ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 16th November, 2010

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL SERVICES POLICY OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 16 November 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 H Pugh (Vice-Chairman), Mrs A D Allen, Mr R Brookbank, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt, Mrs V J Dagger, 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

Webcasting Notice

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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 Introduction/Webcasting

A2 Substitutes

A3 Declarations of Members' Interest relating to items on today's agenda

A4 Minutes of the meeting held on 21 September 2010 (Pages 1 - 10)

A5 Chairman's Announcements

A6 Cabinet Member's and Director's Update (oral)

B. PRESENTATIONS

C. ITEMS FOR CONSIDERATION

C1 Adult Social Services Budget Forecast Report 2010/11 and KASS Debt Position September 2010 (Pages 11 - 22)

C2 Budget 2011/12 and Medium Term Financial Plan 2011/12 to 2012/13 (Pages 23 - 40)

C3 Mid-Year Results for Performance 2010-11 (Pages 41 - 44)

C4 Live it Well - Mental Health Strategy for the Next 5 Years (Pages 45 - 84)

C5 Safeguarding Vulnerable Adults (Pages 85 - 118)

C6 Update on the Whole Systems Demonstrator (WSD) and the Outcomes of the Kent Telehealth Pilot (Pages 119 - 124)

D. ITEMS FOR SCRUTINY

D1 A New Service Model for the Re-provision of Day Activities for People with a Learning Disability in the Ashford District (Pages 125 - 140)

E. ITEMS PLACED ON THE AGENDA BY MEMBERS

E1 Disabled Persons' Registration Card (Pages 141 - 144)

E2 Change to Keep Succeeding (Pages 145 - 202)

F. SELECT COMMITTEE WORK

F1 Update on Select Committee Work (Pages 203 - 204)

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, 8 November 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 Tuesday, 21 September 2010.

PRESENT: Mr K H Pugh (Vice-Chairman, in the Chair), Mrs A D Allen, Mr R Brookbank, Mr L Christie, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt, Mr M J Jarvis, Mr S J G Koowaree, Mr J E Scholes and Mr C P Smith

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

IN ATTENDANCE: Mr O Mills (Managing Director - Adult Social Services), Mrs M Howard (Director Of Commissioning And Provision - West Kent) and Miss T Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

74. Minutes of the meeting held on 25 June 2010
(Item A3)

RESOLVED that the minutes of the meeting held on 25 June 2010 are correctly recorded and that they be signed by the Vice-Chairman.

75. Revised Meeting Dates for 2011
(Item A4)

1. Since publishing the dates for its 2011 meetings in the June agenda, the March 2011 meeting had changed to 7 April 2011.

2. RESOLVED that the revised dates for the POSC's meetings in 2011 be noted.

76. Cabinet Member's and Director's Update (oral)
(Item A6)

1. Mr Gibbens gave an oral update on the following issues:-

   a) *Training for Mental Health Guardianship Panels*: More volunteers from ASSPOSC were encouraged to take part in the training being arranged by KASS and Democratic Services to equip Members to serve on the Panel.

   b) *a recent Valuing People Now event*: This had been a good positive event with an encouraging level of commitment. However, District Partnership Groups across Kent were seeking more volunteer Co-Chairmen and advocates. Mrs Allen and Mr Koowaree both added that their involvement in these bodies had been enlightening and rewarding

and they encouraged other Members to attend and become involved in their local Groups.

c) *update on the Older People's Review*: The consultation on this would end on 1 November, and Mr Gibbens had been visiting residents' groups around the county.

2. Mr Mills gave an oral update on the following issues:-

a) *Queen Elizabeth Foundation (QEF)/Active Lives Network survey outcomes*: An information report was tabled and a brief video clip shown of a client with physical disabilities talking very positively about the new services he has been able to access since the change of service provision and the closure of the QEF centre in Dartford two years ago.

b) *Housing 21 Annual Survey for Better Homes and Active Lives (BHAL) project*: The Housing 21 survey had produced good quality, useful data and the BHAL project was now fully operational.

77. Presentation - 'Liberating the NHS'; an overview of the Health White Paper

1. Mr Mills presented a series of slides setting out the key points, process and timetable for the White Paper. He and Mr Gibbens answered questions from Members, and the following points were highlighted:-

a) the likely scale of GP consortia was not yet clear, and would be decided by GPs themselves, to suit their locality and the local population. The situation would be clearer by the end of 2010;

b) b) Members were assured that the consultation on the White paper was genuine and open and that Members' comments made today and later would be counted. Today's presentation was a summary of key issues to help Members' understanding of the likely effects on adult social care provision, and there were other aspects to be covered. All Members would have an opportunity to debate the issue fully at the October County Council meeting. An interim response would be sent by the KCC to meet the DoH deadline of 11 October, with a supplementary response sent to follow the County Council meeting on 14 October;

c) previous consultation on the Green Paper on the funding of Adult Social Care had shown that most of the UK population had supported the idea of adult social care being funded by tax payers, although the major political parties had considered it could not be fully funded in this way; and

d) there was, as yet, little detail on the status of the new National Health Watch bodies. County Members would have a role to play in shaping these local bodies.

2. RESOLVED that the information given in the presentation and in response to Members' questions be noted, with thanks.

78. Discussion - Informal Member Group (IMG) to look at the Adult Social Services Budget

1. The Vice-Chairman read out a statement which had been prepared by the Cabinet Member for Finance, Mr J Simmonds, to be read out at meetings of each POSC. Each Member was given a copy of the statement and there followed a brief discussion.

2. Members were unhappy at being told they should not continue with planned meetings of the IMG, as the 'scene-setting' discussions which they had at the IMG's first meeting had been really helpful in expanding Members' understanding of budgeting issues. The earlier start of IMGs and longer lead-in time this year would be very helpful in preparing Members for the difficult decisions needed later.

3. It was acknowledged that Members would not be able to, and did not expect to, make any decisions yet about where savings could be made. This level of discussion and decision making could only take place after the Comprehensive Spending Review on 20 October.

4. The Vice-Chairman proposed, and Mr J Cubitt seconded, that the IMG continue its work, and that the meeting planned for 7 October go ahead.

Carried unanimously

5. RESOLVED that the meetings of the Informal Member Group to look at the KASS budget continue as planned, with the next one taking place on Thursday 7 October.

79. Adult Social Services Budget Forecast Report 2010/2011
(Item B1)

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

1. Miss Goldsmith introduced the report and answered questions from Members. The issues highlighted were as follows:-

a) it would be very useful to have an Executive Summary at the start of future reports to set out the key issues before presenting more detailed information and spreadsheets. The report which had previously been presented to Cabinet and was now presented to each POSC would still be included;

b) virement between budget headings was a necessary tool when planning and estimating complex budgets a long way in advance. Adjustments would always be necessary, and the earliest part of the financial year tended to see the biggest adjustments; and

c) it would be very useful for Members to be given a definition of what is meant by 'management action' in managing budgets. This would include measures such as not filling vacancies.

2. RESOLVED that:-

a) the information set out in the report and in response to Members' questions be noted, with thanks; and

b) future budget monitoring reports start with an Executive Summary to set out the key issues, and the next report include a definition of what is meant by 'management action'.

80. Kent Adult Social Services Debt Position, July 2010
(Item B2)

1. Miss Goldsmith introduced the report and explained that it was the first in a new style with a different breakdown of figures. Points arising from questions and discussion were as follows:-

a) the downward trend of debt levels was noted and commended, and Members congratulated staff on the efforts put in to pursue and reduce the extent of client debt;

b) the key aim now, as set out in the new debt management system which started in January 2010, was to control new debt to avoid it becoming established debt;

c) debt outstanding at the time of a client's death could sometimes be recovered through their estate or by probate, although this could be a lengthy process. However, pursuing such debt was not always a viable option; and

d) money owed to KASS by the NHS would not be adversely affected by the changes being made in the White Paper, as some apparent 'debt' was a result of timing or cash flow. However, debt between NHS and KASS would be carefully tracked over the change period to ensure that KASS did not lose out.

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

81. Overview of Performance
(Item B3)

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

1. Mr Sherlock introduced the report and explained that it was a summary of KASS's performance brought together from three headings – the Towards 2010 final report, the Draft KCC Annual Performance Report and the Core Monitoring Report.

2. In discussion, and in response to Members' questions, the following points were raised:-

a) progress against Target 53 had been achieved with the help of discussions between the Carers Advisory Group and Carers Joint Commissioning Group, and Members would be advised of the details and outcome of these latest discussions;

b) although progress against Target 55 had been good, and this is to be welcomed, this inevitably brought a cost to the KCC as more profoundly disabled children survive childhood to go through the transition period and need to access adult services;

c) Members commented that the reporting of 'outcomes' and 'inputs' was confusing, and it would help Members' understanding of the picture if some more definition could be added to future reports, eg outcomes being identified as qualitative or quantitative. Ongoing effectiveness would also need to be measured and reported. Mr Sherlock explained that Performance Indicators had changed since these targets had been set, and new, innovative ways of measuring gave more flexibility and scope for recording different detail; and

d) Supported Employment and the Connexions service offer valuable support to young people, and it is a pity that these are to be affected by the public sector spending reviews.

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

82. Bold Steps for Kent - update
(Item B4)

Mr D Whittle, Policy Manager, was in attendance for this item.

1. Mr Whittle introduced the report and explained that it was being submitted in draft form to all POSCs to allow Members a chance to comment on the priorities within it.

2. In discussion, Members made the following comments on the draft and the process:-

a) the content of the document was not necessarily bold or imaginative. For example, a number of actions under the five key themes were things that the KCC was doing already as a matter of course;

b) Kent should strive to be an exemplar in the services it provided for vulnerable people;

c) one 'bold step' would be to consider whether or not the division of Children's and Adults' Social Services was the right way to organise them; and

d) it was not necessary for steps to be bold, as long as the KCC's commissioning and provision mechanisms were providing the best service and the best value to the people of Kent.

3. RESOLVED that:-

a) the information given in the report be noted, with thanks; and

b) Members' comments on its content be taken into account when preparing the final document.

83. Procedure for Consultation on the Modernisation, Variation or Closure of Services run by Kent Adult Social Services (KASS)
(Item B5)

Mr D Waller, Directorate Manager: Governance, Member Support and Communication, was in attendance for this item.

1. Mr Waller introduced the report, which was seeking Members' views on, and endorsement of, the revised procedure. Members welcomed and supported the report and congratulated officers on its clear layout. Comments made on its content were as follows:-

a) the most important aim was to ensure good governance in the way in which the KCC delivered its services and avoid any grounds for challenge or judicial review;

b) the process is clearly laid out and the public can see its transparency; and

c) the involvement of local KCC Members early in the consultation on a proposal was welcomed.

2. RESOLVED that the revised procedure be endorsed.

84. Kent Adult Social Services - Public Involvement and Consultations Report
(Item B6)

Mrs L Longhurst, Policy Manager, Public Involvement and Customer Care, was in attendance for this and the following item.

1. Mrs Longhurst introduced the report and answered questions from Members. Points arising were as follows:-

a) public groups could become involved in consultation via the Area Involvement Groups, which acted as an independent link between the public and the KCC;

b) feedback on the consultation on the Domiciliary Care re-let would be reported to a future meeting of the POSC;

c) KASS linked to the Community Liaison Managers and Local Boards via the Corporate Board;

d) Members commented that a report dealing with public involvement should use clear terms and avoid the use of acronyms which some people might not understand; and

e) literature was translated into other languages for minority ethnic communities, but more links to these communities were needed.

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

85. Adult Social Services Annual Complaints Report
(Item B7)

1. Mrs Longhurst introduced the report and explained that this was the fist full-year report since KASS had introduced the new, simplified complaints procedure which allowed KASS more flexibility about the approach it took to handling complaints.

2. Mrs Howard emphasised that KASS had always welcomed customers' comments and complaints as a way of constantly testing and improving its service provision, and assured Members that complaints were taken very seriously by the KASS management teams.

3. There had been a 20% increase in complaints in the last year, and the reason for this was difficult to analyse accurately, but Members were assured that only 1% of contacts with clients lead to complaints.

4. In discussion, and in response to Members' questions, the following points were highlighted:-

a) customer care training for KASS staff included how to deal promptly with any complaint so it could be resolved before going any further into a formal procedure;

b) 'easy read' versions of the complaints procedure aimed to help vulnerable clients and those with learning disabilities to be aware of their right to make a complaint if they are not happy with their service, and how they should go about it;

c) 70% of complaints received by KASS come from relatives of clients, but analysis of the complaints received tended to break them down by service type as this was more useful than analysing the source of complaints;

d) the report included a comparison of the number of enquiries, merits (compliments) and complaints for 2008/09 and 2009/10 by type of record but not by area, and it would give a fuller picture if future reports could offer this yearly comparison consistently for all aspects;

e) Members asked to be told which areas the upheld complaints referred to, either in terms of geographic or subject area, so any trends could be identified and then addressed; and

f) it would be useful also to have some indication of how each complaint had been treated, how quickly, and if the outcome was satisfactory to both parties.

5. Mr Mills thanked Members for their comments on the information reported, which would help officers to adapt and improve the reporting style to ensure Members received the information they wanted.

6. RESOLVED that the information set out in the report and in response to Members' questions be noted, with thanks, and that Members' comments be taken into account when preparing next year's report.

86. Self Directed Support (including Personal Budgets and Direct Payments) *(Item D1)*

Mrs P Huntingford, Transforming Social Care Lead Officer, was in attendance for this item.

1. Mrs Huntingford introduced the report and highlighted the breadth of choice and control that Self Directed Support (SDS) offered clients over the support and services they required and how they wished to access those services. For KASS, however, delivering SDS was a very complex process. National Indicator NI 130 did not reflect the aims that KASS had for its SDS services, but it was well placed to meet this target. Mr Mills added that the brief video clip that Members had viewed earlier in the meeting gave a good example of how a client could shape their own services using SDS.

2. In discussion, Members praised the clarity of the report and made the following comments:-

a) it would be helpful to illustrate the SDS process if Members could see some examples of cost assessments and support plans (obviously for anonymous clients), and Mrs Huntingford undertook to supply these;

b) Members were assured that, although KASS was obliged to offer a Direct Payment option to all new clients, no-one would be pressured to take up a Direct Payment if they did not wish to;

c) KASS provided a Criminal Records Bureau (CRB) checking service to clients engaging personal assistants using their Personal Budget and Mrs Huntingford undertook to find out the cost of this service to the KCC and advise Members;

d) by engaging a personal assistant, a client would become an employer and would need to take on responsibility for managing their employee's National Insurance contributions, tax, holiday entitlement, etc. KASS has produced a handbook to guide clients through these issues, and Employment Support Advisors are available to guide and advise; and

e) a Kent client holding a Personal Budget who then moved to another local authority would be subject to the assessment criteria and regime

of the new authority, so would have to re-apply and be re-assessed. As Kent is unusual amongst local authorities in having retained its 'Moderate' eligibility criteria, any service user leaving Kent may therefore find the local authority they move into has set its eligibility criteria at a higher level. However, Department of Health guidance requires the new authority "to take account of the support that was previously received and the effect of any substantial changes on the service user when carrying out the assessment and making a decision about what level of support will be provided".

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

87. Update on Select Committee Work
(Item E1)

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

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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 – 16 November 2010

Subject: **ADULT SOCIAL SERVICES BUDGET FORECAST REPORT 2010/11 AND KENT ADULT SOCIAL SERVICES DEBT POSITION SEPTEMBER 2010**

Classification: Unrestricted

Summary: A report on the updated quarter 1 forecast outturn against budget for Kent Adult Social Services (KASS) and an update on the current position of the KASS social care and accounts receivables debt as at September 2010.

Introduction

1. (1) This is the third report for 2010-11 to this Committee on the forecast outturn against budget for the Adult Social Services Department. This report also includes an update on debt.

Background

2. (1) Policy Overview and Scrutiny Committees (POSCs) 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 Informal Member Group (IMG) was arranged for November 2009 to discuss the future Budget and MTP proposals in more detail. At its April meeting the Scrutiny Board recommended that all POSCs need to formulate their arrangements for contributing to the development of the budget so that they are able to have an input at an earlier stage than previous years. In particular POSCs were asked to consider whether the IMGs set up following the November 2009 meeting should meet regularly between now and December when the draft budget needs to be finalised for formal consultation. As a result three Budget IMGs have already taken place.

First Quarter Updated Monitoring report

3. (1) The revenue monitoring exception report for Adult Social Services was presented to Cabinet in October; this indicated an overall revenue pressure of £2.661m, which is a decrease of £0.177m in the forecast submitted in the first quarter's full monitoring. This position assumes that all savings identified within the Medium Term Plan will be achieved. The pressure will be addressed through a range of 'Guidelines for Good Management Practice', which are in place across all teams in order to help us manage demand on an equitable basis consistent with policy and legislation, and will ensure that the Directorate achieves a balanced position by the end of the year. The Guidelines include ensuring all high cost placements and support packages are reviewed, plus a continued analysis and scrutiny of all requests for waiving of third party top ups to the cost of placements, and rigorous on-going panel arrangements. Furthermore the successful promotion and increased use of enablement continues to result in fewer people needing long term support. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged.

(2) The £2.661m pressure breaks down as follows:
+£0.380m Older People
+£1.876m Learning Disability
+£1.000m Physical Disability
+£0.357m All Adults Assessment & Related
+£0.226m Mental Health
-£0.152m Strategic Management
-£1.060m Strategic Business Support
+£0.034m Other Services
+£2.661m Total

(3) The main movements in the revenue forecast are as follows:

- **+£0.189m Older People Direct Payments** – an increase from an underspend of -£0.131m to a pressure of +£0.058m this month, reflecting a net increase of 23 clients together with increases in one-off payments.

- **-£0.345m Learning Disability Residential** – a reduction in the pressure from +£3.671m to +£3.326m this month, which assumes the transfer of a number of clients back into more community based settings with either a direct payment or into supported living. The reduction also results in part from an increase in the income forecast based on the latest trends of charges made.

- **-£0.243m Learning Disability Other Services** – an increase in the underspend from -£1.069m to -£1.312m this month as a result of small changes to a number of services within this line including day-care, payments to voluntary organisations, Learning Disability Development Framework and Supported Employment.

- **+£0.155m Physical Disability Direct Payments** – an increase in the pressure from +£0.080m to +£0.235m this month following an increase of 18 clients who are in receipt of a direct payment.

- **-£0.246m Strategic Business Support** – an increase in the underspend from -£0.814m to -£1.060m which is spread across a number of teams both at Headquarters and in the two Areas. The reduction in spend reflects vacancy management and further savings against non-pay costs.

- In addition to these variances, there are a number of other smaller variances, each below £0.1m, across all other services which make up a further £0.313m pressure mainly within Older Persons Nursing and Domiciliary care and Learning Disability Direct Payments and Supported Accommodation.

(4) The capital forecast reported to the first quarter's Cabinet meeting was -£5.108m, mainly as a result of further re-phasing against some of the larger projects. Taking the above on board, the KASS capital budget has decreased from £14.456 to £9.714m, a movement of £4.742m. Excluding PFI projects, the forecast for the portfolio has moved by +£0.090m since the last month from -£0.367m to -£0.277m; there have been no major changes to variances.

KASS Debt Position September 2010

4. (1) It was previously agreed that a regular report be presented to update this Committee on the latest debt position for KASS.

Summary Position

5. (1) The overall debt for KASS as at September is £30,654k, of which £13,397k is not yet due for payment, leaving an amount due for payment of £17,257k.

(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	£2,617k
Sundry	£1,963k
Total	£4,580k

(It should be noted that the majority of monies owed by Health is secured through legal agreements)

(4) The client billing debt is currently £17,363k, of which £12,678k is due for payment.

Analysis of Client Related Debt

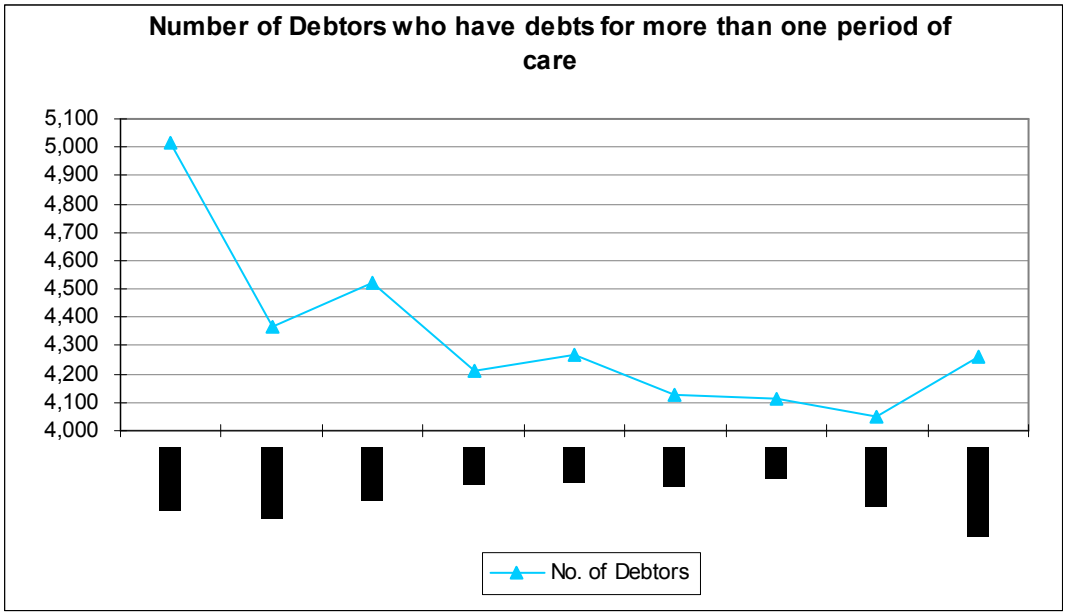
6. (1) The £17,363k client related debt is made up of 12,749 individual debtors, with an average debt of £1,362 each. This compares with £16,866k and 12,580 debtors, with an average of £1,341 each, reported to ASSPOSC in September. The debt for both months is broken down as follows:

Type	September ASSPOSC (July debt) (£000)	November ASSPOSC (Sept. debt) (£000)	Change (£000)
Residential	14,320	14,666	+346
Domiciliary	2,379	2,530	+151
Health Contributions	167	167	0
Total	16,866	17,363	+497

(2) Of the 12,749 debtors, 8,489 (67%) only have a current debt which is not yet due, i.e. all previous invoices have been paid and the only amount to be paid relates to the most recent period of care. This therefore means that 4,260 (33%) have debt for prior periods of care. This split is the same as that reported in September. The following table shows how the number of debtors has changed since January 2010:

Month	No. of Debtors	Change	Change since January
January	5,014	-	
February	4,369	-645	-645
March	4,519	+150	-495
April	4,213	-306	-801
May	4,271	+58	-743
June	4,130	-141	-884
July	4,112	-18	-902
August	4,049	-63	-965
Sept	4,260	+211	-754

This information is presented graphically as follows:



(3) The increase of 211 from August to September has been analysed and it is felt that there is nothing to suggest that the increase is a change in trend, or is a cause for undue concern, as almost all of the clients included in the increase have subsequently paid. Although this report is based on September early indication of the October position has been received and this suggests that the September increase has reduced back down. The position will continue to be closely monitored.

(4) Of the £17,363k only £12,678k is actually due for payment, invoices having only just been dispatched for the remaining £4,685k. Clients and health have 28 days to pay their invoices.

(5) The £12,678k can be broken down between secured and unsecured debt as follows:

• Unsecured – ongoing clients	£5,465k
• Unsecured – terminated/ deceased clients	£923k
Total Unsecured	£6,388k
• Secured with legal charges	£6,172k
• Health contributions	£118k
Overall Total of due debt	£12,678k

Aged Analysis of Unsecured Due Debt

7. (1) Appendix 1 shows an analysis of Unsecured Debt that is due for payment comprising both Ongoing and Terminated/Deceased Debt. The appendix compares the latest position with the position reported last time. Overall the amount of Unsecured Debt that is Due for payment is down £115k from last time which is encouraging.

Analysis of *Ongoing* Unsecured Debt (including Not Yet Due)

8. (1) Appendix 2 shows an analysis of all Unsecured Debt for those debtors who have debts relating to prior periods of care as well as the invoice for the most recent period of care. The appendix includes due and not yet due amounts relating to Ongoing clients, broken down into bands by the value of debt, the number of debtors and the average debt per debtor. The appendix also shows the figures reported last time, together with movements:

Secured Debt

9. (1) During 2009 we carried out a full review of all debts 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.

(2) Of the 4,260 debtors with an outstanding debt 201 of these are secured by a legal charge. The total value of debt for this group is £6,422k which works out at an average of £31,950 each.

Unsecured Deceased/Terminated Debt

10. (1) Of the 4,260 debtors with an outstanding debt, 461 are either deceased or are now no longer receiving a chargeable service. The total value of debt for this group is £936k which works out at an average of £2,030 each.

Bad Debt Provision

11. (1) As at the end of 2009-10 the total bad debt provision for client related debt was £3,972k. 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, which was £2,006k at the end of 2009-10, 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 also allow for specific provisions, which at the end of 2009-10 amounted to £1,966k. 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

12. (1) In 2008-09 £362k of client related debt was written off and this amount was similar in value to that in previous years; there was also £17k of sundry debt written off. However in 2009-10 £421k of client debt and £109k of sundry debt was formally written off. To date in 2010-11 £117k of client debt and £7k of sundry debt has been written off.

Recommendations

13. (1) Members of the Policy Overview and Scrutiny Committee are asked to:

(a) **NOTE** the latest forecast out-turn for revenue and capital.

(b) **NOTE** and **COMMENT** on the latest debt position.

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Background documents: None

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Aged Analysis of Unsecured Due Debt - comparison from September report to November report

Appendix 1

	Under 6 months			Over 6 months			Over 1 year			Total		
	Sep £000	**Nov £000**	**Change £000**	**Sep £000**	**Nov £000**	**Change £000**	**Sep £000**	**Nov £000**	**Change £000**	**Sep £000**	**Nov £000**	**Change £000**
Unsecured – ongoing client debt	2,968	2,979	11	1,045	1,005	-40	1,520	1,480	-40	5,533	5,464	-69
Unsecured deceased/ terminated Client debt	191	163	-28	271	268	-3	507	492	-15	969	923	-46
Total unsecured client debt	3,159	3,142	-17	1,316	1,273	-43	2,027	1,972	-55	6,502	6,387	-115

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Analysis of Ongoing Debt (including Not Yet Due)

Appendix 2

	Last Month (Sep ASSPOSC)			This Month (Nov ASSPOSC)			Change		
Value of debt	**No. of Debtors**	**Total of Debt (£000**	**Average debt (£)**	**No. of Debtors**	**Total of Debt (£000**	**Average debt (£)**	**No. of Debtors**	**Total of Debt (£000**	**Average debt (£)**
Above £25,000.01	29	1,125	38,793	20	804	40,200	-9	-321	1,407
£10,000.01 - £25,000.00	81	1,204	14,864	93	1,366	14,688	12	162	-176
£5000.01 - £10,000.00	174	1,208	6,943	183	1,273	6,956	9	65	14
£1,000.01 - £5,000.00	1,049	2,320	2,212	1,110	2,423	2,183	61	103	-29
£1000.00 and below	2,060	637	309	2,170	722	333	110	85	23
Totals	3,393	6,494	1,914	3,576	6,588	1,842	183	94	1,239

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To: Adult Social Services Policy Overview & Scrutiny Committee – 16 November 2010

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

Subject: BUDGET 2011/12 AND MEDIUM TERM FINANCIAL PLAN 2011/12 TO 2012/13

Classification: Unrestricted

Summary: This report identifies the proposed strategy for determining next year's budget and the financial plans for the following years. This includes an initial analysis of Spending Review 2010, the likely impact on the overall funding for KCC, the indicative cash limit for the Adult Social Services portfolio, and the latest indications of likely pressures facing the Adult Social Services portfolio.

Recommendation: Members are asked to review and comment on the pressures outlined for the Adult Social Services portfolio and to identify their priorities in order to meet the indicative cash limit.

FOR COMMENT

1. Introduction

1.1 The Autumn Budget Statement is due to be presented to Cabinet on 29th November 2010 and will set out the proposed budget strategy following the Spending Review announcement on 20th October. Even after the Spending Review announcement we will not know the full impact on the County Council's grants until we get the provisional Local Government Finance settlement. Indications are that we will not receive this settlement information until early December.

1.2 The Spending Review and Local Government Finance announcements will give us the final detail but we have been planning based on a likely scenario of a 5% per annum reduction in cash terms in Government grants. This assumption was based on the Chancellor's statement in his emergency budget that unprotected spending departments should plan for a 25% reduction in real terms from the forthcoming spending review.

1.3 The overall position for the County Council was that we estimated the combination of reduced grant allocations and demands for budget pressures would amount to a gap of £340m over the next four years. The gap for the next two years was estimated at £136m.

2. Background

2.1 Provisional cash limits for 2011/12 and 2012/13 were approved by the County Council on 18th February 2010 in the Medium Term Plan (MTP) for 2009/12. The approved MTP for the Adult Social Services portfolio is included as appendix 1. These provisional cash limits will be updated for known changes such as transfers of activities or staff between portfolios and identified as base budget adjustments in monitoring reports.

2.2 We are proposing that the provisional cash limits are updated for unavoidable pressures. These may be new pressures, changes to pressures identified in the existing published MTP, or resisting previously identified pressures. In all cases the amounts included as budget pressures have been thoroughly scrutinised to ensure only legitimate unavoidable pressures have been included in cash limits. Any pressures arising from individual portfolio proposals which are not unavoidable will have to be met within existing cash limits through corresponding savings elsewhere in the portfolio.

2.3 Portfolios have been set targets for budget savings via the indicative cash limits on a priority-led basis to target savings according to highest relative spend and KCC priorities for services as outlined in the consultative document "Bold Steps for Kent". In setting these targets we have been clear that we need to drive out as much as possible from efficiency savings. These indicative cash limits are intended to give members and officers an indication of the magnitude of the savings needed in order to close the £136m gap and will be revised before the draft budget is published to take account of the specific proposals contained therein.

2.4 The revised indicative cash limit for the Adult Social Services portfolio is summarised in table 1 below.

Table 1	2011/12 £000s	2012/13 £000s	Total £000s
Existing Approved MTP			
Base	344,452	343,081	**344,452**
Base Adjustments	-8	-1	**-9**
Pressures	10,196	11,172	**21,368**
Savings & Income	-4,045	-4,142	**-8,187**
Total Existing MTP	**350,595**	**350,110**	
New Base Budget Adjustments	18	0	**18**
New & Changed Pressures	3,282	3,282	**6,564**
Savings Target	-10,814	-13,218	**-24,032**
Proposed Cash Limit	**343,081**	**340,174**	

3. Latest Developments: National Context

3.1 The outcome of the Spending Review 2010 was announced on 20th October and set out the Government's **national spending plans** for 2011/15. The Spending Review gives us an overall indication of the Government's spending priorities by department but does not give us detailed grant settlements. We are anticipating provisional grant settlements in early December.

3.2 The overall spending plans are in line with the reductions outlined in the emergency budget in June and the spending review just gives us a clearer indication which departments are to be protected and when reductions will start to bite for different Government departments. The announcements on Formula Grant for local authorities show that the reductions are front loaded with the biggest reductions in 2011/12.

3.3 Other than Formula Grant (which now includes the transfer of Area Based and specific grants into the Formula Grant) we do not have any information on the scale of reductions in other government grants or when the reductions might hit. At this stage we are assuming these reductions will be in line with ministerial statements on the average reduction.

3.4 The Spending Review announcement includes a confusing comparison of cash reductions in Government Department spending (referred to Department Expenditure Limits) and quoted real terms reductions in grants. Ministers have stated that councils will face an average loss of grant of 7.25% in real terms in each of the next 4 years, although we are concerned that the front loading of reductions in Formula Grant will mean that this average could disguise in year differences. The impact of distributional changes as Area Based and specific grants are transferred into the formula (as well as changes to the formula methodology) are also likely to result in further variations from this average for individual authorities.

3.5 As outlined in paragraph 3.2 we do know the cash reductions in Formula Grant. This shows a reduction of £4.1bn over the next two years (14.4%) and £5.6bn over the four years (19.6%). These reductions **include** the extra £1bn for personal social services and the £0.7bn Council Tax Freeze Grant.

3.6 In summary the Spending Review has confirmed the following changes to the national funding arrangements for local government:

- The overall reduction in grants to councils of an average of 7.25% in real terms in each of the next 4 years.
- Reduction in the baseline Formula Grant of £7.2bn reduction in cash terms over the next four years but with savings front loaded into 2011/12. This equates to a 29.2% reduction in cash terms (35.6% real terms) over four years with 22.4% cash reduction (25.6% real terms) in the first 2 years

- Transfer of £3.4bn of Area Based and Specific Grants into Formula grant. These transferred grants are subject to differential increases or reductions over the two/four year period which marginally change the overall reductions
- The allocation of a new £1bn grant for Social Services within the Formula Grant (with a further £1bn to be administered as a specific grant from Department of Health)
- The allocation of a new £0.7bn grant to honour the pledge to support councils in freezing Council tax increases for 2011/12. This grant provides funding for the four year period and thus earlier fears that a freeze would not be sustainable have been alleviated for this spending review period.
- The transfer of Area Based Grants, and Specific Grants, into the Formula Grant, carries with it the risk of KCC losing approximately £5m in respect of Preserved Rights clients. In 2010/11 we received £10.6m based on the actual clients and this represents about 4.5% of the national grant, however our share of formula funding is perhaps 2.2% in which lies the risk. Kent's loss would be the biggest in the country as we still have significantly greater numbers than anyone else. There will also a reduction in the value of Preserved Rights funding over four years by 11% based on an assumption for attrition. However the people left are generally the younger adults with a Learning Disability for whom attrition rates will be relatively low. There is also a tendency for individual costs to increase as needs are becoming more complex over time.
- The Learning Disability Transfer may also end up being funded through the Relative Needs Formula, which carries a similar financial risk to Preserved Rights. Again we will have significantly more clients than our 2.2% share of the Formula would suggest and the potential shortfall in funding could be approximately £4.7m. However, at this stage this has not been explicit in the Spending Review, although it remains a potential risk.
- The Supporting People Area Based Grant also transfers into the Formula Grant which carries a similar risk to that already identified for Preserved Rights and the Learning Disability Transfer.
- The mobility component of Disability Living Allowance will be removed from people after four weeks in local authority funded residential care from 2012/13. Alongside leaving the residents with less money to maintain any limited independence they may have, this could have an impact where a home pools the mobility money to provide transport for outings; providers may come back to KASS for additional funding.
- Anyone on one of the old incapacity based benefits will be reassessed to see if they qualify for the new Employment Support Allowance, the process for which is tougher than for existing benefits. Although our service users are probably the most in need of such a benefit, there is no guarantee that they will all easily transfer to the new benefit. If they fail the assessment then they will have to claim the lower Job Seekers Allowance (or find a job) which could impact on charging.

- The Department for Communities and Local Government has removed the ring fencing from the Disabled Facilities (Capital) Grant and has protected the amount. However removing the ring fencing is a big risk in Two Tier areas like Kent as the grant is given to housing authorities, i.e. districts and borough councils, who are struggling with their own financial challenges. There is a risk that some of this funding will be diverted to other priorities, which may impact on the number of individuals who can continue to be supported in their own homes, through adaptations and improvements.
- The significant reduction in the social care housing capital budget could be a risk to Private Finance Initiative schemes.
- A new public health grant will be introduced from 2013.

3.7 Over the last 2 years inflation initially declined in the wake of the recession in autumn 2008/winter spring 2009 but has been rising since autumn 2009 and has only recently started to marginally decline. Throughout the period other than for a brief period in summer 2009 inflation has exceeded the Government's 2% target for CPI. Inflation remains as one of the most significant pressures on our budgets and resisting inflationary pressures through negotiating with suppliers remains a key strategy to balance the budget.

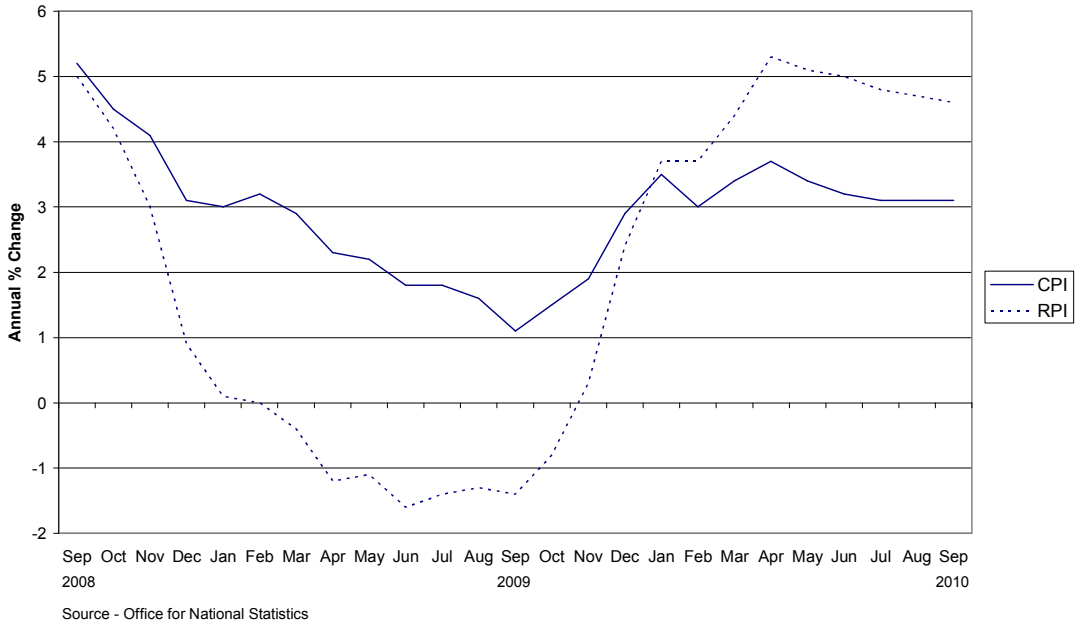
3.8 There are different indices used to measure inflation which enable an annual rate of underlying inflation to be calculated:

Retail Price Index (RPI) – This is the traditionally accepted measure for inflation and has been calculated continuously since June 1947. In the past it is used by the government to update pensions, benefits and index-linked gilts. However, in his Emergency Budget the Chancellor announced that in future all benefits, tax credits and public sector would be updated by CPI rather than RPI (with a guaranteed increase of at least 2.5% for state pensions). RPI is still commonly used to update contracts, and is often taken into account in wage bargaining

Consumer Price Index (CPI) – This is the measure now adopted by Government for targets on the economy. It is based on harmonised consumer index prices (HCIP) and enables comparison on internationally agreed standards throughout Europe. It does not include mortgage interest or indirect taxes but does include some financial services not included in RPI.

Beneath the headline figures for RPI and CPI there are detailed indices for individual areas of spending such as energy, housing, food, etc. We use projections of the detailed indices in determining inflationary pressures rather than the general all items index (for some contracts we use specific indices where these are written into the contract terms).

3.9 The chart below shows the changes in the all items indices of inflation over the last 2 years.



Source - Office for National Statistics

4. Revenue Budget Strategy

4.1 Following the Spending Review announcement we have reviewed our assumptions about the overall gap. We remain confident at this stage that our overall strategy for a gap of £340m over four years is still realistic. However, in light of the front loading of the reductions in Formula Grant we are now estimating that the magnitude of savings needed to balance estimated grant reductions and pressures for 2011/12 and 2012/13 is £153m. At this stage this revision to the targets for the first two years has not been reflected in the indicative cash limits subject to confirmation of provisional grant settlements in early December.

4.2 In order to remain within the indicative cash limit the KASS Directorate is looking to maximise its efficiencies and resist pressures wherever possible.

4.3 **Areas of Efficiencies include:**

- reducing transactional costs, with further developments in e-commerce;
- using technology to redesign more efficient services (telehealth) and enable self management of support;
- improving the collection of management & performance information (SWIFT);
- Joint pathways into services, single assessment process and self assessment;
- Enabling people to have access to services through Kent Contact Assessment Service (KCAS), single assessment, self assessment, and 'fast track' provision of equipment;
- Modernisation of services;

- Total Place - The Directorate is playing a key role in the work being undertaken by KCC to pilot this national initiative;
- Working with the market to ensure the delivery of good quality, value for money services;
- reviewing staffing levels and looking to streamline back office functions and reduce management costs, although it should be remembered that the Directorate has previously taken out 12% of its management costs.

4.4 **Effective Preventative Services:** the development of preventative services is a key priority of the Directorate to alleviate the impact of demographic growth. The key areas which will continue to be focussed upon are:

- Continuing to develop and extend enablement services;
- Building upon and mainstreaming recent innovations such as INVOKE, Brighter Futures;
- The number of older people with dementia has increased and is expected to further increase significantly. Joint work with the NHS is in place to develop a range of community/support services for people with dementia and their carers/families. This will need further development to meet the predicted demand;
- A key area of work is working with the Health Service to develop pathways of support focusing on Strokes and Falls;
- Continued development of community based services to support people with Learning disabilities, physical disabilities and mental health problems.

4.5 **Increased Partnership working**:

- Increased joint commissioning with the NHS and development of integrated commissioning arrangements. There are new opportunities within new Health White Paper around working with new Community Trusts, GP Consortia, and the scope to combine some back office and support functions;
- Working with the District Councils on a number of housing schemes providing accommodation for people with a whole range of needs including the development of “PFI 2” to deliver 228 units of social housing for vulnerable adults;
- The Directorate has a strong relationship with the Voluntary and Private Sector with around 85% of services being purchased from outside the Directorate and we will continue to build upon partnerships with the Private and Voluntary Sector.

5. The current budget and medium term priorities

5.1 The current budget for the portfolio(s) under the oversight of this POSC is as follows:

	Gross spend £'000	Income £'000	Net spend £'000
Portfolio controllable	467,134	-122,545	344,589

Further detail is outlined in Appendix 1.

5.2 In very brief summary this budget provides for the following outcomes, outputs and/or service improvements:

- Approximately 145,400 weeks of permanent residential care for Older People (excluding preserved rights) within the independent sector supporting 2,817 clients as at September 2010, with nearly 10,000 weeks of non-permanent care

- 73,700 weeks of permanent nursing care for Older People within the independent sector supporting 1,405 clients as at September 2010, with a further 5,500 weeks of non-permanent care

- 2,476,500 hours of domiciliary care for Older People provided through the independent sector supporting 6,200 people

- Approximately 35,900 weeks of residential care for people with a Learning Disability (excluding Preserved Rights) within the independent sector supporting 697 clients in permanent placements as at September 2010. Also approximately 31,400 weeks of residential care supporting 599 preserved rights clients as at September 2010

- About 12,100 weeks of permanent residential care for people with a Physical Disability within the independent sector supporting 222 clients as at September 2010

- 2,710 people of all client groups with an on-going direct payment between October 2009 and September 2010

- 252 Mental Health clients in residential care as at September 2010

- Occupational Therapy and Sensory Disability Services working in partnership with Health, Hi Kent and Kent Association for the Blind to provide over 56,000 items of equipment in 2009/10.

- Care Managers and Mental Health Social Work staff carrying out almost 33,800 assessments for new clients in 2009/10, and almost 35,000 clients reviewed overall.

Further detail is outlined in Appendix 2.

5.3 As reported in the quarterly monitoring reports there are spending pressures/savings in the following areas:

- £3,518k pressure relating to gross expenditure on Learning Disability residential placements in the independent sector, where the number of clients and average cost per week are higher than affordable levels.

- £920k similar pressure relating to gross expenditure for Mental Health residential independent sector care.

- £324k pressure relating to gross expenditure for independent sector residential care for the Physically Disabled, due to the average cost being higher than affordable.

- A saving of £830k following the release of the uncommitted balance of the Managing Director's contingency to compensate pressures in the overall position.

- A saving of £520k following the release of uncommitted and contingent funding within Mental Health.

- A saving of £490k related to Older Persons In House Domiciliary Gross expenditure, due to client numbers being below the affordable level.

There is an overall pressure for the Directorate of £2,838k and the expectation is that this will be managed down through the application of Guidelines for Good Management Practice. These are in place across all teams and will help us manage demand on an equitable basis consistent with policy and legislation.

Further detail is outlined in Appendix 3.

5.4 As outlined in the proposed cash limits we are proposing to provide additional funding of £13.5m for 2011/12 and £14.5m over the next two years to cover unavoidable pressures including the following:

- **£17.5m for demand/demographic led pressures:** the current pressures within all services indicate that at least £8.73m is required for demography in 2011/12 and future years. This calculation is based on comparing the movement in client activity and unit cost between 2008/09 and 2009/10 after adjusting for an inflationary uplift. The increase represents both the likely growth in client numbers but also the changing needs and complexity of cases. The calculation does assume that any increase is similar to an historical trend. The growth figure assumed on expenditure for younger adults is similar to the percentage increase being seen nationally.

- **£9.6m prices for Social Care provision:** the current indicative cash limits assumes an inflationary uplift of 1.5% for providers in 2011/12 and 1.8% in 2012/13, however these may now need to be reviewed in light of the Spending Review.

- **£0.9m for Other Prices and Pressures:** this includes £0.8m for pressures in relation to transport, gas and electricity and increases in other prices, as well as £0.1m for the increased costs of enhanced checks by the Criminal Records Bureau.

6. Recommendation

6.1 Members are asked to

(i) note the latest information arising from the Spending Review 2010
(ii) comment on the proposed additional funding for pressures included in the indicative cash limits and outlined in paragraph 5.4
(iii) identify priorities for delivering the indicative cash limits

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Appendix 1 – Existing 2010/13 Medium Term Plan

Adult Social Services Portfolio Revenue Budget	Staffing FTE	2010-11 £'000	2011-12 £'000	2012-13 £'000
Base budget		**340,061**	**344,452**	**350,595**
Base Budget Adjustments - Internal:		-197	-8	-1
Base Budget adjustments- External:		87	0	0
Total Base Adjustments		**-110**	**-8**	**-1**
Revised Base Budget		**339,951**	**344,444**	**350,594**
PRESSURES:				
Pay:				
Non-Kent Scheme (non DSG)		0	0	0
		0	**0**	**0**
Prices:				
Transport		110	114	118
Social Care Provision		0	4,324	5,241
Gas & Electricity		-140	111	207
Other		97	99	120
		67	**4,648**	**5,686**
Unavoidable Government/Legislative Pressures:				
Non DSG:				
CRB Checks		100	100	38
		100	**100**	**38**
Total Unavoidable Government/Legislative Pressures		**100**	**100**	**38**
Demand/Demographic Led:				
Non DSG:				
Increased demand for services - all client groups - originally in 08-09 MTP		6,460	5,448	5,448
		6,460	**5,448**	**5,448**
Total Demand/Demographic Led		**6,460**	**5,448**	**5,448**
Service Strategies & Improvements:				
Non DSG:				
CAB one-off		-250	0	0

	Staffing FTE	2010-11 £'000	2011-12 £'000	2012-13 £'000
		-250	**0**	**0**
Total Service Strategies & Improvements		**-250**	**0**	**0**
Total Pressures: Non DSG		**6,377**	**10,196**	**11,172**
Total Pressures: DSG		**0**	**0**	**0**
Total Pressures		**6,377**	**10,196**	**11,172**
SAVINGS AND INCOME:				
Grant Increases:				
Total Grant Increases		**0**	**0**	**0**
Income Generation:				
Non DSG				
Inflationary uplift of client income - at 2%, 1.5% and 1.8%		-1,139	-863	-1,045
Inflationary uplift of other income - at 0%, 1.5% and 1.8% (mainly Health; this will need to net off against any changes to the prices assumptions)		0	-243	-294
		-1,139	**-1,106**	**-1,339**
Total Income Generation		**-1,139**	**-1,106**	**-1,339**
Savings and Mitigations				
Non DSG:				
FYE Management Saving		-420	0	0
Retirement Savings		-45	-23	-26
Streamline back office support functions	-45	0	-1,517	0
Transactional Finance savings	-7	0	-109	-109
Better targeting of spend on Property Maintenance		-58	0	0
CED Delegated				
Services provided by CED		-214	-232	0
Target reduction in net spend			-1,058	-2,668
		-737	**-2,939**	**-2,803**
Total Savings and Mitigations		**-737**	**-2,939**	**-2,803**
Total Savings and Income		**-1,876**	**-4,045**	**-4,142**
Budget controlled by this portfolio		**344,452**	**350,595**	**357,624**

Appendix 1 – Current Portfolio Revenue Budget (including adjustments/ virement agreed at Cabinet in September)

ADULT SOCIAL SERVICES

REVENUE SPENDING

2009-10 Spending Plans £'000	Spending Plans	2010-11 Gross £'000	Income £'000	Net Cost £'000		Managing Director
	Older people:					
54,854	Residential Care	87,616	-33,310	54,306	The commissioning of services for older people from both in-house units and the independent sector, including occupational therapy equipment.	OM
23,828	Nursing Care	45,690	-21,078	24,612		
38,732	Domiciliary Care	47,498	-10,044	37,454		
3,917	Direct Payments	5,062	-532	4,530		
16,979	Other Services	20,187	-3,137	17,050		
138,310	**Total Older People**	**206,053**	**-68,101**	**137,952**		
	People with a Learning Disability					
55,341	Residential Care	71,361	-18,794	52,567	The commissioning of services for people with learning disabilities from both in-house units and the independent sector.	OM
6,506	Domiciliary Care	7,393	-1,122	6,271		
5,890	Direct Payments	7,865	-143	7,722		
6,503	Supported Accommodation	23,317	-12,643	10,674		
18,137	Other Services	21,603	-1,232	20,371		
92,377	**Total People with a Learning Difficulty**	**131,539**	**-33,934**	**97,605**		
	People with a Physical Disability:					
10,479	Residential Care	12,526	-1,951	10,575	The commissioning of services for people with physical disabilities from both in-house units and the independent sector, including occupational therapy equipment.	OM
7,109	Domiciliary Care	7,661	-449	7,212		
6,121	Direct Payments	7,132	-249	6,883		
405	Supported Accommodation	394	-8	386		
4,903	Other Services	5,805	-896	4,909		
29,017	**Total People with a Physical Disability**	**33,518**	**-3,553**	**29,965**		
34,414	All Adults - Assessment & Related	37,292	-2,020	35,272	Social Work & related costs (excluding Mental Health). Includes Occupational Therapy staff, Specialist Finance Teams, County Duty Service and Out of Hours service.	OM

2009-10 Spending Plans £'000	Spending Plans	2010-11 Gross £'000	Income £'000	Net Cost £'000		Managing Director
	Mental Health Service:					
5,618	Residential Care	6,416	-882	5,534	Commissioning & providing specialist mental health services through collaborative working with the Kent & Medway NHS & Social Care Trust.	OM
903	Domiciliary Care	623		623		
386	Direct Payments	606		606		
292	Supported Accommodation	435		435		
9,184	Assessment & Related	10,001	-876	9,125		
5,641	Other Services	7,180	-902	6,278		
22,024	**Total Mental Health Service**	**25,261**	**-2,660**	**22,601**		
341	Gypsy & Traveller Unit	662	-333	329	Provide, maintain & manage local authority site provision for gypsies and travellers in Kent.	OM
100	People with no Recourse to Public Funds	100		100		OM
1,303	Strategic Management	1,249	-27	1,222	Strategic management costs within Adult Services.	OM
21,325	Strategic Business Support	24,673	-2,007	22,666	Performance management, planning, development, contracting & policy, training facilities, legal costs, pensions, finance, personnel, information systems & public private partnerships, and Facilities Management.	OM
7,462	Support Services purchased from CED	6,787		6,787	Property, Finance, HR and ISG support services purchased from CED.	OM
-6,612	Specific Grants		-9,910	-9,910	Specific Grant income from DoH and DCLG.	OM
340,061	**Budget Controlled by this Portfolio**	**467,134**	**-122,545**	**344,589**		
	PLUS: Budgets controlled by other portfolios:					
5,271	• Central costs • Devolved budgets • Service costs	5,271		5,271		
4,599	Charges for using capital assets	4,599		4,599		
349,931	**TOTAL SERVICE COSTS**	**477,004**	**-122,545**	**354,459**		

Appendix 1 – Current Portfolio Subjective Revenue Budget (including adjustments /virement agreed at Cabinet in September)

REVENUE SPENDING

2009-10 Spending Plans £'000		2010-11 Spending Plans £'000
	Employee Costs	
97,660	Salaries and Wages	98,997
1,695	Pension and Severance Payments	1,125
3,004	Training Expenses	2,919
31	Other Employee Costs	53
102,390	**Total Employee Costs**	**103,094**
	Premises Costs	
817	Repairs, Alterations and Maintenance	842
936	Energy Costs	891
848	Rent	1,017
1,062	Rates	841
975	Other Premises Costs	1,032
4,638	**Total Premises Costs**	**4,623**
	Transport Costs	
159	Vehicle Running Costs	145
967	Hire and Pool Car Charges	985
	Home to School / College Transport	
1,300	Public Transport (Clients)	1,321
3,346	Members and Staff Car Allowances and Travel Expenses	3,355
5,772	**Total Transport Costs**	**5,806**
	Supplies and Services	
2,057	Equipment, Supplies and transfer payments	2,326
	Book Fund	
1,666	Communications and Computing	1,665
119	Members and Staff Expenses (Excl. Travel)	148
26	Grants and Subscriptions	25

2009-10 Spending Plans £'000		2010-11 Spending Plans £'000
354	Levies and Other Costs	424
	Free School Meals	
3,349	Social Services Payments	4,093
	Examination Fees	
676	Professional Fees	543
	Service Agency Agreements	
	PFI Development Costs	250
8,247	**Total Supplies and Services**	**9,474**
	Third Party Payments	
	Highways Contracts	
	Waste Contracts	
	Transport Contracts	
303,386	Social Care Contracts	335,762
	Other	
303,386	**Total Third Party Payments**	**335,762**
13,772	Central Support Costs & Internal Recharges	16,667
4,599	Capital Financing Costs	3,572
	Capital Expenditure Financed by Revenue	
	Contribution to/from(-) Reserves	
442,804	**GROSS EXPENDITURE**	**478,998**
	Income	
-27,374	Contributions	-45,935
-1,677	Sales	-1,447
-55,432	Fees and Charges	-61,939
-487	Other Income	-403
-1,585	Internal Income	-2,912
-86,555	**Total**	**-112,635**
-6,612	Specific and Supplementary Grants	-9,910
-93,167	**TOTAL INCOME**	**-122,545**
349,637	**NET EXPENDITURE**	**356,453**

Appendix 2 – Activity and output data – what the current budget "buys"

- Providing 517 residential and 56 nursing beds for Older People in 16 KCC homes

- Over 1,650 day-care places for Older People per week across 18 KCC sites

- 88 respite beds across five KCC sites for People with a Learning Disability

- Approximately 6,000 clients receiving a service as at the end of 2009/10 from a voluntary organisation that is supported via a grant or service agency agreement

- Approximately 4,300 day-care places per week across 26 KCC sites for People with a Learning Difficulty

- Paying nursing homes for approximately 1,500 clients in receipt of Registered Nursing Care Contribution funded by Health

- Over 330,000 hours of domiciliary care from the independent sector for People with a Learning Disability

- Approximately 20,400 weeks of supported accommodation for People with a Learning Disability

- Approximately 555,000 hours of domiciliary care from the independent sector for People with a Physical Disability

- 370,000 hot meals were delivered during the year 2009/10 to people in their own homes

- 14,600 referrals to the Occupational Therapy service during 2009/10

- All Adults Assessment and Related staffing (including Learning Disability, Sensory Disability, and former Occupational Therapy staff) with 842 FTEs; and 268 FTEs within Mental Health Assessment and Related and Community Services

- Gypsy & Traveller service supporting 150 households on ten sites and one managed encampment, and managing all the unauthorised encampments on KCC land

Appendix 3 – Current budget monitoring details

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	87,616	-33,310	54,306	663	-88	575	Price pressures due to dementia; staff cover for in-house; additional client/health income
- Nursing Care	45,690	-21,078	24,612	-260	24	-236	Activity below affordable level
- Domiciliary Care	47,498	-10,044	37,454	-239	60	-179	Activity in independent in excess of affordable offset by underspend on in-house
- Direct Payments	5,062	-532	4,530	-97	-34	-131	
- Other Services	20,187	-3,137	17,050	-156	-7	-163	Small underspends on a number of lines
Total Older People	206,053	-68,101	137,952	-89	-45	-134	
People with a Learning Disability:							
- Residential Care	71,361	-18,794	52,567	3,777	-106	3,671	Demographic and placement pressures
- Domiciliary Care	7,393	-1,122	6,271	-85	-96	-181	
- Direct Payments	7,865	-143	7,722	97	-40	57	
- Supported Accommodation	23,317	-12,643	10,674	29	-119	-90	Demographic and placement pressures
- Other Services	21,603	-1,232	20,371	-981	-88	-1,069	Releasing of Managing Director's continency to offset overall pressure; number of small underspends
Total People with a LD	131,539	-33,934	97,605	2,837	-449	2,388	
People with a Physical Disability							
- Residential Care	12,526	-1,951	10,575	224	253	477	Demographic and placement pressures
- Domiciliary Care	7,661	-449	7,212	98	23	121	
- Direct Payments	7,132	-249	6,883	95	-15	80	
- Supported Accommodation	394	-8	386	73	-12	61	
- Other Services	5,805	-896	4,909	-88	3	-85	
Total People with a PD	33,518	-3,553	29,965	402	252	654	
All Adults Assessment & Related	37,292	-2,020	35,272	334	95	429	Reduced turnover
Mental Health Service							
- Residential Care	6,416	-882	5,534	854	289	1,143	Forecast activity in excess of affordable level; increased proportion of S117 clients who do not contribute to costs
- Domiciliary Care	623		623	28	0	28	
- Direct Payments	606		606	-176	0	-176	Less than expected activity
- Supported Accommodation	435	0	435	94	0	94	
- Assessment & Related	10,001	-876	9,125	-95	30	-65	
- Other Services	7,180	-902	6,278	-523	-97	-620	Releasing of Managing Director's contingency/ other uncommitted monies to offset overall pressure
Total Mental Health Service	25,261	-2,660	22,601	182	222	404	
Gypsy & Traveller Unit	662	-333	329	60	-55	5	
People with no recourse to Public Funds	100		100	0	0	0	
Strategic Management	1,249	-27	1,222	-94	0	-94	
Strategic Business Support	24,673	-2,007	22,666	-905	91	-814	Uncommitted funding released; vacancy management; non pay savings; grant funded posts
Support Services purchased from CED	6,787		6,787	0	0	0	
Specific Grants		-9,910	-9,910	0	0	0	
Total Adult Services controllable	**467,134**	**-122,545**	**344,589**	**2,727**	**111**	**2,838**	
Assumed Management Action				**-2,838**		**-2,838**	
Forecast after Mgmt Action				**-111**	**111**	**0**	

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 – 16 November 2010
Subject:	**MID YEAR RESULTS FOR PERFORMANCE 2010-11**
Classification:	Unrestricted

Summary: This report updates Members on the results for Kent Adult Social Services' performance indicators.

Introduction

1. (1) The Adult Social Services Directorate has a statutory duty to provide performance information to the Department of Health on an annual basis. A wealth of information is provided via a number of statutory data returns, which produces our performance indicators. In addition, the Self-Assessment Statement provides information about all aspects of our approach to strategic management, policy, service management, planning and customer care across all client groups. Regular meetings with our Care Quality Commission (CQC) colleagues also provide the opportunity for discussion about the issues the Directorate faces and our plans to maintain or improve performance.

(2) The performance indicators are an important part of the Performance Assessment Framework for each Local Authority, although not the whole story as explained above. They are assessed by CQC and form part of the annual assessment cycle, which culminates in the Annual Review Meeting with the CQC Business Relationship Manager and the Regional Director.

(3) This year has been only the third year of a new national performance framework but it should be noted that there are still some outstanding issues with the way in which some of the information is being collected which makes comparison with the previous years difficult. This is explained below.

(4) The new framework was intended to see a reduction in the number of indicators required for each Local Authority, but focuses on the areas of performance that would evidence better outcomes for service users.

(5) This new streamlined approach fits with the personalisation of social care more appropriately than the old framework and was welcomed by Kent.

(6) The Department of Health intended for Local Authorities to experience a reduced burden in producing statistics. Although the performance indicators are reduced, the resource needed to produce the statistical information which underpins this has not reduced significantly.

Results for Mid Year 2010-11

2. (1) Mid year performance is not reported to the Department of Health as part of the annual statutory returns. However, we continue to monitor the key indicators on a regular basis. The results of both the 2009-10 results and the mid year position for 2010-11 can be seen in Appendix A, which outlines what each indicator measures.

(2) With the restructure of the Directorate for the implementation of Self Directed Support in October 2009, the results represent some good progress against some of our key priorities. In particular, the Directorate has delivered:

- A significant increase since 2009-10 results of 3,909 to over 5,199 people receiving a personal budget or direct payment during the first half of 2010-11. This equates to an increase of over 33% within the first 6 months of the year.

- The Directorate assessed 33,781 people during 2009-10. During 2010-11 we forecast we will assess 36,088 people, which is a 6% increase.

- During 2009-10 there were over 15,000 carers with a service, support or advice. Kent is one of the top performing authorities for carer performance. This information is not yet available at mid year.

- 80% of older people receiving intermediate care after discharge from hospital are living at home independently three months later, which is above target for our Local Area Agreement (LAA) and an improvement of 2% on the 2009-10 outturn.

- People continue to be supported to live at home. Although not a performance indicator, it is worth noting that 5% more older people have been helped to live at home in 2009/10 than the previous year, the Directorate placed 7% fewer older people in a permanent residential or nursing care placement.

- Although not a performance indicator, it is also worth noting that over 1700 people have been supported through an enablement service since the introduction of Self Directed Support.

(3) As mentioned above there are some issues with the indicators, both in terms of the definitions and also in terms of how meaningful the indicators are.

- Indicators relating to timeliness (NI132 and NI133), both timeliness of assessments and care packages are likely to continue to either stay the same or decrease in time. The reason for this relates to the implementation of Self Directed Support. Self Directed Support enables people to take control of their own assessment and also their own packages of care and support. This means that people have the ability to choose their own timescales. The Department of Health have acknowledged this, and have confirmed that both of these indicators have been dropped from the National Indicator Set from 2010-11.

The Assessment process

3. (1) In past years, the assessment outcome following the Annual Review with CQC fed directly into the CAA (Comprehensive Area Assessment) process. However, now the CAA has been withdrawn, we are awaiting clarification of how CQC will continue to assess adult social care in light of this decision.

(2) We expect that CQC will continue to assess our overall performance, as in previous years, together with additional evidence that we have provided to demonstrate the progress we have made at a local level for achieving better outcomes for people. This includes service user involvement, preventative and rehabilitation services, safeguarding, quality of services and promoting personalisation and choice. However, this will depend on CQC's considerations, together with the Department of Health and Directors of Adult Social Services.

(3) The Rt Hon Eric Pickles released further guidance on changes to Local Authority Performance Arrangements on 13 October 2010 about the future of LAA. This gives authorities the freedom to drop or amend any current LAA targets. These targets will not now be monitored by the Department for Communities and Local Government. However, we are still required to collect data for NI 125 as part of the National Indicator Set (NIS) as it will inform both KASS and the PCT's judgements.

(4) The further guidance also suggests there will be a replacement of the NIS, with a single comprehensive list of data central government requires from local government. This is still in consultation and any changes are not likely to come into effect for this current financial year's information requirements.

Recommendations

4. Members are asked to NOTE KASS's performance indicators for mid year.

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Background documents: None

APPENDIX A

New Kent Adult Social Services Performance Indicators 2010-11								
Indicator	**Title**	**Description**	**2008-09 Result**	**2009-10 Target**	**2009-10 Result**	**2010-11 Mid Yr Position**	**2010-11 Target**	**Comment**
NI 125	Achieving independence for older people through rehabilitation/ intermediate care (LAA)	Percentage of Older People who are in their own homes three months after receiving intermediate care	**75%**	**77%**	**78%**	**80%**	**79%**	This is our LAA target
NI 130	Social care clients receiving Self Directed Support (Direct Payments and Individual Budgets)	Percentage of all clients receiving a personal budget	**5%**	**8%**	**9%**	**12%**	**30%**	Over 5,199 people are now in receipt of a personal budget
NI 132	Timeliness of social care assessments	Percentage of assessments that take place within 4 weeks	**83%**	**85%**	**83%**	**83%**	**83%**	Maintained timeliness
NI 133	Timeliness of social care packages	Percentage of care packages delivered within 4 weeks	**95%**	**95%**	**87%**	**87%**	**87%**	Although there is a decrease in the timeliness of care packages, this is due to the implementation of Self Directed Support and described in more detail in the main report
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Percentage of service users who have a carer receiving support	**29%**	**29%**	**40%**	**N/A**	**40%**	This information is only calculated on an annual basis. However, KASS have maintained high levels of support to carers.
NI 136	People supported to live independently through social services (all ages)	The number of adults (18 and over) per 100,000 population that are assisted directly through social services funded support to live independently, plus those supported through grant funded services from local government	**3,062**	**3,062**	**3,339**	**3339**	**3,339**	Maintaining levels of people supported independently. This will not include the increasing number of people that have been successfully enabled to return home without a care package.
NI 145	Adults with learning disabilities in settled accommodation	Percentage of people with a learning disability in settled accommodation	**37%**	**40%**	**69%**	**70%**	**75%**	Improved stability
NI 146	Adults with learning disabilities in employment	Percentage of people with a learning disability in employment	**10%**	**11%**	**5%**	**5%**	**8%**	Reduction in percentage relates to the definition change during 2009-10

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 – 16 November 2010
Subject:	**LIVE IT WELL – MENTAL HEALTH STRATEGY FOR THE NEXT 5 YEARS**
Classification:	Unrestricted

Summary:	To provide an update on progress for Members; to ask for endorsement of the new suicide prevention strategy developed by the Public Health lead for the Primary Care Trust (PCT) commissioning team for mental health; and to invite comments.

Introduction

1. (1) The draft "Live it Well" strategy was presented to Members at the Adult Social Services Policy Overview and Scrutiny Committee of 30 March 2010. It set out the strategy for delivering Kent's mental health services for the next 5 years as a more personalised approach which focuses on prevention, health and wellbeing and improving access and reducing discrimination and stigma.

(2) Members resolved that the strategy be welcomed; and asked for their comments to be taken into account in producing the final report. These included the need for joint training with GPs to help them identify mental health issues; the importance of good housing provision for clients with mental health issues and more emphasis on reducing the number of suicides.

Progress since March

2. (1) The strategy has now been finalised and a public launch was held by Medway PCT, who take the lead for mental health commissioning for Kent and Medway. This was arranged to coincide with World Mental Health Day on 10 October 2010.

(2) The concept of "Live it Well" is being developed further. A pilot "Live it Well" centre has been established in Ashford which provides a single point of accommodation for voluntary sector providers together with the local community mental health team. This creates savings and promotes joint working in line with the principles of "Total Place".

(3) A series of events with GPs has been arranged, as part of the regular training days organised by Eastern and Coastal Kent PCT, to advise them of the Live it Well strategy and the range of resources in place. The first of these took place in Thanet and was well received. Forthcoming events have been arranged for the other localities in East Kent. We will seek to arrange similar events in liaison with West Kent PCT.

(4) Additional supported housing provision for mental health has been developed across Kent. New schemes with intensive support will shortly be in place in Herne Bay, Dover and Shepway and these will complete the provision that is required for Kent.

(5) Since March 2010, the Suicide Prevention Strategy for Kent has been published in draft form. This has been developed by the Consultant in public health working for the Kent and Medway PCTs; together with the Kent Director for Public Health, in liaison with Kent County Council. The strategy fits with "Live it Well" and is based on five priorities:

- to reduce risk of suicide in key high risk groups
- to promote wellbeing in the wider population
- to reduce the availability and lethality of suicide methods
- to improve reporting of suicidal behaviour in the media
- to monitor suicide statistics and progress towards national targets and ensure appropriate audit.

(6) Kent Adult Social Services social care commissioning has contributed through our joint work with the PCT lead commissioning team for mental health. The development of this strategy will address comments by Members in March in relation to improving performance indicators for reducing the number of suicides in Kent. It will be integrated with the "Live it Well" strategy, particularly in relation to promoting wellbeing and reducing risk of suicide in high risk groups.

(7) The strategy is due to be formally signed off by the Medway PCT Board on 24 November 2010. The Board will wish to know that the strategy has the general approval of the Adult Social Services Policy Overview and Scrutiny Committee.

Recommendations

3. (1) Members are asked to NOTE progress in relation to the "Live It Well" Mental Health Strategy and to APPROVE the attached Kent and Medway Multi-Agency Suicide Prevention Strategy (Appendix 1).

Lead Officer:

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KENT AND MEDWAY MULTI-AGENCY SUICIDE PREVENTION STRATEGY 2010-2015

April 2010

Acknowledgments

Thanks go to all the members of the Kent and Medway suicide prevention steering group for their support in developing this strategy.

Thanks also to the workshop facilitators at the stakeholder consultation event; Jayne Curran, Sally Denley, Bose Johnson, Athene Lane-Martin, Sara Moreland and Kim Solly

The framework for this strategy was taken both from the National Suicide Prevention Strategy and has also used some of the work from the Kensington and Chelsea Suicide Prevention Strategy 2009

CONTENTS

1. BACKGROUND AND POLICY CONTEXT

1.1 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

1.2 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[1], 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[2] also reinforced the importance of suicide prevention and gave a framework for action.
In 2009 New Horizons was published and restated the Government's commitment to suicide prevention. A refresh of the national suicide prevention strategy is due out in 2010

1.3 This strategy seeks to ensure that the PCTs and local partners across Kent and Medway have an up to date strategy with a set of actions likely to impact positively on the suicide rate across the county.

1.4 Developing a strategy based just on the characteristics of previous cases of deaths from suicides locally is problematic as there are only a small number of cases. It is unlikely that past cases alone can provide sufficient information on the local population to help focus prevention activity. The local data may identify suicide "hot spots" and indicate target groups, but local suicide data needs to be enhanced with national data and research evidence, plus material from other PCTs, in order to inform local service planning in a meaningful way.

1.5 Suicidal behaviour is complex and the contributing factors are many and varied. As suicide often results from an accumulation of risk factors a co-ordinated and collaborative approach is required. Given the nature of suicide, the wide range of services involved in preventing suicides, and the wide range of locations and means used, a multi agency approach is likely to have most impact - this approach is adopted in this strategy. Effective prevention also requires a combination of population level and individual level programmes to reduce the factors associated with suicidal behaviour. The majority of people who die by suicide are not patients of secondary mental health services, so prevention must embrace both primary care and the wide range of other services which are in touch with people at risk of suicide.

1.6 Key policy drivers are:

- Saving Lives: Our Healthier Nation White Paper (1999) Department of Health [1]
- National Service Framework for Mental Health (1999) Department of Health [2]
- National Suicide Prevention Strategy for England (2002) Department of Health[13]
- Avoidable Deaths: Five Year Report of the National Confidential Enquiry into suicide and homicide by people with a mental illness 2006[3]
- New Horizons (2009) Department of Health[4]

2. EPIDEMIOLOGY OF SUICIDE: NATIONAL AND LOCAL DATA

National Data

2.1 The suicide rate has been falling nationally in the past 10 years. However, given the possible link to recession and the rising levels of clinical depression (likely to be the most common illness by 2020), it is possible that the trend in suicide rates will be reversed in the next few years. The suicide rate for England in 2008 showed a sharper increase in any one year than had been the case since 1997. However, it is clearly too early to be able state that this represents any trend.

2.2 Researchers have identified factors that place individuals at higher risk of suicide, but very few persons with these risk factors will actually commit suicide. Suicide is a relatively rare event and it is, therefore, difficult to predict which persons, with these risk factors, will ultimately die by suicide. However, the evidence suggests that "rational suicide" is most probably very rare, and most suicides are likely to be associated with a mental disorder or impaired mental functioning. Within mental disorders the strongest association is with depression. People with schizophrenia, bi-polar disorder, borderline personality disorder and addictions to substances are also at heightened risk.

2.3 There is a large body of literature on the risk factors associated with suicide as well as the factors likely to protect people from suicide. In 2008 a literature review of risk and protective factors for suicide and suicidal behaviour was published by the Scottish government Social Research Unit.[5] In summary, the main risk factors are:

- Previous suicide attempt
- Previous history of intentional self harm
- Mental illness including depression, bipolar disorders, personality disorders
- Mental health patients shortly before, or shortly after, discharge from in patient care
- Poor emotional health in childhood and/or violence and abuse
- Impaired problem solving skills
- Being LGBT
- Substance misuse
- Social isolation
- Family member or close friend who has committed suicide
- Homelessness
- Imprisonment
- Loss – relationship break down, sudden death of loved one, unemployment, poor physical health
- Economic depression, sudden economic change and unemployment
- Poverty and deprivation

It is common for more than one of these risk factors to be linked and present in people who have died by suicide.

2.4 The protective factors are largely a mirror image of the risk factors:

- Family connectedness, good relationships between parents and children, marriage, having children living at home (protective for women).
- Supportive schools.
- Personal resilience and problem solving skills.
- Good physical and mental heath.
- Employment.

- High levels of reasons for living, future orientation and optimism protect against suicide
- Religious participation
- Moral belief that suicide is wrong.
- Social support
- Access to treatment by a health professional may be protective against repeat suicide attempts.

Local Data

2.5 Local data for suicides across Kent and Medway is presented below. This is mainly nationally available information as there is currently no comprehensive suicide audit in place for Kent and Medway. However Kent police carried out an analysis of all suicides taking place between 01/07/08 to 30/06/09. Although numbers are small and therefore meaningful sub group analysis becomes difficult this does provides some useful additional data at a local level.

2.6 Some additional data is available by PCT and can be obtained from the Public Health Directorate but in most cases numbers are not large enough to be meaningful on further detailed sub analysis.

Numbers and rates of suicides in Kent and Medway

2.7 The total average number of suicides in Kent and Medway per year using 2003-2008 data is 136 per year. The table below shows the yearly variation over the last 10 years.

Table 1 : Total number of suicides by year of registration and PCT area 1998-2008

Area	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Kent County	128	111	128	122	117	136	128	125	114	126	88
ECKPCT	71	74	70	69	55	73	70	70	60	68	45
West Kent	57	37	58	53	62	63	58	55	54	58	43
Medway	24	12	18	17	23	13	20	21	23	22	14

Source NCHOD 2009

Rates and trends

National Target:

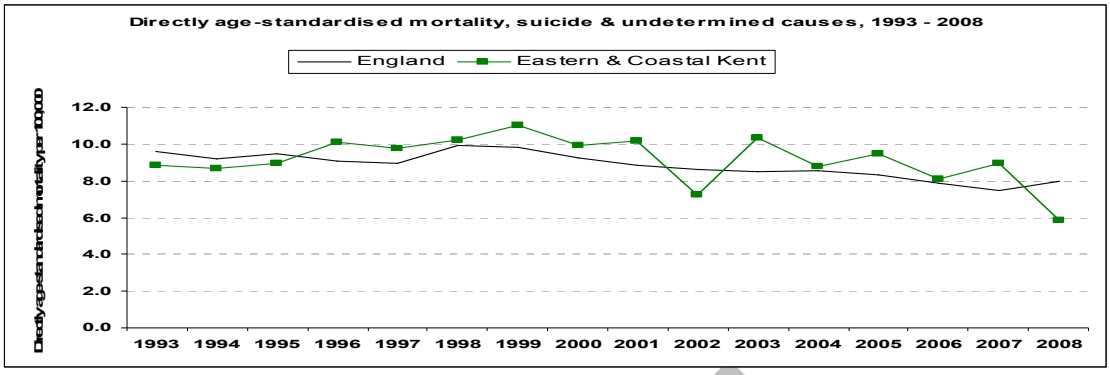
To reduce the rate of suicide and undetermined injury in England by at least 20% by 2010 from a baseline of 1996.

Our Healthier Nation 1999

2.8 Suicide numbers are small so it is difficult to be confident in seeing clear trends at a PCT level. However the figures below set out the best information we have as to rates, trends and future projections by PCT area and for Kent and Medway both from 1993 when data is available and from the 1996 OHN baseline.

For Eastern and Coastal Kent PCT if the baseline is taken as 1993 there is an apparent slight increase in suicide rates up to the present. From 1996 (which is the baseline for the OHN target), when trend lines are fitted it seems that in Eastern and Coastal Kent there is a decrease in suicide rates over this period.(see page 8)

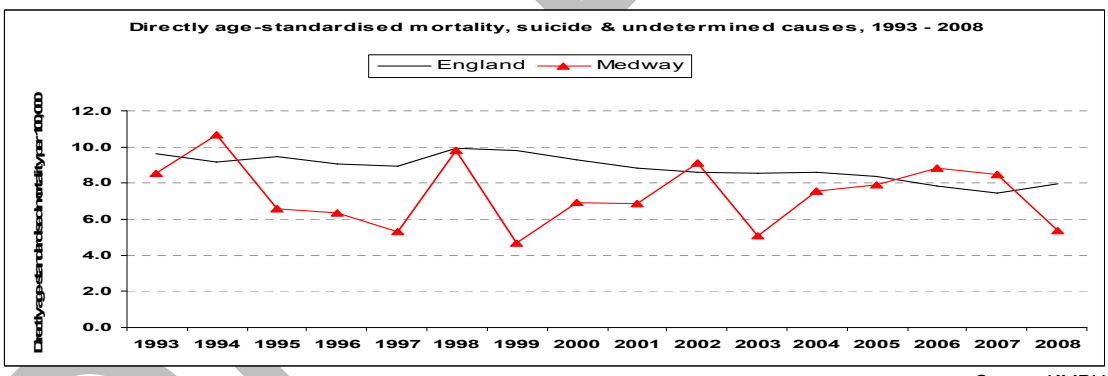
Fig : 1 Directly age-standardised mortality rates for suicide and undetermined causes 1993-2008: NHS Eastern and Coastal Kent compared to England



Source:KMPHO

2.9 For Medway there is an increase in the suicide rates from 1995-97 to the 2006-08 however numbers are very small and so rates tend to fluctuate considerably from year to year. As shown below if the baseline had been taken from 1993 to the present the rate overall may have been similar to that in 1993.

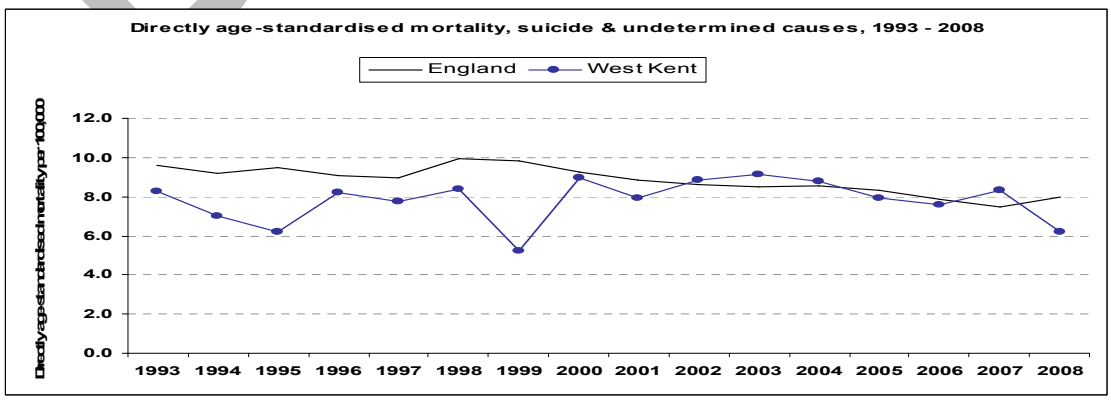
Fig: 2 Directly age-standardised mortality for suicide and undetermined causes 1993-2008: NHS Medway compared to England



Source:KMPHO

2.10 In West Kent from 1995-97 to 2006-8 there has been a slight increase in suicide rates when trend lines are fitted.

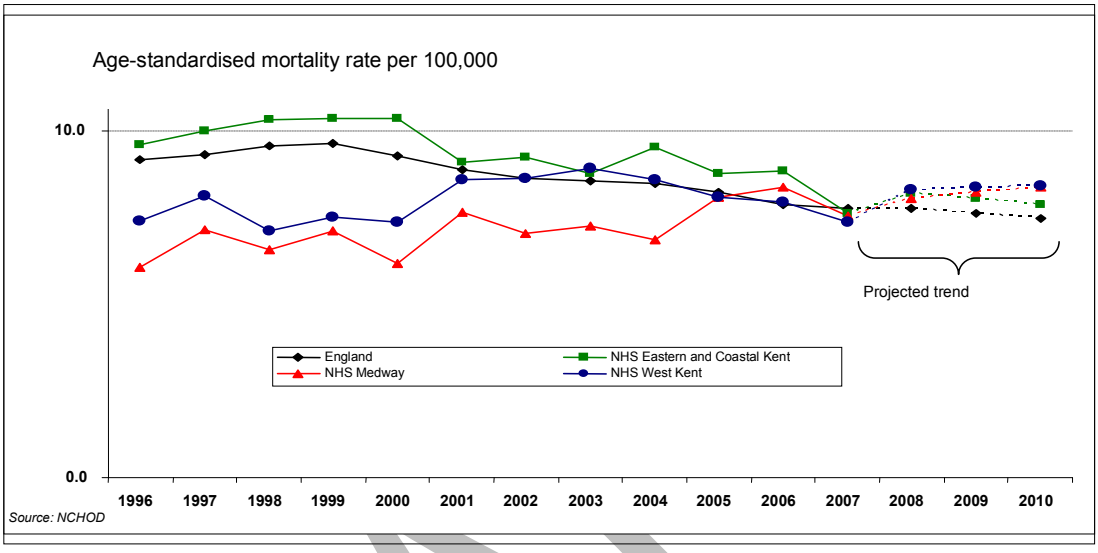
Fig : 3 Directly age-standardised mortality for suicide and undetermined causes 1993-2008: NHS West Kent compared to England



Source KMPHO

2.11 The information below shows the percentage changes in the suicide rates for the different PCT areas from the Our Healthier Nation baseline in 1996 and projected to 2010. This shows that in 2007 (3 year rolling average for 2006-8) Medway had a 25% increase over it's baseline. West Kent and Eastern and Coastal Kent areas have respectively a 5% increase and a 28% decrease in suicide rates.

Fig: 4: Age-standardised suicide and undetermined mortality rates: 1996-2007 projected to 2010 for Kent and Medway PCTS and England (3 year rolling averages)



When the trends are projected to 2010 it seems unlikely that any of the Kent PCTs will meet their targets.

Fig: 5 Directly age-standardized mortality rates for suicide and undetermined injury for Kent and Medway PCTs and England from 1995-7 to 2006-8

		DASR				
Area	Period	Male	Female	Total	% change	% Projected Change 2010
England	1995 - 1997	14.1	4.5	9.2	*-15*	*-18.*
	2006 -2008	12.0	3.7	7.8		
Medway	1995 - 1997	10.2	2.1	6.1	*+25*	*+38*
	2006 - 2008	12.2	3.0	7.6		
ECK	1995 - 1997	14.2	5.2	9.6	*-28*	*-17.9*
	2006 - 2008	11.4	4.1	7.6		
West Kent	1995 - 1997	10.9	4.2	7.4	*+5*	*+14.0*
	2006 - 2008	12.1	3.7	7.8		

Source: KMPHO

Compared to England overall in 2006-8 all of the PCTs were close to the England rate but are projected to increase above it to 2010.

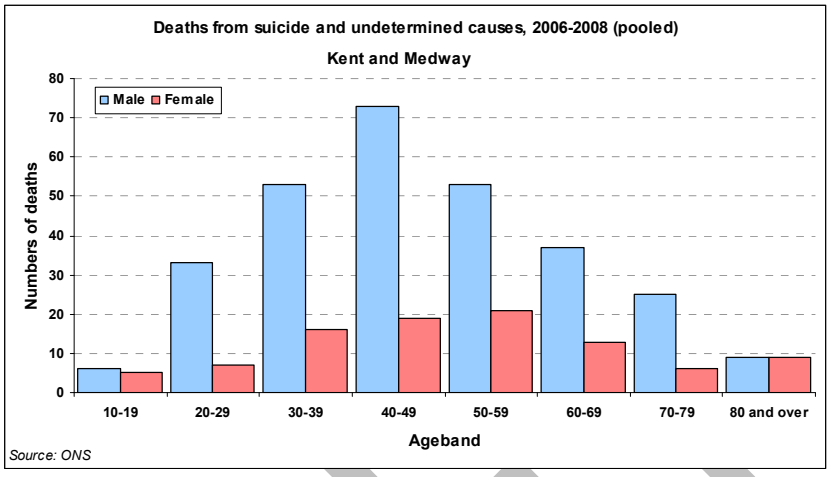
Age and sex

2.12 Nationally suicide is the leading cause of death among men aged 15-24 years and the second most common cause of death among people aged less than 35 years. Suicide is three times more common in men than women with approximately 76% of suicides in Kent and Medway being carried out by men.

The age band with the highest number of deaths for men is the 40-49 year age band followed by the 50-59 and the 30-39 age bands.

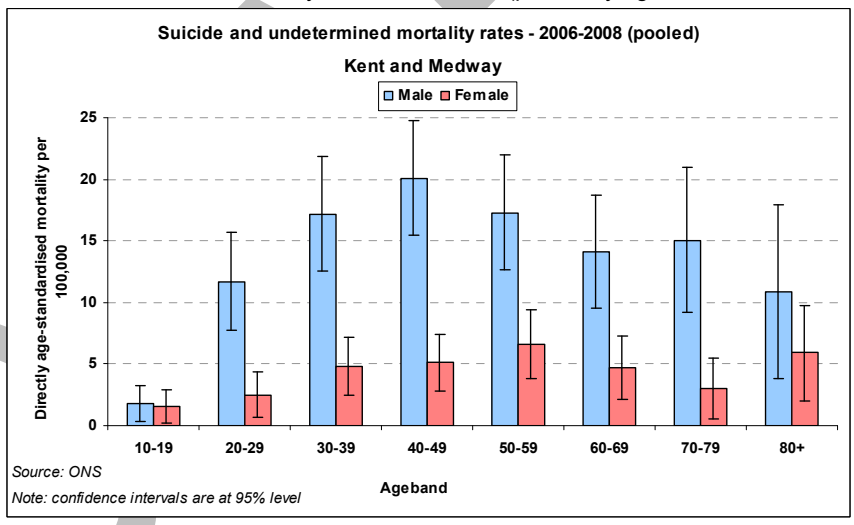
In women the 50-59 age band has the highest number of deaths but the rate is only slightly higher than the 40-49 and 30-39 age bands.

Fig: 6 Numbers of suicides and undetermined deaths 2006-2008 (pooled by age band in Kent and Medway)



Source KMPHO

Fig: 7 Suicide and undetermined mortality rates: 2006-2008 (pooled by age band in Kent and Medway)



Source:KMPHO

Interestingly, looking at the suicide rates (as opposed to numbers) by age, the older age groups are proportionately more significant than we might expect from just looking at the numbers. However as confidence intervals are very wide for our local data it is difficult to say with certainty how large these differences are. National data from 2008 shows even higher rates than our local data in the older age groups.

Self harm

2.14 Studies have shown that that people who self harm are 24.7 times more likely to die by suicide compared with those who do not self harm [6]. NICE guidelines on the physical and psychological management and secondary prevention of self-harm in primary and secondary care were produced in 2004.

In the Psychiatric Morbidity Survey in 2007, 5.6 per cent of people said they had attempted suicide at some point in their life and 4.9 per cent said they had engaged in self

harm. These individuals did not necessarily come to the attention of services: less than two thirds of those who attempted suicide had sought help, and only about half of those who self-harmed. However, people diagnosed with mental illness (notably schizophrenia) are more likely to self harm.

Those who survive a medically serious suicide attempt have a poorer outcome in terms of life expectancy.

The NICE guideline on self harm also notes that:

- 80 per cent of A & E attenders with self harm have taken an overdose of prescribed or over the counter medication
- Self injury is more common than self poisoning in the population as a whole
- Association with a physical illness as a precipitating factor
- Two thirds of those attending A& E for self harm meet the criteria for depression at the time, but two thirds of these no longer meet the diagnostic criteria 1 -16 months later
- Half those attending A& E due to self harm will have consumed alcohol
- There are higher rates in young Asian women

The following table taken from the Kent and Medway Mental Health Joint Strategic Needs Assessment applies national prevalence rate to the Kent and Medway population in order to estimate the number of people who reported self harm in the last year or a suicide attempt (ever).

Table 2: Attempted suicide and self harm in Kent and Medway

Disorder	Medway	East	West	K&M
Suicide attempt ever	11,407	33,505	30,414	75,326
Suicide attempt past year	1,833	5,385	4,888	12,106

Source: KMPHO

Method of suicide

2.15 The method of suicide most frequently used in Kent and Medway between 2002-7 (as nationally) is hanging (43%) followed by drugs overdose (23%). Jumping from a height and gas and vapour poisoning are next highest (6% each). The "other" unknown category accounts for 15% of all deaths.

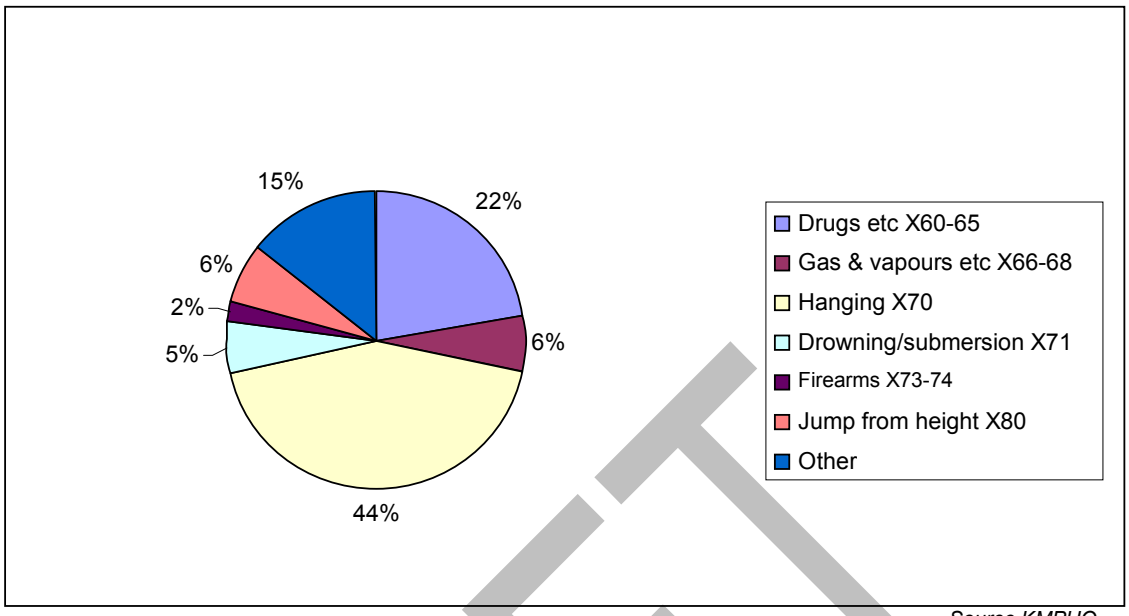
Table 3: Numbers of suicides and undetermined deaths in Kent and Medway 2002-2007 by method of death and PCT

	Medway		ECKPCT		WKPCT		K&M	
Method	No	**%**	No	**%**	No	**%**		**%**
Drugs etc X60-65	23	19%	97	24%	72	21%	192	22%
Gas & vapours etc X66-68	10	8%	27	7%	17	5%	54	6%
Hanging X70	63	52%	155	39%	155	44%	373	43%
Drowning/submersion X71	8	7%	21	5%	18	5%	47	5%
Firearms X73-74	-	-	-	-	12	3%	20	2%
Jump from height X80	-	-	26	7%	-	-	54	6%
Other	13	11%	64	16%	49	14%	126	15%
Total	121	100%	396	100%	349	100%	866	100%

- is entered whenever a value is under 5 or confidentiality would be breached by inserting the appropriate value

Source NCHOD 2008

Fig: 8 Method of suicide and undetermined injury pooled data 2002-2007 Kent and Medway



Source KMPHO

There are differences between males and females with respect to method of suicide chosen as the table below illustrates. Men are more likely to choose hanging as a preferred method with women being more likely to choose drugs overdose.

Table 4. Numbers and percentages of suicides and undetermined injury by method and sex: Kent and Medway pooled 2002-2007

Method	Male		Female	
	No	%	No	%
Drugs etc X60-65	110	16.8	82	38.9
Gas & vapours etc X66-68	49	7.5	5	2.4
Hanging X70	312	47.6	61	28.9
Drowning/submersion X71	30	4.6	17	8.1
Firearms X73-74	20	3.1	0	0.0
Jump from height X80	39	6.0	15	7.1
Other	95	14.5	31	14.7
Total	655	100.0	211	100.0

Source KMPHO

Additional local police data for one year indicated that deaths from train impact account for approximately 5% of suicides for that year in Kent and Medway with an additional 1% being caused by "Other vehicle impact". These would have been recorded in the “Other” category above. National data indicates that 3% of all suicides annually are due to jumping or lying in front of a moving object.

Occupation

2.16 National research seems to indicate that the highest occupational risk groups are medical professionals and farmers. However in Kent and Medway it appears from the data below that the highest numbers are in the routine and manual occupations, the retired and the unemployed and other category. Further analysis needs to be done to understand whether the national research does apply locally.

Table 5: Number of deaths by suicide and undetermined injury in Kent and Medway by occupation 2002-2007 pooled data:

Occupation	Total
Retired	171
Unknown, unlisted or unemployed	146
Skilled construction & building trades	55
Elementary trades, plant & storage related occupations	53
Transport & mobile machine drivers & operatives	42
Skilled metal & electrical trades	37
Elementary administration & service occupations	33
Administrative occupations	31
Caring personal service occupations	30
Business & public service associate professionals	25
Process, plant & machine operatives	22
Managers & proprietors in agriculture & services	21
Corporate managers	19
Sales occupations	17
Housewife	17
Student	17
Science & technology professionals	14
Science & technology associate professionals	14
Culture, media & sports occupations	14
Leisure & other personal service occupations	14
Textiles, printing & other skilled trades	13
Teaching & research professionals	12
Skilled agricultural trades	12
Health & social welfare associate professionals	9
Secretarial & related occupations	9
Business & public service professionals	8
Health professionals	5
Protective service occupations	5
Customer service occupations	-
	866

Source: Public Health Mortality File

- indicates a value between 0-5

Place of death and identification of hotspots

2.17 The average annual number of deaths and suicide rates by local authority areas are shown below. The highest numbers are in Medway but this is likely to be due to the higher population numbers.

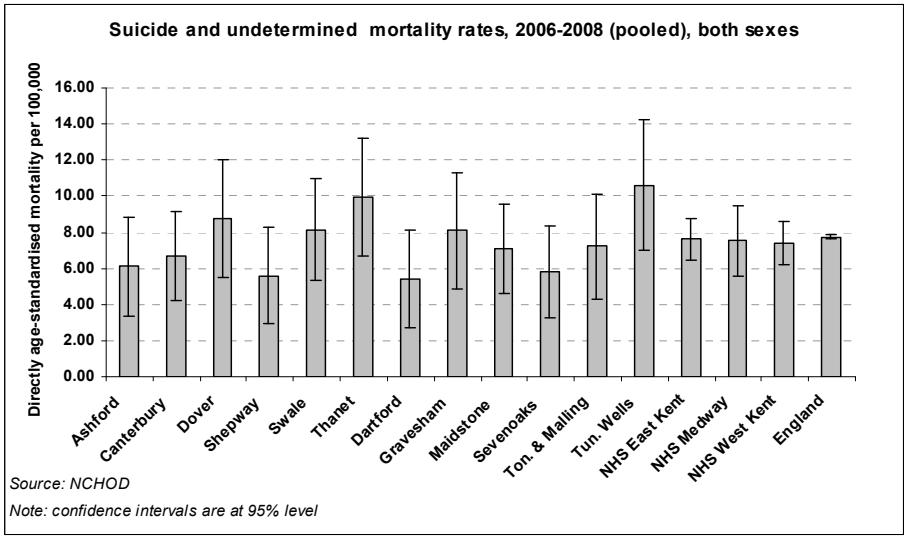
Table 6: Average number of deaths per year by suicide and undetermined injury by Local Authority district in Kent and Medway in 2002-07

Local /unitary authority	Average number of deaths	Local /unitary authority	Average number of deaths
Ashford	9	Sevenoaks	9
Canterbury	13	Shepway	10
Dartford	8	Swale	11
Dover	12	Thanet	13
Gravesham	10	Tonbridge and Malling	8
Maidstone	12	Tunbridge Wells	12
Medway	20	**TOTAL**	**144**

Source: KMPHO

Medway has the highest number of suicides but, when rates are calculated, Tunbridge Wells and Thanet appear to have the highest rates. However as can be seen confidence intervals are wide and overlap. This indicates there is no statistically significant difference between the different local authority areas based on these figures.

Fig: 9 Suicide and undetermined mortality rate 2006-2008 (pooled)



2.19 Nationally, available data on place of death in the sense of type of location or institution for Kent and Medway is shown in the table below. This shows that approximately 50% of suicides take place at home. However the data on place of death is difficult to interpret as suicides who are taken to hospital and subsequently die there are recorded as deaths in the hospital even though the initial suicide attempt may have taken place elsewhere.

Table 7: Number of suicides by place of death 2002-2007 for Kent and Medway

	Year of registration						
Place of death	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**Total**
Home	64	76	73	75	70	75	**433**
Elsewhere	46	43	51	52	47	47	**286**
Other hospitals etc.(NHS)	28	28	23	18	20	25	**142**
Other communal establishments	-	-	-	-	-	-	**-**
Psychiatric (NHS)	-	-	-	-	-	-	**-**
Hospices	-	-	-	-	-	-	**-**
Total	**139**	**148**	**148**	**146**	**137**	**148**	**866**

Source: KMPHO

- indicates that the value is either 0 or under 5

2.20 Probably the most appropriate way of looking at geographical data on place is to look at data on where suicides are initiated and map it to ascertain any possible hotspots or clusters. This gives the most useful information for action. Kent Police have done this using the place where suicide was initiated between 01/07/08 and 30/06/09.
In the year of analysis this showed 64% of suicides taking place at the deceased person's home address, a further 5% in prisons where remanded and 2% in hospitals where admitted for mental illness.

2.21 This analysis can also be used to help to identify possible hotspots in Kent and Medway. (A hotspot is defined nationally as anywhere where more than one death has occurred in any time period). Within the year covered by the police analysis 3 geographical areas have been identified as having more than one death. In two of these areas the deaths were not linked, in the third area the two people involved were husband and wife.

2.22 Further investigation will need to be carried out to ascertain the need for and possibility of appropriate management of these hotspots.

3. A STRATEGIC PARTNERSHIP APPROACH

3.1 In 2007 in Kent and Medway there were 148 suicides and open verdicts recorded in the general population. About 30% of these had been in contact with mental health services[7]. 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. This means that 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

3.2 It was decided that it would be more effective to have a multi-agency Kent and Medway wide strategy than to have individual PCT strategies. 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.

As part of the strategy development process a number of key stakeholders were interviewed and a Kent and Medway wide consultation event was held which was attended by nearly 60 people from a wide range of different organisations.

A list of key partner agencies who are represented on this steering group and who have been involved in the development of this strategy can be found at Appendices 2 and 3.

3.3 The Kent and Medway suicide prevention steering group will link into the PCTs governance structure via the Mental Health Joint Commissioning Boards. It will also report into the Joint Strategic Mental Health Commissioning Board.

3.4 Other partner agencies will be responsible for ensuring appropriate governance arrangements within their own organisations.

4. STRATEGIC PRIORITIES

4.1 Developing strategic priorities for Kent and Medway needs to take into account both national strategic priorities and local services and information.

4.2 The key national priorities can be used to shape the framework for local action. However an understanding of current local services and local data are essential in ensuring that the strategic priorities and local action plans are robust. The current economic climate will also have an impact on which priorities are selected.

4.3 The 6 national priorities for suicide prevention are:

- To reduce risk in key high risk groups
- To promote wellbeing in the wider population
- To reduce the availability and lethality of suicide methods
- To improve the reporting of suicidal behaviour in the media
- To promote research on suicide and suicide prevention
- To improve monitoring of progress towards Saving Lives: Our Healthier Nation target for reducing suicide.

4.4 The local Information set out in the previous section has been obtained from the Kent and Medway Public Health Observatory and from local partners, particularly Kent Police who have carried out a review of all suicides from 01/07/08 and 30/06/09, and KMPT who carry out a detailed suicide audit on an annual basis of all suicides who are in contact with them at the time of their suicide or up to 12 months previously. In addition, feedback from the stakeholder interviews and the consultation event has been used to shape the national priorities to be appropriate for local use. Local strategic priorities are outlined below.

4.5 **PRIORITY 1: TO REDUCE RISK OF SUICIDE IN KEY HIGH RISK GROUPS**

The national strategy indicates the most appropriate high risk groups to target are:

- People who have currently or recently been in contact with mental health services
- People involved in self harming behaviour in the last year
- Young men
- Prisoners
- High risk occupational groups

In Kent and Medway the available data and discussion with stakeholders would broadly support this prioritisation but with the addition of older people and a change to include young to middle aged men with a focus on those who are unemployed.

So this strategy has prioritised the following high risk groups.

- People who have currently or recently been in contact with mental health services
- People involved in self harming behaviour in the last year
- Young – middle aged men with a focus on those who are unemployed
- Offenders, those in prison, in custody and in the community
- High risk occupational groups
- Older people

Stakeholders felt that it was also important that people suffering relationship difficulties, bereavement or financial difficulties and veterans were considered as a priority for appropriate interventions. These groups will be investigated further and are also included in Priority 2 for action.

4.5.1 Reducing suicide rates for people in contact with mental health services

In 2007 in Kent and Medway 29% of all suicides and open verdicts recorded in the general population had been in contact with local mental health services in the previous 12 months[7]. This is clearly a highly significant risk group.

There is also evidence that the majority of all completed suicides have had a previous diagnosis of at least one mental health disorder. International and national research confirms this. The percentage ranges form 89.7% of American suicides to 78.9% of Australian suicides[8]. Those with adult personality disorder, a psychiatric history, schizophrenia, bipolar disorder, depression or neurosis were 6.1 - 19.7 times more likely to die by suicide than those who were not mentally ill with depression and bipolar disorder located at the higher level of risk[9].

Kent and Medway NHS and Social Care Partnership Trust (KMPT) currently leads this work across Kent and Medway. A Kent and Medway Suicide and Homicide Prevention Group is in place to oversee suicide prevention work with people in contact with KMPT mental health services. A Kent and Medway wide suicide audit is carried out on an annual basis for all suicides who are in this group. A strategy has been produced specifically for this group of people which has been shaped by information from the audit.

Reducing suicide rates for people in contact with mental health services clearly needs to remain a high priority. Key objectives identified in the KMPT strategy which need to be supported are as follows:

- Improved inpatient safety
- Safer leave and discharge planning
- Improving co-ordination between services including primary care
- Improved training in risk assessment
- Improved application of the Care Programme Approach including quality improvement via audit
- Improved services for patients, families and carers within the CPA
- Continue with and Implement recommendations from the KMPT suicide audit
- Improve services for personality disorder, intentional self harm and dual diagnosis patients
- Improve services for prisoners post release
- Promote R&D in suicide prevention
- Improved services for young and first episode patients
- Improved documentation and communication (particularly with respect to electronic records

There is representation from KMPT on the multi-agency Kent and Medway Suicide prevention steering group and the yearly audit and progress on these objectives will be reported to the group on a regular basis.

However with the entry of other providers of mental health services across Kent and Medway there is a need to ensure that all providers of mental health services are engaged with this work.

4.5.2 Reducing suicides in people who have self harmed

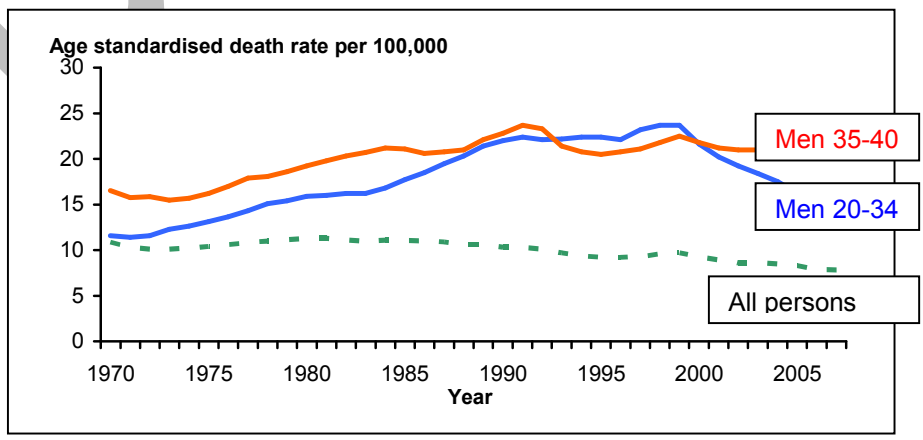
The 2004 NICE guidelines for the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care highlight priority action for a range of agencies in responding to self harm appropriately[10]. The key priorities which need to be audited and implemented locally are as follows:

- Respect, understanding and choice. Ensuring that people who have self harmed are treated with the same care, respect and privacy as any patients.
- Staff training: Clinical and non-clinical staff who have contact with people who self harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.
- Ambulance and emergency department services whose staff may be involved in the care of people who have self-harmed by poisoning should ensure that activated charcoal is immediately available to staff at all times.
- Appropriate triage needs to be available for all people who have self harmed
- Appropriate treatment detailed in the guidance needs to be offered for all people who have self-harmed
- Comprehensive needs assessment: All people who have self-harmed should be assessed for risk: this should include identification of the main clinical and demographic features known to be associated with risk of further self harm and/or suicide, and identification of the key psychological characteristics associated with risk, in particular depression, hopelessness and continuing suicidal intent.
- Psychological, psychosocial and pharmacological interventions: Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and self help should be based upon a comprehensive psychiatric, psychological and social assessment and not be determined solely on the basis of self harm.

4.5.3 Reducing suicides in young to middle-aged men

With respect to targeting men, data presented in the previous section shows that approximately 76% of all suicides in Kent and Medway are men. The greatest number can be found in the 40-49 age band with the next highest number being in the 50-59 age band.

Fig: 10: Trend in suicide rate for men (aged 35-49) and young men (aged 20-34)
Death rates from Intentional Self-harm and Injury of Undetermined Intent, England



This is in keeping with the national data and it is interesting to note that previous data which indicated higher rates nationally in younger men 20 – 34 from the early 1990s now show that rates in men aged 35-49 are higher.

Both young and middle-aged men still remain a priority as the number of years of life lost in the younger age groups remains high.

National pilots as to appropriate initiatives for working with men have yielded ambivalent findings with recommendations that more successful initiatives will be likely to be those that engage men in activity rather than formal class-room based learning. Given current economic conditions a potential focus for work locally is working with unemployed men and improving awareness amongst employers of mental health issues.

4.5.4 Reducing suicides by offenders and those held in custody

Nationally and locally considerable work has gone on to reduce suicides in prisons. Suicide Prevention and Self Harm Management (Prison Service Order 2700, HM Prison Service) gives guidance to all prisons as to all their roles and responsibilities with respect to suicide prevention. Every prison is required to have a suicide prevention co-ordinator and a suicide prevention team which oversees policy development, monitors statistics and reviews cases. Prisons are also required to have Partnership Boards which include PCT membership which are responsible for oversight of this work.

There are nine prison establishments in Kent (out of 139 in England and Wales). They are shown in the following table, with the prison population as of April 2010

Table: 7 Prison establishments in Kent and Medway

Prison	Type	Population
Blantyre House, Goudhurst	Adult male Category C/D resettlement	122
Canterbury	Foreign national prisoners	303
Cookham Wood, Rochester	Male juveniles	110
East Sutton Park, Maidstone	Female (Adult and Young Offenders)	102
Elmley, Isle of Sheppey	Category B/C	1250
Maidstone	Category C adult male, Foreign nationals	610
Rochester YOI	Males up to 21 years	707
Standford Hill, Isle of Sheppey	Male Category D open	446
Swaleside, Isle of Sheppey	Male Category B (accepts life sentences)	1126

Source:HMPS 2010

In 2009/10 there were 6 self inflicted deaths in prisons who were in contact with mental health services in the prison.

A detailed needs assessment was undertaken by the Kent Forensic Psychiatry Service in 2007. As in a number of national studies, the report showed that mental health problems were more prevalent amongst prisoners than amongst the community as a whole.

The Eastern and Coastal Kent Prison Health Strategy states that 90% of prisoners have substance misuse, and/or mental health problems, personality disorder is common and 9% of the UK prisoner population suffer from severe and enduring mental illness.

However it has been increasingly recognized that suicide risk is increased in those held in police custody and offenders in the community.
As one response which works towards mitigating this risk police custody diversion

services have been set up across Kent and Medway. Community Psychiatric Nurses are attached to all police stations to ensure referral and signposting of people with mental health issues into appropriate services. This service has been made permanent in West Kent with pilots in Eastern and Coastal Kent and Medway in place. This service should be supported across Kent and Medway.

Kent Police have their own suicide prevention strategy which includes the development of appropriate training and risk assessment for all police officers.

4.5.5 Reducing suicide in high risk occupational groups

Research indicates that suicide rates are higher in certain occupations. The highest proportional mortality rates were found in medical and allied professions farmers (males only), nurses, health, education and welfare professionals and allied service workers. This list includes professions which would be compatible with higher social classes which runs contrary to what might be expected. This could be because there are lower mortality rates from other causes and there be greater access to means [11].

Locally in Kent and Medway from the data available the greatest numbers would seem to be in the routine/manual workers occupational groups however further analysis looking at rates is necessary in order to confirm that the highest mortality rates are also within these groups. Numbers are also high in the retired and the unemployed groups.

4.5.6 Reducing suicide rates in older people

The ratio of suicide attempts to completed suicides in older people has been found to be about 4:1. This is much lower than in the general population and means that when an older person attempts suicide this should be taken very seriously as it is a very strong predictor of further completed suicide.

Psychological autopsy studies report that between 71% and 95% of those over 65 completing suicide had a diagnosable mental disorder at time of death, so it is clear that the presence of a psychiatric symptoms is strongly correlated to completed suicides in older people[12].

The evidence directly linking poor physical health with suicide is mixed. Some physical conditions do appear to be correlated with higher suicide rates and others less so. The underlying physical illness may result in depression which in turn leads to suicide rather than the physical illness leading to suicide directly[12]

The table below sets out the possible interventions for older people in suicide prevention.

Table 8 Primary, secondary and tertiary interventions for suicide in the older person. Adapted from De Leo, D Scocco, P. Treatment and Prevention of suicidal behaviour in the elderly [12]

Primary Prevention	Secondary Prevention	Tertiary Prevention
Promotion of economic prosperity	Detection of suicidal ideation	Crisis Intervention systems
Personal Health Promotion	Older person help-lines	Education programmes
Retirement planning	Community support programmes	Individual and group Therapies (especially CBT)
Promotion of social participation	Access to mental health services	Self help groups
Building networks of support	Educational programmes	Re-socialisation groups
Reduction in access to means	Treatment of Depression	
	Treatment of Psychological and Physical consequences of physical illness including pain management	

A priority focus in this area will be to improve the psychological assessment and care of older people particularly those with long-term condition and chronic pain.

4.5.6 Overall as part of the action plan in all these 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 two groups, each requiring a different service response.

- Those in contact with primary care
- Those in contact with other services

Primary care

Primary care has a key role to play in terms of appropriate identification, management and referral of people at high risk of suicide. Appropriate suicide prevention responses include depression screening, suicide screening of those with depression, access to medication, social prescribing and psychological therapies, signposting/referral to secondary care, social care and the voluntary sector. These need to be promoted in primary care in line with the appropriate NICE guidance.

Other 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 awareness training, appropriate identification, referral and signposting and management of suicide risk for other agencies.

4.6 PRIORITY 2: TO PROMOTE WELLBEING IN THE WIDER POPULATION

As the number of completed suicides is so small and in reality can come from a wide range of risk groups, promoting mental health and wellbeing in the wider population and for all risk groups an essential element of improving mental health and wellbeing and preventing suicide. In the Mental Health NSF and in the "New Horizons" mental health strategy, preventative work is a key priority.

Work that contributes to improving mental health across Kent and Medway is carried out by a variety of statutory and voluntary agencies. From a health perspective the following resource is dedicated to mental health promotion work in the PCT areas

- NHS Eastern and Coastal Kent: 3 wte mental health promotion specialists
- NHS West Kent: 1 wte mental health promotion specialist
- NHS Medway: Business case approved for 1 wte mental health promotion specialist.

An overarching Kent and Medway mental health strategy 'Live It Well' has been developed which includes a mental health promotion component. In Eastern and Coastal Kent a local mental health promotion strategy has also been developed and a similar process is underway in West Kent. Medway is developing its own mental health promotion framework based on the national strategy. The National Suicide Prevention Strategy[13] notes that the following groups are of particular concern as needing targeted efforts

- Socially excluded and deprived groups
- BME communities
- People who misuse drugs or alcohol

- Survivors of child and domestic abuse
- Children and young people
- Women during and after pregnancy
- Older people
- Those bereaved by suicide

Of this list, for the purposes of this strategy following discussion with stakeholders 'older people' has been moved to a high risk group under Priority 1.

Although numbers are small the analysis carried out by Kent Police in 2008/9 indicates that with respect to recent significant life events financial problems were present in 14% of suicides with an additional 10% having employment problems. Relationship problems were present in 23% of suicides and 8% had suffered serious illness in the preceding 12 months. Very little information is available locally as to triggers but there is some evidence to suggest that arguing with a partner may be a factor.

In addition, where stated in 26% of suicides had consumed an excessive amount of alcohol with a further 15% consuming moderate amounts. 11% had an illegal drug addiction.

The suicide prevention steering group should ensure that all local mental health promotion strategies should take into account all these risk groups. There should be mental health promotion links from the PCTs to ensure that the development of strategies takes into account the needs of these groups. From discussion with stakeholders and looking at the data, the groups in the above list are all relevant locally but some additional groups have also been identified as of concern.

- bereavement particularly older people losing long term partners
- those leaving care
- veterans.
- LGBT
- dual diagnosis
- those who are having relationship difficulties and breakdown
- those who are experiencing financial and employment difficulties
- students

The groups above have been prioritized locally and should also be included in local mental health promotion work. Further investigation is needed in order to develop appropriate actions for all groups The greatest stakeholder consensus supported by the data was around

- bereavement,
- those who are experiencing relationship breakdown and
- those are experiencing financial and employment difficulties
- people who misuse drugs and alcohol.

Actions to tackle these will be included in the initial action plan for this strategy.

4.7 PRIORITY 3: TO REDUCE THE AVAILABILITY AND LETHALITY OF SUICIDE METHODS

There is strong evidence that restricting access to the means for committing suicide is effective in reducing suicides. This is because the level of suicide intent varies over time and deterring suicide when intent is at its highest may deter suicide until the level of intent reduces. Suicidal behaviour can be "impulsive". Although method substitution does occur, a number of people will not go on to use another method and lives can therefore be saved[13]. Some of the actions to restrict access can only be taken nationally and these are set out in the National Suicide Prevention Strategy.

As stated previously using data from 2002-2007 the method most frequently used in Kent and Medway (as nationally) is hanging (43%), followed by drugs overdose (23%). Jumping from a height and death by inhalation and vapours each account for 6% of suicides.

Local priorities for action are as follows:

4.7.1 Reduce the number of suicides by hanging and suffocation

Hanging and strangulation are particularly associated with mental health wards and prisons[13] but these are also frequent methods of suicide for men in the community.

Action has been taken as part of KMPT's work on suicide prevention to remove all potential ligature points in psychiatric inpatient wards.

Action has and is continuing to be taken as part of safer custody initiatives by the police and the prison service to re-design cells and windows in order to make the custody environment safer.

4.7.2 Reduce the number of suicides by self poisoning

National action has been taken on this priority to improve safer prescribing. The appropriate and timely use of activated charcoal in preventing fatalities highlighted in the self harm section will also be a priority action here.

Additional local priority actions have been outlined in the attached action plan and could include auditing the safe prescribing of anti-depressants in primary care and mental health services.

4.7.3 Reduce the number of suicides on the railways

The Rail Safety and Standards Board (RSSB) collects its own data on railway suicides. Data on location of death is also collected by the police as part of monitoring suicides across Kent and Medway. This includes railway suicides. The RSSB has taken the problem of railway suicide very seriously. A major report on Suicides and Open Verdicts on the Railway Network (SOVRN) was published in 2003. Following publication of this a national Rail Fatalities Management Group was set up until 2006 which oversaw a series of visits to station operators by RSSB and the Samaritans to agree programmes of suicide prevention.

Potential rail hotspots in Kent and Medway need to be identified and monitored. Appropriate further local action needed should be agreed and implemented with relevant partner agencies.

4.7.4 Reduce the number of suicides as a result of jumping from high places

Locations offering opportunities for suicide by jumping include bridges, viaducts, high-rise hotels, multi-storey car-parks and other tall buildings, cliffs and other topographical features. Suicidal jumps have a high fatality rate[14] are highly traumatic for people living below the jump site[15] and tend to attract copycat suicides. All the world's leading hotspot sites are in fact jumping sites.

Only one year's data is currently available with respect to identification of jumping hotspots in Kent and Medway. This indicates that the only site with more than one suicide in that time period.

Further investigation and ongoing monitoring of geographical place of death is needed to ensure hotspots are appropriately identified.

Where potential hotspots are identified, relevant partners need to decide and agree on appropriate management action. Possible actions include

- Physical barriers
- Signs and telephone hotlines
- Suicide patrols
- Training for staff of non-health agencies working at or near hotspots
- Restrictions on media reporting.

4.8 **PRIORITY 4: TO IMPROVE REPORTING OF SUICIDAL BEHAVIOUR IN THE MEDIA**

The evidence of the impact of media portrayals of suicide on imitative behaviour and therefore copycat suicides was the subject of a systematic review in 2001[16]. This included 90 studies from 20 countries and concluded that evidence of a link between coverage and imitative behaviour was significant. A guide for the media has been produced by the national MediaWise Trust which highlights good practice with respect to covering suicide.

As a key objective there is a need to ensure that in Kent and Medway all press and media agencies are aware of the appropriate guidance and implementing it.

There is also a need to ensure that the media is monitored for any inappropriate reporting of suicide and appropriate action taken.

4.9 **PRIORITY 5: TO MONITOR SUICIDE STATISTICS AND PROGRESS TOWARDS NATIONAL TARGETS AND ENSURE APPROPRIATE AUDIT.**

In order to understand how to effectively move forward with suicide prevention it is essential that we continue to collect and analyse data relating to suicide and self harm from across Kent and Medway. We need to monitor trends and any specific local variation from national trends in order to develop effective interventions. We also need to be clear as to our local epidemiology to be sure we are effectively targeting local groups

Combining information from partner agencies will allow for a much clearer picture of the current situation than has been the case previously and using this information appropriately will enable more targeted work to be developed. Key agencies that need to be involved in this are KMPT, Kent Police, PCTs and Acute Trusts. Kent Police have committed to continue to monitor all suicides across Kent and Medway and to analyse and share this information. This will need to be done under appropriate information sharing protocols. Information on suicide rates and trends will be reported to the steering group on an annual basis using national data by the PCTs. Other information such as development

of suicide clusters will be shared for appropriate action as appropriate.

With respect to audits of current practice. This has been highlighted under specific priorities earlier but key audits that needed to be continued or promoted are:

- KMPT retrospective suicide audit carried out annually
- Audit of management and treatment of self harm in A&E
- Significant event audits in primary care

Information from these audits will help to inform the actions taken to prevent suicide across Kent and Medway on an ongoing basis.

APPENDIX 1:

CURRENT ORGANISATIONAL MEMBERSHIP OF THE KENT AND MEDWAY SUICIDE PREVENTION STEERING GROUP

East Kent Hospitals Foundation Trust

Kent and Medway NHS and Social Care Partnership Trust: A&E liaison service

Kent and Medway NHS and Social Care Partnership Trust: Chair of KMPT Suicide and Homicide Prevention Steering Group

Kent Drugs and Alcohol Action Team

Medway Drugs and Alcohol Action Team

Kent Police

NHS Medway: Public Health

NHS Medway: Mental Health Commissioning

NHS Medway Medicines Management

NHS Eastern and Coastal Kent: Public Health

NHS West Kent

Rethink

Samaritans

South East Coast Strategic Health Authority

Canterbury Christchurch University

APPENDIX 2: Delegates registered as part of the stakeholder consultation

(some delegates sent alternative representation on their behalf)

NAME	ORGANISATION
Angela Shorter	Acute Care Services Manager, KMPT
Anne Tidmarsh	KCC
April Wiltshire	Assistant Psychologist, Home Treatment Service CHHTOP KMPT
Athene Lane-Martin	Eastern and Coastal Kent
Belinda Wells	Managing Director Organisation Counselling Team Limited
Bonita King	Clinical Nurse Specialist MIMHS Team Kent & Medway NSH and Social Care Trust,
Bose Johnson	Public Health Specialist Practitioner Kent and Medway
Carol Gosal	Rethink Organisation
Caroline Davis	Eastern and Coastal Kent
Chris Allman	Mental Health Recovery Worker
Colette Pinion	Team Leader, CRI Safe Exit
Dave Mottloy	Tenancy Support Officer
Dave Woodward	KCC
David Coldwell	Director - Medway, Gravesham & Swale West Samaritans
Debbie Stock	NHS West Kent
Debra Richards	Community Support worker, KASS
Donna Barker	Team Leader, Casa Support
Dr Ann Andrew	Consultant Psychiatrist
Dr E Lunt	GP Commissioning & IAPT Development
Dr. Joanne Ross	Fit for work pilot Project Manager
Fiona Cave	Community Nurse Learning Disabilities
Gaby Price	Commissioning Manager, Kent Drug & Alcohol Team
Gill Smith	Porchlight
Glenda Ratcliffe	Tenancy Support Officer
Gloria and Malcolm Phyall	Members of East Kent Carers Council
Hana Soliman	Kent and Medway Partnership Trust
Heather Sylvester	Mental Health Recover Worker
Ian Marsh	SUI
Jane Berwick	Senior Occupational Therapist
Jane Wiltshire	Mental Health Commissioning Manager Kent and Medway
Jayne Curran	Eastern and Coastal Kent
Jenny Nuttman	Community Senior KASS mental health team
Jessica Mookherjee	West Kent PCT
Jonathan Sexton	NHS Eastern and Coastal Kent
June Cresswell	Community Support Office, Mental Health
Karen Dorey-Rees	Associate Director - Recovery Services KMPT
Karen Macarthur	Public Health Consultant
Kathy Govett	NHS Eastern and Coastal Kent
Kay Rollinson	NHS Eastern and Coastal Kent
Keith Foster	Suicide Prevention Strategy Implementation Lead National Mental Health Development Unit
Kerry Smith	Operations Manager - KCA
Kevin Molloy	Director of Operations, KCA
Kim Solly	Eastern and Coastal Directorate, Kent and Medway NHS & Social Care Partnership Trust
Laura Bell	Tenancy Support Officer, MOAT HA

NAME	ORGANISATION
Laurence Allen	Acute Care Services Manager, KMPT
Lauretta Kavangh	Director of commissioning for Mental Health Kent and Medway
Lesley Andrews	Kent Gov.
Linda Caldwell	Eastern and Coastal Kent
Linda Meise	PWP
Linda Prickett	West Kent PCT
Lorraine Main	CRI.IDTS HMP Sheppey cluster
Lou Bean	Clinical Audit & Effectiveness Manager KMPT
Louise Parker	Southeast Coast
Lynda Burr	Service Manager, KCA PTP
Malcolm Brown	Clinical Risk Trainer, K&M NHS Trust Learning & Development
Maria Shepperd	Kent PNN Police
Marian Draper,	Locality Service Manager Ashford Community Mental Health Team
Marie Beckett	EKHT
Martin Featherstone	Chief Exec. Medway CVS
Matthew Long	Kent Police
Merryl Chesher	Service Manager Maidstone Mind
Nichola Williams	Immediate Care Team, Folkestone
Paul Absolon	Kent Gov
Paul Burley	Services Manager, Action for Change
Paul Chapman	Samaritans
Peter Konopasek	Tenancy Support Officer, MOAT HA
Phil Kessel	SEVENOAKS AREA mental HEALTH AWARENESS GROUP - MIND
Philip Penders	Samaritans
Professor Hana Soliman	Consultant Psychiatrist
Ray Forrester	Tenancy Support Officer
Raymond Hickton	Rehab home for the NHS
Reena Sooch	Rethink Org
Richard Adkin	Interim Services Manager Mental Health Medway
Richard Adkin	Medway council
Roz Macklin	mental Health Recovery Worker
Sally Castle	CPN, CMHT, NHS
Sally Denley	Eastern and Coastal Kent
Sally Evans	IAPT Clinical Lead, Organisation counselling Team Ltd
Sandra Allen	Senior Practitioners
Sara Moreland	Health Promotion Practitioner Specialist Mental Health - Eastern Coastal Kent
Sean Feeney	Kent and Medway Partnership Trust
Sharon Dennis	IAPT Porgramme Manager, Mental Health Commissioning
Sharon Rowe	Clinical Nurse Specialist MIMHS Team Kent & Medway NSH and Social Care Trust,
Stephen Deaves	Tenancy Support Officer, MOAT HA
Sue Thomson	mental Health Recovery Worker
Theresa Turle	Eastern and Coastal Kent
Tracey Jones	Development Officer - CVS Medway
Tracey Wightman	MCCH
Tracy Smith-Dance	Head of Services, Sevenoaks Area Mind
Vanessa Fowler	Head of Specialist Mental Health & Secure Services Commissioning For Kent and Medway

APPENDIX 3:

EFFECTIVE INTERVENTIONS (Kensington and Chelsea Suicide Prevention Strategy 2009)

1. INTERVENTIONS WITH EVIDENCE OF EFFECTIVENESS

1.1 INTERVENTIONS AIMED AT THE GENERAL POPULATION

- Depression screening and group activity for elderly people
- Gatekeeper training for those in contact with potentially vulnerable people
- Media training and guidelines to promote responsible reporting
- Family based interventions tackling family risk factors linked to mental health of offspring
- Screening tests for suicide risk
- GP Education on risk factors and what to do

1.2 INTERVENTIONS WITH SUB POPULATIONS

- On line screening for suicidality of university students
- Counselling and support for “at risk” Groups in universities
- Sliding doors and barriers on the underground
- Deep pits under rails on the underground
- Skills based training and social support for “at risk” adolescents
- Behavioural change programmes

1.3 INTERVENTIONS WITH “AT RISK” GROUPS THAT WORK

- Optimal clinical care for people with mental illness
- GP Training in recognising and treating depression in older adults
- Anti-depressant prescribing and SSRI
- Prescribing: Clozapine, Lithium, Depot Flupenthixol
- CMHT’s

- Follow up letter after discharge
- Transfer of information to and from prison to ensure continuity of care – especially regarding those considered at risk of suicide
- Counselling for problem drinkers
- Problem solving skills training for at risk adolescents in schools

1.4 INTERVENTIONS WITH THOSE WHO HAVE ATTEMPTED SUICIDE OR SELF HARM

1.4.1 Attempted Suicide

- Training in resucitation and emergency management for hospital staff
- "Chain of care" – structured collaboration, multi-disciplinary network
- Therapies: problem solving, dialectical behaviour
- "ASIST" interventions and "ASIST" training for staff (Applied Suicide Intervention and Support training)

1.4.2 Self Harm (adults)

- "Green Card" with emergency numbers/contacts
- Mentalisation Based Treatment (MBT)
- Dialectical Behaviour Therapy

1.5 MEANS RESTRICTION

- Educating parents/carers about limiting access to means
- Restriction on sale and prescription of barbiturates
- Barriers at jumping sites
- Analgesics in blister packs
- Media blackout/restrictions
- Restrictions on access to alcohol

- Use of lower toxicity anti-depressants
- Removing ligature points from in patient wards/regular audits
- Reduce amount of paracetamol sold per packet
- Restricting the availability of Coproxamol

APPENDIX 4: KENT AND MEDWAY SUICIDE PREVENTION IMPLEMENTATION PLAN 2010-2015

	Action needed	Lead agency/contact	Completion date
Priority 1: To reduce risk in key high risk groups			
Reducing suicide rates for those in contact with mental health services	KMPT Suicide Audit to continue on an annual basis to provide appropriate information for action	Mike Kingham: Kent and Medway NHS and Social Care Partnership	Ongoing As on action plan attached
	Action plan for KMPT suicide prevention strategy to be implemented (See attached)	Mike Kingham Kent and Medway NHS and Social Care Partnership Trust	
	Liaise with other key providers of mental health services to ensure that appropriate suicide prevention action is in place	PCTs Public Health/Mental Health Commissioning	
Reducing suicide rates for those who have self harmed	Promote compliance with NICE guidance on self harm by • clinical staff, • primary care, • other relevant agencies substance misuse staff, housing	Acute Trusts/PCTS/KMPT	
	Specifically • Carry out an audit of the treatment and management of self harm in A&E departments across Kent and Medway.	Lead: Kim Solly A&E liaison	Dec 2010
	• Develop and deliver appropriate training for A&E staff in response to this audit	Lead: Kim Solly A&E liaison	June 2011
	• Links between primary care, A&E and secondary care need to be improved. Robust A&E liason	Lead: Kim Solly A&E liaison	June 2011

	Action needed	Lead agency/contact	Completion date
	services to be in place across Kent and Medway • Ensure appropriate training developed and delivered for primary care staff.	PCTS/MHP specialists	March 2011
Reducing suicide rates in men targeting the unemployed and routine and manual groups	• Ensure Credit Crunch Stressline number promoted across Kent and Medway • Liaise with Jobcentre Plus + other agencies working with unemployed men to ensure appropriate training around mental health awareness and suicide prevention training	Comms PCTs/MHP specialists/Samaritans	August 2010
Reducing suicide rates amongst offenders	• Monitor prison health performance indicators around suicide prevention. • Ensure mental health services for prisons are funded appropriately across Kent and Medway • Ensure permanent funding of CPN assessment in custody suite diversion services across Kent and MedwayPCT. • Training for all police officers in identification and referral for people with mental health disorders	Kent and Medway Offender Health Partnership Board Vanessa Fowler/ Mental Health Commissiong Matt Long Kent Police	Ongoing Ongoing Dec 2010
Reducing suicide rates amongst older people	Training for agencies working with older people to include suicide prevention awareness Investigate introducing a psychological aspect to the care plan of someone with a long-term condition	Karen Macarthur PH Lead	tbc
Improving the primary care response to identification and management of suicide risk	Liaise with primary care to ensure 1 significant event audit carried out per PCT per year on a completed patient suicide . Ensure appropriate training for GPs in all PCTs on	Karen Macarthur PH Lead PCTs	tbc

	Action needed	Lead agency/contact	Completion date
	identification and assessment of high risk patients, depression and suicide screening , signposting /referral to secondary care, social care and the voluntary sector , social prescribing and psychological therapies		
Actions for agencies working across all the risk groups	Ensure appropriate mental health awareness/suicide prevention training (e.g ASIST and STORM) in all agencies working with high risk groups. This includes • Health and social care staff • Job Centre + staff • Voluntary agencies • Police • Youth workers • Probation staff Specifically training needs analysis across Kent and Medway to be carried out for key agencies.	Bose Johnson: MHP specialist/ Partners	Dec 2010
Priority 2: To promote wellbeing in the wider population			
Population based mental health promotion interventions	• To ensure that information as to appropriate information help are widely available. Samaritans, Mental Health Matters information to be publicised more widely. • To support the promotion of the mental health and wellbeing 5 a day message and the Live It Well website on all NHS and provider websites	Comms PCTs MHP specialists	Dec 2010
Targeted interventions for improving the mental wellbeing of those bereaved particularly by suicide	• Circulate copies of “Help is at Hand” suicide bereavement support pack aimed at those who have lost someone through suicide to coroners, registrars, hospitals, police and funeral directors. • Investigate access to bereavement counseling and	NHS Medway/Samaritans/Comms	Dec 2010 Dec 2010

	Action needed	Lead agency/contact	Completion date
	take steps to improve		
Targeted interventions for those in financial difficulties	• Support access to debt advice and ensure all health and social care workers are trained in signposting appropriately	MHP specialists	
Targeted interventions for people who misuse drugs or alcohol	• Carry out training needs analysis to identify current gaps for drug and alcohol workers with respect to mental health awareness and suicide prevention training. • Ensure appropriate training delivered in all providers including signposting to mental wellbeing services. • Kent wide suicide prevention review panel set up to review all cases of suicide in contact with alcohol servces at the time of death or in the previous 12 months	KDAAT/MDAAT	Dec 2010 March 2011 Dec 2010
Targeted interventions for those with relationship difficulties	• Investigate level of current provision across Kent and Medway and identify additional signposting and resource issues	Karen Macarthur MHP specialists	Dec 2010
Priority 3: To reduce the availability and lethality of suicide methods			
Reduce the numbers of suicides by hanging and suffocation	• TBC		
Reduce the numbers of suicides by self-poisoning	• Investigate use of "Scriptwatch" system to produce "pop-up" boxes listing advised volumes and safer anti depressants • Advise prescribers that all patients with a history of self harm in the past 3 months should receive limited supplies of medicine e.g. covering no more than 2 weeks • PCT Medicines management teams to support community pharmacies to conduct audit of antipsychotic medication concordance to identify signs that patients are not taking high risk medicines correctly.	Anne Child Medicines Management NHS Medway	September 2010 September 2010 March 2011

	Action needed	Lead agency/contact	Completion date
	• Ensure activated charcoal available in all A&E's and ambulances and staff appropriately trained .		
Reduce the numbers of suicides on the railways	• Liaise with railways to identify appropriate additional actions.	Karen Macarthur PH Lead	June 2010
Reduce the numbers of suicides by jumping from a high place	• Using police data o identify hotspots o work with local agencies, the police and the Samaritans in order to mange appropriately with reference to national guidance	PCTs/Police/Samaritans Matt Long Kent Police	August 2010
Priority 4: To improve the reporting of suicidal behaviour in the media	• Circulate "*What's the story" Reporting Mental Health and Suicide: A resource for journalists and editors* to all appropriate news agencies in Kent and Medway. • Monitor reporting of suicide coverage in the media and intervene as appropriate	PCTs/ Communications	September 2010
Priority 5: To ensure appropriate monitoring of suicide statistics and audit of services	• To work with KMPHO, PCTs, acute Trusts,the police and other partner agencies to ensure detailed information on suicides across Kent and Medway is collected and analysed. • To prepare and present updated suicide statistics and trends to the K&M suicide steering group, the Kent and Medway Mental Health Strategic Commissioning Board and the Joint Mental Health Commissioning Boards of the 3 PCTs. • To ensure appropriate information sharing protocols are in place and agencies can respond • To carry out audits of management of self harm in A&E across all acute Trusts, • KMPT audit to continue • Significant event audits of suicides in contact with primary care to be carried out • Audit of prescribing of anti-psychotic medication in primary care	KMPHO/ Public Health	Ongoing Annually

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By:	Graham Gibbens, Cabinet Member, Adult Social Services Oliver Mills, Managing Director, Kent Adult Services Directorate
To:	Adult Social Services Policy Overview and Scrutiny Committee – 16 November 2010
Subject:	**SAFEGUARDING VULNERABLE ADULTS**
Classification:	Unrestricted

Summary: This report will provide information about safeguarding adults in Kent in 2009/2010 and national policy developments.

Introduction

1. (1) This report will summarise the safeguarding activity carried out between April 2009 and March 2010. It is a single agency report but includes the support provided to KASS by our multi-agency partners including, Medway Council, NHS Trusts and the Police.

The Kent and Medway Safeguarding Adults Structure and Governance

2. (1) Since the last annual report there has been a full review of the multi-agency safeguarding structure and governance following the appointment of a Safeguarding Adults Board Manager in September 2009. The outcome of the review was confirmation that safeguarding adults arrangements in Kent and Medway are managed through the Kent and Medway Safeguarding Adults Board, chaired by the Managing Director of Kent Adult Social Services or Medway's Assistant Director of Social Care. The Board and a newly formed Executive Team led by the Board Manager involve representatives from the commissioning agencies, which are social services, health and the police.

(2) Plans to maintain the involvement and engagement of other agencies and providers of services will be through two network meetings held each year. Carers and users of services will be involved in safeguarding through the work of the KASS Public Involvement Team and LINks. The aim will be to use our Safeguarding Adults Coordinators and where appropriate, safeguarding leads from partner agencies, to meet with and raise awareness and understanding of safeguarding issues directly to existing groups of users, carers and the public throughout the county.

(3) The full engagement of commissioning and provider partners within operational practice will be led through two AMT safeguarding board sub-groups in Kent and a Medway sub-group, ensuring that locality issues will be addressed effectively.

(4) Other sub-groups of the board are: Training, Policy, Protocol and Guidance and Serious Case Review.

(5) The Board's budget finances the posts of the Board Manager, a Board Administrator, two Multi-Agency Adult Protection Training Consultants and a Training Administrator. In addition, the budget funds the printing of leaflets and booklets to promote safeguarding awareness for the public, service users and service providers.

(6) The governance of safeguarding will primarily be through the Kent and Medway Safeguarding Vulnerable Adults Executive Board, with the Executive Team members taking a lead within their agencies to ensure that decisions taken by the Board are implemented. However, each agency and service will also be responsible, through their own governance structures, to report on their safeguarding arrangements, focussing on the prevention of abuse and their compliance with the multi-agency policy, protocols and guidance.

(7) Given these far reaching changes to the Board and to the major challenges which currently face member agencies at this time, the Board felt it prudent to delay the Multi-Agency Annual Report until the summer of 2011. This report will be a report covering the period of 2009 – 2011. In the meantime it was important that the Directorate kept Members updated on Safeguarding matters.

(8) We continue to have strong links with the Kent Children's Safeguarding Board, of which Kent Adult Social Services are a member. A key priority will be to ensure that this relationship is strengthened over the next year.

The National Context

3. (1) A number of national developments which influenced and impacted upon safeguarding adults work in Kent and Medway include:

- **The Review of No Secrets** started with a consultation document published by the DH in October 2008. Kent and Medway led responses to the consultation which closed at the end of January 2009. The outcome of the consultation was published in July 2009 and amongst the issues identified were the need for: legislation, statutory safeguarding adults boards, building on empowerment of users, supporting choice and control by providing information, quality of services and prevention to have a higher profile. The system must be appropriate to adults and not adapted from safeguarding children. Vulnerable adults are to be fully involved in the process. In January 2010, Care Minister Phil Hope announced that he expected key components to strengthen safeguarding procedures, these were:
    - an interdepartmental ministerial group to coordinate the response across government
    - legislation to put safeguarding boards on a statutory footing.

  The election has led to the delay in publication of the government response which is now expected towards the end of 2010.

- **Law Commission Consultation Paper 192,** published on 24 February 2010, sets out proposals to review adult social care legislation. Responses were required by July 2010. Section 12 considered safeguarding adults and included the proposal to use the term, 'Adult at Risk' in place of, 'Vulnerable Adult'. Responses to the consultation from a safeguarding perspective were made by local authority safeguarding leads in focus groups across the country and formally through the ADASS.

- **Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLs)** came into force on 1 April 2009, providing a legal framework to prevent the unlawful deprivation of liberty occurring. They protect people in care homes and hospitals by providing statutory assessments and authorisation for those who lack capacity to consent to arrangements made for their care and/ or treatment to be deprived of their liberty.

Where deprivation occurs and is not authorised, steps are taken to provide care/ treatment in a way that does not break the law.

- **The Mental Capacity Act 2005** introduced two new criminal offences, which are: a) the ill treatment or b) the wilful neglect of a person who lacks capacity. Convictions for offences are beginning to be successful across the country. However, there is evidence that the CPS will use offences such as common assault or fraud to gain conviction without having to prove lack of capacity. This then relies on the court to reflect the seriousness of the offence against a vulnerable adult in the sentence handed down. In addition, it obscures the number of crimes committed against adults who lack capacity.

- **The Safeguarding Vulnerable Groups Act 2006** led to the introduction of the Independent Safeguarding Authority (ISA). From October 2009 the Vetting and Barring Scheme administered by the ISA became responsible for making decisions about people who should be barred from working or volunteering with children and/ or vulnerable adults. The legislation places a Duty on Local Authorities to report to the ISA any worker or volunteer they believe to have harmed, or placed at risk of harm, a child or vulnerable adult, where the authority considers that the ISA may bar the person. This new duty has led to KASS staff making referrals to the ISA even if the employer has failed in their duty to make the referral. Any failures by the employer to report workers or volunteers to the ISA will be reported to the Care Quality Commission.

- **Care Quality Commission** (CQC). In April 2009, the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Commission merged to form the Care Quality Commission. This has had an impact, with all providers of services including, local authorities and NHS Trusts, having to register with CQC under the new regulations. Some registrations, particularly in the NHS, have been agreed with conditions related to safeguarding adults. This has focussed the attention of all NHS Trusts on their responsibilities in safeguarding adults. In addition, the Department of Health has produced documents for the NHS entitled, *'Clinical Governance and Adult Safeguarding',* along with additional guidance and *'Safeguarding Adults: A guide for NHS commissioners and provider boards'*. These documents and specific performance indicators aim to ensure that the abuse of vulnerable adults occurring in NHS services is recognised as such and is addressed in an integrated manner through the multi-agency safeguarding arrangements, where appropriate.

- **On 24 March 2009 a report by the Health Service Ombudsman,** Ann Abraham, was published following the MENCAP 2007 report entitled, *'Death by Indifference'*. This was a study that identified the neglect and failures of health and social care which were implicated in the deaths of six people with learning disabilities. The Ombudsman's report highlighted:
    - significant and distressing failures in service across health and social care
    - one person died as a consequence of public service failure. It is likely the death of another individual could have been avoided, had the care and treatment provided not fallen so far below the relevant standards
    - people with learning disabilities experienced prolonged suffering and poor care and some of these failures were for disability related reasons
    - some public bodies failed to live up to human rights principles, especially those of dignity and equality

- many organisations responded inadequately to the complaints made against them, which left family members feeling drained and demoralised.

The main recommendation was that NHS bodies and councils urgently confront whether they have the correct systems and culture in place to protect individuals with learning disabilities from discrimination, in line with existing laws and guidance.

- **Health Action Planning and Health Facilitation for people with learning disabilities:** good practice guidance was published in March 2008 and is cross referenced to, *'Valuing People Now'*. It references a succession of reports, including that of Sir Jonathan Michael's independent inquiry, which have highlighted some basic shortcomings in the way that services are provided for people with a learning disability, contributing to poorer health outcomes, avoidable suffering and at worst, avoidable deaths. It maintains that all NHS organisations, whether as providers or commissioners, have a basic duty to promote equality for disabled people and make reasonable adjustments to the way in which services are delivered to meet their individual needs. This should apply as much to promoting health as it does to treating illness. The integration of learning disability health and social care within locality care management teams is a major factor in supporting people with a learning disability to access the health care they need.

Local Context

4. (1) **Personalisation**. Throughout this period, KASS has undertaken a major restructuring of the Directorate, in order to ensure that personalisation is delivered through Self Directed Support (SDS). This involved many staff and managers moving to different roles in new locations. The direct outcome for safeguarding was an increase in the number of Safeguarding Adults' Coordinators, from seven to eleven. This included two additional coordinators for West Kent and two specialist coordinators for learning disability based in each area. The specialist coordinators for learning disabilities main focus is on the care and support provided to people moving from NHS campus care into community settings.

(2) Some managers and practitioners who previously had a support role in addressing adult abuse concerns moved to positions where they are responsible for the effective management of all safeguarding activity including managing safeguarding coordinators. Additional single agency training was set up for these managers and practitioners. This included the role of the practitioner in addressing allegations of abuse, decision making and accountability.

(3) The Positive Risk Management Policy also supports safeguarding principles within the context of personalisation and choice. This policy was presented to members in early 2009 and sets out guidance and support to the management of risk with the context of personalisation

5. (1) **The CSCI / CQC Inspection**. In March 2009, the Commission for Social Care Inspection (CSCI), now the Care Quality Commission (CQC), carried out an Independence, Wellbeing and Choice Inspection of KASS in relation to Safeguarding Adults and Delivering Preventative Services. The outcome of the safeguarding aspect of the report was good and four recommendations relating to safeguarding were made, which have been the focus of activity by KASS with support from our multi-agency partners. A summary of the progress towards the recommendations relating to safeguarding is included in this report at Appendix 2.

(2) Preparation for the Inspection, as well as the Inspection itself, helped to raise the general awareness and understanding of the impact of the abuse of vulnerable adults within KCC and our partner agencies and services.

(3) An important aspect of the inspection preparation was the auditing of adult protection case papers. This has now become a formal part of the adult protection process, ensuring that each case is audited by another senior practitioner prior to closure. The audit tool system does not pose risks to any individual. All paperwork is completed, post abuse care plans are in place and all agencies are aware of the post abuse care plan. The client and their family are kept informed of the process and that the case has been concluded.

6. (1) **Response to CQC in Regard to Safeguarding**. Following on from the Inspection we continue to have an ongoing dialogue with CQC in respect to safeguarding and the way in which we audit cases. Recent discussions have focused on the table below. This shows that 42% of cases are not closed on SWIFT within the standard time of 6 months. The issues behind these figures have been outlined to CQC and are as follows:

- These cases are waiting to be audited or for the case to be signed off by the Head of Service before being input onto SWIFT and the case work has been completed.
- The audit tool delays cases being signed off by Heads of Service and closed on the system, but the cases are closed.
- Closure of cases on SWIFT is an audit and administrative function of the business only and has no impact on the individual.

(2) A recent data quality audit undertaken by KCC internal audit reported a minimal risk within our safeguarding process. This was because, despite the delay in getting cases signed off and closed on SWIFT, the quality of record keeping on all files of the individuals concerned were all up to date.

(3) It is also important to note that the number of multi-agency cases and the number of institutional cases have increased. These add to the complexities of investigations and inevitably take longer.

(4) An action plan is in place to address the backlog of cases waiting to be closed on SWIFT. This will be regularly reviewed by the Strategic Management Team.

30 days or fewer	10.9%
30 - 90 days	22.5%
3 – 6 months	24.2%
Between 6 months and 1 year	24.8%
Over 1 year	17.6%

Closed Cases in April 2009 – March 2010 by length of time between alert and signoff

(5) In order to raise safeguarding awareness for the public, we planned the first Kent and Medway Safeguarding Awareness Week. This took place in June 2010 and the planning and activities during the week involved a wide range of partner agencies and services. As the focus of the activities was to raise awareness amongst members of the public, the events were held in public places, such as shopping centres. 30 events took place and 10,000 pens and leaflets were distributed. Several people raised safeguarding issues which were followed up. Safeguarding Awareness Week coincided with Carers Week. This will be an annual event in the future.

7. (1) Safeguarding Adults Quality in Care. There are two main aims of safeguarding adults work. The first is preventative work, which has focussed primarily on adult protection training, awareness raising and contracting with services that meet our quality standards. The second is protective work, which involves KASS staff coordinating responses to allegations of abuse. The need for this reactive response to what has often been devastating event(s) for victims and their families is also resource intensive for KASS and for our multi-agency partners. Initially, the engagement of multi-agency partners, including the regulatory authority in sharing information, could only be carried out under the auspices of the multi-agency adult protection arrangements. However, with the greater understanding of the impact of adult abuse and the development of a wider remit of safeguarding adults, it has been possible to take a more proactive approach to concerns about poor quality and practice with providers of services.

(2) In both East and West Kent, Quality in Care (QiC) pilot projects have been running, to work proactively with providers where concerns have been raised about their delivery of care which, if not addressed, is likely to lead to the abuse of service users. These projects have been successful in engaging a virtual team of people from different agencies to support the provider to meet their improvement action plan. It has been agreed that the QiC project will be developed into a multi-agency safeguarding adults QiC framework and this will develop into a separate Kent and Medway multi-agency safeguarding protocol.

8. (1) **Competency Framework**. Training is considered to be a very significant aspect of practitioner development. It is, however, essential to ensure that the integration of safeguarding training and practice experiences post training are used to confirm that a practitioner is assessed as competent to carry out aspects of the adult protection process. These include investigation, assessment of the impact of abuse, decision making and accountability and effective post abuse planning. KASS staff have been involved in the development of a multi-agency safeguarding competency framework. An assessment tool will enable all staff to record training and other developmental experiences and for managers and specialist staff to confirm a practitioner or manager is competent to carry out aspects of safeguarding work.

9. (1) **Policy Protocols and Guidance**. The Multi-Agency Adult Protection Policy Protocols and Guidance continue to be reviewed and updated on a six monthly basis by the review group, which includes representatives of the lead agencies, private and voluntary sector service users and carers. The revised document is published on the KCC adult protection website on 31 January and 31 July of each year and can be found at: **www.kent.gov.uk/adultprotection**

10. (1) **Training**. KASS staff access a range of adult protection training. *Level 1: Awareness* training is delivered in house. Staff normally access Levels 2 – 6 through the multi-agency training system. As a result of the KASS restructuring, some practitioners and managers who previously had limited involvement with adult protection required more advanced adult protection training to enable them to carry out their new roles. KASS funded additional KASS single agency courses for *Level 2: The Practitioner Role* and *Level 5: Decision Making and Accountability*. As there is very high demand for the Level 2 courses by KASS and all other agencies, KASS plan to fund at least three additional single agency courses for 2010/ 2011. KASS practitioners also accessed the two pilot Multi-Agency Refresher Training courses for Levels 2 – 6, which aim to keep them up to date with changes related to policy, practice, case law and legislative and guidance changes.

(2) Adult protection training for staff and managers in the private and voluntary sectors has always been a high priority for KASS and the multi-agency training strategy. The *Training the Trainer in Adult Protection* model has been very successful in enabling services to have members of their staff trained to deliver awareness training to all their staff in line with the KASS contracts and the regulations monitored by the Care Quality Commission. Level 2 training for the private and voluntary sectors has been recognised as a priority to ensure that services have an understanding of adult protection processes beyond making a referral; six Level 2 courses for the private and voluntary sectors have been planned for 2010/ 2011.

(3) Following the Pilkington Case, it was recognised that the Community Housing Teams do not currently access multi-agency training, as they do not contribute to the funding pool. To address this potential gap in awareness and to minimise the risks of a similar case in Kent and Medway, safeguarding awareness training was developed and offered to Housing management staff. The training took place over three half days sessions on 20 and 21 May 2010. Several contacts have been made following the events for additional and more advanced training.

(4) Issues of Mental Capacity are often central to adult protection cases and all levels of training include aspects of the Mental Capacity Act 2005 which are relevant to the course concerned. In addition, the Deprivation of Liberty Safeguards implemented in April 2009 considers possible abuse if a person is unlawfully deprived of their liberty.

(5) The interactive e-learning adult protection awareness training package has been commissioned through the multi-agency training arrangements. This package is available to staff and volunteers in all agencies and services in Kent and Medway. It is usually accessed to provide initial or refresher information for those who have booked other training courses.

(6) Adult Protection training is valued by practitioners and managers from all agencies and feedback from courses continues to show a very high level of satisfaction with the trainers, the training content and the course material, which helps practitioners to carry out their responsibilities within the wider safeguarding areas of both prevention and protection.

(7) A summary of courses delivered and attendance over the past two years are shown in Appendix 3.

(8) Work is underway to develop an online application form for safeguarding training provided at a multi-agency level (Levels 2 – 6 and Training the Trainer in Adult Protection). Completed application forms will populate a spreadsheet, enabling data to be analysed to report information requested by CQC. A pilot form will run from 1 November 2010 and it is proposed to have the new system in place on 1 January 2011. This is part of a fundamental review of safeguarding training, given the number of agencies and providers involved.

(9) An online review mechanism is also being introduced for all courses to capture feedback from delegates in terms of how they have used the training in their roles. The information collated will be used to evidence outcomes of training.

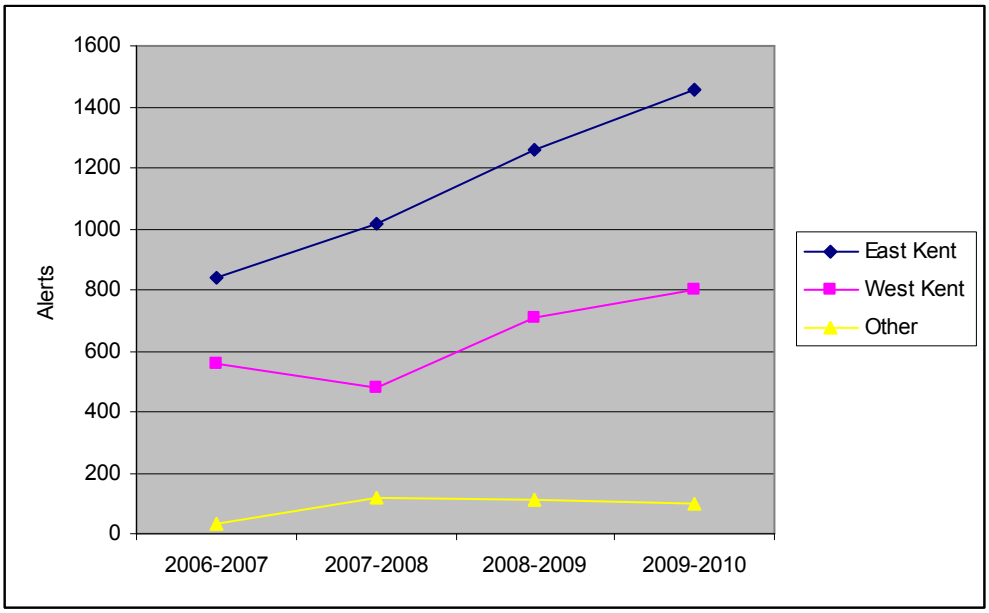
Safeguarding Activity

11. (1) A summary report of adult protection data of cases alerted during 2009/2010 is shown in Appendix 1. The data indicates an increase in the rate of referrals since 2007/2008 (table 1, Appendix 1), which reflects the impact of awareness raising, greater understanding and increased training. It is to be noted that this is set against a backdrop of increasing demographics. Over the last 10 years Kent's older population has increased by 13.3%. In the next 10 years Kent's older population is forecast to increase by 16% and within the next 20 years it is forecast to increase by 30.7%. The older population is forecast to grow at a faster rate than the whole population of Kent. By 2011 the older population in Kent is estimated to be 537,800. There is also an imbalance in the 50+ population between males and females. For every 100 males there are 117 females. (The Older People of Kent, 2008, KCC)

(2) The table and graph below show changes in rates of referrals between 2006/2010. It is predicted that the Quality in Care work described in section 3 will lead to a reduction in Adult Protection Alerts, as concerns about quality and poor practice will be addressed by more proactive work with care providers.

	2006-2007	2007-2008	2008-2009	2009-2010
East Kent	841	1019	1261	1456
West Kent	557	480	705	803
Other	33	119	111	98

Adult Protection alerts recorded in Kent, 2006/2010



Adult Protection alerts recorded in Kent, 2006/2010

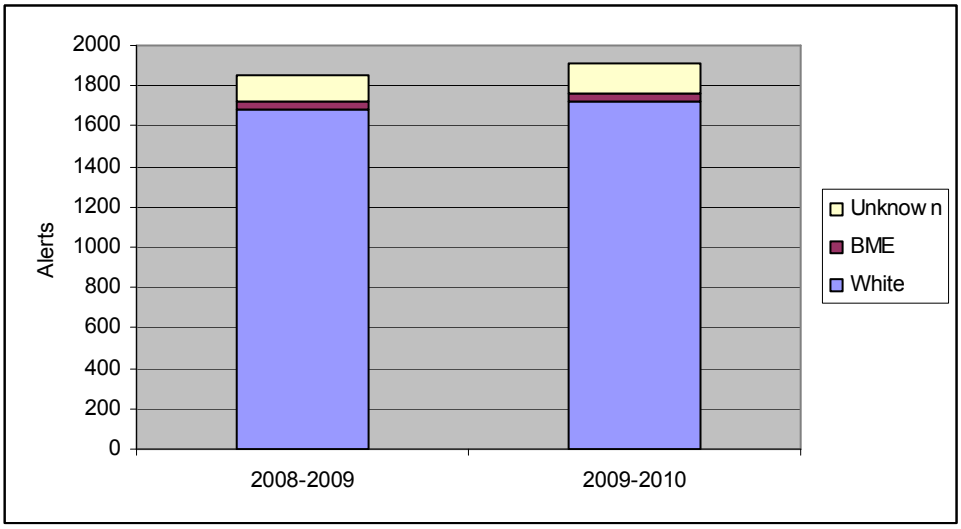
(3) Data shows that there is an increased likelihood of being a victim of abuse for older people, with 66% of alleged victims over the age of 65 (1.2, Appendix 1). Victims of abuse are also more likely to be female than male (62% female, compared to 38% male), with current figures reported in 1.3, Appendix 1, remaining consistent with those reported last year.

(4) There has been a focus on raising awareness amongst BME communities but despite this activity, there has been little impact on the figures reported, as highlighted

in the table and graph below. Work continues with BME communities to explore this issue.

	2008-2009	2009-2010
White	1684	1718
BME	39	41
Unknown	132	150
Total	1855	1909

Adult Protection alerts recorded in Kent 2008/2010, by ethnicity



Adult Protection alerts recorded in Kent 2008/2010, by ethnicity

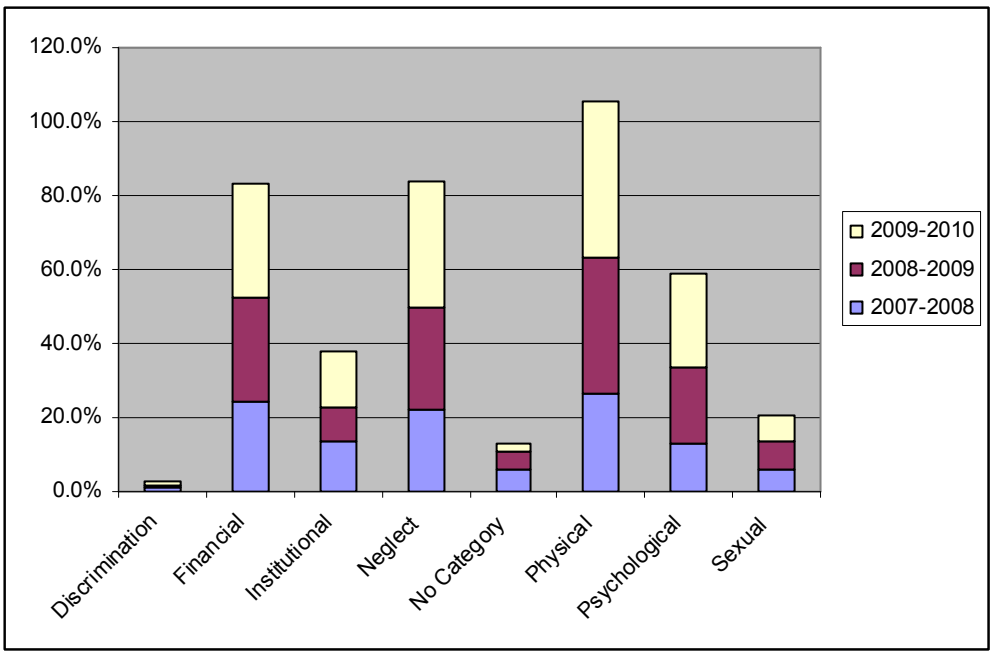
(5) During 2009/2010, the largest source of alerts was Social Care staff, accounting for 38.2% of all alerts (1.6, Appendix 1). Data shows that 37.2% of alleged incidents occurred in individuals own homes and 31% took place in care homes during 2009/2010 (2.1, Appendix 1).

(6) In terms of categories of abuse, the graph below shows that levels of physical abuse continues to be high. Financial abuse is increasing, with the Fraud Act assisting in addressing this type of abuse. In addition, the last year has also seen an increase in levels of institutional, neglect, physical and psychological abuse.

	2007-2008	2008-2009	2009-2010
Discrimination	0.9%	0.6%	1.3%
Financial	24.1%	28.1%	31.3%
Institutional	13.4%	9.2%	15.4%
Neglect	22.1%	27.6%	34.0%
No Category	5.9%	4.9%	2.2%
Physical	26.7%	36.7%	42.0%
Psychological	12.8%	20.7%	25.5%
Sexual	6.1%	7.5%	7.1%

Percentage types of abuse, 2007/2010*

*Figures do not sum as some victims are the subject of multiple abuse.



Percentage types of abuse, 2007/2010

Recommendations

12. Members are asked to NOTE the contents of this report.

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Background documents:
Adult protection report to Members, January 2000
Adult protection report to Members, July 2000
Adult protection report to Members, September 2001
Adult protection briefing seminar for Members, September 2002
Adult protection SCHPOC Report July 2004
Adult protection SCHPOC Report July 2005
Adult protection ASPOC Report November 2006
Adult protection ASPOC Report November 2007
Multi agency safeguarding adults Report 2007/ 08
Multi agency safeguarding adults Report 2008/09

Appendix 1

Adult Protection Annual Performance Report

Background to data

The data for this report was extracted from Swift for the period 1 April 2009 to 31 March 2010.

1. Adult Protection Alerts

1.1 Rates of referrals – changes between 2008/ 2009 and 2009/ 2010

During the year 2008/ 2009, 2,077 Alerts (1,855 clients) were recorded and 2,357 (1,909 clients) for the year 2009/ 2010. The table* below shows there is a general increase of 13% in the referral rate over the two periods.

	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	% change between periods
Ashford and Shepway	37	162	
Canterbury and Swale	38	265	
Thanet and Dover	16	255	
East Kent LD	122	126	
Ashford Adult District	119	64	
Canterbury Adult District	109	47	
Dover Adult District	212	170	
Shepway Adult District	183	91	
Swale Adult District	139	98	
Thanet Adult District	269	173	
East Kent Other	17	5	
East Kent Total	**1261**	**1456**	**15%**
Dartford, Gravesham and Swanley	22	100	
Maidstone and Malling	58	158	
South West Kent	11	114	
West Kent LD	148	146	
Dartford Adult District	36	32	
Gravesham Adult District	66	29	
Maidstone Adult District	156	67	
Sevenoaks Adult District	64	50	
Tonbridge and Malling Adult District	72	44	
Tunbridge Wells Adult District	57	48	
West Kent Other	15	15	
West Kent Total	**705**	**803**	**14%**
Headquarters	4	5	25%
Mental Health	76	51	-33%
Not Recorded	31	42	35%
County Total	**2,077**	**2,357**	**13%**

Table 1: Adult protection alerts recorded in Kent between April 2008 and March 2010

*Alerts were previously recorded in Districts before Localities, therefore, the above table shows both Districts and Localities in order to include all alerts.

Analysis of the table above shows that Canterbury and Swale have the highest number of alerts across the localities. Although the alerts are still increasing, with a 13% increase between 2008/ 2009 to 2009/ 2010, this increase is smaller than that reported in the previous report, 19.1% between 2007/ 2008 to 2008/ 2009.

East Kent has a significantly higher number of Adult Protection alerts than West Kent.

The table below shows the number of alerts recorded for each area over the two years covered by this report, by month to illustrate the fluctuations.

	East Kent	West Kent	Mental Health	Learning Disability	Head Quarters	Not Recorded
Apr 08	104	40	6	23	0	3
May 08	76	39	11	18	1	0
Jun 08	76	39	8	22	0	2
Jul 08	105	89	7	29	1	1
Aug 08	93	34	6	29	0	1
Sep 08	110	37	4	24	0	4
Oct 08	135	38	13	28	0	3
Nov 08	102	48	6	31	0	4
Dec 08	77	42	3	16	0	4
Jan 09	82	40	5	16	0	2
Feb 09	87	47	4	20	0	4
Mar 09	92	64	3	14	2	3
Apr 09	113	48	7	35	0	3
May 09	145	45	7	22	0	5
Jun 09	88	51	4	25	0	4
Jul 09	146	41	3	27	0	3
Aug 09	103	59	2	22	2	4
Sep 09	109	58	5	16	0	5
Oct 09	86	65	2	15	0	2
Nov 09	164	70	4	23	1	4
Dec 09	60	48	6	20	2	3
Jan 10	95	32	3	20	0	3
Feb 10	104	73	5	18	0	1
Mar 10	117	67	3	29	0	5
Total	**2469**	**1214**	**127**	**542**	**9**	**73**

Table 2: Breakdown of alerts by month April 2008 to March 2010

Table 3* below shows the percentage of Alerts that related to vulnerable adults who had been subject to a previous Alert in the last 12 months.

East Kent shows a decrease of 1% over the 2 years, West Kent has not changed. Repeat victimisation is always an issue of concern for all agencies, however, adults who have capacity may choose to stay or return to risky situations. Post abuse care plans provide strategies to reduce risk but clients' choice has to be respected as long as they have mental capacity to make decisions.

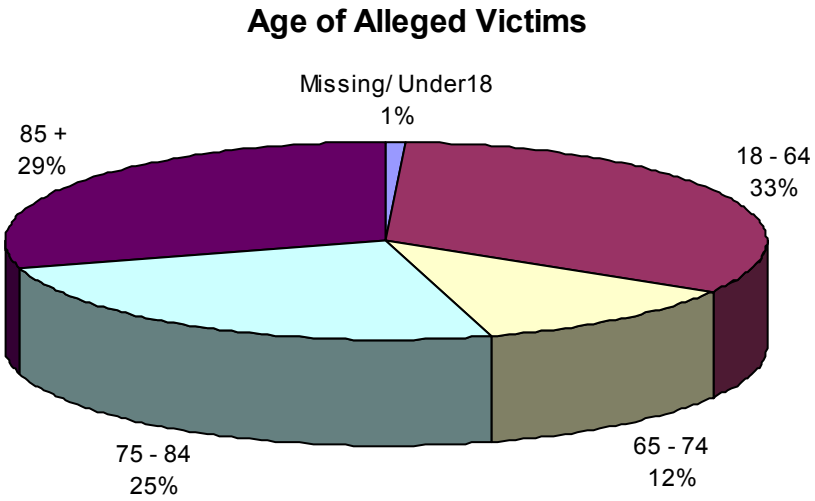
	Apr 2008 to Mar 2009	**Apr 2009 to Mar 2010**	**% change between 1st and last periods**
Ashford & Shepway	19%	14%	
Canterbury & Swale	5%	9%	
Thanet & Dover	6%	16%	
East Kent LD	13%	21%	
Ashford Adult District	21%	19%	
Canterbury Adult District	8%	9%	
Dover Adult District	19%	15%	
Shepway Adult District	30%	18%	
Swale Adult District	13%	15%	
Thanet Adult District	10%	20%	
East Kent Other	6%	0%	
East Kent Total	**16%**	**15%**	**-1%**
Dartford, Gravesham & Swanley	18%	11%	
Maidstone & Malling	31%	12%	
South West Kent	9%	11%	
West Kent LD	16%	20%	
Dartford Adult District	8%	6%	
Gravesham Adult District	11%	10%	
Maidstone Adult District	12%	12%	
Sevenoaks Adult District	11%	14%	
Tonbridge & Malling Adult District	7%	20%	
Tunbridge Wells Adult District	5%	13%	
West Kent Other	7%	7%	
West Kent Total	**13%**	**13%**	**0%**
Headquarters	0%	20%	
Mental Health	9%	8%	
Not Recorded	10%	17%	
County Total	**14%**	**15%**	**0%**

Table 3: Adult protection alerts recorded in Kent between April 2008 and March 2010 – where the alleged victim had a previous alert

* Alerts were previously recorded in Districts before Localities, therefore, the above table shows both Districts and Localities in order to include all alerts.

1.2 Age of Alleged Victims

As previously outlined in the main body of the report, these figures are set against a backdrop of an increasingly ageing population, thereby resulting in a higher percentage of alleged victims and the changing age profiles. Of the 1,909 alleged victims during the period April 2009 to March 2010, there has been no significant variation in the percentages in each age band to the last report (33% are aged 18 to 64, 12% aged 65-74, 25% aged 75-84 and 29% are aged 85 and over). The small variations from the figures last reported are in the 18-64 age group, which has decreased 6%, 75-84, which has increased by 3% and 85+, which has increased by 2%.



The differences between the areas are shown in the graph below.

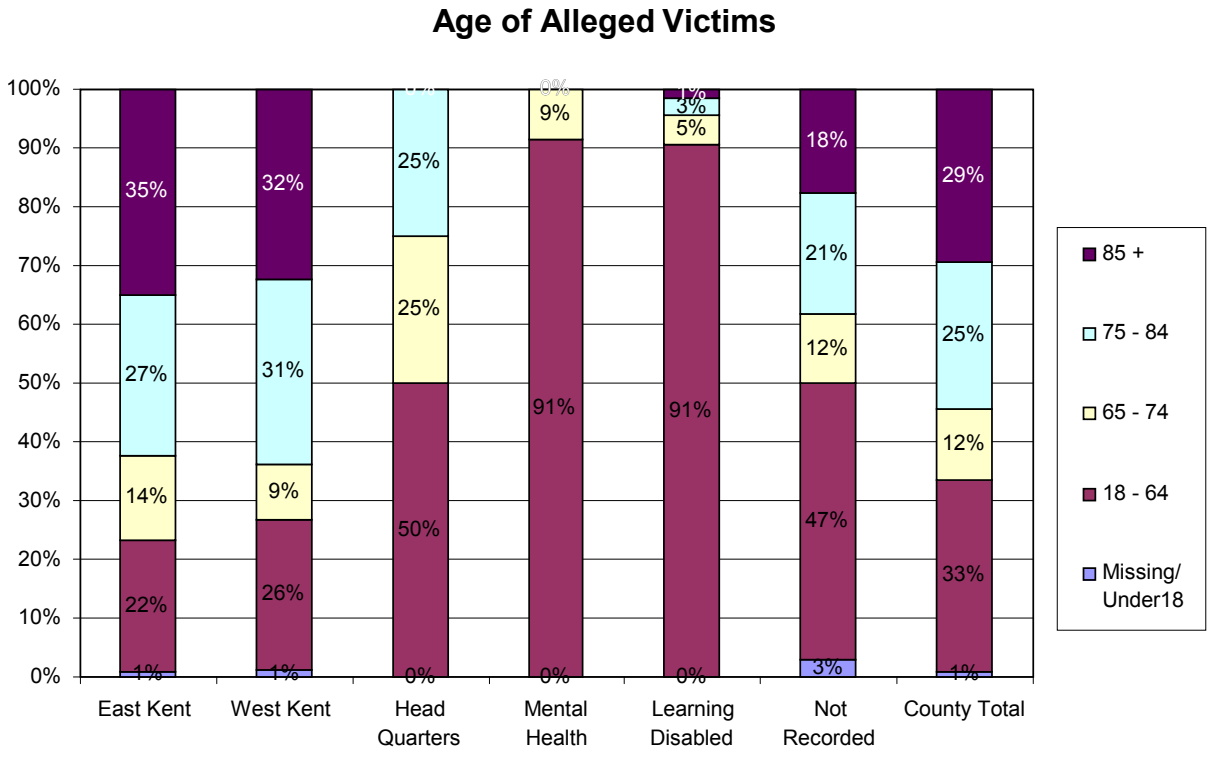


Figure 1: Adult protection alerts recorded in Kent between April 2009 and March 2010 – by age

1.3 Gender of Alleged Victims

As previously noted in the main body of the report, this is set against the backdrop of an increasingly ageing population, where women live longer than men, thereby resulting in a higher percentage of alleged women victims. Of the 1,909 clients that had an alert recorded during the period April 2009 to March 2010, 1180 (62%) of the alleged victims were Female and 727 (38%) Male and 2 Not Recorded, which is statistically too small at 0.1% to record. There was no significant variation in the proportions in this report compared to previous reports. These figures are presented in the form of a pie chart in Figure 2 below.

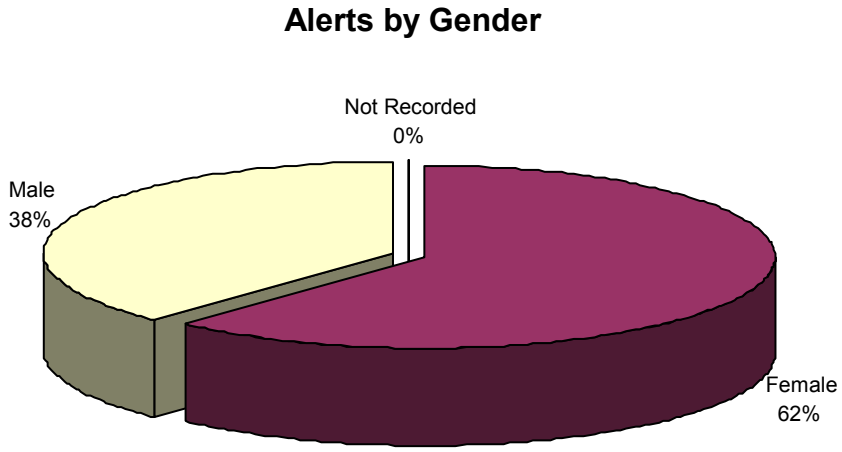


Figure 2: Adult protection alerts recorded in Kent between April 2009 and March 2010 – by Gender

Gender in the 18-64 age group in Kent is split more evenly, with 317 males and 307 females, as shown in Figure 3 below.

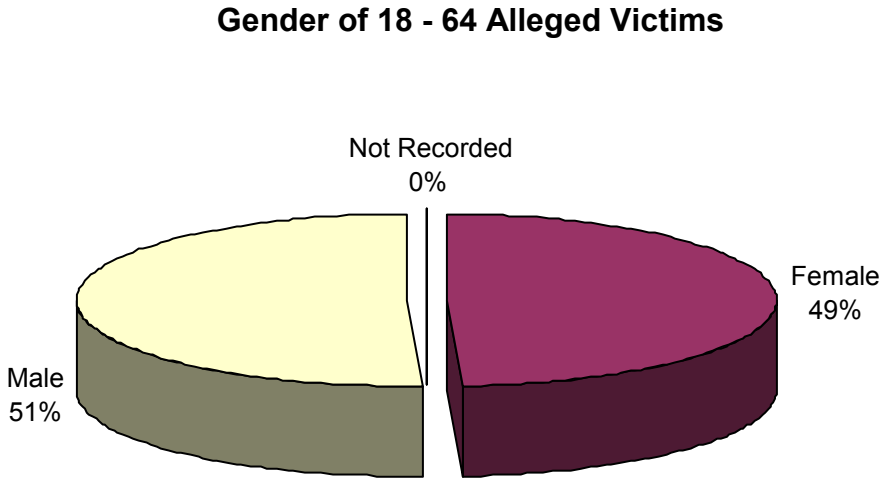


Figure 3: Adult protection alerts recorded for the 18-64 age group in Kent between April 2009 and March 2010 – by Gender

However, differences in the numbers of clients for the 65+ age group are more significant, there are 863 females and 404 males, as shown in Figure 4.

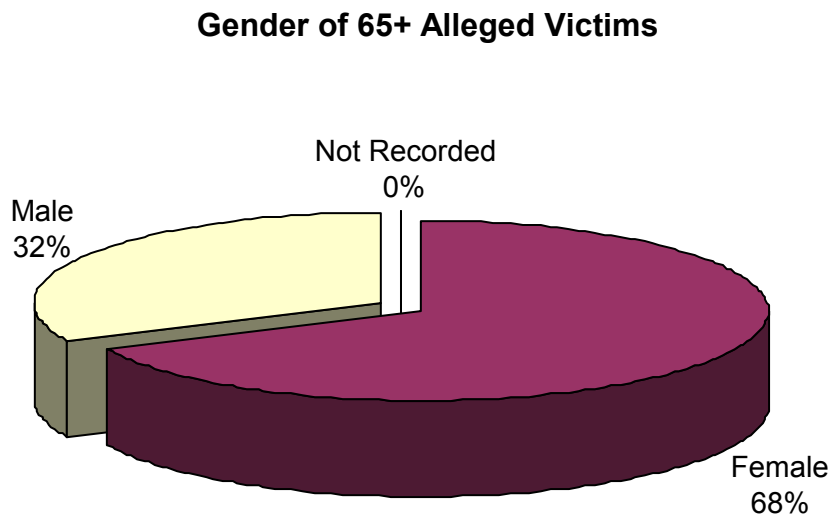


Figure 4: Adult protection alerts recorded for the 65+ age group in Kent between April 2009 and March 2010 – by Gender

1.4 Ethnicity of Alleged Victims

The ethnicity of the 3,764 alleged victims in Kent is broken down into three categories, White, BME and Unknown, which includes Unknown and Not Recorded. There is almost no variation in the proportions between the two periods. These figures are displayed in Table 4 below.

	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	Total	Proportion
White	1,684	1,718	**3,402**	90.4%
BME	39	41	**80**	2.1%
Unknown	132	150	**282**	7.5%
Total	**1,855**	**1,909**	**3,764**	

Table 4: Adult protection alerts recorded in Kent April 2008 and March 2010 – by ethnicity

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 7.5%, and the number of clients from BME backgrounds is 2.1% compared with a BME population for Kent of 6%. These proportions vary very little. Despite extensive engagement we continue to have a low level of safeguarding concerns reported from BME communities. Work continues with BME communities to explore this issue, including looking to the work of other Local Authorities in this area.

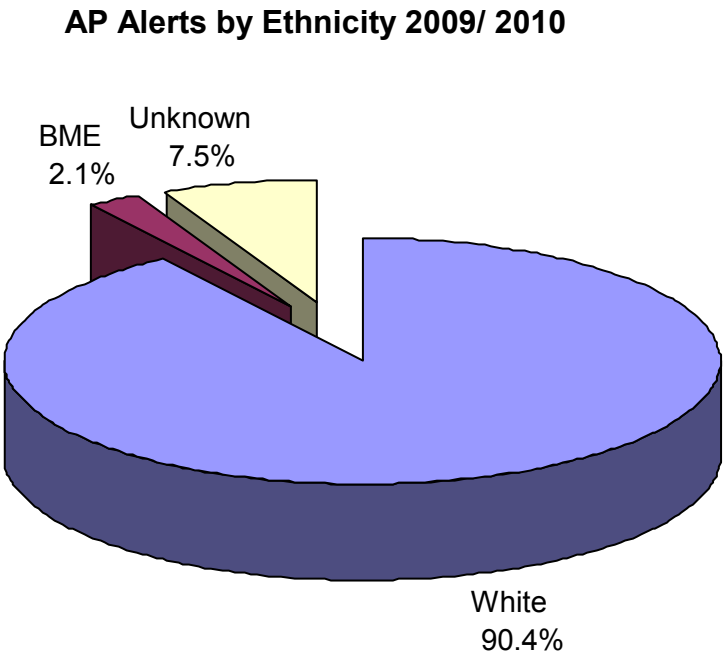


Figure 5: Adult protection alerts recorded in Kent between April 2009 and March 2010 – by Ethnicity

1.5 Client Category of Alleged Victims

The client categories of the alleged victims of abuse in the period April 2008 to March 2010 are presented in Table 5.

	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	Total	Total Proportion	Proportion 2008/09	Proportion 2009/10	Percentage change between 2008/09 - 2009/10
Older	1,164	1,287	**2,451**	**65.1%**	62.7%	67.4%	**10.6%**
Learning Disability	282	284	**566**	**15.0%**	15.2%	14.9%	**0.7%**
Mental Health	83	54	**137**	**3.6%**	4.5%	2.8%	**-34.9%**
Physical Disability	125	153	**278**	**7.4%**	6.7%	8.0%	**22.4%**
Substance Misuse	0	2	**2**	**0.1%**	0.0%	0.1%	
Other	122	81	**203**	**5.4%**	6.6%	4.2%	**-33.6%**
Not Recorded	79	48	**127**	**3.4%**	4.3%	2.5%	**-39.2%**
Total	**1,855**	**1,909**	**3,764**				**13.5%**

Table 5: Adult protection alerts recorded in Kent April 2008 and March 2010 – by client category

Over half, 65.1%, of the 3,764 alleged victims are in the Older Person category. The next highest category is Learning Disability, at 15%. The Not Recorded category is relatively low at 3%.

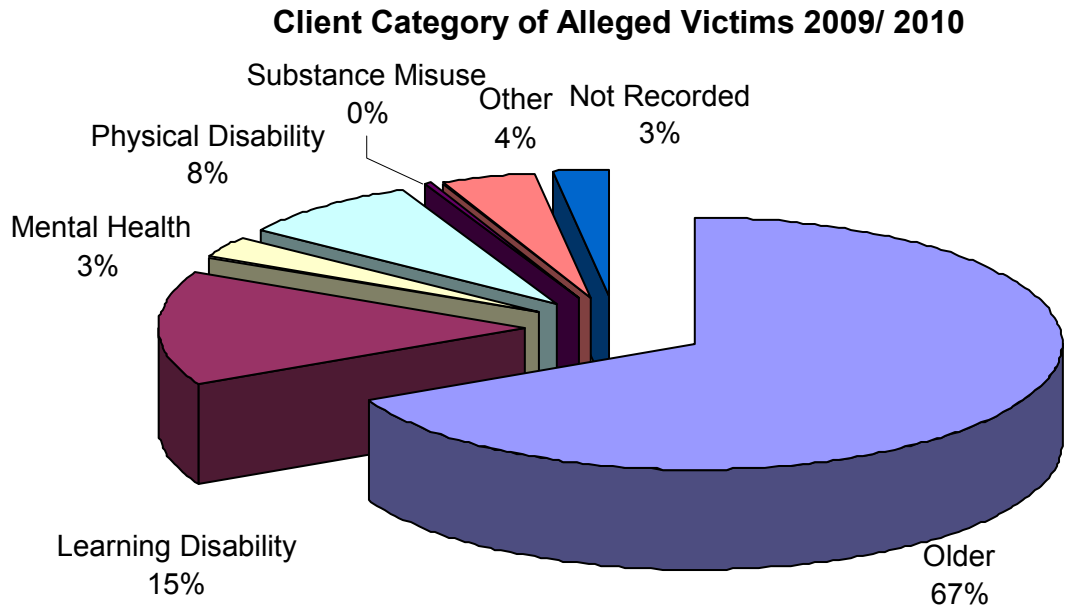


Figure 6: Adult protection alerts recorded in Kent between April 2009 and March 2010 – by client category

1.6 Source of AP Alerts

The sources of the AP alerts are shown in Table 6 for April 2008 to March 2010. There are also figures for the percentage change of source between the two periods and the proportion of total alerts in 2009/ 2010 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 6 shows that the largest source of alerts is Social Care staff, accounting for 38.2% of total alerts in 2009/ 2010. Police and Family Member decreased in numbers.

Source of Referral	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	Percentage Change between 2008/09 - 2009/10
Social Care Staff (CASSR & Independent) - Total	**827**	**901**	**8.9%**
Health Staff - Total	**393**	**441**	**12.2%**
Self Referral	67	85	26.9%
Family member	181	163	-9.9%
Friend/neighbour	42	75	78.6%
Other service user	0	3	
Care Quality Commission	41	57	39.0%
Housing	34	54	58.8%
Education/Training/Workplace Establishment	10	13	30.0%
Police	141	128	-9.2%
Other	183	347	89.6%
Not Known	158	90	-43.0%
Overall Total	**2,077**	**2,357**	

Table 6: Adult protection alerts recorded in Kent April 2008 and March 2010 by the source

2. Incidents of Abuse

2.1 Location of Alleged Abuse

During the period April 2008 to March 2010 there were 3,977 Adult Protection (AP) incidents recorded in Kent. The reduction in alleged abuse in Acute Hospitals reflects improvements that have been made in this area. Residential settings and a victim's own home continue to increase as locations of alleged abuse.

	Apr 2008 to Mar 2009	**Apr 2009 to Mar 2010**
Acute Hospital	55	30
Alleged Perpetrators Home	8	18
Care Home	606	637
Care Home with Nursing	239	272
Community Hospital	14	18
Day Centre	30	19
Education/Training Workplace Establishment	3	0
Not Known	46	35
Other	62	80
Other Health Setting	25	22
Own Home	728	758
Public Place	52	38
Respite/Short Term Break Home	23	20
Supported Accommodation	48	91
Total	**1,939**	**2,038**

Table 7: Location of alleged abuse 2008/ 2010

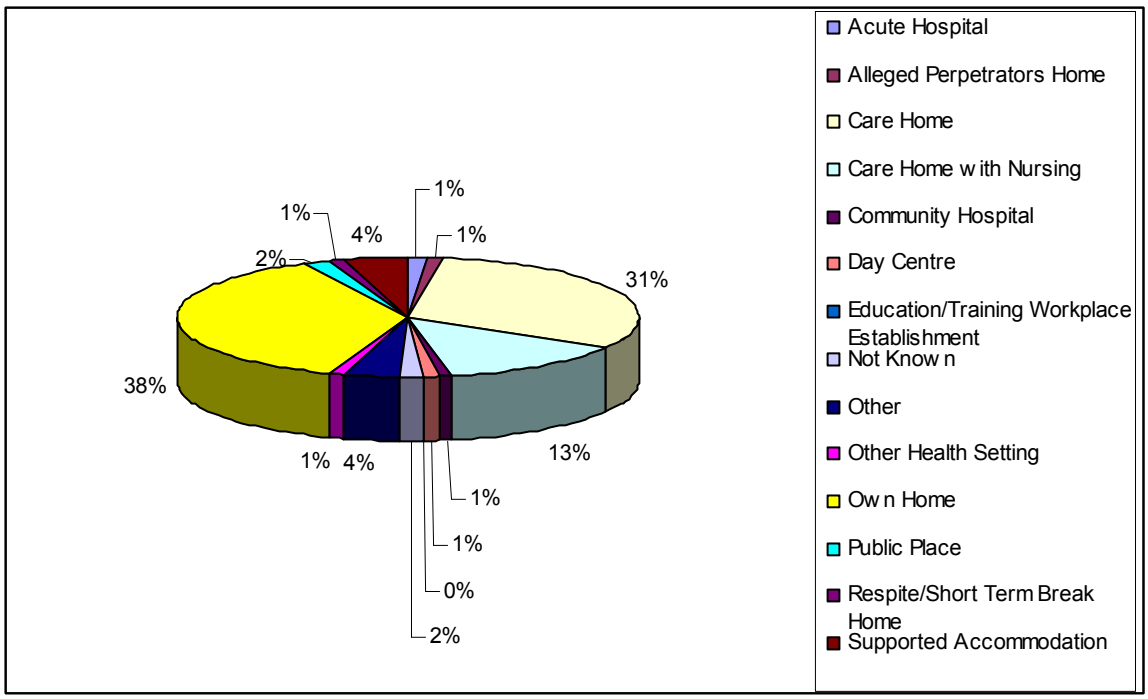


Figure 7: Location of alleged abuse 2009/2010

2.2 Location – Alleged Care Home Incidents by District

The table below shows the number of incidents recorded by District and focuses on the location 'Care Homes'.

	Alleged incident location - Care Home 2009/10	Total Number of Incidents 2009/10	Proportion
East Kent Total	561	1219	46.02%
West Kent Total	328	741	44.26%
Headquarters	2	5	40.00%
Mental Health	3	47	6.38%
Not Recorded	15	26	57.69%
County Total	**909**	**2038**	**44.60%**

Table 8: Alleged care home incidents by district 2009/ 2010

The table below shows the types of abuse that occurred in care homes. Neglect and physical are the dominant categories. There may be more than one type of abuse per incident.

	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	Proportion 2007/08	Proportion 2008/09
Discriminatory	4	7	0.6%	0.8%
Financial	111	80	15.8%	9.6%
Institutional	149	221	21.3%	26.5%
Neglect	285	392	40.7%	47.1%
No Category	45	14	6.4%	1.7%

Physical	274	338	39.1%	40.6%
Psychological	84	96	12.0%	11.5%
Sexual	34	42	4.9%	5.0%

Table 9: Alleged types of abuse occurring in care homes 2008/ 2010*

*Figures do not sum as some victims are the subject of multiple abuse.

2.3 Categories of Abuse

The table below shows the categories of abuse as a percentage for the period April 2008 to March 2010. The dominant category is Physical Abuse in both periods. Institutional, Neglect and Psychological have all increased by 6.2%, 6.3% and 4.8% respectively across the two periods.

Type of Abuse	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010
Discrimination	0.6%	1.3%
Financial	28.1%	31.3%
Institutional	9.2%	15.4%
Neglect	27.6%	34.0%
No Category	4.9%	2.2%
Physical	36.7%	42.0%
Psychological	20.7%	25.5%
Sexual	7.5%	7.1%

Table 10: Percentage types of abuse by period*

*Figures do not sum as some victims are the subject of multiple types of abuse.

The graph below shows the distribution of categories of abuse in the two periods.

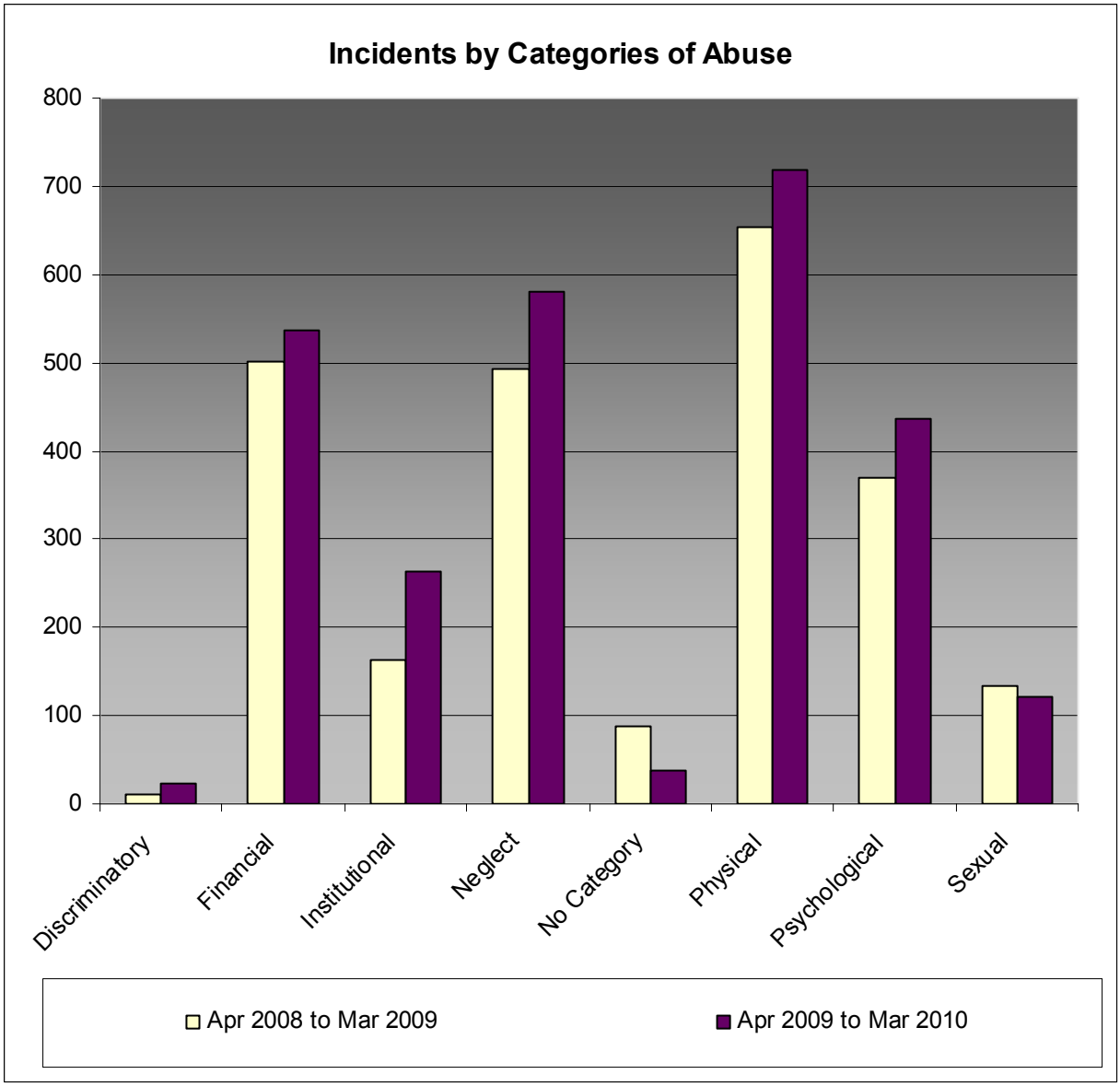


Figure 8: Incidents of abuse categories by period 2008/ 2010

This shows that Physical, Financial and Neglect are still the dominant categories, although the numbers for psychological abuse are increasing and it is becoming a more dominant category.

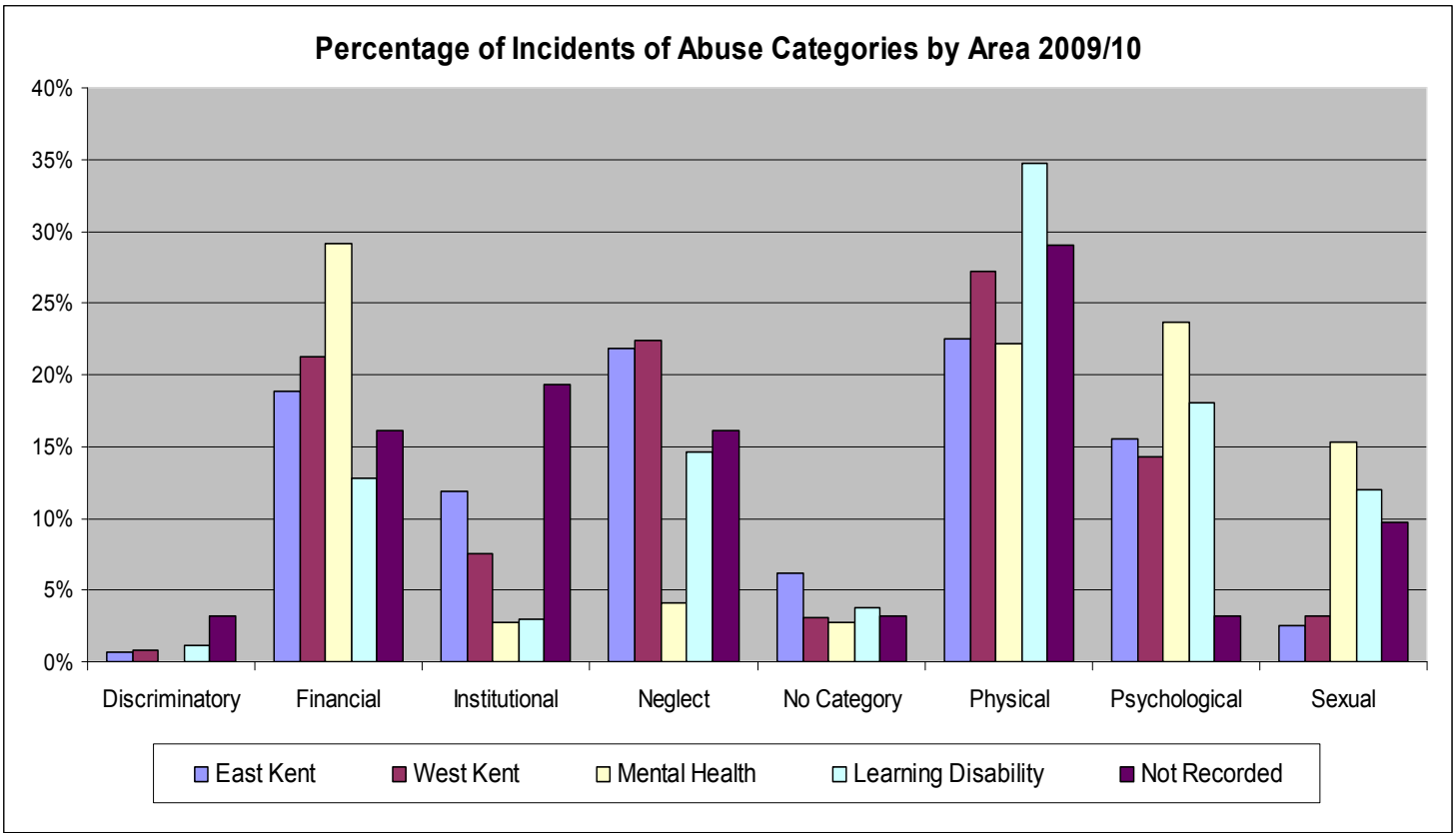


Figure 9: Percentage of incidents of abuse categories by area 2009/10

This graph shows the percentages of Alerts by category of Abuse and Area (team) for April 2009 to September 2010. Mental Health has a significantly higher percentage of psychological, financial and sexual abuse than the other areas. East Kent has a higher percentage of Institutional 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.

3. Closed Alerts

3.1 Breakdown of Decisions

Of the cases that closed during the period of April 2008 and March 2010, the decisions are shown in the table below. There are differences in what was previously reported as we have altered the reports to look at the incident status; this will be more accurate as the incident status is updated as part of the closure procedure and will be updated once there is a CM32 date.

There are significant differences between the percentages substantiated from East Kent 22.5% (highest district being Swale 36.2%) and West Kent 31.4% (highest district being Maidstone 51.8%). The percentages for Not Determined/ Inconclusive are East Kent 9.2% and West Kent 15.1%.

The category 'Other' includes 'Being Evaluated/ Assessed'.

The actual figures are shown in the table below.

	Confirmed	Partly Confirmed	Discounted	Not Determined/ Inconclusive	Other	Not Recorded	Total
Ashford and Shepway	33	16	51	14	7	0	**121**
Canterbury and Swale	42	8	51	8	20	1	**130**
Thanet and Dover	9	4	8	3	41	0	**65**
East Kent L D	64	5	73	31	42	1	**216**
Ashford Adult District	64	6	107	20	12	2	**211**
Canterbury Adult District	44	12	56	21	24	3	**160**
Dover Adult District	17	1	12	5	351	1	**387**
Shepway Adult District	33	10	99	16	62	0	**220**
Swale Adult District	46	8	45	20	8	0	**127**
Thanet Adult District	89	7	107	41	65	4	**313**
East Kent Other	3	0	4	3	14	0	**24**
East Kent Total	**444**	**77**	**613**	**182**	**646**	**12**	**1,974**
Dartford, Gravesham and Swanley	5	11	16	8	19	0	**59**
Maidstone and Malling	37	1	9	21	16	0	**84**
South West Kent	6	1	11	0	15	0	**33**
West Kent L D	78	19	84	34	34	0	**249**
Dartford Adult District	12	2	22	10	3	0	**49**
Gravesham Adult District	16	5	42	11	5	0	**79**
Maidstone Adult District	99	1	39	36	14	2	**191**
Sevenoaks Adult District	21	0	58	10	6	1	**96**

Tonbridge and Malling Adult District	9	1	14	0	1	1	**26**
Tunbridge Wells Adult District	17	5	41	8	7	0	**78**
West Kent Other	3	0	7	8	2	0	**20**
West Kent Total	**303**	**46**	**343**	**146**	**122**	**4**	**964**
Mental Health	23	9	36	26	13	0	**107**
HQ Other	2	0	1	2	2	0	**7**
Not Recorded	9	1	12	2	5	0	**29**
Total	**781**	**133**	**1,005**	**358**	**788**	**16**	**3,081**

Table 11: Decision of investigation recorded between April 2008 and March 2010

The pie charts below show the percentage decision outcomes for closed alerts for 2008/2010. The two largest proportions are Discounted (32%) and Other (26%), although Confirmed is only 1% smaller.

Decisions of Adult Protection Alerts

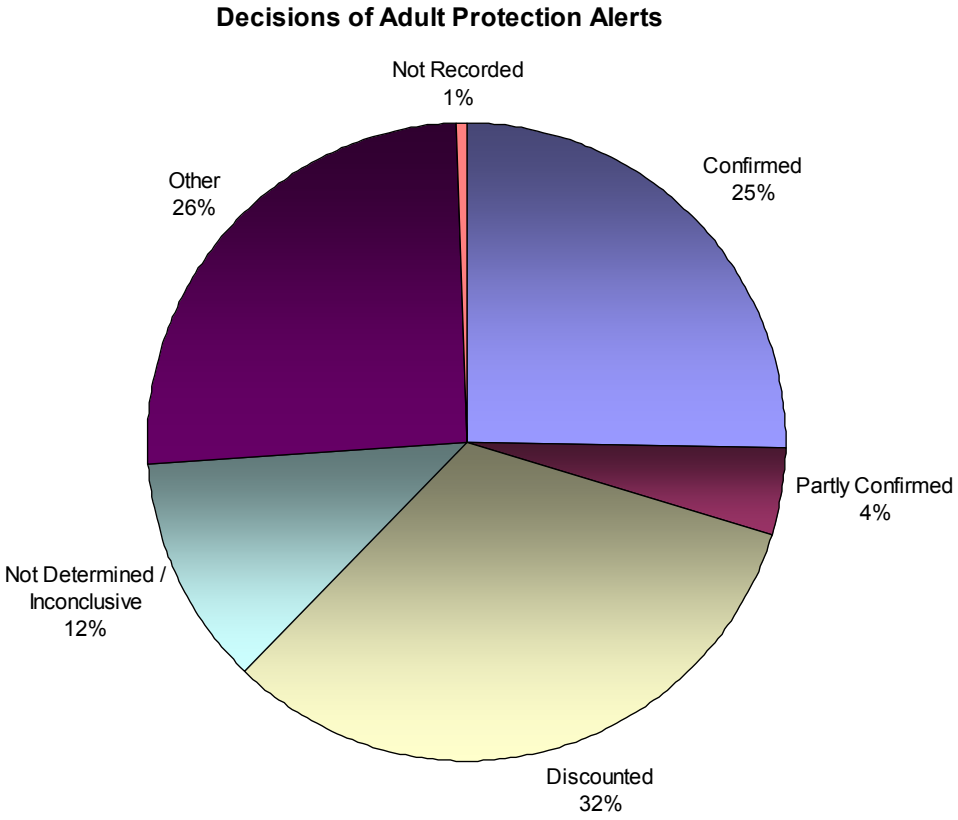


Figure 10: Decisions of investigations recorded between April 2008 and March 2010

The table below shows that of the 1,005 discounted alerts recorded in 2009/2010, 188 (18.7%) are evaluated as not adult abuse. These concerns will have been addressed in an alternative way, which may have included a case management assessment, referral to another agency or through the Quality in Care Framework. (See section 3)

	Evaluated - Not Adult Abuse
East Kent Total	115
West Kent Total	67
Total	**188**

3.2 Investigation/ Assessment Involvements

The table below shows the investigation/ assessment involvements, SSD has the highest total proportion. Figures for 2007/ 2008 were obtained from previous reports. Some alerts do not end in full Adult Protection referral/ investigation as they are dealt with in other ways. Further analysis will be undertaken.

	Apr 2008 to Mar 2009	Apr 2009 to Mar 2010	Proportion 2008/09*	Proportion 2009/10*
SSD	824	694	94.1%	94.8%
Regulatory Body	184	105	21.0%	14.3%
Housing	16	12	1.8%	1.6%
Health	623	542	71.1%	74.0%
Police	712	601	81.3%	82.1%
Service Provider	131	139	15.0%	19.0%
Voluntary Organisation	16	6	1.8%	0.8%
Other	36	18	4.1%	2.5%

Table 12: Involvement of agencies in investigations of abuse in Kent 2008/10

*Proportions will not add to 100% as there can be more that one investigation/involvement for each alert. It is the percentage of the number of closed cases with an investigation in that year that is shown here. See Table 3.1.

The table above shows the high levels of excellent support that we continue to receive from Health and Police colleagues in addressing safeguarding issues.

Appendix 2

This is a summary of all the actions completed and those planned as at August 2010

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

- **Strategic Overview.** This summary focuses on the KASS activity. However, it is to be noted that much of this activity was co-ordinated with other partners on the Safeguards Board. This was 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 to prepare for the Inspection has continued to meet and monitor the implementation of the action plan. SMT and AMTs were updated regularly on progress and both Areas had groups in place to ensure the recommendations were 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

- The Public Involvement Strategy has been developed with a wide range of groups (people who use services, carers, members of the public, disadvantaged groups). In excess of 30 community groups have also contributed. A draft Communication Strategy was reported to SMT in August 2010

- How people access 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

Other Activities Undertaken This Year:

- A Safeguarding Awareness Week – June 2010. During the recent Safeguarding Awareness Week, a wide range of partners came together to promote safeguarding awareness across the County. The focus of the events was to raise awareness amongst members of the public and events were held in public places, such as shopping centres. 30 events took place, including, a joint KASS and EKC PCT event to promote stronger partnership working and awareness of roles. 10,000 pens and leaflets were distributed. Several people raised safeguarding issues which are now being followed up. Safeguarding Awareness Week coincided with Carers Week

- Review plan for the Public Involvement Strategy with the public

- SCRG – monies from this grant used to stimulate community engagement with a focus on BME and hard to reach communities

- Total Place

Further work planned

- Conclusion of Public Involvement Strategy
- Completion of Recommendation 6
- Culturally Competent Care is being reviewed in light of SDS and safeguarding
- Roles and Relationships events with service users and carers in July 2010

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

- Adult Safeguarding Workforce Development Strategy in place
- Competency-based framework drafted – partner agencies involved in its development and committed to making it a part of their workforce strategy
- Safeguarding is an important feature in the KASS Workforce Development Strategy

Outcomes

- 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
- BME issues are embedded in safeguarding training
- Safeguarding issues are embedded into Self Directed Support training

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
- Safeguarding Board will put together an overarching 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 has been agreed which consists of five priority areas aimed at assuring public safety and raising standards of care across the social care workforce in Kent

It is to be noted that the actions within KASS have been completed. Those outstanding relate to the Safeguards Board.

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 2009 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 – 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 indicator 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
- Pilot project in East Kent with a focus on safeguarding in Ashford in partnership with an advocacy service
- 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
- Work is ongoing with Age Concern to focus on a more structured and professional information, advice and guidance service
- KASS have grant funded the extension of the Safeguarding the Older Person (StOP) project until December 2010 – a referral pathway will be developed to ensure advocacy is offered as an option for people involved in the safeguarding process
- 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 – there is sufficient capacity in the advocacy services to meet demand – KMPT have included this in their AP training and are strengthening advocacy in KMPT AP policy
- Built-in support through the Independent Mental Capacity Advocate (IMCA) provision for certain people in some safeguarding cases

Outcomes

- 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. People with learning disabilities have undertaken training and now actively quality assure the advocacy service

- Vulnerable adults going through the safeguarding process can have an independent advocate to represent them

- Contract has been let for a one year project to provide an Independent Advocacy Service for people with Dementia – the need, outcome and impact of the service will be monitored over the course of the year

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/ 2011

- As part of the allocation of SCRG monies, advocacy services for people with dementia will be commissioned

- Work will continue to raise the profile of advocacy services for people with mental health problems, particularly to support service users through safeguarding processes

Appendix 3

Courses	Courses Delivered 2009 – 2010	Number of staff trained	Courses Planned 2010 – 2011
KASS Adult Protection Level 1: Awareness (in house delivery)	45	599	15 plus locally delivered courses
Multi Agency Adult Protection Level 2: The Practitioners Role	25	444	25
KASS only Adult Protection Level 2: The Practitioners Role	1	15	3
Multi Agency Adult Protection Level 3: The Investigators Guide	5	72	9
Multi Agency Adult Protection Level 4: Joint Working in Criminal Investigation	2	24	2
Multi Agency Adult Protection Level 5: Decision Making and Accountability	3	68	6
KASS Only Adult Protection Level 5: Decision Making and Accountability	3	19	0
Multi Agency Adult Protection Level 6: Post Abuse	2	26	6
Private and Voluntary Sector Level 2	0	0	6
Training the Trainer in Adult Protection	4	74	5
KASS Only Adult Protection Minute Takers	3	27	3
Multi Agency Levels 1 – 3 Fast Track	1	10	0
Multi Agency Refresher Levels 2 – 6	2	21	0

Training Courses Delivered 2009 – 2010

Kent and Medway Safeguarding Vulnerable Adult – Multi-Agency Training Provision by Agency 2009 – 2010

Agency	Adult Protection Level 2	Adult Protection Level 3	Adult Protection Level 4	Adult Protection Level 5	Adult Protection Level 6	Training the Trainer in Adult Protection	Level 1 - 3 fast track	Refresher Level 2 - 6	Total
SSD Kent	163	32	6	38	10	19	6	7	281
SSD Medway	37	6	2	5	4	1	1	7	63
Police	0	2	8	8	0	3	3	5	29
Private and Voluntary	0	0	0	0	0	30	0	0	30
Health	173	24	8	7	11	13	3	2	241
Not Stated	71	8	0	10	1	8	0	0	98
Total	444	72	24	68	26	74	13	21	

By:	Graham Gibbons, Cabinet Member, Adult Social Services Oliver Mills, Managing Director, Kent Adult Social Services
To:	Adult Social Services Policy Overview and Scrutiny Committee – 16 November 2010
Subject:	**UPDATE ON THE WHOLE SYSTEMS DEMONSTRATOR PROGRAMME (WSD) AND THE OUTCOMES OF THE KENT TELEHEALTH PILOT**
Classification:	Unrestricted

Summary: This paper provides an overview of Advanced Assistive Technology (AAT) in Kent and a summary of the Outcomes of the Kent Telehealth Evaluative Development Pilot. The paper will also update Members in respect of the Whole Systems Demonstrator Programme (WSD).

Introduction

1. (1) People with Long Term Condition (LTCs) use a disproportionate amount of health and social care services and are frequent users of unplanned hospital visits and unscheduled bed days of care. The number of people with LTCs who have social and health needs is increasing in Kent, nationally and internationally. In 2009 the Department of Health estimated that by 2025 there would be 42% more people in England aged 65 or over. Based on current figures they calculate that this "will mean that the number of people with at least one LTC will rise by 3 million to 18 million" (DH2008a).

(2) In an increasingly difficult financial climate the potential for Advanced Assistive Technology (AAT), such as telecare and telehealth, must play a central role to support self care and improve the quality of life for people with LTC and their carers. Working with NHS partners, KCC has to take the lead nationally in making this a reality in Kent.

(3) Telecare is a combination of a receiver unit which plugs in to the main telephone line and a selection of remote sensors which, when triggered, communicate with the receiver unit which in turn sends an alert to the 24 hour monitoring centre. On receipt of an alert the monitoring centre will determine which response is best that may be a telephone call, a visit by the carer or emergency services. Typically the range of sensors installed for most service users are: receiver unit, pendant, falls detector and a smoke detector. Additional items such as bed and chair sensors, flood detectors and epilepsy sensors may be offered to meet user needs.

(4) Telehealth enables people with LTCs such as lung disease, heart disease or diabetes to take their own health measurements in their own home. The equipment consists a monitor and as set or peripherals such as scales, blood pressure machine depending on which LTCs the individual has. The service user will take their measurements and the monitor saves them until all activity has been completed and then it transmits them down the telephone line to a secure server. The nurse, GP or community matron caring for the person may access the readings as soon as they are transmitted

enabling them to review trends and act to changes in data by intervening as appropriate either with a telephone call or a visit.

(5) Telecare helps with the following:

- Remain safely in their own homes
- Assist in the process of hospital discharge
- Prevent admission to hospital, nursing or residential homes
- Support falls and accident prevention strategies
- Provide support for carers

(6) County Council Members and the former Director of Social Services, (Peter Gilroy), recognised that Telecare could play a key role in meeting these key objectives for Kent residents, and invested £2m in a telecare project. This amount was further boosted by the Preventative Technology Grant introduced by the Local Authority Circular (LAC) (2006)5.

(7) Telehealth enables people with LTCs to self manage at home. In 2004 a commitment of £1m from KCC was made to developing the Kent TeleHealth pilot, Kent County Council led this project in partnership with 5 PCTs.

(8) In 2007 Kent County Council led a successful bid to lead one of the three Whole Systems Demonstrator projects introduced by the White Paper Our health, our care, our say (2006). The bid was successful due to the strong partnership commitment demonstrated between KCC and its partners NHS Eastern and Coastal Kent and NHS West Kent through the earlier pilots. Kent recruited 2103 participants to the programme:

- 449 Telecare group that received equipment straight away
- 631 TeleHealth group that received equipment straight away
- 437 Telecare group that received usual care for a year
- 586 TeleHealth group that received usual care for a year

Advanced Assistive Technology Activity in Kent

The Original Kent Pilots

2. (1) The original Telecare pilot started in Maidstone and was rolled out across six districts in total Swale, Maidstone, Tonbridge & Malling, Gravesham, Shepway and Ashford. The number of service users at the height of the trial was in excess of 1000 with the majority of users being in the first six areas of engagement. No recruitment has been made to the original pilot since the award of WSD and the resultant cohort is circa 630 users. An evaluation was commissioned from the Centre for Health Service Studies (CHSS) based in the University of Kent, the results were published in the document *Piloting Telecare in Kent County Council: The Key Lessons 2006.*

(2) The Kent Telehealth pilot started with 5 PCTs; Shepway, Maidstone & Weald, Ashford, SW Kent and Dartford and Gravesham and was rolled out through GP practices with support from two champion GPs. The pilot was taken through Health Ethics and used validated research tools and scoped the views of carers. 250 service users were

recruited with an even geographical distribution of 50% across both East and West of the County. Attrition rates have been low and no recruitment has been made to the original pilot since WSD started resulting in the current cohort being circa 170 users. The Kent TeleHealth Evaluative Development Pilot was highly successful and the report shows:

- that savings in hospital bed days, visits to accident and emergency, GP contacts and GP home visits were made;
- that the quality of life for patients and carers significantly improved; and
- service efficiencies were made with new ways of working.

(3) A summary of the outcomes is attached at Appendix 1 and a copy of the Executive Summary or a copy of the full Report is available on request.

Whole System Demonstrator (WSD)

3. (1) Telecare provided under WSD consists of the core four items of equipment: receiver (base) unit, smoke detector, falls detector and pendant. The core 4 items being the minimum telecare equipment installed and the assessment providing for other sensors as required. Provision is County wide with the spread approximately 75% in East and 25% in West.

(2) Telehealth provided under WSD for the intervention group is an updated model of the equipment used in the original Kent Pilot. Provision is county wide with the spread 75% in East and 25% in West of the County.

Current status

3. (1) Under the WSD Programme we are obliged to offer all control participants technology. With the exception of a few who we are unable to contact, all WSD participants in the control group have been offered either telecare or telehealth as appropriate. The acceptance rate for telecare is 44% and 20% for telehealth.

(2) For those participants in the control group who accept telehealth they will keep the equipment for a period of 6 months during which time it is anticipated that they will embed self management techniques. This will be supported by the PCT who will provide disease management information. After six months the equipment will be deinstalled and recycled.

(3) A review of the telehealth intervention group will be undertaken and those not meeting the criteria for community matron or specialist nurse (eg heart failure) case load will be taken through the same six months ‘step down’ process as the control group.

(4) All those who were in the intervention group and already have received telecare will keep the equipment for as long as it is useful or other circumstances prevail. This group will be reassessed during the next five months and any additional equipment provided where appropriate.

Mainstreaming

4. (1) All participants from both the telecare and telehealth pilots and all WSD participants who have equipment will be transferred to front line teams by March 2011.

(2) Proposals to integrate telecare and telehealth equipment in to the Community Equipment Stores (a partnership between Health and Social Care) will be developed over the next couple of months.

(3) In light of the outcomes of the Kent Telehealth Pilot we are working very closely with both NHS West Kent and NHS Eastern and Coastal Kent to ensure that telehealth is embedded in to care pathways as a standard. In addition the following activities have been or will be undertaken by the WSD Core Team:-

- Worked with the teams delivering community nursing services to develop a set of telehealth competencies that will form part of the core skills of each community nursing post;

- Currently working very closely with our PCT colleagues to review care pathways and integrate appropriate telehealth technology in to them;

- With PCT colleagues look at introducing telehealth in to prisons, nursing homes. Maternity services, schools and other appropriate environments.

- Jointly with PCT colleagues we have started the process of engaging GPs in readiness for their new commissioning responsibilities.

(4) In respect of telecare we will be looking at all aspects of the service (especially monitoring and response services) to ensure that all agencies such as fire, police and out of hours services are linked in.

- Work with KASS and PCT colleagues to embed telecare in to hospital and community nursing care pathways.

- Work with KASS colleagues to develop a set of telecare competencies that will support workforce development.

(5) In the medium term we will be considering how we may provide different types of Advanced Assistive technology to best support the citizens of Kent.

Recommendations

5. Members are asked to NOTE the content of this report.

Hazel Price
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Background documents: None

Summary of the Outcomes of The Kent TeleHealth Evaluative Development Pilot

Kent County Council in Partnership with NHS West Kent and NHS Eastern and Coastal Kent undertook this innovative and ground breaking pilot. The Pilot, with 250 participants, was the largest trial in Europe at the time ran from March 2005 to December 2007.

This highly significant telehealth pilot sought to improve the 'Quality of Life'; to both empower and improve choice whilst supporting independence.

Summarising briefly, we found that telehealth:

- **Brings piece of mind to patients and carers. Some patients and carers experienced life changing positive outcomes.**

- **Reduced unscheduled hospital appointments and A&E visits.**

  - Regular monitoring showed a reduction of 77 A&E visits and 849 bed days of care for people contributing to the data over six months.

- **It is estimated that over a six month period in 2006/7 the telehealth intervention saved on average £1,878 per patient.**

  - The confidence interval ranged from a saving of £2,718 to a saving of £1,038.

  - This figure is statistically significant at the 0.01 level which means we are 99% confident that the savings fall between these two figures.

- **Generates service and system efficiencies.**

  - In one site, the majority of patients who had complex conditions received telehealth, therefore bringing about a change in working practices.

- **Supports independence and self management**

- **Patients completed self reported health outcomes questionnaires. There was a statistically significant improvement in the physical and general health component summary scores.**

  - The highest scores are where general health increased by 5.4. and the physical health increased by 8.7. A score of over 4 is considered to be significant and such a high score is clinically significant.

The full report may be found at:

http://www.kent.gov.uk/adult_social_services/social_services_professionals/partnerships_and_projects/whole_system_demonstrator.aspx

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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 – 16 November 2010
Subject:	**A NEW SERVICE MODEL FOR THE RE-PROVISION OF DAY ACTIVITIES FOR PEOPLE WITH A LEARNING DISABILITY IN THE ASHFORD DISTRICT**
Classification:	Unrestricted

Summary:	A report on the outcome of consultation on the future service model for Ashford, seeking approval to proceed on a phased basis.

Background

1. (1) Kent County Council's (KCC) modernisation of Day Services for Adults with Learning Disabilities is an integral part of the transformation towards more personalised services reflecting the vision and strategy contained within "Valuing People Now" White Paper (January 2009) and KCC's "Active Lives". This is being underpinned by the "The Good Day Programme – Better Days for People with Learning Disabilities across Kent", Which will ensure people have a wider range of choice, more control and equality of opportunity so that they may lead a full and meaningful person centred life.

(2) This report outlines a new service model for the future of day services currently provided from Ashford Day Opportunities Service (DOS), Tenterden Satellite, Wood 'n' Ware and within the Ashford district. This follows extensive consultation with people who use the service, family carers, staff working within the in-house services and other stakeholders.

(3) Ashford DOS was built more than 40 years ago and is a very large building which in recent times has become increasingly less used, as more people continue to access activities and facilities within the community.

(4) Tenterden satellite started in March 2007, it is currently based at St Johns Ambulance Hall, Beachy Path. This is a small building and is used to provide a local base for 2 days a week, where people with a learning disability can access other facilities within the community.

(5) Wood 'n' Ware in Ashford was based at Ashford DOS but moved in August 2007 to a specialist industrial unit, to become an enterprise hub producing wooden garden products. It has an inclusive approach providing therapeutic work for adults with a learning disability.

Current Situation

2. (1) Out of 395 people known to the Ashford Integrated Adult Learning Disability Team 75 people use the in house day services.

(2) Ashford DOS - this currently has a Service Level Agreement (SLA) for 50, previously reduced from 90 people, currently 57 people attend in total, with a daily average of 37.

(3) Tenterden Satellite – Operates 2 days per week. Figures are incorporated within the Ashford DOS SLA, currently 9 people attend in total, with a daily average of 6.

(4) Wood N Ware - this has an SLA for 15 people, currently 16 people attend in total, with a daily average attendance of 10.

(5) Private & Voluntary Sector - there is a flourishing sector (see table below) within the Ashford district offering a wide range of services and good potential for future service development and partnerships. Many of these are accessed using Direct Payments and / or the Kent Card, which works like a Debit or Visa card, by enabling people to pay for services using funds supplied by KCC. Further details are available from the information points within existing day services and at:

http://www.kent.gov.uk/adult_social_services/your_social_services/your_money/direct_payments/receiving_a_direct_payment.aspx

Private and Voluntary Providers include:

- Karoben
- Canterbury Oast Trust
- Life Skills (Folkestone)
- Martello (Folkestone)
- Aartvark
- Body and Mind
- Tenterden Disabled in Action (Tenterden Age Concern Building)
- Ashford L D Community Interest Company
- Kent Autistic Trust (Manor House)
- Shaw Trust (Employment Support)

Formal Consultation

Process

3. (1) A 10-week period of formal consultation in relation to the 'Procedure for Consultation on the Modernisation / Variation or Closure of Establishments and Services in the Adult Services Directorate' for day services in Ashford was invoked in September 2008. A series of consultation events were arranged as detailed in Appendix 4.

(2) The consultation process was extended firstly as a direct response to important issues raised by those who have involvement with the current in-house services and also to allow the Cabinet Member to have time to meet with and discuss the proposals with the stakeholders.

Outcomes

4. (1) A consultation survey (designed by people who attend services) formed part of the consultation process and this was issued to people who use the services, family carers and other stakeholders. This was published on the Kent.gov.uk website to encourage people to respond. In all 80 out of a possible 200 replied.

(2) Support from Independent Advocacy and a Speech & Language Therapist showed that people, including those with profound multiple learning disabilities need to actually experience new activities and services to be able to make an informed choice.

(3) A key finding was that people with a learning disability and their family carers value the work carried out at Ashford DOS.

(4) People with a learning disability value their friendships, relationships and the support they receive from staff. They enjoy the increasing range of community based activities.

(5) Family / carers highlighted the importance of the respite that day services provides for them and of having a base(s) where people can meet together with their friends when they are not taking part in other activities.

(6) A key priority on the part of all family carers was to ensure the safety of their loved ones.

(7) Family Carers were asking for more information on direct payments, personal budgets and the new Ashford Gateway Plus. A series of workshops were arranged to facilitate this.

(8) The Ashford District Partnership Group gave a voice to a wider representation of people with an interest in the consultation. In general positive support was given to both existing services and continuing plans to provide a wider range of new services.

(9) Staff, Family Carers and one service user visited Durham to see how they have developed their services. Feedback from this visit has been part of the consultation process and this has helped people to consider different options. Family Carers were positive and they presented their findings to the Ashford District Partnership Group.

(10) The above outcomes and other concerns raised during consultation are detailed in Appendix 2.

(11) Following additional workshops and meetings with family carers the new service model has been refined (see Appendices 3 and 4). This will include; dedicated space within community developments located within the borough of Ashford.

The New Service Model

5. (1) The principles for the new service model are to develop services which will enable people to:

- Choose what they do during days, evenings and weekends
- Have the right flexible support
- Be equal citizens in their community
- Have opportunities to lead a full and meaningful life.

(2) The above will be achieved by:

- Ensuring people have a person centred plan with a support plan
- Supporting the family carers in their important caring role
- Providing short term breaks for people with learning disabilities
- Being part of the local community
- Working together across different agencies and services
- Access to training and work opportunities
- Making the best use of resources, through self directed support, direct payments and personal budgets moving from block purchased, segregated building based services towards individually purchased services, which are an integral part of the community
- Dedicated project management to ensure new services are delivered
- Good co-ordination to ensure access to personalised services, which will be effectively monitored.

(3) The key components for the new service model are that:

- Every individual will have a Person-Centred Plan, which will have been made co-operatively with their circle of support; this may include family, friends, and other supporters.

- Everybody will be able to see how much money they can spend on day services from their personal budget. They will be able to choose and buy services directly, using Direct Payments and the Kent Card, alternatively people can ask KCC to continue to purchase services on an individual basis.

- The in-house day services, which are very much valued by students and family carers, will undergo radical transformation.

    - The Ashford DOS site will be used to provide 11 'Move On' apartments under the 'Excellent Homes for All' scheme, which are being planned for completion by 2013 and may include people with a learning disability. The KASS Ashford In House Day Service will be replaced over time by new services including resources to be known as "Community Hubs". These will be at Ashford Gateway Plus, and the Stour Leisure Centre where facilities will include a changing place and be fully accessible to people with complex needs. In addition the existing Tenterden Satellite at St John's Hall, Tenterden will continue to operate. Ashford DOS will remain open until these new services are in place.

- Wood N Ware in Ashford is an existing service providing therapeutic work opportunities. The future of which needs to be explored in terms of its social enterprise potential.

- A range of additional services will be made available as part of the new service design. This will include improvements to access and equipment working in partnership with Leisure centres, Youth Services and Tenterden Gateway, resulting in greater access to community facilities including work, health, leisure and sport.

(4) Details of the new service model are outlined in Appendix 3 and pictorially in Appendix 4, which shows:

- The new service model will present considerable opportunities for people with learning disabilities living in the Ashford district. The model itself has been developed and refined with the full involvement of people with a learning disability, staff and family carers, including the Ashford Mencap Group.

(5) We will know that, we have succeeded when people are able to achieve the following standards:

- Have access to good quality information in an appropriate format
- Are choosing their preferred activities and any necessary support required
- Are able to travel to the places they want to go when they want to
- Can follow / take part in their chosen leisure and sport activities
- Can access community facilities used by other non disabled members of the community
- Have opportunities to run their own services
- Have opportunity to work and access appropriate training activities
- Seek employment opportunities as appropriate.
- When people who use services tell us they are having a good day

(6) Delivery of the new service model, if approved will be as follows

- By spring 2011 - Establishment of Community Hub at the Stour Leisure Centre
- By summer 2011 - Ashford Gateway Plus – Community Hub Established
- By autumn 2011 – Ashford DOS will close

Funding

Capital Works

6. (1) The projects below are to be funded as shown in the table below to pay for the construction or adaptation of buildings for new services.. The Ashford DOS site will be used under the 'Excellent Homes for All' scheme with a Registered Social Landlord who has a Charitable status to provide 11 'Move On' apartments for vulnerable people, which may include people with a learning disability. In return the KASS Area Capital fund receives the amount of £500,000 which will be the contribution towards the Ashford Gateway Plus, including the Community Hub for adults with a learning disability. The capital investment into the community hubs listed in the table below will include dedicated space for KASS and will include changing places facilities and other improvements to

enable access for all. Developer contributions are also being used to support KASS developments.

Income / Source of Funds	**Amount**
KASS Area Capital fund (NB. all client groups)	500,000
Learning Disability Development Fund (LDDF)	62,000
Good Day Programme Capital	200,000
Developer Contributions	**43.000**
Total	**805,000**

Project Expenditure	**Amount**
Contribution to Ashford Gateway Plus (NB. all client groups)	500,000
New facilities at the Stour Leisure Centre – Community Hub	105,000
Adaptations to a variety of existing and developing community facilities as outlined in Appendices 3 and 4	200,000
Proposals to date	**805,000**
Total	**805,000**

Revenue

Current Arrangements

7. (1) The day centre budgets for 2009-10 Ashford DOS (including Tenterden Satellite) and Wood N Ware are shown below by budget categories. In practice service-users require levels of support which can vary from a staff member working one-to-one with a single user to one staff member looking after a group of ten or more. The number of users eligible to attend exceeds the average attendance, and the number of days a user attends per week can vary between one and five.

Ashford DOS	
Staff	465,300
Premises	44,855
Supplies & Services	37,318
Transport	39,961
Sales and Letting Income	-20,622
Net budget	566,812

Wood N Ware	
Staff	69,950
Premises	26,858
Supplies & Services	8,350
Transport	0
Sales and Letting Income	-5,994
Net budget	99,164

Proposed arrangements

8. (1) The proposed day service model somewhat resembles a community support service in that qualified staff members accompany the service users in various activities in community settings, while the more dependent may need slightly higher staffing ratios. Some may become more independent over time, as they become more confident, develop more natural supports and social networks. KASS do not expect any reductions in staffing levels as we move from the existing to the new service model. The costs associated with the day to day running of community hubs would be incrementally transferred over time from the existing revenue associated with Ashford DOS. Personal budgets with the option of direct payments and the Kent Card will enable service users and their families to have more choice and control. The use of Community Hubs will enable easier access to a wider range of activities than at present and for more varied periods of time, for example, in the evenings and at week-ends.

Staff / Personnel and Training Implications

9. (1) Meetings have been held with staff and trade union representatives, initially they expressed concerns around future job roles, redeployment opportunities, pay, contracted hours of employment, pensions, redundancies and retraining. Staff will continue to be fully involved and a steering group will be set up around April 2011, to address the above mentioned issues and to ensure that staff continue to help to shape future services. As the consultation has been extended covering a period of almost two years, staff have been pro-active in continuing to increase the amount of community based support for the benefit of service users including links at the Stour Leisure Centre, Tenterden Satellite and a variety of other community activities. Training and development opportunities for all staff will be ongoing in line with their personal development plans. The Nest Resource Centre will be utilised as a base for staff so that support can be co-ordinated and monitored. Staff will be deployed from the Nest, to support service users to access the community hubs and other activities within the wider community. The Nest will also be used for the purpose of supervision and staff meetings.

Recommendations

10. (1) Members of the Adult Social Services Policy Overview and Scrutiny Committee are asked to:

(a) CONSIDER the feedback gained during consultation, noting that the future service model would be introduced on a phased basis.

(b) NOTE that the Cabinet Member for Adult Social Services will be asked to APPROVE:

(i) Implementation of the new model for learning disability day services within the Ashford District, as outlined in Appendices in 3 and 4.

(ii) The development of two new resources within Ashford to be known as Community Hubs.

(iii) Once the Community Hubs are fully developed and used to the satisfaction of users to close Ashford DOS. The closure of Ashford DOS will not take place until the two new community hubs are in place.

(iv) The adaptation of some of the facilities outlined in appendices 3 and 4 to enable compliance with the Disability Discrimination Act and to improve access for adults with a learning disability and complex needs.

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Background documents: None

Appendix 1

Table setting out the consultation process for the Ashford Good Day Project.

Date	Time	Meeting	Venue
From 8th Sept. 2008	Consultation Information Pack and Invite letter sent to Family Carers, people who attend Ashford DOS, Staff, KCC Local Members and Ashford Borough Councillors		
11th Sept. 2008	2 – 3:30pm	Local Member briefing	Ashford Borough Council Offices, Civic Centre, Ashford
11th Sept. 2008	4 – 5:30pm	Ashford Borough Councillor's Briefing	As above
15th Sept. 2008	2 – 3pm & 3 – 4pm	Staff Consultation Meeting	Ashford DOS St Stephen's Walk Ashford
17th Sept. 2008	1:30 - 3pm	Client Consultation Meeting	Ashford DOS
17th Sept. 2008	3 – 4:30pm	Family / Carer Consultation Meeting	Ashford DOS
24th Sept. 2008	1:.30 - 3pm	Clients / Advocacy Consultation Workshop	Ashford DOS
30th Sept. 2008	6 - 8pm	Family / Carers Consultation Workshop	Ashford DOS
2nd Oct. 2008	10 am – 12 noon	Client / Advocacy Consultation Workshop	Ashford DOS
2nd Oct. 2008	3 – 4:30pm	Open Consultation Meeting	Ashford DOS
7th Oct. 2008	4 – 5.30pm	Staff Informal Consultation Workshop	Ashford DOS
8th Oct. 2008	2 – 3pm	Client / Advocacy Consultation Workshop	Ashford DOS
16th Oct. 2008	10 – 11.30am	Client / Advocacy Consultation Workshop	Ashford DOS

Appendix 1 (continued)			
Date	Time	Meeting	Venue
16th Oct. 2008	4 – 5.30pm	Staff Informal Consultation Workshop	Ashford DOS
23rd Oct. 2008	10 - 11.30am	Client / Advocacy Consultation Workshop	Ashford DOS
30th Oct. 2008	10 – 11.30am	Client / Advocacy Consultation Workshop	Ashford DOS
31st Oct. 2008	9.45 am – 1.00 pm	Ashford District Partnership Group Consultation Workshop	St Simons Church Hall Brookfield Road Ashford
6th Nov. 2008	10 – 11.30am	Client / Advocacy Consultation Workshop	Ashford DOS
18th Nov. 2008	9.30 – 12.30	Family Carer 1:1 Consultation Meetings	Ashford DOS
19th Nov. 2008	10 – 12 pm	Clients / Advocacy Market Day Consultation Event	Ashford DOS
19th Nov. 2008	2 – 4pm	Family Carer 1:1 Consultation Meetings	Ashford DOS
20th Nov. 2008	End of formal consultation / Start of extended consultation		

Appendix 2

The tables below show the outcomes and issues raised by people with a learning disability, family carers and others involved with the consultation.

2 (a) People with learning disabilities that use existing services or are likely to use future services

Issues raised during the consultation	Response given by officers
People with a Learning Disability – had the opportunity to attend the weekly consultation meetings and events. They were supported to take photos and video footage to aid understanding and allow further informal discussions. In general, people who attend Ashford DOS place a high value on both activities within the centre and the increasing range of opportunities within their local community such as football, Saturn Nightclub and using public transport. Current services and staff are highly valued. People have spoken up expressing their right to be involved and their concerns at the possible loss of their existing service, friends and relationships. With support from Advocacy services, many questions were asked and information requested as part of consultation, which helped to shape the consultation itself. Individual situations were highlighted including those of people with profound multiple learning disabilities. Some people have a person centred plan, however many others didn't. Some people took the opportunity to raise issues about family life and housing. Some people who attend the Ashford DOS are involved with the Ashford District Partnership Group including planning and decision making. In addition some people have been involved within the Ashford DOS Client Committee.	Independent advocacy was in place prior to and throughout the consultation process for people with learning disabilities, even though it has been very difficult for people to imagine exactly what future services might look like. Some people have experience of Direct Payments and others have not. Where new opportunities have arisen, such as 'Body and Mind' classes in the local community, these have been very much enjoyed by participants. People with profound multiple learning disabilities have generally had far less opportunity to access activities in their local community. As new services are developed priority will be given to maintaining existing friendships and relationships as well as natural opportunities to develop new ones. Existing services will run alongside new developing services and it is expected that the current trend towards less people using services which are not community based will continue as new opportunities continue to be developed from person centred plans, which will be a major next stage of work to complete. People will also know how much money their service will cost and have more choice and control over how this money is spent in the future. Existing staff are highly skilled and trained and are expected to very much be a part of developing new services and support.

2. (b) Family Carers

Issues raised during the consultation	Response given by officers
Family Carers place a high value on existing services and point out that those they care for, some having attended the Ashford DOS for many years, need to be able to maintain their friendships and have a safe base(s) from which they can access community facilities, with support as necessary. They have asked for more information on person centred planning and the new Ashford Gateway Plus. Some doubt the potential to improve services for people with profound multiple learning disabilities. Others pointed out potential difficulties with transport considering that Ashford is a large rural district. Self Directed Support and Direct Payments are seen by some as positive, however they need to be less complex and be appropriately supported. In general family carers agreed that working together with different agencies needs to continue and in particular opportunities towards The 2012 Olympics should be maximised.	The Ashford Community Interest Company offer support services to assist with personal budgets, person centred planning and brokerage. They also have a Development Worker who is putting together a series of Carer Workshops to provide additional information and support in response to the specific areas arising from the issues of concern raised during consultation. It is hoped that this will provide information in a timelier manner. Workshops will include further details about the Ashford Gateway Plus and Adult Changing facilities. In the future services will be more personalised and personal budgets will result in increased choice and control over what services people wish to purchase. There will be co-ordination so that plans are in place if for example support is delayed or cancelled. Transport issues are different for each individual and will be addressed during person centred planning.

2. (c) Ashford District Partnership Group and Wider Consultation including KCC Local Members and Ashford Borough Councillors

Issues raised during the consultation	Response given by officers
The Ashford District Partnership Group – Consultation event was held on 31st October 2008 and following the presentation people divided into three groups of people with a learning disability supported with a mixture of service providers, members of the Ashford Integrated Learning Disability Team, Other Agencies and even a local Councillor. A fourth group was made up of mostly Carers supported by Officers. The groups each completed part of a consultation questionnaire and fed back to the other groups present. Most of the results are incorporated into the questionnaire responses. Kent County Council Local Members wanted to know about timescales for both the new Ashford Gateway Plus, the Tenterden Gateway and other options in rural parts of Ashford. Emphasis was placed on partnerships with other agencies such as housing, education, work and sports. The impact of change and the importance of retaining current valued activities and existing staff were also highlighted. Attention was drawn to the use of available funding such as the Capital Programme and the Social Care Reform Grant to support changes. The growth in Direct payments was acknowledged and the link to more personalised services. Ashford Borough Councillors highlighted issues of communication in terms of understanding the vision and the need to effectively use consultation to engage with those affected by changes. They also expressed the importance of effective use of resources including partnership working, retaining staff and considering people in transition either from children's to adult services or during other life changes. Direct payments and personal budgets will mean that some people will need support in this area. Safety and protection and concerns about hate crime were highlighted.	A presentation about the Kent wide 'Good Day Programme – Better Days for people with Learning Disabilities in Kent' was given at the Ashford District Partnership Group, prior to the start of the more local Ashford Good Day Project and the formal consultation. People present generally welcomed the information and the vision that people with a learning disability should have more choice about what they do during the day, evenings and weekends, with flexible support and equality of opportunity to access community facilities and to lead a fulfilled and person centred life. Kent Adult Social Services sees the Ashford District Partnership Group as central to planning and decision making around the development of future services. Issues raised by Local Members were in alignment with the approach taken by Officers and gave added value to the consultation. Timescales were explained as were existing partnerships such as the strong links with housing and opportunities for sport approaching the 2012 Olympics. Officers acknowledged the importance of communication and understanding for people with Learning Disabilities and the impact of changes on them and their family carers. Work on transition and the safeguarding of vulnerable adults will continue as an important aspect of the proposed changes. Support for Carers is also part of a wider government initiative and KASS see family carers very much as integral to the lives of the people with Learning Disabilities they care for. An explanation of available support for direct payments and personal budget was given.

Appendix 3

THE ASHFORD SERVICE MODEL

1. There will be a wide variety of services available to people including:

- **The Ashford Community Hubs** (Ashford Gateway Plus and Stour Leisure Centre) – it is planned to have fully inclusive and accessible facilities of an 'adult changing place' and dedicated space within these two community buildings. "The Ashford Community Hubs" will provide space as stated in the agreed specification / plans and people will also be able to access other services operating from the sites and also those close by in the local community. Staff will support services users at these sites. Co-ordination of staff, service users and activities will operate from The Nest Resource Centre.

- **Wood N Ware Enterprise Hub** (Ashford) – this will be the base for the existing enterprise hub and provide work experience and training. The main area of expertise is adult social care and it may be beneficial in the future to look at improving links with the social enterprise sector.

- **Other Community Facilities** – These will be accessible to adults with a learning disability and include the following venues: Tenterden Gateway with an adult changing place facility, Fitness First – music/dance studio, Tenterden Satellite at St John's Hall, The North School – youth wing, The South School run by Ashford L D Community Interest Company, Homelands Golf and Football Club and home to Saturn Nightclub, Tenterden Leisure Centre and Sports Hall, Victoria Park Bowls and many other local community resources, according to individual person centred plans.

- **Private & Voluntary Sector Service Providers** - these will continue to develop to meet the changing needs and to ensure person centred plans become a reality for individuals.

- **Work Opportunities -** Will be supported in the community with local employers. Social Enterprise will be encouraged to enable people to become involved in work whatever their ability. People will be supported to understand how wages may affect current income through the benefits system.

- **Volunteering Opportunities -** there will be an increase in existing voluntary opportunities, to allow all who wish to participate whatever their ability.

- **Leisure Activities** – these include opportunities in dance, music, art etc., to meet up with friends and will be available during the day, evening and at weekends.

- **Sporting Opportunities** – to ensure equal access to the wide variety of sporting facilities throughout the Ashford district and will be available during the day, evening and at weekends.

- **Adult / Further Education** – to ensure equal access to a wide variety of classes available to people at the district's Adult Education centres and Further Education colleges.
- **Further Training in the Chosen Skill Area** - development of this will depend on the information from person centered plans.

- **Health and Healthy Living Opportunities** - to ensure maximum benefit from the Eastern and Coastal Primary Care Trust (PCT) or other relevant Health Body's, regarding health and wellbeing initiatives, such as regular health checks etc. This will include maximization of the benefits from Health staff working within the Ashford Integrated Adult Learning Disability Team, including physio-therapy and occupational therapy.

- **Person Centred Plans -** although all of the above includes ideas from the consultation, further information from individual's person centered plans will inform all developments

- **Information Points** - about services and benefits and help to access them, will be available through out the Ashford District. There will be more information in accessible formats for Self Directed Support, Direct Payments, the Kent Card and Personal Budgets.

There will be a need to work closely with partners including; Job Centre Plus, Adult / Further Education, Health Authorities, Ashford Borough Council, Ashford and Tenterden Gateways, as well as the private and voluntary sector, to ensure that facilities are accessible and friendly for people with learning disabilities.

With the introduction of Self Directed Support all new services will need to work within the context of personal budgets. Services will be provided by a wide variety of organisations in the community including Private and Voluntary services, Social Enterprises, Job Centre Plus, Employment Services and other community organisations on an individual basis. Direct Payments and the Kent Card can be used to purchase services from the Private and Voluntary sector.

Kent Adult Social Services will be setting the standards by developing the new Ashford Community Hubs. Current staff roles will focus more on providing support for individuals to implement their person centred plans with a focus on more self run services and partnership working with other agencies.

Kent Adult Social Services expect the number of people using these facilities to decrease over time as people use their personal budgets or direct payments to make other choices of activities within their local community in line with their person centred plans.

The Ashford Day Opportunities Service, operating from St Stephens Walk, will remain open until new services are established. Individuals' current hours will not be reduced.

Andrew McMillan
Project Manager – The Good Day Programme

Proposed Ashford Model

Tenterden Gateway

Fitness First
Music Dance

Ashford
Gateway Plus

Tenterden Satellite
St John's Hall

Wood N Ware

Person Centred Planning

with People who are
Important to You

The North School
Youth Wing

Victoria Park Bowls

Ashford LD - Community
Interest Company

Tenterden Leisure

Stour Centre

Ashford DPG

Travel Training

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 – 16 November 2010
Subject:	**DISABLED PERSONS' REGISTRATION CARD**
Classification:	Unrestricted

Summary: The purpose of this report is to inform Members of Disabled Registration Card schemes, explore the implications for introducing such a scheme in Kent and consider the way ahead.

Introduction

1. (1) In 2001 the Audit Commission carried out surveys of British public toilet provision which showed it was declining rapidly. Since then the British Toilet Association has estimated that public toilet provision has been reduced by 40 percent.

(2) One consequence of this reduction has been a greater need for people to use toilets that are clearly designated for use by disabled people, whether they are public or those provided by high street businesses. In particular some people with disabilities that are less obvious have complained about being challenged for using or attempting to use disabled toilets. In response to this situation, several disabled card schemes have been developed in other parts of the country in recent years.

Disabled Card Schemes

Disabled Persons' Registration Card

2. (1) Launched by Nottinghamshire County Council in May 2008, the Disabled Persons' Registration Card is a passport size card containing the photograph of the holder and stating that the person is a disabled person. It was designed to be used as a quick and easy way to confirm that the holder:

- has a significant disability
- needs to use toilet facilities provided for disabled people

(2) The card is issued free of charge and is not proof of entitlement to any benefits, goods or services. It is renewable after 3 years.

(3) Nottingham City Council considered introducing a similar scheme when the city's RADAR toilets were threatened. It did not proceed after an Equality Impact Assessment revealed the project could fall foul of its equalities policy.

DANSAC Toilet Cards

3. (1) These 'credit card' sized cards provided by the company DANSAC, are designed as a discreet way for people who have a Stoma or Catheter to request the use of toilet facilities in places such as retail outlets, restaurants, bars or leisure facilities etc. where there is no public facility available.

(2) Issued free of charge the card is obtained by contacting the company's Patient Services Department. Like the Nottinghamshire Disabled Persons' Registration card it does not guarantee access to a disabled toilet, but it can be used to demonstrate urgent need to use toilet facilities.

"Just Can't Wait" Toilet Cards

4. (1) The Bladder and Bowel Foundation, a national charity, issues Just Can't Wait Toilet Cards to people who frequently need to use a toilet when they are out and about. If required to do so the holder can show the card when out shopping or socialising to help them gain access to a toilet, disabled or otherwise. The card costs £5 and states that the holder has a medical condition which requires the urgent need of a toilet. Like the other cards it does not guarantee access to a toilet.

(2) The Bladder and Bowel Foundation is currently working with Nottinghamshire County Council with a view to extending the scheme nationally.

Local Initiative

5. (1) Maidstone Borough Council has partnership agreements with Marks and Spencer, McDonalds and a number of businesses located within the Royal Star Arcade, to make their toilets available during business hours to anyone who urgently require them. The agreement is reviewed annually. There is signage on the High Street informing people of the location of these toilets.

(2) This is a model that may be adopted by other Borough and District Councils and is consistent with the government's emphasis on Localism.

Legal position

6. (1) Under the National Assistance Act 1948 and related directions, anyone whose disability is "substantial and permanent" can register with their local authority. However, registration is entirely voluntary and does not include any duty or requirements on the local authority to issue registration cards.

How Nottinghamshire Determines Eligibility

7. (1) During Community Care Assessments, if a practitioner determines that someone is eligible for registration as disabled and would like to be formally registered, they would refer the person to their Customer Service Centre from where the Disabled Persons' Registration Card is issued.

(2) In addition, a person can qualify for the card if they are in receipt of one of the following benefits:

- Disability Living Allowance (DLA)
- Attendance Allowances (AA)
- Industrial Injury Constant Attendance Allowance.
  or
- is registered blind or partially sighted
- has a valid Blue Badge
- has a long term Stoma or Catheter

(3) The applicant has to complete a form which can be posted to them or downloaded from the county's website. They then post it along with a passport size colour photograph, to the Customer Service Centre where it is processed by an administrator. If the documents are satisfactory the card is issued.

(4) By May 2009, Nottinghamshire's Customer Service Centre had issued approximately 1,200 applicants with disabled registration cards and was receiving between 30 - 40 applications per week. A small percentage of applicants were refused disabled cards.

How KASS Determines Eligibility

8. (1) In meeting its duty to carry out Community Care assessments, under the NHS and Community Care Act 1990, practitioner staff determines:

- whether or not an individual meets its eligibility criteria for a service
- whether or not an individual is eligible to be registered as a disabled person in accordance with Chronically Sick and Disabled Persons Act
- whether the individual wishes to be formally registered.

(2) If the individual wishes to be registered, the relevant Locality Team Administrator issues them with a green passport size registration card. This is useful when people are in the process of applying for:

- major adaptations to their homes via Disabled Facilities Grants
  and/or
- purchasing major items of equipment

as these do not attract VAT. However, if a person is eligible to be registered this is sufficient for them to receive the exemption.

(3) These cards are not designed to be used as proof of disability for people wishing to use disabled toilets.

Cost

9. (1) Based on the above performance data and taking into consideration the size and demography of Kent, the following costs are likely to be incurred by KASS if the Nottinghamshire model is adopted by KCC:

- 1 x full time administrator approximately - £21k.
- recruitment costs
- card production costs
- costs associated with handling appeals, complaint and disputes.

Options for KASS

10. (1) **Do Nothing**

- There is no duty on Local Authorities to provide Disabled Registration Cards
- There are alternatives available in the community

(2) **Endorse the Nottinghamshire Model for introduction in Kent**

- This will incur additional administrative costs in times of budget cuts.

(3) **Publicise National Initiatives**

- Establish links on Kent's website informing people of Just Cant Wait and DANSAC cards and how people can obtain them.
- publicise in GADFLY (KASS' quarterly magazine which is widely circulated to people with social care needs)

Recommendations

11. (1) Members are asked to consider the options and to make a recommendation as to the most appropriate means of addressing the needs of people, not just disabled people, who have urgent need to use toilet facilities within the community.

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Background documents:
None

By:	Jeff Hawkins, Transformation Programme Manager
To:	Adult Social Services Policy Overview and Scrutiny Committee – 16 November 2010
Subject:	Change to Keep Succeeding
Classification:	Unrestricted

Summary: "Change to Keep Succeeding" is a report by the Group Managing Director on the transformation of the County Council's operating framework.

The Adult Social Services Policy Overview and Scrutiny Committee will be given a presentation on the report, the management structure it proposes, and the process for consulting with staff.

Background

1. . "Change to Keep Succeeding" sets out a proposed new structure for the senior management of Kent County Council. It was presented to meetings of the Council's Cabinet, Scrutiny Board and Cabinet Scrutiny Committee in the week commencing 11 October 2010.

2. Following Cabinet and Cabinet Scrutiny, on 15 October Kent County Council started a period of formal consultation on the proposed new senior management structure with the 25 staff impacted by this proposal. At the same time a wider informal consultation was commenced which is open to all staff and partners. The consultation period ends on 3 December 2010. A report will then be made to full Council on 16 December 2010 for a revised management structure and plans for the implementation of that structure.

4. The target is to implement the change in structure, subject to consultation and the decision of the County Council on 16 December, by 4 April 2011.

Recommendation

5. The Adult Social Services Policy Overview and Scrutiny Committee is requested to consider these proposals and to note that the matters raised by Members at this and other Member meetings to which this matter is to be reported will be fully considered as part of the consultative process.

Background Documents*: none*

J L Hawkins
Transformation Project Manager, Sessions House room 1.68, extension 8103

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By: Paul Carter, Leader of the Council
Katherine Kerswell, Group Managing Director

To: Cabinet

Date: **11 October 2010**

Subject: "Change to keep succeeding"
The transformation of the Council's operating framework

Classification: **Unrestricted**

SUMMARY: This report outlines the work to date on a programme to ensure that the Council continues to deliver successfully in the face of the most significant changes facing local government in the external financial and policy context. It needs to be read in conjunction with the draft medium term plan which is being launched for consultation - "Bold Steps for Kent" as this is proposing the draft new strategic vision for the Council which the organisational framework of the Council needs to be able to support and deliver upon. A supplementary and more detailed report will be circulated prior to the meeting on 11th October due to the closing date of the consultation period upon which that part of this report needs to rely. As this further report will include details of the proposed new structure and information about members of staff, its status may be "exempt".

1. Introduction

(i) To reduce the scale of the £156bn public deficit, to repair the nation's public finances and to restore confidence in the national economy, the Government has embarked on a radical plan to reduce public spending. The Comprehensive Spending Review will settle the landscape for public service funding in late October. And the following month the Council will receive a clearer view of the provisional settlement in its external revenue funding. This will present elected Members and officers of the Council with our biggest challenge for a generation. Over the next four years it is likely that some £340m needs to be reduced from the Council's net revenue budget in order to reduce spending and absorb the pressures we face. But the Council does not face this challenge alone – aside from the health service (which has to contain its intrinsic growth pressures rather than substantially reduce its base budgets) most public agencies in Kent and beyond face similar challenges. However, unlike most other public agencies, Kent County Council has the capabilities to meet these challenges head on. For when faced with challenges of this scale the Council needs to draw on its strengths of excellence and innovation.

(ii) Success is a springboard for future success. But simply repeating the success of the past will not be enough to meet the challenges of the future.

Instead the Council needs to make sure that its organisation and services are sufficiently agile to lower their costs to meet the coalition government's challenge on public sector costs and the Authority will need to evolve against the background of significant changes in other sectors including Health, Education, while sustaining and improving service outcomes. Individual services need to continue to strive to be ever more cost-effective but the overall organisation needs also to embrace an ethic of collective cost-effectiveness. This will require a more linked and connected organisation that is able to reap the benefits of scale, lower the cost of organisational infrastructure, and foster higher levels of overall productivity.

(iii) The Council needs to grasp the opportunities of the Government's decentralisation and localist agenda to revive enterprise and employment across Kent. It needs to help shape the future of education and healthcare across Kent to assure ever better life-chances for Kent's people. And it needs to make sure that its own organisation is sufficiently agile so as to continue to lower costs, raise productivity and secure ever better standards of customer service.

(iv) The proposed changes to the senior management arrangements to be outlined in the following appendix to this report (once consultation has closed) will seek to achieve the above and also to make the overall organisation leaner and fitter for future purposes. Without doubt, Kent benefits from the considerable talents and energies of the Council's most senior managers. But these benefits are not without significant cost to the taxpayer. In lowering costs and raising productivity, all layers of management need to be examined to assure cost-effectiveness and fitness for purpose. And it is crucial that the Council's senior management arrangements are reviewed to assure Members that value for money is secured and that these managers can together drive through the essential changes that are required across the County.

(v) In usual times, top-level organisational changes can help drive change throughout organisations. In times of tightening fiscal constraint they are essential to drive even deeper change throughout services and organisations. These top-level changes need to be approached in a disciplined and corporate manner. This is why I am proposing a coherent approach that secures Council-wide improvements in managerial culture, direction, and co-ordination. In particular I am mindful that during a period of major spending reductions, the conventional risks to service delivery pale against the potential risks of failure when services are being delivered on (an average of) three-quarters of their current budget. Controls based on single service or professional domains need to be strengthened by newly fashioned corporate controls to enable Members to better govern the risks to be faced over the next four years.

(vi) In order to deliver sustainable levels of budget savings over the coming four years we will require organisational courage and resilience from Members and officers alike. But these virtues are not of themselves sufficient. The Council needs to ensure that its senior managers are able to execute the changes that are required over the coming period. These senior managers need to possess the competencies and capabilities to take the

whole organisation forward and they need to possess the collective confidence to take the next bold steps.

2. OUTCOME OF THE INFORMAL CONSULTATION PROCESS

(i) The response to the initial informal consultation has been positive with nearly 200 members of staff already offering comment on the design principles. The comments are predominately positive in nature to the proposals contained within the draft design principles. Eight meetings were also held with managers about these design principles and feedback from those meetings is also being incorporated into the final draft recommendations for Cabinet.

(ii) All the feedback received will be collated and reported to Cabinet to inform their decisions and thinking about the way forward. They will also be used to assess the value of the draft design principles that have been circulated and the design of the Council's operating framework that will then flow from these.

3. PROJECT PLAN

Detail of the sequence and timing of the implementation steps will be provided in the following report. The detail of this will need to be based around the final recommendations of any proposed changes to the operational framework to be made to Cabinet.

4. PROPOSED NEW ORGANISATIONAL STRUCTURE.

The supplementary report to follow will cover:

- Details of the proposed directorates' structure,
- The proposed senior posts in each directorate and the business activity reporting into these roles.
- Outline job descriptions for each of the proposed senior roles
- A list of the current posts that it is proposed are deleted and a list of the new posts that it is proposed to create.
- Details of proposals to create a number of new companies to deliver Council services. The detail of these new company models will need to also be developed during the consultation period.

5. REVIEW OF REWARD POLICY FOR SENIOR POSTS

(i) Cabinet is asked to agree to a review, by the HayGroup, of the appropriate salary levels for the proposed senior posts. The review will take account of the level of responsibility and accountability of each proposed role and recommend an appropriate level of salary taking account of internal relativities and market rate. The review will be completed between the 18th October and 5th November.

(ii) The current salaries for senior posts are "spot" salaries, i.e. there is a rate for the job and no salary scale. Some senior posts have a contractual entitlement to a performance payment which applies a percentage lump sum

bonus according to the level of performance. However, these payments were frozen last financial year and will not be paid for this current financial year. It is proposed that senior managers are consulted during the formal consultation period on bringing senior performance pay in line with the Total Contribution Pay scheme in place for all other Kent County Council staff on the Kent Scheme of terms and conditions of employment. This proposal includes removing the current contractual bonuses for senior staff.

(iii) At the end of the formal period of consultation, all proposals for any changes to the terms and conditions for these proposed senior posts will be put to Personnel Committee for consideration before being reported to Cabinet on 16th December.

6. PROCESS FOR APPOINTING TO SENIOR POSTS

(i) Details of the process and timeline for populating the proposed senior level posts will be included in the supplementary report. This could include Member panel interviews preceded by assessment centres. Before any such arrangements like this can be agreed to, it will be necessary to follow the Council's process outlined in the Council's Blue Book of terms and conditions of employment.

(ii) This will of course be followed in deciding whether individual senior managers are "slotted" (i.e. automatically placed) to the proposed posts in the structure. This means that an individual may be slotted if all the following criteria are met:

- the job must be the same grade as before the re-organisation,
- there must be the same number of jobs (or more) as job holders
- the job is deemed 75% the same type of work in term of job accountabilities, activities and broad objectives

(iii) Then there is no recruitment process either internal or external and the employee whose job has been altered by this process is slotted in to the new job. This can only be assessed at the end of the consultation process and following the full Council's final decision on the proposals.

4. CORE VALUES AND BEHAVIOURS

(i) This change programme is aimed at enabling Kent County Council to alter the way it operates so that it can meet the new challenges it is facing. It cannot therefore be solely about the organisation structure, but must also lead to a new organisational culture.

(ii) It is therefore proposed that an external provider is procured to engage with staff across the Authority and with Members and senior managers to design a set of draft values and behaviours. This process when shared with staff has been warmly welcomed as a means of being involved in shaping the Council and ensuring we can deliver as well in the future as we have in the past.

(iii) These values and behaviours will be put forward for discussion and agreement at the County Council meeting on 16th December.
Once agreed these values and behaviours will drive all aspects of the Authority's HR strategy.

5. EXIT MANAGEMENT PROCESS FOR SENIOR POSTS

It is suggested that a voluntary redundancy process is introduced, to be offered to any of the senior managers affected by the restructure proposals at the start of the process. Details of the process for this together with proposals around notice periods, appeals against decisions made and alternative job search support will follow in the supplementary report.

6. RECRUITMENT TO ANY POSSIBLE VACANT SENIOR POSTS

It is critical to the stability of the organisation, the continuation of excellent service delivery and the success of the many significant change programmes being undertaken that any senior posts left vacant are filled as soon as possible. The standard Kent County Council personnel process will be applied to any post that is not filled by a priority candidate, and the post will be advertised to internal staff with external candidates being sought contemporaneously if required. This has worked very successfully in the past and it is hoped that if such a circumstance arises of a vacant post needing to be filled, internal staff are able to come forward and be assessed for the vacancy.

7. FINANCIAL IMPLICATIONS

(i) The Council is facing significant financial challenge more so than at any time in its past by virtue of the economic conditions of the country and the forthcoming comprehensive spending review that is proposing to reduce Council budgets between 25% to 40%. Officer have been working on a series of options to increase the efficient working of the Council and to review ways in which services can be delivered to reduce costs whilst maintaining quality to meet this level of reduction.

(ii) The management costs and organisational structure costs of the authority must be examined along with all other costs within the Council. This process will naturally contribute to the savings required. Details of the proposed savings will be available once consultation has closed and a final draft proposal for Cabinet can be created. Other savings proposals that will affect staffing arrangements in the Council will undoubtedly follow in the budget proposals that will be presented to Members later this Autumn / Winter. Effective corporate programme management will ensure alignment and enable any possible double counting to be dealt with.

8. RISKS

(i) It is important early on in this work to highlight a number of possible risks facing the Council from these proposals. A fuller risk register will be supplied

following the closure of consultation and the draft proposals being able to be concluded.

(ii) This proposed change process is happening at a very congested time for this Council. The Council along with all others in the public sector is facing unprecedented external policy and financial changes. Local people's expectations from services and what they are willing to pay for them is also changing fundamentally. We are in the process of discussing with Members and the Scrutiny committees the Council's new medium term plan "Bold Steps for Kent" which is considering a brand new focus and way of working for the next four years. The draft medium term plan is also on this Cabinet's agenda for approval for consultation.

(iii) It is imperative that the process of transforming our operational framework, preparation of the Council's medium term financial plan and the development of the medium term plan dovetail and absolutely align. They are all intricately related and the individual success of each of them relies upon the success of all.

(iv) The Group Managing Director's role is to ensure the co-ordination of such major developments and also to plan and manage the risk of non-alignment by working very closely with key officers in the Council. Therefore these programmes will be programme managed through the Group Managing Director's office and the Corporate Management Team will be the programme board for these activities. The programme office resource is in place to support this.

(v) It is important to be clear about the need to ensure accurate financial control is maintained throughout this change. This risk will be strongly mitigated by the programme management approach, the corporate management team's role as the programme board and very strong input from the financial services division into the programme team that is already in place.

(vi) In addition to the risk being mitigated by the effective programme management resource, another possible mitigation of this risk could be to delay one or several of these programmes that are occurring at the same time.

(vii) "Bold Steps for Kent" the new medium term plan, has to take place in this timeframe. Our current medium term plan "Towards 2010" has concluded and this Council needs to be clearly focused on dealing with the new policy challenges facing us and being able to plan for and deliver Members' ambitions for the next four years.

(viii) The transformation of the Council's operating framework is intrinsically linked to making certain that the Council can deliver "Bold Steps for Kent" the new medium term plan, which requires of us a new integrated delivery model and new ways of working.

(ix) The new medium term plan “Bold Steps for Kent” also supports and enables many of the proposals currently being developed to deliver the new medium term financial plan and the estimated £340m of reductions that the Council may have to find over the next four years.

(x) The medium term financial plan clearly has to take place at this time to deliver the Council’s budget and respond to the outcome of the comprehensive spending review on the 20th October. The changes proposed by this report will enable many of the financial reductions that will be necessary to be made.

(xi) If we are to avoid a period of managed decline we need to deliver our services at lower cost and in different ways. If we halt the organisational change that this report contemplates we face a different risk of “salami slicing” of services and being unable to deliver the quality of service that Kent is renowned for. It is important that the costs of how this organisation delivers its services are considered and challenged as much as the costs of what we deliver in actual services.

(xii) Kent has a national reputation for being able to seize opportunities at the right moment. If we fail to align these three programmes effectively and not maximise the support they give to each other and manage the pace of each through a co-ordinated and resourced programme office we run the different risk of losing the benefits of these processes and prolonging the period of turbulence for this organisation.

(xiii) Another two risks of all these programmes and in particular the subject of this report are the risks to morale and leadership capacity. Members will be able to see from the responses from staff to this informal consultation (those received to date) that they talk about the uncertainty that they all feel. There are also comments welcoming the fact they we are facing up to this and want to involve staff in how we deal with the situation. There has also been very positive support expressed in the managers meetings about taking up this difficult situation with their teams to help manage the transition and deal with the uncertainty that the external policy changes and financial environment are driving.

(xiv) As our services have to be reduced and the policy challenges we are facing and also wish to create ourselves are changing, we need to examine the most senior posts that we have in this organisation. We must ensure that they along with all the other roles and services are fit for purpose and that the overhead costs that they represent are appropriate. The period between our current operational framework to any different framework that Members agree will need to be very carefully managed through a transition programme to ensure effective capacity is available to keep the programmes of the Council going.

(xv) All areas of this Council are being reviewed and challenged as part of the process to find the £340m reductions needed over the next four years. There is the risk that if we fail to examine the costs of our most senior management structures and whether they are designed in the most effective way for our

future, we will give a contradictory message to the rest of our staff about the different values placed upon roles at different levels in the Council. That is clearly not part of the values of this authority and it is important that we must be seen to be demonstrating explicitly the equity and fairness of the approach that we take to examining all costs at all levels and in all services.

(xvi) This Council can be proud of the fact that we have a strong pool of resilient and steadfast managers who have met such challenges as this in the past and have managed the transition and uncertainty that is necessary in such a turbulent period.

(xvii) Cabinet must also consider in assessing the options that this report will place before them a slightly different type of risk. The risks above can be described as a type 1 risk. The risk of something going wrong that can then either be mitigated or put right.

(xviii)here is also the type 2 risk that needs to be considered. This is the risk of not doing something, that if you had done it – it would have delivered the future you are seeking to achieve.

(xix)The consequence of a type 2 risk in relation to this report and the proposals that are to follow; is that changing the organisation at a later date when the opportunities we are seeking to take advantage of have moved on could be much more costly and damaging for us. The external demands of the policy changes from the new government and the financial reductions we will have to find show no sign of slowing down or reducing, indeed they seem to be accelerating. Cabinet will need to consider the cost of change now in all its dimensions or a possible much increased cost at a later date.

9.RECOMMENDATION

Cabinet is asked to note and agree as appropriate the proposals put forward in this report and to note that further recommendations will follow in the supplementary report.

Note: *This report will also be discussed at a meeting of the Scrutiny Board which is taking place on11 October on the rising of the Cabinet meeting and a meeting of the Cabinet Scrutiny Committee taking place on Friday 15 October 2010*

Background documents: The First Bold step Informal consultation document

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Change to keep succeeding Appendix 1

The challenges facing us

1. As described in the Cabinet report already circulated, KCC is facing; along with all other local authorities and public service agencies, an unprecedented level of and pace of change. The challenges facing the Council arise from three main sources.

    - From the changing patterns of needs and demands from service users and local residents.

    - From the financial reductions that are being applied to public spending generally.

    - From the fundamental changes planned by the Government to public sector policy and our own new policy ambitions in the draft medium term plan "Bold Steps for Kent".

2. The needs and demands of our public do change and are changing rapidly and if we are not equally nimble in responding to them we can appear rigid or fixed in terms of the style of our service delivery and our ability to change our cost base. The demographic changes we are facing in Kent are significant enough on their own but they accompany further social and economic change as well as the fast paced changes in local peoples' use of media technologies such as Face Book campaigns, electronic petitions and the widespread use of direct contact email. KCC has embraced the transparency agenda and this will yield further avenues for media technologies to engage with the delivery of our services and our functioning as a Council.

The demographic challenge

3. Over the next eighteen years the total population in Kent is predicted to increase by 18%, which is higher than the growth predicted for the whole of England and the South East. The particular population growth trend that we need to be mindful of in thinking and planning for our future is the growth of the over 85 population. At one level this should be absolutely celebrated as many more people are living past this age than ever before.

4. Over the next eighteen years the percentage of over 85's in our total Kent population will increase by 99% from a population of 38,700 to 77,400. (ONS – 2008 –based sub national population projections) In contrast our younger population group of 4-10 year olds only increases by 12% between 2009 and 2019 and then remains constant after that.

5. This clearly has major issues for a wide range of services we provide and certainly is not restricted in its impact to adult social care services. The principle that its not just adding years to life but life to those years means each of our services must think very hard how we address this significant increase in our over 85 population.

The service delivery challenge

6. Essentially, future needs and demands for public services will differ in character from those of today – they will not simply differ in the level or amount we deliver. People want more appropriate, more flexible, more personally tailored and responsive services. They want more self-organised services and they expect, wherever practicable, for services to be made available online. How people privately consume goods and services will continue to influence their expectations of our services.

7. In order for us to be able to meet our future challenges, KCC, local government, indeed all public institutions and agencies will need to be more agile in how they organise themselves. The stress will rightly be on redesigning services, on reshaping the systems of service delivery, and on revising "service user pathways" such as in care for elderly people with specific conditions, and really maximising the use of the latent potential of our Gateways. But to do so will require us to be much more flexible in how we finance our services and how we shape our functions and activities. We must also be very clear this does not simply apply to how we work on our own, but increasingly we will be working with our partners and we will need to be flexible and agile in the many differing types of relationships that will emerge.

8. Eight briefing sessions with 219 of the Council's managers have taken place over the informal consultation period. We have discussed the changes that the Council will have to face over the next period. We have also discussed between us the new policies that the Coalition Government is introducing. Members will see from Appendix 2, a summary of the responses from those sessions. One of the very consistent themes raised in those discussions was the impact from the level of financial reductions that we have to plan for and contemplate ahead of the 20th October CSR announcement and also the effects that this could have on local jobs and services in our county.

The financial challenge

9. The Government have adopted a broad plan for public sector reductions. The current plan is for 85 per cent of the planned reductions to come from public spending cuts. The period of private sector recession of 2008-9 is being followed by period of public sector retrenchment from 2010-14.

10. At the very broadest level this presents a background of considerable uncertainty for KCC and its public sector partners in the county, all of whom face the challenge of planning for this future. Nationally local government has had to deliver efficiencies of around 3% a year. As an excellent authority KCC has delivered above that level at around 4% a year. This has required significant focus and activity by the organisation and Members. The level of reductions we are expecting from the CSR announcement translates roughly into reducing our spending by up to eight per cent each year for the coming three years.

11. Efficiencies of three or four per cent can be planned for by way of productivity improvements and the like. Ongoing cumulative reductions of eight per cent are significantly much more demanding – to determine, and then to implement.

12. They require some bold steps to be taken.

The policy challenge

13. The Coalition Government has published an ambitious agenda for fundamentally altering the nature of public service in this country. It has resonated very closely with the future vision for public services that the County Council set out in the Leader's paper "Bold Steps for Radical Reform" in January 2010.

14. Kent's history of innovation, delivery of quality services and strong relationships with Whitehall places us in an enviable position to develop many of these new ideas and bring additional advantages for example through investment in new service models, by a government willing to see its ideas being tested and trialled. All throughout the meetings with managers their willingness to try new ideas and pride in the history of innovation and entrepreneurialism of their Council was very evident and staff are getting ready to step up to these new challenges.

15. The fact that we have two externally driven major changes of a policy framework and a financial framework is significant. We must avoid the pressure of such a reduction in our funding to feel that the future has to be one of managed decline and a timid future then emerging.

16. This point was raised in the consultation process and many staff opted for creating a new future and not just face an endless "salami slicing" of Council services. Their responses are very true to a core aspect of KCC – that of facing up to our future and changing it for the better. That characteristic will be essential for us going forward and managing these challenges. We need to be able to take advantage of the new ideas that are emerging about public services and really offer a different future for public services in Kent. These draft structure proposals aim to enable that capacity to be in place as soon as possible and to aid the financial reductions we must face.

17. The structure charts that are included with this report for Cabinet to approve as a consultation draft for the organisation and our partners, attempt to capture the challenges we face and to enable the County Council to fully respond to the new opportunities in the changing financial and policy environment both from our own draft medium term plan "Bold Steps for Kent" and the Government's radical agenda.

18. A series of design principles were developed and circulated in a leaflet "The first bold step" to all staff to create a debate about what was facing us as a Council and whether we are currently organised and operating in a way that enables us to deal with that future in the most effective manner. The summary of the comments received back from staff is attached at Appendix 2. There are a wide range of comments, both critical and supportive and I have responded to each, full copies of which are available in the Member's Information Point as well as to each Member of Cabinet and the Scrutiny Boards overseeing this report. Overall there is a positive sense of energy and desire to change some of the ways that we operate as an organisation, most notably on how we connect internally and operate as one organisation. Many

of the design principles were supported and they have shaped the draft structure proposals placed before Members today.

19. The changing nature of the delivery of public services will require KCC to think very carefully about the current way it is organised. As recently as Sunday 3rd October the Secretary of State for Communities and Local Government – Eric Pickles MP made a statement of how local government must end duplication and increase its productivity, He urged us all to share more services between Councils and between other public agencies. The proposals in this restructure rise to the challenge that the Secretary of State has thrown out to all local government in ensuring we are joining ourselves up as an organisation and making the use of our internal systems much more productive. This will enable an easier connection to be made as one Council with partners when needing to join up services together.

20. It will also enable us to create new forms of service delivery vehicles with our key partners in Schools and with GP's. It will also help us to deliver more effectively in localities, joining decision making with our other partners in District Councils, the Police and Health and other local organisations to really tailor our services to the particular needs of that locality. The intention is that this locality approach does not stop at the district level but can explore closer delivery with our parish and town Councils and in local neighbourhoods.

21. All of this is exactly in line with the Secretary of State's determined vision for the future of local government delivery. On coming into office the Secretary of State declared his priorities to be;

> "localism, localism and localism – but not necessarily in that order".

22. In the face of that drive to join up and also increase our productivity; how we internally organise our business support resources also needs to alter so that we are connected and integrated as one organisation. We can then become much more efficient and productive in how we use those systems and processes – a "one pass" approach and (leading to much more effective and coherent) can then effectively integrate with others.

Explanation of the structure in general and process for staff impacted

23. In addition to the text below which describes the main themes that the proposed structure is attempting to deliver, it may be helpful for Members to look at the structure diagrams. These are portrayed in two ways, a traditional organogram of posts and reporting lines showing the whole Council and a more detailed picture outlining the top two tiers of management posts in each proposed Directorate that are directly impacted by this proposed restructure consultation. The array of functions that are shown (in the grid boxes) for that Directorate then would lie within their areas of responsibility if those senior posts at first and second tier were approved. Please note these are not all current service teams but also denote capacity and functions that will need to be created.

24. Please also note that the areas described as functions and any staff or managers within those are **not** affected at this stage by any of these restructure proposals. If at a later stage further re-organisation is required then that will be dealt with, within the terms and conditions of the KCC's employment policies. Appendix 5 of this report lists the current senior

management posts that are directly impacted by these draft structure proposals. It needs to be explicitly understood that these are the **only** posts which are affected by this process.

25. Those post holders are **not** placed formally at risk by this consultation process. That can only happen if and when Members take their final decision on the proposals at the Full Council meeting on the 16th December. It will only be at that stage that it will be possible to determine whether any of the current posts have altered significantly and therefore whether any of the post holders are then formally at risk. The Director of Personnel and Development and the Group Managing Director will be writing formally to all senior officers directly impacted by this process on Friday 15th October following the outcome of Cabinet Scrutiny Board. Formal consultation can only begin following the outcome of that meeting. However all senior staff are being briefed on the morning of the 11th October so that they are fully aware of the draft structure proposals and can ask any additional information about the process that they require. The Corporate Management Team have also all been informed of these proposals on Friday 8th October, either in a meeting or by receiving copies of the proposals due to other meetings preventing them attending.

26. It is very important to be aware that the posts at the second tier level do **not** all carry the same level of seniority, size of job or price tag for that job. The inclusion of director level posts in this way represents the first visible sign of implementing the design principle of a flatter structure leading to fewer management tiers between the top of the organisation and the front line.

27. There are a number of posts that have been designated “director” that have a very singular focus such as waste and procurement. These have been included in the most senior tiers of management as they are such significant areas for the Council and to give them a very clear focus and priority.

28. By virtue of the design principle that was endorsed by staff, this structure is aiming to connect all business support services together in one Directorate serving the whole of the Council. There are two posts in that Directorate however that are also members of the Corporate Management Team with the same first tier status as the Corporate Directors leading Directorates. These two posts are Corporate Director Finance and Corporate Director Human Resources. The reporting lines and day to day operational activity of these two divisions need to be part of the Business Strategy and Support Directorate but they play such a significant role in the life of this authority that they will be formally members of the Corporate Management team and enable to enact their strategic role in full. It is also critical for the statutory role of the Chief Finance Officer post that it is a member of the Corporate Management Team in order to be able to fulfil its duty.

29. The Corporate Director Business Strategy and Support has also been designated as Deputy Managing Director. This will ensure continuity of organisational leadership in the absence of the Managing Director. The current job title of the post of Group Managing Director is proposed to be altered through this process to Managing Director. This is now possible due to the other Directorates being re-titled away from being Managing Directors in their own right and also denoting the one Council – one organisation design principle.

Detail regarding the role of the Corporate Director

30. The post of Corporate Director denotes the most senior tier – first tier of management in the authority and membership of the Corporate Management Team. The Corporate Director along with all other first and second tier posts will share identical responsibilities in their job descriptions in regard to overarching responsibilities for being focused on; our customers, working with partners, leading services, leading people, performance, finance and risk. In addition they will also have the specialist responsibilities in line with their Directorate's functions.

31. The Corporate Director is the overall managerial head of the Directorate and as such has a key responsibility for ensuring its smooth running. The post has to have a strong relationship with the business partners who will support the operation of that Directorate. The Corporate Director is also a strategic policy client initiating the development of major policy via the Director of Business Strategy and the resources in that division and in close liaison with their Cabinet portfolio holder. The design of the business strategy division is to ensure a holistic approach can be taken to policy and strategy development in the Council and that the staff working there are able to cross fertilise ideas and develop their thinking in the broadest context of the direction of the Council as a whole.

32. Corporate Directors will still as happens currently take the lead on a number of cross cutting issues and themes that are critical for the smooth running of the organisation. Health and Safety and Equalities are two very obvious areas of work that both require the most senior posts in the authority to champion.

33. Those Directors and Corporate Directors who have responsibility for the business partner relationships for their particular functions with other Directorates are also designated Heads of Profession". This covers finance, human resources, property, IT, communications, consultation and engagement The Director of Governance and Assurance is also the Head of Profession for legal services.

34. The Chief Officer Group has been redesigned over these last three months into a Corporate Management team (CMT) and its new way of working is in line with the design principles. It will be a key element in ensuring effective corporate working and that new silos don't replace the old.

35. CMT's role is primarily in two areas. One is giving advice to Members. In large-scale multi-functional local government there are, inevitably, competing claims for resources, assets, facilities, services and political attention. In this context one key feature of corporate management is the requirement to advise Members on how best to balance differing interests and how best to weigh competing claims. Members may require a plurality of views but these must first be considered through a corporate lens – policy, service and managerial issues need to be considered in the round and not simply through the prism of one singular service domain. This if not counteracted can be a major driver of silo behaviour.

36. The other is managerial leadership. The Council's services, functions and activities are all directed to improve outcomes for the people of Kent. The

Council's top team are collectively responsible for the coherence of management direction and controls – operationally, strategically and corporately. The team is responsible for overall results, the stewardship of resources, the Council's corporate reputation and its effective risk management (results, resources, reputation and risks).

37. The Chief Officer Group whilst it has clearly undertaken a number of the above roles in the past has not operated as explicitly as the new terms of reference of the Corporate Management Team describe. This new Corporate Management Team role is critical for the smooth operation of the new operating framework of the authority.

38. In the face of all our challenges the Corporate Management Team must absolutely share one responsibility that of explicitly challenging all our areas of service and practice to ensure we are truly delivering the best we can. This is not just a question of ensuring that the things we are doing are being done in the right way. But also in the light of the significant financial, and policy changes both nationally and of our own volition that we are now doing the right things.

Delivering the new vision of the authority – delivering the design principles

39. It may seem odd in a report to Members that is primarily about draft structure proposals to say that the future operating framework cannot just be about a structure. Throughout the consultation and in the manager's meetings, we have discussed a way of looking at the organisation through a number of areas, one of which is the structure. We have also discussed the style of the Council – how it works, the systems we use, our shared values, the skills, our staff need, etc. Staff strongly responded to this and have endorsed that we need to develop other aspects of the way we work and organise ourselves and not solely focus on the structural arrangements of services and reporting lines as important as they are.

40. The earlier report that was circulated to Cabinet refers to the development of a new set of shared values and workplace behaviours that will be designed by staff for staff. This too has been welcomed in the feedback as a means of engaging the Council and making the design principles really come to life in our day to day interactions.

41. The Council will shortly be consulting on its draft medium term plan "Bold Steps for Kent". The outline of this was captured in the first design principle which shared with staff the three proposed ambitions for Kent; to grow the economy, tackle disadvantage and put citizens in control. The way we will work to deliver that, will be through operating as one Council and very much focused on the localities of Kent with our partners. The role of KCC in speaking out for the whole of Kent and its needs is also captured in this principle and the need for us to stand up for our county and ensure our needs and demands are clearly understood.

42. The structure proposals have been developed in line with the thinking in "Bold Steps for Kent" and will strongly support the new ambitions and provide capacity to implement the direction of travel for public services in KCC and the whole of Kent that is outlined in there.

43. Draft proposals for consultation on the future structure of Kent County Council

44. It is proposed to create five Directorates – Business Strategy and Support, Customer and Communities, Enterprise, Families, Health and Social Care and Education, Learning and Skills. These Directorates aim to deliver the design principles that have been consulted upon with staff. (see Appendix 2)

45. They are also intended to reflect the three draft Council and county wide ambitions contained within the draft medium term plan "Bold Steps for Kent". These are 1. Growing the Economy – Enterprise Directorate, 2. Tackling Disadvantage – Education, Learning and Skills Directorate and Families, Health and Social Care Directorate and 3. Putting the Citizen in Control – Customer and Communities Directorate. The Business Strategy and Support Directorate contains the policy development and intelligence function for the whole Council and contributes overall to the whole plan. These descriptions are not intended to suggest that the other Directorates would not contribute to any of the other ambitions but to show a correlation between their focus and the Council's ambitions for the future.

46. One of the design principles was to enable the Council to work as a more integrated organisation rather than as a series of federated services. This is an essential shift if we are going to be able to focus completely on the delivery of "Bold Steps for Kent" and those three overarching ambitions. It is also an essential shift if we are to be able to channel our delivery into a series of locality delivery boards and the integrated frontline of the authority to meet the pattern of service delivery that local people require at the price we can afford.

Education, Learning and Skills Directorate

47. Overall the Directorate will focus upon ensuring strategic leadership and the County Council's championship of high quality learning opportunities from early years through to 19+. It will make sure that there is genuine choice and diversity in provision to meet the needs and aspirations of all children, young people, and parents, with information advice and guidance so they can make the appropriate choices. It will coordinate and facilitate collaborative working amongst schools, keeping Kent at the leading edge of educational practice. It will also ensure the coordination of admissions, home to school transport, special needs education and link closely with the children's services team to ensure every child is attending and flourishing in school. Finally it will be keeping a very close eye on standards and achievement, making sure support and intervention is there when required.

48. Capacity has been created within the proposed Directorate to develop with our community of Schools, Head teachers and Governors, a number of new vehicles to provide them with continuing professional development, school improvement, curriculum development and a really strong range of school support services which many of them access currently. It is envisaged that this type of new vehicle will enable us to support both the thinking of the new Department of Education in the greater independence they wish to see schools having and also to continue to support the large number of Kent schools who currently value a very close working relationship with us. This model as a "best of both worlds" approach has been broadly welcomed in recent meetings with head teachers.

49. The proposed Directorate also signals a move to recognise the new policy thinking within the Department of Education on the "every child matters" policy framework of integrated children's services. There have been significant advantages gained from this policy framework. There have however been some losses mostly in the relationship with adult social services in terms of being able to conduct a real integrated assessment and develop properly integrated continuous care pathways for clients. The proposed structure tries to rebalance our service delivery models so that we are able to regain these elements and also retain the excellent work that has been done to date in this county on the integration of children's services.

50. The current Children, Families and Education Directorate has re-organised itself to ensure in the twelve district areas of our county, there are integrated children's services for school support, children's social care services and preventative services such as children's centres. These operate with a series of twelve locality boards and an over arching Kent Children's Trust Board. This is a valuable forerunner of the thinking that is being proposed within the draft medium term plan "Bold Steps for Kent" and the 12 locality district boards and it will be essential to learn from its experiences in the development of the model being proposed for the whole Council.

51. The proposal in this draft structure is to support and maintain those links in the localities of integrated children's services but to designate the line management "home" of targeted Children's services as the proposed Families, Health and Social Care Directorate. Throughout the proposed consultation period there will be a number of bills and white papers published by the Government. Amongst them is expected to be an Education White Paper. This will give us further guidance on what the residual statutory duties of the local authority are likely to be in regard to education and may also discuss what the future statutory role of the Director of Children's Services could be. The consultation period should allow enough time to take into account any proposed changes and give us the flexibility to respond.

52. Bearing in mind the current statutory requirements, it is proposed that a protocol be produced to ensure that the accountability of the Director of Children's Services is properly maintained and not fettered by a different reporting line arrangement. The reporting links to the statutory role of the Lead Member must also be maintained pending any national review. The current statutory guidance on the role of the DCS does not insist that there has to be a direct reporting relationship of these posts.

Families, Health and Social Care Directorate

53. This Directorate will focus on the continued delivery of high quality adult social care services; develop a new model of integrated delivery of social care with our health partners and others, develop the new role of Public Health and work to ensure the Council is able to support the GP practices in the county facing their new agenda as commissioners. The Directorate will maintain the high standards of care practice for children and continue to champion safeguarding for adults and children throughout all the Council's services. It will also seek to deliver new models of more integrated assessment and care pathways with the addition of the children's services division and commissioning, assurance and delivery of services for other vulnerable groups.

54. The draft structure proposals for this Directorate show this as the new home of the Director of Children's Services and the line management arrangements and the locality connections to integrated children's services as described above. It must be emphasised that the dotted line is to represent a real living relationship of the services across these two Directorates.

55. This Directorate is also home to the significant range of adult social care services that are provided by the Council, both their commissioning and provision. The future of direct delivery and possible integration with health services or with other models of delivery are very current. The role of Transition Director in this Directorate is to enable the future model of service delivery to be developed for Members and also to ensure the new relationship with the GP's and their responsibilities under the Health White Paper can be properly developed.

56. Safeguarding is a critical issue for all services in the Council but most notably for adult and children's social care services. Whilst the personal responsibility and activities within the different social care teams – adults and children's, will continue unaffected, there is potential to draw together the support services to the safeguarding boards, training and promotion and the commissioning of and oversight of any investigative work that may need to happen. Whilst adults and children's safeguarding practice have a different legal basis, there are many similarities within the culture, approach and core workload of these different teams to promote and ensure safeguarding is a live issue for all our staff. The function would also be expected to look across the Council and raise the profile of safeguarding for everyone.

57. In this Directorate there is also the role of the joint post of the Director of Public Health. The post holder at present is shared between the two primary care trusts in Kent – Eastern and Coastal Kent and West Kent and ourselves. We share a third of the costs of the post each. The national changes proposed by the Department of Health are as wide ranging as the national policy changes to education. It is certainly one of the most significant policy proposals of this Government. Health is being redesigned to move the majority of commissioning decisions into GP practices, new roles for local authorities are being developed and new roles at a national commissioning body level are also being developed.

58. Kent County Council has a proud history of involvement with health and pioneered the development of Health Watch which has been mirrored by the Government in their new policy framework. We will need to see the Public Health White Paper when it is published and the further detail that will emerge from the Department of Health over the next few months as to how this role will develop. There are very likely to be many changes in this area that we will need to discuss with Members as and when the picture becomes clear.

59. Within this Directorate there is also a new division headed by a Director of Supporting People. This division is intended to house significant commissioning activity to vulnerable groups, via the supporting people commissioning body we have, for children's health and for children's social care. There is also the critical role closely related to commissioning as a function, that of quality assuring the delivery of social care. The safeguarding new function has been referred to above and will be placed here. Youth Offending and KDAAT whilst needing to retain their existing links to the

community safety function will focus on delivering particular support to the vulnerable people in need of those particular services.

Enterprise Directorate

60. Overall this Directorate focuses upon three key areas, the delivery of the regeneration of our county, the planning and environment issues that are associated with that and the delivery of major contracts that affect every single resident in Kent.

61. Growing the Economy is one of the three proposed Council and county wide ambitions in the new draft medium term plan "Bold Steps for Kent". The County Council has made a bid with Essex to create a Local Enterprise Partnership to really drive the growth of the two very significant economies in the south east. The Government has announced the £1bn Growth Fund that we will seek to access for significant work in the LEP. We will continue to invest monies ourselves as a Council in growth activity. We have also made a very strong bid to HM Treasury as part of a place based budgeting bid for the nationally controlled funding stream that is spent within our county.

62. This bid if successful will enable us to decide how that money is most effectively spent. The delivery of this integrated funding stream will be from this Directorate. The regeneration policy development will be led from the Business Strategy and Support Directorate as part of the overall integrated policy unit and will commission this work in the Enterprise Directorate in consultation with the Cabinet Member and Corporate Director for Enterprise. This integrated approach to policy development supports the concept of the "one Council" that ensures that any major initiative is thought through in the context of the whole Council and not just a part.

63. Our highways and waste disposal services are essential in maintaining the quality of life in our county and the smooth passage of all our residents in their daily lives. These are mostly "invisible" services in that their actual provision by the County Council is often invisible to the residents that use them day to day but they are critical and fundamental services to all of us. They become instantly visible and a very high priority if things are not working smoothly. The focus of these two divisions – Highways and Waste will be to ensure just that and that we take forward the very exciting waste agenda that we have embarked upon with our District and Borough colleagues.

64. The Directorate also houses the development control and environment activity of the Council, our keen focus on the rural parts of our county and of course our coastline. The quality of the environment of Kent is very precious to this Council and the very many people visiting and living in the county and this will be a key role for this Directorate to be able to continue to develop partnerships and invest in these services at a time of real financial pressure for the authority.

65. The Directorate will also newly house the re-purposed commercial services operation we have but it will be housed with other services where the we believe there could be a significant advantage if those services could be developed in a different way.

66. This should not be presumed to be on the same business model as our current very successful commercial services division that has operated to

date. The Coalition Government is encouraging the public sector to develop a wide range of new and alternative vehicles for public service delivery – social enterprises, employee buy outs, mutuals, joint ventures etc, which will all contribute strongly to local economic growth and enterprise. This division will help the Council to explore these models. As the Prime Minister said on 6th October

> "The countries that succeed will be those that find new ways of doing things, new ways of harnessing the common good, better alternatives to the old-fashioned state. I am saying to the people who work in our public services - set up as a co-operative, be your own boss, do things your way. I am saying to business, faith groups, charities, social enterprises – come in and provide a great service."

67. This division will also house the project resources for the major regeneration activity that may continue to be invested in by us and our partners. As explained above it will also provide the engine room for any implementation of combined expenditure if we are successful in our Place Based Budgeting proposal on regeneration monies spent in Kent. We will learn more about that after the 20th October and the spending review announcement.

Customer and Communities Directorate

68. The purpose of this Directorate can be summed up very simply as owning the "front line" for the whole Council. It could be thought of as a "Directorate of the front line" – and by that we mean both the physical buildings, the call centre and web access. The Council has made a significant investment over recent years in the Gateways – jointly run with our partners. This has been nationally recognised as excellent practice. This Directorate will have a clear focus on developing the Gateway model across all our public access buildings and re-engineering services to take full advantage of delivering an integrated front line to the public and delivering savings from that.

69. The Directorate will also be home to a range of services that share a similar characteristic in that the public choose to use them – i.e. "they come to us". In addition to the Gateways, there are the registrar service, libraries and our parks. It will also house key strategic services for the Council from community safety and public protection to adult learning, skills and youth services. These services have a particular significance in relation to the Kent economy.

70. This will require a significant change programme to re-engineer services so that the reality of the frontline service can really fulfil the vision of the Gateway model. There are also a number of new approaches to service delivery that will need development. The draft medium term plan "Bold Steps for Kent" contains a proposal to create locality delivery boards. The intention is to pilot a number of these next April. A resource will need to be created to develop these pilots. We have also made two further place based budgeting bids one building on the leading edge work on the Margate Task Force and another building on earlier work around offender management that paved the way for many of the Total Place pilots that then took place nationally. If these bids are successful then the activity will be driven from here. This division is also home to KCC's commitment to create the Big Society. "Bold Steps for Kent" raises a number of ideas such as a Big Society Bank, working more closely with volunteers etc, and all this work will be developed from here.

71. The Directorate will also be home to the new integrated division of Communications, Consultation and Community Engagement. This is a key design principle that has been warmly welcomed. Concerns have been raised about needing to ensure flexibility in communicating to different groups and this is acknowledged in the design principle itself. This division will also co-ordinate all external consultation activity and will also connect the engagement activity that takes place with all areas of Kent but at present is not internally as connected as it could be. We are losing the opportunity to add a whole Council value to this engagement. Further work will be needed to establish what connections with the teams currently involved in community engagement should look like and how embedded in Directorates or drawn together in this division the service should be.

Business Strategy & Support Directorate

72. The provision of a sound, efficient corporate support and strategy function is an essential component in enabling the effective operation of KCC as a public service provider delivering a range of services to the community. Therefore whilst the role of this area of business is self-evident – *how* it is set up and the business model it follows invariably depends on the wider political, financial and policy pressures the organisation must respond to.

73. In responding to the increasingly clear direction set by the Coalition Government for the future of public services it is clear that a number of key principles are critical success factors

    Efficiency
    Effectiveness
    Customer Experience
    Intelligent commissioning
    Engagement

74. Priorities will now have to be set across and between different services – rather than simply within them - in order to deliver the size of the financial savings required by the Treasury. The challenge will not be to become more efficient at doing what is currently being done, but to focus resources on doing the right things. This will require the political and managerial leadership of the authority to continually evaluate what services to provide, how they should be delivered,

75. The role of BSS therefore must be to structure itself and its business model around meeting the changed needs of the organisation – it must therefore:
    - Continue to provide transactional support services, but seek to provide these at ever-lower cost to the organisation.
    - Support the political and managerial leadership in its strategic decision making role in regard to the prioritisation and value of services.

76. These core activities are the driving force behind structural changes that provide support for:
    - A clear separation of the activities that are about 'deciding' what should be provided from those responsible for providing services
    - An overall reduction in layers of management
    - Professional and technical support services and resources to be delivered from a single point and not replicated in individual services

- Priorities to be set in relation to the identified needs based on independent, sound, accurate, reliable data.

77. Therefore central to ensuring KCC is fit for the future is the need for a strong corporate function to offer clear intelligence and effective controls for the organisation in support of its strategic decision-making role, whilst professional, technical and other support services are grouped together to provide consistency, economies of scale and remove unnecessary duplication.

78. Within this Directorate is a new business strategy division. The division would undertake high-quality policy analysis, to provide in-depth professional advice in support of Cabinet and CMT in their strategic decision-making role. The division would act as an integral driving force behind the decisions of Cabinet/CMT, with the functions to ensure they have the capacity to provide the full range of analysis and advice required.

79. This will be a mix of generalist and service specialists networked into the service delivery, partnerships and national and local government policy framework that are able to provide sound evidence based advice and judgement on service policy questions and opportunities in support of Cabinet and CMT. This policy function handles both strategic and specialist policy activities to support the business of the Council, including strategic and spatial planning, regeneration, social and education policy. In addition this function would allow Directorates to access high quality, professional policy advice and support, from specialists with service specific-knowledge. It would also provide the capacity for specific one-off pieces of work on behalf of Cabinet/CMT, as and when the need arises.

80. Partnerships work would be directed by, and inform, organisational strategy in a way that is targeted towards specific objectives. Delivering through and with partners will be a core requirement over the medium to long term and the management and support of partnership arrangements to drive this agenda forward needs to be mainstreamed into the strategic decision making process of the authority.

81. The Business Intelligence Unit would focus on providing the information and research capability that drives meaningful and effective prioritisation and decision making. The logic behind this is both the fundamental role they play in effective, evidence-based strategy & prioritisation, and the critical mass of core skills sets required for these functions.
    Horizon scanning
    Knowledge management
    Needs/ demands analysis function

82. Monitoring and management of KCC's progress against strategic objectives as set by Cabinet/CMT. Working closely with the business review and audit functions, Performance Management will provide the strategic decision-makers of the organisation and external regulators with robust, timely information about how well services are performing, identified reasons for performance variance and options and solutions open to resolve against poor performance. The information gathered by the function will also feed into the analysis and prioritise phases of strategic decision-making, by allowing Cabinet/CMT to gain a holistic understanding of what is working well and what isn't.

83. The corporate and business support to all the Directorates of the authority will be conducted through this Directorate. This includes the key support functions that underpin the business of the whole authority (Finance, Information Technology, Law, HR and Property) as well as governance and democratic support. The overriding objective should be for all our support functions to be provided at the lowest possible cost whilst meeting appropriate business need. Economies of scale require and a 'one Council' approach necessitates the continued provision of support services in Directorates no longer can be afforded. Effective market understanding and sound commissioning / procurement skills should ensure an ability of corporate support services to cater for even the most service specific of Directorate requirements.

84. In order to make the model work all corporate support functions should be grouped together. However, a strategic interface does not necessarily mean that support functions would be delivered to a one-size-fits-all business model. Different support services to different services must recognise their different market conditions and complexities which mean there may be different business solutions as to the most cost effective way to provide these services to the organisation. For any support service there are a number of business models that will be explored by service managers to ensure provision in the most effective way. These will be explored throughout this consultation period.

85. As mentioned earlier in the report there are two Corporate Directors also housed within this Directorate. They are first tier officers who are Members of the Corporate Management Team providing strategic advice and guidance to the operation of the whole authority. They also deliver significant operational activity that supports the smooth running of the whole Council. Therefore on the basis of the design principle they need to be based here. The two statutory posts that reside in this Directorate (Monitoring Officer and Chief Financial Officer) have at all times a clear and direct relationship with the Managing Director even though there is no direct reporting relationship.

86. The post of Director of Governance and Assurance has been created so to reflect the increased need of the authority to build upon its current governance environment and to ensure in the light of the very significant changes both policy wise and financially that we are facing, the Council is spending its money wisely and taking its decision well. It is also intended over time to explore how we could develop our currently very successful legal services into a company

87. Property continues as a division in this structure but will change to become the corporate landlord and home of all the Council's capital development activity.

88. The HR Division will also draw together all the learning and development activity currently undertaken within Directorates to achieve greater economies of scale and coherence within the development programmes of the Council's staff. Some of this training is also directed at the Council's partners and wider related workforces. This will of course be maintained through this new function.

Conclusion

89. Cabinet have before them a draft proposed structure for consultation and new ways of working within the Council. There are also actions contained within the previous report that will enable us to ensure that we can shape the whole of the Council's operating environment and not just the "reporting lines".

90. There have been three weeks of consultation with staff and eight meetings with 219 managers to assess whether in the face of all that we see in the future – policy changes both here and nationally and financial changes to name a few – we are still fit for purpose in our current arrangements.

91. The Managing Directors and Executive Directors and Director of Finance and HR have had a number of 1:1 meetings with the Group Managing Director about these ideas and have had two meetings as sub groups of CMT (due to annual leave) on 1st September and the 8th September and one CMT discussion on the final draft this week – 5th October. It is a very difficult balancing act being both consultee and affected by a developing process and being able to fully discuss matters in a personally disinterested way. I do acknowledge that some members of CMT would have liked more involvement. However I believe the way it has been structured has enabled them to properly influence my advice to Cabinet.

92. A wide range of views have been received, and overall although Members can clearly judge for themselves from the feedback that they have it is my view there is a broad level of support for change and a recognition that we cannot stay the same.

93. Many of them say – "let's see what we could change into" and these draft structure proposals offer that alternative view. This is a genuine consultation and many of the early ideas on what the structure could look like have been altered by the feedback received so far.

94. A risk register is attached as Appendix 3 for Cabinet's assessment in their consideration of their decision to proceed with this consultation. It is important that this is fully considered in the decision process.

95. There are two particular types of risk that Cabinet must consider. There are the type 1 risks that are very clearly laid out in the register and the mitigating actions that are in place or are proposed. There are also the type two risks that if we do not take this decision now – what are the consequences of not acting in the light of all the challenges we face. If this is as successful as it is believed and will position the Council to be able to deal with its challenges in a stronger and more effective way than if we stay as we are – what additional benefits and opportunities do we risk for the people of Kent and our staff.

96. A community impact assessment is also contained as Appendix 4 assessing the implications and impact of this decision to formally consult on a new structure.

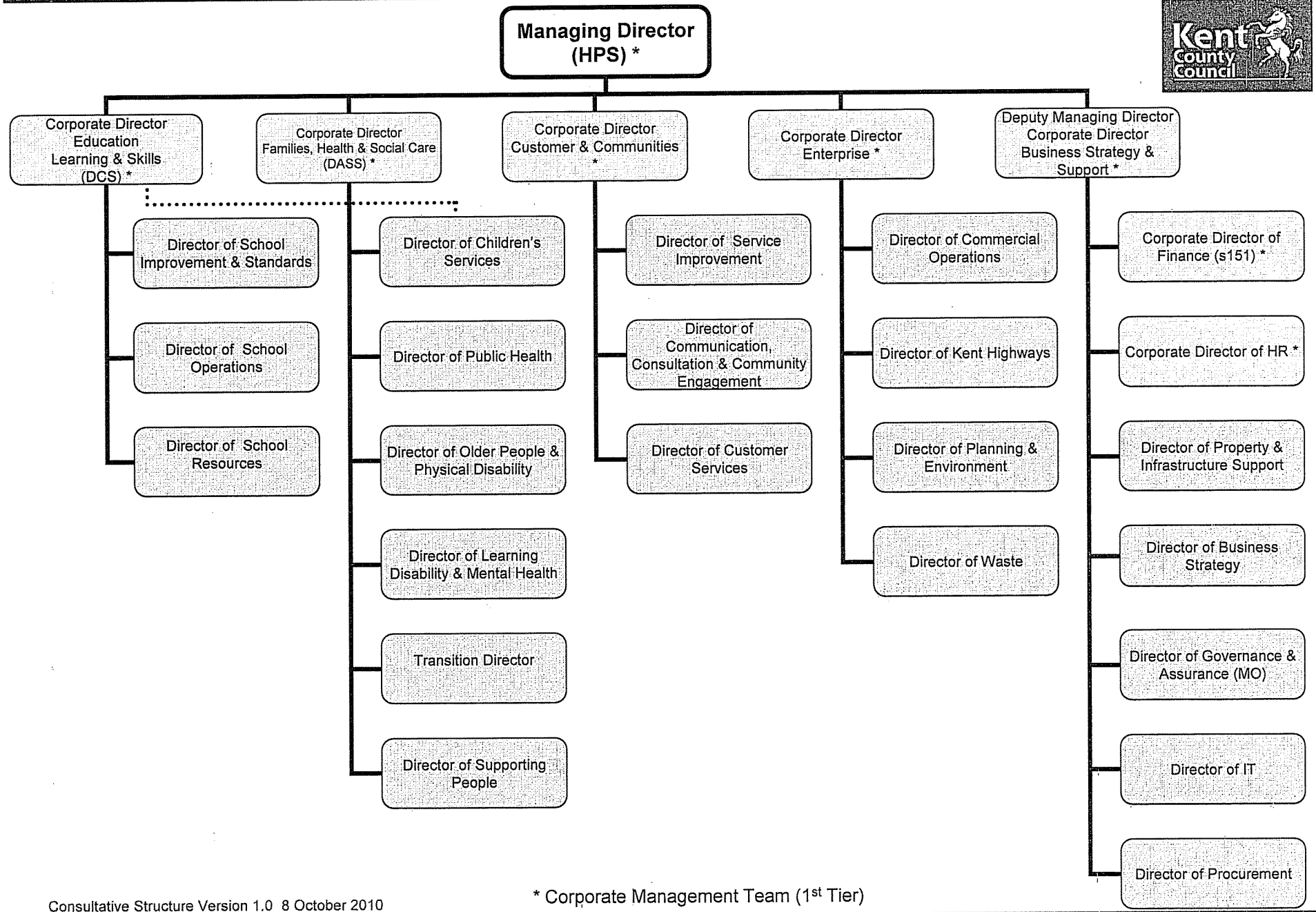
97. In the previous report to Cabinet already circulated paragraph 7. ii) indicates that this restructure must of course contribute to the savings that the council needs to make in response to the CSR shortly to be announced. It is also recognised good practice for any organisation to be constantly assessing

whether its managerial overheads are at the right price and are organised in the most cost effective way for the current and developing circumstances for that organisation. At this stage it is not possible to accurately quantify a amount- although human resources estimate a potential saving of at least £500,000 from these proposals.

98. Whilst that is undeniably useful, what is much more important is whether or not the council's structure and its managerial resources are organised in the best way possible to deliver the quantum of savings that we know we must.

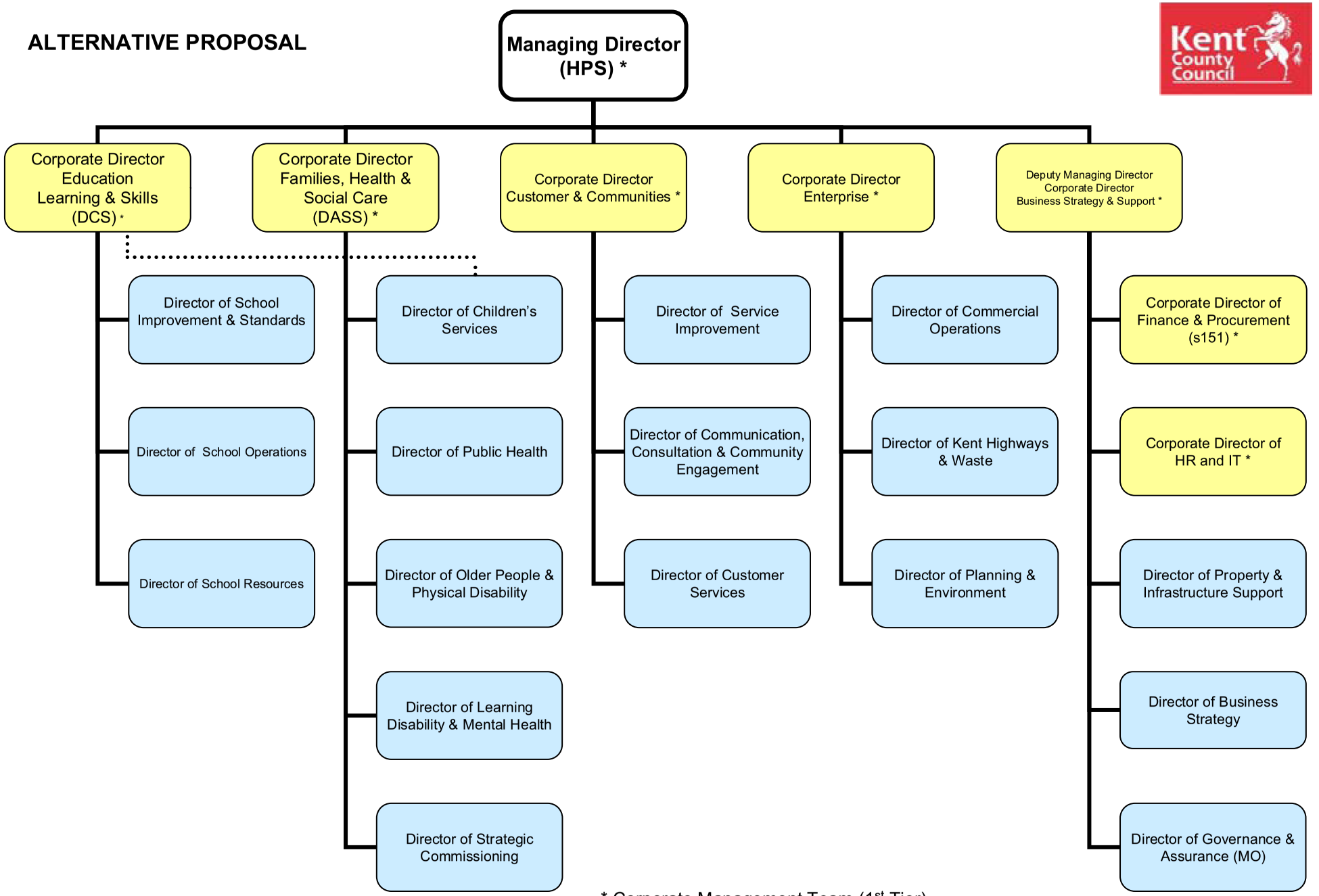
    The real value in this redesign is that it provides the platform as we work through the changes for major savings to be delivered.

99. I commend these draft structure proposals to Cabinet to endorse for formal consultation until the 3rd December 2010. The outcome of that consultation process will then be brought before Full Council for its decision on the 16th December 2010.



* Corporate Management Team (1st Tier)

ALTERNATIVE PROPOSAL



* Corporate Management Team (1st Tier)

CORPORATE DIRECTOR
Education, Learning & Skills
(DCS)

Director of School Improvement & Standards	**Director of School Operations**	**Director of School Resources**	**Dotted line relationship to Director of Children's Services**
Early years and Childcare Standards and School Improvement * Primary School Improvement * Secondary school improvement * Special school improvement Standards and School Improvement 14-19 Entitlement Careers guidance Connexions	Association of Schools Governor Services Information and support for parents Financial Awards Admissions & Transport commissioning Attendance and Behaviour Assessment of Learners with Additional Needs Planning & Provision Children and YP disability (including SEN, health assessment and transition planning) Educational Psychology Specialist services	Education finance, Schools personnel service Development of a schools company/vehicle to include: Property Personnel Traded services Continuous professional development School improvement service	This means that connections are maintained to the team around the child and the team around the school Links with the 12 district teams, locality boards and the Children's Trust

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

CORPORATE DIRECTOR
Education, Learning & Skills
(DCS)

Director of School Improvement & Standards	**Director of School Operations**	**Director of School Resources**	**Dotted line relationship to Director of Children's Services**
Early years and Childcare Standards and School Improvement ▪ Primary School Improvement ▪ Secondary school improvement ▪ Special school improvement 14-19 Entitlement Careers guidance Connexions	Association of Schools Governor Services Information and support for parents Financial Awards Admissions & Transport Commissioning Attendance and Behaviour Assessment of Learners with Additional Needs Planning & Provision Children and YP disability (including SEN, health assessment and transition planning) Specialist services Educational Psychology	Education finance, Schools personnel service Development of a schools company/vehicle to include: ▪ Property ▪ Personnel ▪ Traded services ▪ Continuous professional development ▪ School improvement service	This means that connections are maintained to the team around the child and the team around the school Links with the 12 district teams, locality boards and the Children's Trust

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

CORPORATE DIRECTOR
Families, Health & Social Care
(DASS)

Director of Supporting People	**Director of Children's Services (dotted line to DCS)**	**Director of Older People & Physical Disability**	**Director of Learning Disability & Mental Health**	**Transition Director**	**Director of Public Health**
Youth Offending service (dotted line to youth service & link to attendance & behaviour service) Child Health Commissioning Commissioning of specialist care Quality assurance of health and social care Safeguarding Adults and Children Supporting People KDAAT	Children's Services West Kent (Initial duty and assessment, child protection and long term care, prevention including children's centres) Children's Services East Kent (ditto) Children's Services Mid Kent (ditto) Corporate Parenting (includes, including adoption and fostering, Unaccompanied Asylum Seeking Children and care leavers) Links with the 12 district teams, locality boards and the Children's Trust (joint commissioning with partners to support vulnerable young people)	HoS Ashford /Shepway HoS Dover /Thanet HoS Canterbury /Swale HoS Maidstone / Malling HoS South West Kent HoS Dartford, Gravesham & Swanley Head of Strategic Commissioning OP / PD Contracts & Procurement Planning & Market Shaping	HoS LD – WK HoS LD – EK Head of Strategic Commissioning LD&MH Contracts & Procurement Planning & Market Shaping MH Partnership arrangement with KPMT VPN Manager	Community Health Trust development team (commissioning & back office) Development team to create social enterprises Relationship to Director of Service Improvement	Public Health Intelligence Commissioning of provision Health promotion Case management of Healthwatch

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

ALTERNATIVE PROPOSAL

CORPORATE DIRECTOR
Families, Health & Social Care
(DASS)

Director of Strategic Commissioning	**Director of Children's Services (dotted line to DCS)**	**Director of Older People & Physical Disability**	**Director of Learning Disability & Mental Health**	**Director of Public Health**
Children's Health Commissioning Children's social care Commissioning Supporting People Strategic Commissioning OP / PD & LD & MH Contracts & Procurement Planning & Market Shaping Quality assurance of health and social care Safeguarding Adults and Children	Children's Services West Kent (Initial duty and assessment, child protection and long term care, prevention including children's centres) Children's Services East Kent (ditto) Children's Services Mid Kent (ditto) Corporate Parenting (includes, including adoption and fostering, Unaccompanied Asylum Seeking Children and care leavers) Links with the 12 district teams, locality boards and the Children's Trust (joint commissioning with partners to support vulnerable young people)	HoS Ashford /Shepway HoS Dover /Thanet HoS Canterbury /Swale HoS Maidstone / Malling HoS South West Kent HoS Dartford, Gravesham & Swanley	HoS LD – WK HoS LD – EK VPN Manager Transition support to Directorate to create for e.g. Community Health Trust Development team (commissioning & back office) Development team to create social enterprises Relationship to Director of Service Improvement	Public Health Intelligence Commissioning of provision Health promotion Case management of Health watch

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

CORPORATE DIRECTOR
Customer and Communities

Director of Service Improvement **Need close links to Director of Business support**	**Director of Customer Services**	**Director of Communication, Consultation and Community Engagement**
Re-engineering resource Change resource Developing Models for externalising service delivery, e.g outsourcing/mutuals/social enterprises Locality Delivery Team Place based budgeting delivery of offender management proposals Margate Task force Place based budgeting delivery of Margate task force proposals Supporting independence Welfare reform Kent supported employment Building social capital (SILK) Big Society Volunteering	Gateway Delivery Contact Centre Business web development Health watch Libraries & Archives Registrars Arts & Kent Film Office Sport, Leisure & Olympics Extended Schools Youth Service Community learning & Skills Adult Learning Adult Apprenticeships Countryside Access - PROW Country Parks & Kent Downs AONB Emergency Planning Community Safety Trading Standards	Engagement / public involvement Community Liaison Business partners- Directorate communications Internal Communication Employee Engagement Media and Operations Events Digital & Moving Images

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

ALTERNATIVE PROPOSAL

CORPORATE DIRECTOR Customer and Communities		
Director of Service Improvement **Need close links to Director of Business support**	**Director of Customer Services**	**Director of Communication, Consultation and Community Engagement**
Re-engineering resource Change resource	Gateway Delivery	Engagement / public involvement
Developing new models for externalising service delivery, e.g. outsourcing/ mutuals / social enterprises	Contact Centre	Community Liaison
Locality Delivery Team	Business web development	Business partners- Directorate communications
Place based budgeting delivery of offender management proposals	Health watch	Internal Communication
Margate Task force Place based budgeting delivery of Margate task force proposals	Libraries & Archives	Employee Engagement
Supporting independence	Registrars	Media and Operations
Welfare reform	Arts & Kent Film Office	Digital & Moving Images
Kent supported employment	Sport, Leisure & Olympics	Events
Building social capital (SILK)	Countryside Access – PROW	
Big Society	Country Parks & Kent Downs AONB	
Volunteering	Extended Schools	
	Youth Service	
	Community learning & Skills	
	Adult Learning	
	Adult Apprenticeships	
	Community Safety	
	Trading Standards	
	Youth Offending service KDAAT	

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

CORPORATE DIRECTOR
Enterprise

Director of Waste Management	Director of Kent Highways	Director of Commercial Operations	Director of Planning & Environment
Waste Management	Community Operations Network Management Transport & Development Technical Services Countrywide Improvements	Kent Scientific Services Visit Kent Locate in Kent Produced in Kent Tourism Project management capacity Commercial Services Delivery of regeneration projects and any place based budgeting proposals on regeneration	Development Planning (MWF & LDF's) Planning Applications Environmental Programmes & Partnerships (rural agenda & climate change) Natural Environment & Coast Gypsy & Traveller Unit Heritage Conservation

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

ALTERNATIVE PROPOSAL

CORPORATE DIRECTOR
Enterprise

Director of Kent Highways and Waste	**Director of Commercial Operations**	**Director of Planning & Environment**
Community Operations	Commercial Services	Development Planning (MWF & LDF's)
Network Management	Kent Scientific Services	Planning Applications
Transport & Development	Visit Kent	Environmental Programmes & Partnerships (rural agenda & climate change)
Technical Services	Locate in Kent	Natural Environment & Coast
Countywide Improvements	Produced in Kent	Gypsy & Traveller Unit
Waste Management	Tourism	Heritage Conservation
	Project management capacity Delivery of regeneration projects and any place based budgeting proposals on regeneration	Emergency Planning

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

CORPORATE DIRECTOR
Business Strategy & Support
And Deputy Managing Director

Corporate Director of Finance (Chief Financial Officer - S151)	Director of Business Strategy	Director of Governance and Assurance (Monitoring Officer)	Director of Property and Infrastructure Support	Corporate Director of HR	Director of IT	Director of Procurement
Audit & Risk N.B. direct access to Mo & Hops whenever required. Financial Services Business partners - Directorate Finance Financial Management Strategic Finance	Corporate policy Europe / International Public affairs Public health Economic development Regeneration strategy Strategic planning – spatial & transport. Strategic assets Social policy Education strategy Customer strategy Engagement strategy Performance Management & Monitoring Business Intelligence & service review Partnership support External Funding Cabinet Office	Information resilience and transparency Corporate data protection Democratic Services Legal Services (transition to external arms length trading organisation) Elections Coroners	Capital & infrastructure support Strategic Asset & Enterprise Fund Delivery of Total Place activity BSF, PFI & Academies Directorate PFI & development (KASS) Business partners Directorate – Property Office Transformation Estates management & property operations	HR Business operations (includes graduate scheme) HR Employment Strategy Organisation development (including embedded – learning and workforce development) Business partners Directorate – HR Business support – case work Directorate HR Health and Safety	ICT commissioning ICT operations Kent Connects Business partners - Directorate IT	Procurement team

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

ALTERNATIVE PROPOSAL

CORPORATE DIRECTOR
Business Strategy & Support
And Deputy Managing Director

Corporate Director of Finance & Procurement (Chief Financial Officer - S151)	**Director of Business Strategy**	**Director of Governance and Assurance (Monitoring Officer)**	**Director of Property and Infrastructure Support**	**Corporate Director of Human Resources & Information Technology**
Audit & Risk Financial Services Financial Management Business partners - Directorate Finance Procurement team	Corporate policy Europe / International Public affairs Public health Economic development Regeneration strategy Strategic planning – spatial & transport. Strategic assets strategy Social policy Education strategy Customer strategy Engagement strategy Performance Management & Monitoring Business Intelligence & service review Partnership support External Funding Cabinet Office	Information resilience and transparency Corporate data protection Democratic Services Legal Services (transition to external arms length trading organisation) Elections Coroners	Capital & infrastructure support Strategic Asset & Enterprise Fund Delivery of Total Place activity BSF, PFI & Academies Directorate PFI & development (KASS) Business partners Directorate – Property Office Transformation Estates management & property operations	HR Business operations (includes graduate scheme) HR Employment Strategy Organisation development (including embedded – learning and workforce development) Business partners Directorate – HR Business support – case work Directorate HR Health and Safety ICT commissioning ICT operations Kent Connects Business partners - Directorate IT

Please note: The headings listed below the 1st and 2nd tier Director posts are intended to be indicative of the functions contained within that division and directorate.

Appendix 2

The First Bold Step

Report on the informal consultation process

Informal Consultation process

1. The leaflet 'The first bold step – proposals for consultation with staff on a new KCC' was published on KNet on Wednesday 9 September following agreement by private cabinet and the Conservative Group to this. Hard copies were sent to home addresses for all staff without access to KNet.

2. This was an informal consultation, not done to meet an obligation under employment law, and with no mandated timescale. Three weeks were allowed to the submission of responses from staff.

3. All staff were invited to respond with their views. Responses could be made electronically or in hard copy. Consultation closed on Friday 1 October at which point:

    - 4,000 copies had been distributed
    - 7878 copies were accessed or downloaded from KNet
    - 319 responses had been received: 41 in hard copy and 278 online
    - 170 staff members have requested to be involved in further activity to transform KCC.

4. Responses could be made anonymously and with the implication that staff could speak openly, freely and without recrimination. All responses have been read by Katherine Kerswell who has responded personally to every respondent who opted to include their e-mail address.

5. Comments were predominantly positive and supportive, though some questioned the value of consultation. Most welcomed the proposals for change and overwhelmingly recognised the need for change now. Many advocated a reduction in the cost and number of senior managers, or were fearful that the cost savings would fall disproportionately on front-line staff and service delivery. A large number of comments were specific to their service and directorate, often focussing on improvements to process and cost savings.

6. Comments were wide ranging. A summary of the responses is provided below from paragraph 10 onwards.

7. In addition to seeking responses by email and hard copy, feedback was sought from senior staff though meetings with Katherine Kerswell. In all, 242 senior staff were invited to, and 219 attended, 1 of 8 meetings between 9 September and 30 September at which Katherine presented and sought feedback on whether we should change the organisational framework in order to be able to respond to the very different policy and financial context facing us and our own plans under Bold Steps for Kent. Meetings were all held at Sessions House and each meeting included a question and answer session. There was a balanced mixture of all directorates at every meeting.

8. As part of each 90 minute meeting, feedback was sought from staff on:

   8.1. likes and dislikes – "how I feel about KCC".

   8.2. their view of current KCC values in practice

   8.3. 'horizon scanning' - what risks did they see that would need to recognised and managed as we transform the organisation.

9. Feedback was by individual rather than by groups, unprompted in that individuals could comment on any aspect of KCC, not prioritised or ranked or given a position in a range, and not moderated or challenged. The feedback provides a simple unedited snapshot of managers' opinions of KCC and by implication of themselves. A summary of the feedback is below. It was very evident after the first two meetings that feedback from managers in each meeting was broadly the same in what it praised KCC for and what it criticised KCC for.

Summary of the responses from the Informal Consultation

10. The responses received to "The First Bold Step", whether at meetings with managers or as written responses, are summarised below. Appropriate direct quotes are included in italics.

11. The following general themes were evident:

    11.1. There is appetite for change: we are realistic about the financial situation, and we accept the need to change and do it now. No one denied the financial situation or proposed delaying change.

    11.2. The engagement of staff in the process of change is seen as wholly positive and we want more not less communication. A very few individuals thought information was being withheld and that there were *fake consultations when decisions are pre-made*.

    11.3. KCC is seen as a good employer. There were a small number of negative comments, but the majority view was that we: *value staff*; *value staff contribution*; *train staff*; *are a fair employer*; *a good employer*; and *have good pay and pensions*, we are *inclusive*.

11.4. We like our colleagues. We are *fair, kind, polite, fun, have respect for each other* and are *caring.* We are *principled, honest, show courage,* are *dedicated, committed* and *hard-working* and we are *a loyal workforce.*

11.5. We are critical of our management style.

12. **Our strategy** was accepted. Staff showed their approval of the strategy through their endorsement of *support for vulnerable people, support for the local economy* and a *desire, if not always followed through, to put the customer first*. There were the following challenges to the strategy:

- in addition to tackling disadvantage we should continue to provide high quality services for the rest of the population
- we should not lose sight of children and young people's services as a priority
- our commitment to grow the economy should not be at the expense of the environment.

13. **Our structure** was accepted.

13.1. No one disagreed with a flat structure and no alternative types of structure were proposed. There were only three comments on structure and they proposed:

- three directorates: one for each of the three ambitions of our strategy
- KASS and Children's Services to combine
- the federated system be retained.

13.2. There was a very strong dislike of silos. Among managers 15.2% (i.e. 33) explicitly cited silos as something they disliked about the way KCC worked: *it is sometime easier to work with partners than with other parts of KCC, silo mentality between directorates, silos within directorates; deliberately duplicate to self-protect, protect budgets rather than deal with problems.* There were 2 comments that thought we worked well across directorates. In comparison there were over 50 comments to the contrary on silos, duplication and failure to share information

14. **Our systems**

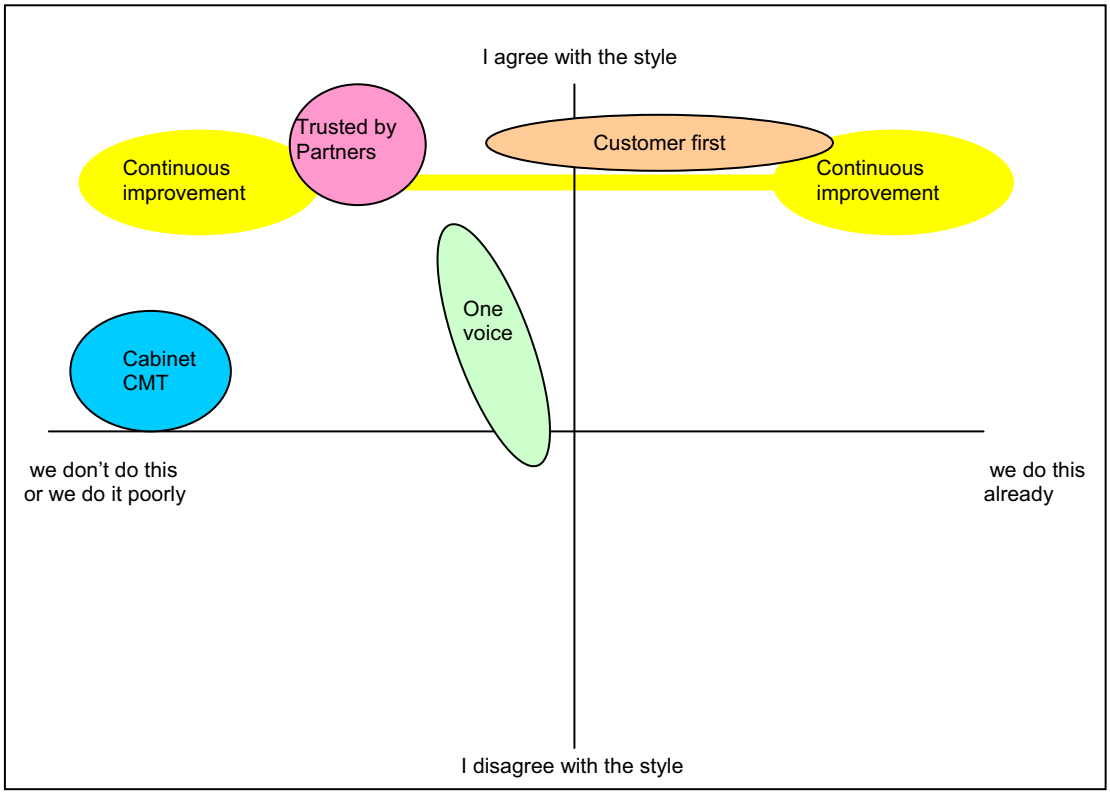
14.1. While some thought we manage well, others were critical of the way we manage and are managed – and that criticism came from managers. We *micromanage*, we *overmanage*; we have *top heavy oppressive management*; we are *obsessed with protocols and process* and *tick boxes*. We *talk big about empowering*

managers but it does not happen; we have *a treacle layer which can be insular and resistant*. There is *favouritism, ego* and *he/she who shouts loudest gets heard*. We *are not decisive*.

14.2. Gateways were welcomed. There were reservations about their implementation and whether staff will be adequately trained to deal with service issues.

15. **Our shared values.** No one thought we had a set of shared values, although some were confident they had a set of shared values within their directorate. No proposals were made for shared values.

16. **Our style** drew the largest response. There was broad agreement with the styles, but considerable disagreement over the extent to which we currently exhibit those styles. Below is a diagrammatic representation of where the responses fell:



16.1. **We put the customer first**

- Staff accepted this without exception as a style we should have for external customers, and showed a massive commitment to public service. But staff were largely silent on how we should treat internal customers.

- Many thought that we already put the customer first, but a substantial number thought we *spoke of putting the customer first but in practice did otherwise*. Specific comments were:

we are *controlling*; we *pretend to consult*; *we don't really want to know what the public thinks*.

16.2. **We communicate as one voice as one unified organisation**

- Staff largely accepted this as a goal. They want us to speak out for Kent as a whole and communicate clearly and more often. Some comments show discomfort over 'one voice' as it *stifles debate* and is *Orwellian. One respondent thought we should retain separate cultures and styles.*

- We are not a unified organisation as evidenced by the comments objecting to silos and duplication throughout the organisation. Autonomy and the flexibility to make local decisions found favour with a few respondents.

16.3. **Cabinet and CMT work as a joint team with clear roles**

- A small number thought the *administration is clear about what it wants* and *liked the experienced leadership at MD level*.

- But the substantial majority of comments were negative. *No joint working with the senior leadership team; CMT in-fighting and 'them and us' between the centre and the directorates; too many plans and directives* with *mixed messages; business planning is meaningless and non-responsive;* and *we challenge Government on regulation but we still over-regulate and monitor internally*. It must be noted that all of these quotes came from managers.

16.4. **Everyone is hungry for continuous improvement**

- Staff accepted this style without exception, but have polarised views on our current performance

- Many staff said we already practiced this style: we are *innovative, creative, willing to change, forward thinking* and *willing to take risks and try new things*.

- A greater number disagreed. Many thought we failed to innovate, others said we are *big on rhetoric of creative and challenging thinking but the reality is we are risk averse;* we are *resistant to change; it has to be like that because that's how we have done is for years; governance restricts innovation;* we *don't deliver but strategise well;* we *fail to act on what we hear,* we *know best* and *fail to learn from the past;* and *we are sometimes dazzled by our own brilliance*.

16.5. **Our relationship with partners should be based on trust**

- Staff accepted this style without exception, but we do not practice it. A few thought *we work well with partners* but most spoke of a poor relationship: *we preach at prospective partners*; we are *autocratic with partners*, we are *dismissive of partners and districts*, we *think we know best* and *we are arrogant*.

17. **Our skills.** The general view was that we value staff training and staff appreciate that, but otherwise this style generated little comment.

J Hawkins
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ext 8103
mobile 077 99 88 4149

Managing Business Risks - Risk Assessment

(template source: Risk and Audit)

Change To Keep Succeeding

completed by: Jeff Hawkins, Transformation Programme Manager

Objective: to deliver a new organisational framework

completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 1	the change to the framework is happening at the same time as other demands on KCC: external policy changes and financial changes; planning and delivering the new medium term plan. That places great demands on KCC management resources.	5	4	20	This change in framework is being led by the Group Managing Director and supported by a programme manager reporting directly to her. CMT is the Programme Board, and the programme has weekly visibility at CMT. (It is the role of GMD and CMT to lead the organisation through major change and manage the inherent risks, and it essential that CMT and their direct reports are committed to the change). A project plan and timeline are in place, a project team established, risks are identified and mitigation steps already taken. Transition planning is taking place and a detailed transition plan is being developed. CMT will discuss and examine the different proposals and create models for new ways of working. **Type 2: the consequence of NOT implementing the new framework at this time:** 1. It is imperative that the process of delivering a new operational framework dovetails and aligns absolutely with the preparation of the Council's medium term plan and delivery to that plan over the next four year. 2. The success of each of these relies upon the success of the others. 3. If we do not make these savings we may have to resort to managed-decline and be unable to deliver the quality of services that Kent is renowned for.	3	3	9

Managing Business Risks - Risk Assessment

(template source: Risk and Audit)

Change To Keep Succeeding completed by: Jeff Hawkins, Transformation Programme Manager

Objective: to deliver a new organisational framework completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 2	Cabinet or Council delay a decision on the new operational framework proposal, or reject the proposal outright.	5	4	20	Cabinet and Members, including opposition Members are being briefed and kept abreast of development and progress. Scrutiny will also play a role in assessing the draft proposals at the outset and then during the process to ensure the proposals made are relevant and appropriate to our future success Informal consultation with managers and staff on the need for change has already taken place to gauge their views. However if a decision is delayed there is no control measure or contingency plan that would allow the new operational framework in place by 1 April 2011. **Type 2: the consequence of deferring a decision or rejecting the proposal:** 1. We would proceed with the savings as currently envisaged yet with uncertainty over management framework in the medium term. 2. We would also not build in at the earliest opportunity capacity to deliver the new policy framework of our new medium term plan or new national policy developments. 3. Making the savings within our current organisational framework would mean we lose the opportunity to make savings from "how" we work and more savings will need to be made from the front line - the "what" we do. 4. We would also lose the new organisational framework's role as the platform from which to deliver the £340 m savings that are required.	5	2	10

Change To Keep Succeeding
completed by: Jeff Hawkins, Transformation Programme Manager
Objective: to deliver a new organisational framework
completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 3	Senior managers do not support the new framework and actively resist the changes. Partners and key stakeholders - headteachers, governors etc - do not support the changes.	3	3	9	Full consultation is taking place in order to engage staff in the process of change and allow them to influence the outcome. Elements of the new operational framework will be designed with staff and managers to create relevant new solutions and buy-in. Early contact, regular communication and other meetings with partners and stakeholders to explain our ideas. Proposals have been made for voluntary redundancy and for filling vacant posts according to standard protocols (i.e. the Council's 'slotting in', priority candidate, and redeployment processes)	2	2	4
RA 4	staff morale falls and impacts on service delivery	3	4	12	Full consultation and engagement has taken place and staff have welcomed the fact that we are actively pursuing change. The risk to morale is limited to senior staff who are impacted by these proposals. Uncertainty damages morale; moving quickly and decisively will reduce this risk. Communication plans are in place and for most staff and most services any proposed changes to, and consultation with, the senior management will not impact their day-to-day delivery of service. It is the role of senior managers to show leadership during change. **Type 2: the consequence of not changing the framework** 1. Failure to tackle silo-working may actually have a worse effect on morale. Staff expect change and are ready for it. 2. Maintaining the current culture may worsen staff morale as the informal dialogue so far has indicated a positive desire among staff for change	3	2	6
RA 5	Staff who are not successful in being 'slotted in' or redeployed to a new post as a priority candidate may leave.	3	3	9	HR is ready to appoint replacements following the standard processes of looking first for internal candidates to 'act up' as interims.	2	3	6

Change To Keep Succeeding

completed by: Jeff Hawkins, Transformation Programme Manager

Objective: to deliver a new organisational framework

completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 6	consultation is legally challenged causing delay	5	2	10	Mitigation has already taken place: - we are allowing longer than statutorily necessary - we are communicating widely and frequently - we have a robust process that is legally defensible - meetings have been held, and will continue to take place, with the Trades Unions	4	1	4
RA 7	HR division does not have the resources to manage the HR elements of the project or produce the new HR structure in time for 1 April 2011	3	3	9	HR have scoped the requirement and dedicated staff to this project	3	2	6
RA 8	Finance division does not have the resources to recast the 2011/2 budgets to align with the new structure, or create the new accounting structure and controls, possibly due to being occupied by other major projects (Oracle release 12 in Nov 2010 and IFRS)	5	4	20	Finance are currently scoping the work. Extra resources will be provided if necessary. The workload will be eased by: - restructuring at directorate level: individual outward-facing services will not be restructured but will either not move or move in their entirety to a new directorate structure - all moves will take place at the end of the FY - so no need for mid-FY adjustments - finance can reassess their current workload priorities in the light of Member decisions today as this proposed new structure was outside their knowledge when the business plan for the division was set in April 2010. **Type 2: the consequence of NOT implementing the new framework on 1 April 2011** The work will become more complex, and maintaining proper financial controls made more difficult if the change does not align with the year end.	4	3	12

Change To Keep Succeeding

completed by: Jeff Hawkins, Transformation Programme Manager

Objective: to deliver a new organisational framework

completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 9	The change in framework weakens financial controls	5	3	15	Finance are engaged on scoping the changes necessary. The work to ensure robust financial controls in the new organisational framework will be itemised in the transition plan. The change at a single date (1 April) means we avoid the intermediate states (and their associated risk of confusion over accountability) which are inevitable if the changes are done as a sequence over time. **Type 2:** taken at face value this risk could be used to advocate not changing the framework at any date	3	3	9
RA10	The change to a new framework causes confusion over accountabilities and responsibilities (not just financial matters, but accountabilities and responsibilities for services in general)	4	4	16	The changeover applies only to Tier 1 and tier 2 managers. Responsibility for services and finance will need to be clarified through the transition plan and the 'D Day' handover plan A single changeover date for all affected will be planned for to reduce the opportunity for confusion among staff in general.	2	2	4
RA 11	Actions 'in flight' and responsibilities are dropped or lost during the change to a new framework (not just financial matters, but accountabilities and responsibilities for services in general)	3	3	9	We will have a scrupulous transfer of all activities including (a) a default destination for activities in each existing directorate - anything that is not itemised goes to the default destination and (b) a small close down team to make sure there are no trailing edges in any directorate that closes.	3	1	3
RA 12	Changes to IT may not be made in time	5	3	15	IT are already working with HR and finance to identify changes to systems, and examining changes to IT support systems. The next stage is to identify whether, as a result of the new structure, staff need access to additional applications (a service moving to a new directorate may need access to some of that directorate's internal systems)	3	3	9

Change To Keep Succeeding
completed by: Jeff Hawkins, Transformation Programme Manager
Objective: to deliver a new organisational framework
completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA 13	Service delivery suffers as a result of changes to top-level structures, and performance drops	3	4	12	Individual services are not being restructured, but continue unchanged except that the reporting line to a director may change on 1 April This 'no change' message for services will be repeatedly communicated. Detailed planning will take place for every directorate to identify every exception to the 'no change' rule. The new directorates will be expected to nominate a transition manager to ensure that all the necessary steps are taken in advance to ensure smooth operation from 1 April. We aim to fill tier 1 posts in January 2011. Tier 1 appointees will be 'designate' until 1 April 2011 giving them time to prepare for a new role.	3	2	6
RA 14	Adverse media coverage. Staff's openness about the areas for improvement could be portrayed by the media in a manner that is damaging to KCC's reputation	4	3	12	By starting the savings on efficiency at the top tiers of management, the changes should be seen in a positive light. The positive support of staff for the changes is a factor that supports us - we need to maintain that support through engagement of staff. It is the sign of an excellent organisation that it is willing to examine how it currently operates and be frank and open about itself and look for ways to improve.	4	2	8

Change To Keep Succeeding

completed by: Jeff Hawkins, Transformation Programme Manager

Objective: to deliver a new organisational framework

completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA15	Not able to plan for the 2011/12 budget. Within the planning for the four-year MTFP - as well as ensuring we are able to achieve overall balance and implementation of any proposals - it is clearly essential that we have proposals costed and ready to balance the 2011-12 budget. This could be disrupted by the change programme. Impact of these proposed changes to senior management and disturbance to existing management teams may undermine the ability of senior officers to support KCC in implementing the significant actions that are likely to be required for the MTFP and the reductions we may face of between 25% - 40% in funding	5	4	20	These changes to management arrangements are being widely consulted upon, have been preceded by a widely-held informal consultation, and officers are well aware that change is underway. The responses have shown a broad recognition of the need for change and awareness of the difficulties we have from our current style of working. The timing of this process is well ahead of the actions necessary for any implementation of the MTFP, and any changes to senior management arrangements should be in place by the end of January 2011. Any vacancies that may arise from this process will, in the first case, be filled by internal acting-up interims to ensure continuity. CMT as the programme board for the change programme and for the MTFP should ensure that work is not carried out in two separate but parallel workstreams but is co-ordinated. A separate workstream with the programme board will oversee the detailed activity necessary to compile the budget proposals for 2011-12 and ensure actions are prepared/pursued appropriately. This will be reported separately to CMT.	5	2	10
RA16	There is currently a safeguarding inspection into Children's social care. It is important that the inspectors do not make any invalid assumptions about the impact upon the service of the consultation or the proposed change to	5	3	15	KK and RT will speak directly with inspectors to explain and allay any concerns	5	1	5

Change To Keep Succeeding
completed by: Jeff Hawkins, Transformation Programme Manager
Objective: to deliver a new organisational framework
completed 7 October 2010

Risk No	Challenges	Assessment of Inherent Risk (with no controls in place)			Risk Control Measure	Assessment of Mitigated Risk (with controls in place)		
		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating
RA17	Risk of opposition to the business support directorate model	4	3	12	Detailed transition planning provides the opportunity to address concerns and, within the remit of a business support directorate, to adjust the delivery of service. Workshops will be held with staff and managers to design new processes for business support. **Type 2. Failure to implement the business support directorate** Retention of the current federated model of business support within directorates perpetuates the duplication of effort and silo-working and their associated cost - something which staff have identified as a feature of KCC that needs to change.	2	3	6
RA18	Risk of opposition to the new Education and Families model from headteachers and partners	4	3	12	Consultation and explanation of the model. Reassurance around Children's Trusts and Locality Boards. Await guidance from Government on new role	2	2	4

EQUALITY IMPACT ASSESSMENT SCREENING GRID

"Change to keep succeeding". The transformation of the Council's operating framework.

Minority strand	Could this policy, procedure, project or service affect this group differently from others in Kent? YES/NO	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO	Assessment of potential impact HIGH/MEDIUM/LOW/ NONE/UNKNOWN		Reason for assessment
			Positive	Negative	
Age	Yes	Yes		Medium	Younger employees may be more likely to have shorter service than others and be less experienced. Younger workers may be impacted in terms of redundancy payments, or in terms of pay progression given the proposal involves staff potentially affected will receive pay based on performance based on the Total Contribution Pay Scheme (TCP). Older staff should also not be treated less favourably over younger staff on the grounds of age. The proposed evaluation of roles by Hay Group will ensure equal opportunities and alignment of pay / roles.

Disability	Yes	Yes		Medium	The recruitment process may require reasonable adjustments to be made for staff with disabilities covered by the Equality Act 2010. The new posts may require reasonable adjustments to be made for staff with disabilities covered by the Equality Act 2010. Managers will need to be aware of disabilities in the above and ensure staff are not treated less favourably as a result.
Sex (Gender)	Yes	Yes		Low	Female senior officers are under-represented compared to the KCC workforce (65% v 84%). Female staff may also have shorter service due to caring responsibilities. Female staff are also more likely to have primary caring responsibilities or be part time. Most post-holders are however full-time.

Gender Reassignment	No	No	None	None	Gender reassignment should not be a factor in this project, either in recruitment or in performing the roles.
Race	No	No	None	None	As above
Religion or belief	No	No	None	None	As above
Sexual orientation	No	No	None	None	As above
Marriage & Civil Partnership	No	No	None	None	As above
Pregnancy & Maternity	No	No	None	None	As above

Current Posts Impacted

Chief Executive's Department
Executive Director of Strategy and Business Support
Director of Finance (s.151)
Director of Law & Governance (MO)
Director of Personnel & Development
Director of Property
Director of Commercial Services
Director of Strategic Development Unit & Public Access
Director of Public Health

Children, Families and Education
Managing Director Children, Families & Education
Director of Commissioning and Partnerships
Director of Capital Programmes and Infrastructure
Service Director - Learning
Director of Resources and Planning
Service Director - Specialist Children's Services

Communities
Managing Director – Communities
Director of Cultural Services
Director of Community Safety & Regulatory Services
Director of Youth Services & Kent Drugs Alcohol Action Team
Director of Policy & Resources

Environment, Highways & Waste
Executive Director, Environment, Highways & Waste Directorate
Director of Environment & Waste
Director of Integrated Strategy & Planning
Director of Kent Highway Services

Kent Adult Social Services
Managing Director, Kent Adult Social Services
Transforming Social Care - Lead Officer
Director of Strategic Business Support
Director of Operations
Director of Commissioning & Provision x 2

NB: These are the only posts directly impacted by this process.

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By: Overview, Scrutiny and Localism Manager

To: Adult Social Services Policy Overview and Scrutiny Committee
16 November 2010

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

Summary: This report updates Members on current and future Select Committee work and invites suggestions for future Select Committee Topic Reviews.

Select Committee work now completed - Renewable Energy and Extended Services

1. Both Select Committees have now completed their reports, which were shared with the relevant Cabinet Members and Directorates in October. A number of useful comments were received on both and the final version of each report made available to the Corporate Management Team. Both reports will then be considered by the Cabinet on 29 November and the County Council on 16 December 2010.

Future Select Committee Topic Review Work Programme

2. Following the meeting of the Scrutiny Board on 3 November 2010, the future work programme has been confirmed as follows:-

Dementia – starting work now. ASSPOSC is the 'parent' committee for this review, with the Membership being drawn from this and the HOSC. The Chairman Designate is Mrs Trudy Dean. The contacts in Democratic Services for this Committee are: Research Officer Sue Frampton (01622 694993) and Democratic Services Officer Christine Singh (01622 694334).

Educational Attainment of Pupils and Schools in Areas of High Deprivation – starting work now. The contacts in Democratic Services for this Committee are: Research Officer Pippa Cracknell (01622 694178) and Assistant Democratic Services Manager Denise Fitch (01622 694269).

The Student Journey – due to start work in Spring 2011. The contacts in Democratic Services for this Committee are: Research Officer Gaetano Romagnuolo (01622 694292) and Democratic Services Officer Theresa Grayell (01622 694277).

Suggestions for Select Committee Topic Reviews

3. If Members have any suggestions of topics they would like to put forward for consideration for inclusion in the future topic review work programme, they should contact the Democratic Services Officer for this POSC.

Recommendation:-

4. Members are asked to note the successful completion of the work of the Renewable Energy and Extended Services Select Committees and the new Topic Review work which is now starting, or soon to start, and to advise the Democratic Services Officer of any topics which they would like to put forward for consideration for inclusion in the future Select Committee Topic Review Work Programme.

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Democratic Services Officer

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Background Information: *Nil*