and the culture of the organisation

    - to implement robust systems for assessing and monitoring mental wellbeing in order to flag areas for improvement and address any risks.

    - to offer flexible working arrangements

    - to strengthen the role of line managers in promoting mental health in the workplace.

- We will explore how PCTs together with occupational health (OH) professionals and others involved in mental health initiatives can collaborate with small and medium size enterprises (SMEs) to offer advice, support and better access to OH services.

- We will encourage the development of more holistic 'wellbeing' strategies, with a sensible mind-body balance, and holistic occupational health responses

- We will ensure this commitment remains a high priority among the community development work we undertake.

iii. We will reduce the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic

communities, and those who are seldom heard

The Joint Strategic Needs Assessment makes the case for specific targeting of support towards more deprived communities, BME communities, carers, and older people. Other groups more prone to common mental health problems are those with long-term physical conditions, the homeless, those with physical or sensory impairments, and offenders.

Black and minority ethnic groups (BME) are overrepresented in mental health services. People from BME groups are also more likely to be detained under the Mental Health Act. 23% of mental health inpatients in 2008 were from a BME group (4.).

Summary of range of current targeted initiatives in place:

Arts on prescription
Books on prescription
Healthy walks
Community choirs, etc.

This table to be revised

This commitment supports one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.) to ensure that access to psychological therapies in primary and secondary care is in line with best practice.

Comments from the four stakeholder workshops held in June included:

- the fundamental issues surrounding wellbeing are the same for all human beings regardless of race or culture;
- current service provision was piecemeal and there was no holistic assessment – wellbeing is multi-faceted and would require the whole person to be considered and not just their mental health;
- providing more support to GPs and Primary Care in general so that the surgeries are more able to deal with mental health as well as the physical healthcare of their patients (eg - access to CPNs);
- some targeting of resources would be useful to address some of the inequalities within Kent – it was cited that the life expectancy in Dartford is 14 years lower than in the more affluent parts of Kent and Medway.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will strengthen our commissioning and support of schemes and initiatives that are targeted towards 'at risk' people or communities, which build their protective factors against mental health problems and provide more social capital. We will link this strongly to needs identified in the Joint Strategic Needs Assessment, such as those of the growing elderly population and of carers. We will identify a variety of avenues to achieve more support, such as using Healthy Living Centres and other 'contact points' such as Gateways and drop-ins, working with voluntary organisations and volunteers to develop buddying schemes, working with social enterprise groups, and with faith communities. We will make judgements on what we support based on social return on investment principles (11.). We will work alongside enhanced primary care schemes in deprived areas, such as the Triple Aim scheme in Thanet.

- We will invest in and deliver psychological wellbeing programmes to help people to build emotional resilience. The programmes will be targeted towards people at higher risk, especially those whose needs have increased following the impact of the economic downturn. We will monitor the outcomes of these interventions and develop tools to measure whether we are improving the psychological wellbeing of target groups.

- Primary Care Psychological Therapy services continue to be rolled out across Kent and Medway, delivered by three different service providers. Psychological therapy provides treatment to people with 'common' mental health problems (anxiety and depression). We will ensure there is wider uptake of these therapies and that people know that they can self-refer for an assessment. We will also ensure that those whose first language is not English can access and benefit from these services. We will evaluate the outcomes of these services regularly and ensure they optimally deliver positive benefits to users. We will also ensure that service providers have networks in place to provide service users with other avenues of support.

- We will take advantage of technology, particularly the developing range of on-line support initiatives, to help people access a wide range of support for mental health and wellbeing. We will continue to invest in the development of the local Live Life Well initiative – an information and resource site (www.liveitwell.co.uk). We will direct people to other resources that provide mental health support such as Signpost Kent (www.signpostuk.org) and the "The Big White Wall" (www.bigwhitewall.com). This is a social networking site that offers support networks for people in emotional distress where they can remain anonymous. The Big White Wall is run in partnership between the Tavistock and the Portman NHS Foundation Trust, and was winner of the 2009 MediaGuardian Award for Innovation in Community Engagement.

- We will ensure there is widespread knowledge of the Mental Health Matters telephone helpline (0800 107 0160), and the NHS credit crunch stress telephone line (0300 123 2000).

- We will actively market these support initiatives with a sustained communications campaign across Kent and Medway.

And, *over the next five years:*

- We will widely circulate and encourage use of the wellbeing equivalent of 'five fruit and vegetables a day' – as developed by the Foresight Mental Capital and Wellbeing Project (7.). These are a list of suggestions for individual action, based on an extensive review of the evidence:

1. **Connect…** With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. **Be active…** Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. **Take notice…** Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. **Keep learning…** Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. :earning new things will make you more confident as well as being fun.
5. **Give…** Do something nice for a friend, or a stranger.

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Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

- We will explore the merits or translating these 'five a day' principles into other languages for different ethnic groups.

- We will encourage and support present and past service users to tell their stories and give support to others who may benefit.

iv. We will demonstrably improve the life expectancy and the physical health of those with severe mental illness, and demonstrably improve the recognition of mental health needs in the treatment of all those with physical conditions.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.), and is fully supported by this strategy because of the wealth of evidence that shows that those people with severe mental health problems have, on average, a significantly shorter life expectancy.

Comments from the four stakeholder workshops held in June included:

- Physical, mental and emotional wellbeing are linked together. To some this means a holistic approach. Some would add 'spritual' to the list;

- Current service provision was piecemeal and there was no holistic assessment – wellbeing is multi-faceted and would require the whole person to be considered and not just their mental health;

- Provide accessible, acceptable and appropriate services in neutral settings without labelling;

- Focus more mental health and welfare help and support in Primary Care.

What we will do or initiate *as a priority* in 2010-11 is…..

To improve the life expectancy and physical health of those with severe mental illness we will:

- As part of our communications campaign we will ensure there is wider awareness of the physical health risks for those with severe mental health problems, that mental health service users are not discriminated against in seeking general health care, and that support mechanisms are more widely

known.

- Ensure our mental health service providers assess the physical health needs of service users, with particular focus on high-risk groups such as those on Care Programme Approach (CPA), dual diagnosis clients, offenders with mental health problems and on all admitted patients (including forensic services), and liaise with the GPs of service users where risks or needs are identified.

- Work with primary care commissioning at each PCT to:

    - ensure the numbers of patients on practice mental health registers (with schizophrenia, bipolar disease and other psychoses) and on depression registers represent local prevalence as fully as possible
    - analyse practice variation on management of these (i.e. for mental health the annual review rates achieved, and follow-up achieved) and to address variation in the degree of exception reporting
    - identify the range of specialist support needed to make improvements in primary mental health care and address inequality

To improve the recognition of mental health needs in the treatment of all those presenting with physical health conditions or problems we will:

- Work with primary care commissioning in PCTs to ensure the continued improvement of recognition of mental health problems among all those with long term conditions – focusing more widely than just on the quality indicator for case-finding for depression among patients on a practice diabetes register and /or the CHD register.

- Improve the specification, delivery and monitoring of outcomes of liaison psychiatry services in both A&E departments and in acute hospital in-patient settings at all District General Hospitals in Kent and Medway.

And*, over the next five years:*

- We will ensure that the specialist community services for patients with long-term conditions (e.g. diabetes, stroke, heart failure, COPD, community matrons or integrated teams) are competent at identifying common mental health problems among patients on their caseloads, use appropriate assessment tools, and can make referrals via appropriate referral pathways.

- We will support the health and social care implementation of 'Your Health, Your Way' and information prescriptions in long-term condition care (which focus on improving self- care and self-management) and ensure people with long-term mental health problems are included in these initiatives.

- We will ensure that cancer services also are competent at identifying common mental health problems among patients they manage, use appropriate assessment tools, and can make referrals for mental health support via appropriate referral pathways.

v. We will reduce the number of suicides

Suicide is a major public health issue. On average, there are approximately 140 deaths from suicide annually in Kent and Medway. Deaths from suicides are in a younger age group than most diseases and therefore account for a much larger number of years of life lost than would be expected for similar numbers of deaths in other disease areas. The National Suicide Prevention Strategy states that many suicides are preventable which gives an added impetus for action.

Reducing the death rate from suicide is a government priority. The National Suicide Prevention Strategy which was published in 2002 reinforced the White Paper Saving Lives, Our Healthier Nation 1999 (OHN), target of a reduction in the death rate from suicide by at least 20% by 2010. It set out the national strategic priorities and actions for how this was to be achieved. In 2007 and 2008 national progress reports were produced giving updates and reinforcing the national commitment. Standard 7 of the National Service Framework for Mental Health 1999 also reinforced the importance of suicide prevention and gave a framework for action

Comments from the four stakeholder workshops held in June included:

- higher than national average level of suicide attempts in some parts of Kent and Medway;
- having a responsive attitude to people seeking help in a crisis – it was noted that the Police are the first port of call for someone contemplating suicide – the NHS needs to be responsive and positive and not to appear determined not to get involved.

What we will do or initiate *as a priority* in 2010-11 is…..

Local research indicates that only 35% of people who commit suicide had been in contact with mental health services. (Lawrence and Bean 2008) This is similar to the national findings. This means that the majority of suicides are not known to mental health services at the time of their death. As a result no one agency can be responsible for suicide prevention. Indeed, in order to be effective a strategy must involve a wide range of agencies who may have an impact on the behaviour of both high risk groups and the wider population.

Consequently in November 2009 a Kent and Medway wide multi-agency suicide prevention steering group was formed with the remit of ensuring that a Kent and Medway suicide prevention strategy was developed and implemented. This includes representation from PCTs, the acute trusts, KMPT, Kent Police and the voluntary sector.

Looking at the national priorities and the epidemiology of suicide in Kent and Medway local priorities will be likely to be:

- To reduce risk of suicide in known key high risk groups including
    - those in contact with mental health services,

    - those who have self harmed,
    - prisoners and young-middle-aged men particularly men in routine and manual occupations.
- To promote wellbeing in the wider population particularly focusing on additional groups who are of concern including those who misuse substances.
- To reduce the availability and lethality of suicide methods. The suicide methods which are most used in Kent and Medway are hanging and self poisoning followed by jumping from a high place and railway suicides. Reducing these will be a priority for action
- To improve reporting of suicidal behaviour in the media. There is good evidence that irresponsible reporting in the media can lead to copycat suicides. A national resource for journalists has been produced to help improve reporting and this needs to be disseminated to all Kent and Medway media.
- To monitor suicide statistics and progress towards national targets and ensure appropriate audit.

Key actions to facilitate these priorities

Overall as part of the action plan in all risk groups appropriate actions need to be outlined for all agencies who are in contact with them. People who contemplate suicide, or take their own life if they are not in contact with mental health services, will fall into one of three groups, each requiring a different service response.

- Those in contact with primary care
- Those in contact with other services
- Those not in contact with any services

Other services will include ambulance services, accident and emergency departments, the police, drug and alcohol services, housing and voluntary sector agencies.

Appropriate service interventions are likely to include appropriate identification, management and referral for depression in primary care, awareness training, appropriate training in referral, signposting and management of suicide risk for other agencies.

For those who are not in contact with any services suicide prevention interventions would include mental health promotion activities, improving self referral opportunities for counselling and support.

In addition, in collaboration with Kent Police and other agencies, suicide hotspots will be identified and appropriate management action taken. This could include the display of signage and contact numbers for the Samaritans or the construction of physical barriers if appropriate.

And, *over the next five years:*

Continue as above.

vi. We will ensure that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs - and that service contact points are more local

The delays experienced by people with critical or urgent mental health needs add unacceptable additional stress and anxiety to them and their carers. The 'If only we could get more immediate help' comment is commonly fed back from service users.

Delayed specialist support has other risks, for example that people present at Accident and Emergency departments where staff less experienced with mental health emergencies may not be able to offer the most appropriate support or interventions, or that people begin to despair or lose awareness and suicide risk increases.

Further, a clear critical and urgent care pathway would help general practice to appropriately refer people to the right service.

This commitment matches one of the pledges made by the South East Coast SHA pledges in 'Healthy People, Excellent Care' (8.).

Comments from the four stakeholder workshops held in June included:

- providing quality services and ensuring continuity of care – working at the pace of the client and always being ready to offer support when the client felt they needed it without having to be re-assessed and having to start from scratch each time they suffered a relapse (timely access to services);

- single access points for health are needed and they should have more flexible hours, perhaps 8-8 and open at weekends;

- reaching out to the population like "street doctors", moving away from the institution.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will commission a single urgent care pathway currently covered by the functions of the intake and crisis response and home treatment services. We will ensure the pathway improves the working arrangements between key agencies involved in crisis and urgent response – primary care, OOH services, emergency services (particularly police and ambulance services), A&E departments, and Crisis Response and Home Treatment teams. We will specifically improve the emergency arrangements for patients who fall under Section 136 of the Mental Health Act. (HICs 2,4,5,9)

- For patients <u>known</u> to the local mental health services, or their carers, and trying to contact in crisis or for an urgent need we will ensure they have a known point of contact (a named care worker) in the service. We will ensure that they or their GP can access this urgently.

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- We will ensure that urgent care face-to-face responses are local and that support includes home based care (HIC 1).

And, *over the next five years:*

- We will ensure that response times to crises are consistent across Kent and Medway and meet a minimum acceptable standard (HIC 4).

- We will ensure that crisis responses are protocol-driven to minimise risk in patient management. These protocols will include how to manage risks for patients who frequently contact or attend emergency services and who need frequent emotional support.

- For patients not known to local mental health services we will ensure there is access to an out-of-hours telephone helpline service and, depending on the risk assessed, that the service can offer the most appropriate support or referral either immediately or on the next working day.

- We will ensure that primary care out of hours (OOH) services have the competence and capacity to manage or refer mental health crises to appropriate support.

vii. We will ensure that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is

'*Social work is committed to enabling every child and adult to fulfil their potential, achieve and maintain independence and self-direction, make choices, take control of their own lives and support arrangements, and exercise their civil and human rights. Its approaches and working methods aim to promote empowerment and creativity.*' (12.).

This position is enshrined in *Putting People First* which "promotes choice and control for all, pushes councils to do more preventive work, explicitly values the 'social capital' that individuals and communities bring with them to the table and is serious - perhaps for the first time - about the need for 'universal services' to be made available to all. At the heart of the Putting People First policy - indeed at the heart of what has come to be known as 'personalisation agenda' - is the individual citizen, each with their own idiosyncrasies, gifts, weaknesses, hopes, worries, dreams and nightmares" (13.).

Our joint commissioning stance is fully in support of implementing more self-directed support and the personalisation agenda.

Comments from the four stakeholder workshops held in June included:

- It was felt that the level of engagement depended on the menu of services available. Personalisation relied on having an assessment of what was required and then making sure that the appropriate response to help and

assist the service user was available. Not a menu but a response to what would really make a difference to the individual;

- "Personal narratives" were felt to be key to helping the personalisation agenda happen, i.e. they need to see examples of success to really believe it can happen;

- "Diversity" is key to personalisation. Personalisation needs to be "outcomes focused", i.e. what is it we want to achieve from this in terms of people's lives. What are the outcomes people want? People have diverse needs. The method of how you achieve the outcomes therefore is less important;

- The individual should be at the centre of care, but it must not be assumed that they know best or that they know how things work. The response therefore needs to be tailored to the individual and to empower them to manage their own care.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will procure more independent brokerage services, develop more widespread use of the 'Kent Card' to enable service users to chose a wider range of services, and ensure brokerage is better regulated.

- We will monitor frequently the reported patient experience of those using contracted mental health services, identifying issues such as the degree to which the service user felt they were consulted or given choice on their treatment and their care plan, and on perceptions of carer attitude.

- We will ensure that all people with severe mental health problems are given the opportunity to use advance directives, statements, agreements and crisis cards to express their wishes about their care when they are well.

And, *over the next five years:*

- We will ensure that providers use a validated assessment tool that enables service users to take a lead in their assessments and the directing of their care.

- We will ensure that every service user has an estimated social care budget, and we will pilot personal mental health care budgets in all localities.

- We will ensure that, wherever possible, service users in in-patient settings have access to the same services and opportunities that people can access in the community, e.g. wifi access, access to exercise.

- We will ensure that waiting lists for access to personalised services are minimal.

- We will enable service users to express a choice over the location of the community mental health services they use across Kent and Medway.

viii. We will deliver better recovery outcomes for more people using services, and in the most appropriate setting for them

People with severe mental health problems have the same wants and needs as anyone else. The trajectory of mental illness is not one of persistent deterioration and people need to be supported to lead meaningful lives and exercise choices. Outcomes for people with severe mental health problems improve when care and treatment supports people's fundamental human needs – for autonomy and self-determination, for confidence, and for relatedness – which are at the heart of a recovery approach.

Comments from the four stakeholder workshops held in June included:

- Therapeutic optimism may be a better term. Service users may be concerned about giving up their access to support, possibly because they have had a hard road to get access in the first place and do not want to go through that again;

- Recovery is multi-faceted and needs to be determined by the individual – staff should be optimistic about what their service users can achieve and encourage them;

- When undertaking an assessment the individual should have one which focuses on the positives rather than accentuating the negatives, and makes full use of Primary Care, Improving Access to Psychological Therapies (IAPT) and other community services;

- Services should focus on providing a series of steps back to recovery following an episode of illness. Emphasis on the positives and helping people regain control of their lives.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will ensure that providers deliver effective and personalised care planning for recovery – and that best theoretical practice becomes mainstream practice. We will ensure that services are organised around the recovery-oriented principles expressed in the Recovery-Oriented Practices Index (ROPI) (14.) and that service users are supported to recovery with goal-setting, tools to measure change, building on their strengths, engagement of their support network in recovery planning, and building social networks and support to remain in employment or with job-seeking.

- Within psychological therapy services we are embedding evidence-based measurement of 'moving to recovery' with use of pre- and post-intervention scales and scoring tools. We will develop the use of these across a wider range of services, using both HoNOS and patient-recorded outcome measures

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(PROMs) (HIC 7). The Recovery Star would be one very useful PROM.

- We will ensure that GPs are better supported to take back the management of appropriate patients from secondary care services.

And, *over the next five years:*

- We will ensure that service users receive the support and care planning they need particularly prior to and over discharge from hospital care and, equally at that time, that support networks are increased (HIC 3).

- We will ensure, as much as is possible for individual service users, that home based care is the norm as part of supporting recovery (HIC 1).

- We will monitor frequently the reported service user experience and provider response in this area (HIC 6).

- We will compare prescribing differences across major therapeutic drug groups to explore reasons for prescribing anomalies and ensure people are receiving the most beneficial medication that they need.

ix. We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service

Our Joint Strategic Needs Assessment identified lack of information about dual diagnosis prevalence as a problem for us. Many people who present to drug and alcohol services have varying degrees of mental health problems, and many of those who present with mental health problems also have some drug and / or alcohol problems. Some of these people also present with problems that are challenging for primary care management. Historic problems exist with 'silo' management of services for one or the other need, but with little integrated care delivery between services.

During 2009-10 we have been assessing the scale of need with our main providers.

Our commissioning approach will address those with less severe mental health problems plus substance misuse as well as only those with severe mental illness.

Comments from the four stakeholder workshops held in June included:

- Overall between 30% to 50% of people with severe mental health problems may have current drug or alcohol issues. Between 20% and 45% of inpatients in acute psychiatric wards have problematic drug or alcohol use. In high secure psychiatric units between 60% and 80% of patients have a history of substance misuse prior to admission. It is possible that as many as two-thirds of those who come into contact with drug or alcohol treatment services may also have some kind of mental health problem;

- A radical change in staff attitudes to enable people to achieve their ambition and to make a contribution to society;

- Employing staff experienced in helping people gain confidence in work and employment through training and education, volunteering, supported work and actual employment.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will ensure that drug and alcohol needs assessments capture dual diagnosis needs and that data is robust enough to inform future service planning. We will ensure that the full picture is informed by data held by a range of different agencies – such as police, probation, health providers, and social care.

- We will ensure that care for those with dual diagnosis is mainstreamed within mental health service providers, and that they receive integrated support.

- We will negotiate protocols with service providers that specify the circumstances in which mental health services provide support to drug and alcohol services for complex patients, and vice versa.

And, *over the next five years:*

- We will include dual diagnosis needs as an integrated part of the annual commissioning treatment plan.

- We will secure full integration between Drug Intervention Programmes and the Police Custody Suite Diversion Schemes to achieve better outcomes for those identified with dual diagnosis in the criminal justice system.

- With mental health service providers we will:

    - Reflect in contracts that joint working around dual diagnosis is part of their core business

    - Ensure staff in both mental health services and in drug and alcohol services are adequately trained to identify dual diagnosis patients using a structured assessment, and can implement and coordinate care planning to the level of national occupational standards

    - Expect prevention and reduction of substance misuse among those with severe and enduring mental illness and those on in-patient wards, and elsewhere in the local mental health services

    - Develop and monitor patient outcomes

    - Ensure that dual diagnosis patients can access talking therapy services

    - Ensure that those with drug and/or alcohol problems and complex mental health problems receive an assertive service if needed.

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x. We will deliver effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems

There are 9 adult prisons across Kent and Medway holding more than 5,000 prisoners at any one time. Rochester has the only Young Offenders Institution in the county. Health among prisoners is not as good as the general population. In 2009 the Prison Reform Trust identified that 72% of male and 70% of female prisoners suffer from two or more mental disorders (1.). Substance misuse problems are also very high amongst offenders. Further, around 60% of released prisoners are not registered with a GP. Re-offending within 3 years of release is as high as 80%.

In 2007 a mental health needs assessment across the Kent and Medway Prison estate found significantly higher prevalence of mental illness amongst the prison population than in community populations. Notably, young offenders at HMYOI Rochester had a very high prevalence of Obsessive Compulsive Disorder. There were five self-inflicted deaths of prisoners with mental health problems across Kent and Medway prisons during 2007 – 2008.

Current prison mental health services in Kent and Medway are not as effective and as high quality as they could be, and are a high priority for improvement and lessening risk. In response to this the MH Commissioning Directorate successfully re-tendered (during autumn 2009) the existing Kent and Medway Adult Prison Mental Health Service to procure a better-specified, safe, high quality and value-for-money service. Further investment is being sought to provide 'end to end', comprehensive mental health services for the prison population. In the interim some additional resources have been received from the National Offender Management Service for HMYOI Rochester to provide bespoke mental health services across the spectrum of need (i.e. primary and secondary care, and a daytime resource centre providing mental health and learning disability services).

We are also implementing recommendations required by the Bradley Review (15.). This clearly sets out the policy mandate for the diversion of offenders with mental health problems and or learning disabilities, where appropriate, away from custody. We are piloting a Police Custody Suite Diversion Scheme across the 6 suites in Eastern and Coastal Kent PCT and the one suite in Medway PCT. The pilot is for eight months and its primary aim is to provide Kent Police and Magistrates with information from the mental health and / or learning disability assessment of people detained in custody. The scheme will provide opportunities for the diversion of offenders with mental health problems and / or learning disability away from custody where appropriate. An evaluation report will be available in May 2010 and a Business Case for recurrent funding will be made should the pilot prove to be effective. This scheme already exists in West Kent PCT.

Comments from the four stakeholder workshops held in June included:

- 50% of offenders seen now have a significant alcohol problem and 20% have a serious drug problem. High levels of obsessive-compulsive disorder and personality disorder at 80%;

- Support would need to be multi agency, the practical side of things like housing, income support, employment, training, education, literacy training, health education etc;

- CPA needs to permeate the prison walls in both directions;

- Help with re-entry to society needed, "Sunlight type centres" coffee shop model mentioned.

What we will do or initiate *as a priority* in 2010-11 is…..

- We will continue to develop safe, 'end to end', equitable mental health services for those in the criminal justice system (HIC4).

- We will establish Police Custody Suite Diversion Schemes across Kent and Medway so that the service is universally accessible (HIC5).

- We will improve access to community forensic mental health services (HIC1).

- We will adopt a blueprint Service Level Agreement and Service Specification for the provision of Psychiatric Court Reports to both Magistrates and Crown Courts (a further Bradley Review recommendation). This will prevent the remanding into custody of offenders in the interim of receipt of a psychiatric report (HIC5).

And, *over the next five years:*

- Following an analysis of the impact assessment of the Police Custody Suite Scheme across Kent and Medway we will review the need for a Court Diversion Mental Health Service. The results of this gap analysis will shape Kent and Medway's future requirement for a Court Diversion Scheme (HIC5).

- We will incentivise innovation among providers by targeting CQUIN incentives towards them. All contracts will have an annual quality improvement plan led by providers in partnership with users of services.

- We will ensure that assertive outreach is made available to those who are or have been in the criminal justice system and would benefit from it.

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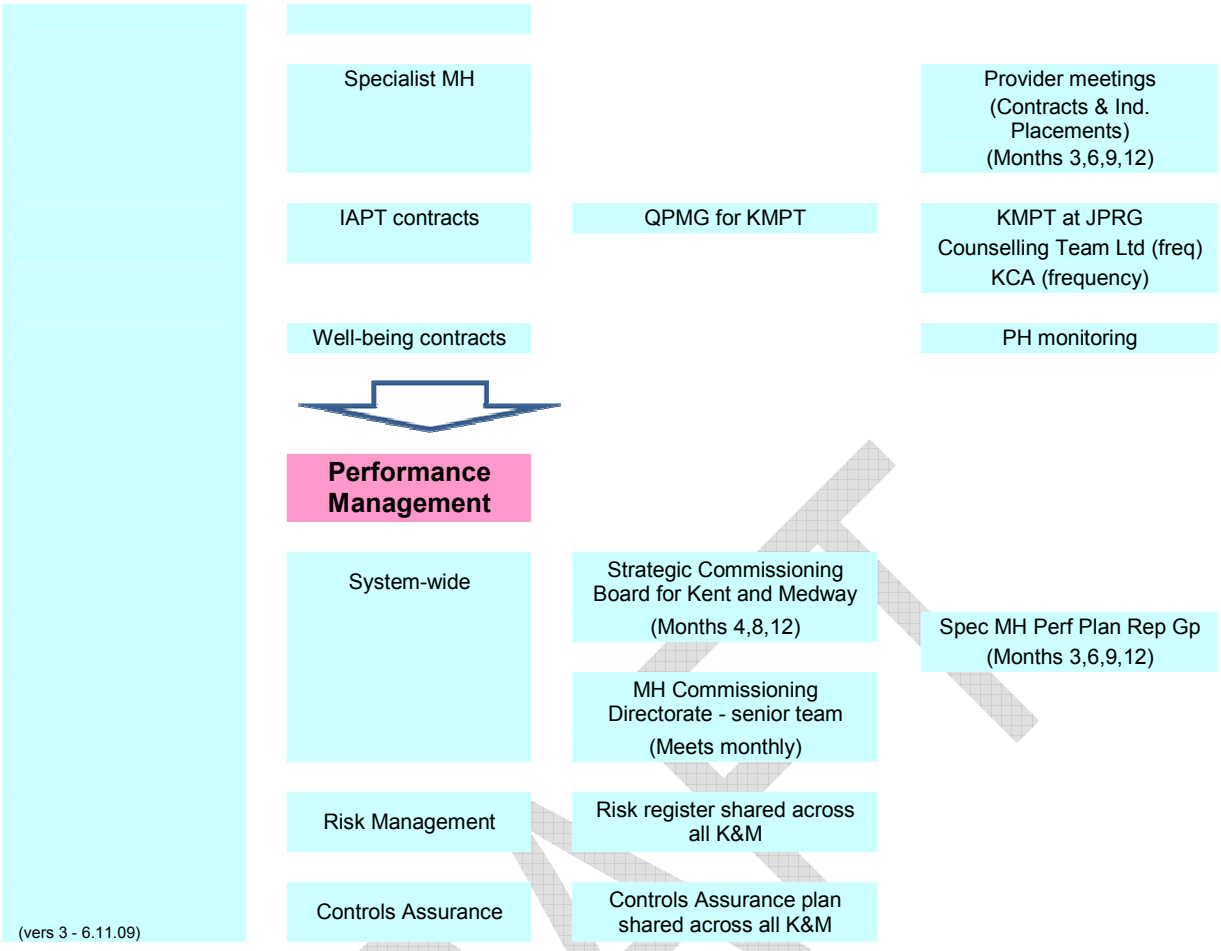
6. How will we monitor our progress?

Throughout this strategy we have made clear our vision, the 10 commitments we will deliver on over the five year period, the actions we will pursue to deliver those commitments and have identified the priority actions that we will implement or initiate within the first year.

We already have in place sound governance and performance management arrangements within Mental Health Commissioning, and strengthened these during 2009-10. These are best seen with reference to a 'system management map' we developed in 2009 to illustrate them (shown below). This shows all the main groups involved for strategy development and commissioning, and for contract review, and the frequency with which they meet during an annual cycle.

Mental Health - System Management

Vision	Strategy Management	K&M wide	Constituency (ECK, Medway, WK)
	Accountable Group	Strategic Commissioning Board for Kent and Medway (Months 4, 8, 12)	Joint Commissioning Boards (for each Constituency) (Months 2,4,6,8,10,12)
		Commissioning Collaborative (Months 2,4,6,8,10,12)	Spec MH Perf Plan Rep Gp (Months 3,6,9,12)
	Statements of Intent	Commissioning Intentions (1 year) - (shared across all K&M)	Additional local Commissioning Intentions (1 year)
	Planning vehicle	MH Commissioning Directorate Business Plan (1 year)	Delivery Plan includes MH Commissioning Directorate objectives and patch objectives
	Delivery Management		
	Contract Monitoring		
Strategy for Mental Health and Wellbeing (5 year)	KMPT	Quarterly Performance Review Group (Months 3,6,9,12)	Joint Performance Review Group (Months 1,2,4,5,7,8,10,11)
		Quality Assurance Group (Months 2,4,6,8,10,12)	
		Patient Safety Group (Months 3,6,9,12)	
	Offender MH	K&M Offender MH Steering Gp (Months 3,6,9,12)	KMPT Forensic Perf Mgt (Months 3,6,9,12)



In addition, for all our contracts we have an arrangement of Key Performance Indicators and Quality Indicators that we measure progress on throughout the year. Those contracts also specify a range of mechanisms and frequencies to secure feedback from users and carers on their experience of aspects of services. Also in our contracts with KMPT and the larger forensic contracts we have introduced the the use of CQUINs in 2009-10, and will further develop these over the next five years.

For the explicit purposes of monitoring the delivery of the strategy we will begin in a number of ways; we will incorporate all the actions against the commitments into our directorate annual business plan and ensure these are reflected in the objectives and action plans of all locality and specialist commissioners, and we will monitor progress against a set of key performance indicators (KPIs) outlined in Appendix 2. We are building a baseline position against all these currently.

We have routinely identified the risks to service delivery and quality as part of governance processes, and developed controls assurance processes, all shared with the three PCTs, and this will continue.

In addition to the regular monitoring shown in the table above we will formally report progress to the three PCT Boards and to the two Local Authorities formally on an annual basis.

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AN ONLINE NETWORK - for mental health and social care in the United Kingdom - providing Reports and Blog Directories for: INDIVIDUALS - CARERS - M/H STAFF - ALLIED WORKERS - ORGANISATIONS

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Appendix 1

1.1. Investments in Public Health

	Eastern and Coastal Kent	Medway	West Kent
Current investments in Public Health (2009-10)			

1.2. Investments in contracted services

2009-10	Eastern and Coastal Kent	Medway	West Kent
KMPT – Contract excluding CQUINs			
KMPT- CQUINs			
SW London and St Georges MH Trust			
South London & Maudsley FT			
NHS Non Contract Activity (other NHS)			
IAPT – Trainee Funding (from SHA)			
IAPT – Locally provided			
Mental Health Placements			

2010-11	Eastern and Coastal Kent	Medway	West Kent
KMPT – Contract excluding CQUINs			
KMPT- CQUINs			
SW London and St Georges MH Trust			

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South London & Maudsley FT			
NHS Non Contract Activity (other NHS)			
IAPT – Trainee Funding (from SHA)			
IAPT – Locally provided			
Mental Health Placements			

1.3. Primary Care expenditure – Quality and Outcome Framework (QOF)

	Eastern and Coastal Kent	**Medway**	**West Kent**
Primary care expenditure – QOF (Mental Health Indicators) (2008-09)			
Primary care expenditure – QOF (Depression indicators) (2008-09)			

1.4. Primary Care expenditure - Prescribing

Primary care expenditure – prescribing (2008-09)			
Antipsychotic group			
Cost/1000 registered patients			
Antimanic group			
Cost/1000 registered patients			
Antidepressants – costs per 1000 Star PU			

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1.5. Current / planned business cases

Business cases awaiting decision or in development

Eastern and Coastal Kent	Medway	West Kent	Offender / Specialist

Business cases planned

Eastern and Coastal Kent	Medway	West Kent	Offender / Specialist

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1.6. CQUINs

Commissioning for Quality and Innovation (CQUINs) is a new national scheme that allows for commissioners to make available a financial incentive as part of the contract for quality improvements and innovative service change. CQUINs were used with all major contracts in 2009-10 and will continue to be used. The CQUINs value was 0.5% of the contract in 2009-10 and is rising to 1.5% in 2010-11.

1.7. Payment by Results / Tariff development

Appendix 2 – Key Performance Indicators by commitment

By 2015 we will have:

		Baseline	Target
i.	Built coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing		
	• Put in place at least three strategic schemes or campaigns over the life of the strategy that require significant collaboration across all stakeholders		
ii.	Lessened the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services		
	• Increase the numbers of employers signed up to the Mindful Employer initiative in Kent and Medway by (xx%), or from XX to YY • Increase the number of organisations pledged to Time to Change		
iii.	Reduced the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk – those in more deprived communities, those in black and minority ethnic communities, and those who		

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	are seldom heard	
	• Psychological therapies – increase the number of referrals / self-referrals to psychological therapies • Psychological Therapies – the number of people who completed treatment who moved to recovery • Psychological Therapies – people with a black or minority ethnic code are accessing IAPT services at same rate as those coded 1 British	
iv.	Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions.	
	• Increase the number of high risk people who have assessments of their physical health, such as those on Care Programme Approach (CPA), dual diagnosis clients, offenders with mental health problems and on all admitted clients (including forensic services) • Increase the number of general practices who have undertaken a review of >90% of registered patients with schizophrenia, bipolar affective disorder and other psychoses in the preceding 15 months. (QOF – Indicator MH9)	

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	• Reduce the degree of exception-reporting on indicator MH9 among practices with above-average levels, and lower the PCT average level of exception-reporting • Increase the number of people supported by liaison psychiatry services in both A&E departments and in acute hospital in-patient settings at all District General Hospitals in Kent and Medway • Increase the number of people with a long term condition receiving some form of psychological support, such as psychological therapy	
v.	Reduced the number of suicides	
vi.	Ensured that all people with a significant mental health concern, or their carers, can access a crisis response service at any time and an urgent response within 24 hrs – and that service contact points are more local	
	• Reduce the number of presentations of clients in crisis to A&E services • Reduce the number of major breakdowns of clients in recovery	

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vii.	Ensured that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is	
	• Increase number of people using mental health services who have a personal budget	
viii.	Delivered better recovery outcomes for more people using services, and in the most appropriate setting for them	
	• Move a proportion of interventions (appointments) currently taking place in secondary care settings to primary care settings • Reduced the number of readmissions of people who have been discharged in the previous 3 years • Increase the % of those with serious mental health problems maintained in employment • Increase the % of those with serious mental health problems assisted back into employment	
ix.	Ensured that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service	
	• Increase the number of people cared for by	

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	mental health or drug and alcohol services who are identified as having dual diagnosis • Increase the number of people cared for by mental health or drug and alcohol services who are identified as having dual diagnosis and are having shared or integrated care under a protocol • Eradicate instances of where dual diagnosis clients report or feel they are being bounced between services • Reduce the number of attendances at A&E for alcohol or substance misuse-related accidents • Increase the number of secure tenancies for dual diagnosis patients receiving enhanced care	
x.	Delivered effective mental health services in prisons in ways that ensure the safety of more offenders with mental health problems	
	• Increase the number of mentally ill people diverted away from custody, where appropriate, following implementation of Police Custody Suite Diversion Schemes across Kent and Medway • Reduce the number of people in prison requiring secondary mental health services and transfer to hospital under the Mental Health Act 2007	

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reduces

- Reduction in re-offending rate of people with mental illness
- Reduction in self-inflicted deaths of people in prison

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Appendix 3 - 10 High Impact Changes to Mental Health Services (4.)

1. Treat home based care and support as the norm for delivery of mental health services.
2. Improve flow of service users and carers across health and social care by improving access to screening and assessment.
3. Manage variation in service user discharge processes.
4. Manage variation in access to all mental health services.
5. Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
6. Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
7. Apply a systematic approach to enable the recovery of people with long-term conditions.
8. Improve service user flow by removing queues.
9. Optimise service user and carer flow through an integrated care pathway approach.
10. Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce

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By:	Graham Gibbens, Cabinet Member Adult Social Services Oliver Mills, Managing Director Kent Adult Social Services
To:	Adult Social Services Policy Overview & Scrutiny Committee – 30 March 2010
Subject:	**ADULT SOCIAL SERVICES BUDGET OUT-TURN REPORT 2009/10 FOR THE THIRD QUARTER**
Classification:	Unrestricted

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

Introduction

1. (1) This is the fourth report for 2009-10 to this Committee on the forecast outturn against budget for the Adult Social Services Directorate.

Background

2. (1) Policy Overview and Scrutiny 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 POSC 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 POSCs 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.

(3) A special Budget IMG was arranged for November to discuss the future Budget and MTP proposals in more detail.

Full Monitoring report for the Third Quarter

3. (1) The full monitoring report for the third quarter for Adult Services as presented to Cabinet on 29 March is attached at Appendix 1 and this indicates an overall revenue pressure of £0.580m. Appropriate 'Guidelines for Good Management Practice' have been implemented to ensure that the Directorate achieves a balanced position by the end of the year.

(2) The main areas to note within the latest position are:

- Most of the savings identified within the Medium Term Plan will be achieved, and the Directorate remains confident that other savings, through the application of "Guidelines for Good Management Practice", will be found to ensure that a balanced budget is achieved by the end of the year. However some risks remain as the current forecast assumes reductions in the number of residential and nursing placements in line with expected trends, although recently attrition rates have been lower than expected and if this continues it will impact on the forecast. In addition to this, although the numbers of frail people over 65 being admitted into residential care are generally not increasing, those being admitted with dementia are increasing, and these placements are at higher cost. In the past couple of months there seems to be an increasing trend of clients presenting themselves for residential or nursing care who are former self funders. This appears to be the case with both Older People and Mental Health, we are unsure at this stage whether this will be an ongoing trend. Other authorities are continuing to approach KASS regarding Learning Disability cases, which they deem that the cost should fall upon Kent due to the client now being ordinary residence. Although the risk has been covered in this forecast, there is potential that further cases will be presented in the remaining weeks of the year. Although KASS is still committed to achieve a balanced position, it is felt that the risks outlined above need to be flagged, as they could have a detrimental effect on the financial position of the portfolio.

- Older People is forecasting a net underspend of £2.040m. Within this is a net underspend of £1.036m against residential care which assumes a reduction in the number of clients based on trends. The number of clients in permanent residential care stood at 2,774 in December, down from the 2,796 as at the end of September; June was 2,733 and March 2,832. There are also price pressures resulting from the increasing numbers of people with dementia. Nursing care is forecasting a net pressure of £0.500m as the number of clients with dementia is expected to increase even though the number of Older People who are frail is expected to remain fairly stable. The number of clients in permanent nursing care increased to 1,386 in December from 1,353 in September; in

June it was 1,340, and 1,332 in March. Domiciliary care remains the most volatile and difficult line to forecast with great accuracy. This line is reporting a net underspend of £0.932m as the overall number of clients remains below the affordable level. As at December there were 6,385 people in receipt of domiciliary care from the independent sector, down from 6,465 in September; in June the figure was 6,422 and March 6,490. A net underspend of £0.529m is being reported against Other Services following the release of £0.200m of Contingency held by the Managing Director to offset the overall pressure, as well as lower than anticipated demand for fast-track occupational therapy equipment and enablement.

- Services for People with a Learning Difficulty is showing an overall pressure of £3.051m as both demographic and price placement pressures continue. These primarily relate to young adults with very complex needs transferring from Children's Services, clients with ageing parents cared for at home but requiring more support, and the numbers of people placed by other authorities but being classed as 'ordinarily resident' (deemed as living in the community rather than in a residential placement) and therefore our responsibility. Kent Adult Social Services has accepted responsibility for five cases, the costs of which come to £0.382m, and we are contesting a number of other applications. The number of residential placements decreased from 642 in September to 636 in December; in June the figure was 632 and March was 640. Activity remains well above the affordable level and this line is showing a net pressure of £2.011m. There are also demographic and price pressures within Domiciliary Care, Direct Payments and Supported Accommodation although there is an underspend against Other Services following the release of £0.600m of Contingency held by the Managing Director to offset the overall pressure within the Directorate.

- Services for People with a Physical Disability have similar pressures to Services for People with a Learning Difficulty and as a result the overall position is a pressure of £0.702m. The number of residential placements has reduced from 229 in September to 222 in December; in June the figure was 213, and in March 222. The number remains well above the affordable level with the result that this line is showing a net pressure of £0.629m. Pressures within Domiciliary Care and Direct Payments are offset by a small underspend in Supported Accommodation and the release of the £0.200m Contingency held by the Managing Director. There is also an underspend in daycare as a number of clients are receiving their care via a direct payment, as well as small underspends against payments to voluntary organisations and occupational therapy.

- There is a net underspend of £0.577m against All Adults Assessment and Related staffing which relates vacancy management and additional contributions from health.

- The position for Mental Health is a net pressure of £0.307m. Within this is a gross pressure of £0.631m against residential care as the number of clients is expected to remain above the level afforded in the budget. It should be noted that the budgets were realigned in 2008-09 to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. This has resulted in an underspend of £0.329m against direct payments. The forecast for residential care also assumes an under-recovery in income of £0.338m as there is an increasing proportion of clients who fall under Section 117 meaning that they do not contribute to the cost of their care. There are also small underspends against Assessment and Related and Other Services.

- There is a small pressure of £0.107m against gross expenditure within the Gypsy and Traveller Unit arising from an unsuccessful bid to redevelop a site. As a result all capital costs incurred so far on the project must be written back to revenue.

- There is a net underspend of £0.835m against Strategic Business Support. Savings have arisen through vacancy management, funding some posts through grants and reductions in non-pay lines including printing and stationery. There has also been an over-recovery in income including contributions from Universities in respect of the Practice Placement Scheme, additional charges to Medway Council for Enhanced Pensions, and to District Councils involved in the new Excellent Homes for All PFI scheme, as well as contributions from partners towards the Safeguarding Adults Board Manager.

(3) The Capital position reflects a variance of -£0.769m with all of it requested to be re-phased into 2010/11. Of this £0.273m relates to Modernisation of Assets, £0.138m relates to Public Access and £0.112m relates to Mental Health related projects. The remaining variance of -£0.246m mainly relates to either tendering delays or delays caused by bad weather against the following three projects: Broadmeadow extension £0.074m; Princess Christian Farm £0.064m, Queen Elizabeth Foundation £0.036m and Thameside-Eastern Quarry £0.014m. The remaining £0.058m is made up of re-phasing against other minor projects.

(4) The outstanding debt that was due for payment as at January was £15.05m of which £12.53m related to client debt with £2.52m of sundry debt. This compared with total due debt as at October of £15.02m of which £12.10m was client debt and £2.92m of sundry debt.

Recommendations

4. (1) Members are asked to NOTE the projected outturn figures for the Directorate as at the March Cabinet report.

Michelle Goldsmith
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KENT ADULT SOCIAL SERVICES DIRECTORATE SUMMARY JANUARY 2009-10 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" ie 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.
- The inclusion of new 100% grants (ie grants which fully fund the additional costs) awarded since the last full monitoring report. These are detailed in appendix 2 to the executive summary.

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

Table 1

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Adult Services portfolio							
Older People:							
- Residential Care	89,552	-32,641	56,911	234	-1,270	-1,036	Price pressures due to complexity; agency staff cover for in-house service; additional client income
- Nursing Care	43,647	-19,507	24,140	2,150	-1,650	500	Demographic and placement pressures offset with additional client and health income
- Domiciliary Care	47,006	-10,317	36,689	-751	-181	-932	Activity below affordable level but price pressures due to complexity
- Direct Payments	4,638	-436	4,202	33	-76	-43	
- Other Services	21,650	-4,661	16,989	-582	53	-529	Release of Contingency to offset overall pressure; lower demand for Fast-track equipment and other small underspends
Total Older People	206,493	-67,562	138,931	1,084	-3,124	-2,040	
People with a Learning Difficulty:							
- Residential Care	64,909	-12,119	52,790	2,497	-486	2,011	Demographic and placement pressures
- Domiciliary Care	6,704	-650	6,054	421	16	437	Demographic and placement pressures; more clients accessing Independent Living Scheme
- Direct Payments	5,465	-84	5,381	1,148	-34	1,114	increased unit cost
- Supported Accommodation	9,582	-1,151	8,431	555	-169	386	Demographic and placement pressures; impact of Ordinary Residence; contribution to reserve

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
People with a Physical Disability:							
- Residential Care	12,254	-1,987	10,267	526	103	629	Demographic and placement pressures
- Domiciliary Care	7,317	-439	6,878	558	-1	557	Demographic and placement pressures
- Direct Payments	6,697	-250	6,447	97	-8	89	
- Supported Accommodation	394	-8	386	-35	-2	-37	
- Other Services	6,530	-1,237	5,293	-549	13	-536	Release of Managing Director's Contingency to offset overall pressure ; underspend against daycare
Total People with a PD	33,192	-3,921	29,271	597	105	702	
All Adults Assessment & Related	37,188	-1,836	35,352	-222	-355	-577	Turnover and vacancy management; additional Health contributions
Mental Health Service:							
- Residential Care	6,456	-974	5,482	631	338	969	Forecast activity in excess of affordable level; increased proportion of S117 clients who do not contribute to costs
- Domiciliary Care	627		627	89	0	89	
- Direct Payments	602		602	-329	0	-329	Less than expected activity
- Supported Accommodation	435	0	435	93	-87	6	
- Assessment & Related	9,982	-876	9,106	-98	-78	-176	
- Other Services	6,736	-904	5,832	-154	-98	-252	Small underspends against a number of budget lines
Total Mental Health Service	24,838	-2,754	22,084	232	75	307	
Gypsy & Traveller Unit	660	-319	341	107	-22	85	Write back of capital costs following failed bid
People with no recourse to Public Funds	100		100	0	0	0	
Strategic Management	1,339		1,339	-92	-14	-106	
Strategic Business Support	24,824	-2,209	22,615	-630	-205	-835	Turnover, vacancy management & some grant funded posts; additional contributions including Universities, District Councils & Medway Council
Support Services purchased from CED	7,301		7,301	-7	0	-7	reduced charge for KPSN
Specific Grants		-7,618	-7,618	0	0	0	
Total Adult Services controllable	**442,759**	**-102,147**	**340,612**	**4,755**	**-4,175**	**580**	
Assumed Management Action				**-580**		**-580**	
Forecast after Mgmt Action				**4,175**	**-4,175**	**0**	

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 **Older People:**

The overall net position is an underspend of £2,040k. Although the number of clients in domiciliary and independent sector residential care remain below 2008/09 levels, there has been an increase in demand for services for people with dementia. It should also be noted that the forecast assumes reductions in residential and nursing placements based on prior year trends. However, recently, attrition rates have been lower than expected. If attrition remains below the expected level then this would increase the forecast level of expenditure.

a. Residential Care

This line is reporting a gross overspend of £234k and an over recovery of income of £1,270k. As at December there were 2,774 clients, compared with 2,796 in September and 2,733 in June, and throughout the year the level has remained below the 2,832 reported in March. The forecast position is 157,368 weeks of care against an affordable level of 157,572, which is a difference of 204 weeks. Using the forecast unit cost of £385.76, this reduced level of activity generates an underspend of £79k. In addition the forecast unit cost is £2.24 higher than the affordable which results in a pressure of £354k and reflects the increasing number of clients with dementia as placements are more expensive. Although the slight reduction in activity also means a reduced level of income of £32k, the actual income per week is £157.19 against an expected level of £150.13. This gives an over-recovery in income of £1,113k.

The forecast number of client weeks of service provided to Preserved Rights clients is 1,345 lower than the affordable level because of increased attrition which is over and above that assumed in the budget. This reduced activity gives an underspend of £523k with a further reduction of £151k because the unit cost is below the affordable level. The reduction in activity also results in an under-recovery in income of £191k, however the actual income per week is higher than the expected level which generates an over-recovery in income of £157k.

In-house residential provision is showing a pressure of £676k on gross primarily on staffing because of the continuing need to cover sickness and absence with agency staff in order to meet care standards, as well as meeting increased occupancy levels. The pressure on gross is offset by an additional £293k of client income due to increased occupancy levels.

b. Nursing Care

There is a pressure of £2,150k on gross expenditure and an over recovery of income of £1,650k. Client numbers have increased to 1,386 in December from the 1,353 reported in September; in June it was 1,340 and March 1,332. The forecast is assuming 2,929 weeks more than budget at a cost of £1,375k. The unit cost is currently forecast to be slightly more than budget, £469.67 instead of £468.95, which increases the pressure by £53k. The additional activity has resulted in increased income of £452k. Also the actual income per week is £154.45 against an expected level of £148.81. This gives an over-recovery in income of £423k. There are also unbudgeted contributions from Health of £354k primarily relating to nursing assessment beds, the costs for which are included in the activity above.

Preserved Rights attrition is currently below that assumed within the budget which adds £201k.

There is currently an overspend of £413k against Registered Nursing Care Contributions with an identical over-recovery of income and is based on the latest estimates of client activity.

c. Domiciliary Care

This service remains the most volatile and difficult to forecast and currently this line is forecasting an underspend against gross of £751k. The continuing trend in the number of clients remains uncertain and the number receiving a domiciliary care package from the independent sector remains below last year's level. As a result the budget still allows for significantly more hours than is being delivered and the current forecast under-delivery is over 45,918 hours, giving a saving of £711k. The forecast unit cost is also £0.441 per hour more expensive than affordable generating an additional cost of £1,123k. This will relate to the fact that people who do receive domiciliary care, in its traditional sense, are more likely to have higher needs and require more intense packages.

There is also a significant underspend of £798k relating to the in-house domiciliary service and £318k against enablement and other block contracts as the number of clients remains well below that afforded within the budget.

There are a number of small variances across the various lines within domiciliary care which add up to an over-recovery of income of £181k.

d. Other Services

This line is showing a gross underspend of £582k following the release of £200k of the Contingency held by the Managing Director to offset the overall pressure within the Directorate. Demand for Fast-track Occupational Therapy equipment has also been below the level anticipated in the budget and makes up approximately £200k of the underspend. There are also small variances, both over and under, against the remaining services, including payments to voluntary organisations, day-care, and meals.

1.1.3.2 **People with a Learning Difficulty:**

Overall the position for this client group is a net pressure of £3,051k. Services for this client group remain under extreme pressure, particularly within residential care and direct payments, and also domiciliary and supported accommodation, as a result of both demographic and placement price pressures.

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, continues to be felt. Alongside these so-called "transitional" placements are the increasing number of older learning disabled clients who are 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. A client would become "ordinarily resident" when placed by another local authority in Kent and following de-registration of the home, the individual moves into supported accommodation. We have accepted responsibility for five clients, the costs of which come to £382k including some backdated amounts, and we are still contesting a number of other applications for which any legal judgements are unlikely to be made before the end of the year. The issue of ordinary residence is being discussed nationally through the Association of Directors of Adult Social Services as the current system penalises those authorities, such as Kent, who have historically been a net importer of residential clients.

a. Residential Care

The overall forecast for residential care, including preserved rights clients, is an overspend on gross of £2,497k partially offset by an over recovery of income of £486k, giving a net pressure of £2,011k. Details of the individual pressures and savings contributing to this position are provided below.

The number of clients has reduced from 642 in September to 636 in December; it was 632 in June and 640 in March. The forecast assumes 1,442 weeks more than is affordable at a cost of £1,640k, and includes those known young people who are in the "transition" process and will be coming to adult social services before the end of the year. The actual unit cost is £1,137.28 which is £27.13 higher than the affordable level and adds £886k to the forecast. The additional client weeks add £258k of income, and the actual income per week is higher than the expected level which generates an over-recovery in income of £267k.

The forecast number of client weeks of service provided to Preserved Rights clients is 130 lower than the affordable level because of increased attrition which is over and above that assumed in the budget. This reduced activity gives an underspend of £102k and also the unit cost is lower than the affordable level which generates a saving of £98k.

As with Older People, in house residential provision is showing a pressure of £148k on staffing because of the need to cover sickness and absence with agency staff to meet national care standards.

There has also been a contribution of £170k to a provision for a potential future liability.

b. Domiciliary Care

This line is showing a gross overspend of £421k. The forecast for services provided through the independent sector assumes 21,539 hours more than is affordable, which with a cost per hour of £12.56 means a pressure of £270k. There has also been an increase in the number of clients accessing independent living services, especially a number with wide ranging and profound disabilities, with the result that this line is currently forecasting an overspend of £126k.

c. Direct Payments

Overall this line is forecasting a gross pressure of £1,148k with a minor £34k over-recovery on income. This forecast assumes 142 weeks less than is afforded within the budget which is causing a saving of £32k on gross expenditure. The actual unit cost is £40.64 more than budgeted which is adding £1,154k to the position. There is also a pressure of £26k against one-off/respite payments.

d. Supported Accommodation

The current position is a gross pressure of £555k and an over recovery of income of £169k giving a net pressure of £386k with the number of clients having increased from 233 in March to 276 in June and 284 in September, however there has been a slight fall over recent months with the December figure standing at 281. The forecast weeks based on these clients shows 546 weeks less than affordable as the budget was based on a higher figure; this generates a saving of £310k. However the unit cost of £566.87 is also £22.56 per week higher than is affordable and this increases the pressure by £379k. It should be noted that the unit cost is skewed by a number of placements transferred from Health under S256 arrangements as these clients cost over £1,200 per week. There has also been a contribution of £331k to a reserve for a potential future liability. A combination of higher than expected average contribution per week plus the impact of S256 placements funded by Health generates an additional £169k of income.

There is also £189k of costs backdated for the two previous financial years relating to a client who, following a recent case has been awarded Ordinary Residence in Kent. The cost of this client for 2009/10 is included within the overall position outlined above. There are also small underspends against group homes and the adult placement scheme.

e. Other Services

This line is showing a gross underspend of £935k following the release of £600k of the Contingency held by the Managing Director to offset the overall pressure within the Directorate. Independent sector day-care is showing an underspend of £214k and this in part relates to a number of clients now receiving their daycare via a direct payment. There are also small variances, both over and under, against the remaining services, including payments to voluntary organisations, day opportunities service and supported employment.

1.1.3.3 **People with a Physical Disability:**

Overall the position for this client group is a net pressure of £702k. Services for this client group remain under pressure as a result of both demographic and placement price pressures. As a result there continues to be a significant forecast pressure against residential and domiciliary care.

a. Residential Care

The overall forecast for residential care, including preserved rights clients, is a pressure on gross of £526k.

Although the number of clients had reduced from 222 in March to 213 in June, the figure as at December was 228, only marginally down from September's figure of 229. As a result the current forecast assumes 1,072 weeks more than is affordable at a cost of £912k. The actual unit cost is £850.71 which is £25.15 lower than the affordable which reduces the pressure by £297k. The additional client weeks add £125k of income to the position however the income per week is less than the level expected which causes a pressure of £113k.

The forecast number of client weeks of service provided to Preserved Rights clients is 271 lower than the affordable level because of increased attrition which is over and above that assumed in the budget. This reduced activity gives an underspend of £221k although the unit cost is slightly higher than the affordable level which adds £79k back into the position. The reduced activity also means an under-recovery in income of £77k.

b. Domiciliary Care

This line is showing a gross overspend of £558k. The forecast for services provided through the independent sector assumes 35,774 hours more than is affordable, which with a cost per hour of £13.19 gives a pressure of £472k. The actual unit cost is also slightly higher than the affordable level which increases the pressure by £88k.

c. Other Services

This line is showing a gross underspend of £549k following the release of £200k of the Contingency held by the Managing Director to offset the overall pressure within the Directorate. As with Learning Disability there is also an underspend of £222k against independent sector day-care as a number of clients are now receiving their daycare via a direct payment. There are also small underspends against the remaining services, including payments to voluntary organisations and occupational therapy.

1.1.3.4 **All Adults Assessment & Related:**

There is an underspend against gross expenditure of £222k as a result of vacancy management. There is also an over-recovery in income of £355k, of which approximately £300k relates to additional contributions from Health. The estimates for gross expenditure have reduced over the last few months due to revised estimates for turnover and vacancy management.

1.1.3.5 **Mental Health:**

Overall the position for this client group is a net pressure of £307k.

a. Residential Care
The overall forecast for residential care, including preserved rights clients, is a pressure on gross of £631k. In the case of non-preserved rights clients the affordable level was reduced as a result of the decision in both 2008-09 and 2009-10 to realign budgets to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. The result is a forecast which is 1,272 weeks more than is affordable at a cost of £699k. The actual unit cost is £549.33 which is £17.33 higher than the affordable which adds £152k to the forecast. The forecast also assumes a significant under-recovery in income as an increasing proportion of clients fall under Section 117 legislation meaning that they do not contribute towards the cost of their care. This has added £228k to the pressure.

The forecast for Preserved Rights clients reflects an underspend of £213k because of increased attrition which is over and above that assumed in the budget. The reduced activity also means an under-recovery in income of £69k.

b. Direct Payments
As referred to above the affordable level has been increased in both 2008-09 and 2009-10 to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated. The result is a gross forecast which is significantly underspending against budget by £329k.

c. Other Services
This line is showing an underspend on gross of £154k resulting from small variances against a number of lines including payments to voluntary organisations, daycare, facilities and community services.

1.1.3.6 **Gypsy & Traveller Unit:**

This line is reporting a gross overspend of £107k following an unsuccessful bid to redevelop a site. As the scheme is no longer continuing within the capital programme all the costs incurred so far on the project, amounting to £140k must be written back to revenue. The overall variance is less than this due to small underspends elsewhere within this budget line.

1.1.3.7 **Strategic Business Support:**

The current forecast is an underspend on gross of £630k and an over-recovery in income of £205k. The underspend on gross is spread across a number of teams both at Headquarters and in the two Areas and reflects savings through vacancy management, the value of which comes to approximately £500k. There are also cases where costs have been funded through a grant. For example several posts are either partly or totally covered through the Social Care Reform Grant. Backfilling of posts has either been done at a lower cost or the post has not been covered, both of

which have added to the underspend. There have also been savings against non-pay costs including £75k against printing and stationery.

Within the over-recovery of income is £118k relating to contributions from Universities in respect of the Practice Placement Scheme, as well as additional additional income from Medway Council in respect of Enhanced Pensions and contributions from District Councils involved in the new Excellent Homes For All PFI scheme. There is also additional funding relating to the Safeguarding Adults Board Manager.

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER
(shading denotes that a pressure/saving has an offsetting entry which is directly related)

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
KASS	LD Residential gross - activity in excess of affordable level in independent sector placements	+1,640	KASS	Older People Residential income resulting from higher contribution per client per week	-1,113
KASS	Older People Nursing gross - activity in excess of affordable level in independent sector	+1,375	KASS	Older People Domiciliary gross - in house activity below affordable level	-798
KASS	LD Domiciliary gross - pressure relating to change in unit cost in independent sector care	+1,154	KASS	Older People Domiciliary gross - reduction in hours in independent care	-711
KASS	Older People Domiciliary gross - pressure relating to change in unit cost in independent sector hours	+1,123	KASS	LD Other Services gross - release of the balance of the Managing Director's contingency	-600
KASS	PD Residential gross - activity in excess of affordable level in independent sector placements	+912	KASS	Older People Residential gross - Preserved Rights increased attrition	-523
KASS	LD Residential gross - pressure relating to change in unit cost in independent sector care	+886	KASS	Strategic Business Support gross - vacancy management	-500
KASS	MH Residential gross - transfer of clients to community based care/direct payments not yet happened	+699	KASS	Older People Nursing income resulting from additional activity	-452
KASS	Older People Residential gross - in house provision staffing	+676	KASS	Older People Nursing income resulting from higher contribution per client per week	-423
KASS	PD Domiciliary gross - activity in excess of affordable level	+472	KASS	Older People Nursing income - additional income due to higher RNCC activity	-413
KASS	Older People Nursing gross - additional spend due to higher RNCC activity	+413	KASS	OP Nursing income - additional contributions from Health	-354
KASS	LD Supported Accommodation gross - pressure relating to change in unit cost	+379	KASS	MH Direct Payments gross - increase in expected activity in community based care/direct payments not yet happened	-329
KASS	Older People Residential gross - pressure relating to change in unit cost in independent sector placements	+354	KASS	OP Domiciliary gross - lower level of activity against block contracts and enablement	-318
KASS	LD Supported Accommodation gross - contribution to reserve	+331	KASS	LD Supported Accommodation gross - activity below affordable level	-310
KASS	LD Direct Payments gross - independent sector activity in excess of affordable level	+270	KASS	Assessment & Related - Over-recovery of income from additional health contributions	-300

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
KASS	MH Residential income - reduced income due to increasing proportion of clients who are S117	+228	KASS	PD Residential gross - unit cost below affordable level	-297
KASS	Older People Nursing gross - attrition in preserved rights lower than expected	+201	KASS	OP Residential income resulting from increased occupancy in in-house units	-293
KASS	Older People Residential income - reduced Preserved Rights activity	+191	KASS	LD Residential income resulting from higher contribution per client per week	-267
KASS	LD Supported Accommodation gross - backdated cost relating to Ordinary Residence	+189	KASS	LD Residential income - additional income resulting from additional activity	-258
KASS	LD Residential gross - contribution to provision	+170	KASS	PD Other Services - underspend on independent sector day-care	-222
KASS	MH Residential gross - unit cost in excess of affordable level	+152	KASS	Assessment & Related gross - underspend resulting from vacancy management	-222
KASS	LD Residential gross - in house provision staffing	+148	KASS	PD Residential gross - Preserved Rights increased attrition	-221
KASS	Gypsy & Traveller Unit gross - write back of capital costs incurred on a failed bid to redevelop a site	+140	KASS	LD Other Services gross - reduced activity in independent sector/transfer to direct payments	-214
KASS	LD Domiciliary gross - pressure against Independent Living Scheme	+126	KASS	MH Residential gross - Preserved rights decreased activity due to higher attrition	-213
KASS	PD Residential income - income per week below expected level	+113	KASS	PD Other Services gross - release of the balance of the Managing Director's contingency	-200
			KASS	OP Other Services gross - release of the balance of the Managing Director's contingency	-200
			KASS	OP Other Services gross - lower than anticipated demand for Fast-track Occupational Therapy equipment	-200
			KASS	LD Supported Accommodation income - resulting from higher contribution per client per week and additional Health funding	-169
			KASS	Older People Residential income resulting from higher contribution per client per week from Preserved Rights clients	-157
			KASS	Older People Residential gross - Preserved Rights saving relating to change in unit cost	-151
			KASS	PD Residential income - additional activity	-125
			KASS	Strat Bus Supp income - additional training income for Practice Placement scheme	-118
			KASS	LD Residential gross - Preserved rights decreased activity due to higher attrition	-102
		+12,342			**-10,773**

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

The forecast pressure of £580k assumes that most of the savings identified within the MTP will be achieved, and the Directorate remains confident that other savings, through the application of "Guidelines for Good Management Practice", will be found to ensure that a balanced budget is achieved by the end of the year.

1.1.5 **Implications for MTP**:

The 2010-13 Medium Term Plan reflects the ongoing pressures on all services at the time the 2010-11 budget was produced.

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

No revenue projects have been identified for re-phasing.

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

The KASS Directorate is wholly committed to delivering a balanced outturn position by the end of the financial year. KASS has 'Guidelines for Good Management Practice' in place across all teams in order to help us manage demand on an equitable basis consistent with policy and legislation. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged. Through these arrangements the Directorate expects to balance the £580k pressure by the end of the year. However this pressure assumes reductions in the number of residential and nursing placements in line with expected trends and risk remains around what additional clients above those either accepted or contested may become "ordinarily resident" in Kent.

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.

The capital cash limits have been adjusted to reflect the position reflected in the 2010-13 MTP as agreed by County Council on 18 February 2010, any further adjustments are detailed in section 4.1.

1.2.1 **Table 3** below provides a portfolio overview of the latest capital monitoring position excluding PFI projects.

	Prev Yrs Exp £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	Future Yrs £000s	TOTAL £000s
Kent Adult Social Services portfolio						
Budget	2,648	4,347	10,835	7,857	1,488	27,175
Adjustments:						
-						0
Revised Budget	2,648	4,347	10,835	7,857	1,488	27,175
Variance		-769	769	0	0	0
split:						
- real variance						0
- re-phasing		-769	+769			0

Real Variance	**0**	**0**	**0**	**0**	**0**	**0**
Re-phasing	**0**	**-769**	**+769**	**0**	**0**	**0**

1.2.3 **Main Reasons for Variance**

Table 4 below, details all forecast capital variances over £250k in 2009-10 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 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 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.

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

			Project Status			
portfolio	Project	real/ phasing	Rolling Programme	Approval to Spend	Approval to Plan	Preliminary Stage
			£'000s	£'000s	£'000s	£'000s
Overspends/Projects ahead of schedule						
KASS						
			+0	**+0**	**+0**	**+0**
Underspends/Projects behind schedule						
KASS	Modernisation of Assets	phasing	-273			
			-273	**+0**	**+0**	**+0**
			-273	**+0**	**+0**	**+0**

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

None

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

None

There are no underlying variances.

1.2.6 **General Overview of capital programme**:

a) Risks

None

(b) Details of action being taken to alleviate risks

None

1.2.7 **PFI projects**

- PFI Housing

1. 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 assets are ready for use and this is by way of an annual unitary charge to the revenue budget. The completion of the assets is phased over two years and some are now operational.

	Previous years	2009-10	2010-11	2011-12	TOTAL
	£000s	£000s	£000s	£000s	£000s
Budget	8,892	51,818	11,779	0	72,489
Forecast	8,892	51,818	11,779		72,489
Variance	0	0	0	0	0

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

Overall costings still as planned.

(b) **Implications for KCC of details reported in (a) ie 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.

- PFI Excellent Homes for All

2. The £44.300m investment in the PFI Excellent Homes for All project also represents investment by a third party. No payment is made by KCC for the new/refurbished assets until the assets are ready for use and this is by way of an annual unitary charge to the revenue budget.

	Previous years	2009-10	2010-11	-23	TOTAL
	£000s	£000s	£000s	£000s	£000s
Budget			22,300	22,000	44,300
Forecast			22,300	22,000	44,300
Variance					

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

Overall costings still as planned.

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

As per PFI housing above.

1.2.8 **Project Re-Phasing**

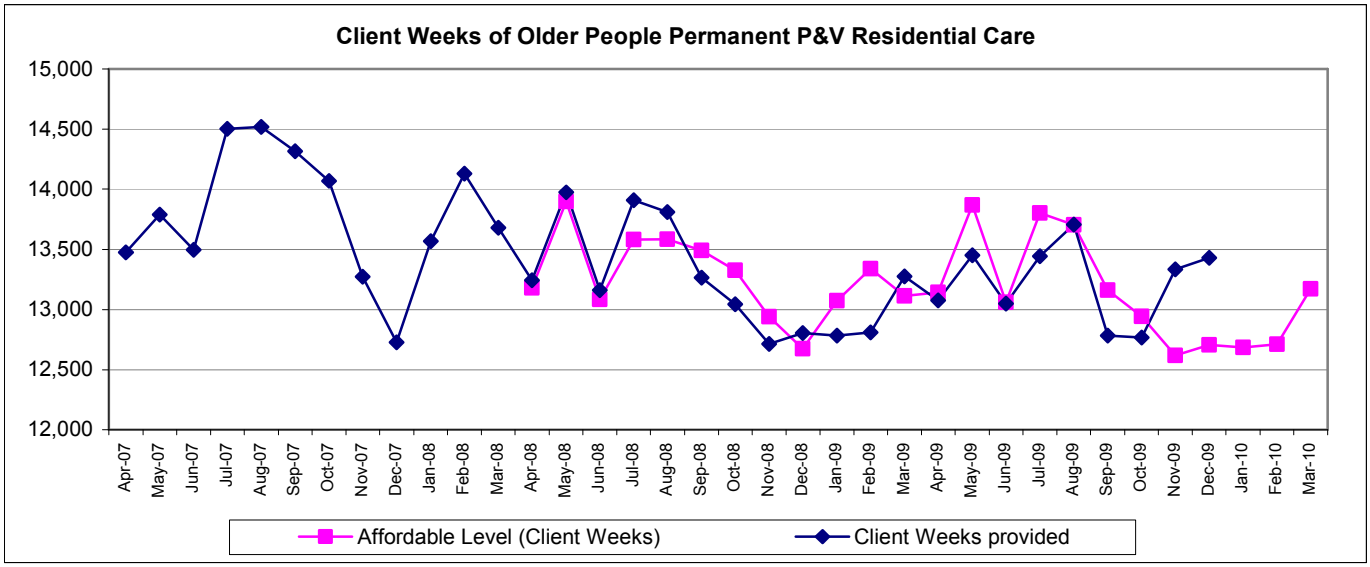
Cash limits are changed for projects that have re-phased by greater than £0.100m to reduce the reporting requirements during the year. Any subsequent re-phasing greater than £0.100m will be reported and the full extent of the rephasing will be shown. The possible re-phasing is detailed in the table below.

	2009-10	2010-11	2011-12	Future Years	Total
	£k	£k	£k	£k	
Modernisation of Assets					
Amended total cash limits	+805	+834	+267	+275	+2,181
re-phasing	-273	+273			0
Revised project phasing	**+532**	**+1,107**	**+267**	**+275**	**+2,181**
Mental Health					
Amended total cash limits	+114	+200			+314
re-phasing	-112	+112			0
Revised project phasing	**+2**	**+312**	**0**	**0**	**+314**
Public Access					
Amended total cash limits	+321	+347	+149	+153	+970
re-phasing	-138	+138			0
Revised project phasing	**+183**	**+485**	**+149**	**+153**	**+970**
Total re-phasing >£100k	**-523**	**+523**	**0**	**0**	**0**
Other re-phased Projects below £100k	**-246**	**+246**			
TOTAL RE-PHASING	**-769**	**+769**	**0**	**0**	**0**

2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

2.1.1 **Number of client weeks of older people P&V residential care provided compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	Client Weeks of older people P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people P&V residential care provided	Affordable Level (Client Weeks)	Client Weeks of older people P&V residential care provided
April		13,476	13,181	13,244	13,142	13,076
May		13,789	13,897	13,974	13,867	13,451
June		13,495	13,084	13,160	13,059	13,050
July		14,502	13,581	13,909	13,802	13,443
August		14,520	13,585	13,809	13,703	13,707
September		14,316	13,491	13,264	13,162	12,784
October		14,069	13,326	13,043	12,943	12,768
November		13,273	12,941	12,716	12,618	13,333
December		12,728	12,676	12,805	12,707	13,429
January		13,568	13,073	12,784	12,685	
February		14,131	13,338	12,810	12,712	
March		13,680	13,114	13,275	13,172	
TOTAL	**169,925**	**165,546**	**159,287**	**158,793**	**157,572**	**119,041**

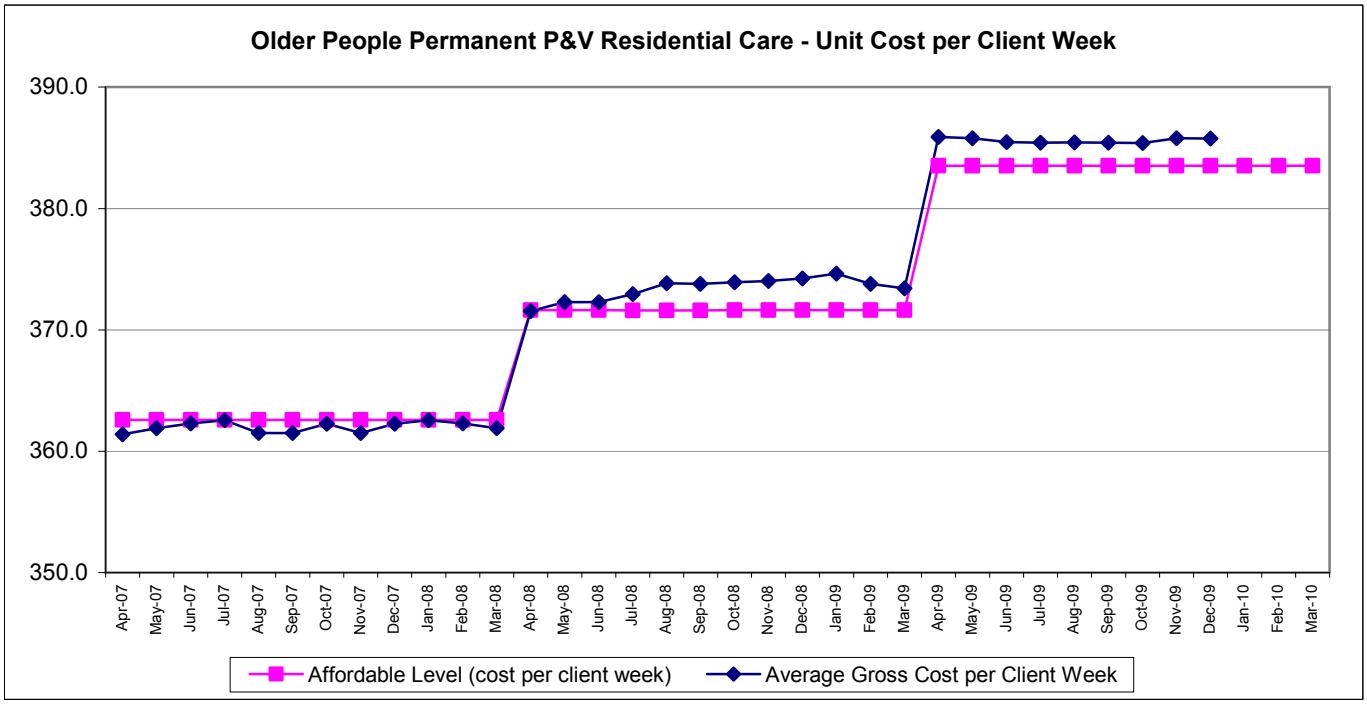


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2007-08 was 2,917 and at the end of March 2009 it was 2,832. In December, the number was 2,774. Although the December position is lower than the March position, there continues to be a pressure relating to older people with dementia.
- The forecast position is 157,368 weeks of care against an affordable level of 157,572, which is a difference of -204 weeks. Using the actual unit cost of £385.76, this reduced level of activity generates an underspend of £79k as highlighted in section 1.1.3.1.a.
- To the end of December 119,041 weeks of care have been delivered against an affordable level of 119,003, a difference of +38 weeks. Although the weeks delivered so far this year is slightly higher than the affordable level, the forecast includes the impact of higher placement numbers at the beginning of the year and includes the ongoing action across the areas to reduce placements. The actual profile is also affected by the number of non-permanent/respite weeks which is volatile. Latest estimates suggest fewer weeks will be needed in the P&V sector in the final quarter of the year because of an increase in in-house weeks and the impact of enablement and intermediate care.

2.1.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week	Affordable Level (Cost per Week)	Average Gross Cost per Client Week
April	362.60	361.41	371.60	371.54	383.52	385.90
May	362.60	361.90	371.60	372.28	383.52	385.78
June	362.60	362.31	371.60	372.27	383.52	385.47
July	362.60	362.56	371.60	372.94	383.52	385.43
August	362.60	361.50	371.60	373.84	383.52	385.44
September	362.60	361.50	371.60	373.78	383.52	385.42
October	362.60	362.27	371.60	373.91	383.52	385.39
November	362.60	361.50	371.60	374.01	383.52	385.79
December	362.60	362.27	371.60	374.22	383.52	385.76
January	362.60	362.56	371.60	374.61	383.52	
February	362.60	362.31	371.60	373.78	383.52	
March	362.60	361.90	371.60	373.42	383.52	

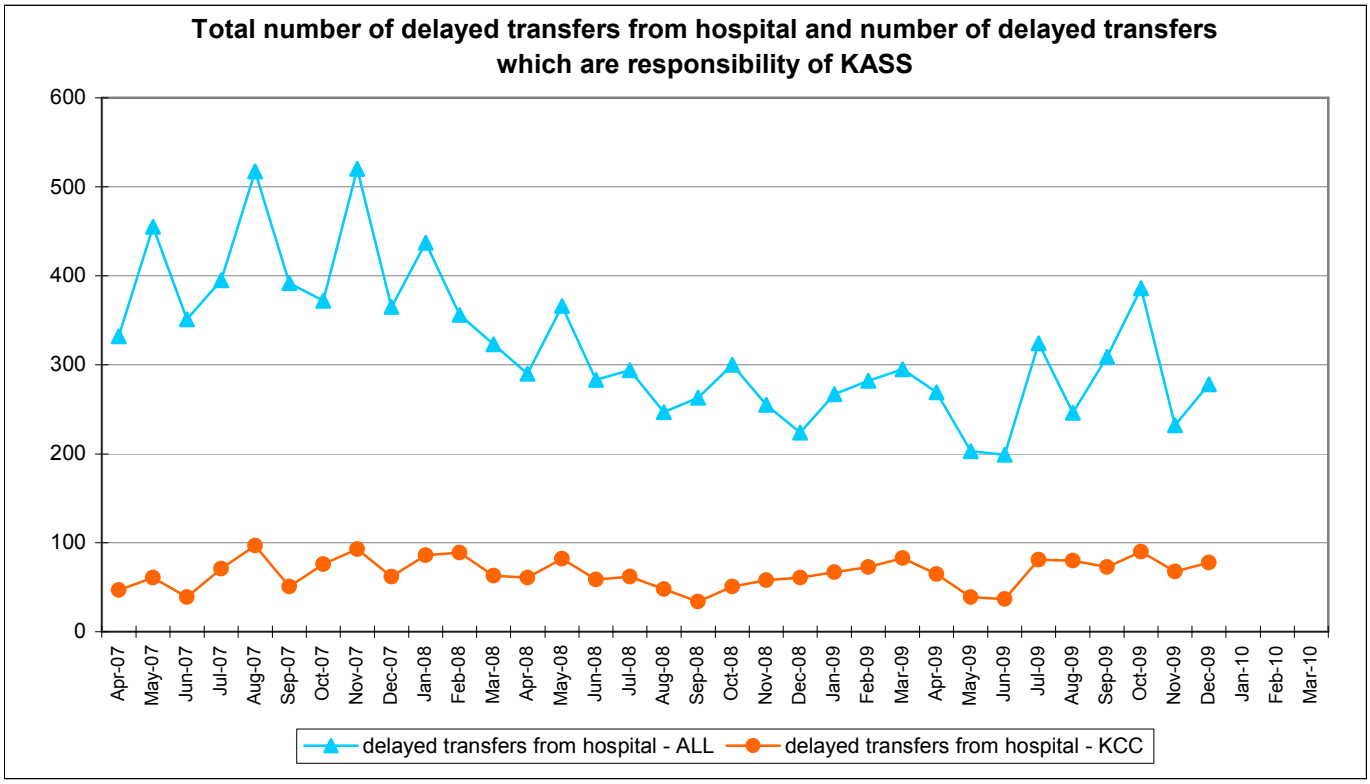


Comments:

- The increase in unit cost over the last year is higher than inflation, but reflects the increasing proportion of clients with dementia.
- The forecast unit cost of £385.76 is higher than the affordable cost of £383.52 and this difference of +£2.24 adds £354k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.1.a.

2.1.3 **Total of All Delayed Transfers from hospital compared with those which are KASS responsibility**:

	2007-08		2008-09		2009-10	
	ALL	KASS responsibility	ALL	KASS responsibility	ALL	KASS responsibility
April	332	47	290	61	269	65
May	455	61	366	82	203	39
June	351	39	283	59	199	37
July	395	71	294	62	324	81
August	517	97	247	48	246	80
September	392	51	263	34	309	73
October	372	76	300	51	386	90
November	520	93	255	58	232	68
December	365	62	224	61	278	78
January	437	86	267	67		
February	356	89	282	73		
March	323	63	295	83		



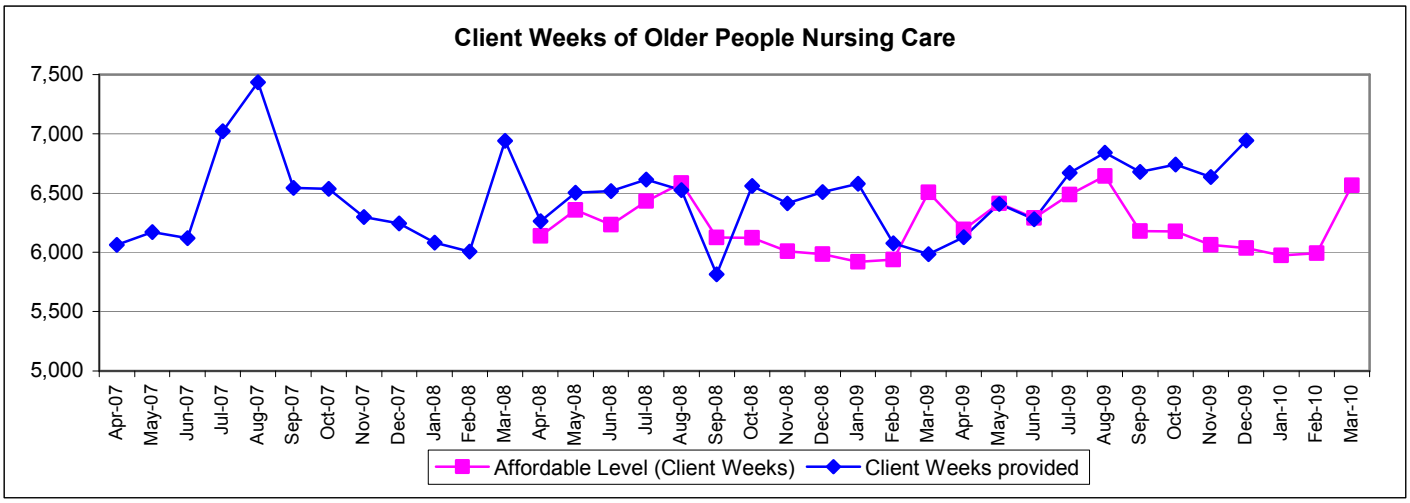
Comments:

- 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. 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 across both Health and Social Care.

- This activity information is obtained from a national database based on data provided by the PCTs.

2.2.1 **Number of client weeks of older people nursing care provided compared with affordable level:**

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	**Client Weeks of older people nursing care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people nursing care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people nursing care provided**
April		6,062	6,137	6,263	6,191	6,127
May		6,170	6,357	6,505	6,413	6,408
June		6,120	6,233	6,518	6,288	6,279
July		7,020	6,432	6,616	6,489	6,671
August		7,436	6,586	6,525	6,644	6,841
September		6,546	6,124	5,816	6,178	6,680
October		6,538	6,121	6,561	6,175	6,741
November		6,298	6,009	6,412	6,062	6,637
December		6,243	5,984	6,509	6,037	6,952
January		6,083	5,921	6,580	5,973	
February		6,008	5,940	6,077	5,992	
March		6,941	6,507	5,985	6,566	
TOTAL	**74,707**	**77,463**	**74,351**	**76,367**	**75,008**	**59,336**

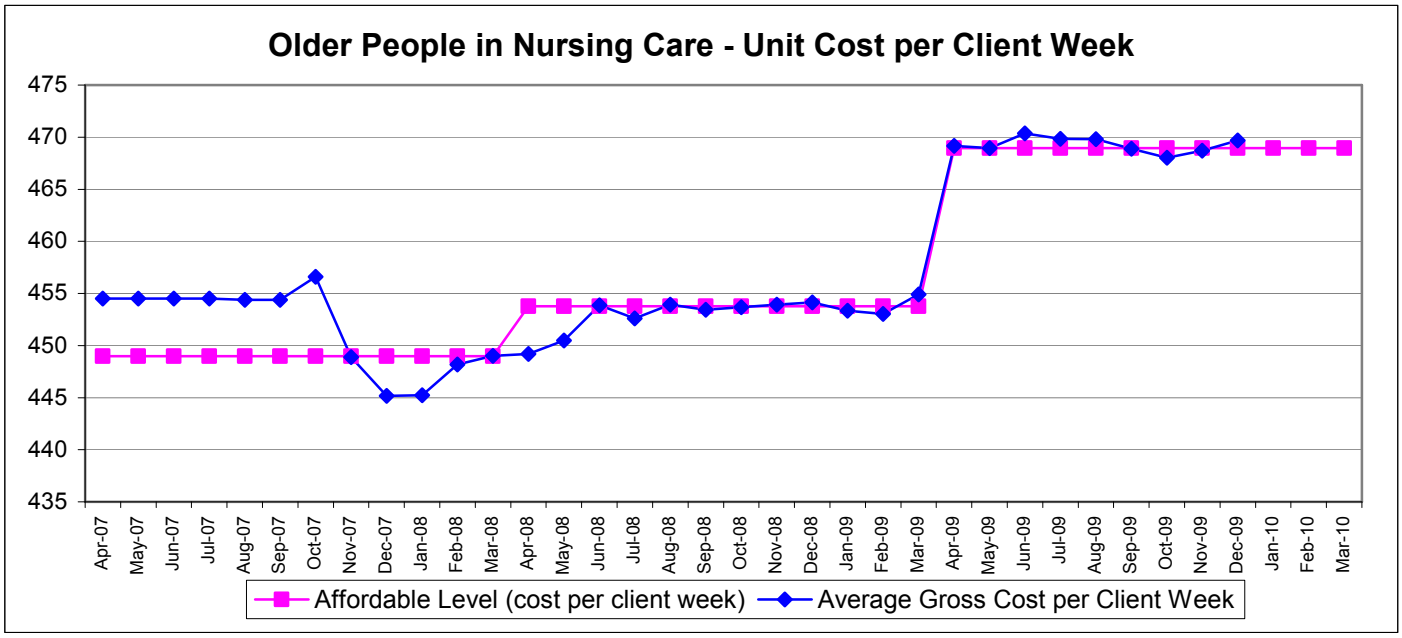


Comment:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2007-08 was 1,386, at the end of March 2009, it had decreased to 1,332 and in December, it had increased slightly to 1,386.
- To the end of December 59,336 weeks of care have been delivered against an affordable level of 56,477 a difference of +2,859 weeks.
- The forecast position is 77,937 weeks of care against an affordable level of 75,008, a difference of +2,929 weeks. Using the actual unit cost of £469.67, this additional activity adds £1,375k to the forecast as highlighted in section 1.1.3.1.b.
- Permanent placements have been slightly higher in the second and third quarters than in the first which means the difference between the forecast weeks and the affordable levels will be larger by year-end. In addition, non-permanent care has increased since the first quarter but it is assumed that this will reduce again in the final quarter and this is reflected in the forecast. The forecast also assumes that placements will reduce in the final quarter based on previous year's levels of attrition.
- There are always pressures in permanent nursing care which may occur for many reasons. Increasingly, older people are entering nursing care only when other ways of support have been explored. This means that the most dependent are those that enter nursing care and consequently are more likely to have dementia. In addition, there will always be pressures which the directorate face, for example the knock on effect of minimising delayed transfers of 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 nursing care.

2.2.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	448.98	454.50	453.77	449.18	468.95	469.15
May	448.98	454.50	453.77	450.49	468.95	468.95
June	448.98	454.50	453.77	453.86	468.95	470.37
July	448.98	454.50	453.77	452.61	468.95	469.84
August	448.98	454.40	453.77	453.93	468.95	469.82
September	448.98	454.40	453.77	453.42	468.95	468.88
October	448.98	456.60	453.77	453.68	468.95	468.04
November	448.98	448.88	453.77	453.92	468.95	468.69
December	448.98	445.16	453.77	454.13	468.95	469.67
January	448.98	445.22	453.77	453.33	468.95	
February	448.98	448.17	453.77	453.02	468.95	
March	448.98	449.00	453.77	454.90	468.95	



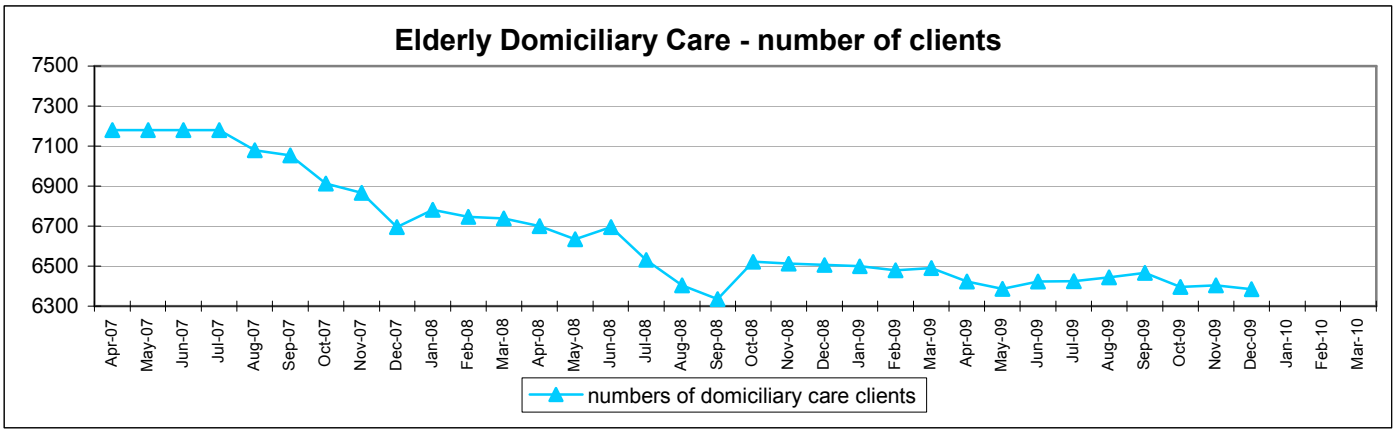
Comments:

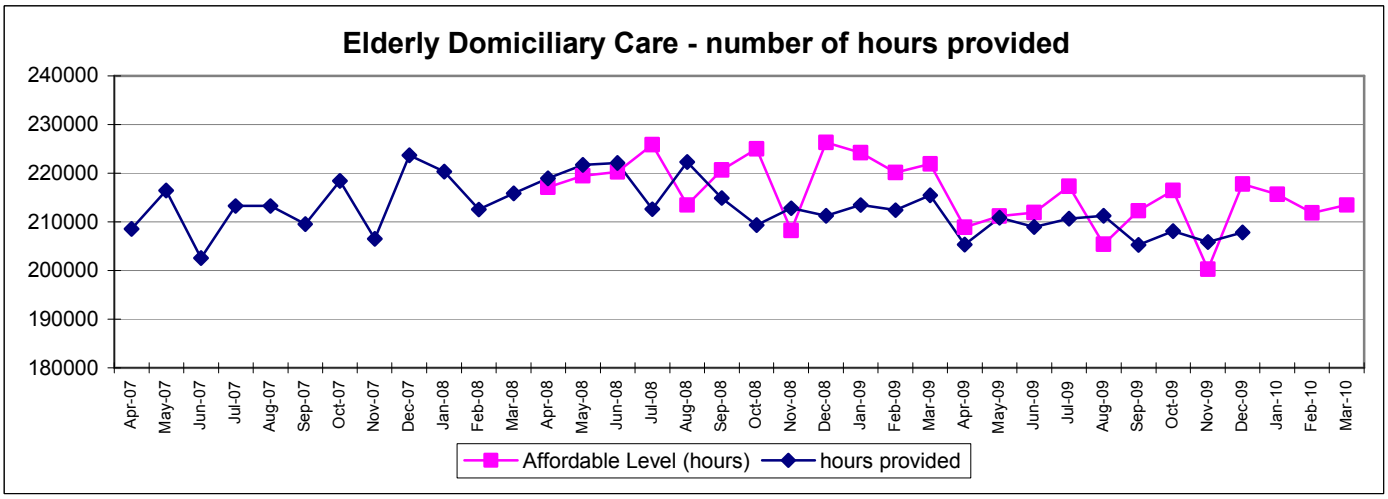
- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care

- The forecast unit cost of £469.67 is higher than the affordable cost of £468.95 and this difference of +£0.72 increases the pressure by £53k when multiplied by the affordable weeks, as highlighted in section 1.1.3.1.b

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

	2007-08			2008-09			2009-10		
	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients
April		208,524	7,179	217,090	218,929	6,700	208,869	205,312	6,423
May		216,477	7,180	219,480	221,725	6,635	211,169	210,844	6,386
June		202,542	7,180	220,237	222,088	6,696	211,897	208,945	6,422
July		213,246	7,180	225,841	212,610	6,531	217,289	210,591	6,424
August		213,246	7,079	213,436	222,273	6,404	205,354	211,214	6,443
September		209,504	7,054	220,644	214,904	6,335	212,289	205,238	6,465
October		218,397	6,912	225,012	209,336	6,522	216,491	208,051	6,396
November		206,465	6,866	208,175	212,778	6,512	200,292	205,806	6,403
December		223,696	6,696	226,319	211,189	6,506	217,749	207,771	6,385
January		220,313	6,782	224,175	213,424	6,499	215,686		
February		212,499	6,746	220,135	212,395	6,478	211,799		
March		215,865	6,739	221,875	215,488	6,490	213,474		
TOTAL	**2,610,972**	**2,560,774**		**2,642,419**	**2,587,139**		**2,542,358**	**1,873,772**	





Comment:

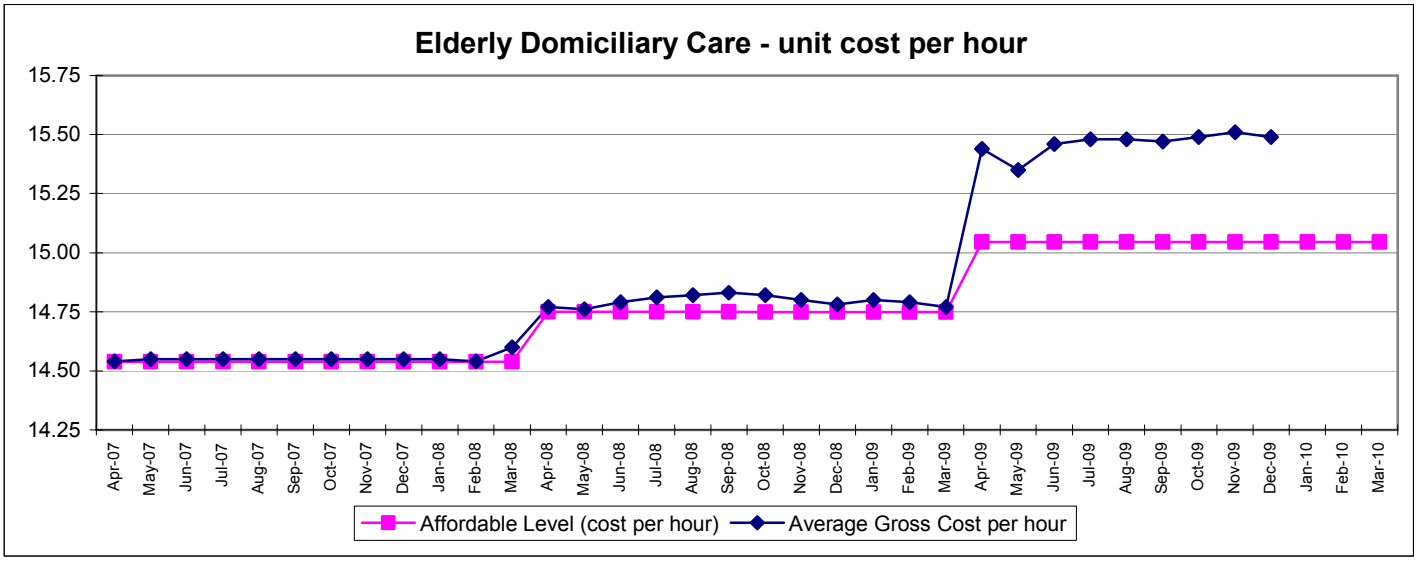
- Figures exclude services commissioned from the Kent HomeCare Service.
- The current forecast is 2,496,440 hours of care set against an affordable level of 2,542,358, a difference of 45,918 hours. Using the forecast unit cost of £15.486, this reduction in activity indicates a £711k underspend, as highlighted in section 1.1.3.1.c.
- The number of people receiving domiciliary care has decreased since 2008/09, and we would not expect the number of domiciliary care clients to be significantly increasing for several reasons. Firstly, the success of preventative services such as intermediate care, rapid response and ongoing service developments with the voluntary sector and other organisations mean that we continue to prevent people from needing 'mainstream' domiciliary care. The LAA target focuses on how we can ensure that people are helped back to their own homes successfully with very minimal support. In the

voluntary sector, people can access services, very often involving social inclusion (e.g. luncheon clubs and other social activities), without having to undergo a full care management assessment. Secondly, public health campaigns and social marketing aimed at improving people's health is already starting to result in healthier older people. Increase in the use of Telecare and Telehealth similarly reduces the need for domiciliary care, and it is possible that this trend will continue despite the growth in numbers of older people. Thirdly, in Kent, as well as nationwide, the take up of direct payments by older people, has for the first time, reached similar levels as people with physical disabilities.

- With the implementation of Self directed support within the Directorate and a key emphasis on enablement services, which is a short term but intensive service, we would expect the average hours per person to increase and this is starting to happen.

2.3.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Hour)	**Average Gross Cost per Hour**	**Affordable Level (Cost per Hour)**	**Average Gross Cost per Hour**	**Affordable Level (Cost per Hour)**	**Average Gross Cost per Hour**
April	14.50	14.54	14.75	14.77	15.045	15.44
May	14.50	14.55	14.75	14.76	15.045	15.35
June	14.50	14.55	14.75	14.79	15.045	15.46
July	14.50	14.55	14.75	14.81	15.045	15.48
August	14.50	14.55	14.75	14.82	15.045	15.48
September	14.50	14.55	14.75	14.83	15.045	15.47
October	14.50	14.55	14.75	14.82	15.045	15.49
November	14.50	14.55	14.75	14.80	15.045	15.51
December	14.50	14.55	14.75	14.78	15.045	15.49
January	14.50	14.55	14.75	14.80	15.045	
February	14.50	14.54	14.75	14.79	15.045	
March	14.50	14.60	14.75	14.77	15.045	

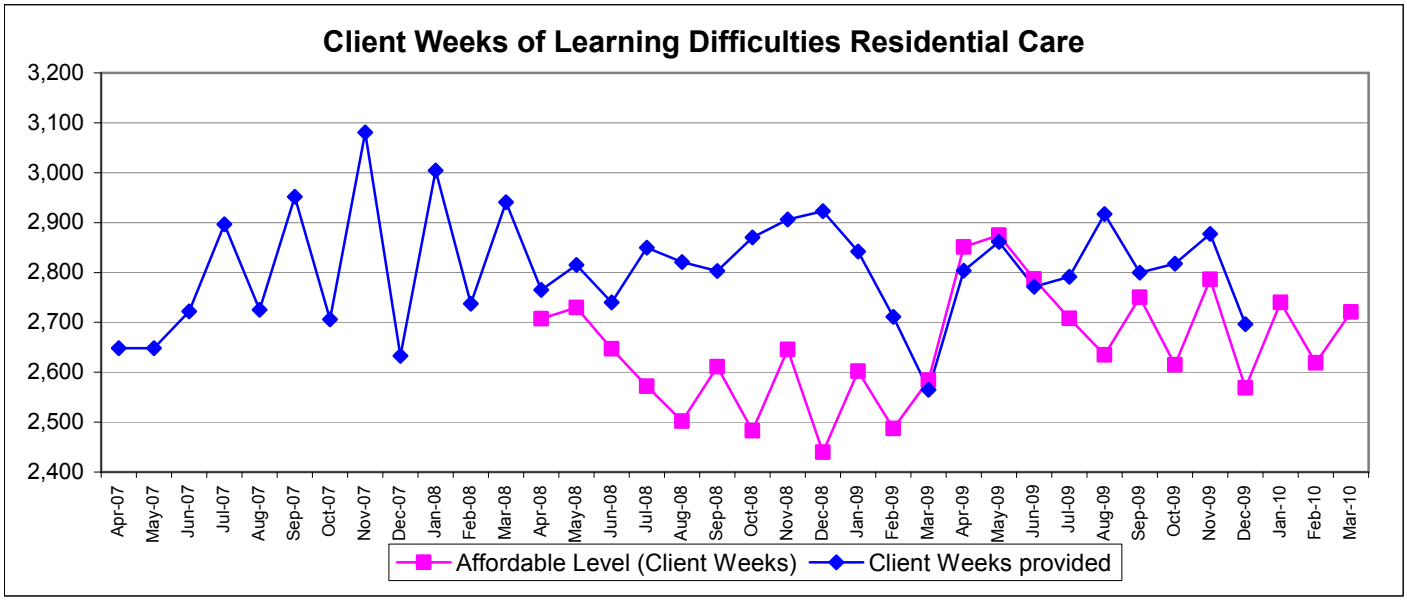


Comments:

- The average unit cost per week is increasing and may reflect the same issues outlined above concerning more intense packages and higher levels of need
- The forecast unit cost of £15.486 is higher than the affordable cost of £15.045 and this difference of +£0.441 increases the pressure by £1,123k when multiplied by the affordable hours, as highlighted in section 1.1.3.1.c.

2.4.1 **Number of client weeks of learning difficulties residential care provided compared with affordable level (non preserved rights clients):**

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided	Affordable Level (Client Weeks)	Client Weeks of LD residential care provided
April		2,648	2,707	2,765	2,851	2,804
May		2,648	2,730	2,815	2,875	2,861
June		2,722	2,647	2,740	2,787	2,772
July		2,897	2,572	2,850	2,708	2,792
August		2,725	2,502	2,821	2,635	3,091
September		2,952	2,611	2,803	2,750	2,640
October		2,706	2,483	2,870	2,615	2,818
November		3,081	2,646	2,906	2,786	2,877
December		2,633	2,440	2,923	2,569	2,696
January		3,004	2,602	2,842	2,740	
February		2,737	2,487	2,711	2,619	
March		2,941	2,584	2,565	2,721	
TOTAL	**30,984**	**33,695**	**31,011**	**33,611**	**32,656**	**25,351**

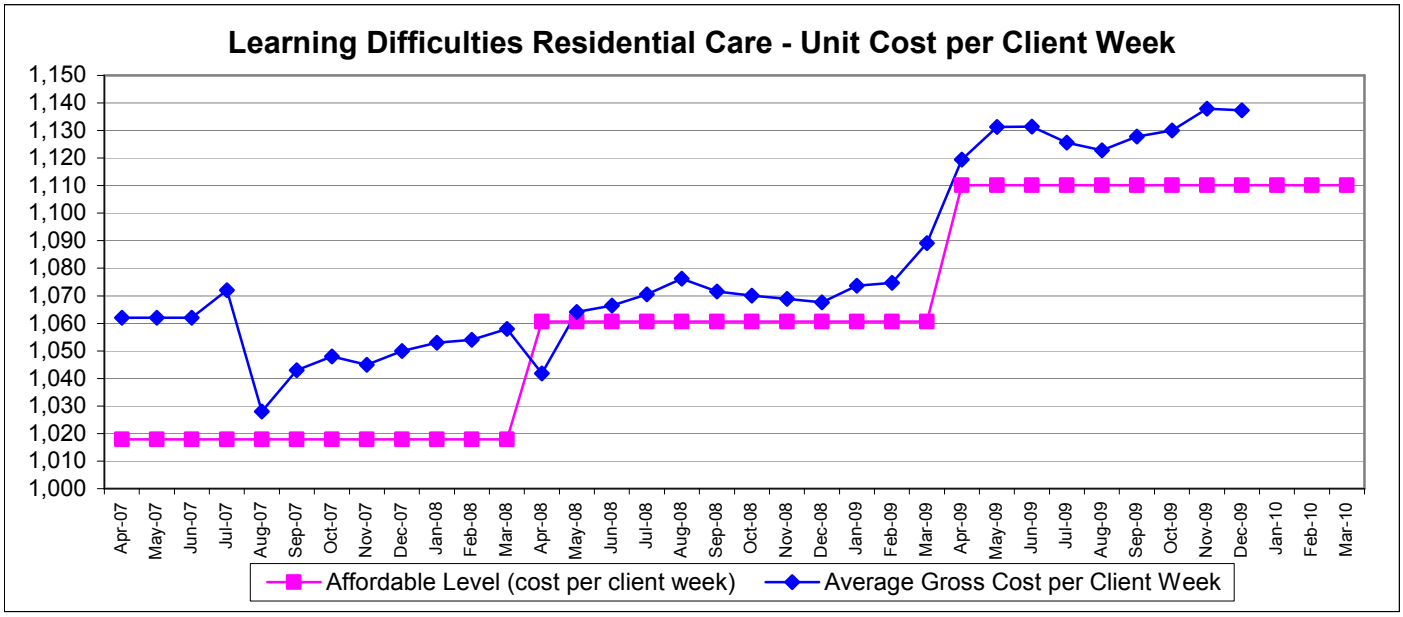


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2007-08 was 633, at the end of 2008-09 it was 640 (with some much higher numbers during the year) and at the end of September 642. In December this number has reduced slightly to 636.
- The forecast position of 34,098 weeks of care is some 1,442 weeks over the affordable level, indicating a pressure of £1,640k using a unit cost of £1,137.28. The forecast is based on the current activity as well as those known young people that will be coming to adult social services before the end of the year, plus an assumption about clients transferring out of residential care to supported living arrangements. Those young people in the "transition" process are known to Social Services as young as 14 and so they can be planned for, as highlighted in section 1.1.3.2.a.
- To the end of December 25,351 weeks of care have been delivered against an affordable level of 24,576 a difference of 775 weeks. The number of people in residential care has decreased slightly in the last couple of months, although the forecast allows for an increase based on known/named clients.
- The forecast includes permanent and non permanent weeks, and the expected increase in non permanent weeks over the remaining months of the year will not therefore be reflected in the movement in client numbers.

2.4.2 **Average gross cost per client week of Learning Difficulties residential care compared with affordable level (non preserved rights clients)**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	1,018.00	1,062.00	1,060.70	1,041.82	1,110.15	1,119.42
May	1,018.00	1,062.00	1,060.70	1,064.19	1,110.15	1,131.28
June	1,018.00	1,062.00	1,060.70	1,066.49	1,110.15	1,131.43
July	1,018.00	1,072.00	1,060.70	1,070.50	1,110.15	1,125.65
August	1,018.00	1,028.00	1,060.70	1,076.27	1,110.15	1,122.81
September	1,018.00	1,043.00	1,060.70	1,071.59	1,110.15	1,127.79
October	1,018.00	1,048.00	1,060.70	1,070.02	1,110.15	1,130.07
November	1,018.00	1,045.00	1,060.70	1,068.95	1,110.15	1,137.95
December	1,018.00	1,050.00	1,060.70	1,067.59	1,110.15	1,137.28
January	1,018.00	1,053.00	1,060.70	1,073.71	1,110.15	
February	1,018.00	1,054.00	1,060.70	1,074.67	1,110.15	
March	1,018.00	1,058.00	1,060.70	1,089.10	1,110.15	



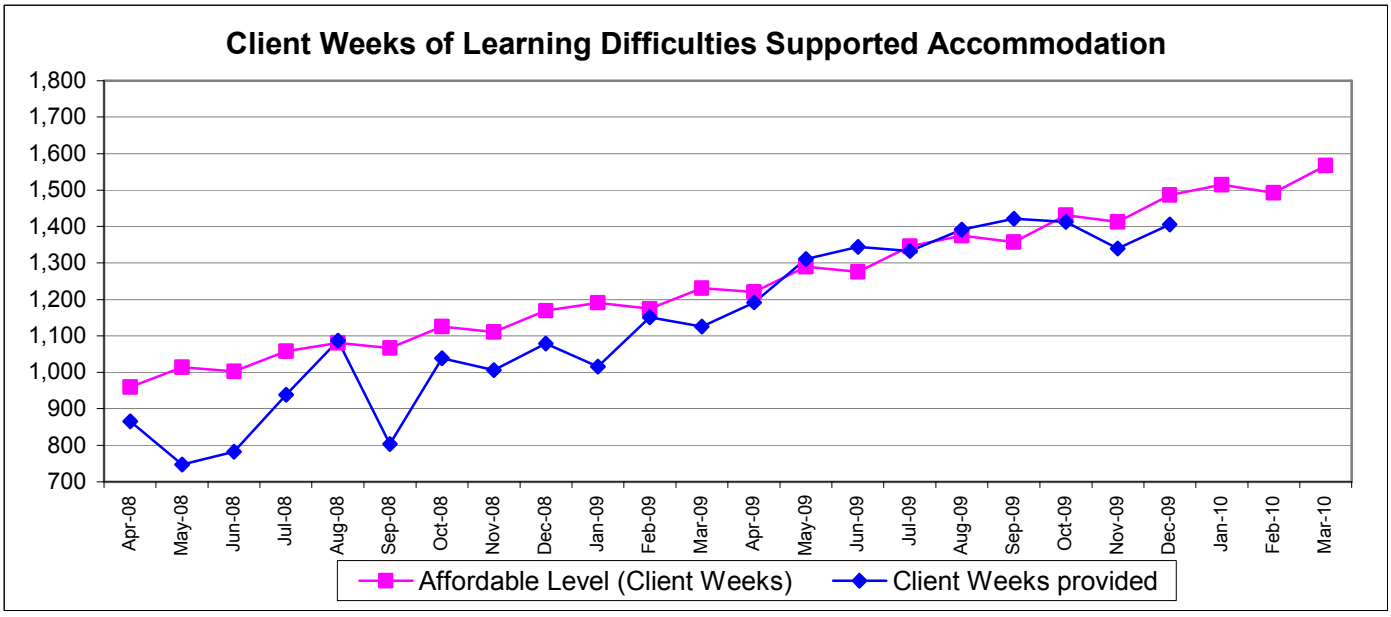
Comments:

- Clients being placed in residential care are those with very complex and individual needs which makes it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,100 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high costs – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases.

- The forecast unit cost of £1,137.28 is higher than the affordable cost of £1,110.15 and this difference of £27.13 adds £886k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.2.a.

2.5.1 **Number of client weeks of learning difficulties supported accommodation provided compared with affordable level:**

	2007-08		2008-09		2009-10	
	Affordable Level (Client Weeks)	Client Weeks of LD supported accommodation provided	Affordable Level (Client Weeks)	Client Weeks of LD supported accommodation provided	Affordable Level (Client Weeks)	Client Weeks of LD supported accommodation provided
April			960	865	1,221	1,192
May			1,014	747	1,290	1,311
June			1,003	782	1,276	1,344
July			1,058	939	1,346	1,333
August			1,081	1,087	1,375	1,391
September			1,067	803	1,357	1,421
October			1,125	1,039	1,431	1,412
November			1,110	1,006	1,412	1,340
December			1,169	1,079	1,487	1,405
January			1,191	1,016	1,515	
February			1,174	1,151	1,493	
March			1,231	1,125	1,567	
TOTAL	**7,618**	**11,156**	**13,183**	**11,639**	**16,770**	**12,149**

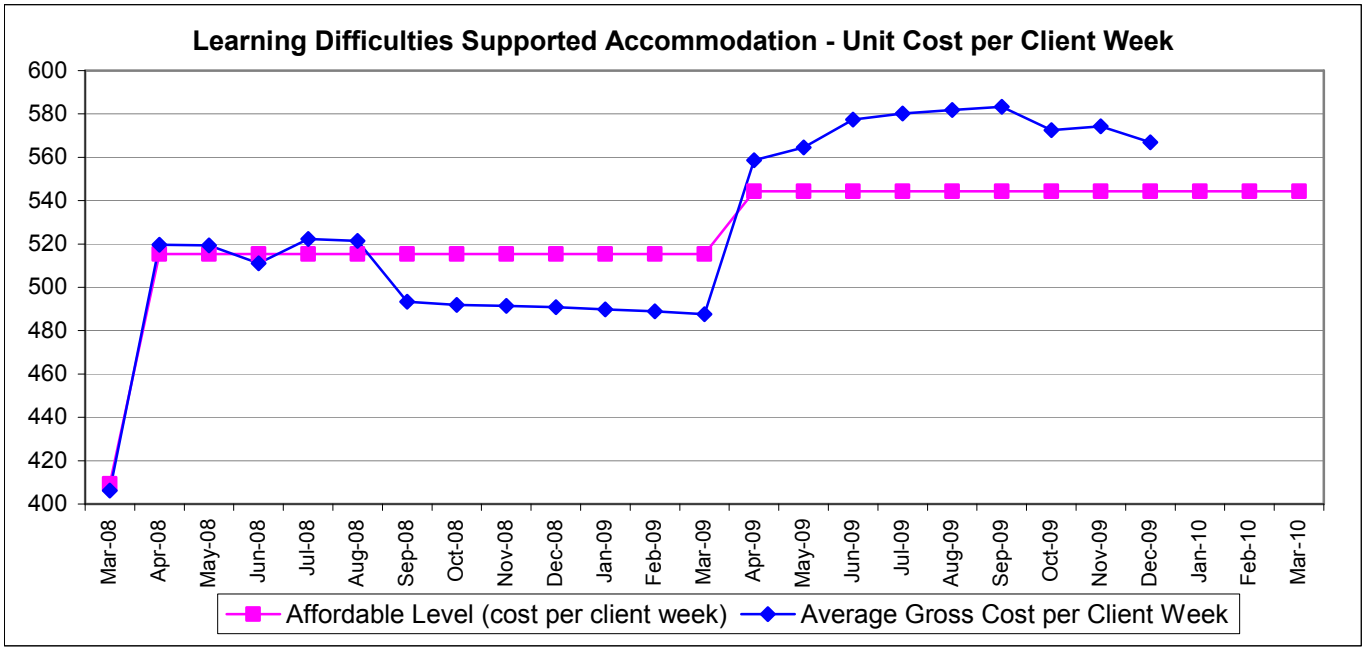


Comments:

- The above graph reflects the number of client weeks of service. The actual number of clients in LD supported accommodation at the end of 2007-08 was 193 and at the end of March 2009 it was 233. As at the end of December, the numbers had increased to 281.
- The latest forecast position of 16,224 weeks clients against an affordable level of 16,770 weeks shows a difference of -546 weeks, which indicates a saving of £310k using a unit cost of £566.87.
- To the end of December 12,149 weeks of care have been delivered against an affordable level of 12,195 a difference of -46 weeks. The affordable weeks for the remaining months of the year were based on much higher levels of activity than are currently being experienced. The latest forecast assumes that between now and the end of the year actual weeks will be below affordable levels by 500 weeks.
- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people, it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that increasingly complex and unique cases will be successfully supported to live independently.

2.5.2 **Average gross cost per client week of Learning Difficulties supported accommodation compared with affordable level (non preserved rights clients)**:

	2007-08		2008-09		2009-10	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April			515.41	519.60	544.31	558.65
May			515.41	519.40	544.31	564.49
June			515.41	511.10	544.31	577.33
July			515.41	522.30	544.31	580.27
August			515.41	521.40	544.31	581.76
September			515.41	493.33	544.31	583.26
October			515.41	491.85	544.31	572.59
November			515.41	491.47	544.31	574.24
December			515.41	490.83	544.31	566.87
January			515.41	489.75	544.31	
February			515.41	488.90	544.31	
March	409.31	406.18	515.41	487.60	544.31	



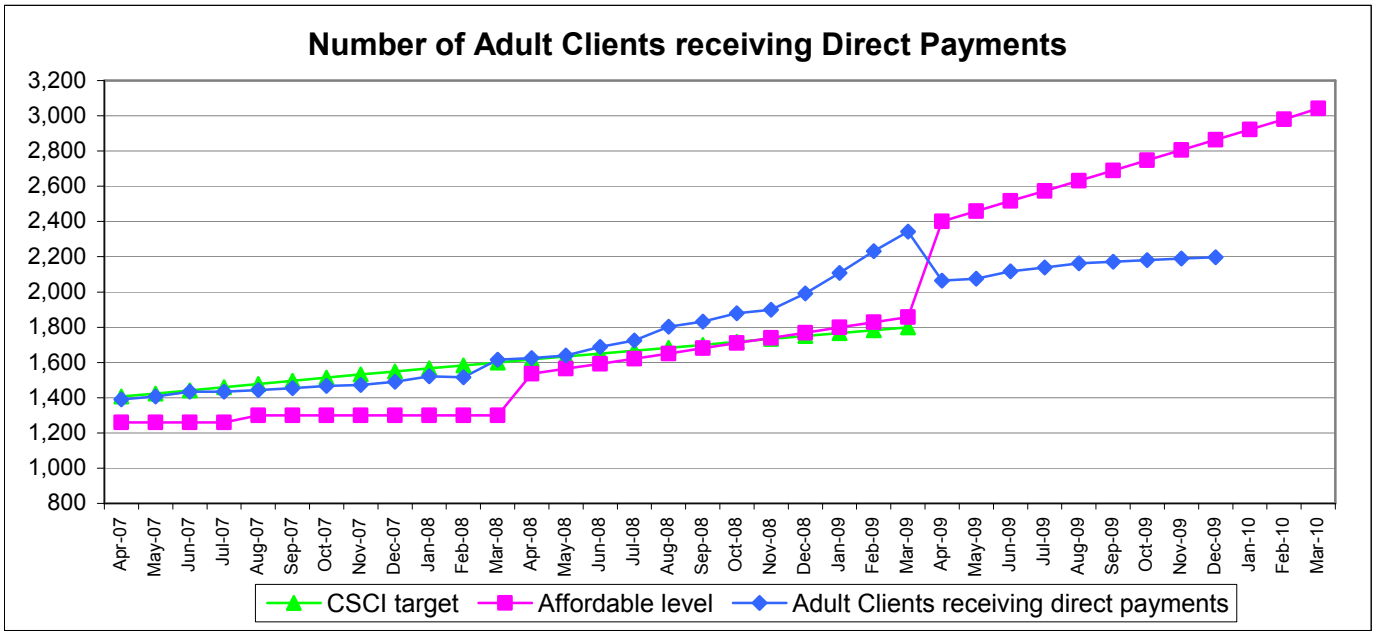
Comments:

- The forecast unit cost of £566.87 is higher than the affordable cost of £544.31 and this difference of +£22.56 adds £379k to the position when multiplied by the affordable weeks as highlighted in section 1.1.3.2.d.

- The costs associated with these placements will vary depending on the complexity of each case and the type of support required in each placement. This varies enormously between a domiciliary type support to life skills and daily living support.

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

	2007-08			2008-09			2009-10	
	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments	CSCI Target	Affordable Level	Adult Clients receiving Direct Payments	Affordable Level	Adult Clients receiving Direct Payments
April	1,406	1,259	1,390	1,617	1,535	1,625	2,400	2,065
May	1,424	1,259	1,407	1,634	1,564	1,639	2,458	2,076
June	1,442	1,259	1,434	1,650	1,593	1,689	2,516	2,097
July	1,460	1,259	1,434	1,667	1,622	1,725	2,574	2,118
August	1,478	1,299	1,444	1,683	1,651	1,802	2,632	2,139
September	1,496	1,299	1,454	1,700	1,681	1,832	2,690	2,179
October	1,514	1,299	1,467	1,717	1,710	1,880	2,748	2,182
November	1,532	1,299	1,472	1,734	1,740	1,899	2,806	2,199
December	1,549	1,299	1,491	1,750	1,769	1,991	2,864	2,247
January	1,566	1,299	1,522	1,767	1,799	2,108	2,922	
February	1,583	1,299	1,515	1,783	1,828	2,231	2,980	
March	1,600	1,299	1,615	1,800	1,857	2,342	3,042	



Comments:

- From April 2008, the national measure for direct payments counted the permanent placements and the number of one-off payments within the year. The position reported for March 2009 represented the total activity for 2008-09 i.e. of the 2,342 adult clients reported as receiving a direct payment, 2,055 were in receipt of ongoing payments and 287 were clients that had received one-off payments at some point throughout the year. From April 2009, we have gone back to again reporting only the permanent placements in line with the requirements for Core Monitoring. For purposes of comparison, the ongoing placements as at March were 2,055, as at December this had increased to 2,247. The affordable level of 2,864 for December assumes 2,315 on-going placements and 549 one-off payments, therefore as at December we are 68 placements below the affordable level for on-going placements across all client groups.
  It should be noted that the actual clients reported for April, May and June in the September Cabinet report included one-off payments and these have now been excluded so that only on-going clients are included. Also figures will have been revised to take account of changes to Swift (client activity system) on the basis of ongoing data quality validation and changing client circumstances.

- From 2009-10, we no longer have a CSCI target for direct payments.

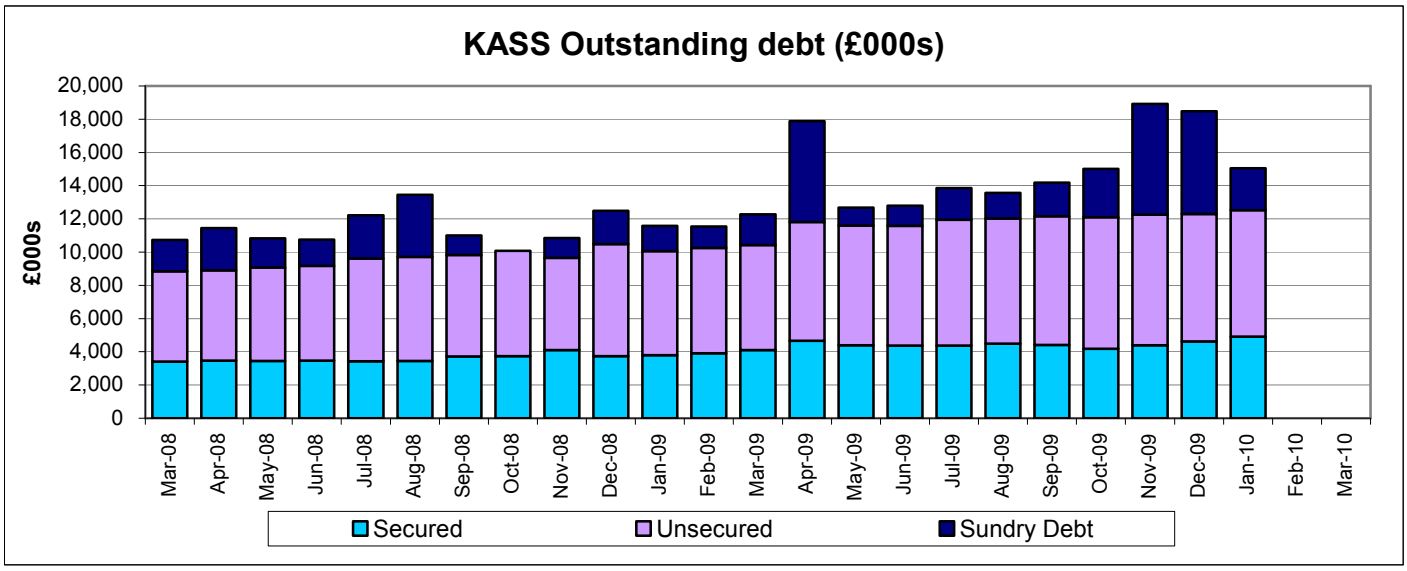
3. KASS OUTSTANDING DEBT

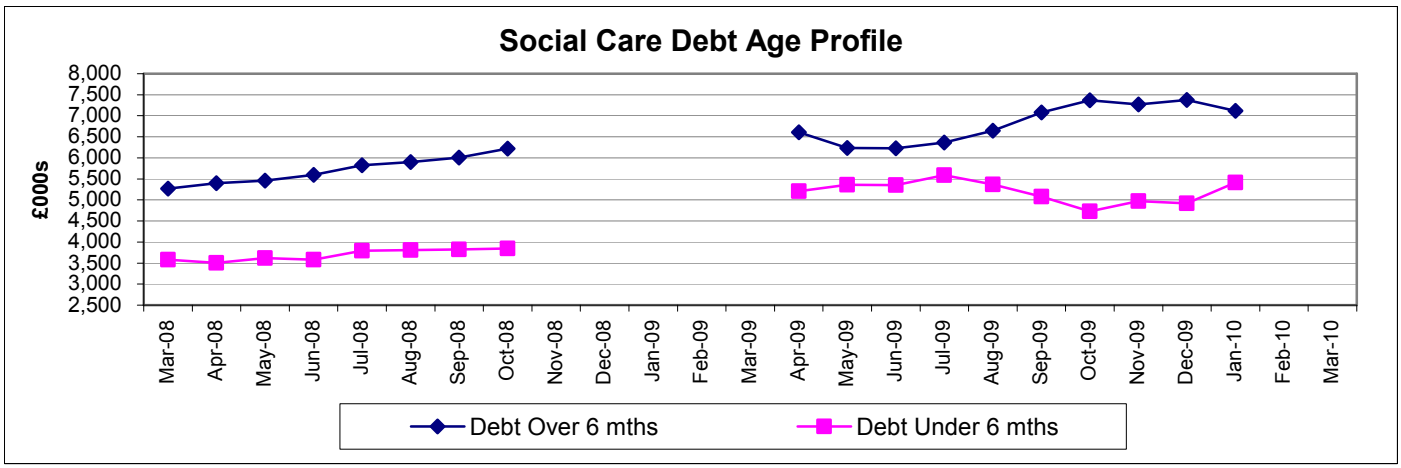
The outstanding debt as at January was £15.1m excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this is £12.5m relating to Social Care (client) debt and the following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year. It also means that as the Directorate moved onto the new Client Billing system in October 2008, the balance will differ from that reported by Corporate Exchequer who report on a calendar month basis, apart from the period November 2008 to March 2009, when the figures are based on calendar months, as provided by Corporate Exchequer, because reports at that time were not aligned with the four weekly billing runs. From April 2009 the debt figures revert back to being on a four weekly basis to coincide with invoice billing runs. The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became "new" for purposes of reporting therefore it was not possible to show ageing until April.

			Social Care Debt				
Debt Month	**Total Due Debt (Social Care & Sundry Debt) £000s**	**Sundry Debt £000s**	**Total Social Care Due Debt £000s**	**Debt Over 6 mths £000s**	**Debt Under 6 mths £000s**	**Secured £000s**	**Unsecured £000s**
Mar-08	**10,727**	**1,882**	8,845	5,268	3,577	3,410	5,435
Apr-08	**11,436**	**2,531**	8,905	5,399	3,506	3,468	5,437
May-08	**10,833**	**1,755**	9,078	5,457	3,621	3,452	5,626
Jun-08	**10,757**	**1,586**	9,171	5,593	3,578	3,464	5,707
Jul-08	**12,219**	**2,599**	9,620	5,827	3,793	3,425	6,195
Aug-08	**13,445**	**3,732**	9,713	5,902	3,811	3,449	6,264
Sep-08	**11,004**	**1,174**	9,830	6,006	3,824	3,716	6,114
Oct-08	*	*	10,071	6,223	3,848	3,737	6,334
Nov-08	**10,857**	**1,206**	9,651			4,111	5,540
Dec-08	**12,486**	**2,004**	10,482			3,742	6,740
Jan-09	**11,575**	**1,517**	10,058			3,792	6,266
Feb-09	**11,542**	**1,283**	10,259			3,914	6,345
Mar-09	**12,276**	**1,850**	10,426			4,100	6,326
Apr-09	**17,874**	**6,056**	11,818	6,609	5,209	4,657	7,161
May-09	**12,671**	**1,078**	11,593	6,232	5,361	4,387	7,206
Jun-09	**12,799**	**1,221**	11,578	6,226	5,352	4,369	7,209
Jul-09	**13,862**	**1,909**	11,953	6,367	5,586	4,366	7,587
Aug-09	**13,559**	**1,545**	12,014	6,643	5,371	4,481	7,533
Sep-09	**14,182**	**2,024**	12,158	7,080	5,078	4,420	7,738
Oct-09	**15,017**	**2,922**	12,095	7,367	4,728	4,185	7,910
Nov-09	**18,927**	**6,682**	12,245	7,273	4,972	4,386	7,859
Dec-09	**18,470**	**6,175**	12,295	7,373	4,922	4,618	7,677
Jan-10	**15,054**	**2,521**	12,533	7,121	5,412	4,906	7,627
Feb-10							
Mar-10							

* In October 2008, KASS Social Care debt transferred from the COLLECT system to Oracle. The new reports were not available at this point, hence there is no data available for this period. The October Social Care debt figures relate to the last four weekly billing run in the old COLLECT system.

Overall Social Care Due Debt has increased by £438k since the last full monitoring report to Cabinet in November, although all of this is secured, and the amount of debt that is unsecured has reduced. The amount of sundry debt increased significantly in November and December due to two large invoices to Health secured through Section 256 agreements, which have now been paid.





* The age of debt cannot be completed for the months between November 2008 and March 2009 as the switch to Client Billing meant that all debts transferring on to the new system became “new” for purposes of reporting therefore it was not possible to show ageing until April (i.e. once these debts became 6 months old in the new system).

By: Overview, Scrutiny and Localism Manager

To: Adult Social Services Policy Overview and Scrutiny Committee
30 March 2010

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

Summary: This report updates Members on Select Committee work going on in 2010.

Current Select Committees

1. (1) Previous update reports promised that all POSCs would be kept up to date on the work of all Select Committees.

Work is currently progressing on the following Select Committees:-

Renewable Energy

(2) This Committee held its first meeting on 26 January 2010, at which it elected a Chairman, Keith Ferrin, and agreed its Terms of Reference, scope and list of potential witnesses. As a departure from Kent's regular Select Committee style, the Committee is trying the Parliamentary method of seeking written evidence first, from which Members will then decide, at a meeting on 31 March, whom they wish to invite to give oral evidence. Hearings, at which oral evidence will be gathered, are planned for April and May. The Committee's final report will be considered by the County Council on 14 October 2010. The contacts in Democratic Services for this Committee are Research Officer Sue Frampton (01622 694993) and Democratic Services Officer Christine Singh (01622 694334), who will be able to supply further information on the work of the Select Committee to any Member who requests it.

Extended Services (previously titled Extended Schools)

(3) This Committee held its first meeting on 19 March 2010, at which it elected a Chairman, Robert Burgess, and agreed its Terms of Reference, scope and list of potential witnesses. Hearings, at which oral evidence will be gathered, are planned for late April through to June. The Committee's final report will be considered by the County Council on 9 December 2010. The contacts in Democratic Services for this Committee are Research Officer Gaetano Romagnuolo (01622 694292) and Democratic Services Officer Theresa Grayell (01622 694277), who will be able to supply further information on the work of the Select Committee to any Member who requests it.

Future Select Committee Work

2. (1) Work is due to start in Summer 2010 on the following Select Committees:-

- Dementia
- Educational Attainment of Pupils and Schools in Areas of High Deprivation

(2) At its meeting on 24 February, the Scrutiny Board received an update on the current Select Committee Topic Review Programme. Although resources to support reviews are all currently allocated, there is potential to start new reviews in November 2010 and January 2011. The Board agreed that Members would be asked if there are any topics they would like to put forward for consideration for inclusion in the future topic review programme. If Members do have any suggestions of topics they should contact the Democratic Services Officer for this POSC.

Monitoring the outcomes of past Select Committee work

3. The Autistic Spectrum Disorder (ASD) Select Committee will shortly be re-convened to receive a report from Kent Adult Social Services on progress against each of its recommendations, one year on from its report being published and considered by the full Council on 30 April 2009. I am hoping to place this meeting in the second half of May.

Recommendation

4. (1) Members are asked to note the progress of the Renewable Energy and Extended Services Select Committees, the further Select Committee work which is planned to start in the summer of 2010, and the arrangements for monitoring the outcomes of the Autistic Spectrum Disorder (ASD) Select Committee, one year on from the publication of its report.

(2) Members are also asked to consider if there are any topics they would like to put forward for possible inclusion in the future topic review programme, and to advise the Democratic Services Officer of any such topics.

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Background Information: *Nil*