# ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE

**Friday, 30 March 2012**

**10.00 am**

**Council Chamber, Sessions House, County Hall, Maidstone**

**Due to the length of this agenda, the Committee will need to break for lunch and reconvene in the afternoon. The timing of the meeting will be determined by the Chairman on the day.**

Kent County Council

**AGENDA**

# ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE

**Friday, 30 March 2012 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 C J Capon (Chairman), Mrs V J Dagger (Vice-Chairman), Mr R E Brookbank, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt, Mr C Hibberd, Mr M J Jarvis, Mr C P Smith and Mr C T Wells *and one vacancy*

Liberal Democrat (1): Mr S J G Koowaree

Labour (1): Mr L Christie

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

**Due to the length of this agenda, the Committee will need to break for lunch and reconvene in the afternoon. The timing of the meeting will be determined by the Chairman on the day.**

**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 10 January 2012 (Pages 1 - 12)

A5 Chairman's Announcements

A6 Oral Updates by Cabinet Member, Corporate Director of Families and Social Care and Director of Public Health

**B. PRESENTATION**

B1 Adult Safeguarding in Institutional Settings

**C. ITEMS FOR SCRUTINY**

C1 Safeguarding Vulnerable Adults - Quality and Effectiveness of Threshold Assessments (Pages 13 - 16)

C2 Dementia Select Committee Report Recommendations - Implementation Plan (Pages 17 - 30)

C3 Amendments to the Charging Policy for Home Care and other Non-Residential Services - TO FOLLOW

C4 The Treatment of Jointly-Owned Property in the Residential Charging Assessment (Pages 31 - 36)

C5 Temporary Financial Assistance for Residential Care (Pages 37 - 40)

C6 The Treatment of Second Homes and Property Other Than a Person's Main Home in the Non-Residential Charging Policy (Pages 41 - 42)

**D. PUBLIC HEALTH ITEMS**

D1 Public Health Performance (Pages 43 - 48)

D2 Winter Intervention Support Kent (WISK) (Pages 49 - 56)

D3 Public Health Transition (Pages 57 - 60)

**E. ITEMS FOR CONSIDERATION**

E1 Health and Social Care Integration Programme - Integrating Adult Community Health and Social Care Provision (Pages 61 - 92)

E2 Update on Adult Social Care Transformation Programme (Pages 93 - 96)

E3 Update on the Good Day Programme - Including: An Interim Report on the Formal Consultation on a New Service Model for Learning Disability Day Services in the Shepway District, and the decision made following the Formal Consultation on a New Service Model for Learning Disability Day Services in the Thanet District (Pages 97 - 128)

E4 Adult Social Care Budget Forecast and Savings Report 2011/12 (Pages 129 - 166)

E5 Performance for Adult Social Care - Quarter 3 - December 2011 (Pages 167 - 184)

**F. ITEMS PLACED ON THE AGENDA BY MEMBERS**

## G. SELECT COMMITTEE UPDATE

G1 Update on Select Committee work (Pages 185 - 186)

## 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
(01622) 694002

**Thursday, 22 March 2012**

*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.*

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**KENT COUNTY COUNCIL**

# ADULT SOCIAL CARE AND PUBLIC HEALTH POLICY OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 10 January 2012.

PRESENT: Mrs A D Allen (Substitute for Mrs V J Dagger), Mr R E Brookbank, Mr L Christie, Mrs P T Cole, Mr N J Collor, Mr J M Cubitt, Mr C Hibberd, Mr P J Homewood (Substitute for Mr C J Capon), Mr M J Jarvis, Mr S J G Koowaree and Mr C P Smith

ALSO PRESENT: Mr N J D Chard, Mr A D Crowther, Mr G K Gibbens, Mrs E Green, Mr M J Harrison, Mr P M Hill, OBE, Mr P W A Lake, Mr R J Lees, Mr R A Marsh, Mr K H Pugh and Mr M V Snelling

IN ATTENDANCE: Mr A Ireland (Corporate Director, Families and Social Care), Ms M Peachey (Kent Director Of Public Health), Mr M Lobban (Director of Strategic Commissioning), Mr A Scott-Clark (Deputy Director of Public Health, NHS E & C Kent) and Miss T A Grayell (Democratic Services Officer)

**UNRESTRICTED ITEMS**

## 65. Election of Chairman for the Meeting

The Democratic Services Officer announced that, as neither the Chairman nor the Vice-Chairman was able to be present, the Committee should elect a Chairman for the meeting. Mr N J Collor then proposed and Mr R E Brookbank seconded that Mr C P Smith be elected Chairman for the meeting.

*There being no other nominations, it was agreed that Mr C P Smith chair the meeting.*

## 66. Membership
*(Item A2)*

The Democratic Services Officer reported that Mr J E Scholes had resigned from the Committee, leaving a vacancy, but Mr Cubitt had decided to remain on the Committee for its final two meetings.

## 67. Declarations of Members' Interest relating to items on today's agenda
*(Item A4)*

Mr R E Brookbank made a general declaration of interest as Chairman of the Trustees of Darent Valley Age Concern.

Mrs A D Allen made a general declaration of interest as a Trustee of North West Kent Age Concern.

**68. Minutes of the meeting held on 10 November 2011**
*(Item A5)*

RESOLVED that the Minutes of the meeting held on 10 November 2011 are correctly recorded and they be signed by the Chairman. There were no matters arising.

**69. Chairman's Announcements**
*(Item A6)*

The Chairman led the Committee in wishing Mr Capon and Mrs Dagger a speedy recovery from, respectively, surgery and a fall.

**70. Oral Updates by Cabinet Member, Director of Families and Social Care and Director of Public Health**
*(Item A7)*

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

- Visited Live it Well Centres at Maidstone and Ashford
- Dartford and Gravesham Members Visit to Older People's Services took place
- Attended Action on Smoking and Health (ASH) AGM and Seminar on 8 December in London
- HOUSE on the Move Celebration/Showcase took place on 12 December
- Hosting Lunch at Public Health England Event on 10 February
- Annual Meeting with Age Concern Chairs taking place on 22 February
- Attending National Public Health Conference on 28 February
- Andrew Wickham organising Kent Older People Chairs meeting on 2 March

In response to questions, Mr Gibbens undertook to advise Members outside the meeting about the following:-

- access to places in the new Abbeyfield residential home in Dartford and Gravesham, including the reason for any delays experienced;

- details of his annual meeting with Age Concern Chairs, to which he extended an invitation to Members of the POSC. This will take place on 22 February at 10.00 am in the Pendragon Room Invicta House, County Hall

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

- Adult Services Transformation
- Budget Setting and MTP – the scale of the financing issues around the transformation programme made this a major piece of work, which is ongoing.
- NHS Integration
- Transition - both Adults' and Children's Services are/will be the subject of White Papers, and work in this area will look at how best to manage change.
- KMPT (Kent and Medway NHS and Social Care Partnership Trust) Appointment – when the new Chief Executive of the Trust is settled in post, roles and arrangements can be clarified and reported to the POSC.

3. Ms Peachey gave an oral summary of the Council's significant new Public

Health responsibilities that were published in six briefing papers by the Department of Health on 20 December 2011, as follows:-

- there are three major changes coming as a result of Public Health reforms – a new leadership role for local authorities, an integrated approach under Public Health England and work with the NHS to promote clinical excellence.

- There are two main priorities – focussing on health outcomes and to secure ring-fenced resources to back up Public Health work.

- The six factsheets published on 20 December outlined the new duties and leadership role of local authorities in health improvement and protection, some of which (eg sexual health) will be mandatory, the changing role of the Director of Public Health, which will become a statutory Chief Officer post, and a mechanism to support professional appraisal and build capacity. Details of the budgets and human resources frameworks which will support these changes are still awaited

The oral updates were noted, with thanks.

**71. DVD trailer of a film 'Amorous Feelings of Beach' made by members of East Kent Mencap**
*(Item B1)*

*Jason Gerlack, Chief Executive Officer of East Kent Mencap, was present for this item with his colleague Paul Wrynne and Melanie Barber, Lee Harrison and Paul Wood from the cast of the film, at the invitation of the Committee..*

1. The Committee was shown a 10-minute trailer for a longer film which was made by, and featuring members of, East Kent Mencap. Mr Gerlack explained that the key aims of Mencap were to challenge attitudes towards and achieve equality for people with learning disabilities and to address the financial hardships which they often face.

2. Members congratulated the cast on the film and thanked them for attending. In discussion, the following points were made:-

a) attitudes towards people with learning disabilities have improved greatly in the last 30 years, since the days of an institutional approach;

b) the film could be shown in schools, to educate and influence young people's attitudes to learning disability; and

c) the innovative work undertaken across the county by people with learning disabilities, such as Shopsafe and 'buddying' schemes, has been very effective in addressing the issues they face, and their direct involvement is much valued.

3. Mr Gerlack was asked to comment on the bid submitted by East Kent Mencap as part of the Thanet Good Day Programme, to run services for people with learning disabilities, about which the Committee had been told at its 10 November meeting. He replied that Mencap has a background of providing a wide range of services in

East Kent and has the ability and — experience to deliver the Good Day Programme. Mencap supports KCC's approach towards modernising services. Mr Gerlack confirmed that no further discussion of detail had taken place since the Committee's November meeting, and Mr Gibbens confirmed that he had not yet taken any decision on the Programme.

4. RESOLVED that those involved in the making of the film be congratulated and thanked for allowing Members the chance to see it, and the points made in discussion be noted.

**72. Welfare Reform**
*(Item B2)*

*All Members of the County Council had been invited to attend for this item, and Mr N J D Chard, Mr A D Crowther, Mrs E Green, Mr M J Harrison, Mr P M Hill, OBE, Mr R J Lees, Mr R A Marsh, Mr K H Pugh and Mr M V Snelling were present.*

*Ms C Grosskopf, Policy Officer, was in attendance for this item.*

*A copy of the slides used in the presentation was circulated to Members present and copied to all Members of the Council after the meeting.*

1. Ms Grosskopf presented a series of slides which set out the background to, main proposals and potential implications of the Government's Welfare Reform Bill. She highlighted the main changes, as follows:-

a) the largest and most radical change is the introduction of Universal Credit from October 2013, which brings together various benefits and tax credits into a single monthly payment. This Credit is intended to encourage and make it easier for individuals to get back to work, and the monthly payment is intended to help them get used to building a budget around a monthly payment of wages. However concern has been expressed about the ability of the more vulnerable claimants to cope with this system. Although the Government intends the majority of people to eventually claim Universal Credit online, they are currently looking into ways to deliver a face-to-face service for the more vulnerable customers. KCC (including the Gateway team) and some of Kent's District Councils are involved in ongoing discussions about this;

b) Council Tax Benefit changes, from April 2013, will pass funds currently held centrally, minus 10%, to local authorities, which will be required to design their own local system of Council Tax benefit;

c) funding for the Discretionary Social Fund will be devolved to local authorities (the upper tier in county council areas) from April 2013. KCC is currently planning how to provide this service, including whether or not to commission a third party to provide it;

d) a cap on the level of benefits claimed by any one out of work household will be introduced from April 2013 (planned to be set at £26,000);

e) Disability Living Allowance (DLA) for people of working age is to be replaced by the Personal Independence Payment (PIP) from April 2013. This will have stricter rules of entitlement. Contrary to earlier indications, the mobility component of DLA and, later, PIP, will not now be withdrawn for people in publicly-funded residential care;

f) Employment Support Allowance (ESA) restrictions from April 2012:- individuals claiming the national insurance-based ESA will only be entitled to it for one year. However, they will be able to go on claiming the means-tested ESA provided they (and their partner, if applicable) pass the means test;

g) easier data sharing between the Department of Work and Pensions and local councils from April 2012 (without the need for individual client authorisation);

h) up-rating of Housing Benefit for private sector tenancies by the Consumer Price Index from April 2013;

i) restrictions to Housing Benefit in the social housing sector from April 2013, based on size criteria;

2. Ms Grosskopf then went through the potential implications of the reforms, including:-

a) whether the reforms would reduce worklessness and benefit dependency or increase poverty and hardship. There are mixed views on this and various factors need to be taken into account, which were set out in the presentation slides;

b) risk to the Gateway model if local authorities are not given a role in the face-to-face delivery of Universal Credit;

c) risk to housing providers if the housing element of Universal Credit is not paid direct to them;

d) Council Tax Benefit reform brings risk to local government finances if billing authorities are unable to collect the required level of Council Tax;

e) localisation of the Social Fund brings reputational risk from local government making the decision to award or refuse benefits or support. On the other hand may be opportunities from increased localism;

f) benefit caps will particularly affect people in London and this may lead to migration to surrounding counties, including Kent; and

g) potential savings from enhanced data sharing.

3. Ms Grosskopf and Mr Ireland responded to comments and questions from Members, and the following points were highlighted:-

a) service users and staff will need to receive training and support to understand and administer the new system. Training in some aspects has already begun. Members expressed a concern about the administrative burden that the new rules will bring;

b) a concern was expressed that benefits paid direct to claimants may not be used for their intended purpose (eg to cover rent and Council Tax payments) and existing problems of arrears and debt will worsen. There may be some scope for payments to be made direct to landlords but this is limited and the majority of benefit recipients will be expected to learn to budget themselves. Concern was expressed about how this would impact on vulnerable groups and on housing providers;

c) the unemployed now includes many professional people who have aspirations and expectations about their scope to re-train and find new employment, but it is those who have never or rarely worked who will need the most help and encouragement to find employment and those at whom the reforms are targeted most;

d) from their experience of working with the National Assistance Board and in the private rental market, Members expressed concerns about how well some of the proposals would work and how well the changes had been thought through;

    i) claimants whose benefits are paid direct to their landlords will not acquire the skill or habit of budgeting for themselves;

    ii) changes such as those proposed will be difficult to introduce at a time of mass unemployment. When jobs are plentiful, it is easier to identify work refusers. Ms Grosskopf said that the Government would say that no-one will be forced off Universal Credit if there is no job for them to go to; and

    iii) concern was expressed that providers of social housing are not geared up to manage rent arrears, and Ms Grosskopf added that this would also affect their ability to borrow from commercial lenders (ie if their income from benefit recipients is not secure);

e) the point was made that the proposed changes might drive rents down. If this does not happen, people would be forced to move to cheaper rental areas – this will particularly affect London Boroughs and migration to Kent is a possibility;

f) Members are sure to be approached by local people seeking help to understand the system and possibly to support them in an appeal, so they will need training to help them understand the new rules; and

g) when starting a new job, people have to wait for up to a month to receive their first salary payment, so there will need to be some

flexibility to cover this waiting period to help people avoid falling into rent or Council Tax arrears. Ms Grosskopf thought that such flexibility may be available to support people back into work.

4. Mr Ireland outlined the risks associated with the changes; to some vulnerable users, for whom it may be difficult to assess their true ability to understand and cope with the changes and who therefore may not get the help and support they need; to KCC staff who might have to cover excessive demands for their involvement and support, and be tasked with taking difficult decisions about local cases; to Members, who might be asked to help and support local people with claims and appeals, and to the Kent economy and service providers as they may be pressured to accommodate tenants priced out of London by changes to rents and benefits.

5. Mr Lake added that, as the Chairman of the Supervisory Committee of Kent Savers, he is involved in assessing the potential risks to housing providers and tenants which will arise from the changes. Kent Savers have launched a pilot scheme across Maidstone, Medway, Swale and Tunbridge Wells, to help both sides to understand the changes and the new rules. Benefit payments for rent can be held by Kent Savers and then paid direct to landlords, for a small fee.

6. RESOLVED that the information set out in the presentation and given in response to comments and questions be noted, with thanks.

**73. Budget 2012/13 and Medium Term Financial Plan 2012-15**
*(Item C1)*

*Miss M Goldsmith, Families and Social Care Finance Business Partner, was in attendance for this item.*

1. Miss Goldsmith introduced the report and responded to comments and questions from Members. The following points were highlighted:-

a) Members requested and were given more detail about various lines of the budget and made the point that it is difficult to compare this with past budgets as items are either listed differently or different items have been included (eg grants are now held centrally, rather than within Portfolio budgets);

b) Members commented that the Informal Member Group which had met through the second half of 2011 to look at the budget and identify potential areas of saving had seemingly wasted its time as the budget now presented is different and they do not feel able to offer constructive comment; and

c) Members asked how they could have input into and influence over the grants paid by the KCC to voluntary organisations, and be able to compare 2012-13 grants to previous years', and Mr Lobban undertook to provide a list detailing which grants are received by individual voluntary organisations.

2. RESOLVED that:-

a) the revenue and capital budget proposals for the Adult Social Care and Public Health portfolio be noted, with thanks; and

b) Members be provided with a list detailing which grants are received by individual voluntary organisations.

**74. KCC Health Inequalities Strategy Update**
*(Item D1)*

*Ms D Smith, Policy Manager, was in attendance for this item.*

1. Ms Smith introduced the report and explained that Members were being asked to comment on the draft Health Inequality Action Plan and agree the next steps in its development. The purpose of the Action Plan is to identify areas in which Kent is working well and those in which more work is needed. The Action Plan is aligned to the strategies and plans of the KCC and District Councils, to make use of existing data and resources.

2. In discussion, Members made the following comments on the content of the Action Plan:-

a) the document is good and contains good aspirations, but these could prove difficult to implement;

b) it contains some useful aspirations, and could be used as a tool for Locality Boards to follow;

c) it will need to include the impact of the ongoing recession, and the potential impact on Kent of an 'overspill' of people who have been priced out of London by welfare reform changes;

d) it needs to take full account of the potential for health education programmes in schools, as part of the PHSE agenda;

e) the reduction in Supporting People funding of £4m has not come at a good time, as the number of homeless households is predicted to continue to rise dramatically in 2012;

f) page 8 of the document refers to the role which could be played by Children's Centres but these have now lost funding and will find it harder to take on this role. Local mothers could share their experience to support teenage parents on a voluntary basis;

g) on page 25, the list of those facing disadvantage should include looked after children (LAC);

h) on page 26, references to young people not in education, employment or training (NEET) need to be supported by some statistics, eg to compare Kent's position with the rest of the UK;

i) page 45 makes some mention of alcohol and substance misuse, but these should have a higher profile as they are key to many other health problems.

3. Mr Gibbens offered Members the chance to meet him and officers to discuss the Health Inequality Strategy and Action Plan in more detail.

4. RESOLVED that the Information set out in report be noted, with thanks, the content of the draft Health Inequality Action Plan be supported, with Members' comments on its content and direction being taken into consideration, and the course of action set out in the report be agreed.

**75. Public Health Performance**
*(Item D2)*

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

**76. Joint Strategic Needs Assessment (JSNA)**
*(Item D3)*

1. Mr Scott-Clark and Mr Gibbens introduced the report and the executive summary draft of the Joint Strategic Needs Assessment and explained that further guidance was awaited from the Department of Health (on what the JSNA should cover?) Mr Gibbens offered to establish an Informal Member Group to allow Members to discuss the matter in more detail.

2. RESOLVED that the information set out in the report be noted, with thanks, and Mr Gibbens' offer to set up an Informal Members Group to discuss this in more detail be accepted. *A meeting of the IMG was subsequently arranged for 31 January at 11.30 am in Mr Gibbens' office.*

**77. Strategic Commissioning and the Transformation of Adult Social Care**
*(Item E1)*

1. Mr Lobban introduced the report and explained that the transformation programme is ambitious, with what is done and how it is done being of equal importance. What is included in it must work and add value. A blueprint for the programme's implementation will be ready for the POSC to see at its 30 March meeting.

2. Mr Lobban and Mr Ireland responded to comments and questions from Members and the following points were highlighted:-

a) Members asked what involvement they would have in the formal consultations with staff which would take place from January to March. Mr Lobban reassured Members that, in identifying the resources needed to deliver the transformation programme, he would not necessarily be seeking a reduction in staff numbers but would look to identify the best way to deliver each target. He would always consider whether or not the KCC should deliver something itself or outsource it;

b) no money had been allocated to Kent this year for Extra Care Sheltered Housing, so Kent should lobby Government to secure finding for this in the future. Mr Lobban undertook to raise this at a meeting with Housing Associations; and

c) although some details of the transformation programme are as yet unknown, ASC has developed a carefully-costed programme to make the best use of Kent's commissioning role, using joint working with partners, eg to avoid long-term care admissions and develop enablement services.

3. RESOLVED that the information set out in the report be noted, with thanks, and an update be given at the POSC's 30 March 2012 meeting.

**78. Interim Report of Formal Consultation on a New Service Model for Learning Disability Day Services in the Shepway District**
*(Item E2)*

*Ms C Beaney, Head of Service, Learning Disability, and Ms P Watson, Commissioning Manager, Learning Disability, were in attendance for this item.*

1. Ms Watson and Ms Beaney introduced the report and responded to comments and questions from Members. The following points were highlighted:-

a) Members were reassured that a thorough and robust advocacy process was being used, in one-to-one or group sessions with service users;

b) each consultation on service modernisation around the county learns from and builds on the lessons learnt from previous consultations in other areas;

c) service users want and expect to be able to choose their activities seven days a week, including evenings, and this holistic and personalised approach is much easier to pursue using community-based support services; and

d) the main themes which have emerged from the consultation so far include the importance of services users being able to maintain social networks and friendships.

2. RESOLVED that the information set out in the report be noted, with thanks, and an update report be made to the POSC's 30 March 2012 meeting.

**79. Local Account 2012**
*(Item E3)*

*Mr M Thomas-Sam, Head of Policy and Service Standards, and Ms E Matthews, Senior Planning Officer, were in attendance for this item.*

1. Mr Thomas-Sam and Ms Matthews introduced the report and explained that the Local Account performance management tool had replaced the CQC report. It is less prescriptive than the former and has to be developed and run by local authorities

themselves. In responding to comments and questions from Members, the following points were highlighted:-

a) although the system had not been due to start until 2012, KCC had run a pilot scheme in 2011 to 'road-test' the new system. Members' views are sought on the content of the draft document;

b) in developing its Local Account, KCC had consulted service users, carers and community groups;

c) although HealthWatch will change due to public health reforms, Local Account will continue to link to and get input from it;

d) although councils would now be able to set their own targets and assess themselves against those targets, a national reporting mechanism would remain, to measure key performance targets such as the number of people receiving a personal budget or direct payments; and

e) Members expressed concern about the target quoted for the number of complaints and complements to be received in the coming year, and Mr Thomas-Sam undertook to review the usefulness of including this sort of target.

2. RESOLVED that the information set out in the report be noted, with thanks, and Members' comments be taken into account in developing the document.

**80. Adult Social Care Budget Forecast and Savings Report 2011/12**
*(Item E4)*

*Miss M Goldsmith, FSC Finance Business Partner, was in attendance for this item.*

1. Miss Goldsmith introduced the report and she and Mr Ireland responded to comments and questions from Members. The following points were highlighted:-

a) a view was expressed that an underspend could be viewed as good news or bad, and that underspend and savings are not the same thing. To achieve savings by delivering services more efficiently or economically is good, but an underspend could mean that some people had not received services. Without more information than was provided, Members are not in a position to judge. Mr Ireland commented that some impact of enablement services is now being seen, reducing the need for long-term and continuing services; and

b) Members asked where in the budget the largest variances had appeared, and officers undertook to supply a copy of the ASC part of the budget reported to Cabinet in December, as the figures had not changed since that time.

2. RESOLVED that the information set out in the report be noted, with thanks, and the report on the ASC budget considered by the Cabinet in December be

sent to POSC Members to provide the background information requested during discussion.

**81. September 2011 Update for Performance for Adult Social Care, and Monitoring of the Projects, Developments and Key Decisions identified in the 2011/12 Annual Operating Business Plans for Families and Social Care, Adult Services**
*(Item E5)*

*Mr R Benjamin, Performance Monitoring Manager, and Ms E Matthews, Senior Planning Officer, were in attendance for this item.*

1. Mr Benjamin and Ms Matthews introduced the report and they and Mr Ireland responded to comments and questions from Members. The following points were highlighted:-

a) national performance indicators still apply, alongside the ones KCC sets itself;

b) it is hoped that, by the end of the current financial year, the KCC will reach its target for the number of people who have been enabled to stay in their own homes. Some projects do not reach their target within monitoring period (the financial year) as they start part-way through the year;

c) Members asked to be given examples of cases in which enablement has been successful so they could be satisfied that the cases addressed cover a range of complexities and not just the easiest to address; and

d) Members were reassured that the SWIFT system had been shown to be fit for purpose, and some minor concerns about data quality can be easily addressed as work progresses.

2. RESOLVED that the information set out in the report be note, with thanks, and Members be supplied with the information on enablement requested.

**82. Update on Select Committee Work**
*(Item G1)*

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

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|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **SAFEGUARDING VULNERABLE ADULTS – QUALITY AND EFFECTIVENESS OF THRESHOLD ASSESSMENTS** |
| Classification: | Unrestricted |


| | |
|---|---|
| Summary: | This report presents the programme of audits commissioned recently by Families and Social Care. The recommendations made following the audits have been incorporated into the FSC safeguarding action plan which is being implemented by the Directorate. |


**Introduction**

1. (1) The Adult Safeguarding Unit has undertaken a programme of audits since December 2010. The audit programme has focused on Families and Social Care (adult social care) and the Kent and Medway Partnership Trust (KMPT).

**Context**

2. (1) In March 2009 Adult Social Care in Kent, including KMPT, were inspected by CQC/CSCI under the Independence, Wellbeing and Choice Inspection programme. In regard to Safeguarding, Adult Social Care in Kent was assessed as 'Good'.

(2) An inspection action plan, agreed with CQC, was fully implemented. At the time of the Inspection and after, the Directorate went through a period of major change in order to establish a structure to deliver Self Directed Support.

(3) Families and Social Care take the lead on investigating allegations of abuse to vulnerable people. This is a highly important function in relation to adult safeguarding. Two years on from the Independence, Wellbeing and Choice Inspection, Families and Social Care (FSC) commissioned a programme of audits which focused on safeguarding investigations. This focused on two major areas of activity:

- Safeguarding Investigations in Adult Social Care in Kent County Council (FSC).
- Safeguarding investigations in Kent and Medway Partnership Trust.

(4) FSC felt it was important to undertake audits as a matter of good practice and because the Care Quality Commission no longer inspect Councils as Commissioners of adult social care on an annual basis. Councils are expected to monitor their own performance.

(5) Safeguarding is a high priority for Families and Social Care and the programme of audits over the past year has demonstrated progressive improvements in the practice and quality of case work. However it is essential we do not get complacent and continue to monitor the quality of practice closely.

(6) Along with the audit programme, the Adult Safeguarding Unit has implemented several quality assurance initiatives to continue to drive improvements. These include a focus on safeguarding training and supervision, implementation of the Quality in Care Framework, LEAN Review of safeguarding processes and a focus on Mental Capacity Act issues.

**Programme of Audits – Families and Social Care (Adult Social Care)**

3. (1) At the beginning of the programme of audits it was noted that all clients had been safeguarded. The audits raised issues regarding the quality of recording risk assessments and the complexities of the safeguarding process which on examination could be made simpler.

(2) As a response to this an action plan was developed to address these issues, including improved risk assessment training and a full revision of the safeguarding process using LEAN methodology. As a result of this review, the safeguarding alert process has been streamlined and improved with an increased focus on risk assessments and recording. This has been reflected in later audits which have identified pieces of case work as Excellent.

(3) The audit action plan has been refreshed in light of these audits with a focus on other areas of practice and continues to be monitored by the Adult Safeguarding Unit.

**Next Steps for Families and Social Care**

4. (1) In discussion with the Corporate Director we are exploring the possibility of a Peer Review, likely to be undertaken by another Local Authority similar to Kent. We anticipate that the review could cover:

(a) Practice and strategic issues within the Local Authority.
(b) Training.
(c) Multi-agency arrangements.
(d) Safeguarding arrangements in respect of providers.

(2) Other key areas which will be followed up in the next few months include:

(a) Continuation of the practice audit programme and initiatives to improve practice.
(b) Continued focus on closure of cases.

(c) Ongoing review of the new safeguarding documentation following the LEAN review.
(d) Implementation of the Adult Social Care element of the Central Referral Unit.
(e) Commissioning of further Adult Safeguarding Training, especially Level 3 – Investigators Guide.

**Programme of Audits Kent and Medway Partnership Trust (KMPT)**

5. (1) At the beginning of the programme of audits it was noted that all clients had been safeguarded. The audits raised issues about the process of recording risk assessments on case files and the interface between safeguarding and the Care Programme Approach.

(2) As a result of these audits internal workshops have been held with Assistant Directors and Service Managers to focus on improving the management of case work and all safeguarding alerts are monitored and tracked by the KMPT Adult Safeguarding Unit. The KMPT Programme Board received regular safeguarding updates.

(3) An Improvement Plan was put in place by KMPT which has been updated to incorporate recommendations made following the audits.

**Next Steps for KMPT**

6. (1) The KMPT Improvement Plan has been updated in light of the findings of the audits and will continue to be monitored on a regular basis by the KMPT Programme Board. A further practice audit has been commissioned to take place in the Summer of 2012.

**Conclusion**

7. (1) In conclusion, the adult social care audits have evidenced an improvement in practice. Given the high priority of adult safeguarding, it is recommended that Members continue to receive updates to ensure that progress in Adult Social Care has been sustained and that the audit action plans are having the desired impact.

**Recommendations**

8. (1) Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE and COMMENT on the report.

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*Background documents:* None

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|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **DEMENTIA SELECT COMMITTEE REPORT RECOMMENDATIONS - IMPLEMENTATION PLAN** |
| Classification: | Unrestricted |

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

**Introduction**

1. (1) The Dementia Select Committee report "Dementia - A New Stage in Life" published in September 2011 and presented to Kent County Council Cabinet on 5 December 2011 is welcomed by the Families and Social Care (FSC) Directorate. The Dementia Committee Report sets out 17 recommendations and FSC is committed to implementing these recommendations in partnership with Customer & Communities, Public Health, Business Strategy & Support, Health colleagues and providers of dementia care and support across Kent.

(2) The purpose of this paper is to present the implementation plan that sets out how the FSC Directorate and key partners intend to deliver on each of the 17 recommendations of the Dementia Committee Report. The key themes of the report's 17 recommendations are:

- Improving and streamlining support for people with dementia and their carers within their communities.
- Improving the rates of (early) diagnosis in Kent.
- Extending the reach of the Admiral Nursing service.
- Raising public awareness and understanding of dementia, including minimising the risk of developing vascular and other dementias.
- Ensuring that children and young people know about dementia and encouraging intergenerational support.
- Acknowledging and supporting the vital role of family carers.
- More consistent and appropriate domiciliary and respite care.
- Raising awareness about the Lasting Powers of Attorney (and possibly providing a service).
- Ensuring people have the information they need about dementia and dementia services.
- Improving the level of dementia awareness and training for enablement workers and ensuring through contractual arrangement that homecare provider organisations can meet the needs of memory impaired clients.

- Integrated working on dementia and pooling of budgets between health and social care.
- Identifying current resources for dementia and modelling future spending.
- Raising GPs' awareness of dementia.
- Improving support for people with younger onset dementia.
- Ensuring people with dementia and family carers are central to service development.

(3) The recommendations of the Dementia Select Committee Report reflect the strategic aspirations of the Kent and Medway Dementia Integrated Plan. This plan is still in devlopment and is bringing together the three joint commissioning plans of the former Kent and Medway PCTs, Kent County Council and Medway Council. There is a Dementia Integrated Plan (QIPP) Board which is chaired by Ann Tidmarsh Director of Older People and Physical Disability Services Families and Social Care.

(4) There is also a long established Kent & Medway Dementia Collaborative which brings together commissioners, providers and academics, with the purpose of informing and overseeing the commissioning decisions of statutory authorities in relation to people with dementia and their carers. The Dementia Collaborative is also chaired by Anne Tidmarsh.

(5) The Dementia Select Committee Report has been shared with both The Kent and Medway Dementia Integrated Plan Board and the Kent & Medway Dementia Collaborative. Once agreed the Implementation Plan will also inform the work or both groups, who will ensure the recommendations of the plan are embedded in their own work programmes.

**Implementation Plan**

2. (1) An Implementation Plan for each of the recommendations is attached to this report [1] as Appendix 1. As well as planned activity it also shows the key areas where progress has been made in the first three months.

**Recommendations**

3. (1) Members of the Policy Overview and Scrutiny Committee are asked to NOTE and COMMENT on the contents of this report.

*Background documents:*
Dementia - A New Stage in Life, September 2011
Living well with dementia: A National Dementia Strategy – Feb 2009
The Operating Framework for the NHS in England 2011/12

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[1] See Appendix 1 Implementation Plan

# DEMENTIA SELECT COMMITTEE RECOMMENDATIONS IMPLEMENTATION PLAN - JANUARY 2012

| THEME: DEMENTIA IN KENT | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R1** | That a business case is developed in Kent for shared care prescribing arrangements or dementia medication and that GPs are encouraged to be more proactive in reviewing all people diagnosed with dementia, regardless of whether dementia medication is indicated. (p50) | **Sue Gratton**<br>Deputy Associate Director, Integrated Commissioning NHS Kent and Medway | It is the intention of the NHS to commission a Primary Care Dementia Pathway which ensures that dementia is viewed and treated alongside other long term conditions. Crucial to the success of this pathway will be ensuring that primary care clinicians are supported to develop skills in the identification, assessment management of dementia including the management and review of medications. | **April 2013** |
| **R2** | That in disposing of KCC buildings, the options for Community Asset Transfer are proactively explored to maximise the opportunity for voluntary sector dementia respite and day services. (p54) | **Emma Hanson**<br>Commissioning Manager Families and Social Care Kent County Council and NHS Kent and Medway | Develop an options appraisal/business case where appropriate regarding specific properties that balance the social value of community asset transfer for schemes against the capital strategy. Options appraisal to be presented to Older People's Project Executive | **Aug 2012** |
| **R3** | That KCC seeks to work with Dementia UK and relevant health organisations including GP practices in Kent to explore ways of widening access to the Admiral Nursing Service in Kent so that more people with dementia and their carers have access to a named, specialist contact. (p57) | **Sue Gratton**<br>Deputy Associate Director, Integrated Commissioning NHS Kent and Medway | The role and function of the Admiral Nurses is being reviewed within the development of the Primary Care Dementia Pathway, see recommendation 1<br><br>There is a countywide Admiral Nurse Steering Group overseeing practice developments, including a pilot in the Maidstone loacility where Admiral Nurses are linked to GP surgeries. | **April 2013** |



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## THEME: SUPPORTING EARLY DIAGNOSIS BY RAISING AWARENESS AND REDUCING STIGMA

| | Recommendation Description | Lead Person & Responsible Agency | Action | By when |
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| **R4** | That, to improve the rates of early diagnosis of dementia in Kent, KCC:<br><br>Works with colleagues in Public Health, the Voluntary Sector, community and faith groups to raise awareness (and dispel appropriate dementia screening tool in the NHS Health Checks programme in Kent (and adherence to relevant NICE guidance. | **Sue Gratton**<br>Deputy Associate Director, Integrated Commissioning NHS Kent and Medway | A key aim of The Kent and Medway Dementia Integrated Plan is to improve current diagnosis rates. NHS commissioners are working with The Kent & Medway Partnership Trust (KMPT) to review the role and function of the current memory assessment services to ensure they are as efficient and effective as possible. Work is underway to develop a differentiated model of assessment with less complex assessments being completed in primary care as part of the Primary Care Dementia Pathway. | **April 2013** |
| **R5** | That to ensure young people have a good understanding of dementia, KCC:-<br>▪ Ensures libraries in Kent have books which explain dementia to children of different ages and encourages schools to do so.<br>▪ Seeks to fund a youth project to create a DVD, raising awareness about dementia and encouraging inter-generational support, which could be shown in Kent schools. (p82) | **Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway<br>**Lydia Jackson**<br>Project Officer<br>Families and Social Care<br>Kent County Council | These actions are included as part of the current Kent County Council Social Innovations Lab Kent (SILK) Dementia Co-Production project.<br><br>Swale Young Carers Project is working with co-production project team at SILK to develop a DVD and booklet to explain dementia to children.<br><br>Additional resources have been allocated to Kent Libraries to ensure a good stock of books is available, including reminiscence aids which can be loaned to providers | **Nov 2012**<br><br>**April 2012** |



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| THEME: SUPPORTING CARERS AND CARING RELATIONSHIPS | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R6** | That KCC acknowledges and highlights the perspective of carers (and former carers) for people with dementia in a '9 steps for dementia carers' for inclusion in the next Kent Carers' Annual Report. | **Michael Thomas-Sam**<br>Interim Strategic Business Adviser<br>Families and Social Care<br>Kent County Council | To consult with the Carers Advisory and Carers Reference Group on the "9 steps for dementia carers".<br><br>Depending on the consultation feedback the nine steps will then be reflected in the next Kent Carers Annual Report which is due to published in Summer 2012. | **April 2012**<br><br>**July 2012** |
| **R7** | That KCC encourages the commissioning of a variety of early intervention measures in order to reduce avoidable, inappropriate and expensive hospital admissions for people with dementia, to improve quality of life and outcomes for a greater number of people with dementia and carers and that commissioning should include:-<br>Implementation of a pilot Shared Lives scheme for people with dementia, in co-operation with PSSRU Kent, which develops the current Adult Placement Scheme and explores whether the management of personal budgets by voluntary sector service providers could help to provide more person centred respite, for example, for people in rural areas using the Shared Lives Model.<br><br>Independent Dementia Advocacy Services for people with dementia in East Kent. | **Mark Lobban**<br>Director of Strategic Commissioning<br>Families and Social Care<br>Kent County Council<br><br>**Jane Barnes**<br>(Shared Lives Lead)<br>Head of Adult Service<br>Maidstone and Malling<br>Families and Social Care<br>Kent County Council<br><br>**Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council<br>NHS Kent and Medway | An Adult Social Care Transformation Blueprint is currently being developed in partnership with stakeholders. The blueprint will be presented to Cabinet Members Meeting on April 16th 2012. Central to the transformation programme is the development of more proactive services, including targeted prevention designed promote independence and reduce costly and unnecessary crisis situations.<br><br>A review of the Kent Adult Placement Scheme is underway, one of the aims of the review is to ensure that the scheme develops to meet the needs of people with dementia and their carers; a working group has been established to oversee this. Consideration currently is being given to developing a research project to look at Adult Placement Scheme/Shared Lives model for dementia. Kent has agreed in principle to be part of research project for a period of up to 2 years.<br><br>Review existing arrangements for the provision of Independent Dementia Advocacy, currently only available in West Kent. Create Business case and secure funding to ensure Independent Dementia Advocacy is consistently available across Kent. | **April 2012**<br><br>**April 2012**<br><br>**Sept 2012** |



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| THEME: SUPPORTING CARERS AND CARING RELATIONSHIPS | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R8** | That KCC seeks to promote greater awareness of Lasting Powers of Attorney (LPA) and considers whether a service could be offered by KCC Legal Services in this regard and that KCC supports the work of the British Banking Association to improve training for staff on LPA in order to minimise stress experienced by carers for people with dementia in organising finances. (p97) | **Michael Thomas-Sam**<br>Interim Strategic Business Adviser<br>Families and Social Care<br>Kent County Council | To liaise with KCC Legal Services and explore opportunities for raising awareness of Lasting Power of Attorney (LPA) with the public and professionals.<br><br>To consult with KCC Legal Services on the establishment of ongoing and refresher LPA training for KCC and Health staff and also potential service development of specialist legal services for people with dementia. | **April 2012** |
| **R9** | That KCC works with Kent Police and relevant health organisations to ensure there is proactive support for and appropriate responses to carers who may be experiencing domestic violence as a result of dementia-related aggression in a loved one. (p99) | **Michael Thomas-Sam**<br>Interim Strategic Business Adviser<br>Families and Social Care<br>Kent County Council | Following discussion with the KCC Community Safety Manager, a meeting has been arranged with Kent Police on how this recommendation can be taken forward. This is also an agenda item for discussion at the Kent and Medway Domestic Abuse Strategy Group in May 2012 and will also inform the next KCC Select Committee on Domestic Abuse. Following on from this the intention is to look at ways of increasing awareness and training delivery of key staff and partner agencies. | **Sept 2012** |
| **R10** | That KCC extends the successful Telecare pilot work by evaluating how different types of assistive technology can support people with dementia to live safely and securely at home and in particular to assist with 'safer walking'. (p104) | **Hazel Price**<br>Project Manager – Tele Technology<br>Families and Social Care<br>Kent County Council | FSC are currently in the process of procuring of range of new technologies to support the independence and positive risk management for people living with dementia. The impact and outcomes for using these new technologies will be evaluated.<br>. | **Nov 2012** |



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| THEME: INFORMATION AND SIGNPOSTING | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R11** | That KCC ensures that people living with dementia and their carers have access to good quality, well maintained information on local services and support in Kent and in their local area and that:<br>▪ Printable, district level information is made available through links on DementiaWeb.<br>▪ KCC works with relevant health organisations and partners in the voluntary sector to ensure that this standard information 'set' is known to/made available through local authority offices, Gateways, Citizens Advice Bureaux, dementia and carer support organisations and in particular GP surgeries.<br>▪ As well as signposting to local groups offering dementia support DementiaWeb provides information about Adult Education opportunities and details of the Health Referral Scheme (50% discount on courses), and Library services for people with dementia.<br>▪ There is a consistent approach to the provision of information and signposting by KCC in response to enquiries regarding people with dementia who are self funded, ensuring that all enquirers are made aware of DementiaWeb and the local information guides. (p111) | **Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway<br><br>**Lydia Jackson**<br>Project Officer<br>Families and Social Care<br>Kent County Council | The information requirements of people with dementia and their carers has been a key theme of the current KCC Dementia Co-Production Project. We are working with people with dementia and their families and carers to improve our advice, information and guidance strategy.<br><br>We are review and evaluate DementiaWeb and the Kent 24 hr Dementia Helpline. Including how they are publicised to ensure maximum take-up. Ensure that fact sheets are available and downloadable from the site.<br><br>Working with Kent Gateways and Kent Libraries to ensure they are able to signpost people to DementiaWeb and the 24hr Helpline. Develop bespoke training for both services to ensure they are dementia aware.<br><br>Ensure that DementiaWeb contains links to Adult Education Classes and support offered by Kent Libraries.<br><br>Contribute to development of Adult Social Care Commissioning Strategy (2013 – 2016) for Advocacy, Information, Advice and Guidance Services; too ensure the needs of people with dementia and their carers are fully met. | **Aug 2012**<br><br>**Aug 2012**<br><br>**Aug 2012**<br><br>**July 2012** |



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| | Recommendation Description | Lead Person & Responsible Agency | Action | By when |
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| **R12** | That KCC and Health Commissioners should ensure that every Kent district or borough has at least one memory cafe as well as peer support for people with dementia.<br><br>That KCC should promote the grass roots development of a network of memory cafes and peer support by engaging local groups such as Rotary, U3A, Older Person's forums, Carer Support Groups and Neighbourhood Watch; encouraging them to apply for funding through Members' Community Grants. (p115) | **Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway | KCC is currently in the process of awarding grants to ensure that there is a Peer Support Group and a Dementia Café in every local authority district throughout Kent.<br><br>Once the grant agreements have been awarded a county best practice group will be established to help providers develop services and maximise impact. | **April 2012** |



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| THEME: DEMENTIA CARE PATHWAY – FUTURE STRATEGY FOR KENT | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R13** | That in establishing and developing the 'core offer' of services and support for people with dementia and their carers, KCC and NHS Dementia Service Commissioners build on existing links with the academic sector (particularly the Dementia Services Development Centre at Canterbury Christ Church University and PSSRU at the University of Kent) to maximise research opportunities and ensure that the development of the dementia care pathway in Kent is informed by evidence and best practice. (p120) | **Mark Lobban**<br>Director of Strategic Commissioning<br>Families and Social Care<br>Kent County Council<br><br>**Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway<br><br>**Sue Gratton**<br>Deputy Associate Director,<br>Integrated Commissioning<br>NHS Kent and Medway | The development of consistent core offer including preventative and universal services will be key feature of commissioning strategy to support implementation of Kent and Medway Integrated Plan and the Kent County Council Adult Service Transformation Programme.<br><br>We recognise that across Kent there is variation in services we are developing standard offer in consultation with people living with dementia and their carers as part of our Co-Production Project. Understanding what services are most valued by users and why and ensuring they are universally available and strategically aligned to promote independence well-being and choice and prevent wherever possible crisis situation occurring. | **April 2013** |



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| THEME: DEMENTIA CARE PATHWAY – FUTURE STRATEGY FOR KENT | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R14** | That, given the high proportion of undiagnosed dementia in Kent, '2nd level' training in dementia should be compulsory for all KCC assessment and enablement workers and basic dementia awareness training should be strongly encouraged for other KCC staff engaged in dementia support work and a requirement for an appropriate level of dementia training should be reflected in contractual arrangements with providers. (p121) | **Sharon Buckingham**<br>Head of Adult Learning Resource Team<br>Business Strategy and Support<br>Kent County Council<br><br>**Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway | A business case is being prepared to secure funds in order to deliver 2nd level or more advance skills in working with people with dementia and their carers for all adult service frontline workers.<br><br>Dementia specific training and competency requirements will be a key feature of all new service specifications. Mark Lobban Director of Strategic Commissioning has issued guidance to all commissioning staff to ensure this happens. | **May 2012**<br><br>**On-going** |
| **R15** | That KCC (through the Health and Wellbeing Board, where appropriate):<br>▪ Encourages GP practices to invite voluntary sector dementia support organisations to protected learning sessions to raise awareness among clinical and non-clinical staff about dementia and the local support available for people with memory problems.<br>▪ Focuses on maximising KCC's role in the training and development of the social care workforce to ensure the safety and quality of care for people living with dementia are given the highest priority.<br>▪ Encourages the commissioning of joint education and training for health and social care professionals including General Practitioners, on dementia to support | **Sue Gratton**<br>Deputy Associate Director,<br>Integrated Commissioning<br>NHS Kent and Medway<br><br>**Sharon Buckingham**<br>Head of Adult Learning Resource Team<br>Business Strategy and Support<br>Kent County Council | Dementia has been selected as an area for priority consideration by the Health and Well Being Board. Development of Dementia Service in Kent will be an agenda item as the March 2012 Board. The Dementia Select Committee Recommendations and Action Plan will be included in the papers presented to the board.<br><br>KCC has invested in a significant programme of highly quality dementia specific training for all operational staff; and has continued to offer dementia training to the private and voluntary sector. Going forward consideration will be give to the benefits of developing a joint education and training strategy across Health and Social Care. To cover all elements recommended by select committee. | **March 2012**<br><br>**Sept 2012** |



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| | integrated working in the future.<br>▪ Encourages greater awareness among hospital staff in Kent about when to engage with liaison nurses to minimise admissions, reduce lengths of stay, ensure dignified care and speed up discharges to appropriate locations for people with dementia in order to minimise distress and contribute to cost savings.<br>▪ Encourages relevant health organisations, including GP practises and partners in the voluntary sector to identify opportunities for pooled health and social care funding of community based care co-ordinators (see recommendation2) and that personalised multi-agency care plans can be readily accessed by professionals providing care and support to people with dementia at home and during transitions of care.<br><br>▪ Identifies as a matter of urgency the approximate current spend on dementia by all agencies and models the change in spend between providers as diagnosis rates improve. This will provide a benchmark for the development of services and a context for assessing the value both in cost and quality of provision of pooled budgets and preventative services (p128/9). | **Anne Tidmarsh**<br>Director of Older People's and Physical Disability Provision<br>Families and Social Care<br>Kent County Council<br><br>**Anne Tidmarsh**<br>Director of Older People's and Physical Disability Provision<br>Families and Social Care<br>Kent County Council<br><br>**Sue Gratton**<br>Deputy Associate Director, Integrated Commissioning<br>NHS Kent and Medway | The reduction in inappropriate non elective or emergency care is a central aim of the Kent and Medway Dementia Integrated Plan. Opportunities for joint working and commissioning will be fully investigated through Transformation Programme and Health and Socail Care Integration Programme (HASCIP). Tis will include developing flexible models of support that operate 24/7 and are focussed on crisis prevention, admission avoidance and discharge facilitation.<br><br>Kent County Council does not categorise service users according to their medical conditions, therefore it is difficult to accurately calculate the cost of dementia care A percentage estimates has been applied to all budgets lines – which clearly shows that the majority of KCC spend on dementia is with the care home sector.<br><br>Further work is needed to calculate the NHS spend on dementia, due to the low formal diagnosis rates and the lack of use of codes which would identify people with dementia using NHS services it is difficult to say with accuracy the actual current cost of services used by people with dementia in Kent. Though it is known that most NHS spend is on bed based inpatient care.<br><br>KCC and the NHS is currently exploring the option of purchasing a whole systems modelling tool, or developing local shared information tool which will help to identify when funds are currently allocated, the priorities for service development and identify which service areas will have the most impact in managing the predicted increase in the number of people with dementia. | **April 2013**<br><br>**Nov 2012**<br><br>**Nov 2012** |



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| THEME: DEMENTIA CARE PATHWAY – FUTURE STRATEGY FOR KENT | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R16** | That KCC considers whether a separate Kent & Medway Strategy for Younger Onset Dementia is required to ensure that the needs of this group are met and that any future dementia strategy or plan:<br>• takes account of the particular circumstances experienced by a younger age group and the development of appropriate services and support based on evidence and best practice.<br>• includes an assessment of the likely impact of increased numbers of people with learning disabilities having dementia in the future.<br>▪ is proactive in mapping where support and services will be needed. (p130) | **Sue Gratton**<br>Deputy Associate Director,<br>Integrated Commissioning<br>NHS Kent and Medway<br><br>**Anne Tidmarsh**<br>Director of Older People's and Physical Disability Provision<br>Families and Social Care<br>Kent County Council<br><br>**Emma Hanson**<br>Commissioning Manager<br>Families and Social Care<br>Kent County Council and NHS Kent and Medway | Dementia Integrated Plan Board to discuss the need for a Kent & Medway Strategy for Younger Onset Dementia. To complete a needs analysis, including service mapping for younger adults with Dementia.<br><br>Promote the use of personal budgets to meet the needs of younger adults with dementia.<br><br>Encourage younger adults to attend dementia Peer Support groups and consider setting up younger onset group.<br><br>Monitor impact of new assessment pathway to ensure the timely and effective assessment of people with a Learning Disability who go on to develop dementia symptoms. A multi disciplinary group has been set up to performance manage the new pathway. Two sucessful learning events have been held and there is a programme of training for KCC staff and providers. | **March 2012**<br><br>**Nov 2012**<br><br>**On-going**<br><br>**Aug 2012**<br><br>**Nov 2012** |



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| THEME: DEMENTIA CARE PATHWAY – FUTURE STRATEGY FOR KENT | | | | |
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| | **Recommendation Description** | **Lead Person & Responsible Agency** | **Action** | **By when** |
| **R17** | That Hospital staff in Kent should be made aware of the need to engage with liaison nurses to minimise admissions, reduce lengths of stay, ensure dignified care and speed up discharge to appropriate locations for people with dementia in order to minimise distress and contribute to cost savings. (p124) | **Sue Gratton**<br>Deputy Associate Director, Integrated Commissioning<br>NHS Kent and Medway | Liaison psychiatry services have a key role in helping to support acute hospital staff in the management of people with dementia. This service is already in place in East Kent and is being implemented in Medway and plans are being developed to implement this service in West Kent.<br><br>Monitor new national CQUIN (Commissioning for Quality and Innovation) being introduced across all acute and community providers in Kent and Medway to screen all people over the age of 75 years for dementia with a view to increasing diagnosis rates.<br><br>All Acute Hospital Trust in Kent now have Dementia Strategy Implementation Groups, which have developed action plans and are tasked with improving the experience of people living with Dementia whilst using acute services. Commissioners to monitor progress of plans and share best practice across Kent. | **Nov 2012**<br><br>**April 2013**<br><br>**April 2013** |



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| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br><br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **THE TREATMENT OF JOINTLY-OWNED PROPERTY IN THE RESIDENTIAL CHARGING ASSESSMENT** |
| Classification: | Unrestricted |


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| Summary:<br><br>FOR COMMENT | A decision is needed to provide clarification to decision 10/01553 taken on 18 January 2011. Decision 10/01553 allowed for a change to the treatment of jointly-owned property in the residential charging assessment. That decision applied only to new service users (ie from 6 June 2011), the rationale being that people previously told their property was being disregarded because it was jointly-owned, could not then be told it was being taken into account. People who had their property disregarded for other reasons (which no longer apply) do not fall into this category but the wording of decision 10/01553 prevents us taking their property into account if they entered residential care before 6 June 2011. A further decision should rectify this problem. |


**Introduction**

1. (1) Until decision 10/01553 was taken it had been the custom and practice for several years to ignore a resident's share of any jointly-owned property as capital for the purposes of assessing their contribution to the cost of residential care. This was because previous legal advice had been that a part share often had very little, if any, value.

(2) Following extensive research and in consultation with Legal Services, it was decided to adopt a tougher and more nuanced approach to this issue (see section 2 (4) below for details). It was also decided that, although a formal decision had never been made to ignore these properties, any change to practice had to involve a decision by the then SMT and the relevant Cabinet Member.

(3) As recommended to him, the Cabinet Member's decision was that the new policy should only apply to new service users. However, since the decision was implemented, operational staff have reported a problem that needs addressing, hence this request for a new decision.

**Policy Context**

2. (1) **The National Assistance Act 1948** is the primary Act of Parliament governing residential placements. The main relevant sections for this issue are:

**Section 21 (1)** – this imposes a duty to provide or arrange accommodation for people aged 18 or above who "by reason of age, illness, disability or any other circumstance are in need of care and attention which is not otherwise available to them".

**Section 21 (2A)** – this states that in determining whether care and attention are "otherwise available" the local authority shall disregard "so much of the person's resources as may be specified (ie the capital threshold, currently £23,250).

**Section 22 –** this enables the local authority to charge for most residential placements arranged by the local authority.

(2) **The National Assistance (Assessment of Resources) Regulations 1992** contains the detailed rules governing how a person's contribution to their charge is worked out. Detailed guidance on the application of these regulations is laid out in the Charging for Residential Accommodation Guide (CRAG) which is issued by the Department of Health and updated every April.

(3) The above legislation allows for people who have in excess of the upper capital limit (currently £23,250) to either be advised that they must make their own arrangements for residential care or be charged the full cost if the placement is arranged by the local authority.

(4) On 18 January 2011 the Cabinet Member for Adult Social Care and Public Health took a decision (10/01553) to change the way KCC treats jointly-owned property in the residential charging assessment. This decision was to have been implemented from 4 April 2011, but due to a high level complaint this was delayed until 6 June 2011 to give time for a further legal review. In the event the decision was implemented in the way it had been originally planned.

(5) The above decision stated that for new service users the following will apply:

- A resident's interest in any jointly-owned property will be taken into account in the charging assessment for permanent residential care.

- The starting point for valuing this interest will be to calculate the resident's percentage share of the market value of the whole property.

- If the above valuation is disputed by the resident (or their representative) then the case will be referred for an expert valuation to determine the value of the resident's share taking into account all relevant factors.

**Further decision required**

3. (1) A further decision is needed to provided clarification to decision 10/01553 taken on 18 January 2011. This decision allowed for a change in the treatment of jointly-owned property in the residential charging assessment for new service users (i.e. new residents who approach KCC for assistance after 4 April 2011, although only implemented from 6 June 2011).

(2) The reasoning behind restricting the policy to new residents was that if someone had been told explicitly that their property was going to be disregarded because it was jointly-owned, it would not be right to tell them at a later stage that it was going to be

taken into account. The resident and their relatives may have made important decisions based on the earlier decision.

(3) Since the decision was implemented it has been reported by operational staff that the decision, as currently worded, prevents them taking the former home into account for a specific group of people that would otherwise have their property taken into account. These are people who entered residential care before 6 June 2011 but whose property was disregarded, not because it was jointly-owned, but because it was subject to one of the mandatory disregards. That is, it was still occupied by certain persons including the resident's spouse or partner. See Appendix 1 for the full list of mandatory disregards. In normal circumstances if the person still occupying the property dies then the property does start to be taken into account (ie in the assessment in the future).

(4) The most common scenario is when the resident's spouse dies leaving the property empty. In most cases when this happens the deceased partner's share passes automatically to the surviving spouse because the property is held as "Joint Tenants". However in some cases the property is held as "Tenants in Common" and the deceased partner has willed their share to someone other than their partner, for example their son or daughter. If this happens the resident only owns a part share of the property. If they only became a resident who approached KCC for assistance after 6 June 2011 KCC is able to take their share into account, subject to the rules (as per decision 10/01553). However, even if the change of circumstances occurred after 6 June 2011, if the resident entered residential care funded by KCC before 6 June 2011, then the wording of decision 10/01553 means the property has to continue to be disregarded. People in this situation were not told that their property was being disregarded because it was jointly-owned but because their spouse/partner still lived in it. Thus, they would expect it to be taken into account if that person died.

(5) The problem identified above would be solved if the Cabinet Member made the following decision: regardless of when they entered residential care, if a mandatory disregard of a resident's property ceases to have effect after the date of the Cabinet Member's decision (i.e. the new decision) then (subject to the normal rules) that property can be taken into account, including if it is jointly-owned, according to the principles set out in decision 10/01553.

(6) It is not clear how many people will be affected by this situation. Most couples do not hold their property as tenants in common and even if they do, if the resident only enters residential care after 6 June 2011 they will be covered by decision 10/01553. However there are significant numbers of people who entered residential care before 6 June 2011 and whose former home is currently disregarded because their spouse/partner still lives in it. If they were to change the nature of their ownership to tenants in common their property may continue to be ignored even where their spouse/partner to die.

**Financial Implications**

4. (1) The impact on the Council's budget can only be positive if the proposals are implemented. However it is not possible to put any figure to this as the information needed to predict this is not available. We do not know how many residents are currently subject to a mandatory disregard on their property and, of these, how many hold this property as Tenants in Common.

**Legal Implications**

5. (1) Legal Advice from KCC Legal Services is that recommendations should be made to change the policy as suggested in this report.

(2) Advice from Democratic Services is that a new decision is needed and that any new policy on this will only apply from the date of that decision. They advised against trying to revisit the original decision so that the clarification could be applied retrospectively.

**Equality Impact Assessment**

6. (1) A full Customer Impact Assessment was carried out on the original decision (10/01553). This is in the process of being updated to include the potential impact of the further decision proposed in this report. However, as stated in point 3 (1) above, we do not know the number of people this may potentially affect. It can only affect people who became residents funded by KCC before 6 June 201, as those who entered residential care after this date are already covered by decision 10/01553. Furthermore, of the former category, it will only affect those who own their property as Tenants in Common as others will already be covered.

(2) It could be argued that the proposal will make the treatment of all residents with a property more equitable as the table below attempts to demonstrate.

| **Issue** | **Property solely owned** | **Property jointly owned** |
|---|---|---|
| | | |
| Client in permanent residential care after 6 June 2011 and former home is still occupied by spouse, partner etc | Property is ignored | Property is ignored |
| As above but then spouse/partner dies leaving the property empty | Property taken into account based on 100% ownership | Property taken into account based on % share owned by client (as decision 10/01553 covers these residents) |
| Client starts in permanent residential care pre 6 June 2011 and former home is still occupied by spouse, partner etc | Property is ignored | Property is ignored |

| | | |
|---|---|---|
| As above but then spouse/partner dies leaving the property empty | Property taken into account based on 100% ownership | We cannot currently take into account the resident's share as the policy decision (no. 10/01553) states that the new procedure (i.e. where jointly-owned property is taken into account) "will apply only to new service users". If a new decision is made, residents in this situation can have their share of the property taken into account, but only if this circumstance arises after the date of the decision (i.e. the new decision). |

(3) If the above proposal in section 3 (5) is agreed, the only residents that will not be covered are as follows:

- Those who entered residential care (funded by KCC) before 6 June 2011, were subject to a mandatory disregard (e.g their spouse lived in the property) and they lost this mandatory disregard between 6 June 2011 and the date of the new decision.

**Recommendations**

7. (1) The Adult Social Care and Public Health Policy Overview and Scrutiny Committee is asked to COMMENT on the proposed policy change as outlined in section 3 (5) above

**Lead Officer/Contact**:
Chris Grosskopf, Business Strategy
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E-mail: chris.grosskopf@kent.gov.uk

*Background documents:* The Treatment of Jointly-owned Property in the Residential Charging Assessment (Decision number: 10/01553).

**Appendix 1**

**Mandatory Property Disregards for Residential Care Financial Assessment**

Where the resident no longer occupies a dwelling as his home, its value should still be disregarded where it is occupied in whole or in part by:

- the resident's partner, former partner or civil partner (except where the resident is estranged or divorced from the partner, former partner or civil partner)

- a lone parent who is the claimant's estranged or divorced partner

- a relative of the resident or member of the residents family who
  - is aged 60 or over, or
  - is a child of the resident aged under 18, or
  - is incapacitated.

| | |
|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **TEMPORARY FINANCIAL ASSISTANCE FOR RESIDENTIAL CARE** |
| Classification: | Unrestricted |


| | |
|---|---|
| Summary:<br><br>FOR COMMENT | The report is seeking a change to the rule whereby residents are only eligible for Temporary Financial Assistance (TFA) from KCC (providing they do not qualify for Deferred Payments) if their liquid capital has decreased to £3,000. It is recommended that this rule be substituted by one which states that a resident will only be eligible for TFA once their liquid capital and income can only support their care costs for twelve weeks. |


**Introduction**

1. (1) Kent County Council currently operates a Temporary Financial Assistance scheme for Residential Care for people who have capital over the capital limit (currently £23,250) but whose liquid capital has reduced to £3,000. This is normally because their other capital is tied up in their former home. There are currently 145 people being provided with assistance via this scheme, with 81 of those coming onto the scheme since April 2011.

(2) When the scheme was initially set up (several years ago) £3,000 would usually last long enough for KCC to make the necessary arrangements and take over the contract with the care home. This is no longer the case, although this will depend on the resident's weekly income.

**Policy Context**

2. (1) **The National Assistance Act 1948** is the primary Act of Parliament governing residential placements. The main relevant sections for this issue are:

**Section 21 (1)** – this imposes a duty to provide or arrange accommodation for people aged 18 or above who "by reason of age, illness, disability or any other circumstance are in need of care and attention which is not otherwise available to them".
**Section 21 (2A)** – this states that in determining whether care and attention are "otherwise available" the local authority shall disregard "so much of the person's resources as may be specified (i.e. the capital threshold, currently £23,250).
**Section 22 –** this enables the local authority to charge for most residential placements arranged by the local authority.

(2) **The National Assistance (Assessment of Resources) Regulations 1992** contains the detailed rules governing how a person's contribution to their charge is worked out. Detailed guidance on the application of these regulations is laid out in the Charging for Residential Accommodation Guide (CRAG) which is issued by the Department of Health and updated every April.

The above legislation allows for people who have in excess of the upper capital limit (currently £23,250) to be charged the full cost if the placement is arranged by the local authority.

(3) **The Health and Social Care Act 2001** (sections 53 - 55) gave local authorities the power to enter into a Deferred Payment arrangement with a resident whereby the value of their main home is disregarded from the financial assessment on a temporary basis, either because they don't want to sell it or cannot sell it quickly enough. However local authorities are allowed to develop their own criteria for these schemes and do not have to offer the arrangement to all residents who do not have access to the capital tied up in their house. In Kent the eligibility criteria for Deferred Payments is as follows:

- There must be no outstanding mortgage or loan already secured on the property.
- The cost of the residential/nursing home must be no more than our current guidelines for Deferred Payments
- The resident must not have more than £23,250 in capital (e.g. savings), other than the value of their home.
- The resident must either not wish to sell their home or not be able to sell it quickly enough.
- The resident must solely own their former home
- The former home must have sufficient equity in it to fund the required care. We expect there to be enough equity to fund a minimum of 5 years in a residential home and a minimum of 3 years in a nursing home.

(4) Currently if a resident with over the capital threshold (but who has no immediate access to this capital) does not qualify for Deferred Payments, they will have to find the funds from some other source and can only expect KCC to help financially once their liquid assets have reduced to £3,000. Once this point has been reached (or is likely to be reached soon) they can apply for Temporary Financial Assistance (TFA) pending the sale of their property. This is a discretionary scheme, although it is arguable that we could not leave a person totally unable to fund the cost of residential care because of our obligations under section 21(1) of the National Assistance Act (see point 2 (1) above).

(5) The decision by KCC to offer, on a discretionary basis, temporary funding for people unable to access funds (usually because they are tied up in property) is directly compatible with Kent's Bold Step to "tackle disadvantage".

**Policy change required**

3. (1) As indicated above, in line with the legislative framework, and in order to protect vulnerable individuals in residential care, Kent operates a Temporary Financial Assistance scheme. This scheme has recently been reviewed and put on a firmer legal footing, with a proper application process and legal agreement.

(2) A decision is sought on just one aspect of the scheme, that is, the level a person's liquid capital must have reduced to in order for them to qualify for assistance. This is currently £3,000 and is felt to be too low, particularly for people whose weekly income is low. For such people there may not be enough time for KCC to process the necessary agreement and to take over the contract with the home. This is even more likely now that we have introduced a formal application process and new legal agreement concerning the legal charge that needs to be arranged over the resident's former home.

(3) The issue can be illustrated with an example: if an individual is in a care home costing £500 per week and they are only able to contribute £120 per week from their weekly income, £3000 savings will only last about 7 weeks. If the home costs £800 per week the same capital will only last about 4 weeks. Clearly if an individual has a higher weekly income, the £3,000 will last for longer.

(4) In view of the fact that weekly income and costs of care homes vary so much, it is recommended that individuals be offered Temporary Financial Assistance when their liquid capital can fund a certain number of weeks care rather then basing the decision on the actual amount of liquid capital they possess. This position is supported by Finance colleagues in the Assessment Teams and by the Finance Management Group.

(5) Consultation with Finance colleagues has led to the conclusion that the policy be changed to state that Temporary Financial Assistance can be applied for when an individual/their representative can demonstrate that they only possess sufficient liquid capital and income to fund their own care for 12 weeks. It must be stressed that this is only one of the criteria necessary for TFA to be granted. Others include the agreement to having a legal charge placed on the former home. If this is jointly –owned, all co-owners must agree to this charge, although the accruing debt will only ever be repaid from the resident's portion.

**Financial Implications**

4. (1) There are currently 145 people being provided with assistance via the Temporary Financial Assistance scheme according to a report run by Finance on 11 January 2012. Of the 145, 81 entered the scheme since April 2011.

(2) It is not possible to predict accurately the financial implications of the proposed change to the policy. The Finance Management Group believes it will provide a longer period to arrange for a charge to be placed on the resident's property before KCC begins funding. This is a good thing as it ensures our debt is secure. The recently revised legal agreement and process for TFA also helps to ensure this.

(3) Basing eligibility for TFA on the number of weeks a person can self-fund, will mean that people in high cost areas approach KCC for assistance earlier than those in lower cost areas.

**Equality Impact Assessment**

5. (1) The proposed policy can only benefit individuals as it allows them to approach KCC for assistance at a point that gives KCC sufficient time to make the necessary arrangements for funding their care (albeit on a temporary basis).

(2) In view of point 1 above, a full Equality Impact Assessment was not deemed to be necessary.

**Recommendations**

6. (1) The Adult Social Care and Public Health Policy Overview and Scrutiny Committee is asked to COMMENT on the policy change as outlined in section 3 (5) above.

**Lead Officer/Contact**:
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*Background documents:* None

| | |
|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **THE TREATMENT OF SECOND HOMES AND PROPERTY OTHER THAN A PERSON'S MAIN HOME IN THE NON-RESIDENTIAL CHARGING POLICY** |
| Classification: | Unrestricted |


| | |
|---|---|
| Summary:<br>FOR COMMENT | This report is seeking a change to an aspect of the charging policy for home care and other non-residential services concerning which assets are to be treated as capital. The current policy states that the value of a "second home" or property elsewhere will be disregarded as a capital asset. This report recommends that the policy be changed so that such properties are taken into account as capital assets in future. |


**Policy Context**

1. (1) Unlike residential charging, local authorities are able to design their own policies on non-residential charging, providing they comply with the statutory guidance on this issue.

(2) The statutory guidance governing charging for non-residential services is:

- Fairer charging policies for home care and other non-residential social services: guidance for Councils with Social Services Responsibilities (September 2003)
  AND
- Fairer Contributions Guidance - Calculating an Individual's Contribution to their Personal Budget (November 2010)

(3) The following is taken from the 2003 guidance: " The value of the main residence occupied by the user should not be taken into account for charges for non-residential social services, *but other forms of capital may be taken into account,* as set out in *CRAG*." (paragraph 59). CRAG refers to the 'Charging for Residential Accommodation Guide' published annually by the Department of Health. This contains the Residential Charging rules which stipulate that properties other than the main home can be taken into account. With regard to the valuation of these additional properties, CRAG states that where there will be actual expenses involved in selling an asset, 10% of the value should be deducted. Any debt secured on the property should also be deducted.

(4) The 2010 guidance does not alter this position. It states, " Following the needs assessment and calculation of how much the personal budget might be (the indicative amount), the council will undertake an assessment of the person's financial

circumstances in accordance with the guidance on Fairer Charging Policies for Home Care and other non-residential Social Services (the Fairer Charging Guidance) issued in 2003." (from introduction).

**Policy change required**

2. (1) The current KCC policy on charging for domiciliary and other non-residential care states that the value of a "second home" or property elsewhere will be disregarded as a capital asset. It further states that any rental income should be taken into account.

(2) A survey of other local authorities in 2011 revealed that of the 22 that responded, all, except one, do take such properties into account as capital assets. There is general consensus that we should change our policy and take these properties into account in line with nearly all other local authorities and in line with legislation affecting welfare benefits.

(3) It is recommended that the policy be changed so that any additional properties (other than a person's main home) are taken into account as capital assets. It is further recommended that such properties are valued in the same way KCC currently values properties for residential charging purposes, in particular that 10% be deducted for the expenses of sale and, if the property is jointly-owned, it is valued according to the current jointly-owned property policy for residential charging.

(4) It is further recommended that people affected by this proposal, but who cannot immediately access the equity in their properties, can be eligible for Temporary Financial Assistance from KCC provided they fulfil the other criteria (including agreeing to a legal charge being put on the property in question).

**Financial Implications**

3. (1) Exact figures are not available, but it is believed (from information provided by Finance) that the proposed policy change will only affect a handful of people as the overwhelming majority of service users living in the community do not own additional properties.

(2) A change in the policy will save the ongoing costs associated with those people that become full cost as a result of the change (precise numbers are not available). It will also remove a mechanism for people to put any capital they own into a disregarded location (e.g. if they hold £100,000 in stocks and shares it is taken into account as capital but, currently, if they convert it into property it is ignored).

**Recommendations**

4. (1) The Adult Social Care and Public Health Policy Overview and Scrutiny Committee is asked to COMMENT on the proposed change.

**Lead Officer/Contact**:
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*Background documents:* None

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Meradin Peachey, Director of Pubic Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012

Subject: **Public Health Performance**

Classification: Unrestricted

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Summary: This report provides an update of Public Health performance, particularly on the two programmes highlighted specifically in the NHS Operating framework (Health Checks and Stop smoking Services)

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**Introduction**

Part of the NHS reforms is the move of Public Health to the local upper tier Local Authority, and the move to the Local Authority of a ring fenced budget for health improvement.

In July 2011, the full Kent County Council approved the Memorandum of Understanding between the County and NHS Eastern and Coastal Kent and West Kent Primary Care Trusts for a change in leadership for Public Health and Health Improvement to the County. The MOU also highlighted the health improvement budget of some £17m, which, subject to national confirmation, is likely to move to KCC in April 2013.

**Performance of Health Improvement Programmes**

The NHS Operating Framework for 2012/13 was recently published. The Framework emphasized two particular elements (NHS Health Checks and Stop Smoking) of commissioning health improvement which are reported on as a priority here

1. **NHS Health Checks**

Eastern and Coastal Kent has a target of 26,655 health checks to be offered by Q4, with a rising trajectory plotted across the 4 quarters of the year. To date for Q3, currently 11,302 checks had been offered by end of December 2011

West Kent has a target of 24,575 health checks to be offered by Q4, again with a rising trajectory plotted across the 4 quarters of the year. With the limited resource and timelines it has been agreed that KCHT will deliver 10,000 invites. Delivery is being monitored weekly and over 4,500 had been delivered by the end of February.

The big issue with these programmes has been the lack of funding; both PCTs are significantly increasing funding for the year 2012/12 (£2.2m).

## 2. Stop Smoking Services

Both East and West Kent Stop Smoking Services achieved Q1 targets. Q2 targets were submitted to the Department of Health on the 9th December 2011.

Both services submitted returns showing they are on track to attain the annual targets (West Kent 4220 quitters and East Kent 5197 quitters)

Eastern and Coastal Kent Stop Smoking Service

| Cumulative quits | Q1 (Apr - Jun) | Q2 (Jul-Sept) | Q3 (Oct-Dec) | Q4 (Jan-Mar) |
|---|---|---|---|---|
| Plan | 1,245 | 2,397 | 3,495 | 5,197 |
| Quits Achieved | 1,285 | 2,545 | 3,788 | 4,384 |

West Kent Stop Smoking Service

| Cumulative quits | Q1 (Apr - Jun) | Q2 (Jul-Sept) | Q3 (Oct-Dec) | Q4 (Jan-Mar) |
|---|---|---|---|---|
| Plan | 844 | 1,688 | 2,743 | 4,220 |
| Quits Achieved | 946 | 1720 | 2,596 | 2,670 |

**Note** Q4 is not closed until early June, thus figures for Q4 appear to be low.
Both Eastern and Coastal Kent and West Kent services are performing relatively well when benchmarked with other Stop Smoking services across the Southeast SHA area

## 3. Other Health Improvement programmes

Performance of these programmes is attached.

**Recommendation:-**

4. Members are asked to note the performance report of Public Health.

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Background Information: *Nil*

## Public Health Monthly Performance Update – MARCH 2012

| Target | WK Headline | | EK Headline | Actions |
|---|---|---|---|---|
| **Sexual Health GUM** – 48 hour access target | Performance for patients **offered and seen** by local and outside providers achieving 100% | | Performing at 94% | WK report – approaching acute trust direct for monthly data |
| **Sexual Health Chlamydia Screening – 2010/11 target 35% of cohort (screens carried out for 16-24 year olds)** | Target for Chlamydia screens and positivity rates will not be met. | | Target for chlamydia screens and positivity rates will not be met<br><br>Vacancy (22.5 hours) due to staff retirement | Technical problems with lab equipment. Contacting clients to arrange repeat screens.<br><br>Catchup programme agreed; focusing on high positivity |
| **Sexual health - teenage pregnancy** | ▪ TP post currently frozen.<br>▪ TP agenda being covered by Jill De Paolis in addition to other commissioning areas.<br>▪ Funding has been reduced. | | | Planning underway to let a new contract to deliver TP. |
| **Sexual health services general** | Plans to take HIV services out of general GU. Concerns raised by GU consultants with Peter Nieuwets (SECSCG Commissioning Manager) about patients accessing specialist services, and how much funding will remain within GU locally thereafter.<br><br>Faiza Khan met Peter Nieuwets on 04/11.2011 | | | Discussions ongoing re future funding streams |
| **Smoking Quitters**: | Current achievement to target: **EAST 75% WEST 60%**<br><br>Shortfall 2990<br>(East 1306<br>West 1684**)**<br><br>*NB: Q2 DH Return submitted 9.12.11* | | Projected overspend NRT (£175k) | Being closely monitored<br><br>Data is following last 2 years pattern and target should still be achieved in the West. Overall combined target is set to be achieved. |
| **Routine Childhood Imms and Vac** (including MMR coverage under 2 | Q1 11/12 (April – June) update published on HPA website on 23.09.11<br><br>Q2 data upload to HPA due 18.11.11<br><br>Q3 data upload to HPA | | Q1 11/12 (April – June) update published on HPA website on 23.09.11<br><br>Q2 data upload to HPA due 18.11.11<br><br>Q3 data upload to | Offered Band 5 post to support breastfeeding, Hep B and national routine childhood imms data.<br><br>PCT's target is 95%. |

| Target | WK Headline | | EK Headline | Actions |
|---|---|---|---|---|
| years)<br><br>Vital Sign is 95% for 2010/11 | 24.02.12 - West Kent achieved highest performer in SEC | | HPA 24.02.12 | GP practices only paid to achieve 90%. |
| **HPV uptake** 10/11 target – 90% uptake for all three doses for year 8 | Total Number in cohort 8: 4448<br><br>Annual coverage data submitted to HPA on 28.09.11 | | Total Number in cohort 8: 4627<br><br>Annual coverage data submitted to HPA on 28.09.11 | improving uptake in schools; streamlining reporting mechanisms |
| **Seasonal flu** Targets: reach or exceed 75% uptake for people aged 65 years and over; Reach of exceed uptake for people under age 65 with clinical conditions which put them more at risk from effects of flu, and pregnant women. | The planning process for 11/12 seasonal flu vaccination programme for both patients and healthcare workers across Kent and Medway will continue to be co-ordinated by the Kent HPA.<br><br>**Patient campaign to over 65+**<br>GP Practices to report uptake of patients 65+ and in the at risk groups on:<br>09.11.11<br>09.12.11<br>11.01.12, and<br>14.02.12<br><br>**Frontline health and social care workers vaccination programme**<br>PCT to report uptake of frontline health & social care workers to DH on:<br>09.11.11<br>09.12.11<br>13.01.12<br>09.02.12 | | | |
| **West Kent Local Authority Healthy Weight Programmes** | 6 Local Authorities (Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge & Malling, and Tunbridge Wells) are commissioned to deliver a healthy weight SLA. This has 3 elements: family weight programme, Adult Weight Management, Change4Life (Healthy Passport Club). It is expected that 60% of the local authority's allocation support programmes under the SLA. | | | |
| **Breast Feeding** 6-8 week continuation VSB1_05 trajector BSB11_ 05 actual: % of babies totally or partially breastfed at 6-8 weeks | East Kent achieved the coverage target, having failed in the previous quarter.<br><br>West Kent failed the target in both quarters.<br><br>Eastern Coastal Kent improved their achievement of the coverage target (95%), over the previous quarter. West Kent failed the target in both quarters, but the percentage remains the same. Achievement of this target is related to primary care completion of the breastfeeding question at the 6-8 week check and this being received and recorded by the CHRD who submit the numbers for the target. In both Q2 and Q3 Kent has not achieved the target for full or partial breastfeeding uptake | | | Post offered for Band 5 to support breastfeeding, Hep B and national routine childhood imms data |

| Target | WK Headline | | EK Headline | Actions |
|---|---|---|---|---|
| VSB11_06 trajectory; VSH11_06 actual: % of records in primary care that indicate breastfeeding status at 6-8 weeks has been recorded | (45.5%). Prevalence in West Kent is 6.6% higher than Eastern Coastal Kent. | | | |
| **Healthy Weight –** measurement of children in years R and 6<br><br>Local stretch target is 90% coverage | KCHT has exceeded the national target and stretch target regarding numbers of children in years R and 6 being weighed and measured. | | | |
| **Health Checks** NHS Vital Sign | Total eligible population: 223,406<br><br>Annual number of offers at full rollout: 44,681<br><br>2011/12 total number of checks to be offered: 24,575 | | Total eligible population: 242,318<br><br>Annual number of offers at full rollout: 48,463<br><br>2011/12 total number of checks to be offered: 26,655 | SHA agreed SHA to use 29.8% for exclusions for our population rather than 26.2%. IE: target for health checks invitations next year is 21,450 rather than 24,575 |
| **Health Trainers** | | | | |
| **WK Local Authority Health and Wellbeing Programmes** | | | | |

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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Meradin Peachey – Corporate Director for Public Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee - 30 March 2012

Subject: **WINTER INTERVENTION SUPPORT KENT (WISK)**

Classification: Unrestricted

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## 1. Introduction

The Warm Homes Healthy People (WHHP) initiative was announced with the publication of the Cold Weather Plan (CWP) for England published on 1st November 2011. A total of £20 million was available across England to be used to reduce the levels of deaths and morbidity that are due to vulnerable people living in cold housing during the winter. Only local authorities could bid for the fund which was made available for the financial year 2011/ 2012. A successful bid for £429,660 was submitted by Kent County Council in partnership with Age UK and the Home Improvement Agencies (HIAs). The criteria stated that programmes should be delivered in partnership with community and voluntary agencies. The Department of Health also stated that the money needed to be used this winter. Both the bid submission and programme delivery were subject to short timescales. There was less than two weeks to develop the bid and around nine weeks to deliver the programme. This resulted in limitations in the types of interventions that can be proposed and delivered.

Age UK aim to increase the range of life-enhancing services and vital support available to people in later life. There are 28 Age UK organisations across Kent. Each one functions independently.

The function of Home Improvement Agencies is to assist vulnerable homeowners and private sector tenants, particularly older people, to repair, improve, maintain or adapt their homes. There are three organisations delivering the Home Improvement Agency function in Kent. The function is delivered by Canterbury City Council and Swale Borough Council for their respective areas and by In Touch Support for the other 10 districts across Kent.

Aims and objectives

The aim of the programme is to reduce the levels of mortality and morbidity in Kent in vulnerable people aged over 75 with an underlying cardiac or respiratory condition who have the potential to be affected by cold temperatures due to living in cold housing.

A number of objectives were undertaken to achieve the aim. These included;

- Developing of a targeted list of those at highest risk is a priority
- Age UK and the Home Improvement Agencies undertaking home visits with those identified on the list to offer support around improving
- Providing training to domiciliary care organisations
- Establishing a winter warmth support fund to offer emergency support to people receiving a home visit

This report is an overview of the project which will be in operation until March 30th 2012. A detailed final report that will include evaluation measures and recommendations will be produced in April 2012 and presented at the Shadow Health and Wellbeing Board.

## 2. Relevant priority outcomes

The Kent Public Health Annual report last year featured excess winter deaths. Mortality data analysed over an eight year period highlighted that there were more winter deaths in comparison to the rest of the year in all 12 local authority districts in Kent. http://www.kmpho.nhs.uk/reports-and-strategies/annual-public-health-report/

Reducing excess winter deaths is a Kent priority and is included in the Joint Strategic Needs Assessment, which recommends that 'It is important to recognise how agencies can work together to identify those at greatest risk of morbidity and mortality due to cold weather' and that 'There should be work with the voluntary and community sector to explore how they can deliver interventions to those at risk'.

In January 2012, the Department of Health published the Public Health Outcomes Framework. Local authorities, in partnership with health and wellbeing boards, will be required to demonstrate improvements in public health outcomes against indicators that reflect local health needs set out in the Joint Strategic Needs Assessment. One indicator included in the published framework is the reduction of excess winter deaths.

## 3. Financial Implications

The programme was fully funded by the Department of Health following a successful bid application for £429,660 for the Warm Homes Healthy People fund. Monitoring of the programme shows that there will be an underspend, although the amount will not be known until the completion of the programme at the end of March.

## 4. Legal Implications

A major barrier to the project was the lack of time in developing an effective proposal and in delivering the programmes.

The programme needed to be as simplistic as possible to plan and deliver effectively given the challenging timescales. A single tender process was utilised with the Age UK and Home Improvement Agency organisations in Kent. Advice was sought from the Chair of the Kent Health and Affordable Warmth Partnership and the Joint Planning Manager of the Kent Joint Policy and Planning Board (Housing). They recommended that Age UK and the Home Improvement Agencies working in partnership with Kent County Council would be the agencies most able to deliver the specified winter intervention support programme to vulnerable older people across the county in the very challenging timescale. The Director of Public Health approved this process and signed documentation outlining the procurement procedure.

A Service Level Agreement was completed for each of the providers outlining the project delivery requirements and payment schedules. The service level agreements were co-signed by the Director of Public Health and a senior representative from each provider.

All people receiving a home visit completed a Kent County Council consent tool. It explained brief details about the project and asked people for permission via their signature for their data to be shared with other partners involved with the project.

**5. Main body and purpose of report**

The targeted lists were developed using databases of Age UK and the Home Improvement Agencies. The aim was to develop a series of list for each district council area in Kent. The criteria was for those over 75 years old that have either a underlying heart or lung condition and live in private owned or private rented accommodation.

A range of interventions were offered to those on the register. Age UK offered support via their Information and Advice Officer who undertook home visits to assess what support people need and raised awareness raising on the risks of living in a cold environment (including the distribution of Age UK 'Winter wrapped up Booklet'). They also assessed if individuals needed provision from the winter warmth support fund, directed people to other agencies (when appropriate) and identified trip hazards and installed equipment such as grab rails to reduce the risk of falls.

Age UK provided to training across the county to domiciliary care workers around increasing their awareness of the health risks associated with cold temperatures and how and were to sign post people to who could benefit from further support. Domiciliary care organisations were contacted requesting their attendance. Their contact details were obtained from the Kent County Council database for domiciliary care providers. The organisation was remunerated at a rate of £22 per person attending. Training participants completed evaluation sheets. The results will be included in the overall project evaluation report.

The Home Improvement Agencies used case workers to undertake home visits and referred to the handyperson to perform home repairs if required. Case workers also offered energy efficiency measures, draught reduction measures, benefit support checks, energy tariff checks, loft insulation level checks, loft clearance to enable insulation, provision of smoke detectors and provision of emergency salt matting to reduce the risk of falls.

A winter warmth support fund was made available for each district in Kent. An amount of £10,000 per district was made available. This was used by Age UK and the Home Improvement Agencies for people identified during home visits. The fund was used to provide emergency warmth for people and included the provision of clothing, energy efficient heaters, CO monitors, blankets and draught reduction measures. The fund was also used for emergency repairs relating to ensuring the home is warm.

An evaluation sheet was designed and given to those who received a home visit. It included information on living environment, attitudes and behaviour, health and social related issues and economic wellbeing. Full details of the evaluation outcomes will be included in the final project report.

Steering group

A steering group has been in operation throughout the duration of the operation of the programme. It met on a fortnightly basis and was chaired by a public health specialist and attended by all provider leads.

What worked well

- The Home Improvement Agencies have delivered the project in all areas and undertook home visits to support those vulnerable to living in a cold living environment. Some of the measures given such as home repairs and benefit advice will have long-term effects and last beyond this winter.
- There has been positive feedback in general from domiciliary care workers attending training and there has been an increase in referrals to Age UK from care organisations since they have been on the training. Further details will be included in the final project report.
- In areas where the local Age UK organisation has embraced the project, there have been a number of people identified and been given support.

Challenges associated with the programme delivery

The extent of the challenges associated with the programme will be fully known after the delivery is complete and the evaluation has been undertaken. A number of challenges have been highlighted via the project monitoring. These include;

- The biggest challenge for the programme was the lack of time to plan and implement the programme.

The Department of Health stated in mid-November that the Warm Homes Healthy People fund would be available to bid for, with successful notification given in mid-December and the money being transferred to Kent County Council at the end of January. This only allowed for around nine weeks of programme delivery.

- A very mild winter has resulted in the level of need being relatively low. For example, it has not been necessary for Age UK to arrange for the delivery of hot meals or to utilise support offered by care worker visits (grocery shopping, transportation to medical appointments).
- Generating lists from Age UK and HIA databases was more resource intensive than initially thought. Many people who were contacted not wanting to go on list because they did not feel that needed support around increasing the temperature of their living environment.
- There has been a lack of capability for certain Age UK organisations to deliver the programme. This was despite support and assurance given from all Age UK organisations in Kent at the start of the project. This will be one of the key reasons for the programme underspend. The programme is still being delivered so the full extent of the underspend is not yet known.
- It has not been possible to use optimal data sources (ie disease registers) to identify people on the district lists due to the time it would take to satisfy information governance arrangements.
- There were inconsistencies in the uptake of domiciliary care workers attending training in different localities. There may have been an excess over provision of training sessions provision. Further details will be provided in the final project report.

## 6. Consultation and Communication

A press release was compiled and this resulted in media communication relating to the programme. This has included an interview with one of the Age UK chief officers on BBC Radio Kent and a television interview with Meridian Television with an Age UK chief officer.

The final project report will be taken to the Shadow Health and Wellbeing Board.

## 7. Risk and Business Continuity Management

The programme underspend highlights a risk because it demonstrates that delivery has not been optimal. The full extent of the underspend will not be known until the completion of the programme at the end of March 2012. A request was made to the Department of Health to keep the underspend to utilise as a receipt in advance to implement a planned programme for next winter taking account of what has been learned this year. This has been agreed by the Department of Health on condition that the money is used during the next financial year to target vulnerable at risk of poor health due to living in a cold living environment.

## 8. Sustainability Implications

There project addressed sustainability implications in that Home Improvement Agencies were providing advice and support on how individuals could make their home more energy efficient. It included measures such as energy efficiency advice, draught reduction measures, benefit support checks, energy tariff checks, loft insulation level checks, loft clearance to enable insulation. The evaluation questionnaire assessed a range of measures around living environment and behaviours/attitudes. The data obtained from the programme evaluation will be of groups such as the Kent Health and Affordable Warmth Group and the Kent Energy Partnership.

Further information outlining the details of sustainable measures undertaken will be included in the final project report.

## 9. Conclusion and recommendation

- This report gives an overview of the Winter Intervention Support Kent (WISK) programme. It is not possible at this stage to give detailed evaluation as the programme is still in operation.
- A presentation and detailed evaluation report will be made to the Shadow Health and Wellbeing Board outlining recommendations and business case for the feasibility of a programme that could be in place for next winter.
- Cabinet Members are asked to note the report.

# Checklist

| | |
|---|---|
| .Author Name: Colin Thompson | Unit: Kent Public Health Department |
| Contact details:<br>NHS Kent and Medway<br>Brook House<br>John Wilson Business Park<br>Whitstable<br>CT5 3DD | Email: colin.thompson@eastcoast.nhs.uk<br>Tel: 01227 791271 |
| Background Documents | *List them here* |
| Previous Council/Cabinet/Committee references | NO<br>Name:<br>Date: |
| Does the report propose a key decision is taken? | NO |
| If yes, is the decision in the Forward Plan? | YES/NO |
| Will further decisions be required? If so, please outline the timetable here | NO |
| Is this report proposing an amendment to the budget and/or policy framework? | NO |
| Have the financial implications (including any capital spend implications) been cleared by the Director of Finance? | N/A<br>Name:<br>Date: |
| Has the report been cleared by the relevant Managing Director? | YES/NO<br>Name: Meradin Peachey<br>Date:15.3.12 |
| Has the relevant Cabinet Member been consulted? | YES<br>Name: Graham Gibbons<br>Date: 15.3.12 |
| Has the relevant Local Member been consulted? | N/A<br>Name:<br>Date: |
| Has the relevant Policy Overview & Scrutiny Committee been consulted? | N/A – this report will be presented to the Policy Overview & Scrutiny Committee<br>Committee:<br>Date: |
| Has the report been cleared by Legal Services? | NO<br>Name:<br>Date: |
| Has the matter been cleared in accordance with the Council's procurement rules (in 'Spending the Council's Money)? | NO |
| Have any communications issues been cleared by Communications and Media Centre? | N/A<br>Name:<br>Date: |
| Has a Customer Impact Assessment been carried out in relation to this report? | NO |
| Are there any community safety implications? | NO |
| Are there any environmental implications? | NO |
| Are there any health & safety implications? | NO |
| Are there any personnel implications? | NO |
| Are there any human rights implications? | NO |

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Meradin Peachey, Director of Pubic Health

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012

Subject: **Public Health Transition**

Classification: Unrestricted

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Summary: This report provides an update on Public Health transition to Kent County Council.

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**Introduction**

Part of the NHS reforms is the move of Public Health to the local upper tier Local Authority. In January 2012 PCT Clusters were required to submit an outline Public Health transition plan to the Strategic Health Authority and in mid-March a more detailed plan in a specified format. Key lines of enquiry include the following:

1. **Ensuring a robust transfer of systems and services**
2. **Delivering PH responsibilities during transition and preparing for 2013/14**
3. **Workforce**
4. **Governance**
5. **Enabling infrastructure**
6. **Communication and engagement**
7. **Health and Wellbeing Board**
8. **HealthWatch**
9. **Risk register**

**Transition Plans**

The following provides an overview on the extent and depth of the transition plan which includes not only the detailed pieces of work required to move the Public Health staff to KCC, but also the ongoing delivery of the Public Health programmes through transition.

Rather than provide detailed plans, a summary of key lines of enquiry are included as follows:

**KCC developing a vision for Public Health to underpin use of resources and new structure**

- What do you want public to see?
- Briefings sessions for members are discussion forums

- Picture of current use of commissioning resources for cabinet and programme budget board

**JSNA and Health and Well-Being Strategy**

- JSNA and Health and Well-Being strategy responsibility of KCC using Health and Well-Being Board form April 12.

**Commissioning arrangements to be in place by April 13**

- Needs assessments, quality reviews, equity audits to be continued by public health during 2012
- Details of contract lengths, costs, performance, national and clinical requirements shared with cabinet March 2012
- Workshop seminar on sexual health services for members and officers June 2012
- 4 mandated services , NHS health checks, NCMP, sexual health services, smoking quitting services to be included in KCC monthly performance monitoring
- Monthly performance reports on all public health services to be given to cabinet member monthly
- Public health services to be subject to KCC service review process possibly YP sexual health services during 2012 to be commissioned alongside youth services
- cabinet member to determine whether PCT commissioning support services to be used or develop team in house within Public Health
- legal services to advise on novation of contracts

**Joint responsibilities with National Commissioning Board and Public Health England (HIGHEST RISK)**

- Develop agreement on the provision of screening and immunisations services and management of health protection issues with the existing Kent Health Protection Unit. These will be the commissioning responsibility of NCB and PHE to commission with quality monitoring by LA team.

**Core Offer to GPs**

- This has already been agreed with the current CCGs in liaison with cabinet member. This is a public health service to be provided to GPs.
- This will need to be revised by April 13

**Workforce**

- Restructure consultation by July 2012.
- Involvement of staff the unions early
- Joint leadership KCC and NHS HR.
- Appoint to consultant vacancy ASAP, cabinet member appointment

**Estates**

- Current public health staff on 4 sites, 3 NHS and some at sessions house
- Expand the number of spaces at sessions house
- Negotiate for some staff to be based with CCGs, District Councils or local KCC offices

**Management of Transition**

- KCC project manager to be identified
- Andrew Ireland to chair transition Board, include HR, estates, legal services, finance, service improvement, communications
- PCT PH Transition programme underway

**Finance**

- PCT Director of Finance to review budgets and share with KCC finance lead.
- KCC finance develop PID
- Response to DH on allocations suggesting revision

**Recommendation:-**

4. Members are asked to note the key elements of the Public Health transition plan

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Background Information: *Nil*

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|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health |
| | Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **HEALTH AND SOCIAL CARE INTEGRATION PROGRAMME – INTEGRATING ADULT COMMUNITY HEALTH AND SOCIAL CARE PROVISION** |
| Classification: | Unrestricted |


| | |
|---|---|
| Summary: | A report on the programme of work to deliver the integration of adult community health and social care provision across Kent. |
| Recommendation: | Members are asked to note the progress being made to integrate the provision of adult community health and social care in Kent. |


## Introduction

1. (1) This report is about the programme of work to deliver the integration of adult community health and social care provision across Kent, with a focus on creating new integrated community health and social care teams.

(2) The programme will deliver the following benefits to Kent citizens:

- Deliver better co-ordination of care, particularly for disabled and older people with complex health and social care needs
- Provide better experiences and improved outcomes for individuals and their families
- Enable people to have more choice and control through underpinning integrated services by a personalisation ethos
- Deliver efficiencies by improving productivity and managing costs

## Relevant priority outcomes

2. (1) The integration of social care with community health services will support the ambition in “Bold Steps for Kent”, which explicitly states that “We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided.”.

(2) This also directly supports the Bold Steps Delivery Framework priorities “Support the transformation of health and social care in Kent” and “Improve services for the most vulnerable people in Kent.”

(3) The Leader of the Council's recent submission (December 2011) of the interim "Kent Health Commission" report to the Secretary of State for Health also recommended the integration of health and social care provision, citing Dover as an exemplar area in which to start this work.

(4) The integration of health and social care provision is an integral component of the Families and Social Care – Adults Transformation Programme 2012–15, which has recently been supported by Cabinet as a mechanism to deliver efficiency savings.

**Financial Implications**

3. (1) Any financial savings achieved through creating more efficient health and social care services will need to be appropriately aligned to the respective organisation, and for KCC this would form part of the savings target allocated to Families and Social Care.

(2) In the longer term, Kent like all other parts of the UK, is facing a demographic pressure of increasing numbers of older people and people living with multiple long term conditions. If services are going to be sustainable in the future, then KCC needs to work in a smarter way with community health service providers to meet the ever growing needs of residents, particularly those with long term conditions.

**Legal Implications**

4. (1) There are a number of legal implications that accompany this proposal. Support is already in place from Business Strategy and Support – HR, Governance and Law, Business Strategy, ICT and Property and Infrastructure divisions.

(2) Implications and consequences include:

(a) A formal partnership arrangement needs to be established in the first phase of the programme, with the Kent Community Health NHS Trust. A solicitor has been appointed to support this work. The form of the partnership agreement is still to be determined.

(b) Information Governance and Data Protection. This will be supported via the Kent and Medway Information Sharing Agreement and reinforced through the partnership agreement. It has been identified by information governance specialists that a more robust information sharing agreement is required to support the work of practitioners and work is in hand to develop this.

(c) Human Resources. In the first phase of the programme HR has supported the introduction of a new 6 month long pilot post in Thanet and Dover (since 2.2.12) – Integrated Community Services Director / Head of Service. KCC has an arrangement with the Kent Community Health NHS Trust for KCC to host this joint management post. The post holder has responsibility for older people and physical disability

services for adult social care and for intermediate care and long term condition NHS services.

HR is also supporting the establishment of jointly agreed HR principles. The involvement of recognised trade unions is already underway.

(d) Policy and operational procedures. There will be a number of policy changes required to support improved co-ordination of care by staff co-located in integrated health and social care teams.

(e) Shared use of KCC and NHS property and IT infrastructure to support integrated, co-located teams.

**Staffing Implications**

5. (1) These recommendations will impact on a significant number of staff as the programme is rolled out across the County. The total staffing cohort across the County, who may be impacted, is outlined below:

- Kent Contact and Assessment staff - 32
- Kent Enablement at Home – 303
- Locality Staff (Assessment & Enablement and Co-ordination staff) – 687
- Operational Support – approx 37, subject to restructure which started in February 2012.

(2) The implications for staff at this time are a possible change in office base and to be working as part of an integrated health and social care team. Changes to management structures for integrated teams are inevitable.

(3) Depending on the nature of any organisational integration in the future (or not), there may be further implications for other KCC staff who provide other business support functions to FSC e.g. HR, finance, policy, performance.

**Main body and purpose of report**

6. (1) A paper was submitted to the Corporate Management Team (CMT) on the 10 January 2012 which asked for decisions to be made on the following:

(a) To agree the strategic direction to integrate adult community health and social care provision.

(b) To note and discuss the implications for the Council and for directorates other than Families and Social Care.

(2) CMT agreed the recommendation to support the integration programme and also of the potential impact to other directorates, most notably Customer and Communities, who currently host the Kent Contact and Assessment Service (see below).

(3) A paper was presented to Families and Social Care Directorate Management Team (FSC DMT) on 21 December 2011 which asked for decisions to be made on the following recommendations:

(a) to agree the strategic direction to integrate community health and social care services for older people and physical disability services.

(b) to agree a proposed operational framework and for "Model A" to be tested out in Dover, Swale and Maidstone/Malling during 2012.

(c) to agree that these three areas would be viewed as the first phase of a significant transformation programme, rather than as pilots.

(4) DMT supported all the recommendations. Rather than repeating the detail of the programme information in this report, a copy of the DMT paper and the proposed Operational Framework can be found in Appendices 1 and 2.

(5) Members of the Policy Overview and Scrutiny Committee are also asked to note that the operational model A was also agreed by the Kent Community Health NHS Trust Board on 24 November 2011.

(6) Some Clinical Commissioning Groups (CCGs) have expressed interest in developing alternative integrated team structures and KCC and health providers are working at a local level with those CCGs to explore options.

(7) There are a number of implications for the council as a whole and for other directorates. These include:

(a) An immediate and direct impact for the Customer and Communities directorate, where the Kent Contact and Assessment Service (KCAS) is hosted. The implication of the preferred model is that the functions currently delivered by KCAS would be realigned so that there is (a) an enhanced information, advice and guidance response by Contact Kent, supported by a shift to better online public access and (b) the more specialist element of the service would be provided in an integrated way in partnership with community health services via a number of "Single Points of Access", jointly commissioned by KCC and the Clinical Commissioning Groups.

(b) Clinical Commissioning Groups (CCGs) have all stated their intention to jointly commission integrated health and social care teams. There is a need for FSC Strategic Commissioning to work closely with CCGs to jointly commission local health and social care services.

(c) Supporting the strategic direction to become a commissioning organisation: There are future opportunities for social care case management services to be provided by organisations other than KCC, for example, social enterprises. This could result in the creation of quality, integrated care organisations. The Right to Challenge process may assist with this.

(d) If, in time, front line social care staff do move out of the direct employment of the council, there is an assumption that operational support, performance, HR, policy and finance functions would also need to be reviewed as part of this.

**Consultation and Communication**

7. (1) Stakeholder engagement activity is detailed in section 4 of the DMT report in Appendix 1.

(2) The Kent Local Involvement Network (LINk) has held places on the programme board since the start of the programme and there has been engagement with the public through some of their meetings.

(3) There have been regular briefings and discussions with the Leader of the Council, Cabinet and Local Members.

(4) Health commissioners (PCT and CCG members) and providers have been actively involved in shaping the proposal.

(5) Engagement events have been held with KCC and health service staff. Managers from Customer and Communities have been involved with the programme for several months now, particularly in relation to the development of Single Points of Access.

(6) There is a Communication and Engagement group which has responsibility for overseeing and co-ordinating the delivery of related activity. There is a detailed Communication and Engagement plan. Staff from the Communications and Engagement division are working in partnership with NHS colleagues to deliver the plan.

(7) KCC's statutory 'Duty to Involve, Consult and Inform' has been considered and one of the Consultation Officers is working with the Kent Community Health NHS Trust in this respect. There is agreement that further public consultation activity will take place early in 2012 to:

- Build knowledge of what the programme is and how it will change individuals' experience of service provision.
- Highlight that the programme has been designed in response to previous feedback from services users about how services need to improve / change.
- Give service users and all stakeholders the opportunity to express opinions on the programme.

**Risk and Business Continuity Management**

8. (1) There are strategic risks with not undertaking the programme. There is a risk that if health and social care commissioners and providers do not work together to deliver integrated services, our health and social care system will remain fragmented, with people falling between gaps in service. People will continue to be

admitted to expensive acute hospital care, where this could be avoided through the provision of more appropriate, cost-effective community health and social care services.

(2) With the establishment of the Single Points of Access (SPAs), there are operational risks associated with the realignment of KCAS resources and with the telephone call handling system. This can be mitigated by phasing the development of the SPAs by managing the alignment of staff and through the introduction of appropriate technological solutions.

(3) All of this work needs to be done within a strong integrated commissioning framework.

**Sustainability Implications**

9. (1) The proposal particularly supports social justice through the development of services for people with diverse needs and improvements to personal well-being. It also supports a sustainable economy, through making efficient use of resources.

**Recommendation**

10. (1) Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE the work being taken forward to integrate adult community health and social care provision across Kent in order to deliver better co-ordinated services that will meet the needs of the most vulnerable people in Kent.

*Background Documents:*

- FSC Directorate Management Team paper 21 December 2011(see Appendix 1)
- Locality Based Integrated Health and Social Care Service: An Operational Framework (September 2011). (See Appendix 2)
- Bold Steps for Kent, KCC, 2010
- Equity and Excellence: Liberating the NHS – White Paper, HMSO, 2010

Lead Officer:
James Lampert
Efficiency Team Manager, FSC
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Appendix 1

By: Anne Tidmarsh, Director of Older People and Physical Disability

To: FSC Directorate Management Team – 21 December 2011

Subject: **HEALTH AND SOCIAL CARE INTEGRATION PROGRAMME**

Classification: Unrestricted

Summary: The purpose of this document is to update DMT on the Health and Social Care Integration programme's progress and to ask for confirmation of the strategic direction.

FOR DECISION

## 1. Background

1.1 "Integration" can mean different things to different people. For the purpose of this report, integration is defined as the assimilation of organisations and/or services into single entities, allowing for greater transparency between partners as well as enhanced benefits for service users (particularly those with complex needs).[1]

1.2 The Health and Social Care Integration Programme (HASCIP) started up in December 2010 in response to a mandate from the Kent Adult Social Services Strategic Management Team. This mandate was given following discussion between KASS Directors and the PCT Cluster Chief Executive.

1.3 The scope of the programme includes OPPD services. Learning Disability and Mental Health (under 65s) are not within the scope of this phase of the programme.

1.4 The programme will deliver integrated adult community health and social care services for the residents of Kent. The benefits:

- Deliver better co-ordination of care
- Provide better experiences and improved outcomes for individuals and their families
- Enable people to have more choice and control through underpinning integrated services by a personalisation ethos
- Deliver efficiencies by improving productivity and managing costs

1.5 There are a number of drivers for this work to be done:

- It is the right thing to do. Co-ordination of care for people with complex needs and long-term illness is poor. Improved care co-ordination can have a significant effect on the quality of life of frail elderly people with multiple long term conditions. Highly integrated care systems that emphasise continuity and co-ordination of care are associated with better experience by the recipient.

[1] Integrated Care Network. Bringing the NHS and local government together. Integrated working: a guide. London: Integrated Care Network; 2004

- Policy drivers include the NHS White Paper "Equity and Excellence: Liberating the NHS" and the Government's Response to the Future Forum.
- Locally, "Bold Steps for Kent"[2] aspires to integrated health and social care provision with new kinds of providers entering the market.
- The Bold Steps Delivery Framework priority 2 is "Support the transformation of health and social care in Kent" and priority 15 is "Improve services for the most vulnerable people in Kent".
- Significant efficiency savings need to be delivered by health and social care organisations. The KCC Access and Assessment related savings attached to this programme for 2013/14 and 14/15 are £4m.
- The FSC – Adults Transformation Programme 2012-15

## 2 Policy context

2.1 The NHS White paper "Equity and Excellence: Liberating the NHS" identified:

- integration of health and social care could be enabled through the roll out of personal health budgets. PHBs will transform NHS culture and improve outcomes for individuals by putting people in control of their own health care choices.
- The key role for the Health and Wellbeing boards will enable the integration of health, social care and children's services, including safeguarding and across the wider local authority agenda.
- Local authorities will have a new responsibility to promote the integration of health and social care, public health and other local services and strategies.
- It is essential for patient outcomes that health and social care are better integrated at all levels of the system.
- Local authorities new functions will help unlock efficiencies across the NHS, social care and public health through stronger joint working.

2.2 Kent County Council's strategy "Bold Steps for Kent" describes a future picture of integrated health and social care provision for the county. The Kent Community Health NHS Trust (KCHT) has also shown its commitment to this aim.

2.3 The "Kent Health Commission" has recently been established by the Leader of the council. A paper, the "Kent Health Vision" will be presented to the Secretary of State for Health this month (December 2011), which will include key recommendations for what the current health reforms could and should mean in practice, using activity in Dover as an exemplar. This report will support KCC and NHS partners in a range of activities, including developing integrated services at a local level. After December, the second phase of work will test and develop recommendations.

2.4 Andrew Lansley, Secretary of State for Health, says in "The Government response to the NHS Future Forum report" (June 2011) that there is an overwhelming case for a new kind of health system where people's health and social care needs aren't treated separately and where local councils have a real say over decisions in the NHS.

[2] Bold Steps for Kent, p6. states "We will work with GP consortia to encourage new healthcare providers to enter the market for health services in Kent. This will drive up standards, provide competition, increase choice and drive greater value for money for GPs and patients. We will work to join up and integrate health and social care service provision to reduce costs and demand that could be avoided - for example, by joining our assessment processes."

2.5 The response also goes on to state that:

- Clinical Commissioning Groups will have a duty to promote integrated health and social care around the needs of service users. e.g. by extending personal health budgets and joint health and social care budgets, in light of the current pilots *(note, KCC and NHS Kent and Medway have started this work with the DH and are one of 18 pilot sites nationally. Integrated personal budgets will be piloted in Dover from February 2012).*
- The NHS Commissioning Board will promote innovative ways to integrate care for patients e.g. by encouraging CCGs to work closely with local authorities.
- The experience of care for too many patients is fragmented between different parts of the health service and between the NHS and social care or other services. There are huge opportunities to make services more integrated, building on the many examples of good practice that already exist.
- Health and Wellbeing Boards will have a stronger role in promoting joint commissioning and integrated provision; they can also be the vehicle for "lead commissioning" for particular services (where functions are delegated to them).

## 3 Evidence base for integration

3.1 There is a large body of evidence supporting the move to deliver integrated health and social care and also supports some successful approaches to follow.

3.2 A Kings Fund report (May 2011) "Transforming our healthcare system: ten priorities for commissioners"[3] supports the need for integrated community health and social care services. The 6th priority recommended is the creation of integrated health and social care teams which can deliver better care co-ordination, improve clinical and social care outcomes and deliver better experience of health and social care services. The Torbay model, which is based around alignment to GP practices supports people with complex needs well.

3.3 The results of the Torbay integration model included:

- Pooling of budgets helped created wider range of intermediate care services
- The appointment of health and social care co-ordinators improved care through harnessing the contribution of all team members
- reduced use of hospital beds
- low rates of emergency hospital admission for people aged over 65
- minimal delayed transfers of care
- reduced use of residential and nursing homes (although an increase in use of home care services)
- Increase in uptake of direct payments for social care

[3] Available at http://www.kingsfund.org.uk/publications/articles/transforming_our.html

3.4 Another Kings Fund paper which explores the Torbay model in depth makes a number of recommendations:

- Base any strategy on the benefits being sought for service users / patients. Specify them in advance and communicate them constantly.
- Use GP registration, not home address to allocate work to integrated teams
- Establish joint governance early
- Use the evidence base to overcome cultural, political, financial and organisational difference. They're not deal breakers.
- Engage middle managers and clinical leaders from the start. Develop non-silo management arrangements. Locate teams together.
- Tie in intermediate care and hospital discharge to the integrated system
- Make sure everyone understands what is meant by the term "integration"

3.5 "Where next for the NHS reforms: The case for integrated care" (Kings Fund, May, 2011) cites earlier research (Curry and Ham, 2010) which concluded that "significant benefits can arise from the integration of services, particularly when those are targeted at those client groups for whom care is currently poorly co-ordinated".

3.6 One British article (2010) from the International Journal of Integrated Care that attempts to capture some of the key themes from the literature on learning so far is entitled "Integrated team working: a literature review"[4]. Recommendations include the need to focus on the management of multi-professional teams, that considerable investment of resources are needed to implement successfully and that there is a need for clear standards for monitoring the success or failure of integrated teams.

3.7 Cornwall County Council and its partners have recently created integrated health and social care "hubs", incorporating an integrated single point of access and co-location of health and social care staff. As an example of early learning, recent performance activity reported a 25% reduction in numbers of referrals entering the system during the first three months, achieved through sharing the first point of access.

3.8 There is little available information to evidence savings associated with integrating health and social care – this is one of the areas of interest for the NHS Future Forum Integration work stream (due to report in December, not available at the time of writing). A recent report by the Audit Commission (December 2011) suggests that integrated working could offer efficiency savings and improve outcomes for people. It will be important to release savings where they are achieved and to have an agreement in place as to how they will be shared between KCC and the NHS.

## 4 Stakeholder engagement

4.1 Kent Local Involvement Network (LINk) has been engaged in this programme from early on and holds 2 seats on the programme board. They, with a number of other voluntary sector organisations, are also represented on the Communication and Engagement sub-group.

4.2 Two presentation and workshop events have been held, via the LINk, to seek views from members of the public. Kent people have said that services feel disjointed and inefficient because there are separate organisations with different systems, processes,

[4] Available at http://www.ijic.org/index.php/ijic/article/viewArticle/529/1042

agendas, budgets and targets. Furthermore, they said that there is a lack of joined up communication which impacts on continuity of care and can cause them delays in getting the right treatment or service.

4.3 Communication and Engagement officers (Customer and Communities) are supporting the programme by working with NHS partners to set up further public consultation activity.

4.4 Regular briefings and discussions have been held with the Leader of the Council, Cabinet Members and other Members.

4.5 The East Kent Commissioning Strategy Committee (sub group of the PCT board) have already agreed (22nd June 2011) the principle of the integration model for community teams described in the paper below – integrated health and social care teams based around GP practices. As a group, East Kent shadow Clinical Accountable Officers reconfirmed their support of the proposed operating model (see below) at a meeting on 29th September 2011 and for the model to be tested.

4.6 A paper was presented to the West Kent Commissioning Group on 18th October 2011. Implementation of integrated health and social care services in Maidstone and Malling was supported in order to inform future commissioning decisions.

4.7 Locality Steering Groups have been established for all 8 CCG areas now, in partnership with KCC and health providers, so that CCG members can influence the model and its delivery.

4.8 The strategic direction to integrate community health and social care was agreed at the Kent Community Health NHS Trust Board meeting on 24th November 2011. Furthermore, the board agreed to support the implementation on Model A in Dover/Deal, Swale and Maidstone/Malling as part of a first phase of rollout.

4.9 A discussion was held at the KMPT Older Persons Programme Board on 19th October. KMPT are doing an internal piece of work to explore the impact of integration and how their existing services may need to adapt to fit the proposed model and to meet the requirements of the future commissioning intentions for OPMH services.

4.10 A Communications and Engagement plan has been developed and related activities are taking place.

4.11 The programme has been a standing item at Joint Consultative Committee meetings for the past year and informal meetings with recognised trade unions have been established, supported by HR.

4.12 There is a real energy and excitement within health and social care organisations in Kent to deliver whole scale community health and social care integrated provision now, more so than there has ever been in the past.

## 5 Programme activity to date

5.1 A programme board was established in January 2011. Membership of this includes Kent LINk, KCC, Kent Community Health NHS Trust (KCHT), Kent and Medway NHS and Social Care Partnership Trust (KMPT) and NHS Kent and Medway.

5.2 There are governance arrangements in place with regard to the programme itself, commissioning decisions, and strategic and operational decisions that respective providers need to make. The governance structure is attached with this report.

5.3 Locality project steering groups have been established for all parts of Kent now, so that local dialogue between stakeholders can take place and plans can begin to be made where they are not part of the "phase 1" activity.

5.4 During the period December 2010 to September 2011, the programme was exploratory in nature and focused on options for whole system transformational change through the creation of integrated health and social care provision in Kent. One of the products of this work has been an operational model to be used as a framework to construct new integrated teams. This is attached as an appendix to this paper and summarised in section 6 below.

5.5 From September 2011 to October 2012, the programme is concerned with developing an implementation plan and testing out the operational model through whole systems changes in three "Phase 1" areas – Dover/Deal, Swale and Maidstone/Malling.

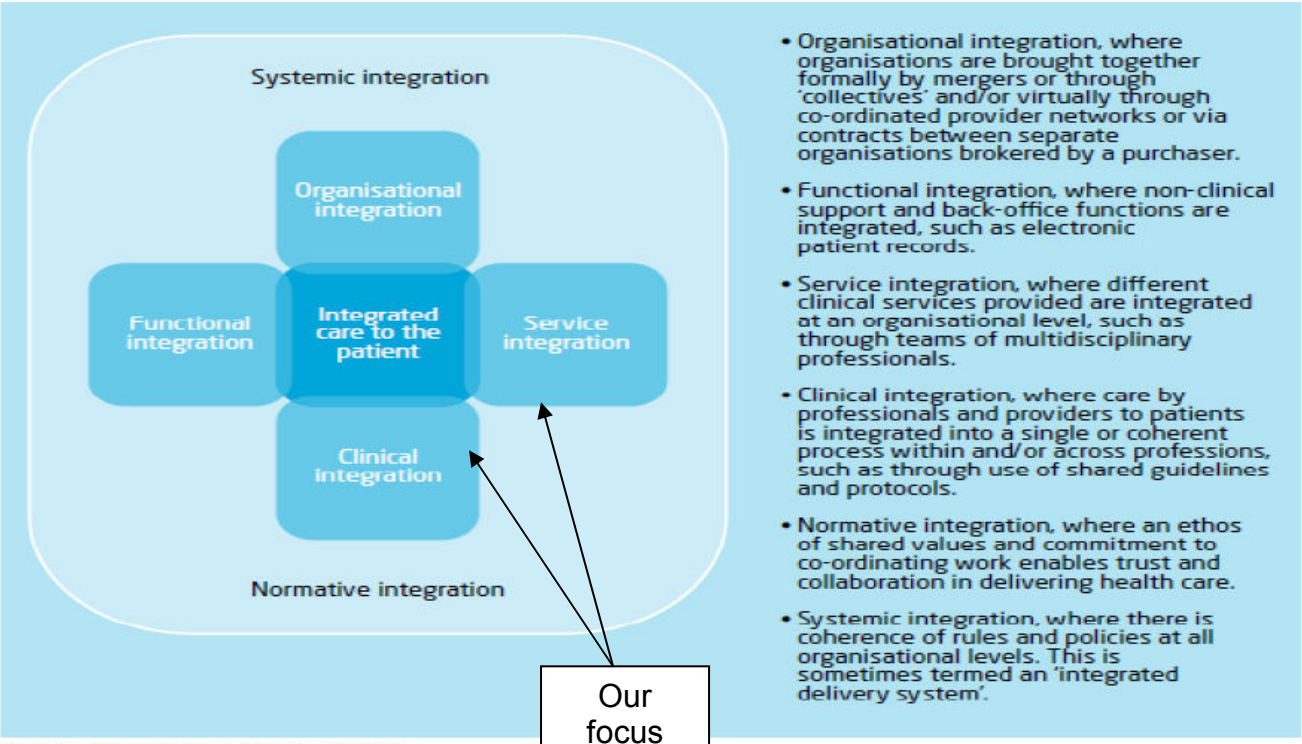
5.6 Milestone for Phase 1 sites are as follows:

- Dover/ Deal and Swale: end February 2012 – SPA established; April 2012 – integrated teams established
- Maidstone and Malling: April 2012 – SPA established; June 2012 – integrated teams established

5.7 The approach being adopted is to focus on delivering service integration (creating multidisciplinary teams) and clinical integration (establishing shared guidelines, processes, protocols). According to the Kings Fund/ Nuffield (2011), these two elements of the "integration recipe" alone could deliver a strong level of co-ordinated care. See figure 1 below.

5.8 A high level programme plan is available and has been included with this report. It details the content of each of the work streams / projects within the programme.

**Figure 1** Fulop's typologies of integrated care (from Lewis *et al* 2010)




Source: Adapted from Fulop *et al* (2005)

## 6 The Operational Model

6.1 Please refer to the "Operational Framework" document in the appendix for details of the models that have been proposed. Specifically, please refer to Model A, which can be found on page 15.

6.2 The model has been through a quality assurance process. It has been shared and discussed through face to face meetings with Sir John Oldham, the DH's national lead for Quality, Innovation, Productivity and Prevention (QIPP) and with Richard Humphries, Senior Fellow at the Kings Fund. Both supported the model, as developed, and agree that this could be a vehicle for delivering some of the challenges that health and social care faces. Sir John Oldham encouraged the mainstreaming of the model, rather than running it as a pilot, on the basis that there is sufficient evidence to demonstrate that integration delivers positive outcomes and supports the management of long term conditions.

6.3 Model A is seen, by most, as the model that bears closest resemblance to the current strategic fit for the current providers of health and social care, with an ambition to move in the longer term to Model B (or variation). This model could see the integration of services currently provided by adult social care (KCC), older people's mental health – dementia (KMPT) and intermediate care/ rapid response, community matrons and primary care nursing (KCHT).

6.4 Model A being used as the basis to develop integrated health and social care services in the three "phase 1" areas: Maidstone and Malling, Dover/Deal and in Swale. The pilots will be established during the early part of 2012, followed by ongoing evaluation, which will be used to inform the development of these types of arrangement in other parts of Kent. Evaluation will include looking at outcomes relating to (i) impact on

service user/ patient experience, (ii) productivity/ use of services and (iii) cost-effectiveness.

6.5 Model A is based on 4 component building blocks:

- 1. Locality based **Single Point of Access team**. This team would deal with self referrals and will be used as a "one stop shop" for referrals from GPs. The service needs to be able to immediately access rapid response services and co-ordinate ongoing health and social care assessment and support.

- 2. Locality based **Integrated Health and Social Care Team incorporating Rapid Response / Intermediate Care and Enablement**. This teams would cover a locality and would work as part of or be aligned to the single point of access. Would manage and deliver rapid and crisis responses.

- 3. **Practice Linked Multidisciplinary Teams** based around GP surgeries. These teams would cater to the needs of people with long term conditions and ongoing social care needs (complex cases). They will co-ordinate care for those people with complex medical and social care needs in order to deliver better outcomes and experiences.

- 4. The 4th building block is made up of other commissioned community health care and social care services, including those provided by the private and voluntary sector.

6.6 Model B shares building blocks 1 and 4, but with a fundamental difference that community health and social care would be delivered through an integrated team arrangement that does not form a distinction between short term and long term conditions management. If Model B were adopted, it is proposed that named individuals from the integrated team would form links with practices.

**6. Recommendations**

DMT is asked to:

1 AGREE the strategic direction to integrate community health and social care services (OPPD).

2 AGREE the Operational Framework and for Model A to be tested out in Dover, Swale, Maidstone/Malling.

3 AGREE that these first three areas to integrate will be viewed as the first phase of transformation and mainstreaming, rather than to be seen as pilots.

4 DECIDE the frequency for the programme's progress to be discussed at DMT.

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# Locality Based Integrated Health & Social Care Service

## An Operational Framework

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**10th September 2011**
**V1.0**
**Unrestricted**

## Contents



## Appendices

# Introduction

The Health and Social Care Integration Programme is a large scale change programme which will bring about improved outcomes for service users / patients.

The experience of care for many patients is fragmented between different parts of the health service and between the NHS and social care or other services.

To improve this, the integration of health and social care is being explored as part of wider changes to both heath and social care. The drivers for this work include the NHS White Paper 'Equity and Excellence: Liberating the NHS', 2010, and support whole system working to 'Benefit health, and to improve overall health gain' (The Operating Plan for the NHS in England 2011/12).

There is a large body of evidence to support this; the recent Kings Fund report 'Transforming our healthcare system: ten priorities for commissioners' (May 2011) recommends the creation of integrated teams to deliver better care co-ordination.

Discussions between KCC and Kent Community Health NHS Trust have resulted in a shared desire to integrate community health and social care to deliver better outcomes to people and deliver more efficient and cost-effective delivery models.

Supported at KCC and PCT director level, the proposal has been shared with lead GPs from the emerging clinical commissioning groups, and received well by most.

Presented to the East Kent Commissioning Strategy Committee in June 2011, the principle of integrating health and social care teams, based around GP practices, was agreed. A similar paper will be presented to the West Kent Commissioning Group in October 2011 for decision. However, informal discussions with West Kent CCG leads have taken place and there is known support for integrated teams.

The overall aim of the change programme is to develop an integrated health and social care service, improving efficiencies and providing more effective support to Kent people. The following objectives underpin this:-

- Enhance health and social care provision to support avoidance of hospital admission and safe early discharge from hospital
- Overcome fragmentation in the delivery of health and social care, providing a co-ordinated experience for patients and carers.
- Address the anticipated growth in demand for health and social care, particularly in view of the ageing population

- Support the principles of personalisation
- Support the delivery of QIPP plans and county council efficiency savings

## Aims of the IH&SC Service

- Deliver personalised health and social care support
- Improved service user experience
- Locally focussed
- Improved overall access to services
- Improved productivity and efficiency
- Reduced time –identification of need to delivery of service/support
- Improved personalisation of services
- Simplified decision making processes
- Increased efficiency of assessment process ( remove duplication)
- Eliminate hand offs
- Improved outcomes
- Reduced communication failures
- Risk stratification

## Key Features of IH&SC Service

- Practice level patient management and co-ordination of health and social care
- Co-located primary, community health and social care staff
- Prevention of crisis
- Critical mass of skill in IH&SC service
- Promotion of independence
- Ability to reduce acute length of stay
- Prevent admission
- Ability to triage through a single gateway
- Training and career opportunities
- Shared caseload with designated key workers
- Shared delegated authority for decision making
- Shared documentation systems
- Improved End of Life care co-ordination
- Shared information systems
- Active profiling of practice level disease registers and development of personalised management plans for patients with long term conditions

## Strategic framework options

This paper presents two alternative strategic models that can be used as a framework to support the development of locality based integrated community health and social care.

***Model A*** is an evolution of the one previously discussed in a number of forums including meetings with CCG leads, PCT and KCC commissioners, KCC and KCHT Directors, managers and KCC Members. The components of this model are:

1. Single Point(s) of Access
2. Practice Linked Multidisciplinary Team
3. Locality based integrated health and social care team
4. Access to other healthcare, access to care and support provision.

***Model B*** describes

1. Single Point(s) of Access
2. One integrated team with staff linked to practices
3. Access to other healthcare, care and support.

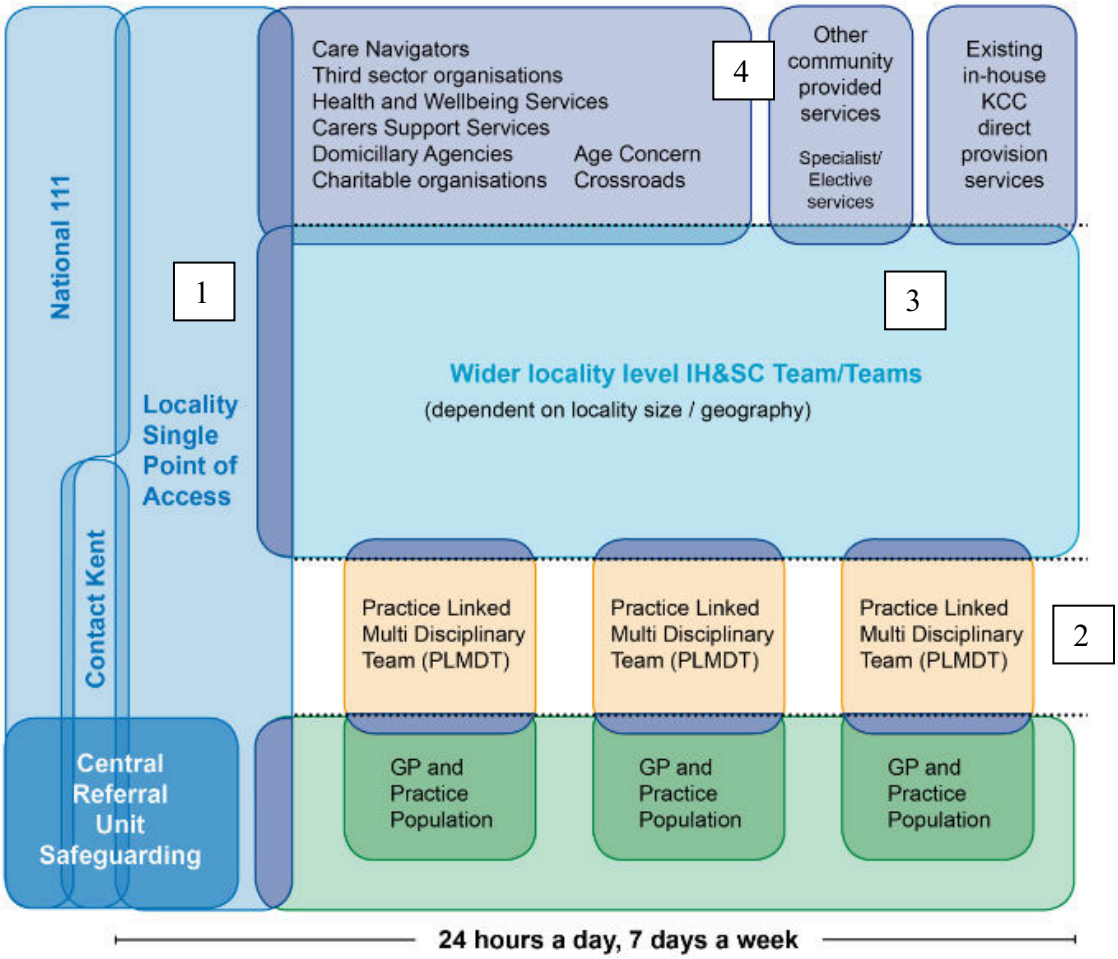
| | **Model A** | **Model B** |
|---|---|---|
| **Similarities** | Single Point of Access<br>Other healthcare, care and support provision<br>Supports the delivery of personalised care and support<br>Includes dementia pathway management within the service | |
| **Differences** | • Team(s) focussed on long term condition management based around a practice or group of practices<br>• AND Team(s) with focus on short-term involvement, rapid response, intermediate care and enablement | • All health and social care staff are based in one integrated team (s), dependent on locality size, but with linked workers to a practice or group of practices.<br>• No separate long term condition team. |

# The detail of the two alternative models

## *Model A*

There are 4 components, or building blocks, to Model A. Each are described in detail in this paper.

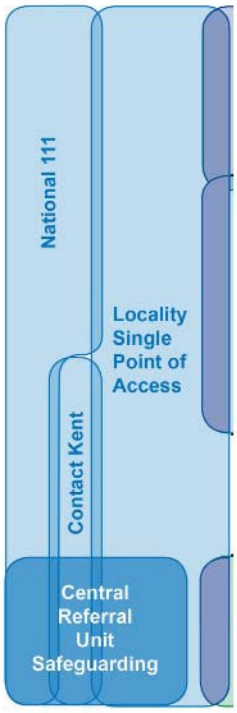
1 Single Point of Access: National / County / Locality (SPA)
2 Practice Linked Multidisciplinary Team (PLMDT)
3 Locality Integrated Health and Social Care Team
4 Other healthcare, care and support provision



## 1. Single Point of Access

A single point of access model based on a three tier approach is recommended:

a. National – via 111
b. County – via KCC's Contact Kent service
c. Locality – via an integrated locality based Single Point of Access service




***National***

The anticipated 111 number will provide access to those individuals requiring direct access to health or social care at a national level, with the "directory of services" being used by the provider of 111 to divert people to the right local health and/or social care service.

***County***

The need to have a countywide single number is recognised for people wanting to self refer into the new integrated health and social care teams or who simply require information, advice and guidance. This single number service is already provided by KCC's Contact Kent service (incorporating the Kent Contact and Assessment Service (KCAS)).

It is anticipated that Contact Kent / KCAS would be used for the purpose of providing health and social care information by telephone. Access will also be available through online and walk-in Gateway channels.

Where a contact assessment is indicated, enquiries would be passed to the locality single point of access (see below).

The Central Referral Unit (CRU), for safeguarding, is also recognised within this model. This new unit, for adults, will include personnel from the police, social care and health. It is anticipated that a CRU service for adults will be up and running as soon as possible after January 2012. The detail of how this service will operate still needs to be determined, but it is expected that any call being dealt with by 111, Contact Kent or the locality Single Point of Access would be transferred to the CRU if it becomes apparent during the conversation that there is a safeguarding issue.

***Locality***

A locality level single point of access (LSPA) will be established for health and social care referrals for ease of access to a guaranteed response by the integrated health and social care services.

For self referrals, where enquiries cannot be resolved by Contact Kent, they would be transferred into LSPA where competent staff, trained to cover health and social care enquiries, will be able to commence a contact assessment and determine the first response, which may be:

- direct provision of equipment
- a rapid response or reablement service
- a non-urgent face to face assessment or nursing / therapeutic intervention

The LSPA will be able to be directly accessed by GPs if they wish to. The LSPA could also be used as a “back-up” point of contact if a GP is unable to make contact with the link person within the practice linked MDT.

The single point will be critical to services like South East Coast Ambulance (SECAMB) for appropriate admission avoidance referrals. To receive these referrals, the integrated service must be able to respond rapidly to ensure that SEC ambulance can be confident that they can leave the patient and that the IH&SCS staff member will be in attendance within a given time frame.

## 2. Practice Linked Multidisciplinary Team (PLMDT)

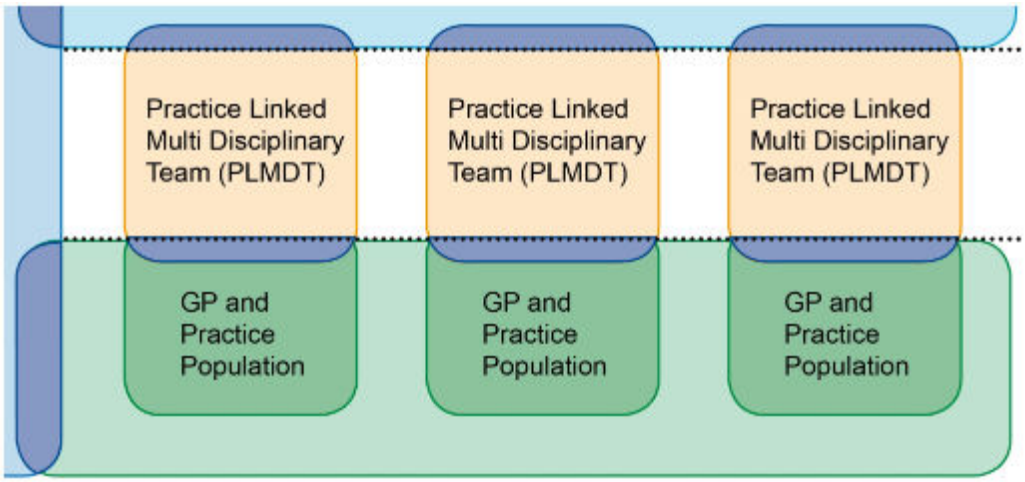
Given that patients residing in the community are the responsibility of general practitioners and their journey, most often, begins and ends in the community, a critical element of the IH&SCS is the practice linked multidisciplinary team that is allied to each GP practice.

These teams will focus on Long Term Condition management.

The PLMDT may cover more than one practice in the locality (dependant on available resources and the requirements of GP practices) but the delivery of the co-ordinated care will be the same for each practice (as per agreed standards).

The PLMDT will comprise of :

- social care case management
- community nursing (matrons, specialist nurses, primary care nursing)
- older people's mental health practitioner(s)
- occupational therapists




***The role of the PLMDT***

The MDT will be responsible for case management of the practice population that require health and social care ensuring that the patient receives all interventions that are required, no matter what that input / support is, and those with long term needs are case managed on an ongoing basis to ensure continuity of provision that is tailored to their needs and delivered in the most personalised, effective and cost efficient way. This can be achieved through the use of a number of technologies for example telehealth, where it is

appropriate to do so, telecare to promote independence and safety in appropriate patient groups.

The MDT will also be able to ensure cross referencing of caseloads, health and social care reducing and eliminating duplication. This can be done in conjunction with practices. The use of a predictive tool to identify patients at high risk of admission and subsequent use of health and social care resources through the use of SPOKE. This is an IT system, currently owned by KCHT.

Patients from each practice population with long term conditions, identified from disease registers, will be reviewed, assessed and appropriate proactive management of self and supportive care implementation via an individual personalised management plan. Integrated personal budgets (i.e. the joining up of social care personal budgets and personal health budgets) will be used to ensure the best clinical and social care outcomes for patients and added value for money for commissioners. Where patients / service users do not require integrated support, the use personal budgets and personal health budgets will be the norm.

The PLMDT will be accountable for delivery to the practice and practice population.

A critical element of the MDT is the communication and relationship with the GPs and wider primary care team that they serve. This will be by the most effective means and will include access to space in practices where the MDT can 'hot desk ' and have regular (daily if necessary) contact with GPs and other members of the primary care team.

Use and input into the GP IT system to ensure that all patient updates and information is available to ensure that GPs are aware of any input of services to the patients and their ongoing health and social care status is up to date.

There will be a focus on improving the care, support and management of patients with dementia, end of life care (linking to the Pilgrims Hospice pilot model) and long term conditions through early intervention, optimisation, promotion of self care and ensuring preferred place of care.

The team will deliver:

- Case management of long term conditions (including dementia)
- Case management of end of life
- Support to care homes
- Predictive modelling of practice populations via disease registers for peatients with long term conditions
- Management of cases through the effective use of teletechnology

## 3. Locality Integrated Health and Social Care Team(s)

Behind the Practice Linked MDT will sit a fully integrated locality service, which will support the work of the PLMDT and also those patients and service users who require short term health and/or social care support or treatment.


It will comprise of:

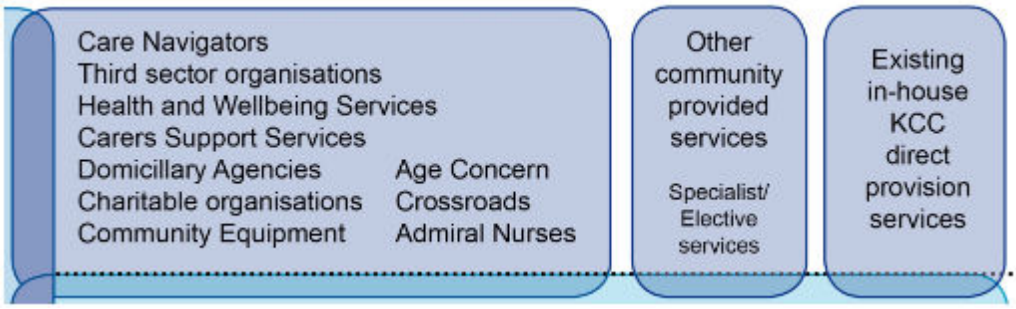
- Adult social care – registered staff (OTs, social workers and nurses)
- Adult social care – unregistered staff
- Rapid response nurses / rehabilitation nurses
- Occupational therapists
- Physiotherapists
- Enablement and intermediate care support workers
- Speech and language therapists
- Dietetics
- Mental Health nurses

***The Practice Linked MDTs and locality health and social care team will both deliver:***

- Ambulatory care pathways
- Clinic services (non housebound patients requiring nursing care and those requiring social care assessments)
- Promotion of self care - health and wellbeing
- Admissions avoidance – step up facilities and intensive home care support
- Re-admissions avoidance
- Telecare response services

## 4.Other healthcare, care and support

A range of other services, both statutory and non-statutory, will be utilised to ensure that all service user / patient and carer needs are met. Patients / service users will be supported to use integrated personal budgets, personal budgets and personal health budgets to ensure that they are able to access the right kind of personalised care and support.

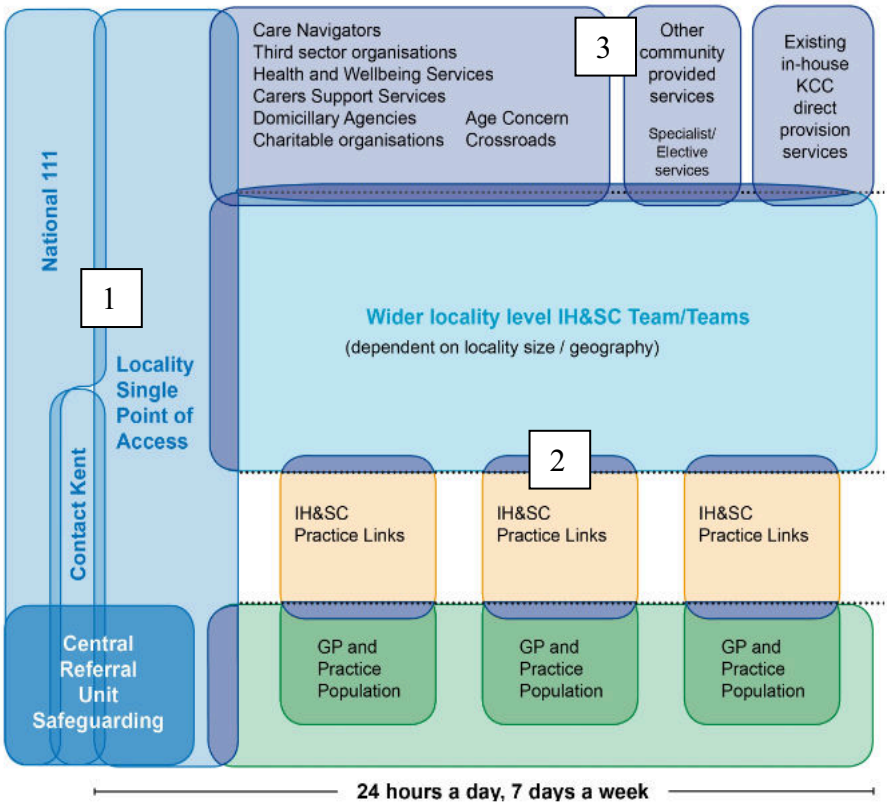



Examples of KCC direct provision services include services provided in integrated care centres. KCC currently has a programme of work in place to review in-house provision to question whether the service is still needed and if it is, to determine who should provide it?

## *Model B*

There are 3 components, or building blocks, to Model B.

1 Single Point of Access
2 One integrated team with staff linked to practices
3 Access to other healthcare, care and support




## 1. Single Point of Access

Same as Model A above

## 2. One integrated team with staff linked to practices

Model B proposes the creation of an integrated health and social care team. There may be one, or a number of these teams within a locality, depending on the optimum unit size of the team for management and population / demand purposes.

It will comprise of:

- Adult social care – registered staff (OTs, social workers and nurses)
- Adult social care – unregistered staff
- community nursing, including long terms condition management, (matrons, specialist nurses, primary care nursing)
- Occupational therapists
- Physiotherapists
- Enablement and intermediate care support workers
- Speech and language therapists
- Dietetics
- Mental Health nurses
- older people's mental health practitioner(s)

All these staff would be based within the same team, but have named linked workers who form a "virtual" team and make the connections with GP practices. Depending on practice size, this would be a single large practice, or cluster of smaller practices.

### 3. Other healthcare, care and support

Same as Model A above

## Other models

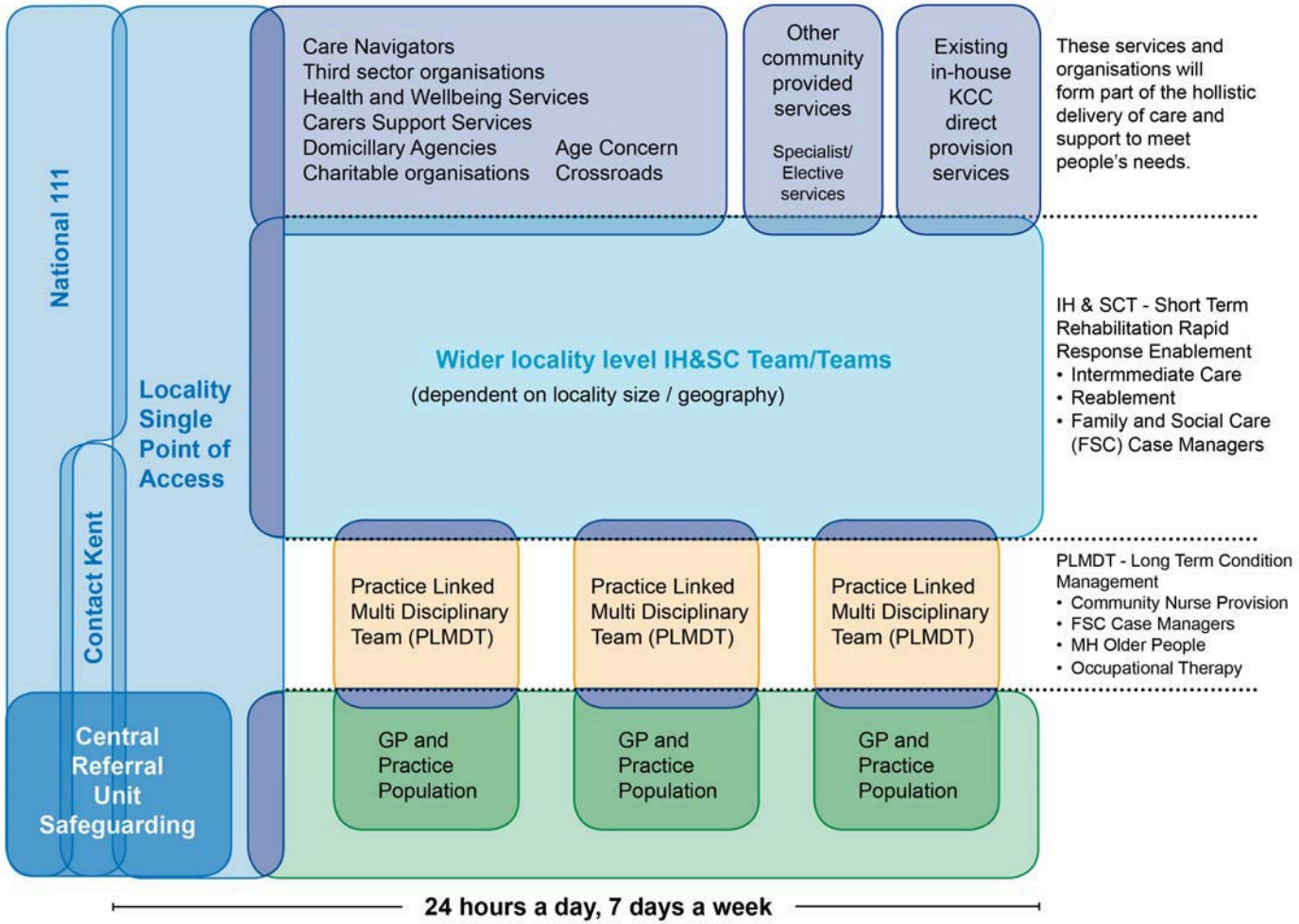
The authors of this paper recognise that alternative models may emerge.

One CCG has proposed that it would like to explore the possibility of a model based on:

- 10 nursing and social care teams, incorporating named individuals as the "single point of access". Teams to include all nursing staff from existing primary care nursing, community matrons and intermediate care nurses.
- A locality based team of therapists (OT, physiotherapists, dietician, Speech and Language therapists)

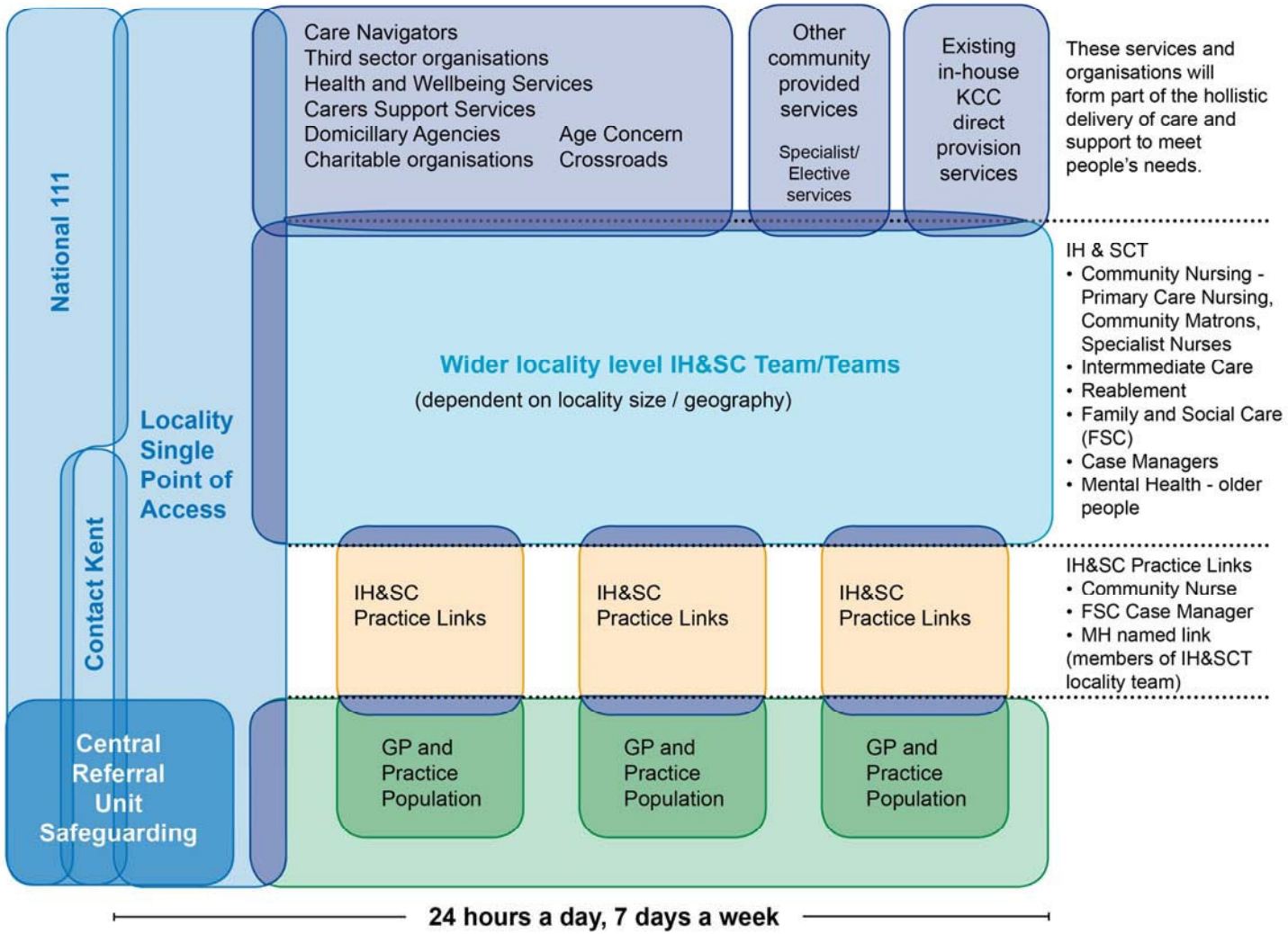
**Model A**

## Locality Level Integrated Health and Social Care Team (IH&SCT)



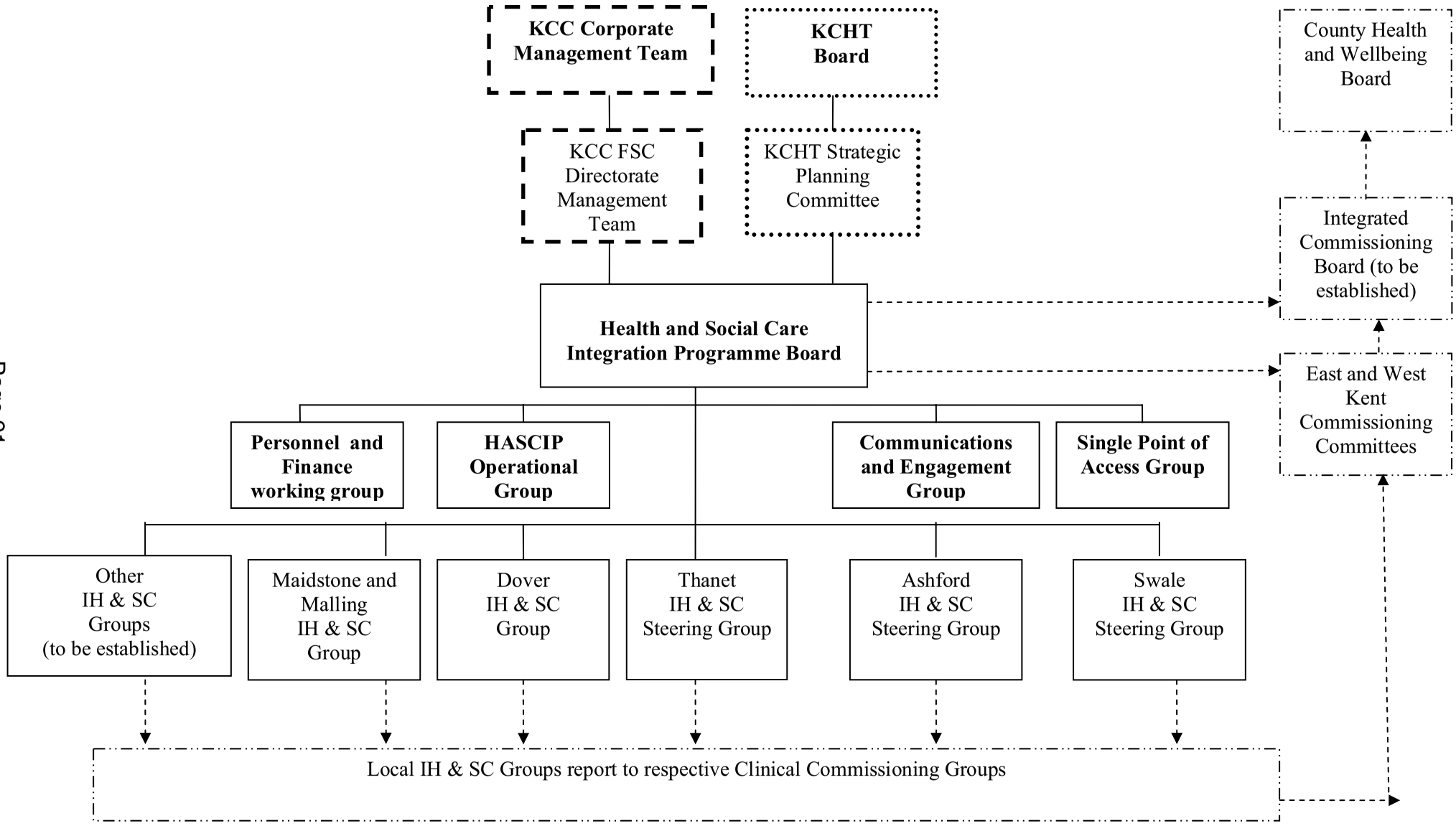
**Model B**

## Locality Level Integrated Health and Social Care Team (IH&SCT)



Appendix 2

# Health and Social Care Integration Programme Governance



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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012

Subject: **UPDATE ON ADULT SOCIAL CARE TRANSFORMATION PROGRAMME**

Classification: Unrestricted

| Summary: | This report updates Members on progress for the adult social care transformation programme. |
|---|---|

**Introduction**

1. (1) A report setting out the proposed development of a Transformation Programme and the role of Strategic Commissioning in delivering this was presented to the Adult Social Care and Public Health Policy Overview and Scrutiny Committee on 10 January 2012. This paper aims to provide an update on progress.

**Stakeholder Engagement**

2. (1) The transformation team has identified the programme stakeholders, analysed levels of interest and influence in order to agree which stakeholders to initially focus our stakeholder engagement with. A stakeholder engagement strategy and plan has been developed in order to engage with stakeholders over the period of January to mid March. This initial phase of communication and engagement is focussed on defining what the transformation programme will aim to achieve and developing some of the key step changes required to reach the end goal.

(2) A number of opportunities to engage with stakeholders have been taken and a number of events have taken place:

- Informal union briefing (19 January 2012)
- Older People/Physical Disability (OPPD) Strategic Commissioning Staff Awayday (20 January 2012)
- Carers Provider Advisory Group (26 January 2012)
- Kent Community Care Association Strategy Group (2 February 2012)
- Directorate Management Team (DMT) visioning session (1 February 2012)
- Divisional Management Team (DivMT) visioning session (9 February 2012)
- Kent Integrated Local Area Workforce Strategy Group (16 February 2012)
- Kent Voluntary and Community Sector Engagement Forum (24 February 2012)
- Domiciliary care providers (28 February 2012)
- Voluntary and preventative service providers (1 March 2012)
- Mental health service users/carers (5 March 2012)
- Housing partners (9 March 2012)
- Residential and nursing care providers (15 March 2012)

- Staff communication, manager packs ( to help them facilitate transformation with their teams), K-net content, on-line questionnaire - to allow staff to feed in their transformational ideas (March 2012)
- Older People/Physical Disability service users/carers (15, 16, 19 March 2012)
- Sensory service users/carers (March 2012)
- Health providers/partners (21 March 2012)

(2) The activity outlined above is just the first of many opportunities over the 3 year programme for stakeholders to input into the programme. In April we intend to set up a multi-stakeholder group to help further progress the detail around the transformation programme. As the content of the programme develops, we will invite stakeholders to get involved in specific project groups to: a) help develop projects in more detail; b) help us to implement projects; c) help us to review how effective the projects were in achieving the desired outcomes. We are hopeful that some members will be willing to be part of these stakeholders groups.

**Programme Themes and Principles**

3. (1) Ideas and views from stakeholder events are being recorded and used to develop a blueprint (future design) for social care in 3 years time. Although stakeholder events are ongoing a number of themes are already taking shape.

(2) Potential key themes include:

- **Empowering people** - enabling citizens to find solutions and meet need outside of the social care system
- **Every penny counts** - ensuring all spend provides value for money
- **Assessment: right time, right place -** providing short term crisis support and maximising enablement to reduce the number of crisis assessments
- **Doing things right** - developing effective processes and making sure they are applied consistently and effectively in all localities
- **Place to live** - housing options to increase independence
- **Social activities** - greater choice in activities and opportunities for people to integrate with the wider community to prevent social isolation

(3) Cross cutting principles include:

- Safeguarding
- Integrated health and social localised provision model
- Better demand management
- Responding rapidly
- Greater focus on personalisation
- Greater use of technology
- Increased use of electronic transactions
- Harnessing community based social capital
- Greater investment in targeted preventative services
- Less done by KCC, more done by others
- Outcome focussed commissioning and incentivisation

**Next Steps and Timeline**

4. (1) All stakeholder feedback will be analysed and prioritised into a list of proposed projects. Other change projects which are on-going will also be added to this list. Projects will be placed in a prioritisation matrix and assessed against criteria such as strategic fit, ease of implementation, level of risk, cost benefit, etc. This matrix will be discussed at DMT on 28 March 2012 to agree the content and phasing of programme activity.

(2) A blueprint will also be developed in line with stakeholder feedback. The blueprint will detail the vision for adult social care, programme principles, programme objectives and planned benefits. It will also provide a high level view of what adult social care looks like now, what it will look like in three years time and identify the key step changes in the transformation process. It will also allow Families and Social Care (FSC) to evidence that stakeholder feedback has been considered in the design of the blueprint. The blueprint will be published and shared with all stakeholders.

(3) Consultancy input from the Institute of Public Care (IPC) have been secured through a successful application for funding to the LGA/ADASS sponsored Adult Social Care Efficiency programme. IPC have been asked to help FSC with cost modelling – identifying what savings can be achieved through the identified projects. The output of this work will be a paper which provides an initial analysis of how the savings will be achieved.

(4) The blueprint and savings profile paper will be taken to:

- DMT - 4 April
- Commissioning and Procurement Board – 17 April
- Corporate Management Team – 24 April

(5) A performance management framework will also be designed to allow FSC to baseline, monitor and evidence the transformation. This will be discussed at the DMT on 11 April 2012.

(6) Governance arrangements and resourcing of the programme will be set up prior to the start of the programme in April 2012.

**Recommendations**

5. Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to NOTE the contents of the report.

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*Background documents:* Report to the Adult Social Care and Public Health Policy Overview and Scrutiny Committee, 10 January 2012 – Strategic Commissioning and the Transformation of Adult Social Care, Item E1

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By: Graham Gibbens, Cabinet Member, Adult Social Care and Public Health

Andrew Ireland, Corporate Director, Families and Social Care

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012

Subject: **UPDATE ON THE GOOD DAY PROGRAMME – INCLUDING:**

**AN INTERIM REPORT ON THE FORMAL CONSULTATION ON A NEW SERVICE MODEL FOR LEARNING DISABILITY DAY SERVICES IN THE SHEPWAY DISTRICT**

**THE DECISION MADE FOLLOWING THE FORMAL CONSULTATION ON A NEW SERVICE MODEL FOR LEARNING DISABILITY DAY SERVICES IN THE THANET DISTRICT.**

Classification: Unrestricted

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Summary: The purpose of this report is to provide the Adult Social Care and Public Health Policy Overview and Scrutiny Committee (ASCPHPOSC) with an update on the Good Day Programme (GDP) and the position of two districts currently in different stages of transition:

- An interim account of the formal consultation on a new service model for learning disability day services in Shepway. An initial interim report was presented to ASCPHOSC on 10 January 2012.
- The decision made following the formal consultation on a new service model for learning disability day services in Thanet along with an update on the current position on the implementation of the new service model.

The results and outcomes of the consultation on a new service model for learning disability services in Thanet were presented to ASCPHOSC on 10 November 2011.

Recommendations: Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to:

(a) NOTE the continuing progress of the GDP and the decision made following the outcome of formal consultation on a new service model for learning disability day services in Thanet.

(b) CONSIDER the feedback gained to date during consultation on a new service model for learning disability day services in Shepway.

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**Update on the Good Day Programme**

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" and KCC's "Active Lives". In 2008 following consultation of "What Makes a Good Day" - a plan to improve days for people with learning disabilities, a decision was made to refresh previous strategies with a new strategy; to improve services for people with learning disabilities during the day, evening and weekends. The Good Day Programme (GDP) was set up to implement the new strategy by providing a countywide framework and support for the local programme of change to improve services for people with learning disabilities.

(2) With the implementation of 'Bold Steps' KCC is keen to see the development of sustainable community resources in partnership with the private, voluntary sector and social enterprise; and aims to evolve fully into a commissioner of community care services rather than a facilitator or provider of them. The Good Day Programme has incorporated these aims and objectives in the planning of proposed future service models, assisting in fulfilling these desired outcomes.

(3) In line with "Valuing People Now" and KCC's "Active Lives" and "Bold Steps" the New Service Model for future services will be based on personalisation, with everyone having choice and control over the shape of their support through the use of direct payments and personal budgets. This person centred approach will uphold the principles and standards of the Good Day Programme.

(4) 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.

(5) The new service model will offer people a range of facilities, activities and opportunities in their local community within inclusive settings.

(6) An example of the proposed New Service Model for Learning Disability Day Services is detailed in **Appendix 1** – New Service Model for Shepway District.

(7) The table below shows the traditional style day centre buildings that have already been closed and a new service model implemented.

| Traditional style day centre buildings already Closed |
|---|
| Maidstone SEC |
| Ashford DOS |
| Canterbury DOS |

(8) The Council is required to undertake a consultation with Service Users and other relevant stakeholders on the impact of a change or variation to a service and consider the findings of the consultation before coming to a final view.
The consultations through the GDP are carried out to:

(a) Inform people about the details of the proposed New Service Model for Learning Disability Day Services.

(b) To invite the views and comments of Service Users, their Family/ Carers and other relevant stakeholders who have an interest in the services.

(9) Consultations are extensive and include Service Users, Family Carers, Staff, Trade Unions, Advocacy, Residents, District Partnership Groups, Community Partners, Integrated teams, Parish Councillors and KCC Members.

**Future steps for the GDP**

(10) The GDP continues to progress with an increasingly wide range of collaborations between KCC and a variety of community partners to offer people a range of facilities, activities and opportunities in their local community within inclusive settings.

(11) With this the GDP will ensure that appropriate mutual legal agreements and licences are in place to protect both KCC's financial investment and the interests and needs of people with learning disabilities.

(12) The table below illustrates current and planned GDP projects throughout the remaining timeframe for the programme.

| Current and planned GDP projects 2011 to 2014 | |
|---|---|
| Dover | Gravesend |
| Swale | Sevenoaks |
| Dartford | Tunbridge Wells |
| Riverside (Tonbridge) | |

**<u>Interim report on the formal consultation on a New Service Model for Learning Disability Day Services in the Shepway District.</u>**

2. (1) A fourteen week period of formal consultation on a New Service Model for Shepway Learning Disability Day Services commenced on 22 November 2011; with a series of consultation meetings held for the main stakeholders.

(2) Consultation packs, containing a questionnaire have been distributed to 420 stakeholders including, Service Users, Family carers, local providers (voluntary and private sector), professional carers, the local MP, KCC Members and Shepway District Councillors, staff and unions. To date 22 completed questionnaires have been returned.

(3) An independent Advocacy service has been involved throughout the consultation period for all Service Users offering a range of workshops, group meetings and individual 1:1 meetings. These arrangements have supported Service Users to understand the proposals and to develop and express their viewpoint.

(4) The consultation project team have recorded all enquiries, comments, risks and concerns' regarding the consultation to ensure all information is captured. In addition, a comprehensive series of communication activities will continue in to the final stages of the consultation period to ensure all stakeholders are able to contribute fully.

**Core themes emerging during the consultation**

**Family Carers**

- Family carers have voiced praise regarding the existing community based activities Service users have been engaged with
- Requested reassurance that Service Users attending the new community hubs will be looked after in the same way as before e.g. if a family/carer is late picking up a Service user, would the same protocols be put in place to ensure the person is in a safe environment.
- Family carers attending a Road show have expressed mixed views regarding the proposals; these concerns have been allayed through extensive information and offering 1:1 meetings.
- Two people have taken the opportunity to have a Family Carer 1:1 meeting to clarify elements of the consultation.

**Service users Update**

- The advocacy service has supported 80 service users to date to feedback their comments and views and they will continue to offer support to service users throughout the remaining weeks of the consultation.
- The advocacy service has reported that all service users have a clear understanding of the consultation and feel able to voice there opinion regarding the proposals.
- Service users attended a road Show on 12 January 2012 to gain more information and to ensure the community based activities they would like to take part in the future are acknowledged; a member of the advocacy service was present at this road show.

**Staff Update**

- A representative from Human Resources has visited the Shepway Day Services team, providing additional support and information to staff regarding employment continuity.

**Other Stakeholders/providers Update**

- Local businesses surrounding the Shepway Resource Centre have not responded to the consultation to date
- Local service providers have expressed an interest in finding out more about how the community hubs will be developed and how local providers can be supported to deliver community based activities in the future.

**Shepway District Partnership Group (DPG)**

- The consultation presentation was delivered at the DPG on 5 December 2011
- An additional short presentation was also given at the DPG on 13 February 2012 as a reminder to those wishing to complete a questionnaire or comment on the proposals.

**Overall outcome of the consultation to date**

(5) Overall feedback to date has been positive. In general both family carers and service users have expressed relatively few concerns on the proposed changes to the service. Service users have for some time now been experiencing increased access to community activities. Therefore the proposals for future change have not come as a surprise as people are already enjoying being part of their local community.

(6) The formal consultation period on a New Service Model for Shepway Learning Disability Day Services closes on 28 February 2012. All views, comments and responses will be gathered and if necessary the proposed new service model will be revised to reflect the outcome of the consultation. This information will be brought together in a report that will be presented to the Cabinet Member for Adult Social Care and Public Health who will be asked to consider and approve the implementation of the new service model.

**Decision following formal consultation on a New Service Model for Learning Disability Day Services in the Thanet District.**

3. (1) Consultation on the New Service Model for Learning Disability Day Services in Thanet was undertaken between 7 June 2011 and 27 September 2011; a 16 week period in order to maximise stakeholder involvement. The decision in relation to this new service model was included in the Forward Plan on 17 June 2011, covering the period 1 July 2011 to 31 December 2011.

**Summary of the outcome of the consultation and issues raised**

(2) 352 consultation packs and questionnaires were distributed to all stakeholders. 115 questionnaires (33%) were returned from the following stakeholder groups:

| | |
|---|---|
| Person with a learning disability | 94 (79 through advocacy) (15 independently or with Carer support) |
| Family/Carer | 17 |
| Staff | 2 |
| Blank | 1 |

(3) An independent Advocacy service was involved throughout the consultation period for all Service Users at Thanet DOS: offering a range of workshops, group meetings and individual 1:1 meetings. They supported Service Users to understand the proposals and to develop and express their views. Advocacy support was also available to family carers throughout the consultation; this was provided through a local charity.

(4) People expressed mixed views on the consultation although Service Users were generally more positive towards the new service model. An alternative proposal was also submitted by East Kent Mencap, however this did not represent value for money. A summary of the main findings are detailed in **Appendix 2.**

**Response to the consultation**

(5) In summary:

- 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"

- Where we have implemented community based services in other parts of the county people with a learning disability have valued the new opportunities, embraced the range of choices and felt part of their local communities.

- The advocacy input to all Service Users about the new service model has enabled KCC to be satisfied that increasing the range of community activities is something that all Service Users have requested.

- The EK Mencap proposal is not recommended as a way forward as outlined in this report.

- The future of the Thanet DOS building was raised in all of the consultation feedback. Because of this we must consider the residual use of the building for community use by partner agencies. This could include a part of the building being used as a community hub for people with learning disabilities.

- The results and outcomes of the formal consultation on a new service model for learning disability services in Thanet were presented to ASCPHOSC on 10 November 2011.

**Current Position**

(6) On 22 February following consideration and endorsement at the Adult Social Care and Public Health Policy Overview and Scrutiny Committee 10 November 2011, the Cabinet Member for Adult Social Care and Public Health made the decision to implement the New Service Model for Learning Disability Day Services in Thanet. The Cabinet Member approved:

(a) the development of new resources within Thanet to be known as Community Hubs, which when fully developed and used to the satisfaction of service users will eventually lead to the closure of the segregated service currently run in the Thanet DOS building.

(b) the implementation of the new service model for learning disability day services within the Thanet District, as outlined in this report.

(c) the commissioning of a feasibility study on the Thanet DOS building and site to ascertain the viability of both capital and revenue investment in terms of using the building as part of the future new service model.

(7) The report on the decision on the new service model for Thanet has been published along with a summery version and distributed to all stakeholders. Arrangements are being made for the interim Director for Learning Disability and Mental Health to meet with the Thanet DOS Carers Forum to provide feedback on the decision and to answer any questions about the decision.

(8) Work is currently underway to commission a feasibility study on the Thanet DOS building and EK Mencap will be fully involved.

(9) Initial negotiations are progressing with external partners, exploring options for Community hubs and facilities, activities and opportunities for people with learning disabilities in the local community.

**Recommendations**

4. (1) Members of the Adult Social Care and Public Health Policy Overview and Scrutiny Committee are asked to:

(a) NOTE the continuing progress of the GDP;
(b) NOTE the decision on the outcome of formal consultation on a new service model for learning disability day services in Thanet;
c) CONSIDER the feedback gained during consultation on a new service model for learning disability day services in Shepway.

*Appendices:*

Appendix 1: Example of the proposed New Service Model for Learning Disability Day Services – New Service Model for Shepway District.
Appendix 2: Thanet Day Services Consultation Summary report.

*Background documents:*

Report on the Outcome of formal consultation on a New Service Model for Learning Disability Day Services in the Thanet District to ASCPHPOSC, 10 November 2011, Item E7

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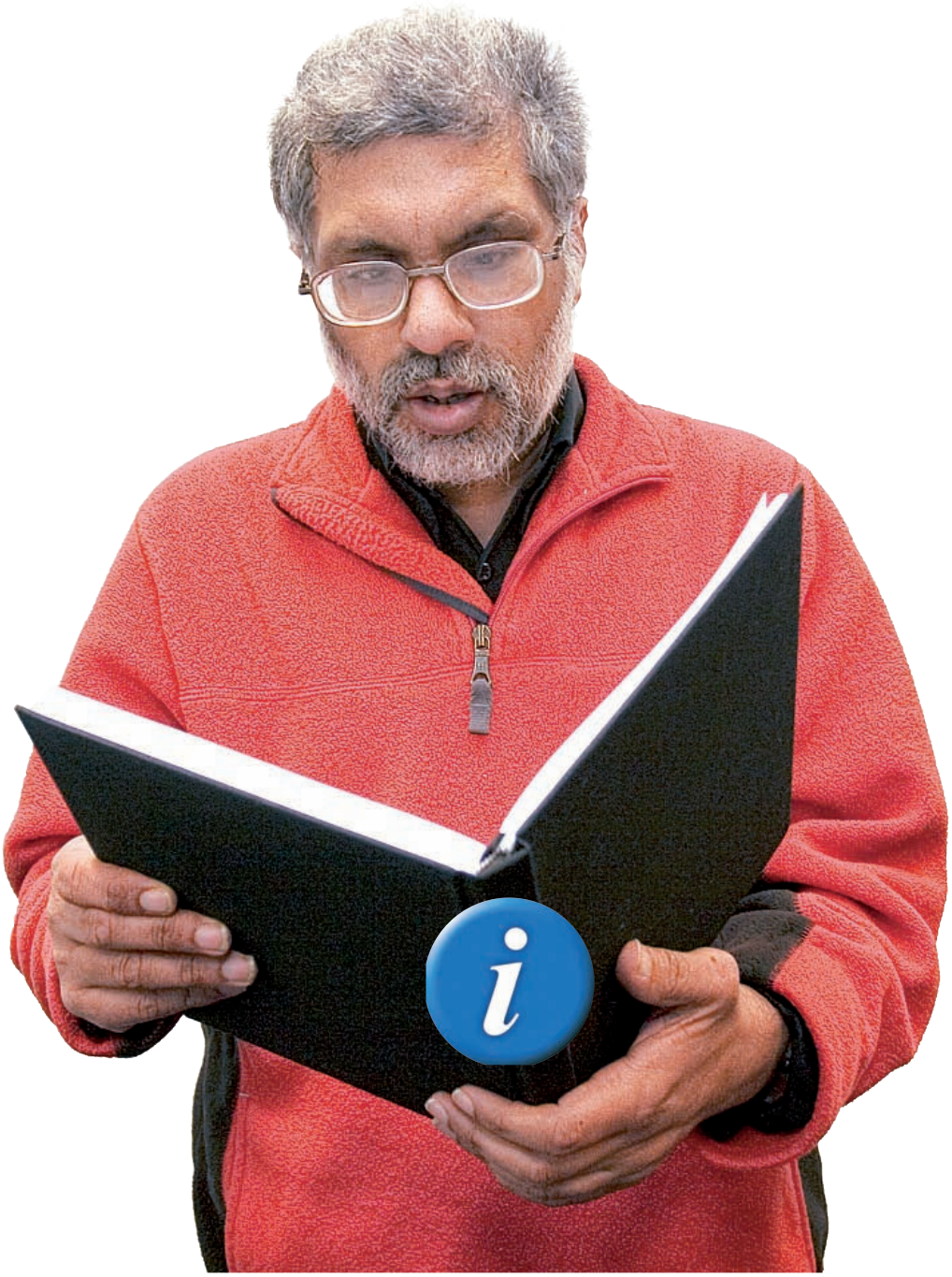
# Learning Disability Services
# New Service Model

## Shepway Day Services Consultation
## November 2011



www.kent.gov.uk/learningdisability

Kent County Council

# Consultation for changes to Shepway Day Services

## 1. Why are we consulting?

In 2001, the Government produced a White Paper called 'Valuing People'. Its aim was to improve the lives of people with a learning disability.

In January 2009 "Valuing People Now" was produced. This was a review of the original strategy. It acknowledged the progress that had been achieved but it also stated that what is needed through this new strategy is the transformation of the lives of people with learning disabilities and family carers.


It asked for stronger leadership from local authorities and set out four top priorities:

- Personalisation
- Health
- Daytime/employment
- Housing.

In 2010 Kent County Council (KCC) launched 'Bold Steps for Kent', medium term plan to 2014/15. This sets out Kent's aims to evolve into commissioners of community care services rather than as providers of them. KCC is keen to see the development of sustainable community resources in partnership with the private, voluntary sector and social enterprise. The proposed new service model will assist in fulfilling this desired outcome.


As part of Kent's response to 'Valuing People Now' we set up The Good Day Programme so that we could co-ordinate changes in the way day services are delivered to people with learning disabilities and enable people to lead a more full and meaningful life.

The site where the Shepway Resource Centre is currently based has hosted learning disability day services since 1985.

We know that some people have been going to these services for a long time and many feel comfortable and happy with it.

The Shepway Resource Centre no longer meets the current and future requirements for people with learning disabilities. So we propose that Shepway Day Service move off the site altogether and transfer with the existing staff team to community locations instead.

For some time now the Shepway Day Services has been working hard with service users to help them become more involved in the community and to offer people the chance to get involved in a wider range of community based activities.

We are starting a consultation programme and want to know what you think of this proposal.

We would like to hear from:

- everybody who uses any of the existing services
- parents and carers
- people who might want to use any of the services in the future
- other service colleagues, health, education and housing
- staff and union representatives
- the general public.

## 2. Why does the Shepway Day Services need to change?

- Since 'Valuing People' and 'Valuing People Now', the staff and service users have been using and getting to know a variety of community groups and activities. This has meant that more and more activities have been taking place in different community locations and people have had a chance to take part in a wider range of things

- A lot of younger people leaving school and their parents want something different and are put off by the style and position of the building. They are choosing other independent day services and supported employment.

This has meant that there are now fewer new people wanting the Shepway Resource Centre as their chosen day service. As a result, the number of people using the Shepway Resource Centre has fallen and the building is now too big and empty

- The service relies upon mini buses to get to and from the building, and this makes accessing community activities more difficult. Also it can mean that some people are on the vehicles for over 2 ½ hours a day whilst they travel across the district picking up and dropping off individuals. More suitable transport arrangements are needed for the future to access local services

- In offering a wider choice of community activities a close working relationship has developed between the SRC and The Bridge Centre and over recent months both services have merged with staff coming together to provide one seamless service.

- The design of the building is old fashioned and despite money being spent on it over the years, there are still lots of things that need updating and replacing. Given that we want more community based activities and greater flexibility, we do not think that we should spend large amounts of money on the building, as it is no longer what is needed.

## 3. What will the new service look like?

Outlined below is the proposed new service model. Below this is a summary explaining each element.

**Offer people a range of facilities, activities and opportunities in their local community within inclusive settings.**

**This will be achieved by:**

- increasing opportunities to make Direct Payments more available to enable people to design and purchase a personalised service
- identifying through Person Centred Planning any elements of the current service provided by Shepway Resource Centre and The Bridge Centre that has the potential to become a Social Enterprise
- investing in community hubs in order to stimulate the external market to deliver opportunities within the local community
- providing skilled staff to support people to access services within the local community
- negotiating with residential care providers to deliver or purchase a day service as described in the agreed support plan
- moving away from large congregate and segregate building based services.


**Increasing opportunities to make Direct Payments more available to enable people to design and purchase a personalised service.**

People currently attending the Shepway Resource Centre and the Bridge Centre will receive a day care review. They will be consulted for their views which will identify, what and how new day services are to be delivered. These services could be purchased from existing and new service providers through personal budgets and individual contracts. Work will need to be undertaken with commissioners and contracting colleagues to commission what people want.

**Identifying through Person Centred Planning any elements of the current service provided by both Shepway Resource Centre and The Bridge Centre that has the potential to become a social enterprise.**

From the outcomes of Person Centred Planning where it has been identified that people want to retain elements of the current service, these will be considered for their potential in becoming a social enterprise. Those assessed to be feasible for social enterprise specifications will be drawn up and the appropriate service provider appointed through competitive tender.

Supported employment will be key in ensuring that, where appropriate, people have support to move into paid employment both within social enterprises and in the mainstream business market. This is essential to ensure a purpose for individuals, therefore offering greater choice and fulfilment. Additional investment in supported employment to accomplish this will be taken into account through the remodelling of the existing in house learning disability staff group.

**Investing in community hubs in order to stimulate the external market to deliver opportunities within the local community.**

A number of 'community hub' type facilities will be available close to where people live offering shared space for people with a learning disability and a place to meet up and take part in inclusive activities. Funding will be provided to enhance or provide accessible space, equipment and facilities within these community buildings to meet people's needs, including: sensory and therapeutic equipment and adult changing facilities. With these improved modern facilities in place there will no longer be a need for the existing out dated large segregated building currently occupied by Shepway Resource Centre.

Funding has recently been provided in The Bridge Centre in Hythe to enhance accessible facilities.

A Shepway Community Hub Focus Group has been established to research the local area and identify suitable community hub options.

The proposed community hub locations identified by the focus group are:

- Folkestone Sports Centre
- The Bridge Centre
- The Community Network
- The Marsh Academy Community Centre

**Providing skilled staff to support people to access services within the local community.**

Suitably skilled staff to support people to access services within their local community will be provided through the remodelling of the existing in house learning disability day services staff group. This remodelled staff group will be restructured to reflect the changes required to deliver community based support in place of building based support. The proposed process of identifying and tendering for potential social enterprises and independent sector day care will result in some appropriately skilled staff transferring to an alternative service provider. The remaining staff group roles will be remodelled to provide a community based support type function. Once this is complete the new model of a community support service will be put forward to the external provider market through a second phase of competitive tender.

Negotiating with residential care providers to deliver/ provide or purchase a day service as described in the agreed support plan.

There are a relatively high percentage of people currently accessing Shepway Resource Centre and the Bridge Centre who live in residential care, 30%. Negotiations will take place with individual people and their residential care providers to identify where it is more beneficial for the person to have their residential care provider deliver or purchase day care opportunities as an alternative choice to Shepway Resource Centre and The Bridge Centre.

**Moving away from large congregate and segregate building based services.**

A number of 'community hub' type facilities will be available close to where people live offering shared space for people with a learning disability and a place to meet up and take part in inclusive activities. Capital funding will be provided to enhance/provide accessible shared space.

This will provide equipment and facilities to meet people's needs, including: sensory and therapeutic equipment and adult changing facilities. With these improved modern facilities in place there will no longer be a need for the existing out dated large segregated building currently occupied by Shepway Resource Centre.

Some of the community based services will include:

- colleges and adult education
- Community Network
- community resource centres
- Folkestone Sports Centre
- local community groups
- private and voluntary service providers
- social enterprise opportunities
- sport and leisure centres
- supported employment
- The Bridge Centre
- The Marsh Academy Community Centre.

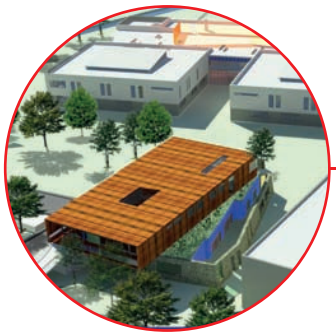
We recognise the importance to people of maintaining and developing existing and new friendships. Particular attention will be given to ensure people continue to meet their friends and have opportunities to make new friends.

**What it might look like for John:**

The Bridge Centre


Folkestone Sports Centre


Community Network



The Marsh Academy Community Centre

Meeting with friends

Personal Interests

Private and voluntary service providers


Work opportunities

## 4. What happens next?

We have planned that this consultation will take 14 weeks, as we want to make sure that as many people as possible are included.

There will be a range of ways for people to get involved and tell us what they think, including:

- individual meetings
- information road shows
- a questionnaire that will be available online and at these meetings

This means that your views will be gathered by 28 February 2012 and we will bring all these different responses together in a report that we will be published in April 2012.

## 5. Questions and answers

Here are some questions we thought you might ask:

**Will I still get the same level of service?**

- Yes.
  The changes will affect where activities take place and if anything open up more opportunities- we do not aim to reduce the service people receive, instead we aim to make it much more person centred.

**Where will the new service be?**

- We know where people live and using this information we will look at places that are central, accessible and affordable
- There will also be a central office base.

## How will this new service be better?

- Planning the service around your views will ensure that what is provided is wanted and working with you and local community groups will make the service more inclusive

- A new community based service will be more flexible and person centred, as it will make accessing wider opportunities easier and open up more choices.

## What will this mean for the staff?

- The service will continue to be provided by the existing staff team, ensuring a good level of service
- The whole team will have access to an office and management support and will continue to have access to a full training programme.

## How will the new service promote safety?

- For some time now we have been accessing a variety of community facilities and so have worked in partnership to put successful systems in place, raise awareness and encourage good practice
- Contract and monitoring performance
- Care Management reviews
- Safeguarding vulnerable adults policy and procedures.


## How will transport needs be met?

- It is our aim to develop a service that is more accessible and personalised. Your Care Manager will discuss any needs on an individual basis.
- Through Care Management review.

## Are these changes being made to save money?

- No
  We aim to use the current budget differently, which means that the budget will be used to support people more flexibly instead of spending it on buildings.
  If any efficiency is achieved through the new service model then this will save money.

**If you have further questions or comments there will be opportunities to share these in the following ways:**

- consultation meetings and events
- completing the questionnaire
- logging on to the website www.kent.gov.uk/learningdisability
- emailing: GoodDayProgramme@kent.gov.uk


**This questionnaire is available in alternative formats and can be provided in a range of languages.**

**Please contact us on 08458 247 100**

# Thanet Day Services
# Consultation Summary Report

## With outcomes and Decision
## February 2012

**Better Days for People with Learning Disabilities in Kent**
**The Good Day Programme**

**This report can be made available in other formats and large print copies are available at Thanet Day Opportunities Service**

# Background

During June to September 2011 we have been talking to people about the future of Day Services in the Thanet district.

Kent County Council's "Good Day Programme – Better Days for People with Learning Disabilities across Kent" comes from the main ideas in 'Valuing People' & 'Valuing People Now' (2001/2009). It also takes account of KCC's Medium Term Plan, Bold Steps. The consultation was about how to change and improve the way we deliver services in the future so that people have a wider range of choice in with what they want to do during days, evenings and weekends. More control, flexible support and opportunity to lead a full and meaningful person centred life within their local community.

The existing services are Thanet Day Opportunities Service (DOS), and includes The Pharmacy Art Gallery and The St Lukes project.

The main idea was to move towards more community based services, develop **Community Hubs** in Thanet and to consider how we might work in partnership to improve other community facilities.

We asked:

- Everybody who uses the services
- Family and Carers
- People who may use services in the future
- People from other services
- Staff & Union representatives
- The general public

# What happened during consultation?


352 questionnaires were sent to different individuals and groups. We received 115 responses.

We held a range of meetings for people who use the services, their Family Carers, Staff, KCC Members, Councilors and other people who were interested.

Family Carers were offered 1 to 1 meetings, and some went to visit Maidstone and Canterbury to see how services there had been developed.

Independent Advocacy supported people who use the service, including those with complex needs to make sure their views were included.


Presentations and updates have been held with Thanet District Partnership Group.


KCC Members and Thanet District and Parish Councilors have attended meetings during the consultation.

Information was provided in the Thanet DOS Newsletters to keep people up to date.

# What did people who use the service say?

The community projects are good. We like going out to different places and meeting new people. We like our friendships and the support from staff. Some people said the centre is safe and it would be sad to think of it closing, but there are not enough sessions and it can be boring. The most popular places are The Centre, The Gallery, St Lukes and the allotments

‘I like going to the allotments”

“I like to go to the Gym at Hartsdown”

“I want to see my friends”

## What things worried people who use the Service?

Feeling sad that the Centre might close or confused about the changes. People said how important it was that they get to see their friends both in small groups and by coming together for social events.

Social events will still be planned in the future.

# What did Family Carers and other people say?

Some carers have known the centre for a long time and value the security and safety of the building. They were unsure about what the new service will be like and some would rather things stay the same. Some felt powerless to stop changes which they felt were being forced.

Some thought that the proposal to move away from the centre building was about making financial savings rather than improving the service?

It is important for family carers to have a break and for people to have a base where they can meet their friends when they are not taking part in other activities.


The Thanet Learning Disability District Partnership Group were able to share and discuss what was happening with their members.

# How will the new service look?

We will work together to identify the new **Community Hubs** which will have good access for everyone, some will have a '**Changing Place**' (a toilet and shower and changing area for people who need assistance with their personal care). People will have their own space to meet up, talk about what they are going to do, have time to rest between activities or to complete some activities when they are not doing other things in the local community. We will also look to develop work opportunities for people with a disability in co-operation with our partners in the local community. We shall pay careful attention to equality.

The aim is to use money differently, which means that money will be used to support people more flexibly instead of spending it on old style day centre buildings.

Money spent on The Thanet DOS site will be re-invested into learning disability services and towards community facilities that meet the needs of people with learning disabilities.


From the **Community Hubs** people will continue to access other facilities including places like:

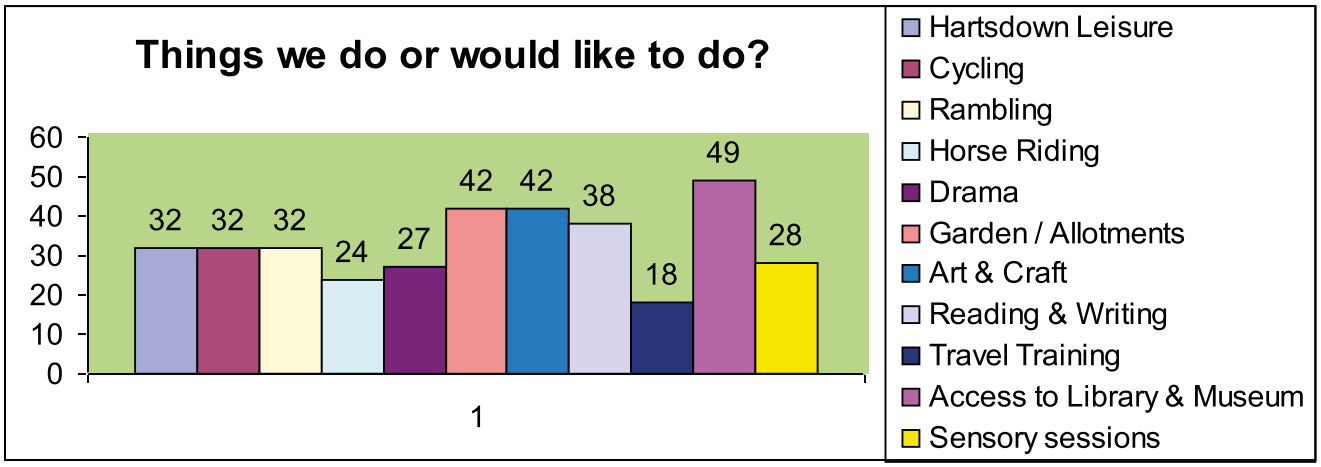
**The Gallery**, **Leisure Centres**, **Thanet Gateway**, as well as exploring other things they may wish to take part in within their local community using a Person Centred approach.

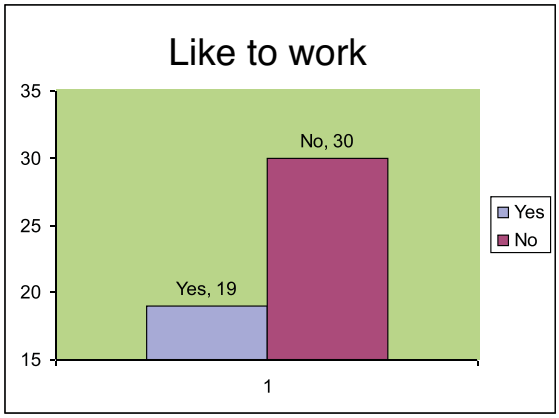
**"I work here every Wednesday and I really like it"**

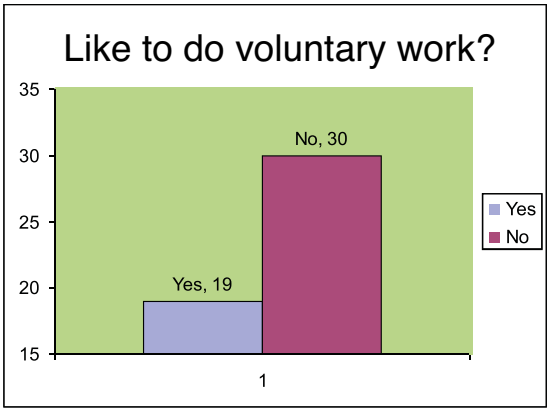
**"I love coming here"**

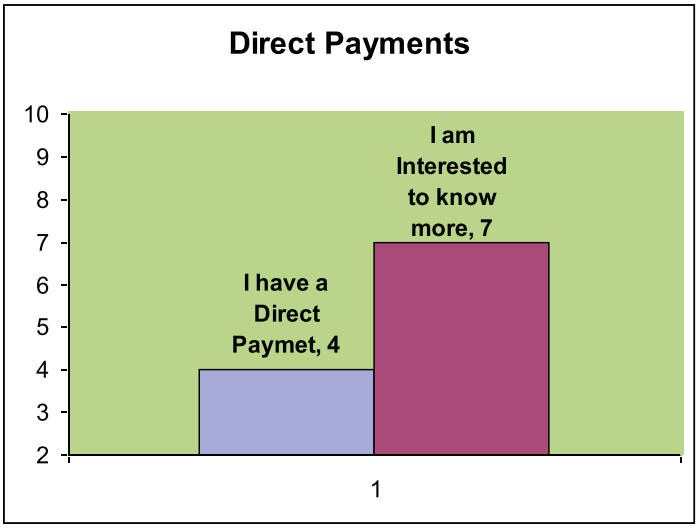
**"At the allotments we grow things"**

# What did people say they want or would like to do?



# What will happen to the Thanet DOS building?

KCC will complete a feasibility study to see if the Thanet DOS building can be included as one of the Community Hubs.  If Thanet DOS building is not used as a community hub, it will not close until the new services are up and running.

Things that are important to people will be kept or moved to another location e.g. Wood and Leather Craft.

# Consultation

The consultation has been really important; people have been supported by independent advocacy to understand what has been proposed, and give their views through meetings, questionnaires and on the Kent County Council web-site.

We are confident that we can continue to support people with learning disabilities to have Better Days in the Thanet District.

It will remain important that people who use the services are at the centre of all the new developments, so people will be involved in identifying and saying what the Community Hubs need to look like.

# Decision

We took peoples views and comments to the Cabinet Member for Adult Social Care and Public Health for him to look at and make a decision.

He agreed that the new service model for learning disability day services within the Thanet District as described in this summary can now happen.

(i) A feasibility study on the Thanet DOS building and site will be carried out to ascertain the viability of both capital and revenue investment in terms of using the building as part of the future new service model.

(ii) the development of new resources within Thanet to be known as Community Hubs, which when fully developed and used to the satisfaction of service users will eventually lead to the closure of the segregated service currently run in the Thanet DOS building.

(iii) the implementation of the new service model for learning disability day services within the Thanet District, as outlined in this report.

Thank you to everyone who has taken part in this consultation and given their views and ideas.
For more information please contact:
Tim Birchley or Paula Watson on 01304 828555


**This questionnaire is available in alternative formats and can be provided in a range of languages.**

**Please contact us on 08458 247 100**

PJ/08/2/12

| | |
|---|---|
| By: | Graham Gibbens, Cabinet Member for Adults Social Care and Public Health |
| | Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **ADULT SOCIAL CARE BUDGET FORECAST AND SAVINGS REPORT 2011/12** |
| Classification: | Unrestricted |

Summary: A report on the forecast outturn and savings position against the budget for Kent Adult Social Care Services of the Families and Social Care Directorate for the third quarter.

## Introduction

1. (1) This is the fourth report for 2011-12 to this Committee on the forecast outturn against budget for Adult Social Care and includes an update on savings.

## Background

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

a) **Budget Monitoring reports**

A detailed quarterly budget monitoring report has been presented to Cabinet, in September, December and March, with a draft final outturn report in July. 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.

**Third Quarter Monitoring Report - Revenue**

3. (1) The full monitoring report for the third quarter for Adult Social Care as presented to Cabinet on 19 March 2012 is attached at Appendix 1 and this indicates an overall underspend of £3.868m.

(2) The £3.868m under spend breaks down as follows:

| | **£m** |
|---|---|
| Older People | -3.117 |
| Physical Disability | 1.435 |
| Learning Disability | -0.875 |
| Mental Health | 0.265 |
| Assessment of Vulnerable Adults | -1.447 |
| Safeguarding Adults | 46 |
| Directorate Management & Support | -0.175 |
| | |
| **TOTAL** | **-3.868** |

(3) The revenue forecast also allows for the impact of the NHS Support for Social Care of £16.226m as well as additional winter pressures funding of £3.775m.

(4) This position assumes that all but £1.795m savings identified within the Medium Term Plan will be achieved.

| | **£'m** |
|---|---|
| LD/PD Procurement | 1.252 |
| Slippage of Enhanced Domiciliary | 0.100 |
| Slippage of Jointly Owned Properties | 0.040 |
| Non residential charging Delay in implementing -NDI/DREA | 0.403 |
| **Total** | **1.795** |

(5) The achievement of savings is pivotal to the delivery of an efficiently managed budget. Robust monitoring arrangements are in place on a monthly basis to ensure that forecasts and expenditure are closely monitored and where necessary challenged.

(6) Our monitoring process includes 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.

**Third Quarter Monitoring Report - Capital**

(7) The full monitoring report for the third quarter for Adult Social Care, as presented to Cabinet on 19 March 2012, is attached at Appendix 2 and this indicates an underspend of £1.996m, of which all of it is requested to be re-phased into 12/13.

**Recommendations:**

4. (1) Members of the Adults Social Care & Public Health Policy Overview and Scrutiny Committee are asked to **NOTE** the Quarter 3 monitoring position for revenue, capital and savings, reported to Cabinet in March.

Michelle Goldsmith
FSC - Finance Business Partner
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*Background documents:* None

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# FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
# JANUARY 2011-12 FULL MONITORING REPORT

## 1. FINANCE

### 1.1 REVENUE

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

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits have been adjusted since the last full monitoring report to reflect:
  - the removal of contingency held against the ending of Social Care Reform Grant following agreement to the use of the £16.226m NHS funding for Social Care. This contingency has been transferred to the Financing Items budgets within the Finance & Business Support portfolio
  - and a number of other technical adjustments to budget.
- The inclusion of new 100% grants (ie grants which fully fund the additional costs) awarded since the budget was set. These are detailed in Appendix 1 of the executive summary, and include £3.775m additional health funding for winter pressures, which has been added to both gross and income budgets within the Other Adult Services budget line.

1.1.2 **Table 1** below details the revenue position by A-Z budget line:

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **Adult Social Care & Public Health portfolio** | | | | | | | |
| Strategic Management & Directorate Support Budgets | 9,898 | -755 | 9,143 | 52 | -182 | -130 | |
| Adults & Older People: | | | | | | | |
| **- Direct Payments** | | | | | | | |
| - Learning Disability | 10,187 | -736 | 9,451 | -920 | 313 | -607 | Activity below budget level; income charge lower than budget |
| - Mental Health | 732 | | 732 | -173 | 0 | -173 | activity below the level budgeted for |
| - Older People | 6,159 | -665 | 5,494 | -392 | 41 | -351 | Unit cost below budgeted level |
| - Physical Disability | 8,248 | -353 | 7,895 | 31 | -41 | -10 | |
| Total Direct Payments | 25,326 | -1,754 | 23,572 | -1,454 | 313 | -1,141 | |
| **- Domiciliary Care** | | | | | | | |
| - Learning Disability | 7,603 | -1,454 | 6,149 | -1,255 | 76 | -1,179 | Activity below affordable level |
| - Mental Health | 898 | 0 | 898 | -362 | 0 | -362 | Activity below affordable level |
| - Older People | 46,554 | -11,925 | 34,629 | -2,644 | 1,466 | -1,178 | Activity below affordable level for both P&V and In-House; average unit income below budgeted level |
| - Physical Disability | 7,684 | -539 | 7,145 | -126 | 47 | -79 | |
| Total Domiciliary Care | 62,739 | -13,918 | 48,821 | -4,387 | 1,589 | -2,798 | |

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **- Nursing & Residential Care** | | | | | | | |
| - Learning Disability | 75,524 | -23,389 | 52,135 | 3,467 | -1,232 | 2,235 | Activity & unit cost in excess of affordable level. Increased income from increased activity |
| - Mental Health | 6,737 | -846 | 5,891 | 123 | 235 | 358 | Unit cost higher than affordable; Increase in Section 117 clients |
| - Older People - Nursing | 45,547 | -22,070 | 23,477 | 115 | -263 | -148 | Activity in excess of budget level; lower unit cost; release of provision & unrealised creditors from balance sheet |
| - Older People - Residential | 88,184 | -36,594 | 51,590 | -3,384 | 1,771 | -1,613 | Activity below affordable level; Modernisation strategy leading to gross savings & reduced income; release of provision & unrealised creditors from balance sheet |
| - Physical Disability | 12,305 | -1,786 | 10,519 | 1,054 | 22 | 1,076 | Activity in excess of budget level |
| Total Nursing & Residential Care | 228,297 | -84,685 | 143,612 | 1,375 | 533 | 1,908 | |
| **- Supported Accommodation** | | | | | | | |
| - Learning Disability | 31,227 | -18,857 | 12,370 | -580 | -173 | -753 | Unit cost below affordable level; activity in excess of budget |
| - Physical Disability/Mental Health | 1,313 | -255 | 1,058 | 968 | -104 | 864 | activity in excess of affordable level |
| Total Supported Accommodation | 32,540 | -19,112 | 13,428 | 388 | -277 | 111 | |
| **- Other Services for Adults & Older People** | | | | | | | |
| - Contributions to Vol Orgs | 14,912 | -902 | 14,010 | -262 | -29 | -291 | Recommissioning strategies |
| - Day Care | | | | | | | |
| - Learning Disability | 13,274 | -284 | 12,990 | -311 | 57 | -254 | Efficiencies; reduced client numbers |
| - Older People | 3,926 | -157 | 3,769 | -374 | 2 | -372 | Recommissioning strategies |
| - Physical Disability/Mental Health | 1,302 | -1 | 1,301 | -69 | 1 | -68 | |
| Total Day Care | 18,502 | -442 | 18,060 | -754 | 60 | -694 | |
| - Other Adult Services | 33,879 | -28,165 | 5,714 | 162 | 452 | 614 | Reduced provision of meals; increased OT equipment |
| Total Other Services for A&OP | 67,293 | -29,509 | 37,784 | -854 | 483 | -371 | |
| **- Intermediate Services** | | | | | | | |
| - Assessment of Vulnerable Adults & Older People | 40,912 | -3,361 | 37,551 | -1,672 | 225 | -1,447 | Vacancy management; uncommitted funding; reduced recharges to health |
| | | | | | | | |
| **Total ASC&PH portfolio** | **467,005** | **-153,094** | **313,911** | **-6,552** | **2,684** | **-3,868** | |

1.1.3 **Major Reasons for Variance**: *[provides an explanation of the 'headings' in table 2]*

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

**Adult Social Care & Public Health portfolio:**
**Overall forecast net under spend of £3,868k (-£6,552k gross and +£2,684k income), details of those variances, in excess of £100k, are detailed below.**

1.1.3.10 **Strategic Management & Directorate Support Budgets (including safeguarding) -£130k (+£52k gross, -£182k income)**
Both the gross and income variances on this heading are due to many minor variances, all below £100k, but with the cumulative effect of £52k gross pressure and £182k over-recovery of income.

1.1.3.11 **Direct Payments: -£1,141k (-£1,454k gross, +£313k income)**

a. Learning Disability -£607k (-£920k gross, +£313k income)
The forecast under spend against the gross service line of £920k is generated as a result of the forecast activity weeks being 1,187 (-£257k) lower than the affordable, coupled with a forecast unit cost being lower than the affordable by £20.28 (-£863k). There is a pressure against one-offs of £219k, due to the number of one-off payments being greater than that afforded in the budget. The remaining variance is against payments to carers.

This service is forecasting an under recovery of income of £313k, because the actual average unit income being charged is £6.91 (+£297k) lower than the budgeted level, plus a minor variance due to the reduced level of activity.

b. Mental Health -£173k (gross)
The forecast number of weeks of care provided is 3,027 lower than anticipated generating a forecast under spend of £171k. There is a minor saving against price, and also a minor pressure in relation to one-off payments, for example for equipment, which make the total saving £173k

c. Older People -£351k (-£392k gross, +£41k income)
This budget line is forecast to underspend by £392k on gross expenditure. The number of weeks of care provided is forecast to be 266 fewer than budgeted, generating a saving of £33k, in addition the unit cost is lower than budgeted by £11.43, therefore generating an under spend of £512k. There is also a gross pressure of £139k due to the number one-off payments being in excess of the level budgeted. The remaining gross variance is due to payments to carers.

1.1.3.12 **Domiciliary Care: -£2,798k (net), (Gross -£4,387k, Income +£1,589k)**

a. Learning Disability -£1,179k (-£1,255k gross, +£76k income)
The overall forecast is an under spend against gross of £1,255k, coupled with an under recovery of income of £76k. The number of hours is forecast to be 195,106 lower than the affordable level, generating a £2,715k forecast under spend. The actual unit cost is £3.40 higher than the affordable level, increasing the forecast by £1,382k. The remaining variance of +£78k against gross, is comprised of many smaller variances including Extra Care Sheltered Housing and Independent Living Service (ILS).

b. Mental Health -£362k gross
There is a gross underspend forecast of £362k. Forecast hours are 22,580 below the affordable level, creating an under spend of £385k, whilst the unit cost is forecast to be £0.42 higher than affordable, which reduces this saving by £23k.

c. Older People -£1,178k (-£2,644k gross, +£1,466k income)
The overall forecast is an under spend against gross of £2,644k, coupled with an under recovery of income of £1,466k. The number of hours is forecast to be 12,427 lower than the affordable hours generating a £185k forecast underspend. The actual unit cost is £0.59 lower than the affordable level, increasing that initial forecast underspend by a further £1,413k.

The Kent Enablement at Home (KEaH), in house service is forecasting a gross underspend of £674k, which is the cumulative effect of less hours of service than budgeted being forecast, and resultant savings in staffing costs. A saving of £307k is also forecast against block domiciliary

contracts, as a result of savings on non-care related costs, and where negotiations to have an element of unused hours refunded has been successful.

Within this budget line is a forecast of £447k of unachievable savings, however this is fully offset by other funds which have been uncommitted. Of this £447k, £100k relates to the domiciliary enhanced procurement element as a result of a delay in notice being served to contractors, with the remainder relating to the delay in implementing the revised charging policy.

The remaining gross variance comprises several smaller variances below £100k, including enablement, provisions for bad debt and extra care housing.

The reduction in activity is forecast to yield an under recovery of income of £50k, this is coupled with a slight reduction in actual average unit charge, which generates a further £1,536k income pressure, offset by several small income over-recoveries including extra care housing and enablement.

d. Physical Disability -£79k (-£126k gross, +£47k income)
The gross variance is caused by the forecast of 59,344 hours below affordable level, creating a £833k saving, this is offset by a unit cost variance £1.26 greater than affordable, causing a pressure of £696k. The remaining gross pressure, and income variance is due to variances on a number of other lines in this heading, all below £100k.

1.1.3.13 **Nursing & Residential Care: +£1,908k (net), (Gross +£1,375k, Income +£533k)**

a. Learning Disability +£2,235k (+£3,467k gross, -£1,232k income)
The overall forecast for residential care is a pressure on gross of £3,467k, partially offset by an over recovery of income of -£1,232k, giving a net pressure of £2,235k. The number of client weeks provided is forecast to be 2,067 higher than the affordable level at a cost of £2,576k. As detailed within section 2.8.1, the forecast activity for this service is based on known individual clients, by individual periods of service, including provisional and transitional clients. (Provisional clients are those who may move from domiciliary/direct payments to residential as a result of deterioration in their condition/personal requirements, as well as clients already in receipt of residential care, but whose personal/financial circumstances deteriorate). The activity trend to date may appear to be low when considered alongside the forecast, in some cases this is as a result of timing differences between when the clients are added into SWIFT (the client activity system), compared to the inclusion within the financial forecast, which maybe as a result of disputes or independent contract negotiations. In addition, there is expected to be increased take-up in the final quarter of the year. The actual unit cost is £1,246.05, which is £16.86 higher than the affordable level and creates a pressure of £649k.
There are also variances on the preserved rights lines, where activity is forecast to be 4,265 weeks lower than affordable. This reduction in activity creates a saving of £3,771k, however the unit cost is more than afforded, resulting in a pressure of £3,877k.

The remaining gross variance of +£136k comprise numerous individual variances below £100k. This includes in-house provision as a result of providing additional 1 to 1 support, minor variances on Registered Nursing Care Contribution (RNCC), and on agency staff required to cover sickness at in-house provision, as well as replacement costs of essential equipment at units.

The additional forecast client weeks for residential care add £843k of income, and the actual income per week is higher than the expected level by £14.15 which generates a further over-recovery in income of £545k.

The reduction in client weeks compared to affordable for preserved rights residential care cause a loss of £1,151k of income, and the actual income per week is higher than the expected level by £29.81 which generates an over-recovery in income of £1,000k.

The remaining income variance of +£5k is related to in house provision and RNCC.

Also, within this budget line is a forecast of £1,196k of unachievable procurement savings as a result of a delay in notice being served to contractors, however this is fully offset by other funds which have been uncommitted.

b. Mental Health +£358k (+£123k gross, +£235k income)

The forecast for residential care is a gross pressure of £123k and an under-recovery of income of £235k, leaving a net pressure of £358k. The forecast number of weeks of care is 91 lower than the affordable level giving a saving of £51k. The actual unit cost is £11.73 higher than the affordable level, which creates a pressure of £114k. There are also minor gross variances on preserved rights and on RNCC. The forecast also assumes a significant under-recovery in income of £226k due to the continual increasing proportion of clients falling under the Section 117 legislation which means that they do not contribute to the cost of their care. There are also small income variances on Preserved Rights.

c. Older People- Nursing -£148k (+£115k gross, -£263k income)
There is a forecast pressure of £115k on gross and an over recovery of income of £263k, leaving a net underspend of £148k. The forecast level of client weeks is 3,619 higher than the affordable level, at a forecast pressure of £1,684k. The unit cost is currently forecast to be £13.36 lower than budget, which gives a forecast under spend of £1,034k. There is also -£540k due to a release of a provision and unrealised creditors following a review of the balance sheet. The remaining gross variance is related to minor variances on preserved rights and RNCC.

The increased activity has resulted in a forecast over recovery of income of £628k, offset by a reduction in the average unit income being charged which reduces the position by £399k. The remaining income variance is related to minor variances on preserved rights and RNCC.

d. Older People- Residential -£1,613k (-£3,384k gross, +£1,771k income)
This service is reporting a gross under spend of £3,384k, along with an under recovery of income of £1,771k. The forecast level of client weeks is 6,419 lower than the affordable levels, which generates a forecast under spend of £2,513k. The unit cost is also £3.32 higher than the affordable levels causing a £530k pressure. Of the remaining forecast gross variance, -£480k reflects the savings against the In-house provision, including Integrated Care centres (ICC), which are beginning to filter through, as part of the Modernisation Strategy. In addition there is -£599k which is due to a release of a provision and unrealised creditors following a review of the payments that have been requested relating to outstanding invoices for 2010-11 and -£230k because the profile of early retirement costs from the closure of homes under the Modernisation Strategy is falling later than expected (i.e. in 2012-13).

The remaining variance comprises a number of smaller variances below £100k.

On the income side, the reduction in activity results in a £1,150k shortfall in income, however this is offset by a higher than budgeted average unit income being charged which has reduced this shortfall by £374k. In addition, there is a forecast under recovery of income of £1,037k for the In-house service & ICCs, mainly due to less permanent clients being placed in the homes because of the OP Modernisation Strategy. The remaining income variance comprises a number of smaller variances below £100k

We continue to expect some volatility in the forecast against this service line this year because of the impact of the Modernisation agenda.

e. Physical Disability + £1,076k (+£1,054k gross, +£22k income)
A gross pressure of £1,054k, along with an under recovery of income of £22k, is reported for this budget. The forecast level of client weeks of service is 1,335 higher than the affordable level, giving a forecast pressure of £1,140k. The forecast unit cost is currently £18.65 lower than the affordable level, which reduces that pressure by £226k. In addition, a +£140k forecast pressure relates to the Preserved Rights service, where the forecast client weeks of service are currently 153 higher than the affordable level.

The additional activity is forecast to increase income by £137k, however the forecast weekly income is £14.92 lower than budgeted resulting in an under recovery of £181k. There are also minor income variances on preserved rights and RNCC.

1.1.3.14 **Supported Accommodation: +£111k(net), (Gross +£388k Income -£277k)**

a. Learning Disability -£753k (-£580k gross, -£173k income)
A gross under spend of £580k, coupled with an over recovery of income of £173k generates the above net forecast variance. The forecast level of client weeks is 532 higher than the affordable levels generating a £521k forecast pressure. The gross unit cost is currently forecast to be

£33.35 lower than the affordable level, which generates a £1,007k forecast under spend. The forecast also includes a £170k addition to the Social Care costs reserve, for potential liabilities relating to ordinary residence, the remaining gross variances totalling -£264k are each less than £100k, across other services including group homes, link placements and resource centres.

The increased activity creates a minor over recovery of income; however the average unit income is higher than budgeted, so creates an over-recovery of income of £123k. The remaining income variance is on several service lines under this heading, each below £100k

Within this budget line is a forecast of £208k of unachievable procurement savings as a result of delays in negotiations with Providers, however this is fully offset by other funds which are uncommitted.

b. Physical Disability/Mental Health +£864k (+£968k gross, -£104k income)
For the physical disability client group the forecast level of client weeks is 708 higher than the affordable level of weeks, creating a pressure of £569k, coupled with a slightly lower than affordable unit cost level which creates a minor £46k saving.
There is also a minor over recovery of income.

For the mental health client group the forecast level of client weeks is 1,724 higher than the affordable level, generating a forecast pressure of £573k, offset by a variance in price of -£128k, caused by the unit cost being £63 lower than budgeted. There is also a small over recovery in income for this client group.

1.1.3.15 **Other Services for Adults & Older People**

a. Contributions to Voluntary Organisations -£291k (-£262k gross, -£29k income)
As part of the ongoing drive to deliver more self directed support through Direct Payments & Personal Budgets, various contracts with voluntary organisations are currently being reviewed/re-negotiated or re-commissioned. We are currently working in conjunction with District Partnership Groups to continue to provide the service, but in a different way. The current overall effect of this is a forecast saving on the gross budget of £262k. The slight over recovery of income is due to an overall increase in Health funding.

b. Day Care -£694k (-£754k gross, +£60k income)
As a result of a culmination of a reduction in staffing levels against Learning Disability Day Services, improved data quality which has enabled efficiencies to be made in the provision of day care and clients ceasing to take up the service, this generates a forecast saving of £280k. A further £343k forecast gross saving relates to a number of re-commissioning strategies for both the in-house and independently provided services, mainly across the Older People client group. The remaining variance is due to a number of minor variances across all clients groups, separate to the reasons above, all of which are below £100k.

c. Other Adult Services +£614k (+£162k gross, +£452k income)
There is a forecast under spend related to the provision of meals, where the volume of meals continues to fall creating a gross underspend of £415k and a £440k under recovery of income.
There is also an overspend relating to the Occupational Therapy unit of £418k, which relates to the provision of equipment being above the budgeted level.
The remaining variances, including a total of +£159k on gross and +£12k on income are due to minor variances, all below £100k, across many different services within this budget line.

1.1.3.16 **Intermediate Services - Assessment of Vulnerable Adults & Older People: -£1,447k (-£1,672k gross, +£225k income)**
The Mental Health assessment & related (A&R) service contributes approximately £1,025k towards this forecast under spend as a result of both vacancy management through continuing to hold posts vacant and delaying any recruitment process pending the outcome of the internal restructure that is currently underway, alongside an historical difficulty in recruiting qualified social work staff. These gross variances are partially offset by a forecast reduction in income, totalling £180k, as 3 of these vacant posts were previously funded by health. There are some other minor income variances totalling +£45k.

In addition to this is £565k of the forecast under spend on gross is the Directorate's prudency in holding back unallocated funding in order to offset other pressures within the directorate. The remainder of the gross variance is due to a number of minor variances totalling -£82k.

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

(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Residential - Learning Disability Gross - Preserved rights unit cost above affordable level | +3,877 | ASCPH | Residential - Learning Disability Gross - Preserved rights weeks of care lower than budgeted | -3,771 |
| ASCPH | Residential - Learning Disability Gross - Forecast weeks of care higher than budgeted | +2,576 | ASCPH | Domiciliary - Learning Disability Gross - Forecast activity below affordable level | -2,715 |
| ASCPH | Nursing - Older People Gross - Forecast weeks of care higher than budgeted | +1,684 | ASCPH | Residential - Older People Gross - Activity forecast below budgeted level | -2,513 |
| ASCPH | Domiciliary - Older People Income - Average income below affordable level | +1,536 | ASCPH | Domiciliary - Older People Gross - Forecast unit cost below affordable level | -1,413 |
| ASCPH | Domiciliary - Learning Disability Gross - Forecast unit cost above affordable level | +1,382 | ASCPH | Residential - Learning Disability Gross - Uncommitted funding held to offset unachievable savings | -1,196 |
| ASCPH | Residential - Learning Disability Gross - Unachievable procurement savings | +1,196 | ASCPH | Nursing - Older People Gross - Unit cost lower than budgeted | -1,034 |
| ASCPH | Residential - Learning Disability Income - Preserved rights weeks of care lower than budgeted | +1,151 | ASCPH | Assessment of Vulnerable Adults - Gross - Staffing savings | -1,025 |
| ASCPH | Residential - Older People Income - Activity forecast below budgeted level | +1,150 | ASCPH | Supported Accommodation - Learning Disability Gross - Unit cost below the level afforded in the budget | -1,007 |
| ASCPH | Residential - Physical Disability Gross - Activity above affordable level | +1,140 | ASCPH | Residential - Learning Disability Income - Preserved rights average unit income above budgeted level | -1,000 |
| ASCPH | Residential - Older People Income - Loss of income related to Modernisation Strategy (as fewer clients placed in-house) | +1,037 | ASCPH | Direct Payments - Learning Disability Gross - Unit cost below affordable level | -863 |
| ASCPH | Domiciliary - Physical Disability Gross - Unit cost above affordable level | +696 | ASCPH | Residential - Learning Disability Income - Forecast weeks of care higher than budgeted | -843 |
| ASCPH | Residential - Learning Disability Gross - Unit cost in excess of affordable level | +649 | ASCPH | Domiciliary - Physical Disability Gross - Forecast activity below affordable level | -833 |
| ASCPH | Supported Accommodation - Mental Health Gross - Activity in excess of budgeted level | +573 | ASCPH | Domiciliary - Older People Gross - savings at Kent Enablement at Home as a result of forecast activity below budgeted level | -674 |
| ASCPH | Supported Accommodation - Physical Disability Gross - Activity in excess of budgeted level | +569 | ASCPH | Nursing - Older People Income - Forecast weeks of care higher than budgeted | -628 |
| ASCPH | Residential - Older People Gross - Unit cost above affordable level | +530 | ASCPH | Residential - Older People Gross - Release of provision & unrealised creditors following review of balance sheet | -599 |

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Supported Accommodation - Learning Disability Gross - Activity above affordable level | +521 | ASCPH | Assessment of Vulnerable Adults - Gross - prudent holding back of unallocated funding to offset other pressures within directorate | -565 |
| ASCPH | Other Adult Services Income - provision of meals below affordable level | +440 | ASCPH | Residential - Learning Disability Income - Average unit income in excess of budgeted level | -545 |
| ASCPH | Other Adult Services Gross - Increased provision of Occupational Therapy equipment | +418 | ASCPH | Nursing - Older People Gross - Release of provision & unrealised creditors following review of balance sheet | -540 |
| ASCPH | Nursing - Older People Gross - Reduction in average unit income charged | +399 | ASCPH | Direct Payments - Older People Gross - Unit cost below affordable level | -512 |
| ASCPH | Domiciliary - Older People Gross - Unachievable savings due to delay in revised charging policy | +347 | ASCPH | Residential - Older People Gross - Savings related to Modernisation Strategy in excess of budgeted savings | -480 |
| ASCPH | Direct Payments - Learning Disability Income - Average unit charge below budgeted level | +297 | ASCPH | Domiciliary - Older People Gross - Uncommitted funding held to offset unachievable savings | -447 |
| ASCPH | Residential - Mental Health Income - Increased number of Section 117 clients who do not contribute to costs | +226 | ASCPH | Other Adult Services Gross - provision of meals below affordable level | -415 |
| ASCPH | Direct Payments - Learning Disability Gross - Number of one-off payments in excess of budgeted level | +219 | ASCPH | Domiciliary - Mental Health Gross - Forecast activity below affordable level | -385 |
| ASCPH | Supported Accommodation - Learning Disability Gross - Unachievable procurement savings | +208 | ASCPH | Residential - Older People income - average unit charge above budgeted level | -374 |
| ASCPH | Residential - Physical Disability Income - Average unit income charge below budgeted level | +181 | ASCPH | Day Care - Older People Gross - Recommissioning Strategies | -343 |
| ASCPH | Assessment of Vulnerable Adults - Income - Reduced recharges to health due to staffing vacancies | +180 | ASCPH | Domiciliary - Older People Gross - saving on block contracts (refund of unused hours of care) | -307 |
| ASCPH | Supported Accommodation - Learning Disability Gross - tfr to reserves for potential liabilities relating to ordinary residence | +170 | ASCPH | Day Care - Learning Disability Gross - Efficiencies in staffing and provision together with reduced take up of service | -280 |
| ASCPH | Residential - Physical Disability Gross - Preserved Rights Activity above affordable level | +140 | ASCPH | Contributions to Voluntary Organisations - Gross - Recommissioning Strategies | -262 |
| ASCPH | Direct Payments - Older People Gross - Number of one-off payments in excess of budgeted level | +139 | ASCPH | Direct Payments - Learning Disability Gross - Forecast weeks of care below affordable level | -257 |
| ASCPH | Residential - Mental Health Gross - Unit cost in excess of affordable level | +114 | ASCPH | Residential - Older People gross - profile of early retirement costs from the closure of homes under Modernisation Strategy falling later than anticipated | -230 |

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Domiciliary - Older People Gross - Unachievable savings connected to enhanced procurement delays | +100 | ASCPH | Residential - Physical Disability Gross - Unit cost below that afforded in the budget | -226 |
| | | | ASCPH | Supported Accommodation - Learning Disability Gross - Uncommitted funding held to offset unachievable savings | -208 |
| | | | ASCPH | Domiciliary - Older People Gross - Forecast activity below affordable level | -185 |
| | | | ASCPH | Direct Payments - Mental Health Gross - Forecast weeks of care below affordable level | -171 |
| | | | ASCPH | Residential - Physical Disability Income - Activity above affordable level | -137 |
| | | | ASCPH | Supported Accommodation - Mental Health Gross - Unit cost below the budgeted level | -128 |
| | | | ASCPH | Supported Accommodation - Learning Disability Income - Average unit charge above budgeted level | -123 |
| | | | | | |
| | | **+23,845** | | | **-27,234** |

1.1.4 **Actions required to achieve this position**

*eg Management Action achieved to date including vacancy freeze, changes to assessment criteria etc.*

The forecast presented assumes the Good Practice Guidelines adopted within the directorate are being adhered to and it is felt that this has assisted Adult's Services to report a position within cash limit this year.

1.1.5 **Implications for MTFP**:

The recently approved 2012-15 MTFP has addressed the significant pressures reported in the current year on specialist children's services.

Work has also been completed to establish the demographic pressures now anticipated in the medium term for adult social care compared to previous estimates, and the recently approved MTFP has been amended accordingly, although this is likely to need further refinement in light of the latest numbers.

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

No revenue projects have been identified for re-phasing.

1.1.7 **Details of proposals for residual variance**: *[eg roll forward proposals; mgmt action outstanding]*

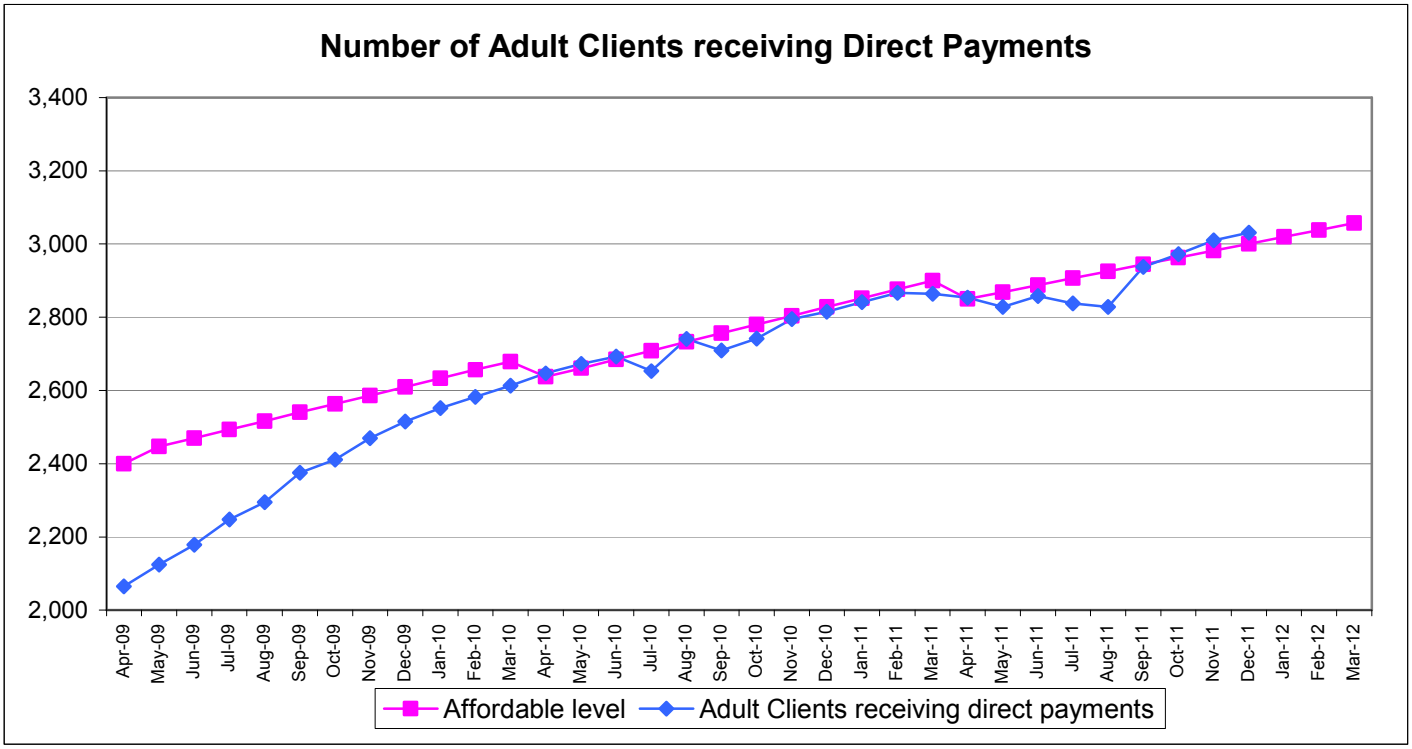
*This section should provide details of the management action outstanding, as reflected in the assumed management action figure reported in table 1 and details of alternative actions where savings targets are not being achieved.*

Work is ongoing within Adult Social Services to finalise the treatment of both NHS support for social care and the recently approved winter pressure funding.

## 2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

### 2.6 Direct Payments – Number of Adult Social Care Clients receiving Direct Payments (DPs):

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level | Adult Clients receiving Direct Payments | Affordable Level | Adult Clients receiving Direct Payments | Affordable Level | Adult Clients receiving Direct Payments |
| April | 2,400 | 2,065 | 2,637 | 2,647 | 2,850 | 2,854 |
| May | 2,447 | 2,124 | 2,661 | 2,673 | 2,869 | 2,828 |
| June | 2,470 | 2,179 | 2,685 | 2,693 | 2,888 | 2,858 |
| July | 2,493 | 2,248 | 2,709 | 2,653 | 2,906 | 2,838 |
| August | 2,516 | 2,295 | 2,733 | 2,741 | 2,925 | 2,828 |
| September | 2,540 | 2,375 | 2,757 | 2,710 | 2,944 | 2,937 |
| October | 2,563 | 2,411 | 2,780 | 2,742 | 2,963 | 2,972 |
| November | 2,586 | 2,470 | 2,804 | 2,795 | 2,982 | 3,010 |
| December | 2,609 | 2,515 | 2,828 | 2,815 | 3,001 | 3,031 |
| January | 2,633 | 2,552 | 2,852 | 2,841 | 3,019 | |
| February | 2,656 | 2,582 | 2,876 | 2,867 | 3,038 | |
| March | 2,679 | 2,613 | 2,900 | 2,864 | 3,057 | |

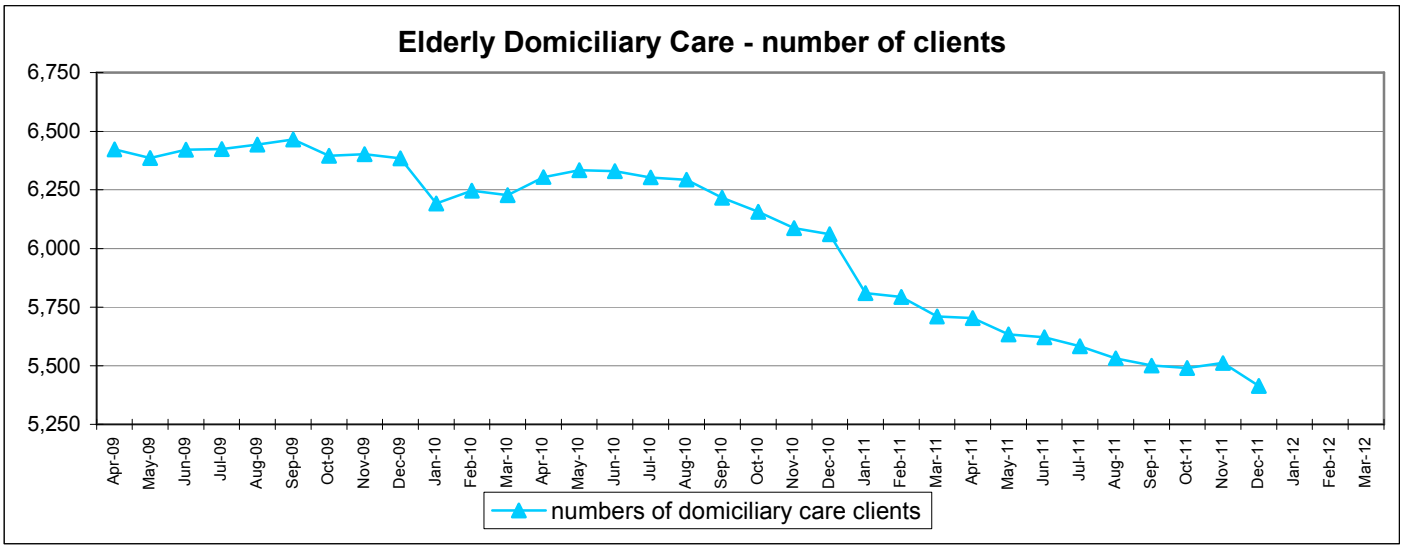


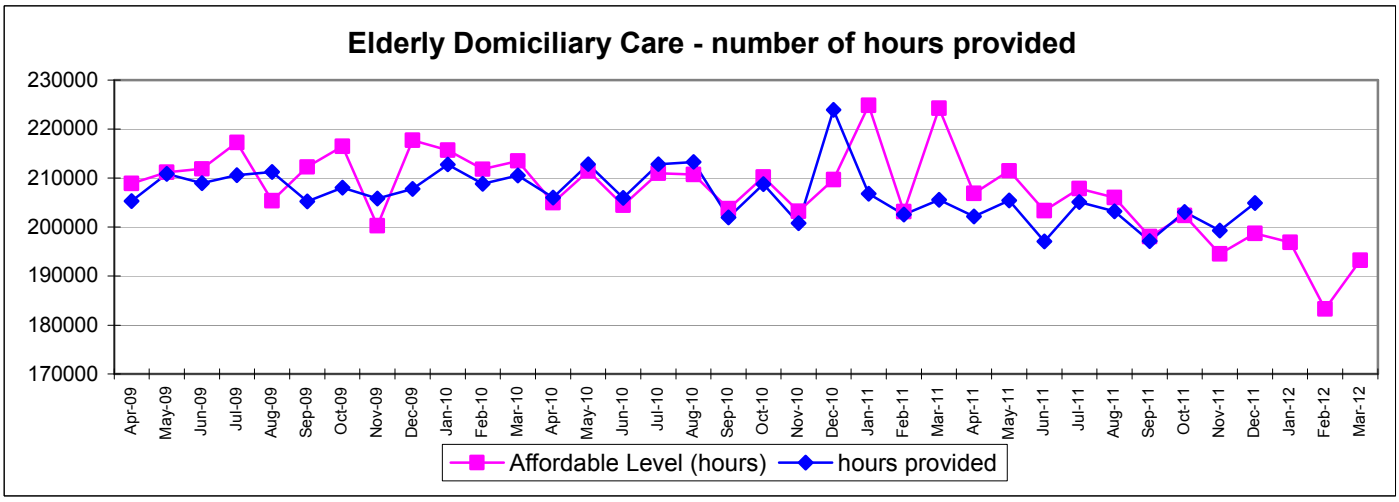

Comments:

- The activity being reported is the long term clients in receipt of direct payments as at the end of the month plus any one off payments during the year. The drive to implement personalisation and allocate personal budgets has seen continued increases in direct payments over the years. There will be other means by which people can use their personal budgets and this may impact on the take up of direct payments, we believe we may be seeing the beginning of this effect, since in the first few months of this financial year, client numbers appear to levelling out, although the number of one-off payments is skewing the analysis.

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

| | 2009-10 | | | 2010-11 | | | 2011-12 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Affordable level (hours) | hours provided | number of clients | Affordable level (hours) | hours provided | number of clients | Affordable level (hours) | hours provided | number of clients |
| April | 208,869 | 205,312 | 6,423 | 204,948 | 205,989 | 6,305 | 206,859 | 202,177 | 5,703 |
| May | 211,169 | 210,844 | 6,386 | 211,437 | 212,877 | 6,335 | 211,484 | 205,436 | 5,634 |
| June | 211,897 | 208,945 | 6,422 | 204,452 | 205,937 | 6,331 | 203,326 | 197,085 | 5,622 |
| July | 217,289 | 210,591 | 6,424 | 210,924 | 212,866 | 6,303 | 207,832 | 205,077 | 5,584 |
| August | 205,354 | 211,214 | 6,443 | 210,668 | 213,294 | 6,294 | 206,007 | 203,173 | 5,532 |
| September | 212,289 | 205,238 | 6,465 | 203,708 | 201,951 | 6,216 | 198,025 | 197,127 | 5,501 |
| October | 216,491 | 208,051 | 6,396 | 210,155 | 208,735 | 6,156 | 202,356 | 203,055 | 5,490 |
| November | 200,292 | 205,806 | 6,403 | 203,212 | 200,789 | 6,087 | 194,492 | 199,297 | 5,511 |
| December | 217,749 | 207,771 | 6,385 | 209,643 | 223,961 | 6,061 | 198,704 | 204,915 | 5,413 |
| January | 215,686 | 212,754 | 6,192 | 224,841 | 206,772 | 5,810 | 196,879 | | |
| February | 211,799 | 208,805 | 6,246 | 203,103 | 202,568 | 5,794 | 183,330 | | |
| March | 213,474 | 210,507 | 6,227 | 224,285 | 205,535 | 5,711 | 193,222 | | |
| **TOTAL** | **2,542,358** | **2,505,838** | | **2,521,376** | **2,501,274** | | **2,402,516** | **1,817,342** | |



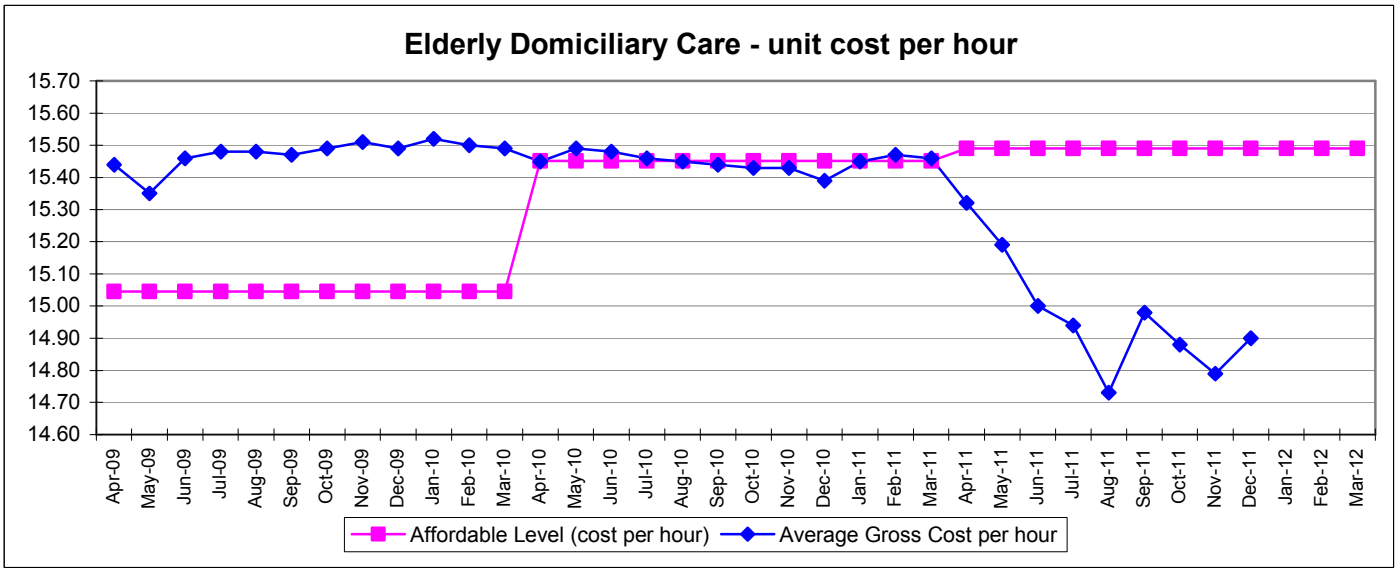

Comment:

- Figures exclude services commissioned from the Kent Enablement At Home Service.
- Affordable levels were changed slightly in quarter 2 to include the release of a provision and some rolled forward grant funding from 2010-11 which is now being used to fund activity.
- Affordable levels have been amended again this quarter to reflect the removal of SCRG transitional funding.

- The actual activity data has been amended from what has previously been reported following a refresh of the data which has been undertaken due to the volatility on this service line and ongoing validation in connection with Transactional Data Management (TDM) data and enablement.
- The current forecast is 2,390,089 hours of care against a revised affordable level of 2,402,516, a difference of -12,427 hours. This forecast is based on a current provision as at January of an average 8.1 hours per client per week. Using the forecast unit cost of £14.90 this reduction in activity reduces the forecast by £185k, as highlighted in section 1.1.3.12.c
- To the end of December 1,817,342 hours of care have been delivered against an affordable level of 1,829,085 a difference of -11,743 hours.
- Domiciliary for all client groups are volatile budgets, with the number of people receiving domiciliary care decreasing over the past few years as a result of the implementation of Self Directed Support (SDS). This is being compounded by a shift in trend towards take up of the enablement service. However, as a result of this, clients who are receiving domiciliary care are likely to have greater needs and require more intensive packages of care than historically provided - the 2010-2011 average hours per client per week was 7.8, whereas the average figure for 2011-12 is 8.4 for data to the end of December.

2.7.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | **Affordable Level (Cost per Hour)** | **Average Gross Cost per Hour** | **Affordable Level (Cost per Hour)** | **Average Gross Cost per Hour** | **Affordable Level (Cost per Hour)** | **Average Gross Cost per Hour** |
| April | 15.045 | 15.44 | 15.452 | 15.45 | 15.49 | 15.32 |
| May | 15.045 | 15.35 | 15.452 | 15.49 | 15.49 | 15.19 |
| June | 15.045 | 15.46 | 15.452 | 15.48 | 15.49 | 15.00 |
| July | 15.045 | 15.48 | 15.452 | 15.46 | 15.49 | 14.94 |
| August | 15.045 | 15.48 | 15.452 | 15.45 | 15.49 | 14.73 |
| September | 15.045 | 15.47 | 15.452 | 15.44 | 15.49 | 14.98 |
| October | 15.045 | 15.49 | 15.452 | 15.43 | 15.49 | 14.88 |
| November | 15.045 | 15.51 | 15.452 | 15.43 | 15.49 | 14.79 |
| December | 15.045 | 15.49 | 15.452 | 15.39 | 15.49 | 14.90 |
| January | 15.045 | 15.52 | 15.452 | 15.45 | 15.49 | |
| February | 15.045 | 15.50 | 15.452 | 15.47 | 15.49 | |
| March | 15.045 | 15.49 | 15.452 | 15.46 | 15.49 | |



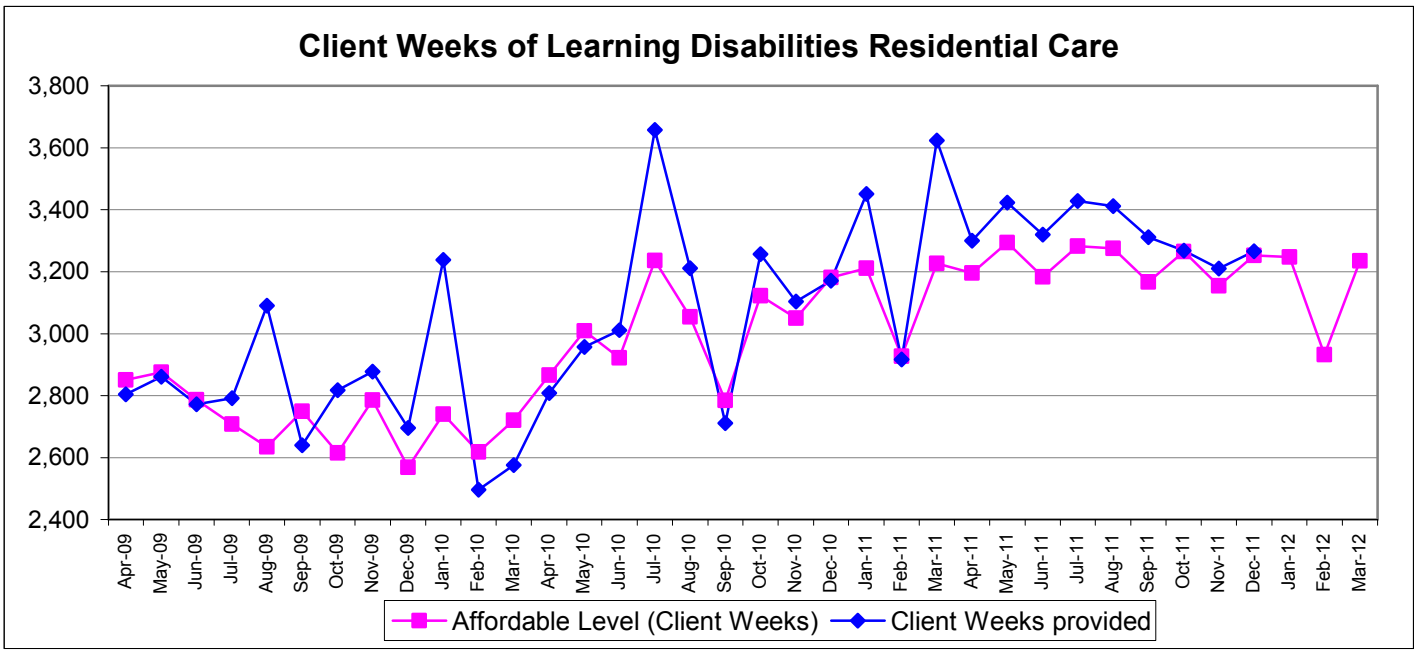

Comments:

- The forecast unit cost of £14.90 is lower than the affordable cost of £15.49 and this difference of -£0.59 reduces the forecast by £1,417k when multiplied by the affordable hours, as highlighted in section 1.1.3.12.c

- The unit cost continues to be lower than the affordable because current work with providers to achieve savings requires them to provide a service at a lower cost – this is ongoing work with all homecare providers and will contribute to the domiciliary re-let. In addition, we are focussing on reducing the unit rate of care packages which are provided in ½ and ¾ hours which have traditionally been slightly more expensive.

2.8.1 **Number of client weeks of learning disabilities residential care provided compared with affordable level (non preserved rights clients):**

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided |
| April | 2,851 | 2,804 | 2,866 | 2,808 | 3,196 | 3,300 |
| May | 2,875 | 2,861 | 3,009 | 2,957 | 3,294 | 3,423 |
| June | 2,787 | 2,772 | 2,922 | 3,011 | 3,184 | 3,320 |
| July | 2,708 | 2,792 | 3,236 | 3,658 | 3,282 | 3,428 |
| August | 2,635 | 3,091 | 3,055 | 3,211 | 3,275 | 3,411 |
| September | 2,750 | 2,640 | 2,785 | 2,711 | 3,167 | 3,311 |
| October | 2,615 | 2,818 | 3,123 | 3,257 | 3,265 | 3,268 |
| November | 2,786 | 2,877 | 3,051 | 3,104 | 3,154 | 3,210 |
| December | 2,569 | 2,696 | 3,181 | 3,171 | 3,253 | 3,266 |
| January | 2,740 | 3,238 | 3,211 | 3,451 | 3,248 | |
| February | 2,619 | 2,497 | 2,927 | 2,917 | 2,932 | |
| March | 2,721 | 2,576 | 3,227 | 3,624 | 3,235 | |
| **TOTAL** | **32,656** | **33,662** | **36,593** | **37,880** | **38,485** | **29,937** |




Comments:

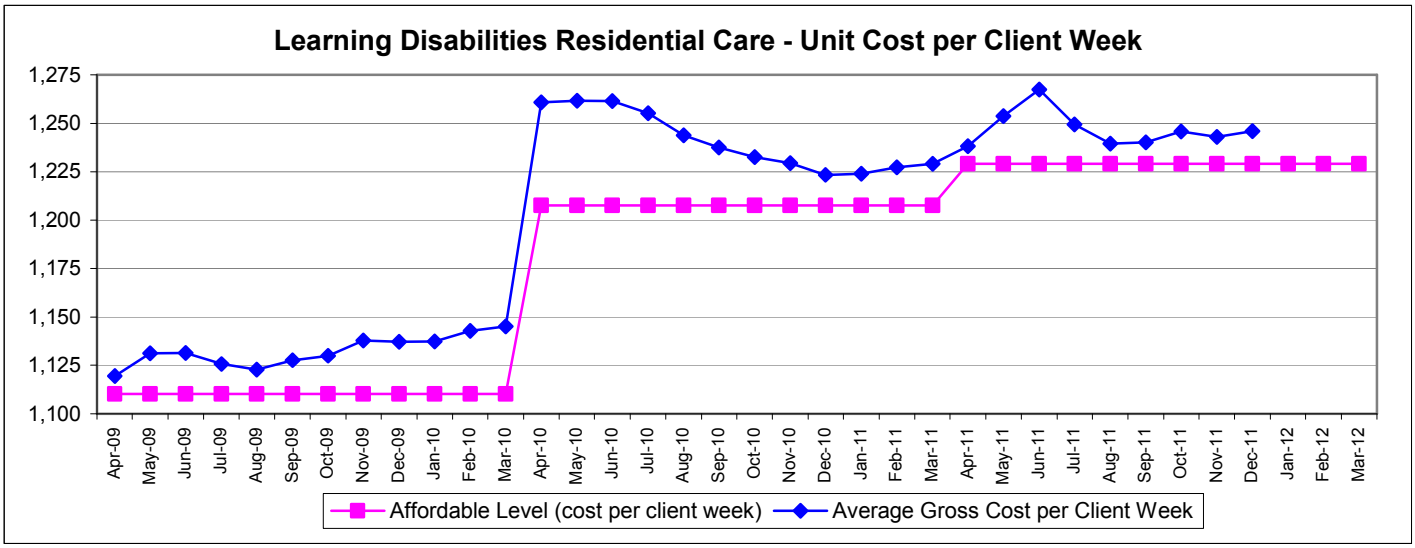
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2009-10 was 632, at the end of 2010-11 it was 713 and at the end of December 2011 it was 748 including any ongoing transfers as part of the S256 agreement, transitions, provisions and Ordinary Residence.
- The current forecast is 40,552 weeks of care against an affordable level of 38,485, a difference of +2,067 weeks. Using the forecast unit cost of £1,246.05, this additional activity adds £2,576k to the forecast, as highlighted in section 1.1.3.13a. The forecast activity for this service is based on known individual clients, by individual periods of service, including provisional, transitional and ordinary resident clients. (Provisional clients are those who may move from domiciliary/direct payments to residential as a result of deterioration in their condition/personal requirements, as well as clients already in receipt of residential care, but whose personal/financial circumstances deteriorate). This is a volatile demand led budget forecast meaning that each month may present changes to the forecast as new data is obtained. In some cases there are timing differences between when the clients are added into SWIFT (the client activity system), compared to the inclusion within the financial forecast, maybe as a result of disputes or independent contract negotiations. The forecast appears high compared to the year to date activity because there is expected to be an increased

take-up in the final quarter of the year with known new placements coming into the service - January's activity data is indicating approx 3,500 weeks, with further increases expected in the final months of the year.

- To the end of December 2011 29,937 weeks of care have been delivered against an affordable level of 29,070, a difference of +867 weeks.
- The forecast is based on individual clients, including those prospective young people coming in via transition. It is not always possible to predict the trend for this; comparisons with previous trends are consequently not always meaningful.

2.8.2 **Average gross cost per client week of Learning Disabilities residential care compared with affordable level (non preserved rights clients)**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** |
| April | 1,110.15 | 1,119.42 | 1,207.58 | 1,260.82 | 1,229.19 | 1,238.24 |
| May | 1,110.15 | 1,131.28 | 1,207.58 | 1,261.67 | 1,229.19 | 1,253.68 |
| June | 1,110.15 | 1,131.43 | 1,207.58 | 1,261.46 | 1,229.19 | 1,267.40 |
| July | 1,110.15 | 1,125.65 | 1,207.58 | 1,255.21 | 1,229.19 | 1,249.41 |
| August | 1,110.15 | 1,122.81 | 1,207.58 | 1,243.87 | 1,229.19 | 1,239.50 |
| September | 1,110.15 | 1,127.79 | 1,207.58 | 1,237.49 | 1,229.19 | 1,240.17 |
| October | 1,110.15 | 1,130.07 | 1,207.58 | 1,232.68 | 1,229.19 | 1,245.76 |
| November | 1,110.15 | 1,137.95 | 1,207.58 | 1,229.44 | 1,229.19 | 1,242.97 |
| December | 1,110.15 | 1,137.28 | 1,207.58 | 1,223.31 | 1,229.19 | 1,246.05 |
| January | 1,110.15 | 1,137.41 | 1,207.58 | 1,224.03 | 1,229.19 | |
| February | 1,110.15 | 1,142.82 | 1,207.58 | 1,227.26 | 1,229.19 | |
| March | 1,110.15 | 1,145.12 | 1,207.58 | 1,229.19 | 1,229.19 | |

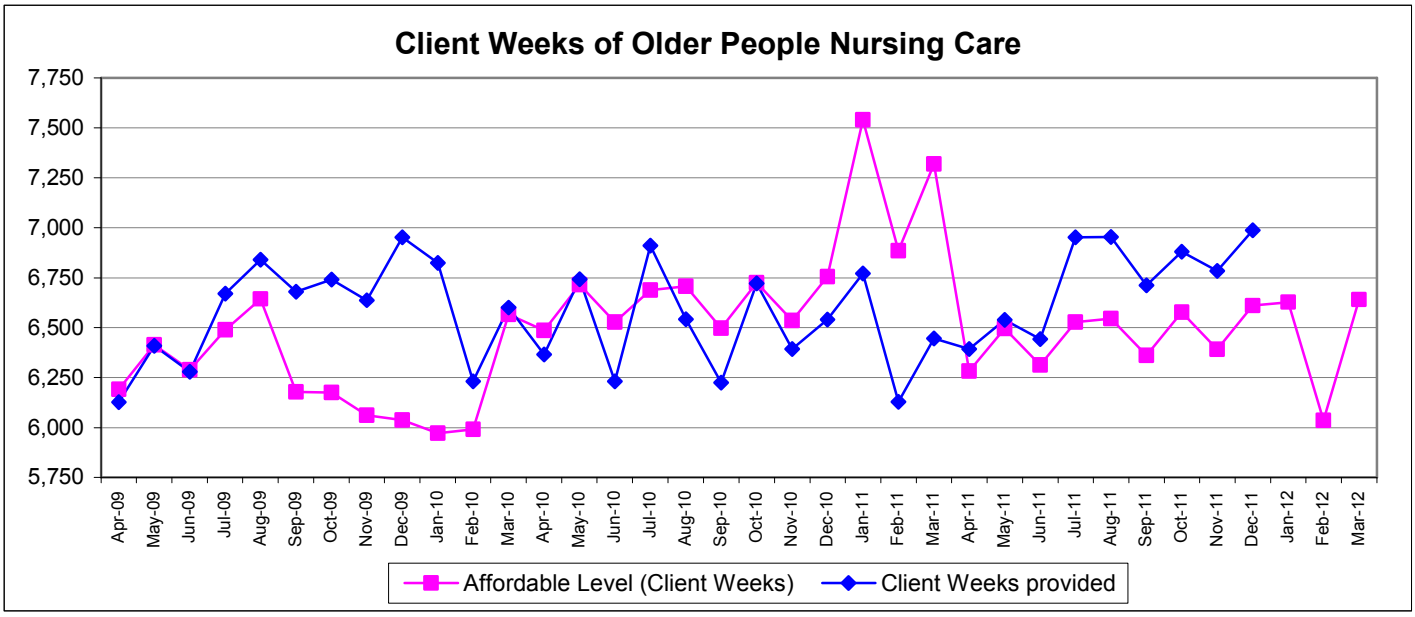



Comments

- Clients being placed in residential care are those with very complex and individual needs which make it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,200 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high cost – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases
- The forecast unit cost of £1,246.05 is higher than the affordable cost of £1,229.19 and this difference of £16.86 creates a pressure of £649k when multiplied by the affordable weeks, as highlighted in section 1.1.3.13a.

2.9.1 **Number of client weeks of older people nursing care provided compared with affordable level:**

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided |
| April | 6,191 | 6,127 | 6,485 | 6,365 | 6,283 | 6,393 |
| May | 6,413 | 6,408 | 6,715 | 6,743 | 6,495 | 6,538 |
| June | 6,288 | 6,279 | 6,527 | 6,231 | 6,313 | 6,442 |
| July | 6,489 | 6,671 | 6,689 | 6,911 | 6,527 | 6,953 |
| August | 6,644 | 6,841 | 6,708 | 6,541 | 6,544 | 6,954 |
| September | 6,178 | 6,680 | 6,497 | 6,225 | 6,361 | 6,713 |
| October | 6,175 | 6,741 | 6,726 | 6,722 | 6,576 | 6,881 |
| November | 6,062 | 6,637 | 6,535 | 6,393 | 6,391 | 6,784 |
| December | 6,037 | 6,952 | 6,755 | 6,539 | 6,610 | 6,988 |
| January | 5,973 | 6,824 | 7,541 | 6,772 | 6,628 | |
| February | 5,992 | 6,231 | 6,885 | 6,129 | 6,036 | |
| March | 6,566 | 6,601 | 7,319 | 6,445 | 6,641 | |
| **TOTAL** | **75,008** | **78,992** | **81,382** | **78,016** | **77,405** | **60,646** |



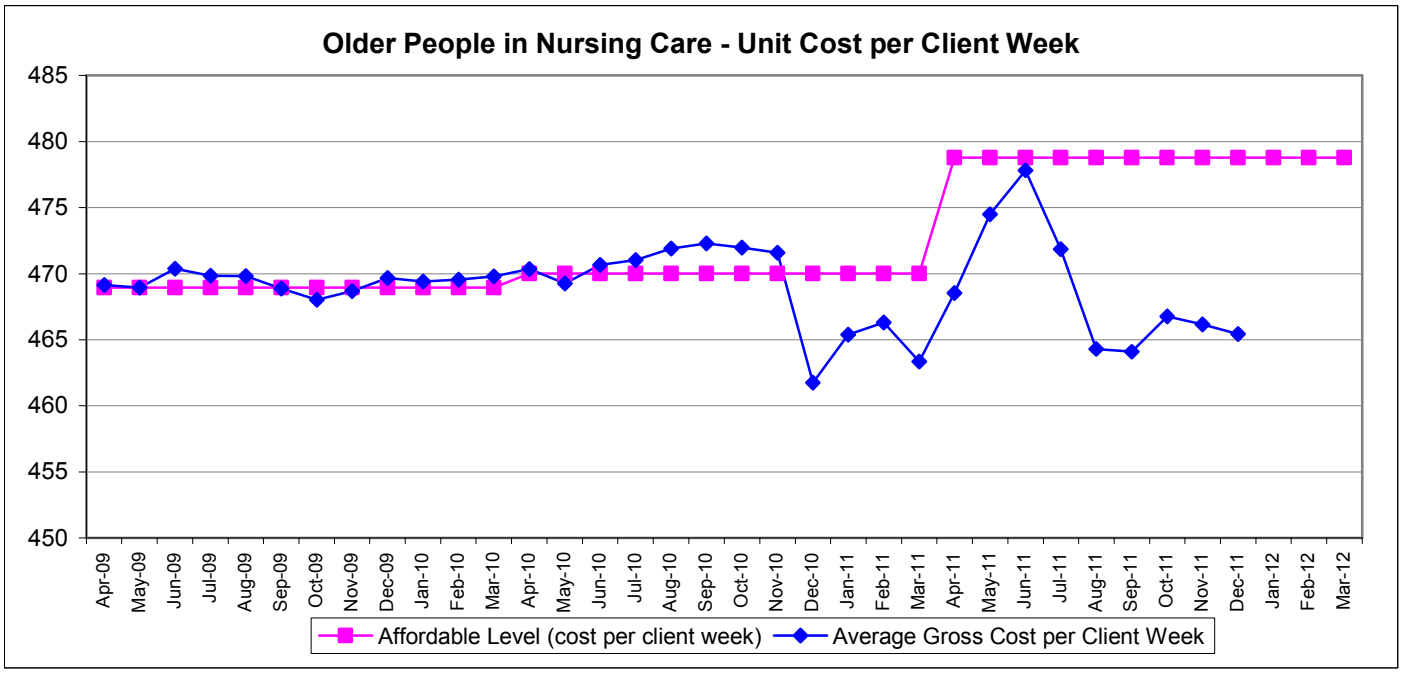

Comment:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2009-10 was 1,374, at the end of 2010-11 it was 1,379 at the end of December 2011 it was 1,508.
- The current forecast is 81,024 weeks of care against an affordable level of 77,405, a difference of +3,619. Using the actual unit cost of £465.44, this increased activity adds £1,684k to the forecast, as highlighted in section 1.1.3.13c
- To the end of December 2011 60,646 weeks of care have been delivered against an affordable level of 58,100 a difference of +2,546 weeks. The attrition rate this year appears to be lower than in previous years.
- There are always pressures in permanent nursing care, which may occur for many reasons. Increasingly, older people are entering nursing care only when other ways of support have been explored. This means that the most dependent are those that enter nursing care and consequently are more likely to have dementia. There is not the same distinction between clients with dementia in nursing care as with residential care as the difference in intensity of care for nursing care and nursing care with dementia is not as significant as it is for residential care. In addition, there will always be pressures which the directorate face, for example the knock on effect of minimising delayed transfers of care. Demographic changes – increasing numbers of older people with long

term illnesses – also means that there is an underlying trend of growing numbers of people needing nursing care.

2.9.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 468.95 | 469.15 | 470.01 | 470.36 | 478.80 | 468.54 |
| May | 468.95 | 468.95 | 470.01 | 469.27 | 478.80 | 474.48 |
| June | 468.95 | 470.37 | 470.01 | 470.67 | 478.80 | 477.82 |
| July | 468.95 | 469.84 | 470.01 | 471.03 | 478.80 | 471.84 |
| August | 468.95 | 469.82 | 470.01 | 471.90 | 478.80 | 464.32 |
| September | 468.95 | 468.88 | 470.01 | 472.28 | 478.80 | 464.09 |
| October | 468.95 | 468.04 | 470.01 | 471.97 | 478.80 | 466.78 |
| November | 468.95 | 468.69 | 470.01 | 471.58 | 478.80 | 466.17 |
| December | 468.95 | 469.67 | 470.01 | 461.75 | 478.80 | 465.44 |
| January | 468.95 | 469.42 | 470.01 | 465.40 | 478.80 | |
| February | 468.95 | 469.55 | 470.01 | 466.32 | 478.80 | |
| March | 468.95 | 469.80 | 470.01 | 463.34 | 478.80 | |



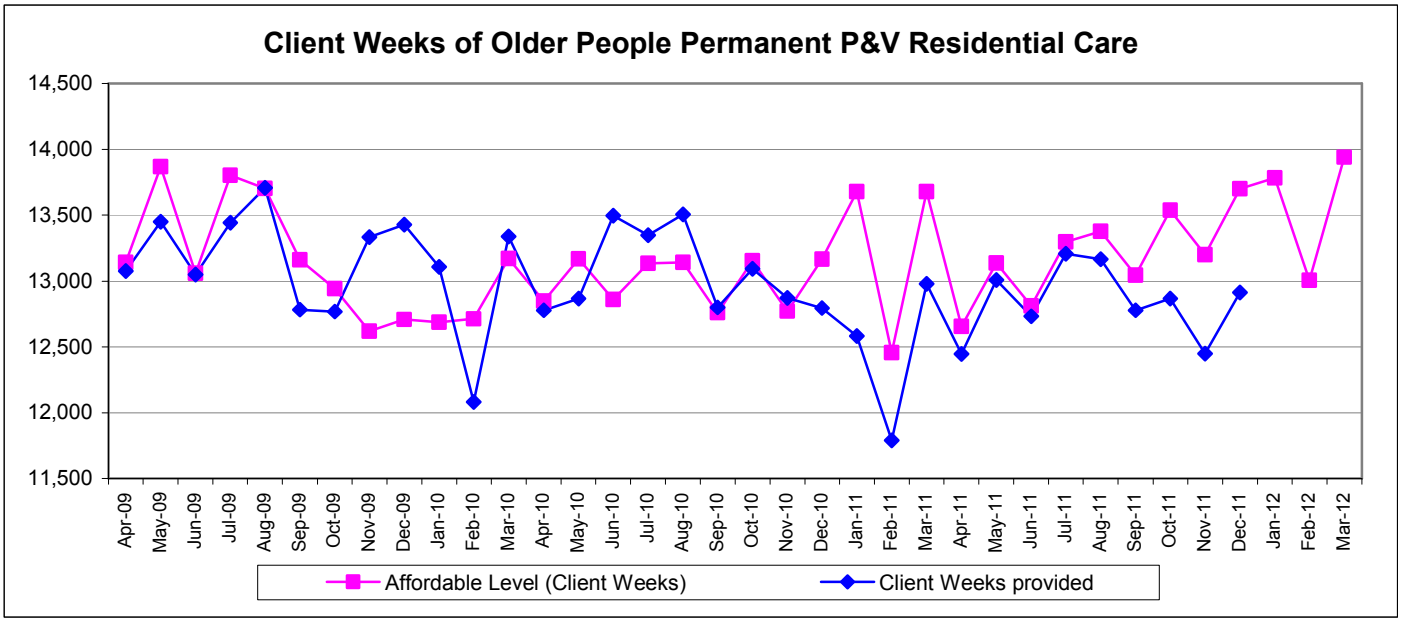

Comments:

- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care, which is why the unit cost can be quite volatile.

- The forecast unit cost of £465.44 is lower than the affordable cost of £478.80 and this difference of -£13.36 creates a saving of £1,034k when multiplied by the affordable weeks, as highlighted in section 1.1.3.13c

2.10.1 **Number of client weeks of older people permanent P&V residential care provided compared with affordable level**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | **Affordable Level (Client Weeks)** | **Client Weeks of older people permanent P&V residential care provided** | **Affordable Level (Client Weeks)** | **Client Weeks of older people permanent P&V residential care provided** | **Affordable Level (Client Weeks)** | **Client Weeks of older people permanent P&V residential care provided** |
| April | 13,142 | 13,076 | 12,848 | 12,778 | 12,655 | 12,446 |
| May | 13,867 | 13,451 | 13,168 | 12,867 | 13,136 | 13,009 |
| June | 13,059 | 13,050 | 12,860 | 13,497 | 12,811 | 12,731 |
| July | 13,802 | 13,443 | 13,135 | 13,349 | 13,297 | 13,208 |
| August | 13,703 | 13,707 | 13,141 | 13,505 | 13,377 | 13,167 |
| September | 13,162 | 12,784 | 12,758 | 12,799 | 13,044 | 12,779 |
| October | 12,943 | 12,768 | 13,154 | 13,094 | 13,538 | 12,868 |
| November | 12,618 | 13,333 | 12,771 | 12,873 | 13,200 | 12,448 |
| December | 12,707 | 13,429 | 13,167 | 12,796 | 13,700 | 12,914 |
| January | 12,685 | 13,107 | 13,677 | 12,581 | 13,782 | |
| February | 12,712 | 12,082 | 12,455 | 11,790 | 13,007 | |
| March | 13,172 | 13,338 | 13,678 | 12,980 | 13,940 | |
| **TOTAL** | **157,572** | **157,568** | **156,812** | **154,909** | **159,487** | **115,570** |




Comments:

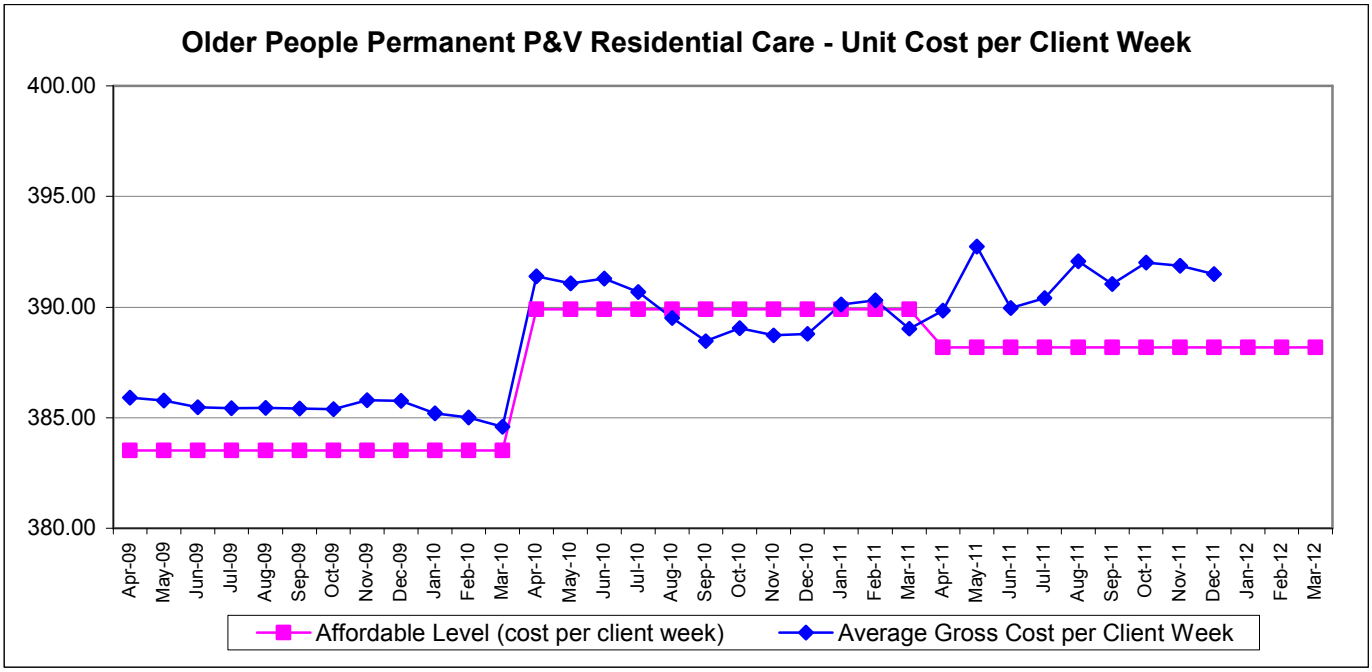
- Affordable levels were changed slightly in quarter 2 to include the release of a provision and some rolled forward grant funding from 2010-11 which is now being used to fund activity.
- Affordable levels have been amended again this quarter to reflect the removal of SCRG transitional funding.
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2009-10 was 2,751, at the end of 2010-11 it was 2,787 and by the end of December 2011 it was 2,764. It is evident that there are ongoing pressures relating to clients with dementia. Of the 2,751 clients in older people nursing care at the end of March 2010, 1,209 had Dementia (i.e. 43.9%) but as at 31 December 2011 this percentage had increased to 45.2% (i.e. 1,248 of the 2,764 total clients)
- The current forecast is 153,068 weeks of care against an affordable level of 159,487, a difference of -6,419 weeks. Using the forecast unit cost of £391.50 this reduced activity saves £2,513k within the forecast, as highlighted in section 1.1.3.13d. This forecast appears low compared to year to date activity but the forecast assumes that client numbers continue to reduce throughout the final quarter as, at the time of writing this report (mid February), the attrition rate has risen through the

winter months thus far, ahead of expectations, and hence the final quarter's activity is expected to be significantly lower than budgeted.

- To the end of December 115,570 weeks of care have been delivered against an affordable level of 118,758 a difference of -3,188 weeks.

2.10.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 383.52 | 385.90 | 389.91 | 391.40 | 388.18 | 389.85 |
| May | 383.52 | 385.78 | 389.91 | 391.07 | 388.18 | 392.74 |
| June | 383.52 | 385.47 | 389.91 | 391.29 | 388.18 | 389.97 |
| July | 383.52 | 385.43 | 389.91 | 390.68 | 388.18 | 390.41 |
| August | 383.52 | 385.44 | 389.91 | 389.51 | 388.18 | 392.07 |
| September | 383.52 | 385.42 | 389.91 | 388.46 | 388.18 | 391.04 |
| October | 383.52 | 385.39 | 389.91 | 389.06 | 388.18 | 392.02 |
| November | 383.52 | 385.79 | 389.91 | 388.72 | 388.18 | 391.87 |
| December | 383.52 | 385.76 | 389.91 | 388.80 | 388.18 | 391.50 |
| January | 383.52 | 385.20 | 389.91 | 390.12 | 388.18 | |
| February | 383.52 | 385.01 | 389.91 | 390.31 | 388.18 | |
| March | 383.52 | 384.59 | 389.91 | 389.02 | 388.18 | |

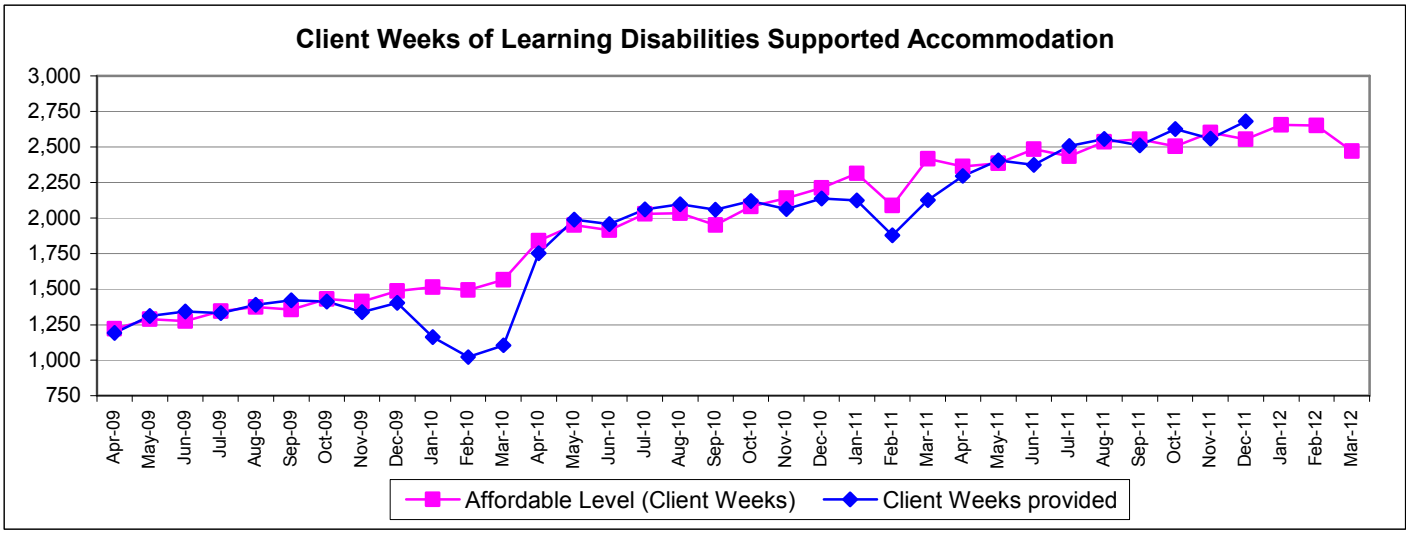



Comments:

- The 2011-12 affordable unit cost has marginally increased from what has previously been reported because this includes the unit cost for both regular Older People (OP) residential care & Older People Mental Health (OPMH) residential care, which are averaged to produce the unit cost reported here. The removal of SCRG transitional funding has altered the weighting towards OPMH which is slightly more expensive.
- Average unit cost per week has increased above the affordable level as a reflection of the increasing numbers of clients with dementia.
- The forecast unit cost of £391.50 is higher than the affordable cost of £388.18 and this difference of £3.32 creates a pressure of £530k when multiplied by the affordable weeks, as highlighted in section 1.1.3.13d.

2.11.1 **Number of client weeks of learning disabilities supported accommodation provided compared with affordable level:**

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided |
| April | 1,221 | 1,192 | 1,841 | 1,752 | 2,363 | 2,297 |
| May | 1,290 | 1,311 | 1,951 | 1,988 | 2,387 | 2,406 |
| June | 1,276 | 1,344 | 1,914 | 1,956 | 2,486 | 2,376 |
| July | 1,346 | 1,333 | 2,029 | 2,060 | 2,435 | 2,508 |
| August | 1,375 | 1,391 | 2,034 | 2,096 | 2,536 | 2,557 |
| September | 1,357 | 1,421 | 1,951 | 2,059 | 2,555 | 2,512 |
| October | 1,431 | 1,412 | 2,080 | 2,119 | 2,506 | 2,626 |
| November | 1,412 | 1,340 | 2,138 | 2,063 | 2,603 | 2,560 |
| December | 1,487 | 1,405 | 2,210 | 2,137 | 2,554 | 2,680 |
| January | 1,515 | 1,163 | 2,314 | 2,123 | 2,655 | |
| February | 1,493 | 1,021 | 2,088 | 1,878 | 2,652 | |
| March | 1,567 | 1,105 | 2,417 | 2,125 | 2,472 | |
| **TOTAL** | **16,770** | **15,438** | **24,967** | **24,356** | **30,204** | **22,522** |



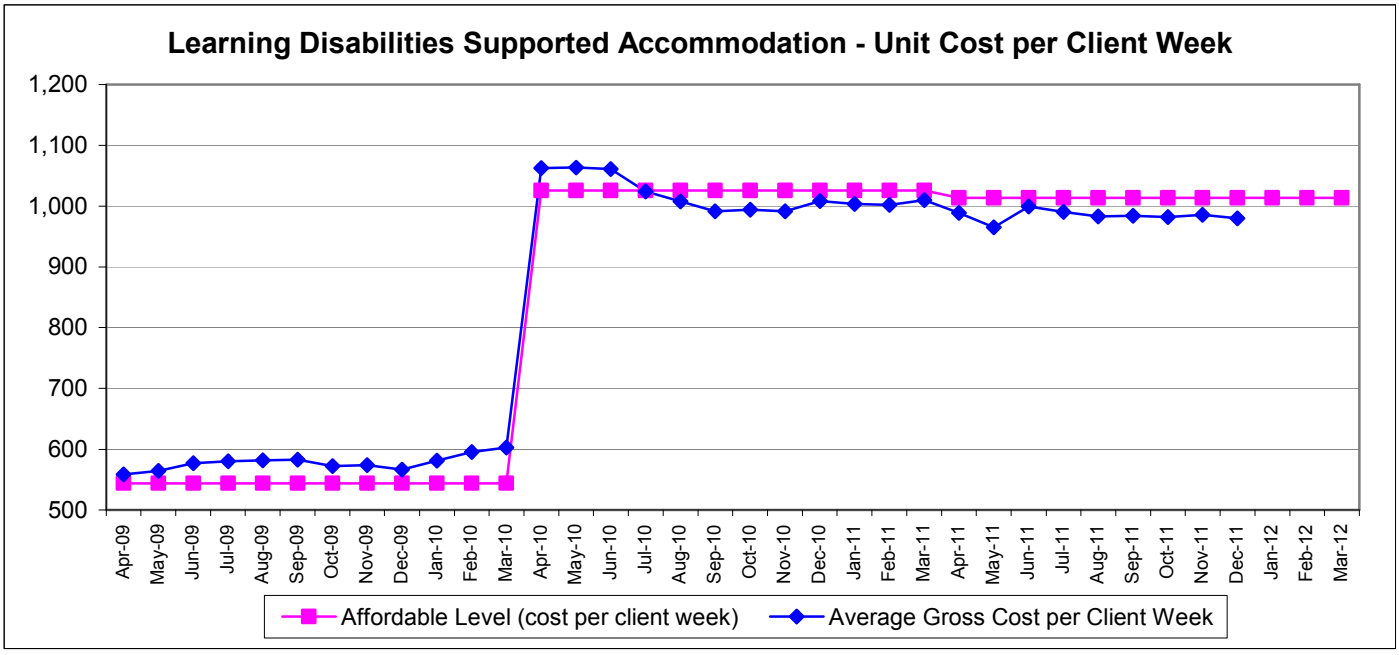

Comments:

- The above graph reflects the number of client weeks of service provided. The actual number of clients in LD supported accommodation at the end of 2009-10 was 309, at the end of 2010-11 it was 491, of which 131 were S256 clients, and at the end of December 2011 it was 612.
- The current forecast is 30,736 weeks of care**,** against an affordable level of 30,204, a difference of +532 weeks and includes people that we expect to be supported through supported accommodation and adult placement. Some of this is as a result of the transfer of clients from NHS who were previously S256, following the closure of LD Campus.
- Using the forecast unit cost of £979.83, this increase in activity adds £521k to the forecast, as reflected in section 1.1.3.14a.
- To the end of December 22,522, weeks of care have been delivered against an affordable level of 22,425, a difference of -97 weeks
- The forecast activity for this service is based on known individual clients, by individual periods of service, including provisional, transitional and ordinary resident clients. The service is provided via community support hours and/ or accommodation solutions and can be a complex package suited to meet the individual's needs. However, as an objective for the directorate is to achieve independent living for as many people as possible, supported accommodation has been a focus with the success of increased placements, particularly in recent months. It can be a volatile demand led budget and has to be forecast based on individuals, rather than straight line forecasts
- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people,

it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that more and increasingly complex and unique cases will be successfully supported to live independently.

2.11.2 **Average gross cost per client week of Learning Disability supported accommodation compared with affordable level (non preserved rights clients)**:

| | 2009-10 | | 2010-11 | | 2011-12 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 544.31 | 558.65 | 1,025.67 | 1,062.38 | 1,013.18 | 988.73 |
| May | 544.31 | 564.49 | 1,025.67 | 1,063.22 | 1,013.18 | 964.95 |
| June | 544.31 | 577.33 | 1,025.67 | 1,060.59 | 1,013.18 | 999.24 |
| July | 544.31 | 580.27 | 1,025.67 | 1,023.90 | 1,013.18 | 990.45 |
| August | 544.31 | 581.76 | 1,025.67 | 1,007.58 | 1,013.18 | 983.09 |
| September | 544.31 | 583.26 | 1,025.67 | 991.20 | 1,013.18 | 983.85 |
| October | 544.31 | 572.59 | 1,025.67 | 993.92 | 1,013.18 | 981.78 |
| November | 544.31 | 574.24 | 1,025.67 | 991.56 | 1,013.18 | 985.45 |
| December | 544.31 | 566.87 | 1,025.67 | 1,007.95 | 1,013.18 | 979.83 |
| January | 544.31 | 581.53 | 1,025.67 | 1,003.21 | 1,013.18 | |
| February | 544.31 | 595.89 | 1,025.67 | 1,001.98 | 1,013.18 | |
| March | 544.31 | 603.08 | 1,025.67 | 1,009.82 | 1,013.18 | |




Comments:

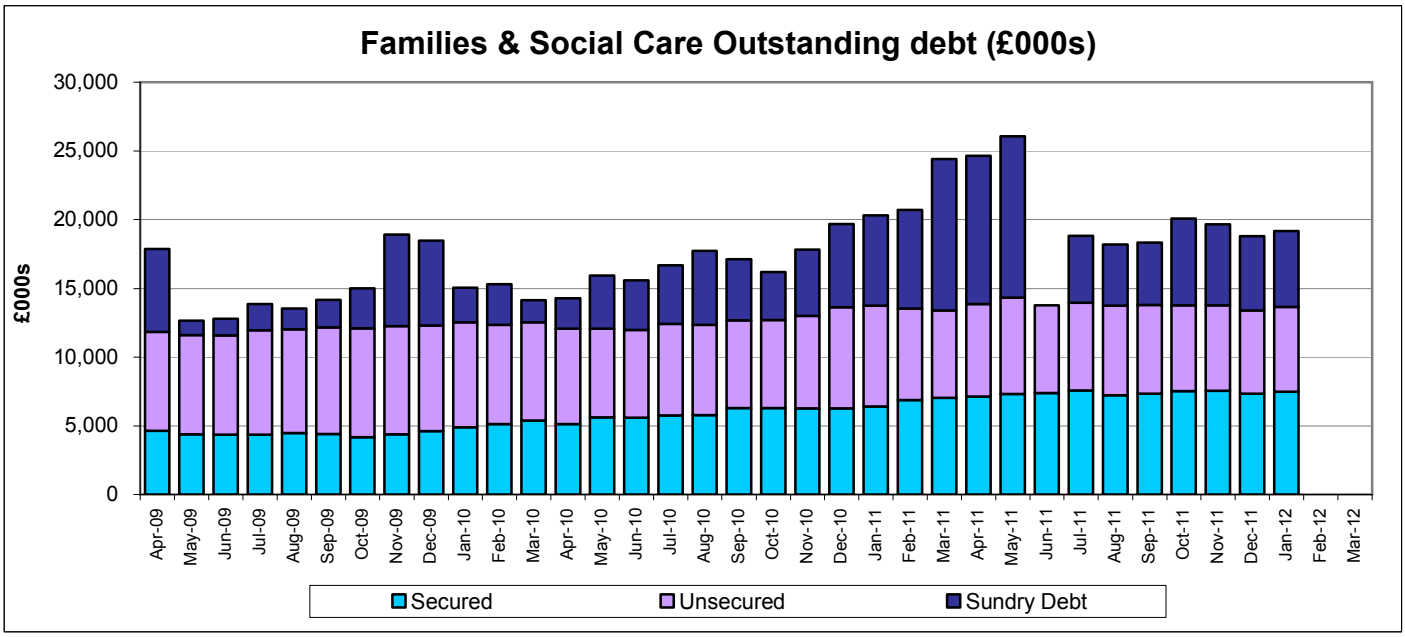
- The forecast unit cost of £979.83 is lower than the affordable cost of £1013.18 and this difference of -£33.35 provides a saving of £1,007k when multiplied by the affordable weeks, as reflected in section 1.1.3.14a.
- There are three distinct groups of clients: Section 256 clients, Ordinary Residence clients and other clients. Each group has a very different average unit cost, which are combined to provide an overall average unit cost for the purposes of this report.
- The costs associated with these placements will vary depending on the complexity of each case and the type of support required in each placement. This varies enormously between a domiciliary type support to life skills and daily living support.

## 3. SOCIAL CARE DEBT MONITORING

The outstanding debt as at the end of January was £19.180m compared with October's figure of £20.078m (reported to Cabinet in December) excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this figure is £5.518m of sundry debt compared to £6.304m in October. Within the outstanding debt is £13.662m relating to Social Care (client) debt which is a decrease of £0.112m from the last reported position to Cabinet in October. The following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year.

***** It should be noted that the Sundry debt reports were not successful in June, and hence no figure can be reported, the problem was rectified in time for the July report, but reports are unable to be run retrospectively.

| | | | Social Care Debt | | | | |
|---|---|---|---|---|---|---|---|
| **Debt Month** | **Total Due Debt (Social Care & Sundry Debt) £000s** | **Sundry Debt £000s** | **Total Social Care Due Debt £000s** | **Debt Over 6 mths £000s** | **Debt Under 6 mths £000s** | **Secured £000s** | **Unsecured £000s** |
| **Apr-09** | **17,874** | **6,056** | 11,818 | 6,609 | 5,209 | 4,657 | 7,161 |
| **May-09** | **12,671** | **1,078** | 11,593 | 6,232 | 5,361 | 4,387 | 7,206 |
| **Jun-09** | **12,799** | **1,221** | 11,578 | 6,226 | 5,352 | 4,369 | 7,209 |
| **Jul-09** | **13,862** | **1,909** | 11,953 | 6,367 | 5,586 | 4,366 | 7,587 |
| **Aug-09** | **13,559** | **1,545** | 12,014 | 6,643 | 5,371 | 4,481 | 7,533 |
| **Sep-09** | **14,182** | **2,024** | 12,158 | 7,080 | 5,078 | 4,420 | 7,738 |
| **Oct-09** | **15,017** | **2,922** | 12,095 | 7,367 | 4,728 | 4,185 | 7,910 |
| **Nov-09** | **18,927** | **6,682** | 12,245 | 7,273 | 4,972 | 4,386 | 7,859 |
| **Dec-09** | **18,470** | **6,175** | 12,295 | 7,373 | 4,922 | 4,618 | 7,677 |
| **Jan-10** | **15,054** | **2,521** | 12,533 | 7,121 | 5,412 | 4,906 | 7,627 |
| **Feb-10** | **15,305** | **2,956** | 12,349 | 7,266 | 5,083 | 5,128 | 7,221 |
| **Mar-10** | **14,157** | **1,643** | 12,514 | 7,411 | 5,103 | 5,387 | 7,127 |
| **Apr-10** | **14,294** | **2,243** | 12,051 | 7,794 | 4,257 | 5,132 | 6,919 |
| **May-10** | **15,930** | **3,873** | 12,057 | 7,784 | 4,273 | 5,619 | 6,438 |
| **Jun-10** | **15,600** | **3,621** | 11,979 | 7,858 | 4,121 | 5,611 | 6,368 |
| **Jul-10** | **16,689** | **4,285** | 12,404 | 7,982 | 4,422 | 5,752 | 6,652 |
| **Aug-10** | **17,734** | **5,400** | 12,334 | 8,101 | 4,233 | 5,785 | 6,549 |
| **Sep-10** | **17,128** | **4,450** | 12,678 | 8,284 | 4,394 | 6,289 | 6,389 |
| **Oct-10** | **16,200** | **3,489** | 12,711 | 8,392 | 4,319 | 6,290 | 6,421 |
| **Nov-10** | **17,828** | **4,813** | 13,015 | 8,438 | 4,577 | 6,273 | 6,742 |
| **Dec-10** | **19,694** | **6,063** | 13,631 | 8,577 | 5,054 | 6,285 | 7,346 |
| **Jan-11** | **20,313** | **6,560** | 13,753 | 8,883 | 4,870 | 6,410 | 7,343 |
| **Feb-11** | **20,716** | **7,179** | 13,537 | 9,107 | 4,430 | 6,879 | 6,658 |
| **Mar-11** | **24,413** | **11,011** | 13,402 | 9,168 | 4,234 | 7,045 | 6,357 |
| **Apr-11** | **24,659** | **10,776** | 13,883 | 9,556 | 4,327 | 7,124 | 6,759 |
| **May-11** | **26,069** | **11,737** | 14,332 | 9,496 | 4,836 | 7,309 | 7,023 |
| **Jun-11** | **13,780** | * | 13,780 | 9,418 | 4,362 | 7,399 | 6,381 |
| **Jul-11** | **18,829** | **4,860** | 13,969 | 9,609 | 4,361 | 7,584 | 6,385 |
| **Aug-11** | **18,201** | **4,448** | 13,753 | 9,315 | 4,438 | 7,222 | 6,531 |
| **Sep-11** | **18,332** | **4,527** | 13,805 | 9,486 | 4,319 | 7,338 | 6,467 |
| **Oct-11** | **20,078** | **6,304** | 13,774 | 9,510 | 4,264 | 7,533 | 6,241 |
| **Nov-11** | **19,656** | **5,886** | 13,770 | 9,681 | 4,089 | 7,555 | 6,215 |
| **Dec-11** | **18,788** | **5,380** | 13,408 | 9,473 | 3,935 | 7,345 | 6,063 |
| **Jan-12** | **19,180** | **5,518** | 13,662 | 9,545 | 4,117 | 7,477 | 6,185 |
| **Feb-12** | **0** | | 0 | | | | |
| **Mar-12** | **0** | | 0 | | | | |


Families & Social Care Outstanding debt (£000s)
£000s
30,000
25,000
20,000
15,000
10,000
5,000
0
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
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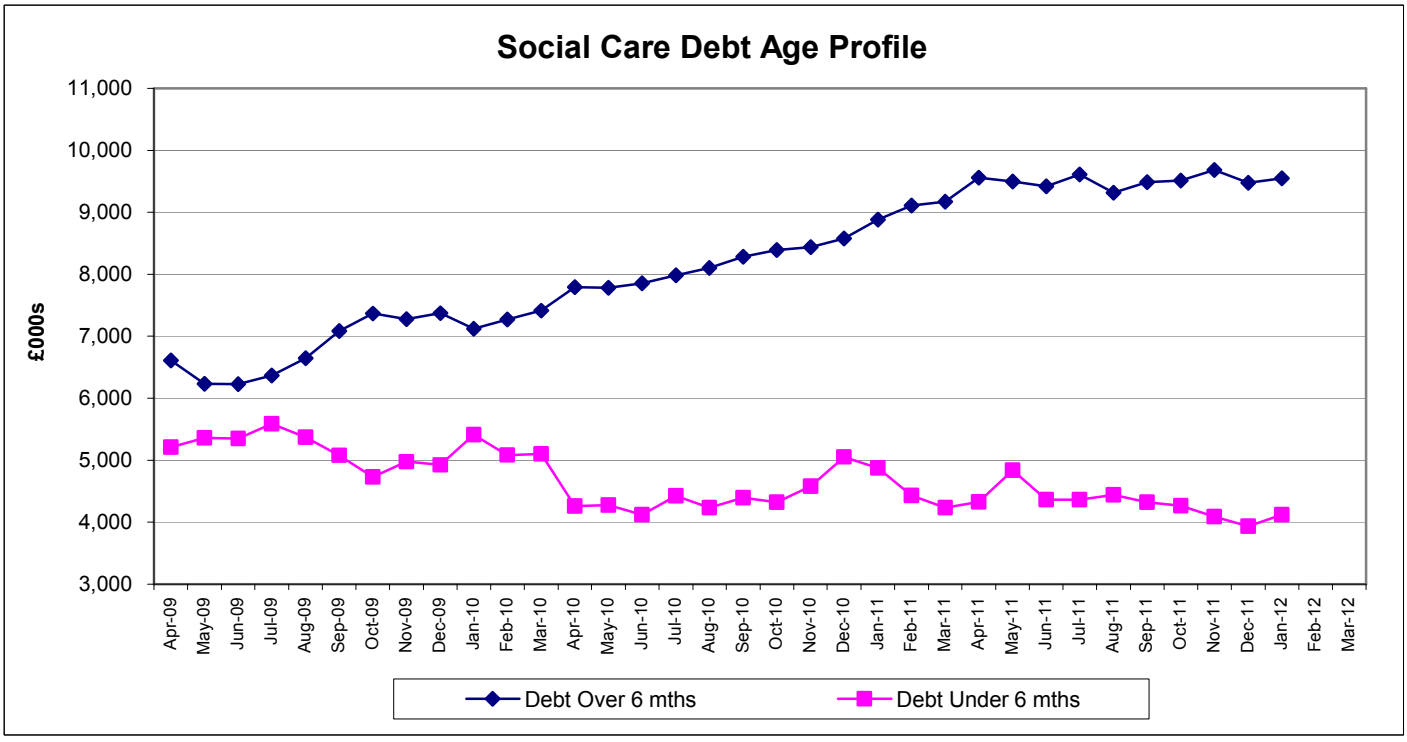
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Secured
Unsecured
Sundry Debt


Social Care Debt Age Profile
£000s
11,000
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
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Sep-10
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Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Debt Over 6 mths
Debt Under 6 mths

## Gross, Income Net position – revenue budget

| | CASH LIMIT | | | |
|---|---|---|---|---|
| **Portfolio** | **Gross** | **Income** | **Net** | |
| | £k | £k | £k | |
| Adult Social Care & Public Health | 466,145 | -149,615 | 316,530 | |
| Per December report | 466,145 | -149,615 | 316,530 | |
| | | | | |
| **Changes to grant/income allocations:** | | | | |
| | | | | Grant name: |
| ASCPH | 3,775 | -3,775 | 0 | Additional Health funding for Winter Pressures |
| ASCPH | -21 | 21 | 0 | reduction in Health funding for Integrated Community Equipment Store |
| ASCPH | -176 | 176 | 0 | reduction in Health funding for telehealth/ telecare |
| | | | | |
| **Corporate Adjustments:** | | | | |
| ASCPH | 9 | | 9 | return of equalities budget from BSS |
| ASCPH | -99 | 99 | 0 | tfr of LD grant to BSS for finance support |
| ASCPH | -27 | | -27 | tfr of K Melling's post to C&C |
| ASCPH | 58 | | 58 | redundancy funding (Mental Health) |
| ASCPH | -54 | | -54 | tfr of L Longhurst to C&C |
| ASCPH | 14 | | 14 | Sensory Money from Kent Supported Employment |
| ASCPH | 16 | | 16 | redundancy funding (M Howard) |
| ASCPH | -200 | | -200 | removal of transitional SCRG funding |
| ASCPH | -550 | | -550 | removal of transitional SCRG funding |
| ASCPH | -1,150 | | -1,150 | removal of transitional SCRG funding |
| ASCPH | -90 | | -90 | removal of transitional SCRG funding |
| ASCPH | -160 | | -160 | removal of transitional SCRG funding |
| ASCPH | -650 | | -650 | removal of transitional SCRG funding |
| ASCPH | -350 | | -350 | removal of transitional SCRG funding |
| ASCPH | 76 | | 76 | return of PFI budget from BSS |
| ASCPH | -70 | | -70 | tfr shortfall in mental health rent budget to corporate landlord |
| ASCPH | -128 | | -128 | shortfall in premises budget tfr to corporate landlord |
| ASCPH | -11 | | -11 | tfr shortfall in FM charge budget to corporate landlord |
| ASCPH | 77 | | 77 | return of Handyman budget from Corporate Landlord |
| ASCPH | 22 | | 22 | return of Handyman budget from Corporate Landlord |
| ASCPH | 18 | | 18 | return of Handyman budget from Corporate Landlord |
| ASCPH | -154 | | -154 | tfr of ex-FSC property agency staff budget to Corporate Landlord |
| ASCPH | 460 | | 460 | tfr supplies & services budgets back from Corporate Landlord |
| ASCPH | 184 | | 184 | tfr supplies & services budgets back from Corporate Landlord |

| | CASH LIMIT | | | |
|---|---|---|---|---|
| **Portfolio** | **Gross** | **Income** | **Net** | |
| ASCPH | 63 | | 63 | A Fitzgerald's supplies & Services budget from Corporate Landlord |
| ASCPH | 20 | | 20 | Copyright Licence Agency Fee from Corporate Landlord |
| ASCPH | -10 | | -10 | tfr shortfall in Modern Records Centre budget to Corporate Landlord |
| ASCPH | -4 | | -4 | tfr shortfall in Park & Ride budget to Corporate Landlord |
| ASCPH | 71 | | 71 | return of Staff Care Services budget from Corporate Landlord |
| ASCPH | -18 | | -18 | removal of internal recharging for Hosting arrangements with Corporate Landlord |
| | | | | |
| **Technical Adjustments:** | | | | |
| ASCPH | 25 | | 25 | Mgmt & Support: tfr of contracts assistant from Assessment of Vulnerable Adults |
| ASCPH | -25 | | -25 | Assessment of Vulnerable Adults: tfr of contracts assistant to Mgmt & Support |
| ASCPH | -80 | | -80 | tfr of budget for Adults contribution to |
| | | | | |
| Revised Budget | 467,006 | -153,094 | 313,912 | |

# FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
# JANUARY 2011-12 FULL MONITORING REPORT

## 1. FINANCE

### 1.1 REVENUE

### 1.2 CAPITAL

1.2.1 All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader, or relevant delegated authority.
The capital cash limits have been adjusted to reflect the position in the 2012-15 MTFP as agreed by County Council on 9 February 2012, any further adjustments are detailed in section 4.1.

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

| | **Prev Yrs Exp** £m | **2011-12** £m | **2012-13** £m | **2013-14** £m | **Future Yrs** £m | TOTAL £m |
|---|---|---|---|---|---|---|
| | | | | | | |
| **Adults Social Care & Public Health Portfolio** | | | | | | |
| Budget | 4.381 | 5.633 | 10.198 | 6.586 | 3.573 | 30.371 |
| Adjustments: | | | | | | |
| Rephasing as per December monitoring | | -0.150 | 0.150 | | | 0.000 |
| Folkestone ARRCC | | -0.023 | | | | -0.023 |
| | | | | | | 0.000 |
| Revised Budget | **4.381** | **5.460** | **10.348** | **6.586** | **3.573** | **30.348** |
| Variance | | -1.996 | 1.982 | 0.014 | 0.000 | 0.000 |
| **split:** | | | | | | |
| - real variance | | | | | | 0.000 |
| - re-phasing | | -1.996 | 1.982 | 0.014 | | 0.000 |

1.2.3 **Main Reasons for Variance**

Table 4 below, details all forecast capital variances over £250k in 2011-12 and identifies these between projects which are:

- part of our year on year rolling programmes e.g. maintenance and modernisation;
- projects which have received approval to spend and are underway;
- projects which are only at the approval to plan stage and
- Projects at preliminary stage.

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

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

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

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

| portfolio | Project | real/ phasing | Rolling Programme | Approval to Spend | Approval to Plan | Preliminary Stage |
|---|---|---|---|---|---|---|
| | | | £m | £m | £m | £m |
| **Overspends/Projects ahead of schedule** | | | | | | |
| | | | | | | |
| | | | **0.000** | **0.000** | **0.000** | **0.000** |
| **Underspends/Projects behind schedule** | | | | | | |
| | | | | | | |
| ASC&PH | LD Good Day Programme | phasing | | | -0.373 | |
| ASC&PH | Transforming Social Care | phasing | | -0.297 | | |
| ASC&PH | Mental Health SCP | phasing | | -0.290 | | |
| ASC&PH | Modernisation of Assets | phasing | -0.269 | | | |
| | | | | | | |
| | | | **0.269** | **0.587** | **0.373** | **0.000** |
| | | | **-0.269** | **0.587** | **-0.373** | **0.000** |

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

N/A

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

N/A

1.2.6 **General Overview of capital programme**:

(a) Risks

The risks linked to the Families and Social Care Directorate must be similar to those felt throughout the Authority in this current financially suppressed climate. As a Directorate that works alongside many partners such as District Councils, Private/Voluntary Organisations and Primary Care Trusts (PCT) in order to provide the most comprehensive service delivery to our users, the risks to FSC are potentially compounded.

(b) Details of action being taken to alleviate risks

The Directorate continues to closely monitor those risks associated with our partnership working arrangements on a regular basis through Divisional Management Teams which run alongside its over-arching capital strategy. However, the Directorate may not always be able to influence/control the final outcome.

1.2.7 **PFI projects-**

Excellent Homes for All (EHFA)

A Value for Money review by the Homes and Communities Agency (HCA) and Department for Communities and Local Government (DCLG) for all Housing PFI projects has reduced the PFI credit allocation from £70.42m to £66.8m, a reduction of 11%. A number of other changes have been imposed such as a reduced contract length, from 30 years to 25 years, and a requirement for the Authority to make a contribution to the cost of the project of up to £175k per annum for the

contract period. No decision has been made by KCC to pay the contribution and how this contribution, if paid, will be shared by district council partners is still under discussion.

The £66.8m revised PFI credit for 'Excellent Homes for All' PFI project also represents investment by a third party. The figures are not final and are subject to change until we reach financial close. No payment will be made by KCC for the new/refurbished assets until they are ready for use. Any payment will be by way of an annual charge to the revenue budget.

| | Previous years | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 | TOTAL |
|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m |
| **Budget** | | | | 35.210 | 35.210 | | 70.420 |
| **Forecast** | | | | | 33.400 | 33.400 | 66.800 |
| **Variance** | | | | -35.210 | -1.810 | 33.400 | -3.620 |

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

The above table shows the revised costings.

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

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

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

1.2.8 **Project Re-Phasing**

Cash limits are changed for projects that have re-phased by greater than £0.100m to reduce the reporting requirements during the year. Any subsequent re-phasing greater than £0.100m will be reported and the full extent of the re-phasing will be shown. The possible re-phasing is detailed in the table below.

| | 2011-12 | 2012-13 | 2013-14 | Future Years | Total |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| **Modernisation of Assets (ASC&PH)** | | | | | |
| Amended total cash limits | 0.366 | 0.015 | 0.000 | 0.000 | 0.381 |
| re-phasing | -0.269 | 0.255 | 0.014 | 0.000 | 0.000 |
| **Revised project phasing** | **0.097** | **0.270** | **0.014** | **0.000** | **0.381** |
| | | | | | |
| **Mental Health SCE (ASC&PH)** | | | | | |
| Amended total cash limits | 0.196 | 0.000 | 0.000 | 0.000 | 0.196 |
| re-phasing | -0.179 | 0.179 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.017** | **0.179** | **0.000** | **0.000** | **0.196** |
| | | | | | |
| **Public Access - Approval to Spend (ASC&PH)** | | | | | |
| Amended total cash limits | 0.295 | 0.000 | 0.000 | 0.000 | 0.295 |
| re-phasing | -0.222 | 0.222 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.073** | **0.222** | **0.000** | **0.000** | **0.295** |
| | | | | | |
| **Mental Health SCP (ASC&PH)** | | | | | |
| Amended total cash limits | 0.292 | 0.000 | 0.000 | 0.000 | 0.292 |
| re-phasing | -0.290 | 0.290 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.002** | **0.290** | **0.000** | **0.000** | **0.292** |
| | | | | | |
| **IT Infrastructure (ASC&PH)** | | | | | |
| Amended total cash limits | 0.284 | 0.610 | 0.000 | 0.000 | 0.894 |
| re-phasing | -0.197 | 0.197 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.087** | **0.807** | **0.000** | **0.000** | **0.894** |
| | | | | | |
| **LD Good Day Programme (ASC&PH)** | | | | | |
| Amended total cash limits | 1.019 | 3.777 | 0.093 | 1.002 | 5.891 |
| re-phasing | -0.373 | 0.373 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.646** | **4.150** | **0.093** | **1.002** | **5.891** |
| | | | | | |
| **Transforming Social Care - Approval to Spend (ASC&PH)** | | | | | |
| Amended total cash limits | 0.320 | 0.000 | 0.000 | 0.000 | 0.320 |
| re-phasing | -0.297 | 0.297 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.023** | **0.297** | **0.000** | **0.000** | **0.320** |

| | 2011-12 | 2012-13 | 2013-14 | Future Years | Total |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| **Public Access - Approval to Plan (ASC&PH)** | | | | | |
| Amended total cash limits | 0.150 | 0.150 | 0.300 | 0.300 | 0.900 |
| re-phasing | -0.130 | 0.130 | 0.000 | 0.000 | 0.000 |
| **Revised project phasing** | **0.020** | **0.280** | **0.300** | **0.300** | **0.900** |
| | | | | | |
| **Total re-phasing >£100k** | **-1.957** | **1.943** | **0.014** | **0.000** | **0.000** |
| | | | | | |
| **Other re-phased Projects below £100k** | **-0.039** | **0.039** | **0.000** | **0.000** | **0.000** |
| | | | | | |
| **TOTAL RE-PHASING** | **-1.996** | **1.982** | **0.014** | **0.000** | **0.000** |

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| | |
|---|---|
| By: | Graham Gibbens, Cabinet Member for Adult Social Care and Public Health<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012 |
| Subject: | **PERFORMANCE FOR ADULT SOCIAL CARE – QUARTER 3 – DECEMBER 2011** |
| Classification: | Unrestricted |

Summary: This report provides Members with the Core Monitoring performance report for the second quarter, based on September 2011.

**Introduction**

1. (1) The Adult Social Care Directorate has a statutory duty to provide performance information to the Department of Health on an annual basis, via a number of statutory returns.

(2) The process for assessing Adult Social Care in Councils is changing. In the past, Councils were expected to complete the Self-Assessment Statement which provided 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 were also in place to provide the opportunity for discussion about the issues the Directorate faced, together with our plans to maintain or improve performance. This was used by CQC, together with the performance indicators, to form an assessment of each Council.

(3) The role that CQC now has in relation to assessing Councils is much reduced; there is no longer a requirement for self assessment nationally, and no process for judging each Council.

(4) In its place, there are proposals and ongoing work to determine how Councils can rely on peer and sector led assessment, as well as having mechanisms in place for the public to hold Adult Social Services to account. This work is beginning to be developed, with much emphasis expected in 2013.

(5) Although performance indicators are still being collected for this year, the Department of Health has started a "Zero Based Review" of all data collections for Adult Social Care, with the long term intention that Councils will only submit information that is relevant and meaningful, and will provide a reduced burden in producing statistics. This new streamlined approach fits with the personalisation of social care more appropriately than the old framework and is welcomed by Kent

(6) The reduction in a national requirement for performance information will also support the national expectation that Councils will develop local performance frameworks to deliver the Health and Social Care agenda.

**Quarter 3 update – December 2011**

2. (1) As part of the Council Wide performance framework, the Core Monitoring provides a summary of the Key priorities for the Directorate which are a mixture of national indicators and local indicators. The latest results for these can be found at Appendix A.

(2) The Directorate continues to see some good improvements. In particular;

- A significant increase in people receiving a personal budget. As at December 2011, over 10,000 people were in receipt of a personal budget. Of these, 2,800 are in receipt of a direct payment.
- Over 1,000 people were being supported through the provision of Telecare technology.
- Increasing numbers of people are benefiting from enablement. Over 1700 people received enablement in the last three months and nearly 6,400 people in the last year.
- 78% of people who received enablement in the six month period to September 2011 returned home with no further support. 13% people received ongoing homecare support whilst 3.5% people received support through the provision of equipment.
- People continue to be assessed in a timely way with 78% of people assessed within six weeks.
- Nearly 74% of outcomes identified at assessment were met at their first review.

(3) Further information relating to the progress against these key indicators can be found in the Core Monitoring report at Appendix A.

**Performance in 2012/13**

3. (1) As part of the Transformation programme, a new performance framework will be developed and implemented to ensure that ongoing performance is maintained and that progress of transformation is monitored carefully.

(2) This new performance framework will also reflect national priorities and requirements and will be incorporated into Business Plan Monitoring and Core Monitoring in 2012/13.

**Recommendations**

4. (1) Members are asked to NOTE the Adult Social Care performance indicators for 2010-2011.

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steph.abbott@kent.gov.uk

*Background documents*: None

# KCC Quarterly Performance Report
# Adult Social Care
# Quarter 3, 2011/12

# Key to RAG (Red/Amber/Green) ratings applied to KPIs

| | |
|---|---|
| **GREEN** | Target has been achieved or exceeded |
| **AMBER** | Performance is behind target but within acceptable limits |
| **RED** | Performance is significantly behind target and is below an acceptable pre-defined minimum * |
| ⇧ | Performance has improved relative to targets set |
| ⇩ | Performance has worsened relative to targets set |

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.



# Performance Assurance Team (PAT)

Against each KPI there is a section to provide information on any discussion by the Performance Assurance Team (PAT). PAT's role is to consider and challenge the action plans for improving performance, including addressing constraints and barriers and to provide additional reassurances to elected members that the action plans and the information being reported within this report are robust.

PAT meets monthly and is chaired by the Deputy Managing Director. Membership includes a nominated director from each directorate. It also includes two non-executive directors (NEDs) who are staff from the grass roots of the organisation. This ensures PAT has cross-organisation membership from all levels to provide a 'whole organisation' approach to improvement.

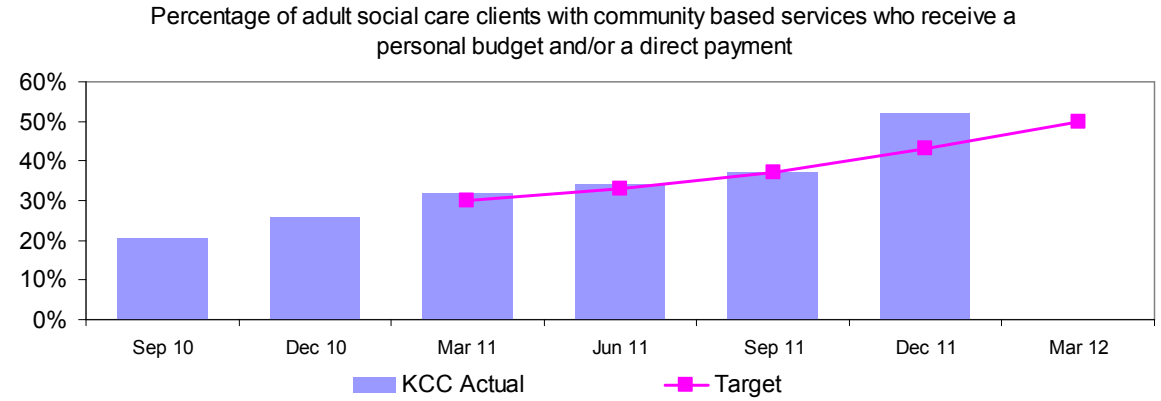
PAT meetings include discussion with accountable managers of poor or declining performance on KPIs included in the Quarterly Performance Report. Any red or repeatedly amber indicators will be called in by PAT for further discussion. As well as looking at performance problems PAT will also examine areas of strong performance, the 'greens', and whether this could be as a result of good practice or learning that can be shared or any 'gold plating' that may need to be addressed.

Prior to each PAT meeting the Cabinet Member for Business Strategy, Performance and Health Reform receives a full set of papers and the Chair of PAT will brief him on the key issues. They meet again following PAT to discuss the outcomes and agreed actions which are also summarised in a formal report. The Cabinet Member for Business Strategy, Performance and Health Reform has the right to attend PAT during the year and the Chair of Governance and Audit Committee may also attend PAT on an exceptional basis.

## Summary of Performance for our KPIs

| Indicator Description | Service Area | Page | Current Status | Previous Status | Direction of Travel in Performance |
|---|---|---|---|---|---|
| Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment | Adult Social Care | | Green | Green | ⇧ |
| Number of adult social care clients receiving a telecare service | Adult Social Care | | Green | Green | ⇧ |
| Number of adult social care clients provided with an enablement service | Adult Social Care | | Amber | Amber | |
| Percentage of adult social care assessments completed within six weeks | Adult Social Care | | Green | Green | |
| Percentage of clients satisfied that desired outcomes have been achieved at their first review | Adult Social Care | | Green | Green | ⇧ |

| Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment | | | Green ⇧ |
|---|---|---|---|
| **Bold Steps Priority/Core Service Area** | Empower social service users through increased use of personal budgets | **Bold Steps Ambition** | Put the Citizen in Control |
| **Cabinet Member** | Graham Gibbens | **Director** | Anne Tidmarsh |
| **Portfolio** | Adult Social Care and Public Health | **Division** | Older People and Physical Disability |




**Data Notes.**
Tolerance: Higher values are better.
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as the snapshot position of current clients at the quarter end.

**NB** This is different from the national indicator which is measured for all clients with a service during the year, including carers.

| Trend Data | Previous Year | | | Current Year | | | |
|---|---|---|---|---|---|---|---|
| | **Sept 10** | **Dec 10** | **Mar 11** | **Jun 11** | **Sep 11** | **Dec 11** | **Mar 12** |
| KCC Result | 20.8% | 25.8% | 32.0% | 34.0% | 37.0% | 52.2% | |
| Target | | | 30% | 33% | 37% | 43% | 50% |
| Client numbers | 4,220 | 6,430 | 7,740 | 8,085 | 8,892 | 10,079 | |
| Rag Rating | | | Green | Green | Green | Green | |

**Commentary**

Performance continues to improve significantly. This key indicator is monitored on a monthly basis by the Directorate Management Team and the indicator receives a high level attention nationally as well as locally.

For the related national indicator Kent achieved 30% in 2010/11, compared to a national rate of 37%. Kent is now in line with that National average and as personalisation is further embedded through reviewing existing clients, the forecast of 50% for March 2012 has now been exceeded.

| Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment | Green ⇧ |
|---|---|

**What actions are we taking to improve performance (and drivers of performance)**

The approach to increasing Personal budgets is threefold:

1. To ensure that all new clients are allocated a personal budget.
2. To ensure that all existing clients are allocated a personal budget at review.
3. To ensure that data quality issues are resolved as and when they arise.

Targets have been set across all the teams, and management information reports have been developed to allow the teams to manage and monitor their own performance. This is monitored and managed closely by the Divisional and Directorate Management Teams through Locality Action plans. These Action plans ensure that performance is owned by the operational teams, accountability is held at all levels, including setting individual targets and action plans, and training and knowledge gaps are identified, whether policy, practice or system based. Training has already been provided for localities where it has been highlighted and this will continue.

Teams are targeted if data quality or practice issues arise:- e.g where reviews have been undertaken and no personal budget is allocated.

The Locality Coordination Management meeting set up a Task and Finish group to achieve underlying organisational changes in order to get permanent improvement, with one head of service as the owner, reporting to Divisional Management Team.

**Risks and mitigating actions**

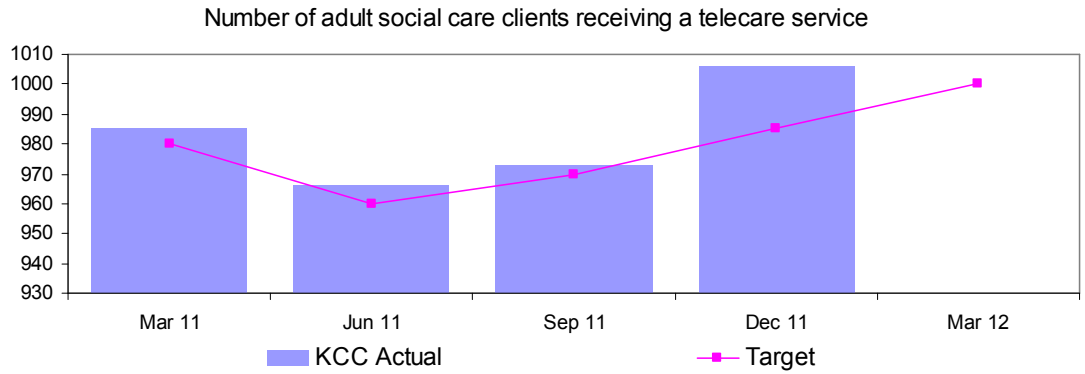
1.Performance timelines not being met, due to aligned work not being managed such as: number of reviews to increase as planned.
2. Organisational and cultural changes taking longer than planned.
3. Productivity targets new for Families and Social Care and may take longer than planned to develop.

**Action taken**

1. Tight system of performance monitoring in place; performance identified as key priority and escalation routes clarified.
2. Individual responsibilities, team and managers' responsibilities clearly set out ; implementation monitored and addressed at supervision and action planning reviews.
3. Timelines clearly set out and operational feedback sought on a monthly basis.

| Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment | Green ⇧ |
|---|---|
| | |
| **Discussion and actions agreed by PAT** | |
| | |

| Number of adult social care clients receiving a telecare service | | | Green ⇧ |
|---|---|---|---|
| **Bold Steps Priority/Core Service Area** | Empower social service users through increased use of personal budgets | **Bold Steps Ambition** | Put the Citizen in Control |
| **Cabinet Member** | Graham Gibbens | **Director** | Anne Tidmarsh |
| **Portfolio** | Adult Social Care and Public Health | **Division** | Older People and Physical Disability |




**Data Notes.**
Tolerance: Higher values are better.
Unit of measure: Number
Data Source: Adult Social Care Swift client system

Data is reported as the position at the end of the quarter.

No comparative data from other local authorities is currently available for this indicator.

| Trend Data | Previous Year | | | Current Year | | | |
|---|---|---|---|---|---|---|---|
| | **Sept 10** | **Dec 10** | **Mar 11** | **Jun 11** | **Sep 11** | **Dec 11** | **Mar 12** |
| KCC Result | | | 985 | 966 | 973 | 1006 | |
| Target | | | 980 | 960 | 970 | 985 | 1,000 |
| Rag Rating | | | Green | Green | Green | Green | |
| **Commentary** | | | | | | | |

| Number of adult social care clients receiving a telecare service | Green ⇧ |
|---|---|

It should be noted that the decrease in the actual and target numbers between March 2011 and June 2011 is primarily due to a review of all clients and a data quality update that was undertaken in preparation for mainstreaming the service within the operational teams. Some service users opted to finish their involvement when the Whole System Demonstrator finished in April. The data quality clean up was completed in June and the baseline starting point was re-set to 960.

The number of people in receipt of telecare has now exceeded the end of year target.

**What actions are we taking to improve performance (and drivers of performance)**

Telecare has very recently been transferred to the operational teams as a mainstream service and is being promoted as a key mechanism for supporting people to live independently at home through the teams. This includes promoting telecare through the hospitals and also to support people after a period of enablement.

The availability of new monitoring devices (for dementia for instance) is expected to increase the usage and benefits of Telecare, and a strategy and commissioning plan are being developed in relation to this.

In addition, the provision of Telecare can now be included within Personal Budgets, where appropriate.

Awareness training has been delivered to many teams, and will be delivered to all teams, which ensures that staff optimises the opportunities for supporting people with teletechnology solutions.

Targets have been set across all the teams, and this is monitored and managed closely by the Divisional and Directorate Management Teams through Locality Action plans, which requires Heads of Services to report back on their performance, ensure targets are set at team and individual level and identify training needs within their teams.

Significant data quality work has improved the recording of telecare within the teams.

**Risks and mitigating actions**

1. Operational teams' not understanding SWIFT (our client database) in relation to Telecare.
2. Telecare equipment not meeting needs, client groups may be missed out for use of Telecare.

| Number of adult social care clients receiving a telecare service | Green ⇧ |
|---|---|

3. Operational staff may not be identifying Telecare as a means of meeting assessed needs.

**Action taken** :

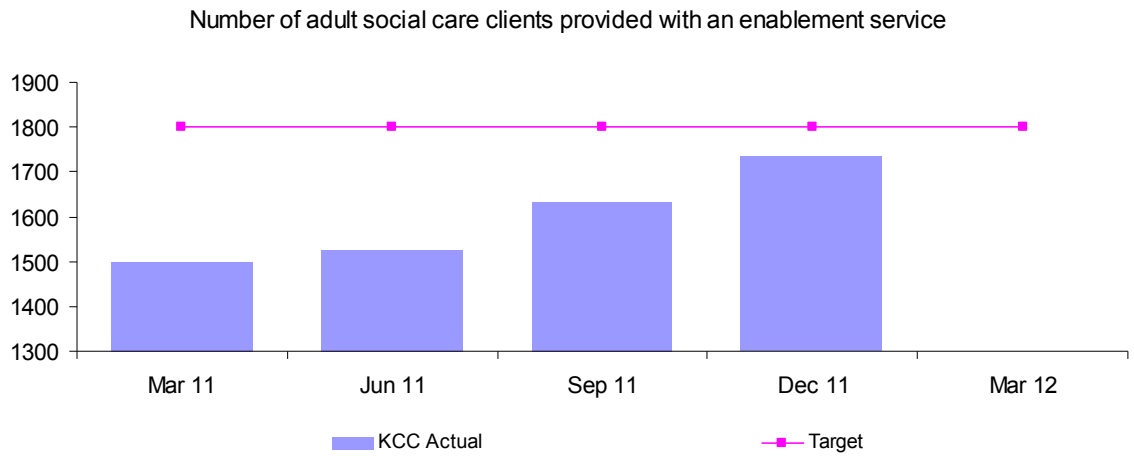
1. Telecare SWIFT training in place for staff and ongoing refresher training offered including floor walking as well as additional support for data quality.
2. Equipment needs reviewed through Teletechnology Strategy group and strategy and commissioning plan being developed.
3. Telecare covered as an ongoing topic in individual supervision, Personal Action Planning, and managers meetings. Monthly performance monitoring by Divisional Management Teams.

| **Discussion and actions agreed by PAT** |
|---|
| |



| Number of adult social care clients provided with an enablement service | | | Amber |
|---|---|---|---|
| **Bold Steps Priority/Core Service Area** | Empower social service users through increased use of personal budgets | **Bold Steps Ambition** | Put the Citizen in Control |
| **Cabinet Member** | Graham Gibbens | **Director** | Anne Tidmarsh |
| **Portfolio** | Adult Social Care and Public Health | **Division** | Older People and Physical Disability |

| Number of adult social care clients provided with an enablement service | Amber |
|---|---|




**Data Notes.**
Tolerance: Higher values are better
Unit of measure: Number
Data Source: Adult Social Care Swift client system

Data is reported as number of clients accessing the service in the last month of the quarter.

No comparative data for other local authorities is available for this indicator.

| Trend Data | Previous Year | | | Current Year | | | |
|---|---|---|---|---|---|---|---|
| | Sept 10 | Dec 10 | Mar 11 | Jun 11 | Sep 11 | Dec 11 | Mar 12 |
| KCC Result | | | 1500 | 1527 | 1631 | 1736 | |
| Target per quarter | | | 1800 | 1800 | 1800 | 1800 | 1800 |
| Rag Rating | | | Amber | Amber | Amber | Amber | |

**Commentary**

Enablement has been in place for over a year to support new client referrals to Adult Social Care. Past performance has shown the expected increase in enablement during its early development phase, with continued increases. The last quarter would have exceeded the target, for the first time, had the service not experienced low demand through the Christmas period. All the assessment and enablement teams now have enablement services available for their locality.

The target is for 600 people per month to received enablement. The monitoring shows the full quarter's performance.

**What actions are we taking to improve performance (and drivers of performance)**

Numbers are expected to increase in the future since more people are accessing enablement services as part of their assessments and people who are already receiving packages are now being referred to enablement services with the aim of increasing their

| Number of adult social care clients provided with an enablement service | Amber |
|---|---|

independence.

In addition, reasons for not receiving enablement are examined carefully. About 60% of people who do not receive enablement need the provision of equipment to allow them to live independently. Some localities are participating in an Occupational Therapy project which targets existing people in receipt of homecare and hopes to make them more independent with the provision of equipment. This is another form of an enabling service.

Enablement is a key priority for the localities and teams and Targets have been set. This is monitored and managed closely by the Divisional and Directorate Management Teams through Locality Action plans, which requires Heads of Services to report back on their performance, ensure targets are set at team and individual level and identify training needs within their teams.

Based on some pilot work to date, DivMT's are also looking at the impact of providing equipment as another way of enabling people successfully, and they will measure its impact on the demand of the enablement service in the future.

Externally commissioned enablement services including the Active Care service are within the figures.

Kent Enablement at Home continues to work to increase its capacity to ensure that all demand is being met.

An enablement review has been carried out to examine why people are not being referred or accepted into enablement schemes. Actions will be put into place to address any issues where improvements can be made.
Volumes of enablement are monitored on a monthly basis at Divisional and Directorate Management Teams. All heads of service and team leaders are proactively ensuring that enablement should be the main care pathway for all appropriate referrals.

Intermediate care is another form of rehabilitation which is used to assist with discharge from hospital, as well as preventing hospital admission and is subject to a joint health and social care assessment. At the end of March 2011, Kent's results for the national indicator *NI125 – proportion of people who are back home 91 days following discharge and after receiving intermediate care* was 85%. *In December, this was 87%*. This compared very favourably with our comparative Councils.

**Risks and mitigating actions**

Enablement targets might not be met due to :

1. Staff not referring.
2. Lack of enablement capacity or specialism (dementia).

| Number of adult social care clients provided with an enablement service | Amber |
|---|---|

3. Other enabling type services may meet the demand for enablement in other ways, such as provision of equipment or intermediate care.

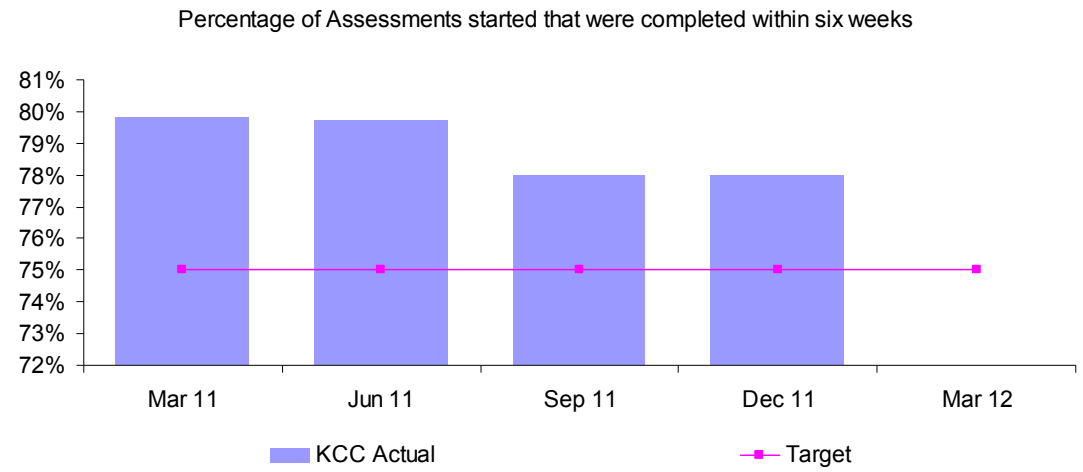
**Action taken**

1. Enablement review carried out, staff and teams monitored against target set.
2. Review of crisis services in East Kent carried out and new services proposed to be commissioned.
3. Careful monitoring of all other services to evidence its impact in terms of outcomes for people and the enablement service.
4. Review to identify changes in new cases and referral numbers and action to be taken from there.

**Discussion and actions agreed by PAT**

| Percentage of adult social care assessments completed within six weeks | | | Green |
|---|---|---|---|
| **Bold Steps Priority/Core Service Area** | Empower social service users through increased use of personal budgets | **Bold Steps Ambition** | Put the Citizen in Control |
| **Cabinet Member** | Graham Gibbens | **Director** | Anne Tidmarsh |
| **Portfolio** | Adult Social Care and Public Health | **Division** | Older People and Physical Disability |

## Percentage of adult social care assessments completed within six weeks — Green




**Data Notes.**
Tolerance: Stable performance is better
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as percentage rate achieved for each quarter.

No comparative data for other local authorities is currently available for this indicator.

| Trend Data | Previous Year | | | Current Year | | | |
|---|---|---|---|---|---|---|---|
| | Sept 10 | Dec 10 | Mar 11 | Jun 11 | Sep 11 | Dec 11 | Mar 12 |
| KCC Result | | | 79.8% | 79.7% | 78.0% | 78.0% | |
| Target | | | 75% | 75% | 75% | 75% | 75% |
| Rag Rating | | | Green | Green | Green | Green | |

**Commentary**

This indicator looks at the timeliness of assessments. The aim of the indicator is not to ensure that assessments are completed more and more quickly – this would be detrimental to the individual if the enablement service was ended too soon.

This indicator serves to ensure that we have the right balance between ensuring enablement is delivered effectively and ensuring the whole assessment process is timely. To this end we have reviewed the target and would expect 75% of assessments to be within 6 weeks, and would challenge teams who would be either allowing people to spend too much time in an enablement service, or who were pushing people through the assessment process too quickly.

Factors affecting this indicator are linked to waiting lists for assessments, assessments not being carried out on allocation and some long standing delays in Occupational Therapy assessments. There are also appropriate delays due to people going through enablement as this process takes up to six weeks and the assessment can not be completed until the enablement process is completed

**What actions are we taking to improve performance (and drivers of performance)**

| Percentage of adult social care assessments completed within six weeks | Green |
|---|---|

A review of unallocated cases is taking place through a Task and Finish Group of assessment and enablement managers and good practice in some localities is being shared and implemented.

In addition to this, the support provided through enablement and the interaction with the staff providing the service, all contribute to the final assessment. The better the monitoring of the individual through this process, the more timely the assessment will be. Assessment completion dates are being reviewed and action proposed as directed by the outcome of the review.

Comparison to other local authorities to be carried out in relation to enablement impacting on timelines for assessments.

Regular monitoring of all contacts to Adult Social Care is undertaken, which identifies the outcomes for all these people, including how many are supported with AIG, how many are referred for enablement, how many are from the hospital, etc, to ensure that any areas of inconsistencies are identified.
This key indicator is monitored on a monthly basis by Divisional and Directorate Management Teams.

**Risks and mitigating actions**

1. Unallocated cases not addressed, delaying assessment completion.
2. Kent Contact and Assessment Services (KCAS) changes affecting AIG referrals completion.
3. Task and Finish Group review outcomes not being addressed through action planning.

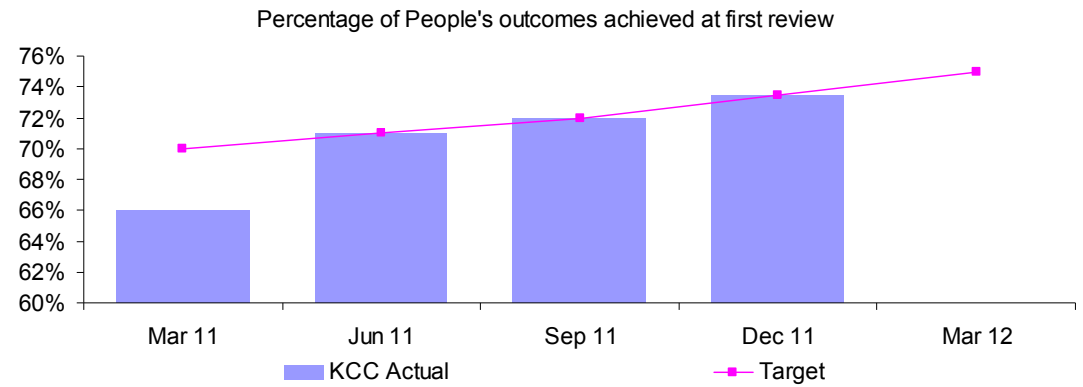
**Action taken :**

1. Task and Finish Group in place.
2. Director for Older People and Physical Disability on the KCAS Project Group and a Service Level Agreement is being proposed.
3. Divisional Management Team, heads of service, assessment and enablement managers, and individual staff responsibilities identified and progress monitored.

**Discussion and actions agreed by PAT**

| Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review | | | Green ⇧ |
|---|---|---|---|
| **Bold Steps Priority/Core** | Empower social service users through | **Bold Steps** | Put the Citizen in Control |

| Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review | | | Green ⇧ |
|---|---|---|---|
| **Service Area** | increased use of personal budgets | **Ambition** | |
| **Cabinet Member** | Graham Gibbens | **Director** | Anne Tidmarsh |
| **Portfolio** | Adult Social Care and Public Health | **Division** | Older People and Physical Disability |




**Data Notes.**
Tolerance: Higher values are better
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as percentage for each quarter.

No comparative data is currently available for this indicator.

| Trend Data | Previous Year | | | Current Year | | | |
|---|---|---|---|---|---|---|---|
| | **Sept 10** | **Dec 10** | **Mar 11** | **Jun 11** | **Sep 11** | **Dec 11** | **Mar 12** |
| KCC Result | | | 66% | 71% | 72% | 73.5% | |
| Target | | | 70% | 71% | 72% | 73.5% | 75% |
| Rag Rating | | | Amber | Green | Green | Green | |

**Commentary**

The percentage of outcomes achieved has increased from 66% in March 2011 to 73.5% in Dec 2011. People's needs and outcomes are identified at assessment and then updated at review, in terms of achievement and satisfaction.

**What actions are we taking to improve performance (and drivers of performance)**

Many people who contact Adult Social Care need information, advice and guidance, or the provision of fast track equipment. This key indicator is a relatively new way of recording information and results are monitored on a monthly basis at Divisional and

| **Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review** | **Green ⇧** |
|---|---|

Directorate Management Teams through the Locality Action Plans. These require Heads of Service to comment on and action performance improvement, as well as identify training needs and risks.

The information will increasingly be used to support the process for development and commissioning of services.

An action plan has been set linked to the Personal Budgets and Reviews action plans. The assessment and enablement managers Task and Finish group is leading on the system with cultural change be delivered to ensure delivery of the target.

This to include: Hospital Teams when carrying out first review recording outcomes on SWIFT (the client database); Enablement services, when carrying out first review, ensuring outcomes are recorded or reported to the assessment officer for recording on SWIFT; Assessment officers and case managers recording of outcomes.

Local good practise for ensuring timely reviews are undertaken is being shared across the localities.

The annual service user survey resulted in a national indicator relating to “Self reported experience of social care users”. The Families and Social Care Directorate are very aware that Kent’s performance was not as high as other councils and continue to promote and monitor the achievement of people’s outcomes to support this.

**Risks and mitigating actions**

1. Target linked to accurate recording of reviews on SWIFT, data-quality risks.
2. Interdependency on achieving Personal Budgets and Review action plans.
3. New target data-quality risks not fully known.

**Action taken** :

1. Part of the Review action planning lead by coordination managers’ Task and Finish group.
2. See 1. The dependency of these action plans identified with responsibilities clearly set out.
3. Close monitoring by Divisional Management Teams and active involvement of data quality staff.

**Discussion and actions agreed by PAT**

This indicator has not been subject to discussion by PAT at this time.

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By: Head of Democratic Services

To: Adult Social Care and Public Health Policy Overview and Scrutiny Committee – 30 March 2012

Subject: **UPDATE ON SELECT COMMITTEE WORK**

Classification: Unrestricted

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Summary: This report updates Members on current Select Committee review work and monitoring of the outcomes of past work and invites suggestions for future Select Committee Topic Reviews.

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**Current Select Committee Review Work**

1. The following reviews are in their closing stages:-

**The Student Journey** - The Select Committee, under the Chairmanship of Mr K Smith, agreed its final report on 28 February. The final report and recommendations will be shared with the relevant Cabinet Members on 27 March and will be considered by Cabinet and County Council in May 2012.

The contacts for this Select Committee are: Research Officer Gaetano Romagnuolo (01622 694292) and Democratic Services Officer Theresa Grayell (01622 694277).

**Educational Attainment at Key Stage 2** - The Select Committee, under the Chairmanship of Mr C T Wells, agreed its final report on 5 March. The report will be shared with the Cabinet Member and Director on 2 April and will be considered by Cabinet in May and County Council in July 2012.

The contacts for this Select Committee are: Research Officer Pippa Cracknell (01622 694178) and Assistant Democratic Services Manager Denise Fitch (01622 694269).

2. A Select Committee on **Domestic Abuse** has just started work. The Membership is: Mrs A D Allen, Mr H J Craske, Mrs T Dean, Mr J D Kirby, Mr S Manion, Mrs E M Tweed, Mrs C Waters and Mr A T Willicombe. At its first meeting on 23 February, the Committee elected Mr Kirby as its Chairman and agreed its Terms of Reference and scope, work programme and list of potential witnesses. In April, Members will receive background briefings and training from the Kent Domestic Violence Co-ordinator, with professionals involved in domestic abuse work. They will then make a series of visits, including to specialist domestic abuse courts and multi-agency domestic abuse one-stop-shops around the county and the new multi-agency central referral unit. They will also have the opportunity, in small groups, to visit refuges and meet survivors of domestic abuse. A visit will also be organised to observe a perpetrator course session run by the Probation Service. Evidence-gathering hearings will take place in June and July.

The review will link closely with the Kent and Medway Domestic Abuse Strategy Group, District Forums and a task-and-finish sub-group appointed by the Community Safety Partnership (which is looking at funding for Independent Domestic Violence Advisors (IDVAs)). The Select Committee is expected to submit its final report to the County Council in December 2012.

The contacts for this Select Committee are: Research Officer Sue Frampton (01622 694993) and Democratic Services Officer Christine Singh (01622 694334).

**Monitoring of the outcomes of past work**

3. Two Select Committees which published their final reports about one year ago have recently re-convened for their 'one year on' monitoring meetings.

The **Renewable Energy** Select Committee met on 24 January 2012 and noted progress against its recommendations, proposed that a conference be organised to demonstrate the potential savings around renewable energy and agreed that Select Committee Members should act as 'champions' of renewable energy issues.

The **Extended Services** Select Committee met on 15 February 2012 and agreed that, because of the number of work streams which are still evolving, it would meet again in autumn 2012, with the Cabinet Members, to receive a further update report on activity which is currently ongoing but has not yet been able to proceed as far as the Committee would have liked. Members also agreed that, when a new document, *'The Impact of Extended Services in Kent'*, becomes final (expected to be in May or June), an informal briefing be arranged, to which all KCC Members will be invited.

**Suggestions for future Select Committee work**

4. 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 Committee.

**Recommendation:-**

5. Members are asked to note the review work currently coming to fruition, new work starting and monitoring of the outcomes of past work, and 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*