SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 12th June, 2013

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 12 June 2013, at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

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

Tea/Coffee will be available 15 minutes before the start of the meeting

Membership (13)

Conservative (8):	Mr C P Smith (Chairman), Mrs A D Allen, Mr A H T Bowles, Mr R E Brookbank, Mrs P T Cole, Mrs V Dagger, Mr G Lymer and Mr P J Oakford
UK Independence Party (2):	Mr L Burgess and Mrs M Elenor
Labour (2):	Ms C J Cribbon and Mrs S Howes
Liberal Democrat (1):	Mr S J G Koowaree

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

The Chairman will assume that all Members will read the reports before attending the meeting. Officers are asked to assume the same when introducing reports.

A. COMMITTEE BUSINESS

A1 Introduction/Webcast Announcement

A2 Substitutes

A3 Election of Vice-Chairman

A4 Declarations of Members' Interest in items on today's Agenda

A5 Minutes of the Meeting of this Committee held on 21 March 2013 (Pages 1 - 14)

A6 Minutes of the Meeting of the Corporate Parenting Panel held on 28 February 2013, for information (Pages 15 - 24)

A7 Chairman's Announcements

B. ITEMS RELATING TO ADULT SOCIAL CARE

B1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

C. ITEMS RELATING TO SPECIALIST CHILDREN'S SERVICES

C1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

C2 13/00045 - Kent County Council Sufficiency Strategy (Pages 25 - 34)

C3 Local Children Services Arrangement (Pages 35 - 42)

C4 Local Government Ombudsman Report (Pages 43 - 48)

C5 Children's Centre Future Service Options Programme (Pages 49 - 56)

C6 Child Poverty Strategy (Pages 57 - 96)

D. ITEMS RELATING TO PUBLIC HEALTH

D1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

D2 Progress update on Genito-Urinary Medicine (GUM) service transfer from Darent Valley Hospital to Gravesham Community Hospital (Pages 97 - 100)

D3 Update on the Measles outbreak in England (Pages 101 - 104)

D4 Health Protection Assurance (Pages 105 - 112)

E. PERFORMANCE MONITORING ITEMS

E1 Children's Services Improvement Plan Update (Pages 113 - 118)

E2 CAMHS update (Pages 119 - 128)

E3 Kent County Council Local Account for Adult Social Care for 2012 - 2013 (Pages 129 - 132)

E4 Families and Social Care Performance Dashboards for 2012/13 for Adult Social Care for March 2013 (Pages 133 - 156)

E5 Families and Social Care Performance Dashboard for 2012/13 for Specialist Children's Services (Pages 157 - 174)

E6 Public Health Performance Dashboard - Health Improvement Performance Report (Pages 175 - 178)

Motion to Exclude Press and Public for Exempt Item

That under Section 100A of the Local Government Act 1972 the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.

Key or significant Cabinet Member Decision(s) for recommendation or endorsement

F1 13/00010 - Appointment of Efficiency Partner for Delivery of Transformation Programme - Exempt Minute from 21 March meeting (Pages 179 - 182)

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

Tuesday, 4 June 2013

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KENT COUNTY COUNCIL

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Social Care and Public Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Thursday, 21 March 2013.

PRESENT: Mr C P Smith (Chairman), Mrs A D Allen (Vice-Chairman), Mr R E Brookbank, Mr N J D Chard, Mr L Christie, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby and Mr A T Willicombe

ALSO PRESENT: Mr G K Gibbens and Mrs J Whittle

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), Ms M MacNeil (Director, Specialist Children's Services), Mr A Scott-Clark (Director of Health Improvement (KCC), NHS Kent and Medway), Mrs A Tidmarsh (Director of Older People and Physical Disability), Mr M Walker (Head of Service, Learning Disability, West Kent) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

77. Minutes of the Meeting of this Committee held on 11 January 2013
(Item A4)

RESOLVED that the Minutes of the meeting of this Committee held on 11 January 2013 are correctly recorded and they be signed by the Chairman. There were no matters arising.

78. Minutes of the Meeting of the Corporate Parenting Panel held on 14 December 2012, for information
(Item A5)

RESOLVED that the Minutes of the meeting of the Corporate Parenting Panel held on 14 December 2012 be noted.

79. Adult Services Oral Updates by Cabinet Member and Director
(Item B1)

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

- ***Spoke at End of Life Care Conference on 12 February,*** at which Kent was commended for its end of life care.
- ***Held Annual Meeting with Age UK Chairs on 13 February***, at which some good frank discussion took place.
- ***Spoke at The Dementia Pledge Event on 19 February***
- ***Attended Sevenoaks Leisure Centre Disabled Facility Launch on 28 February***

- ***Kent and Medway Safeguarding Board*** has commended Kent as excelling in the way in which it deals with safeguarding issues.

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

   - ***Post-Winterbourne Safeguarding Conference – 13 March***. There was very positive feedback from the 250 multi-agency professionals at this event, raising awareness of the risk of institutional abuse.
   - ***Dementia Intergenerational Project*** – Kent has had commendation from the Department for Health and from Angela Rippon, who is part of the Prime Minister's Dementia Challenge Group, on the work being done with two Gravesend Schools and their intergeneration dementia projects. Kent is cited as an exemplar as part of a government project to tackle Dementia.

3. The oral updates were noted, with thanks.

80. Children's Services Oral Updates by Cabinet Member and Director
(Item C1)

1. Mrs Whittle gave an oral update on the following issues:-

   - ***an Ofsted Inspection of the Adoption Service*** is currently proceeding. There has been much improvement in the service since the Improvement Notice, and it is critical that progress is sustained. Updated figures: in 2012/13, 141 children have been placed for adoption (compared to 68 in 2011/12), 105 children have been formally adopted (compared to 70 in 2011/12) and there has been a 25% increase in the number of adopters recruited. The partnership with Coram is working well and challenging questions are being asked.
   - ***Children and Families Bill***
   - ***Recently met with Our Children and Young People's Council (OCYPC) and Care Leavers*** – these meetings had two keys themes in common: the need for stability of allocated social workers and adequate social worker recruitment.
   - ***KCC Cabinet report on UASC burden on Council Tax payers of Kent*** – this seeks a unified approach, to resolve the previous clash of views between the Home Office and the content of the Children Act about local authorities' duty to support young people who have exhausted all rights to stay (ARE cases). KCC is seeking a Court declaration about Kent's responsibilities.

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

   - ***Ofsted inspection of the Adoption Service*** – it is vital to be realistic about the likely outcome; it is very difficult to go from an 'inadequate' to a 'good' rating.
   - ***Formal judgement from the Ofsted inspection of Children In Care*** is still awaited, along with an indication of the future inspection schedule.
   - ***Kent had a Peer Challenge visit in early March, looking at Children's Centres and Early Intervention.*** This was led by the Director of Children's Services in Hampshire, and was part of the national sector-led improvement

programme. The final report is awaited but initial feedback is positive, with helpful suggestions about how Kent can further develop.

3. Mrs Whittle and Mr Ireland responded to comments and questions from Members and the following points were highlighted:-

a) it is important to be realistic about the rating that Ofsted are likely to give the Adoption service. It is very rare that a rating will go from 'inadequate' to 'good' in one step. It is likely to take three years to make the necessary improvements and for them to bed in, and this is the third year. The last stage of progress is often harder to make. It is hoped that, regardless of the rating awarded, the great improvement that KCC has made will be acknowledged in Ofsted's report so the public can see what KCC has been doing to address problems;

b) it is important also not to be complacent and 'satisfied' but to be alert and look ahead for the next challenge. It is impossible to do *too* well;

c) it has previously been reported, incorrectly, that the number of children in care in Kent had reduced, as not all the children who should have been counted had been included in the total. Mrs Whittle undertook to rectify this error and advise Members of the correct figure;

d) regret was expressed that Ofsted inspectors were not able to observe the Cabinet Committee's meeting, and it was suggested that they instead be invited to view the webcast if they wish to;

e) the challenge posed by UASC is ongoing, and a deal negotiated by a previous Government to address this has never been implemented. Legal advice is being sought about the possibility of getting a Courts declaration setting out Kent's responsibilities. The Cabinet report will cover the range of impacts for Kent, eg on education, worklessness, etc;

f) it had previously been reported that the Adoption team is made up entirely of female staff. More male adoption workers would be welcomed, and it was confirmed that two good male candidates had come forward and were being considered. Universities could be encouraged to attract more men into social work courses, although the predominance of women in careers involving children is a long-established phenomenon; and

g) Kent still experiences much pressure from children in care placed by other local authorities, and Mrs Whittle and her team was thanked for the way in which the issue is being tackled.

4. The oral updates were noted, with thanks.

81. 13/00001 - Every Day Matters: Kent County Council's Children and Young People's Strategic Plan 2013 - 2016 (Decision to be taken by the Cabinet Member for Specialist Children's Services)
(Item C2)

Mr M Thomas-Sam, Strategic Business Advisor, FSC, was in attendance for this item

1. Mr Thomas-Sam introduced the report and he and Mr Ireland responded to comments and questions from Members.

2. In debate, Members made the following comments:-

   a) the four outcomes of the vision do not include the successful transition from childhood to adulthood, and Members requested that this be added as a fifth outcome;

   b) one speaker sought reassurance that the list of outcomes and priorities is achievable, eg under priority 4 'ensuring that every child or young person has access to a good or outstanding school' does not seem to be achievable. The figure quoted on page 7 of the Strategic Plan, ie that 55% of primary schools are judged to be good or outstanding, should be updated to 61%;

   c) another speaker welcomed the ambitious targets and asked why every child should not aspire to have access to an 'outstanding' rather than a 'good' school. Kent's aim should be for all of its schools to be outstanding; and

   d) the 'governance architecture' outlined in the report, within which the Strategic Plan will be delivered, has to reflect and accommodate the reality of joint working in modern public life.

3. RESOLVED that:-

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

   b) the decision proposed to be taken by the Cabinet Member for Specialist Children's Services, to adopt the draft 'Every Day Matters: Kent County Council's Children and Young People's Strategic Plan 2013 - 2016' as the overarching framework for Kent County Council's Children's Services, be endorsed, taking account of the comments made by the Cabinet Committee in debate, set out above.

82. Public Health Oral Updates by Cabinet Member and Director
(Item D1)

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

- ***He is very concerned about the difference between East and West Kent delivery of various public health elements*** and will seek to address this after 1 April to achieve high quality in all areas. A good level of public health funding is available to support this.
- ***Spoke and Presented Accreditation Certificates at the Public Health Champions Celebration Event on 26 February***, at which there was excellent attendance.

- ***Chief Executive of Public Health England, Duncan Selbie, visited Kent on 7 March*** and there was a good meeting and discussion.

2. Ms Peachey then gave an oral update on the following issues:-

- ***Public Health is ready to deliver on 1 April as PCTs are abolished***, after two years of planning. Kent is very fortunate in having been able to retain most of its public health posts, and the service already appears well integrated. The style will be to minimize bureaucracy and concentrate on 'the public's health'.
- ***Spoke at a national conference on heat wave planning***, which is a new responsibility for the KCC. The conference was well attended with a broad range of participants.
- ***Met with the arts and culture organisations in Kent***, at their request, which was very enlightening.
- ***Improved teenage pregnancy rates in Kent*** – these had fallen by 6%, which is to be welcomed, and some areas have exceeded this. *Ms Peachey undertook to provide Members with a District by District breakdown of figures.*
- ***Spoke at National Adaptation Conference***.

3. Mr Gibbens and Ms Peachey responded to comments and questions from Members and the following points were highlighted:-

a) the Committee recorded its congratulations to everyone who had passed the Public Health Champions course;

b) beside the fall in teenage pregnancy rates, the rate of terminations in teenagers has increased by 5%;

c) there has been much discussion about transferring the pension scheme of public health staff to the KCC. The outcome is that staff transferring from the NHS will retain their NHS terms and conditions and pensions arrangements; and

d) concern was expressed about the workload of this Committee and the potential for public health issues to receive insufficient attention at the end of a long agenda.

4. The oral updates were noted, with thanks.

83. 13/00022 - To identify an interim solution for the Genito-Urinary Medicine service at Darent Valley Hospital (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health)
(Item D2)

1. Ms Peachey introduced the report and clarified key points, as follows:-
- the proposed change in service delivery gives the KCC an opportunity to improve the quality of provision,
- a new Head of Public Health Commissioning had recently been appointed, plus one member of staff to work specifically on sexual health issues,
- GUM and HIV services are funded separately, so data on service delivery is recorded separately,
- the new service will require the establishment of a Health Advisor role,

- the Local Area Teams (LATs) referred to in the report are part of a regional tier of the National Commissioning Board, and sit below the four regional teams.

2. Ms Peachey responded to comments and questions from Members, as follows:-

a) Members sought to understand the need for the proposed interim solution and what had failed in the previous arrangement, and asked about the scope to build into the next contract a clause to protect against future failure. Ms Peachey advised that any provider could give notice that they would no longer be able to provide a service. The current contract will end on 31 March but the current provider has agreed to continue service provision until 1 May to allow time for interim arrangement to be established;

b) if the KCC is dissatisfied with the quality of provision, it can give six months' notice to the provider to improve performance or face cancellation of the contract; and

c) the KCC will not wait until the end of the one-year interim arrangement to go out to tender for the next long-term contract, but will start work on the specification for it imminently. *The detailed specification will be reported to the June meeting of this Committee.*

3. RESOLVED that:-

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

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to agree that the GUM service in Darent Valley Hospital be handed over to Kent Community Hospital Trust to provide it from Gravesham Community Hospital as an interim solution, for the reasons set out in the report, for one year (with the service then being tendered out in 2014) be endorsed; and

c) the detailed specification for the contract which is to tendered out in April 2014 be reported to the June 2013 meeting of this Committee.

84. 13/00024 and 13/00023 - Public Health Transition (Decisions to be taken by the Cabinet Member for Adult Social Care and Public Health)
(Item D3)

Mr D Oxlade, Transition Programme Manager, was in attendance for this item.

1. Mr Oxlade introduced the report and, in response to a question, said he was confident of there being no complications around the transfer in terms of information technology issues. KCC Public Health staff will need to access some NHS systems, but this is a data rather than a hardware issue.

2. Ms Peachey thanked Mr Oxlade for the exceptional work he had put into preparing for the transition in the last eight months, and the very positive approach

which had been engendered and which is vital to making the new arrangement work well. Members added their thanks to Mr Oxlade.

3. The Cabinet Member, Mr Gibbens, added his thanks and said he was confident of the steps which had been taken to ensure a smooth transition on 1 April. He welcomed the NHS staff who will shortly be joining the KCC.

4. RESOLVED that:-

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

b) the decisions proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, as follows:-

13/00024 - to agree for the County Council to take over responsibility for the existing National Health Service contracts which are used to deliver those Public Health programmes for which the Authority will have responsibility from 1 April 2013, and

13/00023 - to agree that KCC shall take on responsibility for the relevant existing National Health Service Assets and Liabilities which relate to the previous delivery of Public Health programmes for which the Authority will have responsibility from 1 April 2013,

be endorsed; and

c) the Committee's thanks to Mr Oxlade for the exceptional work on the transition and the very positive approach which has been engendered, and welcome to the NHS staff who will shortly be joining the KCC, be formally recorded.

85. FSC Directorate Financial Monitoring Report 2012/13
(Item E1)

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

1. Miss Goldsmith and Mr Ireland introduced the report and, in response to a question, explained that the current budget allocation had been based on the assumption that the number of children in care in Kent would reduce substantially, which had not ultimately proved to be the case. Next year's budget assumed a smaller, more realistic reduction in the number.

2. RESOLVED that the revenue and capital forecast variances from budget for 2012/13 for the Families & Social Care Directorate (Adult Social Care & Public Health and Specialist Children's Services Portfolios), based on the second quarter's full monitoring to Cabinet, be noted.

86. Children's Services Improvement Programme: Progress Update
(Item E2)

Ms J Maiden-Brooks, Programme Manager, FSC Improvement Team, and Mr M Gurrey, Interim Assistant Director for Safeguarding, were in attendance for this item.

1. Mr Gurrey introduced the report and said that both the recent Ofsted inspection and a Peer review had identified much progress in Children's Services since the Improvement Notice had been issued in 2010. There is much excellent practice and work across the county. Mr Gurrey and Mr Ireland responded to comments and questions from Members. The following points were highlighted:-

a) a key objective in the improvement plan, and a long-standing concern for Members, is to improve the recruitment of full-time, permanent social work and other staff to the KCC and to reduce the number of agency staff. Mr Ireland commented that, although he shared Members' concern and supported this aim, there are many very good workers amongst the agency staff, including some social work managers, whose professional experience had been of great benefit to the KCC. He assured Members that KCC will recruit only top quality social work staff. A new Adoption manager is shortly to be appointed, and to have the whole top management team then in permanent contracts will help a lot. A review of every part of the recruitment package has been commissioned, to address problems being experienced in some geographical areas and to maximise the opportunity to develop existing KCC social work staff, eg to take on first line management roles;

b) Members had previously requested that social work recruitment data be included on the Directorate's dashboard, and this request was repeated so the situation can be kept under constant review. Mr Gurrey undertook to ensure its inclusion in future dashboard reports; and

c) both the recent Ofsted inspection and a Peer review had been very useful in showing that the service had become somewhat introspective and focussed too much on statistics, and had helped KCC to look at the broader picture. This broader view was welcomed.

2. RESOLVED that:-

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

b) data on social worker recruitment rates be included in future dashboard reports.

87. Ofsted Inspection: Protection of Children
(Item E3)

Mr M Gurrey, Interim Assistant Director for Safeguarding, was in attendance for this item.

1. Mr Ireland introduced the report and said the inspection had been rigorous and thorough, having looked at more than 200 cases, and the relationship with inspectors had been constructive. The initial outcome had been positive, with KCC being

described as 'knowing itself well'. Areas which had attracted criticism are areas in which there is already a plan in place for improvement. It is important to be realistic about the rating the KCC might receive, and to move from 'inadequate' to 'adequate' would be as much as could realistically be expected. Mr Ireland and Mr Gurrey responded to comments and questions from Members and the following points were highlighted:-

a) the fact that no children are described as being 'at risk' and no cases which urgently need safeguarding measures was welcomed;

b) planning for children in need is the main area in which the KCC is still relatively weak, and action has already been put in place to address the two recommendations made by Ofsted in relation to this area. All children in need cases are being reviewed and there is a practice improvement programme which will focus on continuous improvement; and

c) Ofsted had not been concerned about a lack of audit of children in need cases but that audits had not always been carried out well, and that the reason for the audit had not always been made clear. This view was accepted as a fair comment, and a series of random monthly file audits will address it.

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

88. Update on the Children and Young People's Mental Health Services (CAMHS)
(Item E4)

Mr I Darbyshire, Senior Associate, Kent and Medway Commissioning Support, Ms C Infanti, Strategic Commissioning, Children's Services, Ms L Reid and Ms S Button, Sussex Partnership NHS Foundation Trust, and Ms L Kavanagh, NHS Kent and Medway, were in attendance for this item.

1. Mr Darbyshire introduced the report and explained that it followed on from the update given at the Committee's previous meeting. He introduced the visiting speakers, who were present in response to the Committee's request that representatives from the service provider attend to answer Members' questions. A service model and performance data from Sussex Partnership NHS Foundation Trust were tabled.

2. Officers and visiting speakers responded to comments and questions as follows:-

a) do Kent's arrangements, service level agreements and targets differ from those of any other local authority the Trust works with? Ms Kavanagh responded that the model of support used in Kent is comparable to that used elsewhere, and had been based on known examples of best practice from elsewhere. Ms Reid added that the 'Right from the Start' model, which aims for early assessment and quick progress, had been developed by the Trust and previously used in

Hampshire. In Kent, this model has been implemented faster than it had been anywhere else. The service specification and key performance indicators are similar to those of all the Trust's other clients;

b) concern was expressed that, as the service had stopped using the homeopathic hospital at Tunbridge Wells, and other services may have insufficient staff to cover, young people with eating disorders may be allowed to drop out of the system. West Kent may, in effect, be subsidising services in Sussex. Ms Button explained that a major service transformation had increased the staffing and resources in West Kent to ensure that the range and number of staff available there is sufficient to meet local demand. The staffing model used at the homeopathic hospital is one of large teams arranged in hubs and satellites to cover a large area, offering maximum accessibility and choice, delivering services locally via methods that people want, eg via GPs, schools, youth hubs, etc. There are sufficient resources to ensure that any gaps, eg staff sickness, are covered*;*

c) The questioner remained unconvinced by the responses given to points a) and b). Ms Kavanagh added that Sussex is able to provide a faster service now as its model was established five years ago and has thus had more time to bed in and deliver shorter waiting times, so its speed is not at the expense of services in Kent. Kent can benefit from the experience gained in Sussex and the lessons learnt in establishing its model;

d) one speaker stated that he would not wish to take on the contract for CAMHS in Kent as the service has historically had such a poor reputation. As KCC is judged by the outcomes which it achieves, the delivery of a good service is more important than the model used to deliver that service, and Kent should be given the CAMHS service it deserves. What is needed is fast improvement;

e) how does the inherited backlog of cases in Kent compare to those of other authorities the Trust has worked with? Ms Reid replied that the backlog had been larger than expected, but the Trust intended to deliver a very good service and was alert to the challenges ahead;

f) how long did it take to turn around the service in Sussex? Ms Reid replied that it had taken 18 months to reduce the waiting list in Sussex when the Trust had worked there five years ago. From this, it had learnt much. Good models and performance indicators are vital for measuring progress. It is intended that Kent's progress will be faster than that achieved in Sussex. The initial cultural change is the slowest part and can take more than a year to achieve;

g) how does the level of resource in Kent compare to that in Sussex and Hampshire? Ms Button replied that the Trust had found fewer staff in West Kent than they had expected but had addressed this by some recruiting as well as transferring some from East to West Kent. In North and West Kent, there is much competition with London to recruit

specialist staff, including emergency out-of-hours staff. The target is to reduce the waiting time for an initial assessment appointment to 4 – 6 weeks by July 2013, and there have already been signs of progress towards this. There is no waiting period for young people needing emergency appointments;

h) another speaker expressed a lack of confidence that the service in North West Kent could deliver the reduction in waiting times shown in the trajectory charts in the report, which seemed to show aspirational rather than realistic targets. Many adolescents drop out of the system while they are waiting to be seen. Ms Button sought to reassure Members that the increased staffing levels in West Kent will reduce waiting times, and the Trust's model will ensure engagement with young people who drop out. The model allows young people to choose how and where they want to be engaged. Ms Kavanagh added that the NHS could see clear dissatisfaction with the service as it was, hence the re-procurement of the service. The trajectory charts were not aspirational but were realistic and could be achieved by July 2013;

i) another speaker supported the views already expressed and the lack of confidence around reducing waiting times in North and West Kent. If the times stated are not achieved by July 2013, this Committee will hold the Trust to account. Ms Kavanagh replied that it is important to have a realistic picture of waiting times in different areas of the county so the scale of the challenge can be seen. The wait between referral and starting treatment is currently 8 – 12 weeks. The aim is to provide equitable resources and an equitable experience for all young people across Kent, regardless of area. To this end, all eight Clinical Commissioning Groups share the same responsibility, working to the same specification and same targets;

j) does the fast-track of urgent and severe cases create a two-tier system? Ms Button explained that young people in crisis have priority and do not have to wait for an appointment. There is some prioritisation for those whose needs are assessed as 'less severe', but apart from these cases, the Trust ensure that those who have waited the longest are seen first. It is important to treat each case in the best and safest way possible. Ms Kavanagh added that the Trust ensures that parents know what to do and how to contact the service to seek more urgent attention if a young person's circumstances change;

k) a speaker commented that the tables showing numbers waiting and the length of wait, in the papers tabled at the start of the discussion, are not clear and do not help Members' understanding of the picture. In the chart which lists figures for each area, neither Sevenoaks nor Tonbridge and Malling are represented, and the correlation between these figures and the trajectory charts in the report is not clear. Ms Button explained that the towns and areas listed do not relate strictly to administrative districts but are the names of area teams (in which, Sevenoaks and Tonbridge and Malling come under T2 Tunbridge Wells and T2 Maidstone, respectively). She undertook to re-supply the

Committee with the same data broken down by administrative districts; and

l) Members asked that a further update report on the CAMHS service be made to a future meeting of this Committee so progress can be closely monitored.

3. The Cabinet Member, Mrs Whittle, commented that a key issue for KCC was to recognise and resource the need for early intervention, which it was seeking to do via the Young Healthy Minds initiative. Services will be commissioned jointly, and aspirations and goals also need to be jointly held. Joint referrals and assessments will ensure that every patient receives the most appropriate service for their needs. The backlog of cases needs to be cleared before the service can be sorted out. Today's discussion has been useful in indicating the need for additional investment.

4. RESOLVED that:-

a) the information set out in the report and given in response to Members' comments and questions be noted;

b) a further update report on the CAMHS service be made to a future meeting of this Committee: and

c) the information and clarifications requested by Members, ie data on waiting times and numbers broken down by administrative district, and a comparison of resources available in Kent, Sussex and other south east regions be circulated to Members of the Committee following this meeting.

89. Families Services Directorate Performance Dashboard for January 2013
(Item E5)

Mr R Benjamin, Performance Monitoring Manager, and Ms M Robinson, Management Information Services Manager for Children's Services, were in attendance for this item

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

a) the headings in the dashboard relating to Specialist Children's Services mirror the areas requiring attention which were listed in the Improvement Notice; and

b) Members had previously asked that monitoring of social work recruitment be included in the dashboard, and this will be shown in future dashboard reports. Recruitment figures are available for February 2013 and these will be circulated to Members of the Committee following the meeting.

2. RESOLVED that:-

a) the content of the Families and Social Care dashboards, and the information given in response to Members' comments and questions, be noted; and

b) the social work recruitment figures for February 2013 be circulated to Members of the Committee following the meeting.

90. PH Performance Dashboard - Health Improvement Programmes Performance Report
(Item E6)

1. Mr Scott-Clark introduced the report and gave an oral update on smoking quits. The number of quits is currently a little behind target in West Kent, but it is hoped that the final number of quits for the year across the whole county will rise by the end of the current financial year . He responded to comments and questions from Members and the following points were highlighted:-

a) the number of health checks in West Kent is still lower than that for East Kent because it is geared to delivery solely through GPs' practices, whereas in East Kent a wider range of methods of delivery is used;

b) West Kent has historically had lower investment than East Kent across public health initiatives in general, and is only just catching up now; and

c) when a GP identifies a smoker who wishes to quit and is willing to commit to a target date, a start date is agreed and the GP monitors the patient's progress at 4 weeks and 12 weeks. Patients who complete the four week stage without smoking are counted as having quit successfully. Some GPs are more proactive than others and the pattern across the county is uneven, but the public health team are working with GPs to address this.

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

SUMMARY OF EXEMPT ITEM (Where Access to Minutes Remains Restricted)

The Committee resolved that, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act.

91. 13/00010 - Appointment of a Transformation and Efficiency Partner - Adult Social Care Transformation Programme (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health)
(Item B2)

1. The Committee had an extensive debate of the issue and made a number of comments on it. Officers responded to questions of detail.

2. The Cabinet Member, Mr Gibbens, acknowledged and responded to the comments made by Members in debate.

3. Mr L Christie proposed that the decision proposed to be taken by the Cabinet Member be deferred until a future meeting of this Committee, to allow exploration of the way in which the proposed contracting arrangement will work. Mr K A Ferrin seconded the motion, having sought clarification on various points of fact.

Lost on the Chairman's casting vote.

4. The recommendation in the report, that Members endorse the decision proposed to be taken by the Cabinet Member, was then put to the vote.

Carried

5. RESOLVED that:-

a) the information set out in the report and given in response to Members' comments and questions be noted; and

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to identify the preferred bidder, to agree the award of the contract to that bidder as FSC adult transformation and efficiency partner, and to delegate authority to the Corporate Director of Families and Social Care, in consultation with the Cabinet Member for Adult Social Care and Public Health, to enter into the necessary contracts, following the satisfactory negotiation of detailed terms and conditions, be endorsed.

KENT COUNTY COUNCIL

CORPORATE PARENTING PANEL

MINUTES of a meeting of the Corporate Parenting Panel held in Darent Room, Sessions House, County Hall, Maidstone on Thursday, 28 February 2013.

PRESENT: Mrs A D Allen (Chairman), Mr M J Vye (Vice-Chairman), Mr R E Brookbank, Mrs P T Cole, Mr G Cooke, Mrs E Green, Mr S Griffiths, Mr P W A Lake, Mr L B Ridings, MBE and Mrs J Whittle

IN ATTENDANCE: Ms M MacNeil (Director, Specialist Children's Services), Mr P Brightwell (Performance and Quality Assurance Manager, CIC), Mrs S Skinner (Service Business Manager, FSC) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

25. Minutes of the meeting held on 14 December 2012

(Item A2)

RESOLVED that the Minutes of the meeting held on 14 December 2012 are correctly recorded and they be signed by the Chairman. There were no matters arising.

26. Cabinet Member's Oral Update

(Item A4)

1. Mrs Whittle gave an oral update on the following:-

- **At a recent meeting with Mairead MacNeil and Care Leavers** about entitlements and the Care Leavers' Charter, the need for a 'stage, not age' approach was emphasised. Longer-term funding and flexibility are also needed. These issues will be taken forward and work with Care Leavers will continue.
- **A meeting on 25 February with the Leader of the County Council and the Immigration Minister, Mark Harper, about Unaccompanied Asylum Seeking Children (UASC)** showed up a conflict between the content of the Children Act 1989 (that Local Authorities have a duty to support UASC whose rights to stay have been exhausted (ARE)) and the view of the Home Office (that Local Authorities have no statutory obligation to support these young people, and hence do not receive government funding towards it). KCC will continue to lobby the Government about this issue and *a progress report will be made to the Panel's next meeting.*
- **At a recent meeting with Mairead MacNeil and the OCYC**, the role that young people used to play in recruiting Social Workers was discussed.
- **A recent conference,** run *by* the Office of the Children's Commissioner for England, Dr Maggie Atkinson, and media coverage has addressed the issue of exploitation of Children in Care and other vulnerable children, including the public misconception that KCC is responsible for children's homes in Kent. The BBC is making a documentary programme about this issue.

- **Foster Carers:** various issues raised by Foster Carers are being tackled, eg when seeking to extend a Foster Carer's home to accommodate children in care, only 50% of their income is taken into account when calculating a mortgage. KCC will lobby for their whole income to be taken into account, and more work is needed on finding a better process.

2. Mrs Whittle and Mr Brightwell responded to comments and questions from the Panel and the following points were highlighted:-

- If the KCC exceeds it statutory requirement to support ARE, surely it is supporting the 'industry' around UASC by making it easy for ARE to stay? A wide-ranging solution is needed. *By supporting ARE, KCC fulfils a moral and statutory obligation to support vulnerable young people, and can avoid judicial review, eg from the Refugee Council, which would cost much more than the current £3m annual cost of supporting ARE. The money spent on supporting ARE could be viewed as 'invest to save'. Clarification of the issue is being sought from the Children's Minister, Edward Timpson, and a report to the KCC Cabinet in March will set out the implications of this for Kent.*
- The issue needs to be resolved so Kent rate payers are not penalised by the financial burden just because Kent is a main point of entry for UASC. A national and international solution is needed, rather than a local one. *The key issue is that the UK Border Agency does not deport ARE as promptly as it could, so the care bill for KCC mounts up while they are waiting. The 'Children First' Parliamentary Inquiry noted the tension around this issue and emphasised that UASC are children first and foremost.*
- A view was expressed that it is correct that KCC continues to support ARE. The report to Cabinet needs to be robust and strongly-worded; it's high time for action. Perhaps KCC could threaten to increase the Council Tax to offset the cost of supporting ARE, to grab the Government's attention? The Cabinet needs to back up the work that Mrs Whittle has done on this over the years.
- KCC has a moral obligation to children in care in Kent, and is the last resort for them. Care leavers face many issues through life and may need more support later. Other young people can return home to their parents in the event of a marriage break-up or loss of their job or home. children in care should have access to this same extended support from their Foster Carers.
- One Panel Member meeting their MP tomorrow undertook to mention all these issues during that meeting. All lobbying helps!

3. The oral updates were noted, with thanks.

27. Update regarding the work of the Head Teacher of Virtual School Kent (VSK)
(Item B1)

1. Mrs Skinner introduced the report and highlighted the following:-

- further progress on attainment targets and absence was expected, as well as a further reduction in the rate of permanent exclusions.
- there are approximately 72 children currently in Key Stage 2 who will be undergoing SATS testing this year. Many of these have a statement or additional needs, and it is important that these children are given as much support as possible to overcome their particular problems.

- Young people had been consulted about and engaged in staging two participation days in the February half-term holidays, and more such days will take place in each school holiday through the year.

2. Mrs Skinner, Ms MacNeil and Mr Brightwell responded to comments and questions from the Panel and the following points were highlighted:-

a) where a child has a statement or additional needs, it is important to measure any progress that they make in education, quite apart from the measures set out in national performance targets. Progress itself is a target, and it is always helpful to have as much information as possible, especially for the forthcoming Ofsted inspection;

b) while it is important to identify children who have no education plan, what is of more concern, and very difficult to identify, is the number of children who attend school only part-time, with only a partial daily timetable. Schools do not tend to record or show these numbers. Pupils who are present at both morning and afternoon registration will be recorded at both and could be assumed to have been present for the whole day. In fact, they may only have attended for the time between the two registrations. It would be useful for the Panel to ask for more information about the extent of this issue and what can be done to identify this cohort of children;

c) VSK works with all schools, whether KCC-maintained or Academies, but some are more supportive than others of VSK's work. It is not possible to distinguish any one type of school as being any more or less supportive; it is the individual relationship VSK establishes with each school that dictates this;

d) good education opportunities should be shared by all Kent children in all Kent schools. There are concentrations of troubled children in some areas of Kent, and some schools are coping with a disproportionate share of these children. Standards are applied as if the playing field were level, but the playing field cannot be level while some schools are coping with this burden. Some schools in deprived areas do much work with disadvantaged children and produce excellent results, but as progress does not necessarily meet the academic standards listed in the national performance targets, it does not show up;

e) part of the role of Independent Reviewing Officers (IROs) is the scope to be the 'pushy parent' of children in care, although they are unable to challenge schools directly. Corporate Parents could also take on this role. VSK challenges schools on behalf of children in care, and is robust and proactive;

f) Members were reassured that the 'fund raising' mentioned on page 11 of the agenda papers relates only to money raised for things like refreshments and add-ons at events as part of the participation and engagement agenda; the events themselves are funded from the VSK budget. The OCYC could potentially become a charity and be able to

apply to various funding streams to support this type of event in the future;

g) a major piece of work is currently underway, via which KCC seeks to ensure that any other local authorities placing children in care in Kent will fulfil all their responsibilities to those children, and explore what role VSK could play in this. *The outcomes of this piece of work will be reported to a future meeting of this Panel;*

h) it would be useful to be able to have an oversight of how schools spend the pupil premium which comes with each child, but this issue should be more appropriately taken up by the Education Cabinet Committee; and

i) one Panel Member who had attended a half-term activity day in Sandwich said the day had been excellent and he looked forward to attending another. During the day, children and young people had made a video, produced a booklet and recorded a song. He asked how VSK would go about engaging young people who are not so outgoing, and how difficult this might be. For such a day to be successful, it has to be fun, with a range of activities to appeal to as many young people as possible, both boys and girls. A different range of activities could be offered at the next day, to extend its appeal to a broader range of young people. Officers commented that, from experience, it is not necessarily the case that the young people who attend activity days are the most outgoing.

3. RESOLVED that:-

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

b) a regular item reporting back the views of Children in Care be included on the Panel's agendas; and

c) the outcome of a piece of work to ensure that local authorities placing children in care in Kent fulfil all their responsibilities to those children be reported to the future meeting of the Panel, setting out what role VSK might play in this initiative.

28. Independent Reviewing Officer Service Update
(Item B2)

Mr P Brightwell, Performance and Quality Assurance Manager, Children in Care, Mr N Foad, Ms D Gant and Ms C Liggins, Independent Reviewing Officers, and Ms T Smith, Manager, Independent Reviewing Officer Service, were in attendance for this item.

1. Mr Brightwell introduced the regular update report which was presented as part of the agenda papers and explained that colleagues from the Independent Reviewing Officer (IRO) service were in attendance to answer questions from the Panel about their role and work. Mr Brightwell, Ms MacNeil and the Independent

Reviewing Officers responded to comments and questions from the Panel and the following points were highlighted:-

a) IRO teams now mirror area Children's Social Work teams so they can work more closely together;

b) IROs' average caseload has reduced over the last year and is currently around 80, having been 120 a year ago. This reduction has been made possible by successful recruitment to all 22 IRO posts, and the result is that IROs now have more time to spend with each child. The aim is to reduce caseloads further, but it is important to do this carefully, by transferring cases by natural progression, only when they are ready to transfer and it is timely and appropriate to do so;

c) IROs often have more and closer knowledge of a child than social workers, as the latter have a higher turnover, so IROs are often the only or the most consistent contact in a child's life, and provide vital continuity;

d) concern was expressed about the 30% of children in care who have inadequate care plans. It is a top priority that every child in care has an adequate care plan, and work is ongoing to identify and address the reason for the shortfall. However, the situation has improved in the last two years, with the figure having previously been 50%. The figure quoted in the report relates to the period from June to September 2012. Every child is reviewed every six months, so it may take two quarters' reports to show up a change to this figure;

e) IROs were asked if they feel truly independent and if they feel their independent role is generally respected. An example was given of an IRO using the independence of the role to bring to an end to delay in arranging extra teaching support for a 7-year-old in care with a part-time school timetable. Being independent of the County Council, IROs have no problem in challenging KCC colleagues. Managers in District teams have mutual respect for the IRO role, without necessarily agreeing with their professional judgement, and social workers, carers and young people find IROs' independence useful. The IROs present said their independence is respected and they have had no qualms about using it to influence and press for improvement for a child in care. A more recently recruited IRO said she had been recruited for her ability and willingness to challenge. Mr Brightwell confirmed that IROs do need to have an opinion and be able to express it confidently. Appropriate and respectful challenge, with support to address issues, is important. IROs should never feel obliged to hide the truth if they are concerned, and they need to be independent to be honest. Panel Members were reassured by these answers;

f) although the average workload has been reduced to 80, IROs were asked what would be the ideal minimum workload. The Children Act of 1989 had recommended 55 to 75 as a minimum, alongside a drive for good quality care plans and eliminating drift. Good national investment in the service should reduce caseloads nationally. Recent research by

London Boroughs into children in care had set out three key aspects of a good care experience:- coming into care early, reducing social work and IRO caseloads and securing investment in services and support, and these three tenets seems to be having an impact;

g) the IROs were asked if they believe that children come into care at the right time. Cases still appear in which, in their professional opinion, a child should have come into care earlier, although the situation is generally improving. A Panel Member expressed the view that focus should be on reviewing thresholds and early intervention policy. An IRO gave an example of siblings aged 2 and 12 who had come into care at different times, the 12-year-old having come into care much later in her childhood; too late in the IRO's opinion. Her 2-year-old sibling had come in much earlier and, as a result, would inevitably have a very different and, hopefully, better experience of being in care. Panel Members were recommended to read the findings of the Family Justice Review Report of 2011.

h) asked what KCC is not good at, IROs listed transition, and frustration at the delay in the decision making process. The latter is not a problem peculiar to Kent, although KCC's high social worker turnover exacerbates the loss of time and momentum in decision making. Social worker turnover is a key frustration, but recruitment of social work managers is an equally large problem. Good social work management will help recruit and retain good social workers, and the quality of social work supervision is vital in setting the standard of the service. Where social workers are not able to give the time and energy they need to care planning, the IRO service sometimes plugs the gap. This can blur the boundaries between the IRO and social worker roles and could compromise IROs' independence; and

i) Panel Members asked if KCC had existing staff which could be trained as social workers, to 'grow our own', but this takes much time and cost, and many people, despite having gained a social work qualification, are simply not suitable to the challenging role. What is needed is short-, medium- and long-term plans to address the shortage of social workers. University courses in social work need realism, and trainee social workers need the chance to gain practical experience. Good training and support is vital in attracting and retaining newly-qualified social workers while they build confidence and develop vital professional experience in their first few years in the job.

2. RESOLVED that:-

a) the information set out in the report and given in response to comments and questions be noted, with thanks, and quarterly updates be made to the Panel; and

b) information on the effects and outcomes of coming into care early be reported to a future meeting of the Panel.

29. Staying Together Scheme
(Item B3)

Ms M Lowe, Performance and Quality Assurance Officer, Children in Care, was in attendance for this item.

1. Ms Lowe introduced the report and explained that it had been prepared at the request of the Panel to clarify the purpose and rules of the Staying Together scheme, following discussion at the Panel's October meeting. She highlighted the following key points:-

- KCC's scheme is more generous and wider ranging than those run by many other local authorities, including many of the London Boroughs. KCC continues to pay Foster Carers at the original rate for two years beyond the date of the Order, whereas other authorities reduce the level of payment over time or stop when a child reaches 16. Also, KCC does not reduce its payments to take account of benefits received by the Foster Carer, with the exception of child benefit.
- fewer carers have taken up the Staying Together scheme than had been hoped, but by raising awareness of it, it is hoped that more will take it up.
- work to identify the financial issues relating to young people aged over 16 is being undertaken by a working group, and the outcomes of this work will be reported to a future meeting of the Panel.

2. Ms Lowe responded to comments and questions from the Panel and the following points were highlighted:-

a) for young people who return to their foster home in the holidays from higher education, Foster Carers can apply to receive the same level of support for those weeks as they would have received if the young person were still in care. Such applications are currently decided by Assistant Area Directors on a case-by-case basis, but a more consistent approach needs to be developed and applied across the county;

b) a key issue to address in presenting the scheme, raising awareness and attracting more takers is the perception by many carers that the scheme can lead to a loss of income;

c) young people also need to be aware of their entitlements under the scheme; and

d) the scheme currently seems to involve several mechanisms, and a review of it will bring the opportunity to streamline and simplify it.

3. RESOLVED that:-

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

b) the outcomes and recommendations of the working party looking into the financial issues relating to young people aged over 16 be reported to a future meeting of the Panel.

30. Briefing Report on the Parliamentary Inquiry 'Children First: The Child Protection system in England - messages regarding services and support for children and young people in care'
(Item B4)

1. Mr Brightwell introduced the item and pointed out that many of the issues covered by the Inquiry link to other issues on today's agenda and had been touched upon in other discussions. He and Ms MacNeil responded to comments and questions from the Panel, and the following points were highlighted:-

a) the Parliamentary Inquiry can be seen as a useful tool to drive forward issues which the Panel had been considering for some time, but the timing for action needs to be right, and lobbying needs to be well supported by evidence. KCC is currently working constructively with the Courts Service to address the need to improve the standard of evidence and reduce the time taken for a case to come to court;

b) the Inquiry had found concern that current policy could lead to forced adoption, an issue which the Minister, Edward Timpson, will return to in future work. A view was expressed that, given the length of time it takes to go through the adoption process to achieve an Adoption Order - approximately nine months - and the scope which birth parents have during that time to contest the adoption, to talk of 'forced adoption' is ridiculous;

c) a Panel Member who is an experienced Foster Carer said he had had good experience of the social work service, and had not experienced excessive social worker turnover. He made the point that good social workers will tend to move on over time. He had seen great improvement in the IRO service during his time as a Foster Carer and had a good constructive relationship with them. He confirmed that IROs do indeed challenge and question on behalf of children in care;

d) the KCC's social worker recruitment campaign has not been as successful as had been hoped, and change has been incremental but slow. Short-, medium- and long-term plans are needed to give new social workers a path along which to progress, with the aim of retaining young and enthusiastic recruits. KCC struggles with recruiting social work managers, although Kent now has a better image than previously and sets a high standard. Much recruitment comes about from word-of-mouth recommendations;

e) in a county the size of Kent, it is difficult to offer social workers good managerial responsibility and experience so they can develop and progress. KCC could liaise with universities to identify high-flyers to develop as future managers, although it was pointed that staff sometimes need to move to other authorities to broaden their professional experience and develop their careers, and can then bring the benefits of this experience back to Kent;

f) when shortcomings are shown up in social work practice (eg a previous example of poor record keeping), this could be because of poor supervision and management, or challenges in recruiting and/or retaining sufficient social work managers or staff;

g) by identifying the particular problems which deter social workers from applying to work in an area, a local recruitment strategy can be tailored to address them. These may include the perceived image of an area, the affordability of housing, the availability of school places for social workers' families, travel networks, etc. *It would be useful to have a report and discussion about this issue at a future meeting of the Panel*;

h) surprise was expressed at the extent to which the number of children in care had fallen between 1980 (95,000) and 2011 (65,500). It is not possible to state a 'right' number of children to have in care, although it would seem ideal to have none at all. Identifying a 'good' number of children to have in care depends on many factors, including the reasons for taking them into care (eg safeguarding) and what the care system is intended to do to help them. Avoiding or delaying taking a child into care can be damaging and can compromise their outcomes; and

i) Children's Centres have an outreach service which helps to identify and engage the most high-risk families which would be unlikely to attend Centres. Young parents who are the second or third generation in their family to be in care may have poor role models to follow. An outcome measure of the success of work by Children's Centres and health visitors today will be the quality of parenting that today's children are able to give their own children in 20 years' time.

2. RESOLVED that:-

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

b) a report on a recruitment strategy which can be tailored to address issues in a particular area be made to a future meeting of the Panel.

31. Performance Scorecard for Children in Care
(Item B5)

1. Mr Brightwell introduced the report and explained that future scorecards will be accompanied by an exceptions report which will give more detail of issues for which progress is rated red. Members had previously asked that the frequency of change of social worker for a young person be also included, and this will become possible with the new Protocol system, from June 2013. In the discussion of the Virtual School Kent update (item B1 on this agenda), information had been requested on the number of students who achieve passes at KS4 in both English and maths. Mr Brightwell confirmed that both of the requested items will be included in future scorecards.

2. RESOLVED that:-

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

b) the following areas of additional information requested be included in future scorecards as soon as possible:-

- the frequency of change of social worker for a young person (which will be available in the new Protocol system, from June 2013),
- the number of students who achieve passes at KS4 in both English and maths, and
- a new standard appendix of an exceptions report to give more detail of issues for which progress is rated red.

32. Oral Update on Adoption Figures

1. Although the Adoption update report had been sent to Panel Members as an information item only, and thus was not for discussion at the meeting, Ms MacNeil took the opportunity at the end of the meeting to update the Panel briefly on the latest adoption figures, which show much progress. So far this year:-

- 131 children have been placed for adoption (up from 105, reported at the December Panel meeting)
- 94 children have been adopted (up from 75, reported at the December Panel meeting)
- 75 adopters have been approved.

2. Ms MacNeil placed on record her thanks to the staff who had made this progress possible.

From: **Jenny Whittle, Cabinet Member for Specialist Children's Services**

Andrew Ireland, Corporate Director, Families and Social Care

To: **Social Care and Public Health Cabinet Committee – 12 June 2013**

Decision No: **13/00045**

Subject: **Kent County Council Sufficiency Strategy**

Classification: **Unrestricted**

Future Pathway of Paper: Cabinet – 15 July 2013

Electoral Division: All

Summary: The Sufficiency Duty came into force in April 2011. It requires Local Authorities to secure, as far as reasonably practicable, sufficient accommodation for Children in Care and those children in need who are at risk of care or custody. The guidance states that Local Authorities should be able to evidence that they are taking steps to meet the sufficiency duty as far "as reasonably practicable".

Recommendation(s):

Cabinet approval is being sought to publish the Sufficiency Strategy on the Kent.gov website and to approve an update of the Sufficiency Strategy on an annual basis. The Cabinet Committee has the opportunity to comment on the draft Strategy and endorse, or make recommendations to the Cabinet Member for Specialist Children's Services, on the proposed decision.

1. Introduction

1.1. Section 22G of the Children Act 1989 ('the 1989 Act') requires Local Authorities to take steps that secure, so far as reasonably practicable, sufficient accommodation within the authority's area which meets the needs of children that the Local Authority is looking after, and whose circumstances are such that it would be consistent with their welfare for them to be provided with accommodation that is in the Local Authority's area ('the sufficiency duty').

1.2. The sufficiency duty applies in respect of all children who are defined as 'looked after' under the 1989 Act. However, an important mechanism, both in improving outcomes for children and in having sufficient accommodation to meet their needs, is to take earlier, preventative action to support children and families so that fewer children become looked after. This means that this duty also applies to children in need who are at risk of care or custody (sometimes referred to as children 'on the edge of care').

1.3. Families and Social Care, in line with 'Sufficiency: Statutory Guidance on Securing Sufficient Accommodation for Looked After Children' (March 2010), has developed a KCC Sufficiency Strategy 2013-15.

2. Financial Implications

2.1 The Sufficiency Strategy makes reference to the reduction in the level of funding for Local Authorities over the next four years and that the focus on efficiency and value for money will be stronger than before.

3. Bold Steps for Kent and Policy Framework

3.1 The Sufficiency Strategy links with the Bold Steps for Kent Priority 1: Improve how we procure and commission services, Priority 15: Improve services for the most vulnerable people in Kent, and Priority 16: Support families with complex needs and increase the use of community budgets.

3.2 The Sufficiency Strategy is also set within the context of national policy, legislation and guidance. It is linked to key local planning documents, in particular to Every Day Matters, the Multi-Agency Looked after Children Strategy, and Phase 3 of the Kent Safeguarding and Looked after Children Improvement Plan "Putting Children First", and is consistent with KCC's pledge to Children in Care.

4. Detail

4.1 The Sufficiency Statutory Guidance states that Local Authority provision should enable children:

a) To live near their family home;
b) To remain in their current education or training setting;
c) Where appropriate, to be placed with siblings;
d) With a disability to have their needs met; and
e) Wherever it is safe to do so, to remain in their own Local Authority area.

4.2 Where it is at all possible, this provision should be provided within the Local Authority area and should be accompanied by a commissioning strategy that outlines the authority's commissioning intentions and approach to meeting local need.

4.3 The guidance also states that local authorities should be able to evidence that they are taking steps to meet the sufficiency duty as far "as reasonably practicable". In assessing whether the steps they are taking are reasonably practical, it is recommended that Local Authorities may wish to consider:

a) Progress towards commissioning intentions to meet the sufficiency duty;
b) The number of children for whom a placement is not consistent with their needs and welfare;
c) The extent to which local universal services meet needs;
d) The state of the market (locally by district) and the supply that exists;
e) The degree to which the market is being managed;
f) The resourcefulness of local providers to meet needs of children; and
g) The overall effectiveness of local and regional partnerships.

4.4 The appropriate areas have been considered in Kent's Sufficiency Strategy which can be seen in Appendix 1. The appendices attached to the Sufficiency Strategy provide the data which has been collated and analysed to develop the strategy.

4.5 A robust Placement Action Plan and commissioning strategy is being developed to address the needs and gaps identified within the Sufficiency Strategy.

4.6 The Sufficiency Strategy and Placement Action Plan will be reviewed regularly to ensure that Kent is still fulfilling the requirements of the Sufficiency Duty. Key impact measures will be closely monitored and reported on formally every six months to the Specialist Children's Services Divisional Management Team for the duration of the strategy. The strategy will be updated on an annual basis to reflect any changes to the numbers of Children in Care or the Council's accommodation.

5. Conclusions

5.1 To ensure compliance with Section 22G of the Children Act 1989 ('the 1989 Act'), Kent County Council must have in place, and make public, a Sufficiency Strategy for its Children in Care.

5.2 Families and Social Care has developed the Sufficiency Strategy in line with the statutory requirements, and this strategy will inform the development of a robust placement action plan to address the needs and gaps identified in the Sufficiency Strategy.

5.3 The Sufficiency Strategy will be updated on an annual basis to reflect any changes to the numbers of Children in Care or the Council's accommodation.

6. Recommendation(s)

Recommendation(s):

The Social Care and Public Health Cabinet Committee is asked to consider and endorse, or make recommendations to the Cabinet Member for Specialist Children's Services, on the proposed Cabinet decision to adopt and publish the Kent Sufficiency Strategy.

7. Background document(s)

The full draft Sufficiency Strategy can be found at:

https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=747&MId=4895&Ver=4

8. Contact details

Report Author

- Helen Jones, Head of Strategic Commissioning
- 01622 696682

- helen.jones@kent.gov.uk

Relevant Director:

- Mark Lobban, Director of Strategic Commissioning
- 01622 694934
- mark.lobban@kent.gov.uk

Kent County Council

Sufficiency Strategy 2013-2015

Executive Summary

Local Authorities are required to take steps to secure, so far as is reasonably practicable, sufficient accommodation for children in care within their local area. In 2010, the Statutory Guidance for the Sufficiency Duty was issued. This guidance is explicit in placing a duty on Local Authorities to act strategically to address gaps in provision by ensuring that they include, in relevant commissioning strategies, their plans for meeting the sufficiency duty.

The Children Act 2008 defines Sufficiency as "a whole system approach which delivers early intervention and preventative work to help support children and their families where possible, as well as providing better services for children if they do become looked after. For those who are looked after, Local Authorities and their Children's Trust partners should seek to secure a number of providers and a range of services, with the aim of meeting the wide-ranging needs of looked after children and young people within their local area."

The strategy addresses the needs of children and young people from birth to the age of 21(or 25 where children's services continue to have statutory responsibility) including children and young people with disabilities who are, or who may be, accommodated by KCC. It meets the requirements of the sufficiency strategy by collating needs and resource information and market analysis but also describes what needs to happen in relation to work with children in care or children at risk of coming into care.

It is consistent with our pledge to Children in Care (CIC) which is based around six themes:

- A sense of belonging
- An adult who is there for each child in care
- A good education
- Good memories for the future
- Getting ready for being an adult
- Championing each child's needs and interests

The strategy identifies **four** key strategic objectives, all of which focus on reducing the numbers of children in our care where safe to do so, and using our resources in the most efficient and cost effective way. The document also includes some impact measures which will be monitored to evidence progress on delivery. These are:

Key Objective 1: To intervene early and support children to remain safely within their family

Children's needs are best served in their own families if this can be safely supported. Helping families stay together must therefore be a key focus for all Children's Services. Early identification of need and effective early intervention is essential. Early intervention and prevention services can reduce the number of children and young people reaching the threshold for care and needing to become CIC, avoid repeat entry into care or support them to return safely to their families in a timely manner.

Key Objective 2: To manage risk within the family/community

We must manage risk effectively with families that are approaching the threshold for care, and work to ensure the right children come into care at the right times, and are supported to leave at the right time. We will provide a range of effective interventions which support families to make changes whilst always ensuring that children and young people are kept safe.

Key Objective 3: Provide and commission placements to meet identified needs

We need to be sure that we have the right range of placements to meet the assessed needs of CIC. As a result of rising numbers of CIC, we need to focus on increasing capacity in our in-house fostering service in Kent, and develop strong partnerships with our Independent Fostering and Residential Providers to promote choice stability and value for money.

Key Objective 4: Good Care Planning

Having a clear Care Plan in place is essential for children and young people in care, not only to ensure that they come into and exit care at the right times, but to meet our statutory obligations under the Care Planning Regulations. We need to ensure that children do not 'drift' through care, but have clearly-planned processes which allow them to be reunited with family and friends where possible, have stable, supported and well matched placements with alternative carers and exit the care system in a timely and positive way at whatever age this happens.

A detailed Action Plan has been developed to support implementation of the strategy, which will be supported over the next two years.

The following impact measures have been identified as the key indicators of the success of the strategy and will be closely monitored and reported on formally every six months for the duration of the strategy:

- Overall Number of CIC
- Current and Projected Spend on placements with independent providers
- Number of Children beginning/ceasing to be CIC per month, by area and age band
- Proportion of Residential, In house Fostering, IFA fostering and supported living placements
- Numbers of CIC placed for adoption and made subject of SGO
- Level of capacity, referrals to and actual placements made in in-house foster service
- Net gain of in-house foster placements by locality and placement type
- Decrease in the use of Bed and Breakfast accommodation for 16/17 year olds presenting as homeless.

The strategy contains supporting background data in relation to the needs of Kent's CIC, and the current provision accessed by those CIC. This meets our responsibilities to undertake a review of sufficiency, and sets the context for the development of a detailed commissioning strategy.

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Mrs Jenny Whittle Cabinet Member for Specialist Children's Services	13/00045

For publication

Subject:
Kent County Council Sufficiency Strategy

Decision:
As Cabinet Member for Specialist Children's Services, I agree that the Sufficiency Strategy for Kent County Council, as attached, be adopted and published accordingly.

Reason(s) for decision:
The strategy is a response to the Sufficiency Duty which came into force in April 2011. Local Authorities are required to secure, as far as reasonably practicable, sufficient accommodation for Children in Care and those children in need who are at risk of being taken into care or custody.

Cabinet Committee recommendations and other consultation:
The Social Care and Public Health Cabinet Committee will consider the proposed decision at its meeting of 12th June and comments will be considered by the Cabinet Member before the decision is taken.

Any alternatives considered:
None, the strategy and its contents are a response to statutory guidance.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:
None

....
signed date

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From: **Jenny Whittle, Cabinet Member for Specialist Children's Services**

Andrew Ireland, Corporate Director, Families and Social Care

To: **Social Care and Public Health Cabinet Committee – 12 June 2013**

Decision No: *not yet allocated*

Subject: **Local Children Services Arrangement**

Classification: **Unrestricted**

Future Pathway of Paper: Cabinet – 15 July 2013

Electoral Division: All

Summary: This paper informs Members about the proposed local children services arrangement to support the county Children and Young People's Joint Commissioning Board at the Clinical Commissioning Group Health and Wellbeing Boards level rather than retaining a district-based arrangement.

Recommendation(s):

The Social Care and Public Health Cabinet Committee is asked to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Specialist Children's Services, to approve the local children services arrangement, after taking into account the views put forward by the Cabinet Committee.

1. Introduction

1.1 This report sets out proposed local arrangements for the Kent Children and Young People's Joint Commissioning Board. The Joint Commissioning Board functions as the strategic commissioning partnership body with the aim of improving outcomes for all children and young people.

1.2 The Joint Commissioning Board has had children services local partnership arrangements under consideration since May 2012. A central issue for the Board has been the need to decide on the kind of local collaborative arrangement which will help with joined up commissioning and integrated working, with a clear focus on improving health, education and social care outcomes for all children and young people.

1.3 It is the intention of the County Council to use the opportunity now provided by having seven local Health and Wellbeing Boards operating at Clinical Commissioning Groups (CCG) level instead (Appendix 1). This is in response to having to work in a context of joined up commissioning and integrated service delivery, with a view to a more efficient use of resources and focusing

on actions that will help achieve better outcomes for all children, with minimum duplication.

1.4 In the light of the central role of the Health and Wellbeing Boards (county and local levels), there is now a compelling case, for the reasons set out in this report, to organise local children services arrangement at the CCG Health and Wellbeing level, to ensure more effective joint commissioning with the health service and other key partners.

1.5 The Kent Health and Wellbeing Board considered the proposal on 29 May 2013. Also, the Joint Commissioning Board discussed a report on the proposal at its meeting on 30 May 2013.

1.6 The purpose of this report is to inform Cabinet Committee Members and to provide them with the opportunity to comment on the proposal before the Cabinet Member for Specialist Children's Services takes the formal decision.

2. Financial Implications

2.1 The recommendations will not have any direct impact on the capital or revenue budgets of the Authority. The indirect impact should be through improved joint commissioning and value for money services delivering better outcomes for Kent children and young people.

3. Bold Steps for Kent and Policy Framework

3.1 The proposals support the commitment within Bold Steps to transform how we procure and commission services to support new models of service delivery and will support the development of a consistent single process for all contracting and procurement for children's services.

3.2 Policy Context:

a) Section10 of the Children Act 2004 contains the main provision for the Children's Trust arrangements. Section 10 is essentially about the 'duty to cooperate' placed on local authorities and named statutory partners (Schools and colleges, Early Years and Childcare, Health Services, Police, Adult social care, Housing authorities, British Transport Police, Prison Service, Probation Service, The secure estate for children, Youth Offending Teams, The United Kingdom Border Agency, Children and Family Court Advisory and Support Service, Armed Services, Voluntary and private sectors and Faith Organisation).

b) The prescriptive statutory guidance governing the arrangements was withdrawn on 31 October 2010. Nonetheless, each local authority with responsibilities for children's services must still have a Children's Trust Board, but the manner in which it operates, what it is called and, how it works with the bodies such as the Health Wellbeing Board and the Police and Crime Commissioner is a matter for local determination. As a result, the Children and Young People's Joint Commissioning Board has replaced the former Kent Children's Trust.

c) More recently, the 'Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children'

(March 2013), came into effect as of 15 April 2013. It is a requirement for this statutory guidance to be followed by "all the relevant persons and agencies including local authority Chief Executives, Directors of Children's Services, Local Safeguarding Children Board Chairs and senior managers from health services, adult services, the police, Academy Trusts, education and the voluntary and community sector".

d) The Kent Health and Wellbeing Board was established under provisions of section194 of the Health and Social Care Act 2012. It formally came into being on 1 April 2013. It is the duty of the Health and Wellbeing Board to provide system-wide leadership for improving the health and wellbeing of the population of Kent.

e) The Joint Commissioning Board has also recently asked for the development of 'Every Day Matters – Kent's Multi-agency Strategic Plan for Children and Young People 2013-2016'. This is an overarching vision document, informed by the principles of 'Working Together to Safeguard Children' (2013).

4. Detail

4.1 Background:

a) The strategic review of the former Kent Children's Trust Board arrangements culminated in a report to KCC Cabinet on 19 September 2011. Cabinet approved the recommendation to "cease the Kent Children's Trust Board and replace it with a Children and Young People's Joint Commissioning Board". The decision was made under Kent Children's Trust Strategic Review - Key Decision number 10/01528.

b) Local arrangements for children's partnership have been under consideration since May 2012. The Joint Commissioning Board conducted a 12 week consultation exercise on proposals regarding local partnership arrangements during summer of 2012. The feedback on the consultation was reported to the Joint Commissioning Board on 29 November 2012. In the context of changing policy environment, clarification of the roles and responsibilities of local partnership arrangement was welcomed. The majority of respondents preferred a form of partnership configuration which is district-based.

c) The different contributions of Local Children's Trust Boards over the years are acknowledged, as is the intelligence and knowledge of how local services are delivered. Consequently, a means for tapping into the voice of local players would be reflected in moving forward with the proposal.

4.2 Proposed local arrangement:

a) The proposal is that local children services arrangements should move to a CCG-level basis. It is recognised that an appropriate mechanism for feeding district- level views into the CCG-level arrangements will be required. It is also accepted that there is no single ideal solution upon which to build local children services arrangement. However, the establishment of local Health and Wellbeing Boards which bring together

key organisations to consider joined up commissioning and integrated service delivery, provide a workable platform for reshaping integrated service delivery that can and better address gaps in services and demonstrate positive benefits.

b) The proposed local children services arrangement has been influenced by a number of reasons, including:

- the need to deliver more effective joint commissioning which helps 'universal' and 'targeted' children services to address gaps in vital provision, by making sure that all the available resources for children's services are fully utilised;
- a strong case for obtaining the best out of service integration, especially where this would have the desired impact and add considerable value;
- making sure that local services are delivered in a way that improves the experience and outcomes for people;
- the need to respond to the pressure on public sector resources by seeking more efficient use of resources
- stretched management capacity, especially for the NHS.

5. Conclusions

5.1 The Joint Commissioning Board and Kent Health and Wellbeing Board, CCG-level Health and Wellbeing Boards also have to consider the proposal. This will enable details regarding the terms of reference including membership to be agreed.

5.2 The Chairs of Local Children's Trust Boards have been informed about the proposal pending the formal decision by the Cabinet Member for Specialist Children's Services. The notification of intent acknowledged the contribution and the role played by the Local Children's Trust Boards, in particular, that of the Chairs.

5.3 The aim is to have the detailed working arrangement to be signed-off by the Joint Commissioning Board and local Health and Wellbeing Boards by no later than July 2013. This will confirm, amongst other things, organisation of meetings which enable focusing on children and education matters as well as the representation of schools and head teachers.

5.4 The Cabinet Member for Specialist Children's Services would then take the decision as soon as due process allows.

6. Recommendation(s)

Recommendation(s):

The Social Care and Public Health Cabinet Committee is asked to:

1. Comment on the proposal to move to a CCG-level arrangement rather than retaining the district-based structure.

2.	Consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Specialist Children's Services, to approve the local children services arrangement, after taking into account the views put forward by the Cabinet Committee. .

7. Contact details

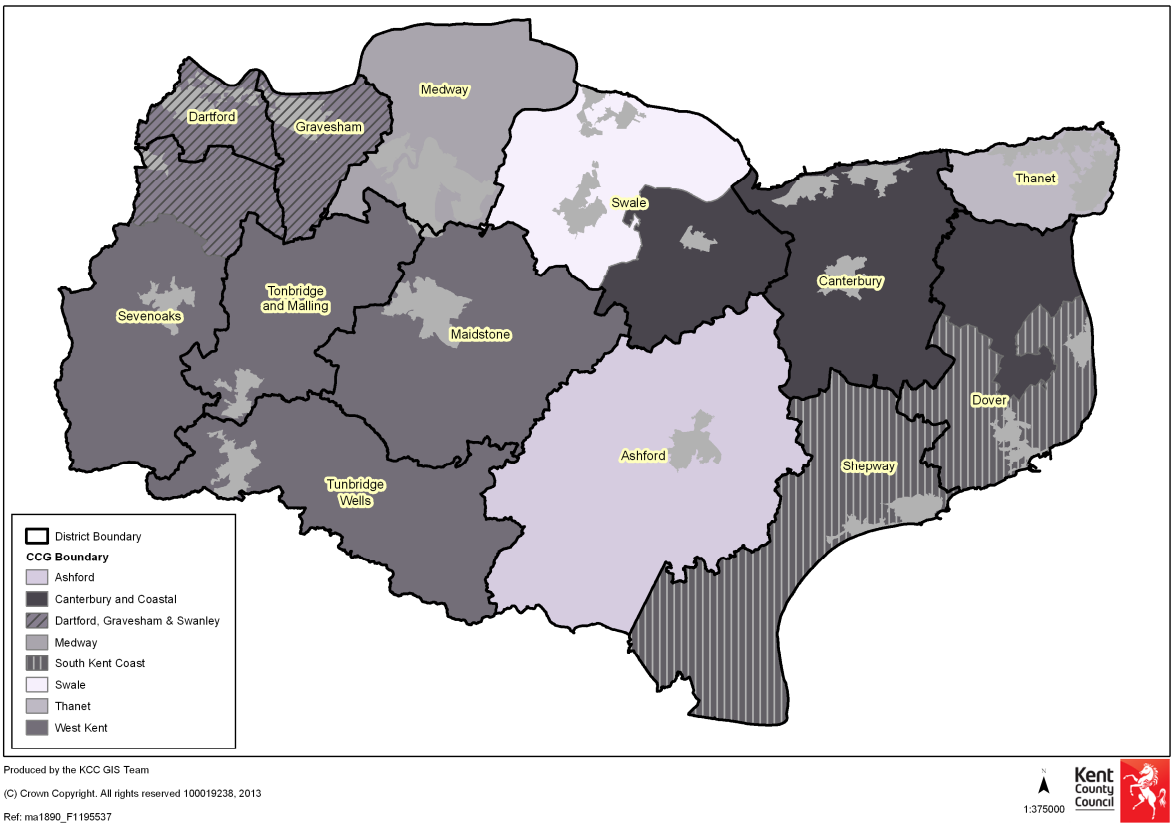
Report Author:

- Michael Thomas-Sam, Strategic Business Adviser
- 01622 691984
- Michael.thomas-sam@kent.gov.uk

7. Background documents:

Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, March 2013.

Every Day Matters – Kent's Multi-agency Strategic Plan for Children and Young People 2013-2016(Draft).



Map showing proposed seven local Health and Wellbeing Boards operating at Clinical Commissioning Groups (CCG) level.

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Mrs Jenny Whittle Cabinet Member for Specialist Children's Services	*Not yet allocated*

For publication

Subject:
Local Children Services Arrangement

Decision:
As Cabinet Member for Specialist Children's Services, I agree that the Local Children Services Arrangement for Kent County Council, as attached, be adopted and published accordingly.

Reason(s) for decision:
There is a need to deliver more effective joint commissioning and ensure that local services are delivered in a way that improves outcomes whilst using resources more efficiently.

Cabinet Committee recommendations and other consultation:
The Social Care and Public Health Cabinet Committee will consider the proposed decision at its meeting of 12th June and comments will be considered by the Cabinet Member before the decision is taken.

Any alternatives considered:
The Joint Commissioning Board conducted a 12 week consultation exercise on proposals regarding local partnership arrangements during summer of 2012. The alternative option is to retain district-based arrangements.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:
None

..... signed

..... date

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By: Jenny Whittle, Cabinet Member for Specialist Children's Services
Andrew Ireland, Corporate Director Families and Social Care

To: Social Care and Public Health Cabinet Committee - 12th June 2013

Subject: **LOCAL GOVERNMENT OMBUDSMAN REPORT**

Classification: Unrestricted

Summary: Report sets out the findings of the audit which was required by the Local Government Ombudsman following the publication of the "Report of Investigation into complaint about Kent County Council and Dover District Council" (July 2012**)**

Recommendations: Members are requested to consider the findings of the audit and note the resulting actions.

1. Introduction

(1) In 2009 the Law Lords heard the Appeal in the case of "G" vs. The London Borough of Southwark, and concluded that the Children Act (section 20) must take precedence over the homelessness legislation when a 16 or 17 year old presents as homeless. In essence, a 16 or 17 year old must be assessed, and if it is not possible for them to return home, then in all but the most exceptional cases, they will be found to be a child in need, and offered support under Section 20 of the Children Act.

(2) In 2012 the Local Government Ombudsman (LGO) published a report on the investigation of a complaint about KCC and Dover District Council in respect a homeless young person. The report made a number of recommendations including:

"That council(s) should undertake audits to satisfy themselves that their staff now about and apply the "Joint Protocols" about homeless young people aged 16-21. The results of these audits should be reported to the Executives on the appropriate Scrutiny Committee."
LGO Report 31 July 2012

(3) This report responds to the LGO recommendation by providing the findings of an audit of young people aged 16 to 17 who were referred to Specialist Children's Services between the 1st July and the 30th September 2012. The audit was completed by a team from the Safeguarding Unit, Youth Offending Service, 16plus, and District Social Work teams, in November 2012.

2. Financial Implications

(1) The audit identified a number of areas for development in relation to the needs of 16/17 years olds presenting as homeless. The future planning and provision of this resource is addressed in the Local Authority Sufficiency Statement for Children in Care which is reported separately to this committee.

3. Bold Steps for Kent and Policy Framework

(1) This area of activity falls within the perspective of "Tackling Disadvantage", one of KCC's three Ambitions.

4. The Report

The principal issues identified from the audit of 61 cases are as follows:

(1) The initial response from the County Duty service showed an understanding of the G vs. LB Southwark Judgement and that the young person was likely to reach Child in Need Threshold at Tier 3 in accordance with Kent & Medway Inter Agency Threshold Criteria for Children in Need.

(2) The principle established in the Southwark judgement, reiterated in statutory guidance (DCSF/DCLG 2010); that there can be no doubt that where a young person requires accommodation, as a result of one of the factors set out in S20 Children Act 1989, then that young person is in need and must be provided with accommodation and as a result as being accommodated the young person will be looked after; was not consistently understood across the Districts.

(3) Although the audit found some good examples of practice with rounded assessment and support being put in place in 15% (9) cases the referral was dealt with inadequately, and in one further case immediate action was required. These 9 cases were characterised by early closure. Reasons for the inadequate rating included the case being closed before the housing problem was resolved (see below), or the young person's immediate accommodation need being provided through Bed & Breakfast, but lack of follow through to ensure they were supported, for example to claim benefits, or more permanent living arrangements

"The Secretary of State considers that Bed and Breakfast accommodation is unsuitable for 16 /17 years old"
DCSF/DCLG Guidance 2010

(4) Almost half the young people in the audit sample were already known to Youth Offending services, which may demonstrate a link between disadvantage, deprivation and further problems such as homelessness.

(5) In 29% (18) cases the young person became Looked After. Two of the young people had been Looked After for a period in early childhood.

(6) Auditors noted in the majority of cases, that there were underlying problems and needs, associated with the presenting problem of homelessness.

(7) In the entire open caseload (86 cases) 59% had two or more previous referrals, with 16% (14) having more than 5 previous referrals to Specialist Childrens Services. In 29% (18) cases the young person had returned home or to a family member in the early stages of intervention. However closure of the cases before the young person's problems had been resolved was a theme in the inadequate cases.

(8) Auditors saw examples of the young persons' cases being closed and re-opened in a short period of time, with subsequent re-referral, with the same problem. In 43% (26) cases auditors queried why the case had been closed before a solution had been found for the young person and there were ongoing needs.

5. Conclusions

(1) The audit identified a need for Specialist Children's Services response to homeless 16 and 17 year olds to be urgently addressed. The following developments are proposed by Specialist Children's Services Divisional management team:

(a) Adolescent Support Teams have been established in each Area, and County Duty now refers homeless 16/17 year old cases in North, West and South Kent to qualified social workers in these teams. To address the need for qualified staff to provide the service in East Kent, due cognisance is being given to transfer of staff from other front line teams in the area.

(b) Training workshops have been organised for staff from the new Adolescent Support Teams, Housing Options Managers, Youth Offending, Connexions, 16plus, Kent Integrated Adolescent Support Services, and Skills and Employability Managers.

(c) All new and locum staff in Specialist Childrens Services will be given training on Youth Homelessness.

(d) A new dispute resolution process between Housing and Specialist Childrens Services (to be overseen by the Chair of the JPPB and the Director of Specialist Childrens Services) will be included in the updated Joint Protocol.

(e) The Dartford Model of early intervention and family reconciliation will be taken forward County wide with the oversight of Specialist Children's Services DivMT. Initial discussions have taken place with the Chair of the Joint Planning and Policy Board (Housing) to start the process of establishing the model with the other eleven local housing authorities in Kent.

In 2011 Specialist Childrens Services and Dartford Borough Council, alongside the Adolescent Resource Centre, YMCA, Thames Gateway and Dartford Connexions, agreed to initiate a pilot scheme for Kent County Council, which was based on the Brent model. The 'Dartford' pilot works

with the homeless young person and offers rapid response mediation with the family. If the young person returns home there is regular contact, and fortnightly case review meetings, until all parties are satisfied the crisis is over. The lead professionals are a Senior Homelessness Prevention Officer (District Council) and a social work assistant, with regular management supervision.

If a young person is unable to return home due to safeguarding or other issues, then an initial assessment, under the Children Act 1989, takes place and the young person is given an explanation of the implications of becoming a Child in Care or a Child in Need. Crash Pad accommodation is offered in the YMCA for a maximum of 14 nights until more permanent accommodation can be found.

(f) Joint funding arrangements for emergency bed spaces/supported lodgings to be explored so that a Kent wide response is available.

(g) The Joint Planning and Policy Board (Housing) is looking for formal consultation and involvement in the development of the sufficiency statement. This will include discussion of the resources for the two actions above.

(h) Training on the Common Assessment Framework (CAF) to be delivered to all housing staff.

(2) The findings of the audit identify a range of actions necessary to improve services to this group of vulnerable young people. Specialist Childrens Services will continue to work closely with local partners and the LGO to monitor and review services to homeless 16/17 year olds and ensure that they receive appropriate support as defined by the Southwark Judgement.

6. Recommendations

Members are requested to consider the findings of the audit and note the resulting actions.

7. Background Documents

(1) Local Government Ombudsman Report on an investigation into complaint no 09 017 510 about Kent County Council and complaint no 09 017 512 about Dover District Council

(2) Joint Protocol to address the needs of homeless young people aged 16 to 21 in Kent, 2010,

(3) DCSF/CLG Statutory Guidance “Provision of accommodation for 16 and 17 year old young people who may be homeless or require accommodation”

(4) Re G vs. LB Southwark (2009)

8. Contact details

Mandy Lowe
Performance & Quality Assurance Officer (CiC)
Safeguarding Unit
Sessions House
Maidstone
Mandy.lowe@kent.gov.uk

Amanda Hornsby
BSS – PSR
Sessions House
Maidstone
Amanda.hornsby@kent.gov.uk

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By: **Jenny Whittle, Cabinet Member for Specialist Children's Services**

Andrew Ireland, Corporate Director for Families and Social Care

To: **Social Care and Public Health Cabinet Committee – 12th June 2013**

Subject: **CHILDREN'S CENTRE FUTURE SERVICE OPTIONS PROGRAMME**

Classification: **Unrestricted**

Electoral Division: **All**

Summary: The purpose of this report is to introduce the Cabinet Committee to the Children's Centre Future Service Options Programme. This includes outlining the aims of the Programme, the proposed timetable and the proposed level of member involvement.

Recommendation(s): The Social Care and Public Health Cabinet Committee is asked to note and comment on;

(a) The aims of the Future Service Options Programme.
(b) The proposed timetable
(c) The proposed level of member involvement

1. Introduction

1(1) The nationally prescribed core purpose of a Children's Centre is to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers through a combination of the following universal and targeted services;

Universal Services:

- High quality, inclusive, early learning and childcare
- Information and activities for families
- Adult learning and employment support
- Integrated child and family health services

Targeted Services:

- Parenting and Family Support
- Targeted evidence-based early intervention programmes

- Links with Specialist Services

1(2) A Children's Centre is a place or a group of places which should make available these services either by providing the services at the centre itself or by providing advice and assistance to parents and prospective parents in accessing services provided elsewhere[1]. Local authorities must ensure that Children's Centres provide some activities for young children on site[2].

2. Aims of the Future Service Options Programme

2(1) The Children's Centre FSO Programme aims to;

- Deliver better, earlier support to those children and families who need it
- Continue to provide Children's Centre services to improve health, education and social care outcomes
- Strengthen the working relationship between Children's Centres, early years settings, schools and health services
- Meet budget savings (of at least £1.5 million by 1 April 2014) and address areas that could be improved further

3. Financial Implications

3(1) The Children's Centre Future Service Options Programme is required to meet efficiency savings of at least £1.5 million in the 2014/15 financial year.

3(2) These savings are in addition to £1.4m savings from April 2013 and a budget reduction of £2.8m between April 2010 and April 2012.

4. Bold Steps for Kent and Policy Framework

4(1) At the heart of **Bold Steps for Kent** is the need to change the way we work, not only to improve our own services, but also to reflect the changing shape of wider public services. Increasingly, those directly responsible for delivering front line services will be empowered to design and commission services that better fit the needs of parents, children and communities. Therefore, we must adopt an approach that is both inclusive and sees prevention and intervention as a continuum so that it is never deemed too late to positively intervene and prevent the deterioration in an individual child or young person's circumstances.

4(2) KCC's Children and Young People's Strategic Plan 2012-2015, Every Day Matters, provides the overarching framework within which KCC's children's

[1] Section 5A (5)
[2] Section 5A(4)(c)

services work together seamlessly to deliver integrated services and the best possible outcomes for all children and young people in Kent. Kent's Children's Centres and the Futures Service Options Programme support the delivery of the strategic priorities as set out in Every Day Matters;

- Safeguarding and protection
- Early help, prevention and intervention
- Community ambition, health and wellbeing
- Learning and achievement
- Better use of resources

4(3) Kent's Early Intervention and Prevention Strategy (August 2012) sets out that Children's Centres need to strengthen their working relationship with early years settings and schools in order to improve the quality of early years education, improve readiness to learn and ensure young children and their families in need of early support can access this at the earliest point.

4(4) Kent Integrated Adolescent Support Service provides the model for early intervention and prevention services for young people aged 11-19. The new service delivery model aligns professionals and integrates activity through a Framework of Integrated Adolescent Support so that young people access the right services, at the right time, in the right place. Children's Centres across Kent are actively supporting this service to reduce teenage pregnancy rates and improve outcomes for teenage parents and are developing a model of integration 0-11 to provide transition into this service.

4(5) Action on Health Visiting Programme (designed to define and implement an improved health visiting service and an expanded health visiting workforce to deliver improved health and social outcomes for children), sets out its intention to deliver improved outcomes through delivery of a public health and Healthy Child Programme aligned service for children aged 0-5 years and their families.

5. Undertaking the Future Service Options Programme

5(1) Work to review Kent's Children's Centres has been undertaken to inform decisions around the future focus and purpose of Children's Centres across Kent through;

- Understanding how the service currently operates
- Identifying the pressures and need for change
- Identifying the opportunities for change

5(2) Corporate Board, on the 10th December 2012, agreed that the findings from the review would be addressed through the development of Future Service

Options. Four key elements have been developed to shape a future model. These include;

- The use of an empirical approach.
- The development of an alternative resource model based on need.
- The investigation of potential opportunities from revised staffing structures.
- The use of local engagement information to shape the development of a number of 'local solutions'

5(3) During January and February 2013, a strategic and series of district engagement workshops were held. These workshops focused on a number of principles which were designed to support the development of a number of options to deliver efficiency savings and support the development of a Strategic Plan for the Kent Children's Centre Programme. Participants supported a policy and planning approach which:

- Gave emphasis to a consistent approach to service delivery and planning across Kent;
- Supported a shift to more focus on the neediest children and families by developing a Kent enhanced offer;
- Harnessed Children's Centre to add value to existing services and extend functional role and brief to support siblings of Under 5s up to age 11;
- Ensured the continued provision of Children's Centres in every community;
- Ensured consolidation of service provision and embedding of integrated working;
- Encouraged service delivery alignment and integration.

5(4) As part of the Future Service Options Programme's engagement with stakeholders, it was expressed that there is a need to refresh alignment with all partner agencies, with a particular focus on developing betters links with:

- Clinical Commissioning Groups and GPs
- Community health services and primary care
- Local Health Watch and GPs
- Adult Social Care relating to harm from substance misuse, Domestic Abuse and Violence and Mental Health.

5(5) During February 2013 Kent Children's Centres were part of a peer challenge as part of the South East Sector Led Improvement Programme. The positive peer challenge identified that "there is cause for general confidence and optimism but the current work on reviewing the role and function of Children's Centres will be critical to their future." It is recognised that a need exists to formalise arrangements through the establishment of an agreed integrated

model that will strengthen and clarify process and pathways for children and families to access services and support. There is also an acceptance by all partners that Kent's Children's Centres role can offer further value added by through access to a continuum of services (0-11) to align with Kent Integrated Adolescent Support Strategy (11-19).

6. Principles underpinning a Future Model

6(1) A future model needs to;

- Maximise the use of our resources and meet efficiency savings of at least £1.5million in 2014/15.
- Identify potential opportunities to achieve additional savings in 2015/16.
- Involve local health services and other agencies at the heart of service delivery.
- Prioritise 'need' and continue to meet local needs and deliver services that are reflective and responsive to changing need, including targeted support.
- Protect service delivery by reducing management, administration and accommodation costs.
- Deliver an integrated continuum of support and formalise an integrated model of delivery.
- Maintain a comparable accessibility to existing delivery.
- Consider risk and mitigating actions.
- Formalise Kent's offer to support the wider family and operate outside of the 0-5 age range (pre-birth to11 years) and improve access to specialist services locally.
- Align delivery with local strategies and continue to meet legislative requirements.
- Require a full Public Consultation to be undertaken in line with the Childcare Act 2006.

7. Consultation

7(1) Any final proposals will be subject to formal public consultation. The Committee will be able to contribute to that consultation at a future meeting.

8. Timetable

8(1) Cabinet Committee is asked to note the timetable below;

Activity	Date
Initial discussion at Social Care and Public Health Cabinet Committee	12th June 2013

Preparation of proposals for formal consultation	June/July 2013
Formal public consultation and opportunity for engagement (12 weeks)	July to September 2013
Opportunity for Cabinet Committee to discuss and to contribute its views to the consultation	13th September 2013
Analysis of consultation responses and preparation of recommendations for decisions	October 2013
Report to Cabinet Committee for discussion prior to the decision being taken	8th November 2013
Decision taken	November/ December 2013

9. Conclusions

9(1) Children's Centres are required to deliver efficiency savings of £1.5 million in 2014/15, to be achieved by the Children's Centre FSO Programme. It is imperative that timescales are met in order to achieve required savings in 2014/15.

10. Recommendation(s)

The Social Care Cabinet Committee is asked to note and comment on;

(a) The aims of the Future Service Options Programme.
(b) The proposed timetable
(c) The proposed level of member involvement

11. Background Documents

Sure Start Children's Centres Statutory Guidance (April 2013)

http://www.clusterweb.org.uk/userfiles/CHC/file/CC%20Staff%20Documents/Home%20Page/childrens%20centre%20stat%20guidance%20april%202013.pdf

Ofsted Framework for Children's Centre Inspections (April 2013)

http://www.ofsted.gov.uk/resources/framework-for-childrens-centre-inspection-april-2013

Sure Start, Early Years and Childcare Grant and Aiming High For Disabled Children Grant Capital Guidance (DfE capital 'clawback')

http://media.education.gov.uk/assets/files/pdf/s/capital%20guidance.pdf

Kent Future Service Options Programme documentation at:

http://www.kent.gov.uk/education_and_learning/childcare_and_early_education/childrens_centres/future_service_options_program.aspxm

This includes;

- A map of current Children's Centre locations
- The executive summary of the hypothesis-led supporting analysis
- Workshop presentation for each district
- Analysis of the district workshop feedback forms
- A Frequently Asked Questions document

12. Contact details

Name of Author *Karen Mills*
Job Title of Author *Commissioning Manager*
Telephone Number 01622 694531
E-mail *karen.mills@kent.gov.uk*

Name of Author *Amy Watson*
Job Title of Author *Commissioning Officer*
Telephone Number 01622 694613
E-mail *amy.watson2@kent.gov.uk*

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By: Jenny Whittle, Cabinet Member for Specialist Children's Services

Andrew Ireland, Corporate Director for Families & Social Care

To: Social Care & Public Health Cabinet Committee, 12th June 2013

Subject: **CHILD POVERTY STRATEGY**

Classification: Unrestricted

Summary: The draft Kent Child Poverty Strategy updates the Committee on Kent's approach to child poverty, including discharging responsibilities under the Child Poverty Act 2010, and provides a strategic action plan and monitoring framework against which progress will be tracked.

Recommendations: The Committee is asked to comment on the draft Strategy prior to consideration by the Integrated Children's Services Board, and Cabinet Member approval.

1. Background

(1)Part 2 of the Child Poverty Act 2010 requires county and unitary authorities to set out their strategic priorities for child poverty in line with the national target of ending child poverty by 2020. The original legislation required such authorities to undertake a child poverty needs assessment and prepare a child poverty strategy for their area, with provisions in the act for further requirements to be set out in statutory guidance from the Secretary of State.

(2) However, the incoming coalition government subsequently decided in August 2010 that they would not issue statutory guidance in regards to Part 2 of the Act, in support of the localism agenda and the Coalition's broader commitment to reduce unnecessary legislative and bureaucratic burdens on local authorities. This was intended to support the ongoing activity in many local authority areas to address child poverty, and provide discretion about how authorities were to discharge their duties under the act. The non-statutory guidance that subsequently emerged clarified expectations:

a) That authorities were required to undertake and publish a child poverty needs assessment, but this could be integrated into other needs assessments as required.

b) No requirement for authorities to publish a separate stand-alone child poverty strategy (although they are free to do so) where their strategies for tackling child poverty are discharged through, or can be incorporated, into other activity.

c) An ability to track progress on approaches and activities for tackling child poverty is necessary for local authorities to evidence that they are discharging their duties under the Act.

(3) The guidance also stressed the multi-faceted approach required to tackle child poverty, with the emphasis on the need for county and unitary authorities to utilise partnership networks wherever possible to take forward the child poverty agenda in their area.

(4) In 2011, the Government subsequently published the national Child Poverty Strategy, *A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives* which emphasised the need for:

- A stronger focus on ensuring that families who are in work are supported to work themselves out of poverty
- Support for families who are unable to work to live with dignity
- Provision of services for those who can work but are not in work to help them overcome barriers to accessing employment
- Early intervention by intervening early to improve the development and attainment of disadvantaged children and young people throughout their progression to adulthood.
- A stronger focus on place and delivering services as close to the family as possible

(5) In November 2012 the Government launched a consultation about how to measure child poverty, recognising that it is not only about low income, but also low aspirations and opportunities, and limited choices that then prevent children from reaching their full potential. The Government is therefore looking to broaden the definition of child poverty from one focussed solely on income and material deprivation to one that also encompasses other dimensions such as housing, parental skill levels, family stability and parental health.

(6) Kent's approach to date has been focussed on integrating activity to tackle child poverty into its broader activity to support vulnerable families, in much the same way as the national strategy has done. Kent's needs assessment, refreshed in 2012 to take account of the most up to date data nationally and locally, confirmed the need for a focus on sustainable employment, and recognised that children must not be seen in isolation from the wider circumstances of their families and communities. However, the combination of the economic climate and welfare reform changes, which are increasing the pressures on families nationally in the short-term, provided an impetus for a stand-alone Kent Child Poverty Strategy for 2013-16.

2 Relevant priority outcomes

(1) The Child Poverty Strategy builds on and impacts on all three of the ambitions in Bold Steps for Kent:

a) *Growing the Economy* (there needs to be good jobs for people as the most important route out of poverty is usually getting sufficient, reasonably paid work)

b) *Tackling Disadvantage* (this incorporates priorities around reducing health and educational inequalities, promoting early intervention and prevention, and focussing on the early years)
c) *Putting the Citizen in Control* (encouraging people to take responsibility for improving life for themselves and others in their community).

3 Consultation and Communication

(1) Discussions about the Strategy have been held with the Joint Commissioning Board, the Kent Council Leaders' Tackling Disadvantage Sub-Group and the Kent Youth County Council. In addition, a multi-agency workshop was held on 30 January to identify the key components of the Strategy, and earlier drafts have been shared with invitees and participants.

4. Financial Implications

(1) None directly – the action plan is about how to best use existing resources in a difficult financial climate, rather than seeking new expenditure.

5. Legal Implications

(1) The Strategy and action plan will become the over-arching vehicle by which KCC discharges its responsibilities under the Child Poverty Act 2010.

6. Kent's Child Poverty Strategy

(1) The Cabinet Member for Specialist Children's Services commissioned the Policy & Strategic Relationships Team to develop a Child Poverty Strategy, and this action is contained within the 2013-14 Business Strategy Business Plan. The rationale for developing the strategy is that families in Kent (and nationally) are under particular financial pressure because of the economic climate, and in some cases this is exacerbated in the short-term by the welfare reform changes. Child poverty can have profound and long-term effects on children, blighting their future. It is therefore vital that the County Council focuses on how it can reduce and alleviate child poverty across all its services.

(2) One of the challenges in writing a Child Poverty Strategy is the breadth of the subject, which touches just about everything the County Council does. This Strategy has therefore been kept deliberately short and very high level, providing a framework against which child poverty can be tracked, and an action plan that marshals current activity against the priorities of the Strategy. It does not stand alone, but is closely connected to other strategies, notably Unlocking Kent's Potential (Kent's strategy for growth and jobs), Bold Steps for Education, and Mind the Gap (Kent's Health Inequalities Action Plan). A separate report, going to Policy & Resources Cabinet Committee in June, has been commissioned specifically on the impact of welfare reform changes, and the need to develop a methodology to track that impact, and that will be one of the key ways in which changes in child poverty will also be tracked.

(3) The Strategy emphasises the importance of both short and long-term actions. The top priority is the alleviation of extreme poverty, as no child should be

in a situation where they do not have enough food, suitable clothing, or suitable housing. But it also seeks to prevent today's children in poverty from becoming tomorrow's poor adults, by promoting those factors that protect children from the long-term impact of poverty (such as learning, high aspirations for the future, and strong social networks). The diagram on page 10 of the Strategy summarises this.

(4) Following discussion at this Cabinet Committee, the draft Strategy, which covers the period 2013-2016, will be considered by the Integrated Children's Services Board prior to Cabinet Member approval. Annual reports will then be provided to the Cabinet Member for Specialist Children's Services and the Corporate Director for Families & Social Care on progress.

7. Recommendations

(1) The Social Care and Public Health Cabinet Committee is asked to comment on the draft Strategy prior to consideration by the Integrated Children's Services Board, and Cabinet Member approval.

8. Background Documents

- A guide to part 2 of the Child Poverty Act 2010: Duties of Local Authorities and Other Bodies in England, Department for Education
- Child Poverty in Kent, Research & Evaluation Statistical Bulletin, KCC, January 2012
- Family Poverty Strategy, Research Analysis and Summary, KCC, August 2012
- Children and Young People's Plan 2011-14, Needs Assessment for Children and Young People, KCC, 2010

Contact details

Debra Exall
Strategic Relationships Adviser
Debra.Exall@kent.gov.uk
Ext 1984 (01622 221984)

A Child Poverty Strategy For Kent

May 2013

DRAFT

www.kent.gov.uk

"No child or young person should be living in extreme poverty in Kent, and we will work in partnership across the county to reduce child poverty and mitigate the impact of child poverty."

The Kent Child Poverty Strategy Commitment

Table of Contents

Introduction: Reducing Child Poverty in Kent

56,000 children and young people In Kent (18%) are currently living in poverty [1]. Kent County Council has a statutory duty under the Child Poverty Act 2010 to set out Kent's strategic priorities for tackling child poverty and to provide a means of tracking and evidencing progress in line with the national target to end child poverty by 2020, and this Strategy is the vehicle by which that is delivered. It sets out a framework to address the causes and effects of child poverty, identifying those areas where the county council and its partners can have greatest impact.

Child poverty is a multi-faceted and complex issue which is not only about low income, but also low aspirations and limited opportunities that reduce wellbeing and prevent children from achieving their full potential. This Strategy seeks to deal holistically with child poverty, recognising that children are part of a family, which in turn is part of a community, and the circumstances of both will directly affect outcomes for children. It also acknowledges the wider economic factors affecting family circumstance and examines the County Council's role in mitigating the effects of child poverty and tackling its root causes, where this is possible to do. The best outcomes for children are achieved by seeking to ensure that they experience a nurturing and stimulating environment in their family, school and community, as well as having their basic needs met.

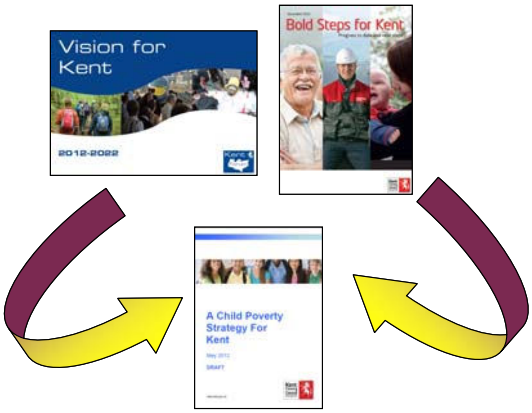
The key aims of the Strategy are:

1. **Immediate alleviation of extreme poverty** – whenever services come across families where children do not have enough to eat, appropriate clothing, or are in unhealthy accommodation then support must be given.
2. **Increase family income** (for low income families) through supporting workless parents into employment, seeking to support the upskilling of parents in low paid employment to increase their earnings, and through ensuring families access benefits to which they are entitled.
3. **Reduce family costs/increase disposable income** by, for example, promoting projects that reduce the costs of fuel, food, travel and childcare for low income families
4. **Reduce health and educational inequalities** by focusing action to improve educational achievement and health on low income families to bring them closer to the average.
5. **Increase family and community resilience** - i.e. enabling families to cope with periods of low income, and promoting those factors that protect children against the long-term disadvantages of poverty, which includes actions to improve the quality of life for families on low income.

The Institute for Fiscal Studies is now predicting that child poverty will increase over the next few years as a result of the tax and benefit changes being introduced[2]. The total resources available to the county council will continue to reduce over the medium term and it will not have the resources to compensate for such a macro-economic trend, should it indeed come to pass. This provides an interesting challenge for this Strategy as child poverty could still increase in spite of many successful actions being taken by KCC.

Nonetheless, we aim to tackle child poverty by working together with families, communities and other organisations to be ever more innovative in making more effective and efficient use of diminishing resources. This will require service transformation, reconfiguring how support and advice is provided in order to better target those families in extreme poverty who need immediate support, those families who are vulnerable to tipping into poverty in the future, and to mitigate the effects of poverty on those children who are likely to suffer the greatest disadvantages.

This Strategy...



.... sits beneath the Vision for Kent (Kent's Sustainable Communities Strategy) and Bold Steps for Kent (KCC's Medium-Term Plan) which are both built upon the three ambitions of 'growing the Kent economy', 'tacking disadvantage' and 'putting the citizen in control'. It is linked to all three ambitions.

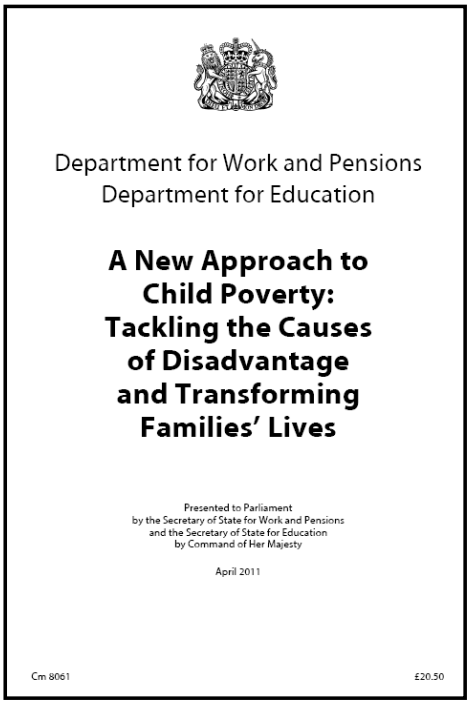
.... seeks to set out an approach to tackling poverty that will help us to focus on those issues where there is a need for collective and concerted action over and above (or instead of) what is already happening.

.... does not set out the detailed rationale for tackling poverty. There is weighty evidence elsewhere that does this[3]. This Strategy starts from the basis that poverty has insidious and potentially long-term effects on families and children as well as direct and immediate impact. Poverty in childhood is toxic because it can have persistent ill effects on nervous and stress hormone systems, leading to lifelong problems with learning, behaviour and physical and mental health. Children in poverty are less likely to do well educationally, thus less likely to develop the skills and aptitudes needed to secure well paid employment in the future. In these and other ways poverty can bring about a multiplicity of disadvantages which reduce a child's life chances and opportunities in the future. There is also clear evidence that children's life chances are most heavily predicated on their development in the first five years of life, so it is particularly important to focus on families with very young children.

Measuring Child Poverty

The Government recently consulted on how to measure child poverty. In our response we welcomed the breadth of issues under consideration in the Government's consultation report, and have built this Strategy around those issues and others, because poverty is not just about low income but also about reduced choices, opportunities and experiences. Nonetheless, low income is the unifying theme underpinning poverty, and the most straightforward indicator.

In this Strategy, the terms 'poverty' and 'severe poverty' come from standard definitions in the Child Poverty Act 2010 and the Coalition Government's 2011 Child Poverty Strategy (see table overleaf for definitions).



Department for Work and Pensions
Department for Education

A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives

Presented to Parliament
by the Secretary of State for Work and Pensions
and the Secretary of State for Education
by Command of Her Majesty

April 2011

Cm 8061 £20.50

We use the term 'extreme poverty' to mean that basic needs (food, warmth, shelter) are not being met. Whilst this level of poverty is not tolerated, and will result in statutory interventions when agencies become aware of it, there can be families who experience episodes of extreme poverty from time to time because of crises or cash flow problems.

There are also families on the edge of extreme poverty who need support to move into a more sustainable position. We do not have information about the incidence of extreme poverty, as the only robust local data available relates to those below 60% of median income, but it is reasonable to assume that its distribution will correlate with poverty generally.

Levels of Poverty		
Level	**Defined by**	**Definition**
Poverty	**Child Poverty Act 2010**	**Households whose income after tax is less than 60% of the median household income. The income level varies according to the number of adults and children in the household (see table below).**
Severe Poverty	**Coalition Government's Child Poverty Strategy 2011**	**Proportion of children who experience material deprivation and live in households whose income after tax is less than 50% of the median household income.**
Extreme Poverty	**Locally determined in Kent – no common definition**	**Basic needs (food, warmth, shelter, appropriate clothing) are not being met.**

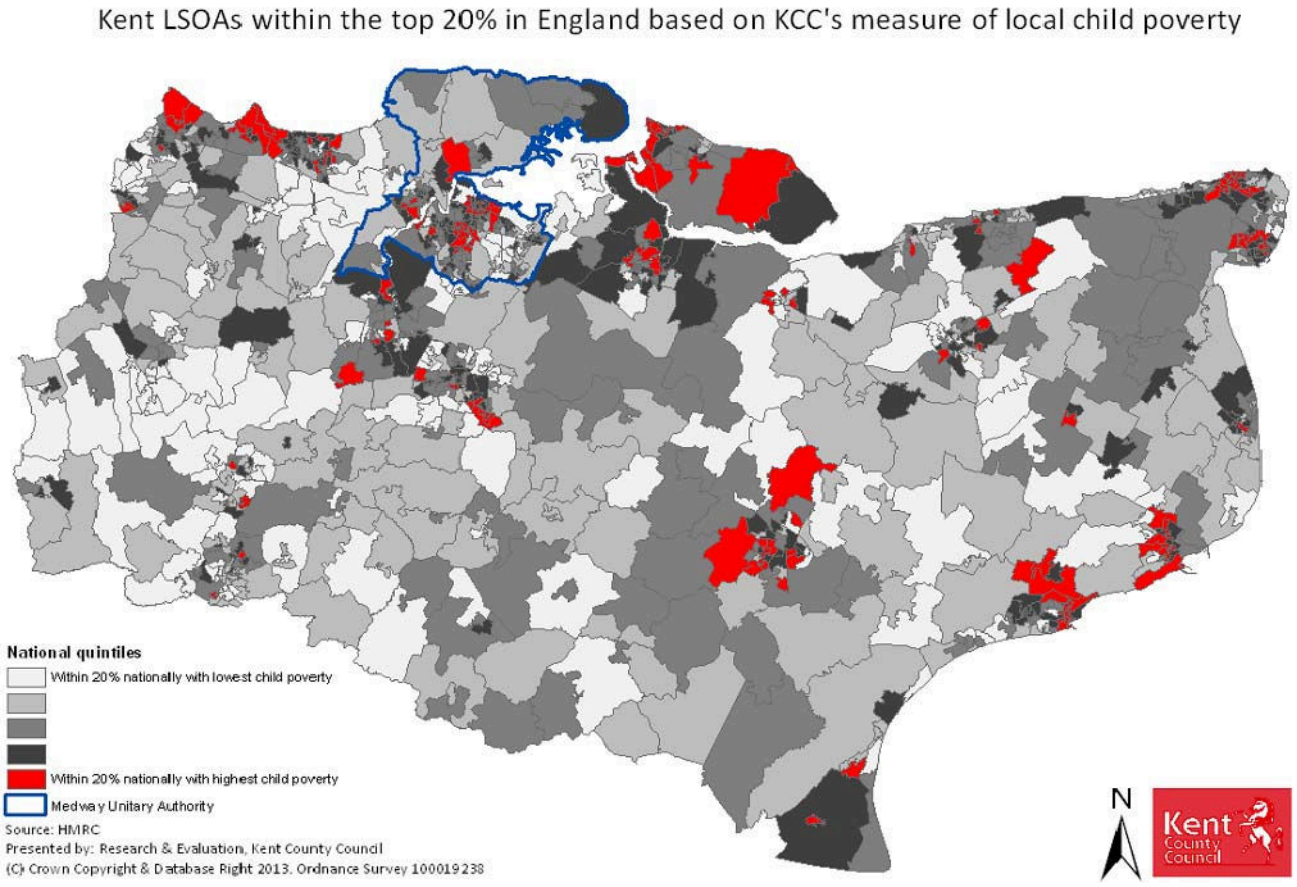
Source: Households below average income, DWP, 2010/11

Poverty Thresholds ('60% below median income')		
Family composition	**Low income thresholds before housing costs £ per week**	**Low income thresholds after housing costs £ per week**
Single with no children	168	125
Couple with no children	251	215
Lone parent with two children under 14	269	211
Couple with two children under 14	351	301

Source: Households below average income, DWP, 2010/11

Context: Child Poverty in Kent in 2013

There are 56,350 children in poverty in Kent [4] (17.7% of the child population). This is below the national figure of 20.6% but higher than the equivalent regional figure of 15%. The greatest child poverty is in Swale, Shepway, Thanet, Dover and Gravesham with rates of over 20% contrasted with rates of only 11% in Tonbridge & Malling, Sevenoaks and Tunbridge Wells, but of course there is considerable variation within Districts (see poverty map below).



The county is geographically diverse and has many contrasts including wide socio-economic disparities and pockets of ethnic and linguistic diversity. 72% of residents live in urban areas and towns, and 28% live in rural areas. Although parts of the county are affluent with incomes levels and property values which are significantly higher than national averages, this disguises the fact that there are pockets of high deprivation. The most deprived areas of the county are the coastal fringes of Thanet, Dover, Deal, Shepway and Swale in the East, but also Dartford and Gravesend in the West.

National research tells us that areas where there are high concentrations of child poverty are often also those where local services are placed under pressure, where there are generally poorer facilities such as safe outdoor play areas, and fewer shops or leisure activities. This combination can generate generally lowered aspirations for the future lives of children and young people ("poverty of aspiration") and lead to

difficulties in relation to community cohesion. On the other hand, children affected by poverty in much more affluent areas can be hard to reach by the services available to support them, and may find the emotional impact of being perceived to be poor by peers to be greater than in areas where there is more general poverty.

Over half of Kent families in poverty have at least one parent in work – a growth in in-work poverty (whether due to low pay or low numbers of hours, or both) has been a significant change over the last ten years[5]. The number of people in workless low-income households has remained at around five million but the number of people in low-income working households has grown almost every year since 2004/5 (before which it was more or less constant). Growth of in-work poverty has happened as costs have increased faster than wages, particularly for low earners. Whether the government addresses this national structural economic issue through the state (tax credits and benefits) or via employers (a "living wage") is a live issue, but either way it is important for services to recognise that poverty affects as many working families as workless ones when targeting support.

Although the proportion of children in poverty in Kent who live in a lone parent household (68.8%) is only just above the national average (68.4%), the proportion of workless people in Kent who are lone parents (13%) is above the national average[7].

Whilst Kent has always had relatively high levels of private rented housing in areas of deprivation, including the coastal towns, **the proportion of families in poverty living in the private rented sector is rising nationally**[6]. This is a trend requiring further examination in Kent as a relatively high proportion of the private rented sector (around 9% in East Kent) is deemed unfit, despite robust actions being taken to improve the sector.

Kent is below the regional average for skills. According to the 2001 Census, 22.5% of people aged 16 and over in Kent have no qualifications compared to 19.1% in the South East region and 22.7% overall in England and Wales. The average household income in Kent is lower than in the rest of the South East.

In Kent, as is the case nationally, families in 2013 have been operating in an environment where wages are rising more slowly than costs, so many families are experiencing real terms reductions in spending power.

The **welfare reform changes** then bring an additional dimension which at the time of writing this report is hard to predict. Over time, the changes are designed to make work pay and reduce welfare dependency. In the short term, it is not possible to know how many low income families will move into Kent from London, or within Kent from high value property areas to lower value areas, in response to the housing benefit changes and benefit cap. How many workless parents will succeed in securing employment, thus avoiding the benefit cap? How many low income families will be unable to cope with the accumulation of relatively small changes such as loss of Council Tax benefit combined with rising prices and the introduction of single monthly payments via Universal Credit?

In the short-term, the Institute of Fiscal Studies has calculated that families with children will lose proportionately more from the tax and benefit changes than single adults and couples without children. **We are putting in place mechanisms to track the impact of the welfare reform changes to enable our services, and those of our partners, to target support most effectively.**

A substantial minority of Kent children will experience poverty at some point. Whilst there are some families who remain in poverty for a sustained period, many more have episodes of poverty, moving in and out of poverty. Nationally, a third of people had experienced at least one period of poverty between 2005 and 2008 . The subsequent economic climate and the tax and benefit changes since then are likely to have increased the proportion of people experiencing poverty.

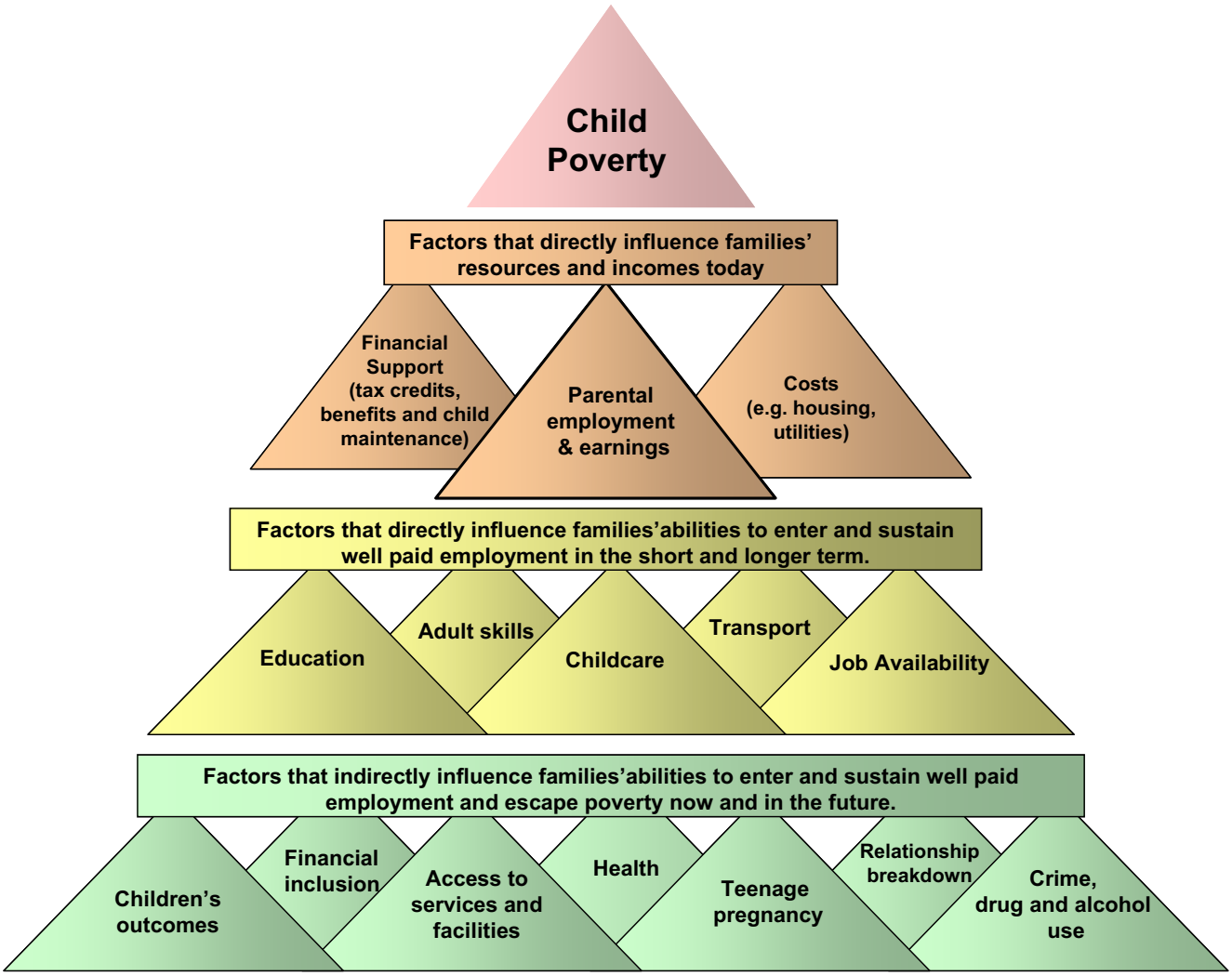
It is easy to forget what poverty looks and feels like for a child when reading bald statistics. Annex 1 sets out some case studies that aim to paint a picture of child poverty in Kent in 2013.

Meeting the challenge

Local government and its partners in Kent have limited influence on much of what determines poverty. Government sets the level of welfare payments, myriad factors affect the jobs market, and the resilience of individual families is also dependent on a host of factors beyond our control.

Nonetheless, there are a range of actions that we can take which will have a positive impact. Taking a holistic approach requires that we explore those factors that:

- directly influence family income, such as parents' ability to enter the labour market and sustain well paid employment,
- indirectly influence families' ability to escape poverty now and in the future, and
- enable families to be resilient to the potentially negative long-term effects of poverty, coping with periods of low income without permanent damage to health and future prospects



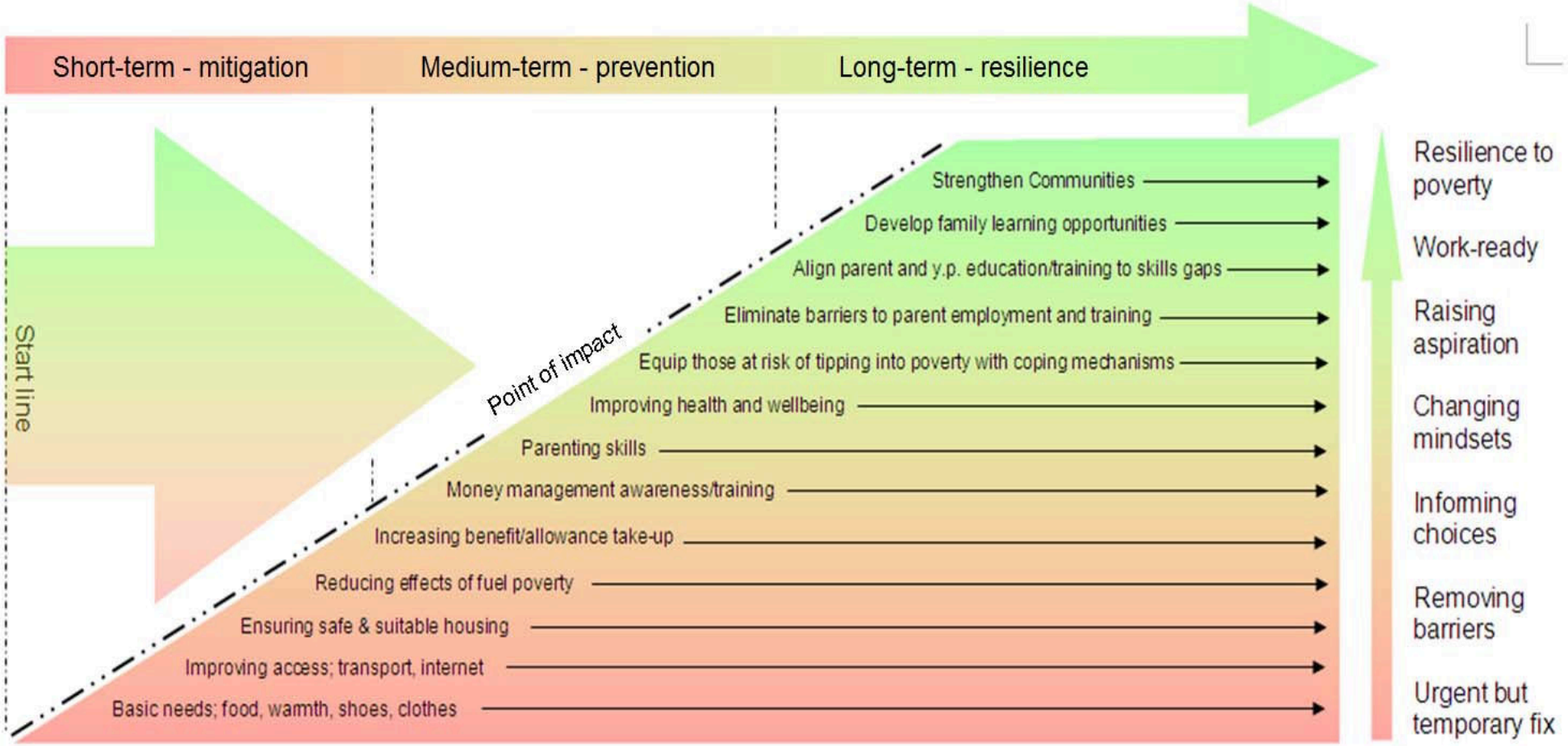
Source: Adapted from Child Poverty Unit, DoE

The diagram on page 12[8] seeks to illustrate the range of factors affecting children and their families, most of which KCC can and does take action to influence. The diagram overleaf illustrates the range of issues and activities that this Strategy encompasses, emphasising that whilst some of the action needed will have immediate impact, we must also take action that will reap benefits in years to come. There is a clear rationale for preventing today's poor children from becoming tomorrow's poor adults, even though the financial savings to the public sector will take some years to feed through. Some of the most difficult and intangible work around this involves changing attitudes and behaviours in order to raise aspirations and provide a family and community environment in which children and young people can thrive, learn and reach their full potential.

There are some sets of circumstances that can increase the likelihood of a child living in poverty. If a parent has a disability or mental health problem, that can reduce their ability to work. Similarly, if a disabled child has significant care needs, that can impact on the parents' capacity for paid employment. Certain groups of young people are more likely to become poor adults, such as Children in Care and gypsies and travellers. It is vital that KCC services are responsive to the particular needs of vulnerable groups such as these.

Much activity is already underway in Kent which will impact on child poverty now and in the future. We already have robust strategies in place to deliver economic growth, reduce fuel poverty, reduce health inequalities and cut the educational achievement gap between children from low income families and the average. Programmes such as the Troubled Families programme, our work to expand availability of apprenticeships opportunities, and the establishment of the Kent Integrated Adolescent Support Service all contribute to preventing and mitigating child poverty. Services which are provided from Children's Centres are important in supporting families with young children, and provide a universal offer and targeted support to families who are vulnerable, whether because of low income, disability, or health issues.

Libraries and Gateways also provide a wealth of community activity and opportunities. Kent has the biggest library volunteering programme in the country, and many of those volunteers work with families in poverty. We have activity aimed at keeping children safe on the roads and pavements, particularly targeted in areas of deprivation, and transport initiatives to help low income families access work, school and leisure activities, including the **Freedom Pass**.


Short-term - mitigation
Medium-term - prevention
Long-term - resilience
Start line
Point of impact
Strengthen Communities
Develop family learning opportunities
Align parent and y.p. education/training to skills gaps
Eliminate barriers to parent employment and training
Equip those at risk of tipping into poverty with coping mechanisms
Improving health and wellbeing
Parenting skills
Money management awareness/training
Increasing benefit/allowance take-up
Reducing effects of fuel poverty
Ensuring safe & suitable housing
Improving access; transport, internet
Basic needs; food, warmth, shoes, clothes
Resilience to poverty
Work-ready
Raising aspiration
Changing mindsets
Informing choices
Removing barriers
Urgent but temporary fix

A family's values and choices are affected by their experiences, history, and the values around them. Messages that KCC and its partners try to deliver (eg around financial planning and management, priorities for spending money, healthy diet, exercise, importance of employment, education and training) will be in competition with messages from the wider media, peer pressure and the community around them. Understanding where individual families come from is crucial in supporting them to help themselves, and we are increasingly improving staff's ability to work with families to change behaviour (such as using motivational interviewing techniques and other tools).

The Joint Kent Chief Executives have set up a cross-agency Welfare Reform Task and Finish Group to raise awareness of the implications of the reforms, help people understand the extent to which they personally could be affected, and support people in preparing for and adapting to the changes. KCC is fully engaged with that group, which provides a vehicle for driving forward some of the actions that require multi-agency working, and is connected to the work of professional groups such as the Revenue & Benefits Managers, the Kent Housing Group and the Kent Customer Service Group. The **Kent Support and Advisory Service**, which has been established following the localisation of the Social Fund, is working across Kent with front-line services (particularly Children's Centres, Libraries and Gateways), other public services and the voluntary sector to ensure a more co-ordinated response to people facing financial crisis.

Priorities for Action

A high level action plan is attached at Annex 2. This brings together those areas of KCC activity that will significantly impact on preventing or reducing child poverty or on mitigating its effects. The action plan has been drawn up against the key aims set out at the beginning of this document, which can be explained and expanded as follows:

Our top priority is the immediate alleviation of extreme poverty.

We believe that it is unacceptable in 2013 for some children to be regularly hungry, or in such poor accommodation that it affects their health and their safety, or unable to go to school because of a lack of shoes or suitable clothing. Where families are facing this level of poverty, they should be supported to ensure the basic needs of their children are being met. Children cannot thrive and learn if they are cold and hungry. We have anecdotal evidence[9] that such poverty is currently increasing as a result of the economic climate. Whilst authorities do intervene when they encounter extreme poverty, there are families on the edge who can be tipped over by a set of unlucky circumstances [see case studies in Annex 1]. With the further welfare reform changes being implemented there will be further volatility during the transition to Universal Credit. It is therefore possible that the number of families facing periods of extreme poverty will increase over the next year or two.

There are a range of actions that KCC and its partners can take to improve the co-ordination of support to families in severe poverty (as those are the families most vulnerable to episodes of extreme poverty) including making better use of existing resources to target those families most in need, raising awareness amongst those front-line staff dealing directly with families of the different sources of available support, and ensuring public services don't inadvertently contribute to the costs borne by families through poor customer care.

Monitoring the effectiveness of such actions will not be straightforward as we will be largely reliant on proxy indicators and output measures. As part of KCC's response to the Welfare Reforms, a methodology to monitor and track the impact of the reforms is being developed. An aspect of that will seek to monitor "extreme poverty", although it should be recognised that this will be through triangulated evidence, including feedback from staff, as there is no robust income data available to us in Kent. It is interesting to note that only 12 out 14,304 child in need referrals in 2012/13 cited low income as the main reason for the referral.

Increasing family disposable income

Employment is the most important source of income for families, so getting workless parents into work, or increasing hours, or increasing pay are key ways to raise income. Short-term impact can also be achieved by promoting greater take-up of benefit entitlement and other available support, and by providing financial and debt management advice and access to low-cost finance.

More medium-term impact is delivered by increasing workless parents' skills and experiences to make them "work ready", and **upskilling parents on low incomes to enable them to take up higher paid employment**. Access to training and development is thus a key plank of this strategy, along with aiming to increase the availability of good quality jobs.

Advice on managing household finances (particularly once single monthly payments, including rent, paid to one householder come into effect) will be needed by some families, along with access to cheap finance and encouragement to save. **Kent Savers** and other credit unions have a key role to play here.

KCC and its partners can and do also undertake lobbying and advocacy and seek to influence work on, for example, the evolution of welfare reform and its relationship with economic development and regeneration.

Reducing family costs

Ways in which costs for low income families can be reduced include:

- *Reducing fuel poverty through the cross-Kent Retrofit Programme*
- *Stimulating more community transport schemes, and finding other ways to reduce transport costs and enable families to access work, childcare, school and community activities*
- *Increasing take-up of the free or subsidised childcare already provided, and seeking to promote more affordable childcare – this is particularly important for lone parents*
- *Provision of free internet access*
- *Expansion of rural broadband*
- *Promotion and development of community schemes that reduce cost of food, such as bulk buying, "grow your own", or classes on preparing and cooking nutritious and cheap meals.*
- *Sensitive and responsive customer care (by KCC and partners).*

Reducing health inequalities and the educational achievement gap

There is a strong correlation between low income, poor educational achievement, and poor health outcomes. There is also clear evidence that intervention in the early years is needed in order to prevent poor children from becoming poor adults[10]. We

must focus on low income families with very young children to support those parents to ensure that their children are getting all that they need to become happy, healthy and successful adults, able to support and nurture their own children.

This is not just about meeting basic needs of food, shelter and clothing, but ensuring children are getting the stimulation and experiences they need to thrive. Having parents or carers with good parenting skills and a good home learning environment is key to children's future success[11].

Reducing health and educational inequalities are critical to reducing poverty in the longer term.

We are progressing a number of actions that show the steps we are taking now which is helping to address these twin challenges. In brief, from the Mind the Gap Health Inequalities Action Plan they include:

- 'Targeted intervention through family nurse partnerships and commissioned support around High Need Families;
- Identify and improve access to services for substance misusing parents;
- Provide clear and quick access through a redesign of child and mental health services (CAMHS);
- Strengthen midwifery and stop smoking resources to reduce smoking in pregnancy'
- Support infant feeding by achieving UNICEF's Baby Friendly accreditation and putting the infant feeding action plan in place;
- Develop a needs assessment for breastfeeding to support targeted and commissioning of services'.

We are responding through the Education Learning and Skills Vision with a range of actions which will assist in making improvement to the educational achievement gap. Specifically, these include:

- Children's Centres working closely with early years settings and their local Primary Schools for disadvantaged children and their families to receive targeted early support.
- Deliver a good 14-16 vocational programme, and the work of schools, colleges and the Vocational Skills Centres to undertake vocational courses, helping many young people to move into an apprenticeship.
- Re-design vocational qualifications, so that young people continue to have an improving vocational offer with good pathways to meaningful learning and qualifications post 16;
- Build improvement and increase capacity in the Kent education system by ensuring the Early Years Foundation Stage and Key Stage 1 are strengths and perform above average, with year on year reductions in achievement gaps
- Support all schools to achieve well in the basics of literacy and mathematics, especially in reading and writing by age 6
- Focus on improvement and innovation in teaching and learning so that satisfactory teaching improves to good very quickly
- Promote peer based learning and school to school collaboration which is designed to bring about rapid learning, professional development and improvement
- Support system wide innovation and experimentation, especially in the design of the curriculum, the development of new provision and better models of support for vulnerable learners
- Develop and support system leaders to lead and support change beyond their own schools including the development of the Teaching School model, the school partnership model, the federation model and the multi-academy trust model.

Increasing family and community resilience

Earlier sections of this report have outlined the very significant negative impact that child poverty can have on the rest of the child's life. But some children who live in poverty do well. There are protective factors (such as strong social networks and support from the local community, school or extended family; and a set of values that accords high priority to education, learning and skills) that enable some families to avoid the long-term and pernicious effects of poverty for their children, and we must seek to support low income parents in nurturing their children's wellbeing. Universal KCC services are really important for providing free or cheap activities that can enrich family life, such as country parks, libraries, and the youth service.

A series of actions are being pursued which **strengthen family resilience** through these times of austerity, preventing the children in such families from remaining in poverty when they reach adulthood.

Examples of activities that have direct impact on increasing family and community resilience include:

- The Troubled Families Programme
- Family Intervention Projects (FIP), which provide more intensive support for a family. A designated FIP worker engages with the family at a critical period of early intervention before the family's needs become more complex, preventing escalation of need;
- Using a Team Around the Family to put together an effective Family Action Plan which blends both support and intervention approaches that ultimately move the family towards independence and sustainability.
- Increasing participation in education and reduced involvement in both anti social and offending behaviour by young people within the targeted families
- Commissioning a wide range of early intervention services -intensive family support workers;, Family advice workers, emotional health and wellbeing services (part of the Community Child & Adolescent Mental Health Service jointly commissioned with NHS Kent & Medway), family mediation service; services to build protective factors with young people who have witnessed domestic abuse
- Advice about employment options, using the expertise of Jobcentre plus and agencies working with families where worklessness is a major issue;
- Establishing the Kent Integrated Adolescent Support Service in some districts and will be extended to all each districts in Kent;
- Establishing a rapid response service for adolescents and their families who are in crisis situations (commissioned during the summer of 2012);
- Working with housing partners to develop a housing and accommodation strategy that ensures suitable provision is available to meet the needs of vulnerable 16 and 17 year olds (including those who are homeless and care leavers).

Low income families can be vulnerable to being drawn into criminality as a solution to their financial problems. Whilst domestic violence occurs across all socio-economic groups, the pressure of poverty can exacerbate family tensions. Also, many ex-offenders will be in poverty when they leave prison, so we need to work closely with the prison service, probation and police to target vulnerable families with the support they need. The **Kent & Medway Community Safety Framework** contains actions to address these issues.

There is enormous diversity between communities within Kent, and different solutions are needed for different localities. But tackling problems on a community basis can be incredibly effective, strengthening social cohesion, developing transferable skills, as well as providing support to individual families.

This theme is difficult to judge and monitor. How do we know whether people are "coping" better with squeezed income or are better able to deal with their

circumstances? How do we judge whether a community has become more resilient? The action plan contains some activity which could contribute, but in practice this will need to be monitored in terms of outputs, and qualitative indicators.

Underpinning themes within the action plan

Better use of existing resources

It is striking how many different initiatives are currently underway aimed at tackling poverty in the broadest sense, including supporting vulnerable families and supporting young people into employment. Over time, those wards in Kent that have the highest levels of deprivation have had considerable investment of resources and some of those communities are experiencing "initiative fatigue". This is not to say that less money should be spent in those communities, but that there should be more joining-up of initiatives to increase effectiveness.

Building Intelligence

Whilst this Strategy has been informed by considerable data, national and local, the picture is one of rapid change, particularly given the implementation of the welfare reform changes. National reports on child poverty or welfare reform seem to appear on a weekly basis. Good intelligence is required to enable services to work together seamlessly to support those most in need. Clarity and agreement on the key measures of poverty is also essential to monitor the impact of this strategy. Generating that baseline information, and researching and monitoring changes in patterns of poverty, is therefore a key action.

Way Forward

Child poverty is such an all-encompassing theme that there is a danger of trying to cover too much ground, and losing focus as a result.

For this reason, the action plan concentrates on those actions which the county council needs to take in order to:

- respond to the welfare reform agenda,
- address the top priority of alleviating extreme poverty, and
- utilise its resources most effectively in delivering its statutory responsibilities relating to children's wellbeing

An annual monitoring report will be prepared for KCC's Statutory Lead Member on Children's Services and Director of Children's Services, informing them of progress against the priorities set out in this document. The key indicators will be the national Child Poverty targets, including whatever the Government decides to measure following its recent consultation on measuring child poverty. But we will also seek evidence, qualitative and quantitative, of the impact of KCC's services on the outcomes for children from low income households. The methodology being developed to track the impact of the welfare reforms will be useful in this regard. The table overleaf sets out examples of the evidence that will be sought to track improvement. This will be further sharpened and refined for monitoring purposes.

The Strategy should be reviewed and revised in 2016.

These are challenging times in which to aim to reduce child poverty, as funding for public services is reduced, there are not yet firm signs of economic growth in the county, and the welfare reform system is in transition. But by focussing on the priorities set out within this strategy, KCC and its partners can help people to have access to the right resources in the right way at the right time in order to manage their lives and give their children the opportunity to achieve their full potential. In the long-term, the success of this strategy will be measured by improvements in outcomes for children.

Alleviation of extreme poverty/ increase income/ reduce costs

- Evidence of reduced costs for the poorest families (fuel, food, transport, childcare)
- Evidence of support for families in crisis which gets them back on track
- The poorest children have reduced school absence
- Improved housing conditions in the private rented sector
- Evidence of support to improve the quality of family life (eg money management, healthy meals, engagement with community projects).

Narrower health and achievement gaps

- The qualifications gap between children on free school meals and the general child population decreases
- Life expectancy rates increase faster for the 20% most disadvantaged in the population
- Child health indicators improve faster for families in poverty.
- Children on free school meals access out of school clubs and activities
- Reduce birth rates to teenage parents.

FEWER FAMILIES IN POVERTY
(whatever national targets are agreed)

Greater Family and Community Resilience

- Evidence that early intervention and prevention services are increasing the resilience of the families they support (e.g. improved parenting skills).
- Evidence that community projects are reaching more of those people who most them.
- Less domestic abuse and involvement in crime and anti-social behaviour.

Better Use of Resources

- Evidence of improved joint working to provide seamless services (effective use of data and information; more joint assessments; reduced repeat assessments; appropriate signposting)
- Staff understand the causes and effects of poverty and have access to information that enables them to signpost effectively.

References

1. Kent Family Poverty Needs Analysis refresh 2012, using the definition from the Child Poverty Act 2010 (below 60% of median income).

2. Child and Working-Age Poverty in Northern Ireland 2010 to 2020, May 2013

3. Most significantly the Family Poverty Strategy Research Analysis and Summary, KCC, Oct 2012; Family Poverty Strategy Supporting Evidence, Oct 2012; Children's Joint Strategic Needs Assessment, December 2011; Children and Young People's Plan 2011-14, Needs Assessment for Children and Young People, KCC, 2010

4. HMRC children under 18

5. Joseph Rountree Foundation 'Monitoring Poverty and Social Exclusion 2012'

6. Households Below a Minimum Income Standard, Joseph Rountree Foundation, April 2013

7. Joseph Rountree Foundation 'Monitoring Poverty and Social Exclusion 2012'

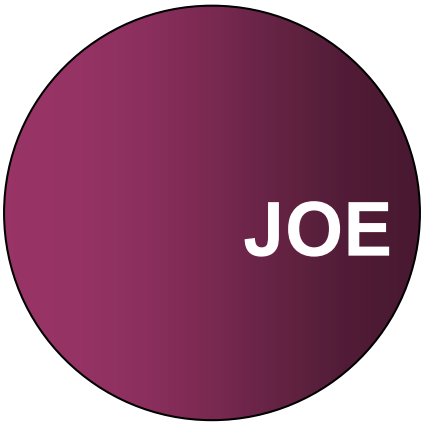
8. Department of Education - Child Poverty Unit

9. Child Poverty Workshop 30 Jan 2013 identified increases in: requests to front-line staff for help with basic needs; underweight children; food banks; homelessness; pound stores and pay day loan companies.

10. Frank Field's report of the Independent Review of Poverty and Life Chances, Dec 2010

11. Washbrook, E. (2010) Early environments and child outcomes. University of Bristol.

Annex 1:
Child Poverty in Kent
Case Studies



Joe is twelve. He lives with his Mum, Step-Dad and two brothers in rented accommodation. His Mum has recently lost her job and his step-dad has been unemployed for many years. His natural father lives in another town, is disabled and suffers from chronic long term health problems. He rarely sees Joe and his brothers as he does not have access to a car and cannot afford public transport. Joe's Nan (maternal grandmother) lives close by. She is a pensioner who has a part-time job and provides the family with practical, emotional and financial support.

The family subsist on a very low income. It is hard to buy food and heat the family home in winter. The landlord is making improvements to the family home by adding double glazing and central heating, which will make the house warmer in the longer term. But the improvements are taking a long time to complete and currently the family is using temporary heaters that are very expensive to run and are only used for limited periods in the evening. There is no heat in the house during the day and the family wear coats whilst indoors during the winter months.

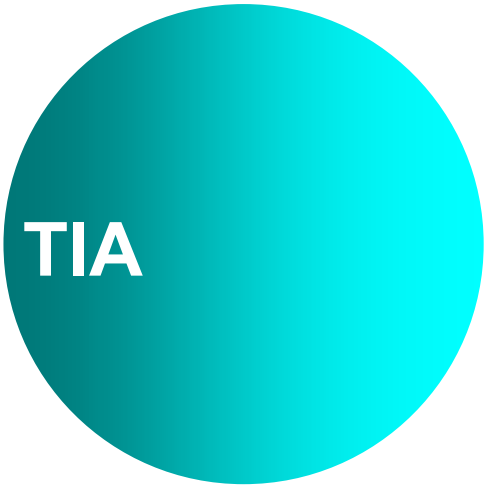
Hot water is heated by an emersion heater. This is very costly. The family do not have a shower, only a bath. As it is too expensive to heat enough water for a bath every day the children bath, on average, every third day. On a none-bath day the children wash in water boiled in a kettle. The bathroom is very cold so this is an uncomfortable and very quick wash. The family have a washing machine and clothes are laundered regularly but drying is problematic in the winter months. Clothes smell musty.

The family are looking forward to the completion of the improvements to their house but are concerned that even when the heating is installed it will be too expensive to use.

Joe has problems at school. He is often in trouble about his uniform as he doesn't always have the correct clothes or PE kit. This is mainly because it is hard to dry clothes for the next day if things get dirty and when his shoes need replacing his mother cannot afford both trainers and schools shoes so he is often missing the correct footwear. Jo gets angry about the school complaining about this as he sees it as a criticism of his Mum. He gets teased because his clothes smell and sometimes he goes to school without a bath or hair wash. He gets angry about this too.

Joe's Mum shops at the local shops. The supermarket is a bus ride away. There is a market in the next town which she likes to visit to buy food but it difficult to get to and she can only afford the bus fare on occasions.

It is Joe's birthday soon and he is very excited. He wants a new pair of trainers for PE and to go to McDonalds with his "whole family" for tea. Joe's Mum is very worried about this as she can not afford both the trainers and the family tea. She thinks she will get the trainers and Joe can go to McDonalds with his Nan for tea but she knows Joe will be very upset about this.



Tia is 10 and she lives with her Mum Kelly. Tia's Mum and Dad split up two years ago and her Dad moved away. Tia talks to her Dad a lot on the phone but she doesn't see him very often. This makes Tia sad.

When her Mum and Dad were together they lived in a house with a garden but when they split up she moved to into a flat with her Mum. Tia misses the garden; she used to have a swing. Now she lives in the flat she doesn't go out to play much. There is a playground but there are a lot of teenagers who use it and Kelly doesn't like her going there on her own.

Kelly isn't working and she and Tia live on benefits. The GP is treating Kelly for depression. The flat is warm but money for food is sparse. Kelly shops at the local store as she doesn't have the money for the bus into town. The shop doesn't have much selection and it doesn't regularly stock fresh fruit and vegetables. Sometimes Tia does the shopping; she likes this as she gets to choose what she wants to eat.

Tia has put on a lot of weight in the last couple of years and is bullied at school and by the local children about her weight. She has recently seen the Dentist who removed five of her first teeth because they were decayed. Her Mum worries about Tia's weight and her teeth but doesn't know what to do about it.

Tia doesn't like going to school or out to play because of the other girls making fun of her. She likes staying in with her Mum.

Fire crews attended a small house fire that had been caused by a tea light being placed on a sofa. When they entered the property, the crews found that there were six people living in a two bed property including a two year old and a new born baby . The property was of poor standard including dangerous wiring, poorly equipped kitchen and little furniture. The crews referred the family to Kent Fire & Rescue Services' vulnerable persons team for a visit the following day. During the visit the officer discovered that the household comprised two families who, due to a relationship breakdown, had moved in together. They were using candles as the electric lights in the property kept fading on and off and when they plugged anything into the sockets they "sparked". The property was rented from a private landlord. The officer asked if they had complained about the condition of the flat but was told they hadn't because they were given a cheap rental deal and didn't want to upset the landlord and get evicted because they couldn't afford better quality housing . We had no choice but to refer the case to the private rental officers of the district council because the fire risk was so great.

Annex 2:
Kent Child Poverty Action Plan

Priority/Aim 1: Immediate Alleviation of Extreme Poverty		
Objective	**Outcome**	**Delivered through**
Information and advice on managing money, benefit entitlement and support is easily available to families	It is easier for families in deep poverty to access information about available support and advice, maximising gross disposable household income and minimising outgoings.	Welfare Reform Task & Finish Group
Support the Voluntary & Community Sector, and in particular the Citizen's Advice Bureaux, to deliver better co-ordination and targeting of (a) hardship funds and (b) access to cheap finance.	A more coherent and targeted use of hardship funds in Kent. Families with children in deep poverty, or who are facing a financial crisis, are able to access one-off grants for e.g. purchase of school shoes or uniform.	Voluntary and Community Sector Review Programme Board Voluntary & Community Sector Engagement Forum
Staff training programme designed and implemented, covering the causes and effects of poverty, and the implications of legislative reforms. Taking account of the drive to integrate service delivery this programme is embedded in the Workforce Development Priorities of the County Council.	• All front-line staff have, and are able to use, a multi-agency training and information resource. • Staff know what they should do when they encounter families or children in extreme poverty • Families in poverty feel able to discuss issues with staff and receive consistent accurate information.	Workforce Development Strategy
Information on the myriad of multi-agency projects and services dealing with poverty is consolidated in one place, so that staff can signpost knowledgeably and effectively.	A compendium of projects, products and services is assembled and available in all public-facing service points as well as remotely. Contact Centre Customer service teams & front line reception staff will be briefed	Welfare Reform Task & Finish Group Customer Services Board
Parents are supported to provide better family care through social care interventions, or appropriate referrals into Tier 1 or 2 service provision	Children and young people receive the correct levels of support to reduce the impact of neglect, and to grow up in a safe environment.	Kent Safeguarding and Children In Care Improvement Plan

Priority/Aim 2: Increasing Family Income

Objective	Outcome	Delivered through
Promote regeneration in Kent, to provide employment opportunities for workless parents, and continue to require contractors to employ local people where possible.	Economic development activity continued that promotes growth in Kent and creates good quality jobs for local people, delivered via Continuing to Unlock Kent's Potential.	Continuing to Unlock Kent's Potential
• The array of existing courses and qualifications available to enable parents to find or improve their job prospects are publicised • Local training and employment forums include basic literacy and numeracy skills and advice on setting up a business/ working for yourself • Family Learning programmes are targeted on primary schools in deprived areas • 'Response' provision in Kent's poorest communities, addressing families via infrastructure agencies including Children's Centres, schools, health centres, housing associations and voluntary sector organisations. • Focussing on Bold Steps for Education: Shape education and skills around the needs of the Kent Economy by 2015 • Documented learning from programmes that create employment opportunities for 18-24 year olds who are currently in receipt of Job Seeker Allowance is shared and developed in line with the 14 – 24 Learning, Employment and Skills Strategy Objectives.	• Parents (and especially single parents) are equipped with tangible experience and confidence to help improve chances of employment • Existing resources to improve employment outcomes, confidence and aspiration are used to best effect • There will be full participation in education and work based training for all 16-18 year olds following year on year reductions in the NEET Figures • The employability skills of 19 year olds in the County will have improved, especially in English and Maths. • The outcomes for 19 year olds from disadvantaged backgrounds will be above the national average and the achievement gap between this group and other students will have reduced by 10% • There will be a significant impact on unemployment among 18-24 year olds so that current levels reduce by 4000 to below 2008 levels. • Development of Youth Employment and Learning Zones in hotspots where youth unemployment among 18-24 year olds exceeds 20%	Community Learning and Skills (working with Job Centre Plus) Libraries Business Plan 14 -24 Learning, Employment and Skills Strategy

Adopted parents are made aware of their entitlements, as stipulated in the new Adoption Passports	Increased knowledge about entitlements, such as priority access to council housing, improves family situations and encourages people to consider becoming adoptive parents	Kent Safeguarding and Children in Care Improvement Plan
A Task and Finish Group is established to explore how KCC and partners could better enable parents of younger children to access learning.	Local activity and projects are put in place around the county to address barriers to learning such as childcare and transport.	Policy & Strategic Relationships
Ensure universal services such as Nurseries, Schools and Children's Centres provide better support for disabled children.	Parents of disabled children have access to child care and other support needed to enable them to take paid employment, should they wish.	Special Educational Needs and Disabilities Strategy

Priority/Aim 3: Reducing Family Costs and Increasing Access

Objective	Outcome	Delivered through
Revised Children's Centre Service Offer is integrated with other aspects of Children's Services Delivery, and local staff work well with GP Surgeries and integrate their approach to supporting families with Health and Social Care	Services are targeted at the most vulnerable children and parents, and the Universal Offer supports Children and their siblings up to the age of 11 with key transition points and school readiness	Kent Children's Centres Strategic Plan 2014-2016
The availability of free and affordable childcare, particularly in areas of deprivation, is promoted (target actions taken from the Childcare Sufficiency Assessment report)	Parents and carers can access the right information to make appropriate childcare choices	Childcare Sufficiency Planning
• Information, advice and guidance on fuel poverty, including Green Deal, is made available • Funding available through the Green Deal is used to improve energy inefficient housing in areas of deprivation.	• Service users and providers are aware of the implications of fuel poverty, and ways to combat it. • Targeted neighbourhoods/homes have reduced energy bills and improved living conditions.	Kent Environment Strategy
Innovative solutions developed to the problem of transport (to work, school, and other activities) developed.	Transportation problems addressed	Growth without Gridlock

Promotion and development of community schemes that promote the availability of healthy and affordable food. Explore whether fruit and vegetable suppliers could make available surplus and outshaped products to families.	• Families have the opportunity to provide their families with a more balanced diet, and cheaper food bills • Suppliers could benefit from reduced disposal costs	Kent Support and Advice Service Policy & Strategic Relationships Health Inequalities Action Plan 'Mind the Gap' District Level Action Plans
Comprehensive training on ways to save money and mitigate poverty (delivered via free sessions run at adult education centres, schools, Children's Centres, libraries and Gateways) is available to families.	• Families are better informed about financial planning and debt advice. • Families in debt receive appropriate impartial advice and guidance to minimise their difficulties.	Welfare Reform Task & Finish Group
Work with Broadband Delivery UK to upgrade Kent's broadband infrastructure to enhance access to better broadband services and eradicate 'not spots' (i.e. areas with no broadband coverage) across the County.	Improved access to broadband/online services across the County	Digitising Kent Action Plan
Develop a digital action plan to maximise take up of new services and foster greater digital literacy	Greater uptake and utilisation of online services	Digitising Kent Action Plan Libraries Business Plan
As part of the ongoing implementation of the Customer Services Strategy, KCC services are assessed to ensure they are flexible, responsive and designed around the needs of families in poverty	Unnecessary costs are not unwittingly imposed on families through poor customer service.	Customer Services Strategy
KCC works with partner agencies and developers to: (a) help ensure new affordable housing is provided in Kent at a time when grant funding to the Homes & Communities Agency and resources for other housing providers are falling in real terms. (b) ensure vulnerable young people have accommodation and housing-related support	• Improved availability of affordable housing to meet the needs of Kent's population • Housing that supports strong communications, a good quality of life and reduces household costs (including tackling fuel poverty)	Kent & Medway Housing Strategy

Priority/Aim 4: Reducing Health Inequalities and the Educational Achievement Gap		
Objective	**Outcome**	**Delivered through**
To ensure all pupils meet their full potential by 2015	Foundation stage outcomes for 5 year olds will continue to improve so that the percentage of children achieving the expected level 6+ in all aspects of learning will improve by 5%. The achievement gaps at key stages 2 & 4 will be less than the national gap figures and pupils from low incomes backgrounds (and other vulnerable groups) will be achieving better progress and outcomes than similar groups nationally. Following a review programme for PRU's and the further development of alternative provision for pupils aged 14 and above there will be fewer than 50 pupils permanently excluded from school.	Bold Steps for Education
Reduce health inequalities in Kent.	The health status of the poorest families and communities in Kent is improved, bringing it closer to the health status of the average resident.	Mind the Gap: Kent's Health Inequalities Action Plan
• The attendance and educational attainment of Children in Care is improved. • The percentage of Children in Care having regular health care assessments and dental checks is improved.	• No children who are looked after will be excluded from school, fewer than 10% will be persistently absent and their attainment will be in line with the targets in the Kent Pledge for Looked After Children and Care Leavers. • Health inequalities between Children in Care and the general population are reduced.	Kent Safeguarding and Children in Care Improvement Plan.
• The Kent Apprenticeship Programme effectively supports employers to recruit 350 apprentices over the next four years • Children in Care given opportunities for participation in employment through the participation worker scheme	• Young people who might otherwise drop out of education, employment and training are provided with opportunities to enter the workplace	14-24 Learning, Employment and Skills Strategy

Priority/Aim 5: Increasing Family and Community Resilience		
Objective	**Outcome**	**Delivered through**
Future options proposals for Children's Centres position their services at the heart of KCC's response to child poverty	• Service provision alleviates poverty for families in crisis. • Factors which prevent poverty from having long-term negative implications for children are developed and encouraged.	Kent Children's Centres Strategic Plan 2014-16
Implement the Kent Community Safety Framework, which seeks to reduce domestic abuse, drug and alcohol abuse, road traffic accidents and youth offending amongst Kent communities as part of its overall aim to reduce crime and disorder and the impact of crime and disorder on people's lives.	Crime and disorder is reduced, particularly in the more deprived Kent communities, both through preventative activity and responsive activity.	Kent Community Safety Partnership
KCC works through the voluntary sector and partner agencies to promote the foundation of community crèches, community shops, community cafés and food banks through resources in kind, use of assets and publicly-owned buildings, sharing lessons learned about good practice, and working with local media to publicise good news community stories.	Communities are provided with the right infrastructure to become stronger, more resilient and empowered to play a full part in community life. Media stories encourage aspiration and promote successful community initiatives in which people can participate.	KSAS linking with Children's Centres to provide food, clothes and fuel. Development of signposting website and online resource Gateways developing Voluntering Pathway to Work
Services with a physical community presence such as libraries, Gateways and Children's Centres should continue to find ways of ensuring that the most vulnerable families engage in social and community activities.	Expansion and roll out of outreach work schemes and pilot projects that increase vulnerable families' participation in social and community activities. (E.g. volunteers bringing parents with young children to Children's Centres/Library/Gateway activities.)	Libraries Business Plan
Implement "Involving the whole community: The Kent Approach to Literacy and Reading". Good literacy underpins poverty prevention as it is becoming almost impossible to secure good employment without functional literacy, and it is harder for parents with poor literacy skills to support their children's learning.	By 2021 there will be 100% literacy in Kent. To achieve this, there will be a particular focus on Children in Care, NEETs, and children and young people excluded from school. Free adult literacy classes are available to support parents who cannot read.	The Kent Approach to Literacy and Reading Libraries Business Plan

Priority/Aim 6: Better Use of Resources (underpinning theme)		
Objective	**Outcome**	**Delivered through**
Families in deep poverty are supported wherever they first present.	• KCC's integrated offer by Children & Families provides "No Wrong Door"	All front-facing KCC and jointly delivered services.
Implementation of the KCC Early Intervention and Prevention Strategy	• Providing consistent and targeted early help and intervention that appropriately meets the needs of children, young people and their families • Access to Early help supports vulnerable families across Kent, enabling parents to better access joined up services	Children and Young People's Joint Commissioning Board (multi-agency panel)
Commissioning and decommissioning is managed to take account of the cumulative impact in order to avoid duplication, whether that is geographically or client based.	Joint Commissioning Plans are agreed with the Children & Young People's Joint Commissioning Board and shared with key stakeholder groups both Locally and County Wide.	Children and Young People's Joint Commissioning Board (multi-agency panel)

Priority/Aim 7: Building Intelligence (underpinning theme)		
Objective	**Outcome**	**Delivered through**
Ensuring that a robust evidence and intelligence base is built and maintained in real-time, integrated with existing performance and data mechanisms.	All agencies in Kent are fully briefed on the evolving picture of poverty in Kent	Welfare Reform Task & Finish Group
Research mapping of children in poverty is plotted against housing type and tenure	A shared understanding of the drivers of child poverty and where and how best to target interventions to assist those households is obtained	Welfare Reform Task & Finish Group
Staff work alongside families and communities to better understand how we can target resources and co-design services to promote resilience. Also ensure service user feedback (including the child's voice) is collated and recorded in casework and used to inform the development of strategies and services which provide services to the most vulnerable families	Service provision is informed by, and more responsive to, service user need, leading to more resilient families.	Customer Services Strategy
Families in deep poverty are known to KCC and we are able to understand and support their needs through comprehensive assessment and analysis of how they currently use our services.	Greater understanding of the need levels of children in poverty and clarity regarding how many of the 56,000 children facing poverty are known to KCC and its partners.	Longitudinal research to be commissioned.

A Child Poverty Strategy For Kent

Sessions House, County Hall, Maidstone, Kent ME14 1XX
www.kent.gov.uk

May 2013

From: Graham Gibbens, Cabinet Member Adult Social Care & Public Health

Meradin Peachey, Director of Public Health

To: Social Care and Public Health Cabinet Committee - 12th June 2013

Subject: **Progress Update on Genito-Urinary Medicine (GUM) Service Transfer from Darent Valley Hospital to Gravesham Community Hospital**

Classification: Unrestricted

Past Pathway of Paper: Corporate Board

Future Pathway of Paper: N/A

Electoral Division: Countywide

Summary: Commissioning of Genito-urinary services became the responsibility of the County Council from 1st April 2013.

The GUM service currently provided by the Dartford and Gravesham NHS Trust from Darent Valley Hospital site will be transferring to Kent Community Health Trust KCHT at Gravesham Community Hospital, on June 3rd for a period of 12 months, as an interim arrangement. This was the subject of a decision by the Cabinet Member for Adult Social Care and Public Health, following discussion at the March 2013 meeting of this Committee.

The cost of this service is approximately 2.5 million pounds.

Recommendation(s):

The Cabinet Committee is asked to note the update on the transfer of the GUM service from Darent Valley Hospital to Gravesham Community Hospital.

1. Introduction

1.1 The purpose of this paper is to report progress on the transfer of the Genito-urinary medicine service provided from Darent Valley Hospital (DVH) to Gravesham Community Hospital (GCH).

2. Financial Implications

2.1 The contract for this service is based upon payment by results (PbR). The tariff in 2013/14 for new appointments is £157.00 and for follow up appointments £123.00. There have been some costs linked to IT and setting up the service at GCH. The cost for HIV drugs and HIV treatment will be met by NHS England (specialist commissioning) which in 2012/13 was approximately 1.4 million pounds.

3. Bold Steps for Kent and Policy Framework

3.1 This activity supports Bold Steps for Kent core themes:

- To put the citizen in control - through open access /self-referral to the service
- To tackle disadvantage – providing an integrated service which gives clients entry to a breadth of service provision in one place

4. Detail

4.1 Background

4.1.1 In August 2012 Dartford and Gravesham NHS Trust served notice to NHS Kent and Medway with the intention to cease providing the Genito-Urinary Service from DVH, with effect from 1st May 2013.

4.2 Progress

4.2.1 The process of consultation with staff at DVH commenced on March 14th with the addition of a further member of staff added on April 11th. The board at DVH made an internal decision on 24th April to defer transfer of the service because there was concern that the preparations for transfer to KCHT were not complete.

4.2.2 Commissioners held an urgent meeting, discussed the concerns raised by DVH and have made response both through formal letter and activity. The impact of moving the clinic has filtered to other disciplines namely radiology and pathology as KCHT are not maintaining the same level of provision from these services at DVH. Communications to stakeholders, clients and the wider public have been prepared to be disseminated following the completion of the consultation period with staff. To be compliant with the governance for the supply of high cost HIV drugs has required negotiation with proposal for a community model which has been made. This model will be developed and implementation phased in with an interim arrangement continuing with the support of DVH until August 2013.

4.2.3 Agreement to work toward a revised transfer date was made on May 8th with commissioners. The service will cease at DVH on Friday May 31st and commence at GCH from Monday 3rd June.

4.3 Performance Monitoring

4.3.1 There are increased requirements for information, from the sexual health commissioners and the Department of Health, which will be reviewed quarterly. Improved electronic recording of data and consistency of recording information across the service will be developed.

5. Conclusions

The move of a clinical service has incurred impact elsewhere within the hospital trust which needed to be determined and completion of consultation with staff before transfer could take place This GUM service has transferred to provide a continuing service for residents and non-residents.

This transfer presents opportunities to review opening times and further improve open access to services.

6. Recommendation(s)

Recommendation(s):

The Cabinet Committee is asked to note and comment on the update on the transfer of the GUM service from Darent Valley Hospital to Gravesham Community Hospital.

7. Background Documents - none

8. Contact details

Report Author

- Wendy Jeffreys
- 07850214458
- wendy.jeffreys@kent.gov.uk

Relevant Director:

- Meradin Peachey, Director of Public Health
- 01622 694293
- meradin.peachey@kent.gov.uk

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From: Graham Gibbens, Cabinet Member Adult Social Care & Public Health

Meradin Peachey, Director of Public Health

To: Social Care & Public Health Cabinet Committee - 12th June 2013

Subject: **Update on the Measles Outbreak in England**

Classification: Unrestricted

Electoral Division: Countywide

Summary: There has been an increase in laboratory confirmed cases of measles in England. The increase in cases is amongst the teenage population who possibly have been affected by the adverse publicity given to MMR vaccination in mid 1990s. The highest numbers of cases are in North East and North West England. The lowest numbers are in the South East Region.

A catch up programme has been launched in England to immunise all partially immunised and unimmunised children between the ages of 10 and 16 years. There are almost 15,000 children in Kent who fall in this category. The local catch up programme is being led by NHS England Area Team.

Recommendation(s):

The Cabinet Committee is asked to note and approve the actions taken in Kent in response to the measles outbreak as part of the new health protection duties of KCC. The rates of measles are low in Kent. A MMR catch up programme has been put in place to immunize children.

1. Introduction

1.1 The purpose of this paper is to provide an update on the measles outbreak in England. According to the Health and Social Care Act, the Directors of Public Health needs to ensure that there are local plans for immunisations[i]

2. Financial Implications

2.1 Money has been set aside within the public health budget to meet any unexpected costs should there be an outbreak of measles in Kent

3. Detail

3.1 Background

3.1.1 Outbreaks of measles in England have been increasing in the last two years with an annual total of 1,920 confirmed cases in 2012, the highest annual figure since 1994. In the first quarter of 2013, 587cases were confirmed in England. Cases have been spread across England, although the highest totals have been in the North West and North East. The key difference in the

pattern of infection in 2013 is a high rate of cases in teenagers, which has not been experienced in previous years. Secondary schools provide an opportunity for rapid spread of infection, as has happened in Swansea. This age group has most likely been affected by the adverse MMR publicity between 1998 and 2003. There have been 17 lab confirmed cases in South East which is the lowest amongst any region across England.

3.1.2 The target is that by 30th September 2013, at least 95% of young people aged 10 to 16 years who are partially vaccinated or unvaccinated will have received at least one dose of MMR. This figure is similar to the level now being achieved in younger children and should provide a level of herd immunity that will reduce transmission and spread of measles to other age groups.

3.1.3 According to the Child Health Records data there are 15,027 unimmunised or partially immunised children aged 10-16 years across Kent.

3.2 NHS England Area Team Response

3.2.1 The Kent and Medway Immunisation Campaign LES has been activated to implement the MMR catch up campaign

3.2.2 The national Measles campaign leaflets and posters have been sent to every GP practice, pharmacy and Children's Centres across Kent and Medway

3.2.3 A non-worded /picture poster has been developed for non -English speaking and vulnerable communities for display in GP practices.

3.2.4 Letter drafted for school nurses and community providers.

3.2.5 Child Health Records Team has identified cohorts of partially immunised and unimmunised children aged 10-16. Lists of these children have been sent to each GP practice with a request for practice to up-date/validate MMR child record.

3.2.6 All GPs have been sent a copy of the national MMR catch up letters and MMR Q&A and the national LES variation letter.

3.2.7 Visits are being arranged for the GP walk in centres with the intention of disseminating additional MMR information materials.

3.2.8 Registered traveller sites aligned to the GP practices have been identified in order to identifying unvaccinated children in the traveller communities.

3.2.9 Colleagues in offender health settings have been contacted to identify groups of unvaccinated children

3.3 Public Health England Response

3.3.1 PHE is responding to this incident as a level 3 (Incident and Emergency Response level) requiring national co-ordination.

3.3.2 PHE and NHS England are continuing to develop the national implementation plan with input from all partners including the Department for Education.

3.3.3 NHS England has put in place a formal operating procedure and PHE is working with NHS England to identify at risk groups and individuals

3.3.4 The plan will have 3 essential components; namely

- Active identification of children at risk.
- Offering MMR vaccine to children at risk.
- Improving and sustaining the current MMR programme.

3.3.5 The PHE Centres are working in collaboration with NHS England Screening and Immunisation teams and DsPH to plan and coordinate the local response, based on the national implementation plan, to ensure the population is fully protected, with a particular focus on 10-16yr olds.

3.4 Clinical Commissioning Groups Response

3.4.1 Each CCG has sent a press release with CCG chair sign up. This was developed collaboratively with NHS ATs, PHE leads and Local Authority DPH (s) to ensure consistent messaging.

3.5 Kent County Council's Response

3.5.1 The Director of Public Health has given radio interviews to raise the profile of MMR

3.5.2 Public Health in KCC is working with NHS England AT to identify groups of vulnerable children in the 10-16 age groups who attend schools in Kent, home educated children, looked after children and children in pupil referrals centres who may be at risk.

3.5.3 Letters produced by PHE containing information about measles are being sent to all primary and secondary schools in Kent through existing communication channels in KCC for onward dissemination to the pupils.

3.5.4 Information about the measles has been added to the KCC website.

4. Conclusions

4.1 According to the Health and Social Care Act it is the responsibility of the Director of Public Health to advise on whether immunisations programmes in the area are meeting the needs of the population, and whether there is equitable access. By working collaboratively with other stakeholders involved in this outbreak the DPH can ensure that there is an appropriate response to meet any challenges arising from this outbreak.

5. Recommendation(s)

The Cabinet Committee is asked to note and approve the actions taken in Kent in response to the measles outbreak as part of the new health protection duties of KCC. The rates of measles are low in Kent. A MMR catch up programme has been put in place to immunize children.

6. Background Documents

6.1 Public Health in Local Government, Commissioning Responsibilities, Department of Health, Dec 2011

7. Contact details

Report Author

- Dr Faiza Khan, Consultant in Public Health
- 0300 333 5052
- faiza.khan@kent.gov.uk

Relevant Director:

- Meradin Peachey, Director of Public Health
- 01622 694293
- meradin.peachey@kent.gov.uk

[i] *Public Health in Local Government, Commissioning Responsibilities, Department of Health, Dec 2011*

From: Graham Gibbens, Cabinet Member Adult Social Care & Public Health

Meradin Peachey, Director of Public Health

To: Social Care & Public Health Cabinet Committee - 12th June 2013

Subject: **Health Protection Assurance**

Classification: Unrestricted

Electoral Division**:** Countywide

Summary: This paper provides an update and overview of how KCC will ensure its health protection duties are delivered in 2013/14.

- Emergency planning
- Immunisations
- Screening
- Severe weather events
- Infection control and health care acquired infections
- Response to outbreaks and other health protection incidents, not requiring an emergency planning response

Recommendation(s):

The Cabinet Committee is asked to consider and endorse the reporting arrangements and organisational structures designed to ensure health protection assurance and delivery of the new health protection duties of Kent County Council.

1. Introduction

1.1 The purpose of this paper is to provide assurance to members on the implementation of their new statutory health protection function. The following elements of health protection need to be covered by structures and reporting arrangements and they are dealt with in turn in this document

- Emergency planning
- Immunisations
- Screening
- Severe weather events
- Infection control and health care acquired infections
- Response to outbreaks and other health protection incidents, not requiring an emergency planning response

2. Financial Implications

2.1 A health protection budget has been set aside to enable the DPH to carry out the above functions.

3. Detail

3.1 Background

3.1.1 Directors of Public Health acting on behalf of the local authority will have a pivotal role in protecting the health of its population. Under this duty, local authorities (and Directors of Public Health on their behalf will be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full scale emergencies, and to prevent as far as possible those threats arising in the first place.

3.2 Key Partners in the new health system for health protection are:

- The NHS England Area Team
- The Public Health England Centre (Surrey , Sussex, Kent)
- Public Health in Kent County Council
- Providers of health services
- Providers of Social Care Services
- 7 CCGs in Kent

3.3 Regulations pertaining to Health Protection in Health and Social Care Act 2012

3.3.1 "Each local authority shall provide information and advice to every responsible person and relevant body within, or which exercises functions in relation to, the authority's area, with a view to promoting the preparation of appropriate local health protection arrangements ("health protection arrangements"), or the participation in such arrangements, by that person or body…..

The information and advice which a local authority shall provide in relation to health protection arrangements may address any threat to the health of individuals in the authority's area and, in particular, may concern arrangements to deal with the following:

- infectious disease;
- environmental hazards and contamination; and
- extreme weather events.

The information and advice which is to be provided by the local authority in relation to health protection arrangements shall be determined by the authority having regard to the needs of individuals in the authority's area and may include information and advice relating to the following:

- the appropriate co-ordination of roles and responsibilities between any responsible or relevant bodies;
- effective testing by the responsible and relevant bodies of the health protection arrangements;
- appropriate emergency provision to deal with incidents which occur outside the normal working hours of the responsible or relevant bodies;
- arrangements for epidemiological surveillance;
- arrangements for environmental hazard monitoring;
- arrangements with other local authorities for managing incidents which affect the area of more than one authority in an integrated and coordinated manner;
- arrangements for stockpiling of medicines and medical supplies."

3.4 Emergency Planning – How this will be done

3.4.1 The emergency preparedness and response function is covered by the following arrangements. The Local Health Resilience Partnership (LHRP), co-chaired by the Lead Director of Public Health and the NHS England Area Team Director, provides a framework for local assurance, including maintaining an accurate assessment of the effectiveness of the resilience capability and capacity across all member organisations.

- That the plans reflect the strategic leadership referenced and thus will ensure robust service and local level response to emergencies.
- Coordination between health organisations is included within the plans.
- That there is opportunity for co-ordinated exercising of local and service level plans in accordance with Department of Health (DH) policy and the CCA 2004.
- That the health sector is integrated into appropriate wider Emergency plans and structures of civil resilience partner organisations within the Local Resilience F ora area(s) covered by the LHRP.
- That co-ordination and understanding between the LRF and local health providers is reviewed and continually improved.
- That provision is in place to coordinate with neighbouring LHRPs, (and where appropriate EPRR organisations in neighbouring Devolved Administrations) and regional arrangements are in place to develop and maintain mutual aid and integrated health response arrangements.
- That arrangements (including trigger mechanisms and activation and escalation arrangements) are in place for providing and maintaining health representation at multi-agency controls (Gold/Silver commands) during actual or threatened emergencies.
- An on call rota has been developed for the Kent and Medway Public Health Consultants to work alongside the emergency planning team in KCC.

3.5 Response to outbreaks not requiring an emergency response – how this will be done

3.5.1 KCC will need to respond to outbreaks and other health protection incidents not requiring an emergency planning response. Central to this is appropriate urgent notification of, and involvement with, incidents and outbreaks to Director of Public Health and her team to enable them to take appropriate steps. Outbreaks will be reported by Public Health England representative to the Health Protection Committee by exception.

3.6 Immunisations

3.6.1 **Directors of Public Health will also need to ensure that there are local plans for immunisations**[i]

The Director of Public Health will advise on whether immunisations programmes in the area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS England Area Team on its performance through the JSNA and discussions at the health and wellbeing board on issues such as raising uptake of immunisations and how outcomes might be improved by addressing local factors. They will also have a role in championing

immunisation, using their relationships with local clinicians and CCG and in contributing to the management of serious incidents. Directors of Public Health will play a role in ensuring that immunisation care pathways for programmes such as neonatal hepatitis B are robust. The Director of Public Health will need to ensure that the CCGs respond appropriately to any challenges from the local public health teams and make any improvements where required.

3.7 Screening

3.7.1 **There is also an expectation that under the duty of protecting the health of its population the Directors of Public Health will ensure that local plans exist for screening programmes**[i]

The Director of Public Health will advise on whether screening programmes in the area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS England Area Team on its performance through the JSNA and discussions at the health and wellbeing board on issues such as raising uptake of screening and how outcomes might be improved by addressing local factors. They will also have a role in championing screening, using their relationships with local clinicians and CCG and in contributing to the management of serious incidents. Directors of Public Health will play a role in ensuring that screening care pathways for programmes such as the antenatal screening are robust. The Director of Public Health will need to ensure that the CCGs respond appropriately to any challenges from the local public health teams and make any improvements where required.

3.7.2 How this will be done

3.7.2.1 In Kent and Medway the assurance for screening and immunisations will be sought through the Health Protection Committee which is proposed as a subcommittee of the Kent Health and Wellbeing Board. The screening and immunisation leads at NHS England will provide the Health Protection Committee with appropriate assurance reports. Where services are not delivering to a high standard for the population of Kent and Medway , NHS England will be invited to provide further assurance , such as action plans to address shortfalls.The collective purpose of the Kent and Medway Health Protection Committee is to provide assurance on behalf of the population of Kent and Medway that there are safe and effective plans in place to protect the populations health, to include communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, screening and immunisation programmes.

3.7.2.2 The Committee will comprise a number of professional partner members who hold health protection responsibilities to include the following: communicable diseases (Public Health England), local health resilience partnership, emergency planning, infection prevention and control, sexual health, antenatal/new born and adult screening, and immunisation & vaccination.

3.7.2.3 The Health Protection Committee will carry out a health protection assurance function on behalf of the Health and Wellbeing Boards from April

2013. (The reporting arrangements are shown in the appendix to this report.)

3.7.2.4 NHS England Area Team will be establishing mechanisms for the co-ordination of immunisation work in Kent and Medway. Monitoring reports on immunisation uptake and associated issues in Kent and Medway will be provided to the Health Protection Committee by the NHS England.

3.7.2.5 NHS England Area Team will be establishing arrangements for the different screening issues (e.g breast, cervical, diabetic eye screening). Monitoring reports will be provided to the Health Protection Committee by the NHS England Area Team.

3.7.2.6 Extraordinary risk concerns and complex risk management issues will be escalated to the Health and Wellbeing Boards as well as through partner organisations as appropriate.

3.8 Extreme Weather Events – Heat wave plan

3.8.1 Public Health are working with the Emergency Planning Team at KCC to develop a cascading mechanism for distributing information about heat wave to nursing homes, schools, detention centres, care homes and hospitals etc. In addition fact sheets are being developed containing relevant information for different organisations. Audits will be undertaken to ascertain whether any action plans have been developed in response to the information cascaded.

3.9 Infection Control

3.9.1 Acute providers will be required to produce plans for prevention and control of infection, including those which are healthcare related. It is the responsibility of the Director of Public Health to ensure these plans exist and are robust.

3.9.2 Disputed cases of Methicillin Resistant Staphylococcus Aures Blood Stream Infection (MRSA BSI)

3.9.3 Involvement of the Director of Public Health

- In exceptional cases, where the acute trust or the CCG is unable to determine within one week which organisation should be assigned a case of MRSA BSI, the DPH of the local authority responsible for the CCG of the patient *will be informed and is expected to then lead a review panel to assess the evidence presented in the PIR*. The DPH can call on the assistance of CCGs, DIPC or equivalent, PHE and others as appropriate.
- The DCS will automatically notify the relevant DPH if no final assignment has been made within 7 days of the PIR being initiated.
- The result of the DPH's PIR Panel will be reported on the DCS within 14 days of the notification to the DPH, and the outcome discussed with the relevant Trust and CCG. If it emerges that there are some incidents which require reporting to other authorities these should also be agreed at the DPH-led panel meeting.

- The data from the PIR process will help the DsPH assure themselves that the infection prevention and control processes of providers and commissioners within their areas are targeting any systemic weaknesses in infection prevention and control at a local level.

- As part of their oversight remit with respect to protecting public health under the new healthcare system, the DPH may wish to conduct regular audits of cases within their local areas, to ensure that the patients are being managed appropriately, that the PIRs are being conducted properly and that all is being done to reduce infections. The data from the PIRs held on the DCS should be used to help to fulfil this function.

- In cases where a PIR has not been submitted by the due deadline, the DCS system will inform the DPH of the Local Authority containing the CCG with responsibility for the patient who will decide on the final assigning of the case.

3.9.4 How this will be done

3.9.4.1 Public Health Kent has employed, initially for a three month period, an Infection Control nurse who is providing infection control support for KCC and 4 CCGs in Kent.

- CCG CNO have set up data capture systems for MRSA and C Diff with their providers and share data with PH
- CCG CNOs are working with KMCS re data reports and quality challenge (Swale will lead SeCAMB and WKCCG KMPT)
- data will be shared with the AT
- the PIR process is led by each CCG CNO, depending where the issue is. the PH will support the PIR process
- the PH ICN will liaise with PH England to ensure matters of non NHS outbreaks etc. are shared
- monthly infection control reports will be generated by the PH team
- each CCG CNO will link with their medicines management colleagues re antibiotic usage reports etc.
- each CCG CNO needs to set up relevant infection control logins to the national system
- primary care infection control issues and offender health will be overseen by the AT
- E coli, MSSA, and TB will be included in the planning
- PH will do audits to ensure that organisations are compliant with the IC policies.

4. Recommendation(s)

Recommendation(s):

The Cabinet Committee is asked to consider and endorse the reporting arrangements and organisational structures designed to ensure health protection assurance and delivery of the new health protection duties of Kent County Council.

5. Background Documents

5.1 Health and Social Care Act
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

5.2 Heat Wave Plan 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/201039/Heatwave-Main_Plan-2013.pdf

6. Contact details

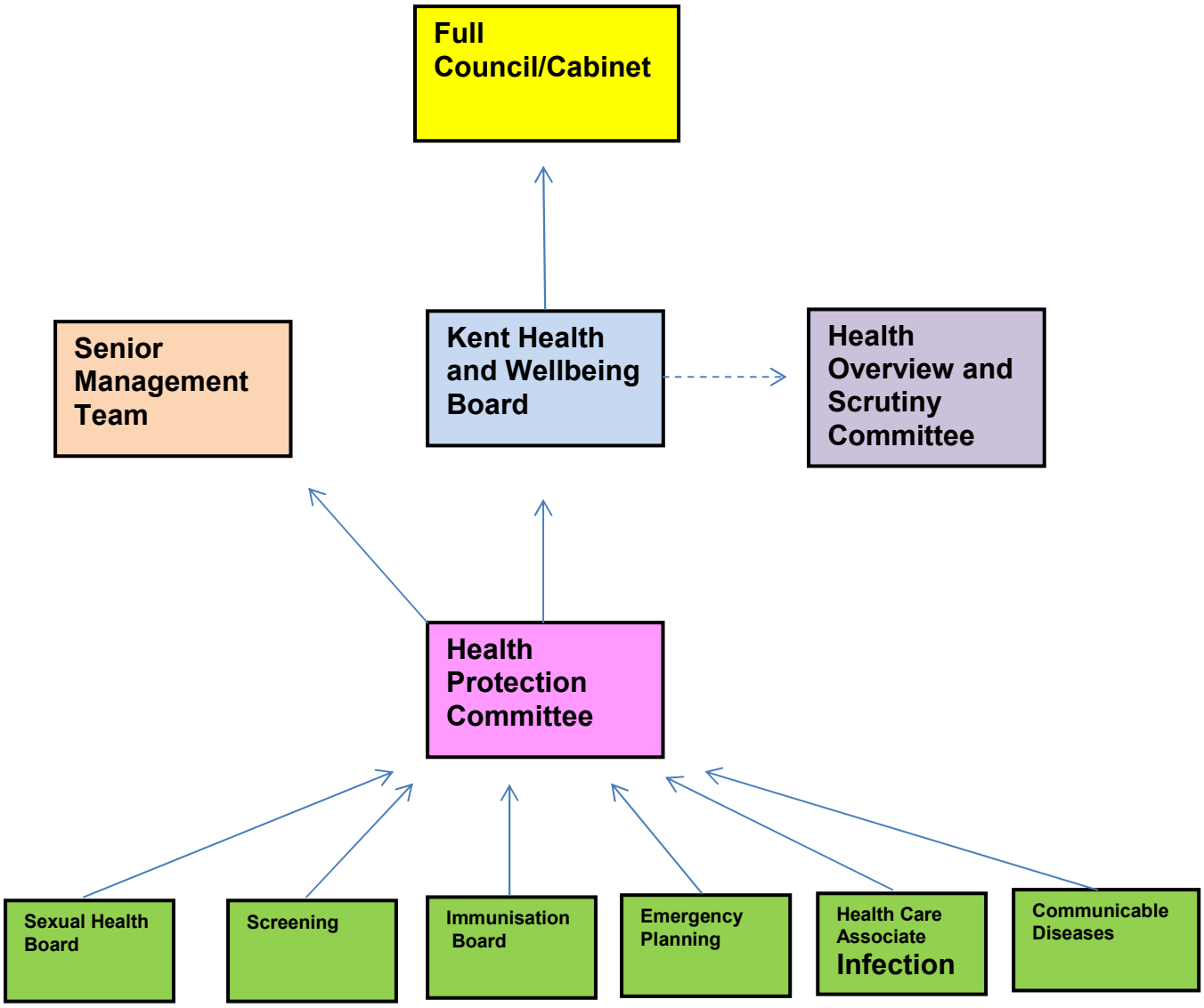
Report Author

- Faiza Khan, Consultant in Public Health
- 0300 333 5250
- faiza.khan@kent.gov.uk

Relevant Director:

- Meradin Peachey, Director of Public Health
- 01622 694293
- meradin.peachey@kent.gov.uk

Reporting Arrangements



By:	Jenny Whittle, Cabinet Member for Specialist Children's Services Andrew Ireland, Corporate Director for Families and Social Care
To:	Social Care and Public Health Committee – 12 June 2013
Subject:	**CHILDREN'S SERVICES IMPROVEMENT PLAN UPDATE**
Classification:	Unrestricted

Summary:	This report summarises the key improvement work in children's services since January 2013

1. Introduction

1.1 The last Children's Services Improvement Panel (CSIP) was in January 2013; the subsequent one was cancelled due to close proximity to election. This report summarises the key improvement work in children's services since that date.

1.2 Members will recall that Ofsted conducted an unannounced Safeguarding Inspection in November 2012. The report of that inspection was published in January 2013. The overall judgement was that services are now 'adequate' and the report commented positively on progress made since the last report as well as identifying further improvement work still required. It was of note that the inspectors did not find any children at risk of immediate significant harm and they also commented positively on the high level of self-awareness within the service.

1.3 The service also was subject to an inspection into its adoption function carried out by Ofsted in March. Unfortunately, the draft report has not yet been received by the Council so we are unable to comment more formally at this stage about either its judgements or our response to any recommendations. The verbal feedback given at the end of the inspection (22nd March) appeared to be satisfactory although we did write to the lead inspector seeking clarification of some of the evidence they quoted in that session and how it was being used to support their overall judgements.

1.4 As a consequence of the safeguarding inspection and what we expect to be a satisfactory adoption inspection judgement, Kent has now received the new revised Improvement Notice, appended to this report. Its contents have been arrived at through some helpful negotiation with the DfE and Board members will note the increased expectations set on partners, especially through the KSCB, and the decrease in the numbers of specific targets and focus on processes to a greater focus on outcomes for children. Set out below is how we will be responding to the various demands within the Notice.

1.5 There are two significant changes nationally which will potentially impact upon the way the service is judged in the future and in particular how services to children in

care are judged given that remains the one area from the 2010 inspection not yet subject to follow up scrutiny.

1.6 Firstly, the Children's Improvement Board had, rather unexpectedly, its funding withdrawn by the DfE so it will not exist post July 2013. There are discussions within the sector about the ability to maintain some of its work without the infrastructure or funding but it will impact on future functioning of peer reviews.

1.7 Secondly, there have been some substantial changes in Ofsted away from their proposed inspection regime for this and future years. They have dropped their commitment to generate a multi-inspectorate safeguarding inspection and their commitment to work with CQC to generate a Children in Care inspection regime. Instead we now know they will return to a joint safeguarding and children in care inspection run solely by themselves, not dissimilar therefore to the inspection we had in 2010 and which they intend to start delivering from September 2013. They have also announced that they intend to run some children in care only inspections through the summer until the new regime is agreed.

1.8 This is a confused and changeable picture and it is difficult to be clear about implications for Kent. Officers are proceeding on the basis that an inspection into our children in care services could still be conducted at any time (and will almost certainly be unannounced) and we remain focussed on continuing to improve services such that any inspection will be satisfactory and, most importantly, outcomes for children are improved.

2. Improvement Notice

2.1. Kent's response to the Notice will be captured in seven ways:

a. **Ofsted Inspection Follow-Up** – the safeguarding inspection made a number of recommendations all of which are due for completion by July.

b. **Quality and effectiveness of social work practice** – this work will be driven through our delivery of the 'Social Work Contract' and its constituent parts. This is a comprehensive and ambitious programme but one we are confident will deliver the quality of social work practice required in the County if we are to meet the needs of our service users. A more detailed implementation plan will be developed but it is important to clarify that the work described in it could never be said to be 'finished' and that there will always be developments in our supervision, learning and development offer, systems and IT etc. We are also in the early stages of developing a similar contract more specifically applicable for staff in our children's centres and early intervention teams.

c. **Workforce Development** – we are continuing to develop our place in what remains a very competitive market through a developing recruitment and retention strategy and we have developed a new and much improved recruitment micro-site: (http://www.kent.gov.uk/jobs_and_careers/draft/childrens_social_care.aspx)

As the social work contract develops and its products become more evident to staff, so we anticipate it impacting positively on both our recruitment and our retention rates.

d. **KSCB** – its Business Plan sets out what it will focus on in the coming year and the Chair will be providing regular updates to the Improvement Board.

e. **CAMHS Service** – improvements to these services will be reported on by health colleagues and the Board may wish to set out more detail about what it would like to be informed about and its meeting schedule.

f. **Adoption** – future developments in the Adoption Service will be set by both the continued partnership work with Coram and the following of the Ofsted report and its recommendations. The Adoption Sub Group will continue to scrutinise plans and progress actions as required.

g. **Performance Information** – finally, whilst the new Improvement Notice helpfully excludes any specific data-driven targets, we will continue to table the County Scorecard. The Scorecard has been developed further for 2013-14 and a report setting out end of year outline and a rationale for the new scorecard is attached.

2.2. Specialist Children's Services has developed a new **Quality Assurance Framework.** This refreshes the previous policy and captures the comprehensive and holistic nature of the approach we are seeking to take. Members can have some confidence that the focus on performance that has been evident in the service since 2010 will not be lessened. The key points in the framework are that:

a. It places the prime responsibility for practice improvement with the operational team and services.

b. We have re-configured all our performance and quality assurance staff to better support and challenge operational teams and services.

c. It retains the centrality of the "Deep Dive" methodology as our prime performance management process. Significant changes are detailed in the Framework, notably the expectation that areas generate their own self-evaluation to initiate each deep dive and that each sessions is informed by data analysis; IRO and Conference Chair feedback; file audits and service user feedback including complaints

2.3. Separately tabled to this meeting is the performance outturn for SCS for 2012-13 Overall the scorecard presents some very satisfactory evidence about progress within the service with 22 indicators rated on green, 13 on amber and 9 on red (two of those, placement stability and children subject to plans for 2+ years are arguably against ambitious targets.)

a. Children subject to a second or subsequent child protection plan. This remains higher than target and the focus on the quality of risk assessment; of child

protection plan construction and delivery on “step down” arrangements will continue.

b. Section 47 Investigations proceeding to Initial Child Protection Case Conference – 36% remain low and we will retain a focus on ensuring that initial risk assessments are proportionate and that formal investigation only convened as required.

c. The timeliness of children moving through care proceedings and where appropriate, on to adoption will remain an area of major focus in the service. We are aware that there remain some “historical” cases in the systems which, although now being properly managed through the system, will continue to have a negative impact on our performance reporting.

2.4 Managers in the service have worked on the construction of a new scorecard, set against some new (or revised) targets. A detailed explanation for each KPI, the targets and the tolerance bandings for the RAG ratings is available if required. We also have developed or are finalising detailed and specific scorecards for some of our specialist service provision – early intervention, fostering, adoption, Catch 22 and disabled services all now have their own dedicated scorecards and the overall County scorecard captures the key data from each of them.

The key changes from last year are:

a. The layout now better reflects the journey of the child through our system, from CAF-related measures through to children in care and adoption.

b. Some of the activity measures no longer have targets attached to them. Number of referrals, number of initial and core assessments, number of children in need etc. are all rates we need to continually monitor and track any variation over time or across areas. However, they are activity levels only and setting targets implies a desired level to be attained and remedial action to be taken if those levels not attained. There is sufficient evidence now to suggest that the previously month-on-month variations in activity rates have now dissipated and all are now at steady levels.

c. A number of targets that were not attained or are set at what remains a realistic and ambitious level in 2012-13 have been rolled forward, e.g. number of CAFs; length of CP plans.

d. In advance of developing our response to the single assessment as set out in ‘Working Together’ (a Government document that sets out the inter-agency arrangements for the safeguarding of children, a revised version of which was published in March 2013 and set out some changes consistent with the recommendation s of the report into child protection carried out by Professor Munro in May 2011), we will now be measuring initial assessments on a ten month rather than seven day timescale.

2.5 Finally, it is important to highlight our continuing focus on improving front line practice. In particular we are implementing two key changes in the service:

a. Firstly, we are revising and re-providing the Practice Improvement Programme (PIP) carried out throughout the service during 2012. This was experienced as a successful intervention and worked well with front line staff to identify areas of vulnerability and work with them to address and improve those areas. The PIP moved across the entire County and all operational teams were covered. For 2013, the programme is being repeated as the Practice Development Programme (to build on previous improvements). A series of initial scoping meetings have been held with operational management teams to set out the specific areas to be addressed through this programme and a programme constructed in response. The PIP2 will be more inclusive than the PIP, integrating the skills and expertise already present in the teams and working with staff.

b. Secondly, in order to further develop the Social Work Contract (referenced in 2.1.b) and for the service to respond pro-actively to the new 'Working Together', a number of Expert Practitioner Reference Groups are being convened. They have been formed through management nominations and constitute some of our very best and most effective practitioners.

2.6 It is crucial that both these areas work for front-line staff and are developed in ways that enable them to practice in the way we and they want to. It is also a welcome opportunity to acknowledge the skills and expertise we have in our own workforce.

2.7 The Children's Services Improvement Panel will resume meetings shortly, giving Members who would like to join the Panel, an opportunity to be involved in regular in-depth scrutiny of the quality and availability of services for vulnerable children.

3. Recommendations

Members of the Cabinet are asked to NOTE and comment on the contents of this report.

4. Contact Details

Name of author: Mark Gurrey
Job Title: Assistant Director of Safeguarding
Telephone: 01622 69485
Email: mark.gurrey@kent.gov.uk

Background documents: *none*

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By:	Jenny Whittle, Cabinet Member for Specialist Children's Services Andrew Ireland, Corporate Director Families and Social Care
To:	Social Care & Public Health Cabinet Committee - 12 June 2013
Subject:	**Child and Adolescent Mental Health Services (CAMHS) Update**
Classification:	Unrestricted

Summary: This report updates the Cabinet Committee on the Community Children and Young People's Mental Health Services (CAMHS).

1. Introduction

1.1 At the previous meeting in March 2013, Members expressed concern regarding the waiting list for the Community Children and Young People's Mental Health Service (CAMHS) and requested a further update on progress made.

2. Background

2.1 The service is provided by Sussex Partnership Foundation Trust (SPFT). The contract started on 1 September 2012.

2.2 The annual total value of the children and young people's mental health service is £14m of which KCC contributes £1m, specifically for the Children in Care (CIC) element of the service.

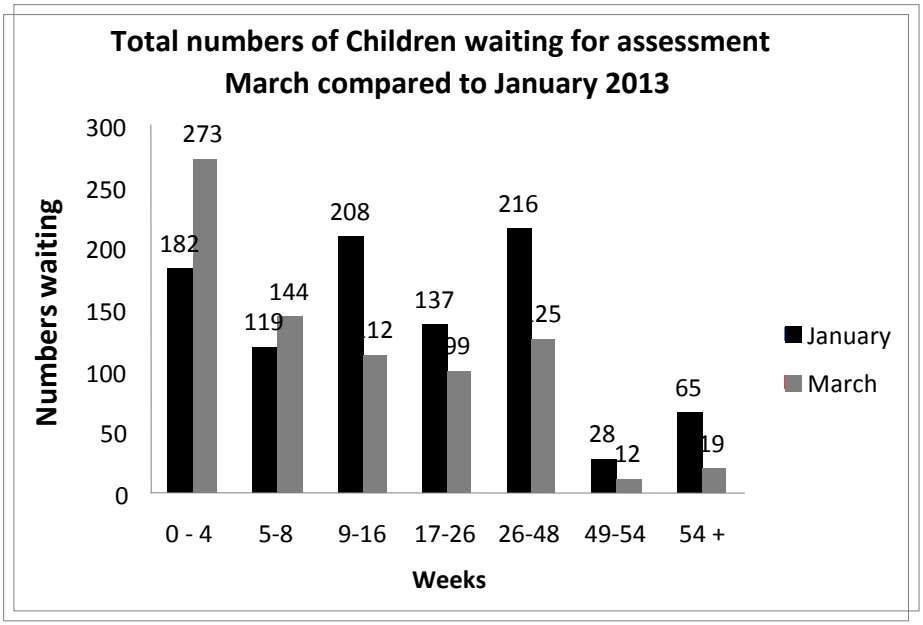
2.3 Since the start of the contract SPFT have undertaken a major review and restructure of the service, both the Community CAMHS and Children in Care elements as outlined in the previous paper (March 2013, attached at the end of this paper).

2.4 At the time of taking over the contract, SPFT inherited significant waiting lists which they have been working to reduce. They have an action plan in place to reduce the waiting times to 4-6 weeks by the end of July.

3. Progress

3.1 There has been a significant improvement in the numbers awaiting assessment. Figure 1 below shows the reduction in total number of children waiting.

Figure 1.



3.2 In East Kent the average waiting time for assessment is 6 weeks or less. In West Kent the average waiting time for assessment ranges from 9 weeks to 38 weeks. It should be noted that the waiting time for the tier 3, specialist services is shorter than for tier 2 services.

3.3 The pressure on waiting times has been greater in West Kent and this is where SPFT has focused the waiting list initiative. This process has been hampered by the need to recruit suitable staff to undertake the assessments. The proximity to neighbouring London Trusts has made recruitment more difficult and they have had only marginal success. However, some additional staff are in the process of moving from East to West teams and a major recruitment campaign is underway. The difficulty in recruiting staff has not taken the trajectory for recovery plan off course but has meant that the provider has not been able to improve the trajectory and achieve the target any sooner.

3.4 Teams in West Kent are showing improvements in their average waiting time (Figures 2 and 3). There remains pressure for tier 2 services in Dartford where the rate of progress has been the slowest due to staff shortages as outlined above.

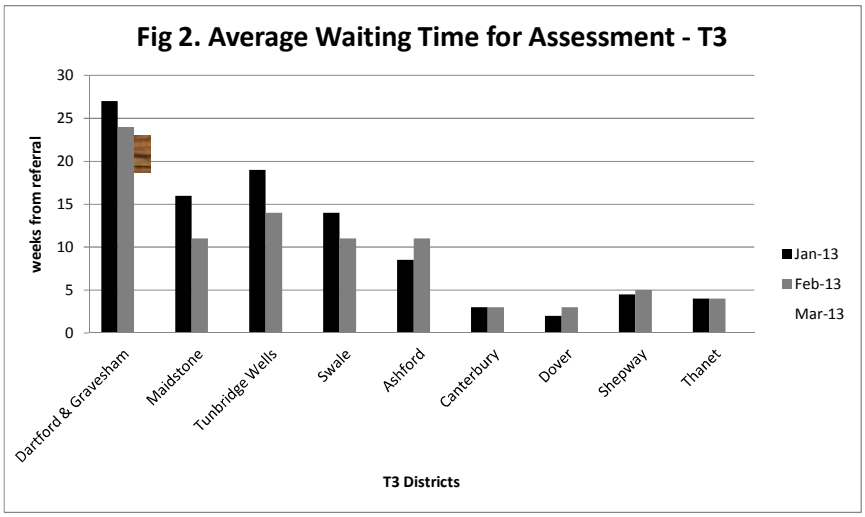


Table 2. Average waiting times (weeks from referral) Tier 3

	Jan-13	Feb-13	Mar-13
Dartford & Gravesham	27	24	23
Maidstone	16	11	9
Tunbridge Wells	19	14	13
Swale	14	11	7
Ashford	8.5	11	6
Canterbury	3	3	4
Dover	2	3	2.5
Shepway	4.5	5	0
Thanet	4	4	5

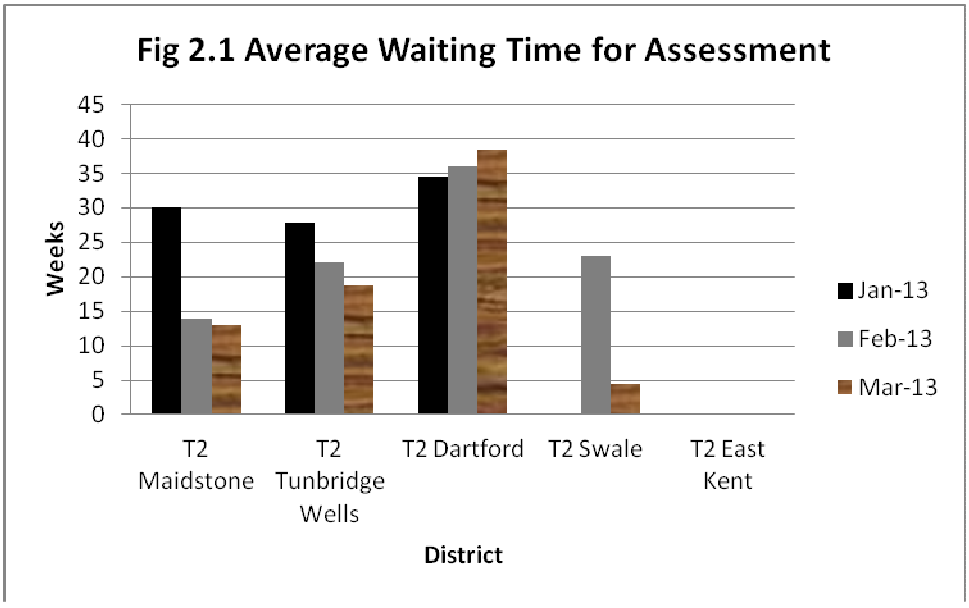


Table 2.1 Average waiting time for Assessment (Tier 2)

	Jan-13	Feb-13	Mar-13
T2 Maidstone	30	14	13
T2 Tunbridge Wells	27.8	22.05	18.7
T2 Dartford	34.5	36	38.5
T2 Swale	0	23	4.5
T2 East Kent	0	0	0

Further information showing the reduction in numbers waiting for assessment is given in appendix 1.

3.5 There has been an increase in the average waiting time for Tier 2 services in Dartford in March. SPFT report this is primarily a result of a focus on the T3 waiting lists within a district where there were insufficient staff numbers and inadequate focus of moving those children and young people on the inherited waiting lists onto more appropriate services.

3.6 SPFT are addressing the waiting times in Tunbridge Wells (T2) and Dartford and Gravesham (T3) and Dartford (T2) by introducing a taskforce of senior practitioners and staff to focus on the mechanisms for assessment and treatment. In addition, SPFT have deployed 8 staff from Sussex to work on bringing the waiting lists down with a specific focus on those who been waiting for a significant amount of time.

3.7 SPFT are prioritising those young people who are flagged up as urgent and have ensured that all families and referrers know that if the situation worsens to contact the service.

3.8 SPFT have systems in place to ensure that there should be no slippage once the waiting list target is achieved i.e. all routine appointments are seen within 4 -6 weeks for assessment and 8–10 weeks for follow up/ generic treatment. If, however, there is a change in referral pattern leading to an increase in numbers of young people requiring CAMHS, this will be flagged to commissioners at the monthly performance and contract review meeting.

3.7 The CAMHS - CIC service has been re-designed to provide a wider reach to this group and will be fully operational by July 2013. This follows a consultation with staff and will require further recruitment. CAMHS is currently working with a total of 296 Children in Care (CIC). The CAMHS-CIC service is providing support to 193 Kent CIC.

4. Reporting data

4.1 During May 2013 SPFT are implementing a new ICT system. Previously, data has had to be collated manually based around the teams and structure that the previous providers had in place.

4.2 The geographical areas covered by the teams are shown in appendix 2. Once the new ICT system is in place data will be provided routinely on the Clinical Commissioning Group boundaries. Information on the CIC will be provided on a district basis.

4.3 This report provides the most up to date information as at the end of March 2013. Further information will be provided at the Cabinet Committee meeting.

4.4 Members of the Cabinet Committee requested information on the funding of the Kent contract in comparison to other areas where SPFT are providing services. This is as follows;

Area	Contract value	Population
Kent and Medway	£15 million (but does not include services provided by Medway UA)	1.7 million
Sussex (including east, west and Brighton)	£12 million (but does not include services provided by Brighton UA)	1.5 million
Hampshire	£9 million	1.2 million

5. Conclusion

5.1 SPFT have completed two staff consultation exercises and are in the process of completing recruitment to the staff vacancies following the restructure.

5.2 SPFT remain confident that they can achieve the target of a 4 – 6 week wait for assessment by the end of July 2013.

6. Recommendations

The Social Care and Public Health Cabinet Committee is requested to note and comment on the contents of this paper.

7. Contact details

Ian Darbyshire, NHS Commissioning Manager. Tel: 07545934670
e-mail ian.darbyshire@nhs.net

Carol Infanti, Commissioning Officer, Tel: 01622 696299.
e-mail carol.infanti@kent.gov.uk

Background documents:

Social Care and Public Health Cabinet Committee – 21 March 2013 - Update on the Children & Young People's Mental Health Service (CAMHS)

K:\CFE Commissioning Unit\4

Reduction in numbers waiting for assessment **Appendix 1**

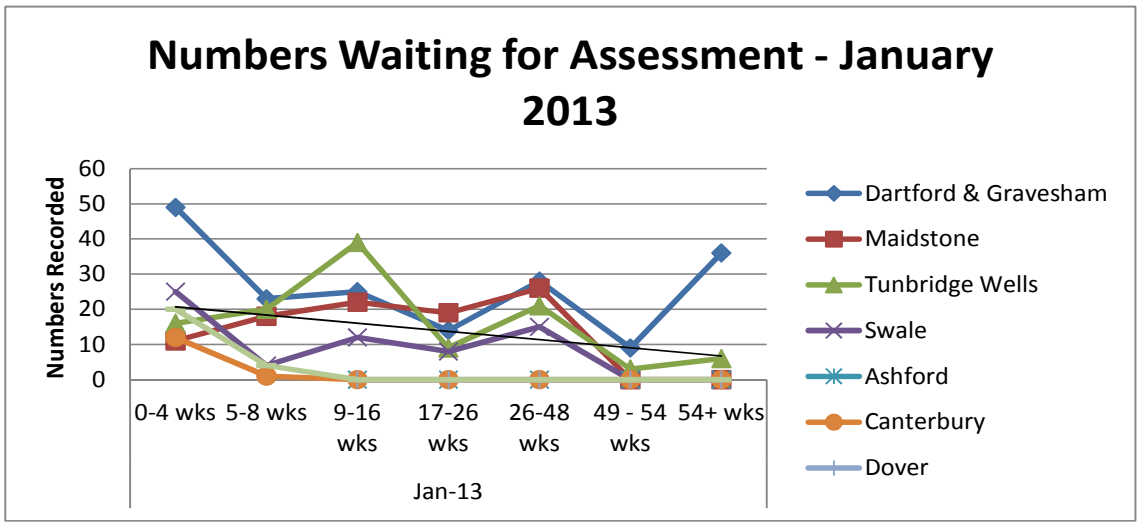


Table of Figures – January 2013

	Numbers waiting for assessment by weeks						
	0-4 wks	5-8 wks	9-16 wks	17-26 wks	26-48 wks	49 - 54 wks	54+ wks
Dartford & Gravesham	49	23	25	14	28	9	36
Maidstone	11	18	22	19	26	0	0
Tunbridge Wells	16	20	39	9	21	3	6
Swale	25	4	12	8	15	0	0
Ashford			0	0	0	0	0
Canterbury	12	1	0	0	0	0	0
Dover			0	0	0	0	0
Shepway			0	0	0	0	0
Thanet	20	4	0	0	0	0	0

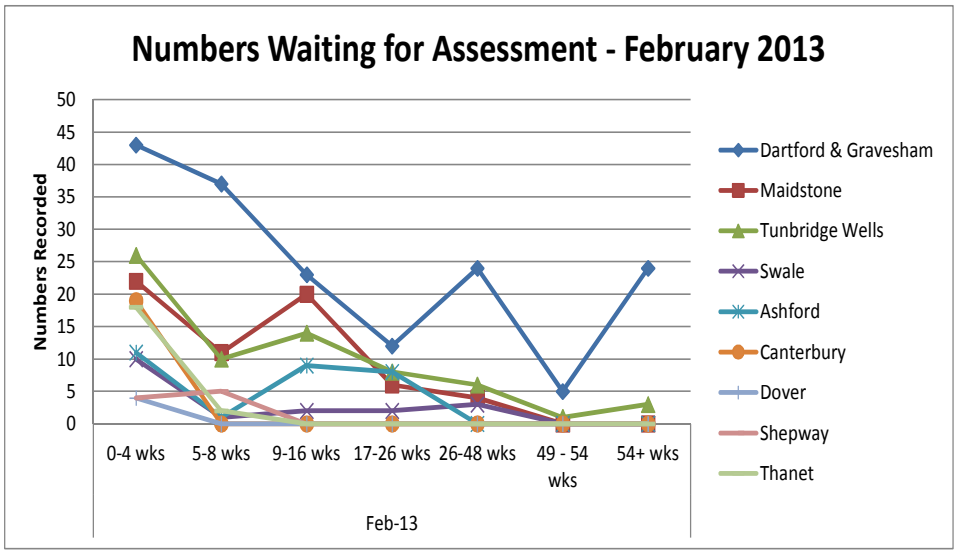


Table of Figures – February 2013

	Numbers waiting for assessment by weeks						
	0-4 wks	5-8 wks	9-16 wks	17-26 wks	26-48 wks	49 - 54 wks	54+ wks
Dartford & Gravesham	43	37	23	12	24	5	24
Maidstone	22	11	20	6	4	0	0
Tunbridge Wells	26	10	14	8	6	1	3
Swale	10	1	2	2	3	0	0
Ashford	11	1	9	8	0	0	0
Canterbury	19	0	0	0	0	0	0
Dover	4	0	0	0	0	0	0
Shepway	4	5	0	0	0	0	0
Thanet	18	2	0	0	0	0	0

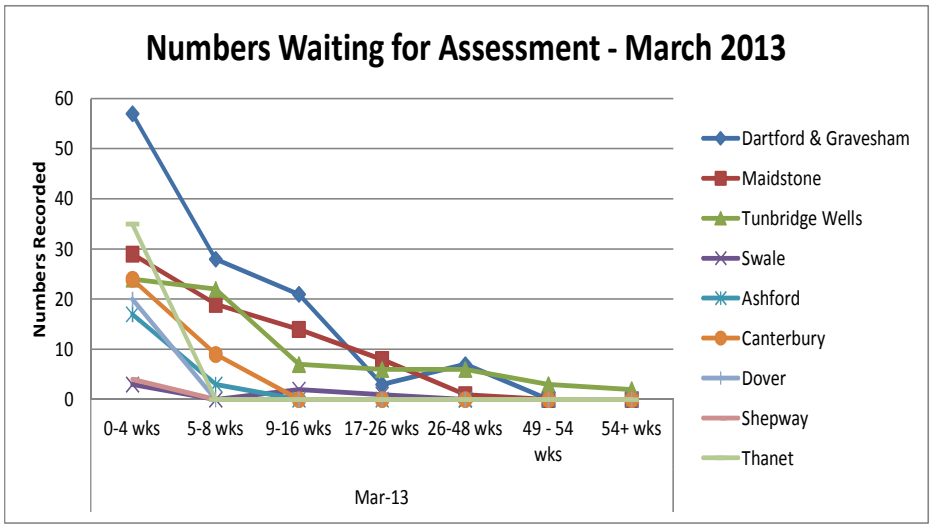


Table of Figures – March 2013

	Numbers waiting for assessment by weeks						
	0-4 wks	5-8 wks	9-16 wks	17-26 wks	26-48 wks	49 - 54 wks	54+ wks
Dartford & Gravesham	57	28	21	3	7	0	0
Maidstone	29	19	14	8	1	0	0
Tunbridge Wells	24	22	7	6	6	3	2
Swale	3	0	2	1	0	0	0
Ashford	17	3	0	0	0	0	0
Canterbury	24	9	0	0	0	0	0
Dover	20	0	0	0	0	0	0
Shepway	4	0	0	0	0	0	0
Thanet	35	0	0	0	0	0	0

Geographical areas - CAMHS Team Areas **Appendix 2**

Maidstone	Allington, Boxley, Detling and Thurnham, Hollingbourne, Harrietsham, Lenham, Leeds, Headcorn, Sutton Valence and Langley, Staplehurst, Marden, Yalding, Nettlestead, Coxheath & Hunton, Barming, East and West Farleigh, Maidstone, Wateringbury, Aylesford, Leybourne, Bearsted, Borough Green, Boughton Monchelsea, Burham, Snodland, Staplehurst, Headcorn, and West Malling.
Tunbridge Wells	Tunbridge Wells, Southborough, Paddock Wood, Cranbrook, Hawkhurst, East Peckham, Chiddingstone, Penshurst, Tonbridge, Hadlow, Sevenoaks, Edenbridge, Westerham, Knockholt, Crockenhill, Farningham, Snodland, Ditton, Burham, Wouldham, Blue Bell Hill, Aylesford and Wateringbury, Sevenoaks as far as Westerham and Dunton Green,
Dartford & Gravesend	Dartford, Stone, Darenth, Swanscombe, Southfleet, Longfield, Hartley, Horton Kirby, Crockenhill, Swanley, New Ash Green, Hextable , Cobham, Eynsford, Sutton at Hone, Wilmington, West Kingsdown, Higham, Gravesend, Fawkham, Joydens Wood, Northfleet & Greenhithe
Medway & Swale	Grain, Hoo, High Halstow, Cuxton with Medway GP, Higham with Medway GP, Strood, Rochester, Borstal, Chatham, Walderslade, Lordswood, Gillingham, Twydall, Rainham, Parkwood, Wigmore, Upchurch, Lower Halstow, Newington, Iwade, Sittingbourne, Milton, Kemsley, Bobbing, Murston, Babchild, Teynham, Queenborough, Sheerness, Minster, Eastchurch, Leysdown on Sea, Warden and Halfway
Ashford	Kennington, Mill Court, Willesborough, Kingsnorth, Singleton, Musgrove Park, Hollington, Tenterden, Wye,Charing, Hamstreet, Sellindge, Woodchurch, Chartham, Headcorn, Chilham.
Canterbury	Canterbury, Herne Bay, Whitstable, Wingham, Aylesham, Staple, Sturry, Faversham, Ospringe, Boughton, Chartham, Chilham, Littlebourne, Hersden.
Dover	Dover, Deal, St Margarets at Cliffe, St Martin's Mill, Sholden, River, Walmer, Eythorne, St Radigans, Temple Ewell, Shepherdswell, Tower Hamlets, Guston Aycliffe, Elvington and Whitfield
Shepway	Folkestone, Sandgate, Sandling, Elham, Capel le Ferne, part of Sellindge, Hawkinge, Densole, Lyminge, Lympne, Hythe, Seabrook, New Romney, Dymchurch, Dungeness, Greatstone, Littlestone, Brenzett, St Mary's Bay and Lydd.
Thanet	Margate, Ramsgate, Broadstairs, Minster, Monkton, Sartre, Ash, Eastry, Westgate, Westbrook, Sandwich
Learning Disability & Challenging Behaviour	The whole of the East Kent area
Tier 2 EK	The whole of the East Kent area.
T2 Swale	Isle of Sheppey (Sheerness, Minster, Queenborough, Warden and Leysdown), and Sittingbourne urban and rural – postcodes ME9, 10, 11 and 12
ACCENT West	Dartford, Gravesend and Swanley Sevenoaks Tonbridge and Malling Tunbridge Wells (from Southborough to just east of Cranbrook) Maidstone
ACCENT East	Swale (Isle of Sheppey, Sittingbourne, etc) Canterbury Thanet Dover Shepway (from Folkestone to Dungeness area on the coast and inland a fair way) Ashford (from the Sussex border up to slightly east of Chartham)

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee - 12 June 2013
Subject:	**KENT COUNTY COUNCIL'S LOCAL ACCOUNT FOR ADULT SOCIAL CARE FOR 2012-13**
Classification:	Unrestricted

Summary:	This report updates Cabinet Committee on the progress in developing the 2012-13 Local Account document. With the withdrawal of the Care Quality Commission (CQC) from assessing and rating Councils with Adult Social Care responsibility, there is now greater emphasis on Councils to work collaboratively to improve performance and outcomes for people. Sector Led Improvement is the national programme designed to do this, and one of the underpinning principles of the sector-led improvement programme in adult social care is a stronger accountability by using increased transparency to promote improvement in services. The publication of an annual Local Account is one means of achieving this. The 2011-12 Local Account was agreed in January 2013, and the development of the 2012-13 has started.
FOR COMMENT	

Introduction

1. (1) The Government's approach to the assessment of adult social care performance has changed in recent years. With the withdrawal of the Care Quality Commission (CQC) as the independent assessor of Council performance, there is now more emphasis on the requirement for councils to manage their own performance, work collaboratively with the sector to improve performance and outcomes and explain how they have performed to local residents. The Local Account has emerged as a standard feature of the new local accountability framework.

Policy Context

2. (1) The Publication of the 'Transparency in outcomes for Social Care' and the 'Vision for Social Care; Capable Communities and Active Citizens' in 2010, set out a future for people receiving support from Social Care which focused on outcomes, transparency and Quality and outlined the seven principles for a modern system of Social Care; Prevention, Personalisation, Partnership, Plurality, Protection, Productivity and people.

(2) The publication of the "Think Local, Act Personal" in 2011, a partnership agreement developed and co-designed by a number of national and local social care organisations, including service users and carers, set out the shared ambitions for moving forward with personalisation and community based support.

(3) More recently, the publication of the White Paper, "Caring for our future; reforming care and support" reinforces these visions, placing emphasis on maintaining independence, choice and control, quality, dignity and respect and clear information advice and guidance.

(4) With accountability moving from being a relationship between Councils and CQC to being a relationship between Councils and their communities, there is an expectation that Councils will work with their local communities, transparently. In addition, a new national performance framework is evolving which will help councils to manage their own performance collectively, through 'Sector Led Improvement' as well as to help Government to monitor the progress with these key priorities. It is expected that Councils will publish a "**Local Account**" to enable their service users, carers and communities to be able to hold them to account.

(5) Kent County Council published its first ever KCC Annual Report (Local Account) on Adult Social Care in December 2011. The second report, for 2011-12 was published in January 2013 after approval by the Cabinet Member for Adult Social Care & Public Health following discussions at the Cabinet Committee.

Progress on the 2012-13 Local Account.

3. (1) The Local Account is a new concept and has evolved over the last year as service users, carers and members were consulted.

(2) It was identified at the last Cabinet Committee that the process for developing the annual Local Account needs to engage more service users and carers, including partnership boards and the voluntary sector, as well include more timely information and data.

(3) It was agreed that the process should start much earlier on, in January 2013, so that Cabinet Committee can be updated of progress in June 2013.

(4) To date, there have been two workshops for service users, carers and the voluntary sector to engage people to consult on the content and the format of the document, as well as various visits to local forums and Service/ user groups, which has enabled us to consult with over 200 people.

(5) The learning disability partnership board has actively been consulting with people with a learning disability on our behalf.

(6) An initial draft report has been produced which is being revised to take into account the feedback from all the consultation. This will include revising the format of the content, including more information about accessing services and be simpler in format. Importantly, the document will be renamed, as "Local Account" was not deemed to be very dynamic.

(7) The revised draft report will then be scrutinised by an editorial board, which consists of volunteers from the consultation.

(8) In addition, Members from this Cabinet Committee will be invited to take part in reviewing the revised draft document before it is finalised.

Publication and feedback

4 (1) The final document will be ready for publication in July and will be circulated to Members prior to being published. The document will be signed off by the Cabinet Member and in taking this decision he will consider Members' comments and any recommendations made by this committee. It is also proposed that it is considered by the Cabinet Committee in September.

(2) There are already feedback mechanisms in place, including through the Kent County Council website, twitter, email, post and phone. These will be further publicised when the new report is released.

(3) Service users and carers will be encouraged to continue to play a part in the evaluation of the document.

Recommendations

5. Members of the Cabinet Committee are asked to note and comment on the progress in the development of the 2012-13 report.

Background Documents

Transparency in outcomes for Social Care' 2010

Vision for Social Care; Capable Communities and Active Citizens' 2010

Think Local, Act Personal 2011

Caring for our future: reforming care and support White Paper, Department of Health, 11 July 2012.

KCC Annual Report (Local Account) 2011-12

Contact details

Steph Abbott
Head of Performance and Information Management
Families and Social Care
Steph.abbott@kent.gov.uk
01622 221796

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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
Andrew Ireland, Corporate Director for Families and Social Care

To: Social Care and Public Health Cabinet Committee -12 June 2013

Subject: **FAMILIES AND SOCIAL CARE PERFORMANCE DASHBOARD FOR 2012/13 FOR ADULT SOCIAL CARE FOR MARCH 2013**

Classification: Unrestricted

Summary: The draft Families & Social Care performance dashboard provides members with progress against targets set for key performance and activity indicators for 2012-13 for Adult Social Care.

Additionally, the end of year business plan reports for the Older People & Physical Disability, Learning Disability & Mental Health and Strategic Commissioning divisions are attached for information.

Introduction

1. (1) Appendix 2 Part 4 of the Kent County Council Constitution states that:

"Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

(2) To this end, each Cabinet Committee is receiving a performance dashboard.

Performance Report

2. (1) The main element of the Performance Report can be found at Appendix A, which is the Adults Social Care dashboard which includes latest available results for the key performance and activity indicators.

(2) The Adult Social Care dashboard is a subset of the detailed monthly performance report that is used at team, DivMT and DMT level. The indicators included are based on key priorities for the Directorate, as outlined in the business plans, and include operational data that is regularly used within Directorate. The dashboard will evolve for Adults Social Care as the transformation programme is shaped.

(3) Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes, and this will be a key element for reviewing the dashboard

(4) A subset of these indicators is also used within the quarterly performance report, which is submitted to Cabinet.

(5) As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

(6) Performance results are assigned an alert on the following basis:

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

Amber: Performance is below current target but above minimum standard.

12/13 End of year business plan reports

3. (1) Each division within Families & Social Care produces an annual business plan. These are discussed by the Cabinet Committee prior to being agreed by Cabinet at the start of each business year. At the end of the business year, reports summarising the delivery of the plans is provided to Cabinet Committee.

(2) Attached for information, as Appendix B, are the 12/13 end of year business plan reports for:

- Older People & Physical Disability
- Learning Disability & Mental Health
- Strategic Commissioning

(3) As the Strategic Commissioning division supports both Adults' and Children's Services its report covers elements that that are outside the remit of adult social care but it is present here for completeness.

Recommendations

4. Members are asked to:

REVIEW and comment on the Families & Social Care performance dashboards

REVIEW and comment on the end of year business plan reports

Contact Information

Name: Steph Abbott
Title: Head of Performance for Adult Social Care
Tel No: 01622 221796
Email: steph.abbott@kent.gov.uk

Background documents:

None

Adult Social Care Dashboard

March 2013

APPENDIX A

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.

Adult Social Care Indicators

The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet, and a subset of these indicators feed into the Bold Steps Monitoring. This is clearly labelled on the summary and in the detail.

Some indicators are monthly indicators, some are annual, and this is clearly stated.

All information is as at March 2013 where possible, with a few indicators still requiring some update, with new targets and indicators being chosen.

Following months will provide all information.

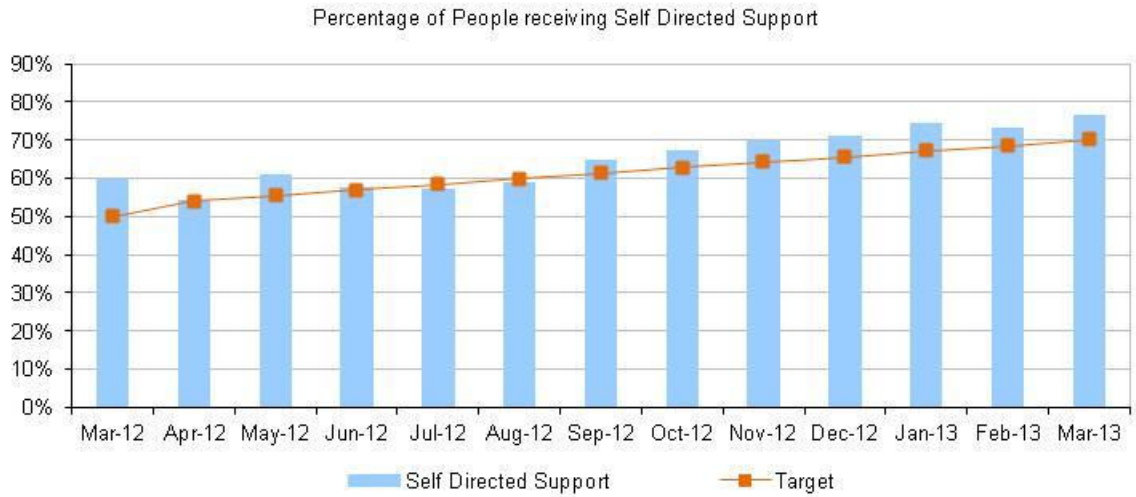
APPENDIX A

Summary of Performance for our KPIs

Indicator Description	Bold Steps	QPR	2011-12 Out-turn	2012-13 Target	Current Position	Data Period	RAG	Direction of Travel
1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment	Y	Y	59%	70%	**76.7%**	12M	GREEN	↑
2. Proportion of personal budgets given as a direct payment	Y		24.13%		**21.7%**	12M	**See Page 5**	
3. Number of adult social care clients receiving a telecare service	Y	Y	1032	1300	**1596**	Cumulative	GREEN	↑
4. Number of adult social care clients provided with an enablement service	Y	Y	612	700	**603**	Month	AMBER	↑
5. Percentage of adult social care assessments completed within six weeks		Y	76.68%	75%	**78.77%**	12M	GREEN	↑
6. Percentage of clients satisfied that desired outcomes have been achieved at their first review		Y	73.6%	75%	**72.5%**	Month	AMBER	↑
7. Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			85.9%	85%	**82%**	Month	AMBER	↑
8. Delayed Transfers of Care	Y		5.04	5.40	**5.63**	12M	AMBER	↑
9. Admissions to Permanent Residential Care for Older People			164	145	**149**	12M	AMBER	↓
10. People with Learning Disabilities in residential care	Y		1288	1260	**1265**	Month	AMBER	↑
11. Proportion of adults in contact with secondary Mental Health in settled accommodation	Y		62.0%	75%	**84%**	Quarterly	GREEN	→

APPENDIX A

1. 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/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



Data Notes.
Units of Measure: Percentage of people with an open service who have a Personal Budget or Direct Payment
Data Source: Adult Social Care Swift client System – Personal Budgets Report

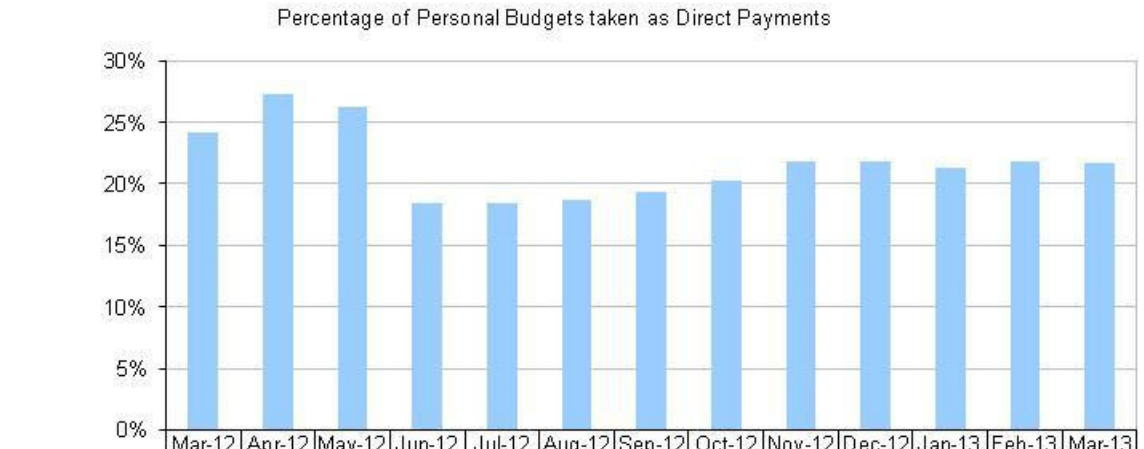
Data is reported as the snapshot position of current clients at the quarter end.

Quarterly Performance Report Indicator
Bold Step Indicator

Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Percentage	59.70%	54.30%	60.90%	57.50%	57.20%	58.90%	64.90%	67.20%	69.7%	71.20%	74.40%	73.09%	76.71%
Target	**50%**	**54%**	**55%**	**57%**	**58%**	**60%**	**61%**	**63%**	**64%**	**66%**	**67%**	**69%**	**70%**
Client Numbers	11416	10132	10549	10256	10453	10865	10612	11541	11595	11732	12192	12099	12225
RAG Rating	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

APPENDIX A

2. Proportion of Personal Budgets taken as Direct Payments



	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Direct Payments	24.13%	27.26%	26.29%	18.40%	18.42%	18.67%	19.4%	20.3%	21.8%	21.8%	21.3%	21.8%	21.7%

Data Notes.

Units of Measure: Percentage of Personal Budgets taken as a Direct Payment

Data Source: Adult Social Care Swift client System – Personal Budgets & Direct Payments Reports

Bold Steps indicator

Commentary

There has been some significant progress in recent months with the allocation of personal budgets. This has been achieved through the teams focussing on reviewing clients and ensuring that support plans are in place. Updated review and support planning policies have been reissued, together with a simpler data collection process. The allocation of personal budgets is part of the review and support plan process. Targets have been in place for the teams all year, which they are continuously monitored against. There are reports available for managers to use in supervision with their staff to ensure that clients are reviewed, have support plans and personal budgets.

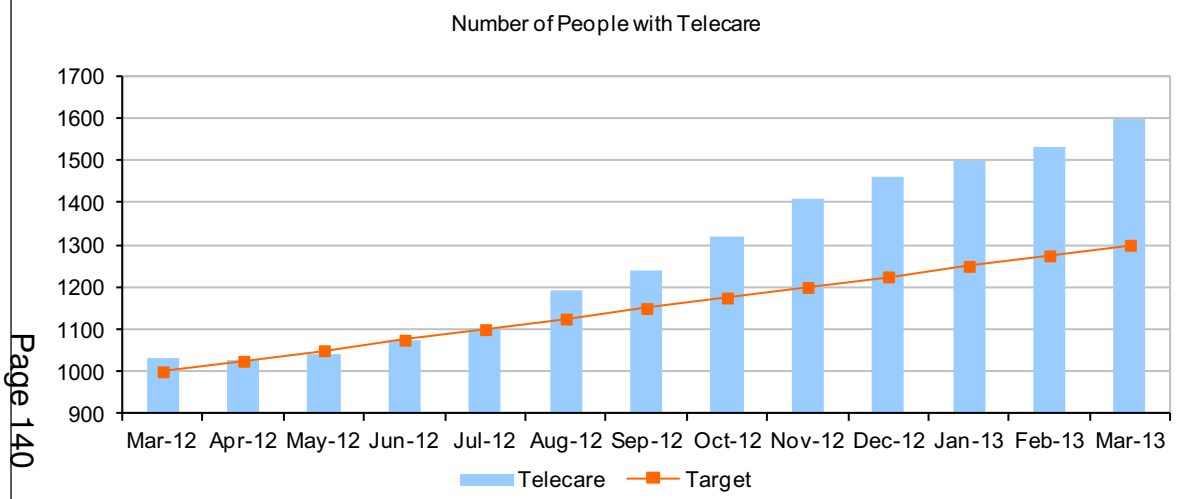
Continued emphasis and local monitoring of progress will continue, which will also ask Managers to raise training needs for both operational practice and system input in their teams so that this can be dealt with quickly.

The proportion of people who take their personal budget as a direct payment has increased in the last month.

NB: As discussed previously at Cabinet Committee, this indicator is not RAG rated because direct payments are a choice that service users take.

APPENDIX A

3. 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/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability/ Learning Disability and Mental Health



Data Notes.
Units of Measure: Snapshot of people with Telecare as at the end of each month
Data Source: Adult Social Care Swift client System

Quarterly Performance Report Indicator
Bold Step Indicator

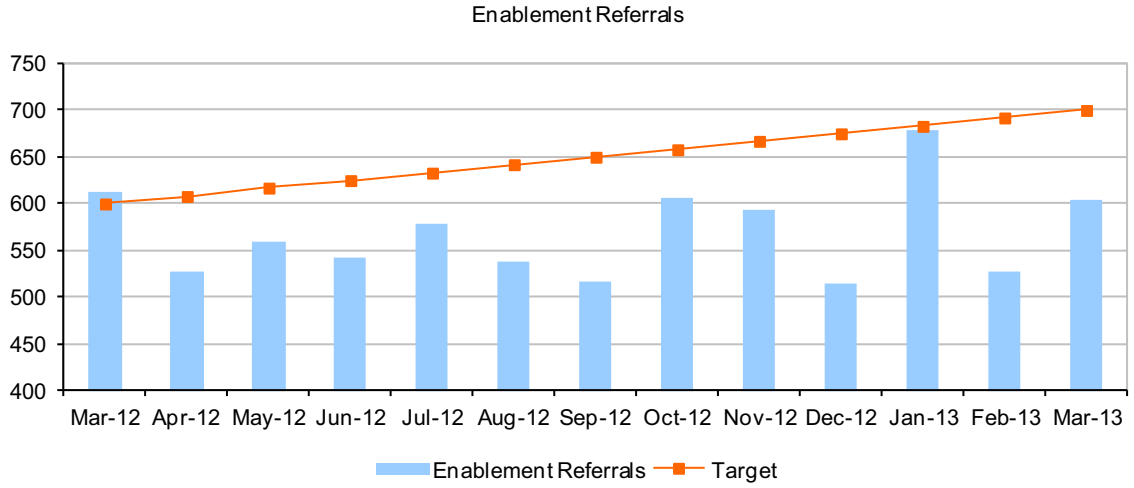
Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Telecare	1032	1027	1042	1074	1102	1192	1240	1321	1407	1460	1497	1534	1596
Target	**1000**	**1025**	**1050**	**1075**	**1100**	**1125**	**1150**	**1175**	**1200**	**1225**	**1250**	**1275**	**1300**
RAG Rating	GREEN	GREEN	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Telecare is now a mainstream service, after being managed centrally. The teams are now more experienced in considering telecare at every opportunity when assessing and reviewing clients as a means for maintaining independence. In addition, there is improved communication between the hospitals, the teams and the equipment store so data input is more timely. Targets have been set for all teams during the year, which are monitored on a monthly basis. There will be a focus on 2013-14 on the type of equipment being installed.

APPENDIX A

4. 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



Data Notes.
Units of Measure: Number of people who had a referral that led to an Enablement service
Data Source: Adult Social Care Swift client System – Enablement Services Report

Quarterly Performance Report indicator
Bold Steps Indicator

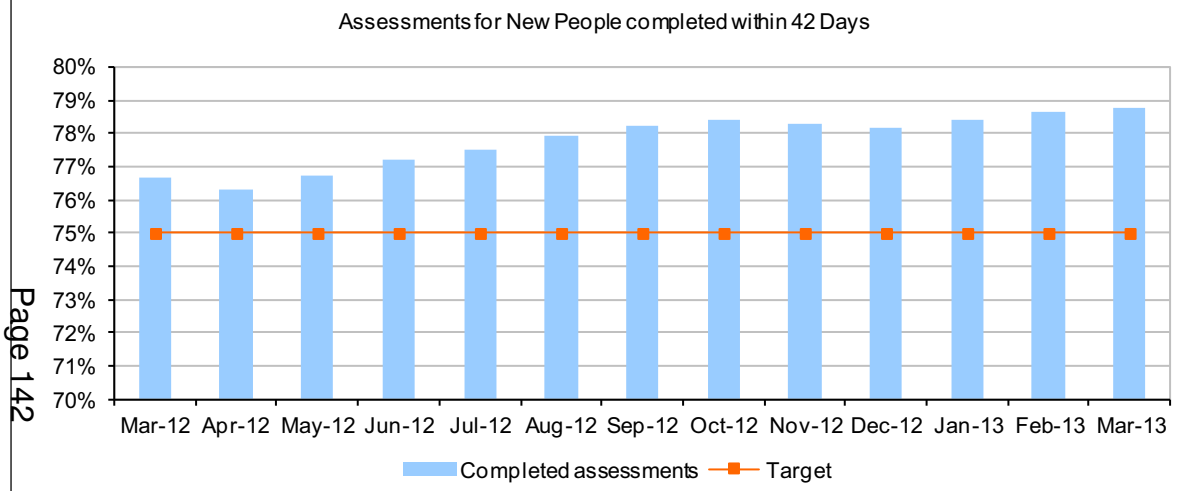
Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Enablement Referrals	612	527	560	542	579	538	517	605	593	514	679	527	603
Target	**600**	**608**	**617**	**625**	**633**	**642**	**650**	**658**	**667**	**675**	**683**	**692**	**700**
RAG Rating	GREEN	RED	AMBER	RED	AMBER	RED	RED	AMBER	AMBER	RED	AMBER	RED	RED

Commentary

Although higher, referrals to enablement are not at the anticipated levels. Targets are set for each team to ensure that the provision of enablement is maximised. In order to address these lower levels, research into the availability of enablement places for people has been undertaken, together with an analysis of reasons for placements being refused. In addition, it is becoming apparent that other key services such as intermediate care, provision of equipment, including telecare and the Short term bed strategy may be reducing the overall need for enablement. In addition, the enablement service will be increasingly supporting more people directly from hospital in a more effective way. This will ensure that more people are able to access enablement more quickly.

The indicator for next year will focus on all enabling services, including intermediate care and equipment.

5. 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/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



Data Notes.
Units of Measure: Percentage of assessments completed within 42 Days
Data Source: Adult Social Care Swift client System – Open Referrals without Support Plan Report

Quarterly Performance Report Indicator

Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Completed	76.7%	76.3%	76.8%	77.2%	77.5%	78.0%	78.2%	78.4%	78.27%	78.14%	78.41%	78.68%	78.77%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

The target for 2012/13 remains 75%, which represents an acceptable balance between timely completion of assessments and the provision of enablement to new people.

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.

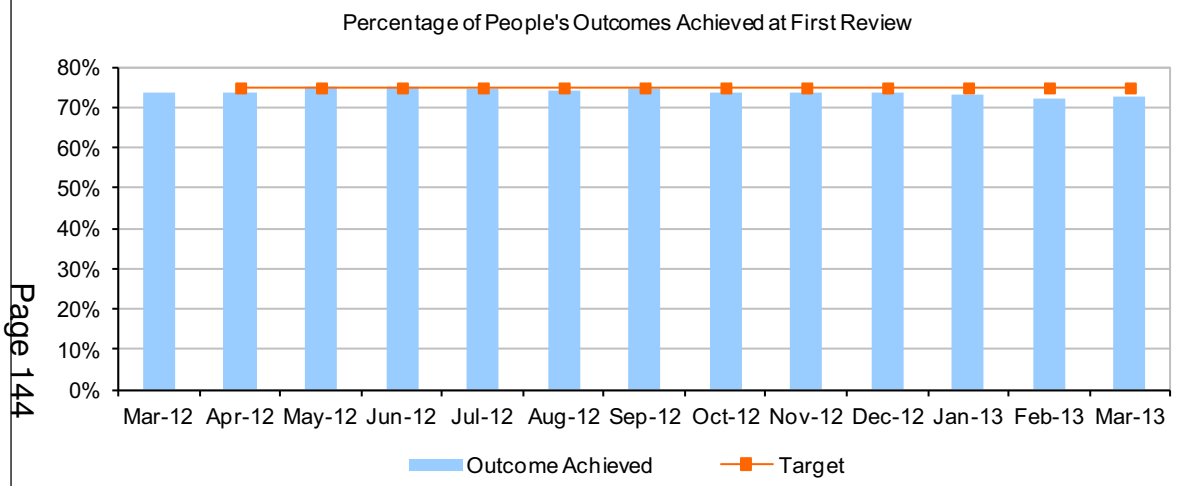
This indicator serves to ensure that we have the right balance between ensuring enablement is delivered effectively and ensuring the whole assessment process is timely. To this end we have reviewed the target and would expect 75% of assessments to be within 6 weeks, and

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.

As with the other performance indicators, these targets are set across all the teams and monitored through the Divisional Management teams on a monthly basis.

APPENDIX A

6. Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review			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/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



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.

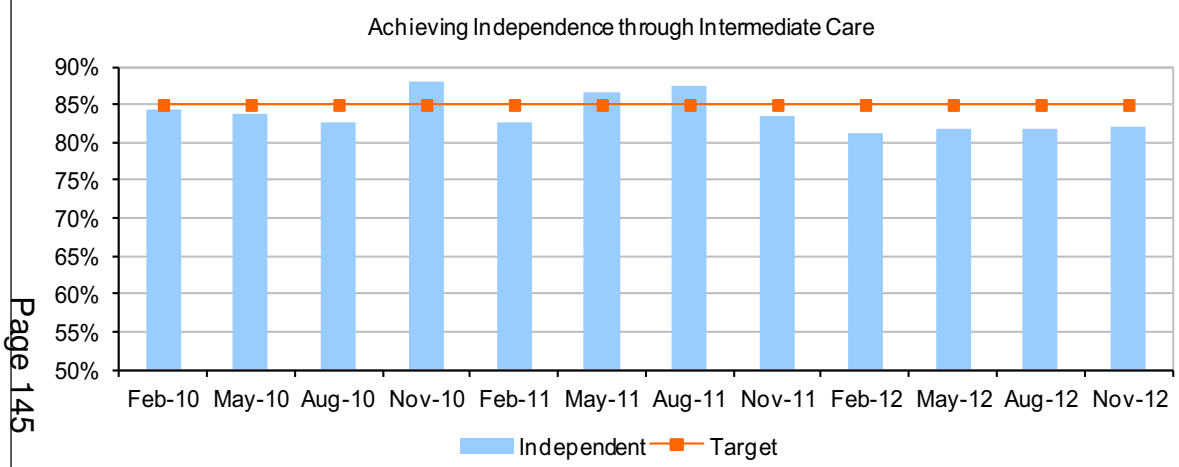
Quarterly Performance Report Indicator

Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Achieved	73.6%	73.6%	75.0%	75.3%	74.7%	74.0%	74.6%	73.6%	73.6%	73.7%	73.4%	72.3%	72.5%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	AMBER	AMBER	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

Commentary

The percentage of outcomes achieved has increased from 66% in March 2011 People's needs and outcomes are identified at assessment and then updated at review, in terms of achievement and satisfaction. Workshops will begin with the operational teams in June to provide additional training and guidance in respect of identifying outcomes.

7. Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			AMBER ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**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.
Units of Measure: Percentage of older people achieving Independence and back home after receiving Intermediate Care following discharge from hospital
Data Source: Manual Data Collection

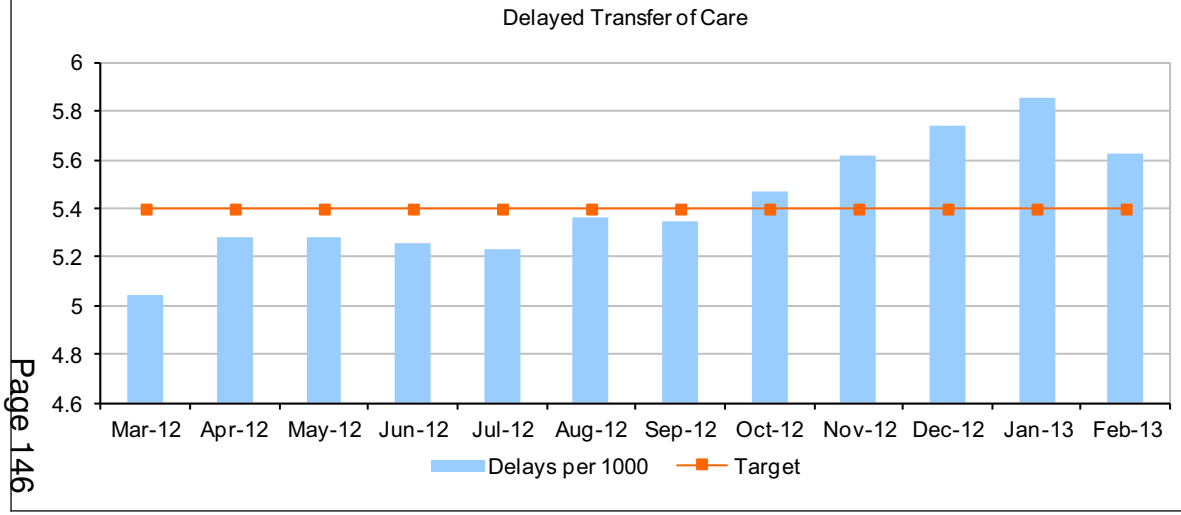
Trend Data	Aug 10	Nov 10	Feb 11	May 11	Aug 11	Nov 11	Feb 12	May 12	Aug-12	Nov-12
Percentage	82.7%	88.1%	82.6%	86.7%	87.4%	83.6%	81.3%	81.7%	81.87%	84.0%
Target	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**
RAG Rating	AMBER	AMBER	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

Commentary

This indicator identifies where patients are **three months** after receiving intermediate care and relies on health and social care data being compared. There are about 500 referrals a month which are supported from hospital and into intermediate care.
This indicator continues to be monitored, particularly in light of the increasing pressures being experienced from the hospitals, including ward closures and where there are some waiting lists for intermediate care, which can put pressure on the teams to make residential and nursing placements.

APPENDIX A

8. Delayed Transfers of Care			AMBER ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**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.
This indicator is displayed as the number of delays per month as a rate per 100,000 population.

Bold Step Indicator

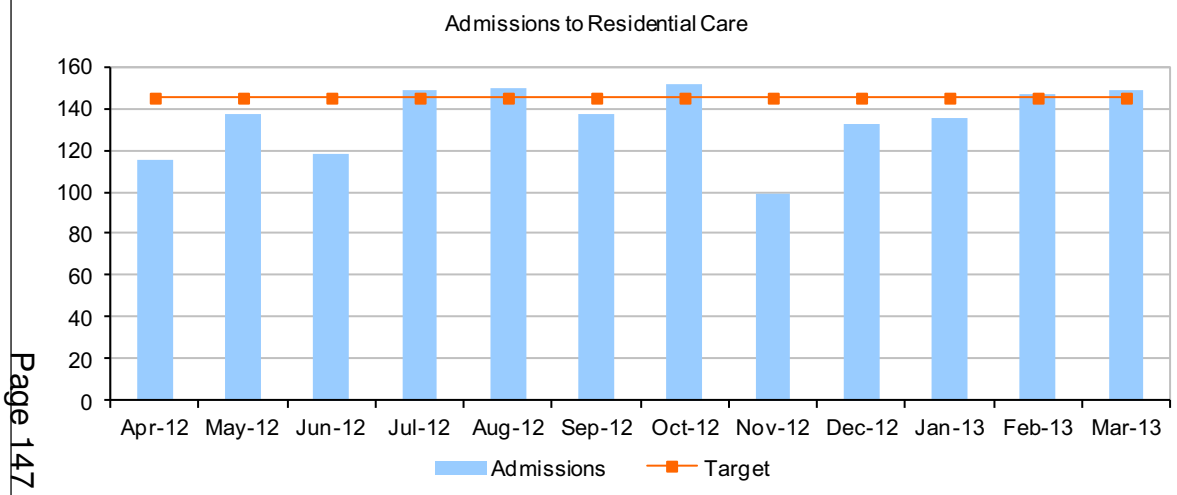
Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
People	5.04	5.28	5.28	5.26	5.23	5.36	5.35	5.4	5.62	5.74	5.86	5.63
Target	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently about 25% delays are attributable to Adult Social Care. The top three reasons for delays includes: Waiting NHS non-acute care, patient choice and then Social care assessment.

APPENDIX A

9. Admissions to Permanent Residential Care for Older people			AMBER ⇩
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**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 & Physical Disability



Data Notes.

Units of Measure: Older People placed into Permanent Residential Care per month.

Data Source: Adult Social Care Swift client System – Residential Monitoring Report

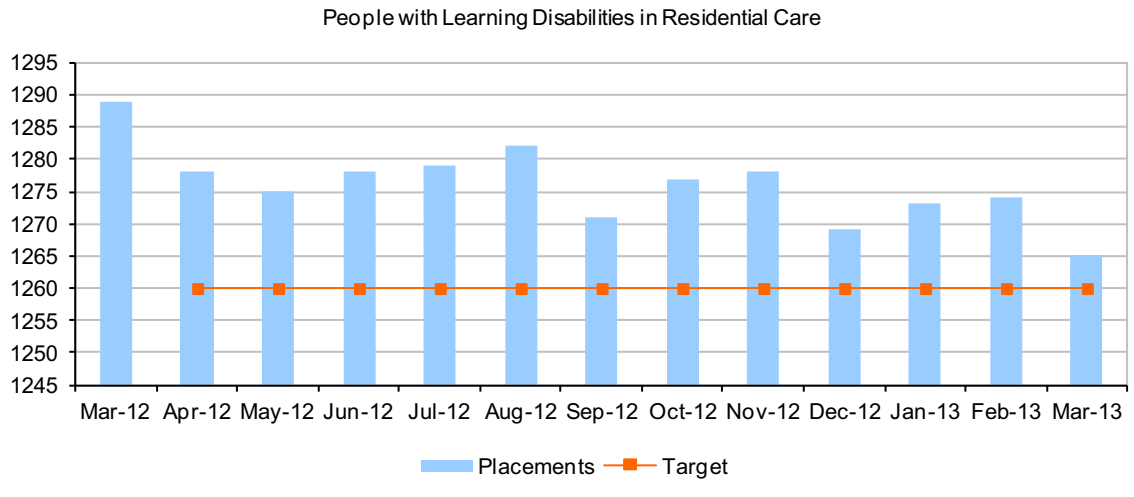
Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Admissions	164	115	137	118	149	150	137	151	99	132	135	147	149
Target		**145**	**145**	**145**	**145**	**145**	**145**	**145**	**145**	**145**	**145**	**145**	**145**
RAG Rating		GREEN	GREEN	GREEN	AMBER	AMBER	GREEN	AMBER	GREEN	GREEN	GREEN	AMBER	AMBER

Commentary

Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. As part of the monthly budget and activity monitoring process, admissions are examined, to understand exactly why they have happened. The objectives of the transformation programme will be to ensure that the right services are in place to ensure that people can self manage with these conditions, and ensure that a falls prevention strategy and support is in place to reduce the need for admission. In the meantime, there are clear targets set for the teams which are monitored on a monthly basis, and an expectation that permanent admissions are not made without all other alternatives being exhausted.

APPENDIX A

10. People with Learning Disabilities in residential care			AMBER ⇧
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Learning disability



Data Notes.
Units of Measure: Number of people with a learning disability in permanent residential care as at month end.
Data Source: Monthly activity and budget monitoring.

Bold Steps Indicator

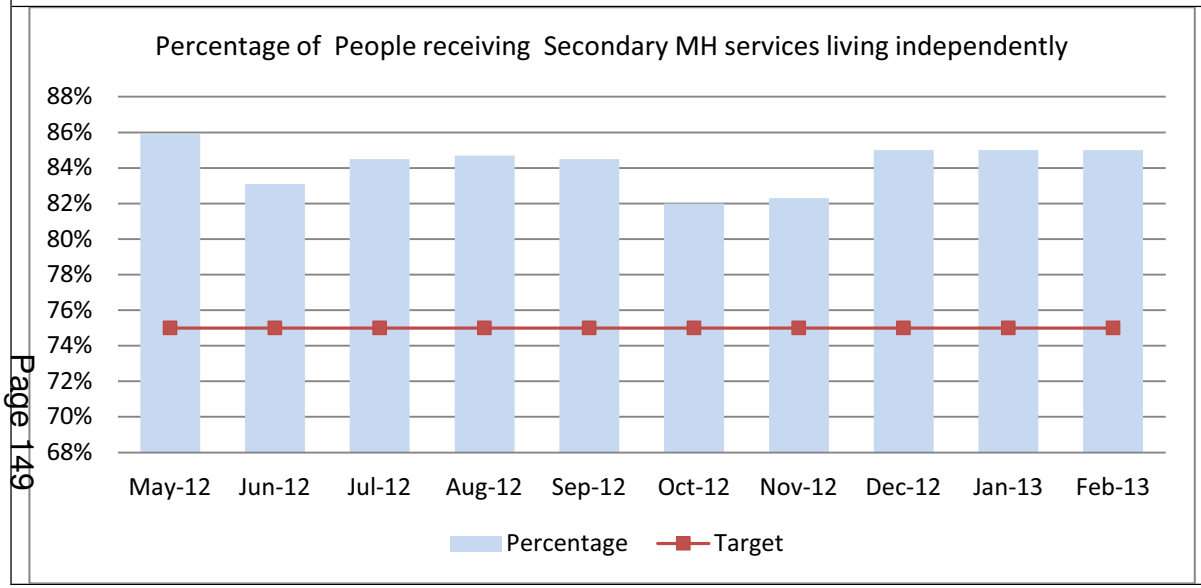
Trend Data	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Placements	1289	1278	1275	1278	1279	1282	1271	1277	1278	1269	1273	1274	1265
Target		**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**
RAG Rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

Commentary

It is a clear objective of the Directorate to ensure that as many people with a learning disability live as independently as possible. All residential placements have now been examined to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. In addition, the teams continue to work closely with the Children's team as young people coming into Adult Social Care through transition from the majority of the new residential placements.

APPENDIX A

11. Proportion of adults in contact with secondary Mental Health services living independently, with or without support			GREEN ⇨
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	People with Mental Health needs



Data Notes.
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

Bold Step Indicator

Trend Data	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan 13	Feb 13
Percentage	85.9%	83.1%	84.5%	84.7%	84.5%	82%	82.3%	85%	85%	85%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**

Commentary
This has been included for the first time, including data from KPMT and will be updated on a quarterly basis. Settled accommodation "Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence." It provides an indication of the proportion of people with mental health needs who are in a stable environment, on a permanent basis.

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Families and Social Care Directorate – End of Year Business Plan Report 2012/13

Division: Older People / Physical Disability

Priority:	**Progress**
1. Integration of Health and Social Care and wider partnership working	Green
2. Performance	Green
3. Personalisation	Amber
4. Prevention	Amber
5. Long Term Conditions	Green

Key Achievements

- Significant progress on joint working with health including the restructure of KCC Hospital Case Management teams and establishing the community ward at Maidstone hospital.
- The delivery of the short term bed programme to prevent service users accessing inappropriate use of hospital beds and facilitating early discharge for those in hospital reducing long term care admissions.
- Implementing the Long Term Conditions model with Integrated Health and Social Care teams, using models of Proactive Care and Health and Social Care coordinators.
- The mainstreaming of telecare as a core service leading to significantly over achieving the target set for clients receiving this form of support
- Increase in the number of Direct Payments for carers
- Kent and Medway Commissioning Support and KCC are one of nine Department of Health funded: Going Further, Faster programmes. This is to build the momentum for Personal Health Budgets (PHBs) by embedding PHBs into the Continuing Health care pathway and test Integrated Budgets in South Kent Coast CCG.
- Dementia Commissioning Strategy developed and rolled out. Establishment of dementia cafés, launch of Maidstone Buddy - support for Carers and people with Dementia, new leaflets to provide information to people with early diagnosis, launch of Dementia Web and Dementia Crisis service
- Building Homes for the 3rd Age Strategy launched in August, additional Extra Care Housing developed in may localities and another PFI: *Excellent Homes for All* scheme started. Homelessness Protocol launched in September
- Excellence in Care Homes project, training within the care home sector, supporting the sector to develop their management quality.

Key issues:

- The changes to the way of the National Health Service is set-up during 2012/13 has meant some changes to original plans and has informed proposals on how the Division is structured.
- The Transformation agenda spans several years and in-year progress against original

targets need to be referenced to dynamic change within the Division

- The deferment of the planned date for the renewal of the Kent card and the review of the personalisation co-ordinators has delayed achieving the full ambition of the use of the Kent Card for Direct Payments. The percentage of clients on personal budgets/ direct payments has seen significant increases but is below target
- Significant progress in driving the take up of enablement services but higher success rates required within the context of the transformation agenda

Division: Learning Disability and Mental Health

	Progress
LD/MH Priority 1: Ensuring the continuation of core business	Green
LD/MH Priority 2: Personalisation	Green
LD Priority 3: Implementing new arrangements for the Kent Learning Disability Partnership	Green
LD/MH Priority 4: Review and Transformation of In-House Services	Amber
LD Priority 5: Transition	Green
LD Priority 6: Working with Health	Amber
LD/MH Priority 7: Safeguarding	Green
MH Priority 8: Kent County Council / Kent and Medway NHS and Social Care Partnership Trust Partnership Programme 1	Amber
MH Priority 9: Kent County Council / Kent and Medway NHS and Social Care Partnership Trust Partnership Programme 2	Green

Key Achievements

- The development and implementation of the Supporting Independence Service
- Increase in number of clients utilising the Kent Card
- The Home Support Network/Life/Choice/Independent Living Scheme has been reviewed. Decision to pilot a new model through the Transformation Programme before forming a final proposal for consultation
- Formal consultation completed in Thanet, Shepway and Tonbridge re Good Day Programme and new services are currently in the implementation stage. Development of community hubs in Canterbury completed
- Increased access for people with learning disabilities to prevention, screening and health promotion including annual health checks
- Each GP practice has a named practitioner from the Local Team for People with Learning Disability Team allocated to them

Key issues:

- **P4** amber, delays re Good Day Programme consultation in Swale, Dartford and Gravesend, and in the delivery of the hydrotherapy project.
- **P6** amber, delay in the recruitment of the CPN posts LD/MH and roll out of LD Health checks
- **P8** amber, KR11 review underway which will establish leadership around personalisation in each team. Delay in the review of social care input into Forensic Services and recording for the FASC target on RIO/SWIFT

Division: Strategic Commissioning

Priority:	Progress
PRIORITY 1: Strategic Commissioning Transformation Programme	**Green**
PRIORITY 2: Restructure Strategic commissioning	**Green**
PRIORITY 3: Ensure we provide the most robust and effective public protection - ADULTS	**Green**
PRIORITY 4: Develop and commission a range of outcome based preventative services to avoid unnecessary family breakdown	**Green**
PRIORITY 5: Deliver high quality early years services that provide value for money and are targeted at the most vulnerable families in Kent (Children Centre FSO)	**Amber**
PRIORITY 6: Develop and commission services to improve outcomes for children and young people in care and seek to reduce the number of adolescents becoming looked after where appropriate and safe to do so	**Green**
PRIORITY 7: Ensure KCC deliver statutory services that offer value for money and support the delivery of efficiency savings	**Green**
PRIORITY 8 : Improve how we procure and commission services	**Green**
PRIORITY 9: Advice, information and Guidance	**Green**
PRIORITY 10: Support for carers	**Amber**
PRIORITY 11: Review use of residential care – building on prevention, enablement and avoiding long term admissions wherever possible.	**Amber**
PRIORITY 12: Developing a range and choice of services that support people in the community and help them to be as independent as possible	**Green**
PRIORITY 13: Accommodation & Housing Solutions	**Green**
PRIORITY 14: Sensory Services	**Amber**
PRIORITY 15: Business Continuity	**Green**
PRIORITY 16: Continuously review performance information and scrutiny to support and improve operational business and outcomes for service users	**Green**
PRIORITY 17: Support the delivery of FSC key business objectives with timely, relevant, effective information management	**Green**

Key Achievements

- Priority 1 – Appointment of Efficiency Partner to support implementation and identify levels of savings
- Priority 2 – New Strategic Commissioning Structure implemented with effect 1.10.12
- Priority 3 – The delivery of the Post Winterbourne Conference in March 2013
- Priority 3 – The implementation of the new arrangements for the Deprivation of Liberty (DOLS)
- Priority 4 – Outcome based specifications acknowledged in the peer led improvement review.

- Priority 8 – 2 consortia bids successful as part of the Early Intervention Framework
- Priority 11 – Carer Assessments and Support Services – new contracts let and work is on-going with new providers to embed new contracts and ensure smooth handover for carers from one organisation to another.
- Priority 12 – New Supporting Independence Services Contract in place, with a review in place to respond to feedback from providers about the consequences of new contract.
- Priority 12 – Single Tender Action with current meal delivery provider, with agreed price negotiation to remove bandings and generate savings. Re-let of contract will be part of the Transformation Programme.
- Priority 13 – A Place to Live – Accommodation Strategy being developed in line with Transformation Blue Print – full document due in November with appendices to be developed over the following years
- Priority 16 – have made use of EY Web mandatory, resulting in significant efficiency and cost savings (due to split of Children's Performance Team - now responsibility of ELS)
- Priority 16 – Development of KNet – use of SharePoint for publishing Performance Monitoring reports
- Priority 17 – significant improvements in safeguarding data and performance, through 1:1 support and training with the teams, ensuring staff are aware of safeguarding procedures and the correct data input.
- Priority 17 – allocation of personal budgets has met the new National targets, with on-going support to the teams.

Key issues:

- Priority 3 – Volume of safeguarding alerts has increased significantly, and over 40% of alerts are from residential settings requiring more complex investigations.
- Priority 5 - is reported as Amber due to the complexity of the Children Centre FSO review which has meant that there has been a revised timetable put in place.
- Priority 10 – Short Breaks Commissioning Strategy to be delivered as part of the Transformation Programme
- Priority 11 – will be delivered through the Transformation Programme – Efficiency partners now appointed.
- Priority 12 – Day Opportunities – no new procurement pending commissioning strategy and transformation. Grants now end 2014 (was 2013) to allow this to happen.
- Priority 14 – is reported as Amber due to the delay of the Sensory Commissioning Strategy, which is now expected to be completed October 2013. Procurement of Sensory Services will follow, and commence this year 2013/14

RAG Rating Definition
Red – Project/Action/Milestone is not complete and will not be completed
Amber – Project/Action/Milestone is partially complete or continuing
Green – Project/Action/Milestone has been completed

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By: Jenny Whittle, Cabinet Member for Specialist Children's Services
Andrew Ireland, Corporate Director for Families and Social Care

To: Social Care and Public Health Cabinet Committee - 12 June 2013

Subject: **FAMILIES AND SOCIAL CARE PERFORMANCE DASHBOARD FOR 2012/13 FOR SPECIALIST CHILDREN'S SERVICES**

Classification: Unrestricted

Summary: The Families & Social Care performance dashboard for Specialist Children's Services (SCS) provides members with progress against targets set for key performance and activity indicators for 2012-13.

Introduction

1. (1) Appendix 2 Part 4 of the Kent County Council Constitution states that:

"Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

(2) To this end, each Cabinet Committee will receive a performance dashboard.

Performance Report

2. (1) The dashboard for Specialist Children's Services (SCS) is attached as Appendix A.

(2) Members are asked to note that the SCS dashboard is used within the FSC Directorate to support the Improvement Plan.

(3) A subset of these indicators is used within the quarterly performance report, which is submitted to Cabinet.

(4) As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

Performance dashboard

3. (1) The SCS performance dashboard includes latest available results, and year out-turn for 2012/13 for the key performance and activity indicators.

(2) The indicators included are based on key priorities for Specialist Children's Services, as outlined in the business plans, and includes operational data that is regularly used within Directorate. Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes.

(3) Where frequent data is available for indicators the results in the dashboard are shown either with the latest available month and a year to date figure, or where appropriate as a rolling 12 month figure.

(4) Performance results are assigned an alert on the following basis:

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

Amber: Performance is below current target but above minimum standard.

12/13 End of year business plan reports

4. (1) Each division within Families & Social Care produces an annual business plan. These are discussed by the Cabinet Committee prior to being agreed by Cabinet at the start of each business year. At the end of the business year, reports summarising the delivery of the plans is provided to Cabinet Committee.

(2) Attached for information, as Appendix B, are the 12/13 end of year business plan reports for:

- Specialist Children's Services
- Strategic Commissioning

(3) As the Strategic Commissioning division supports both Adults' and Children's Services its report covers elements that that are outside the remit of Specialist Children's Services but it is present here for completeness.

Recommendations

5. Members are asked to:

REVIEW and comment on the Families & Social Care SCS performance dashboards

REVIEW and comment on the end of year business plan reports

Contact Information

Name: Maureen Robinson
Title: Management Information Service Manager for Children's Services
Tel No: 01622 696328
Email: Maureen.robinson@kent.gov.uk

Background documents:

None

Families and Social Care

Specialist Children's Services Performance Management Scorecard

Quarter 4 – 2012/13

Guidance Notes

POLARITY

H	The aim of this indicator is to achieve the highest number/percentage possible.
L	The aim of this indicator is to achieve the lowest number/percentage possible.
T	The aim of this indicator is to stay close to the target that has been set.

RAG RATINGS

R	A red rating indicates that the current performance is signficantly away from the target set.
A	An amber rating indicates that the current performance is close to the target set.
G	A green rating indicates that the current performance has met the target that has been set.

DIRECTION OF TRAVEL (DOT)

↑	A green arrow indicates that performance has improved this month when compared to last month. Depending on the polarity of the indicator, an improvement in performance could either be a reduction or increase in numbers/percentage.
→	An amber arrow indicates that performance has remained the same as last month.
↓	A red arrow indicates that performance has worsened this month when compared to last month. Depending on the polarity of the indicator, a worsening in performance could either be a reduction or increase in numbers/percentage.

KEY TO ABBREVIATIONS

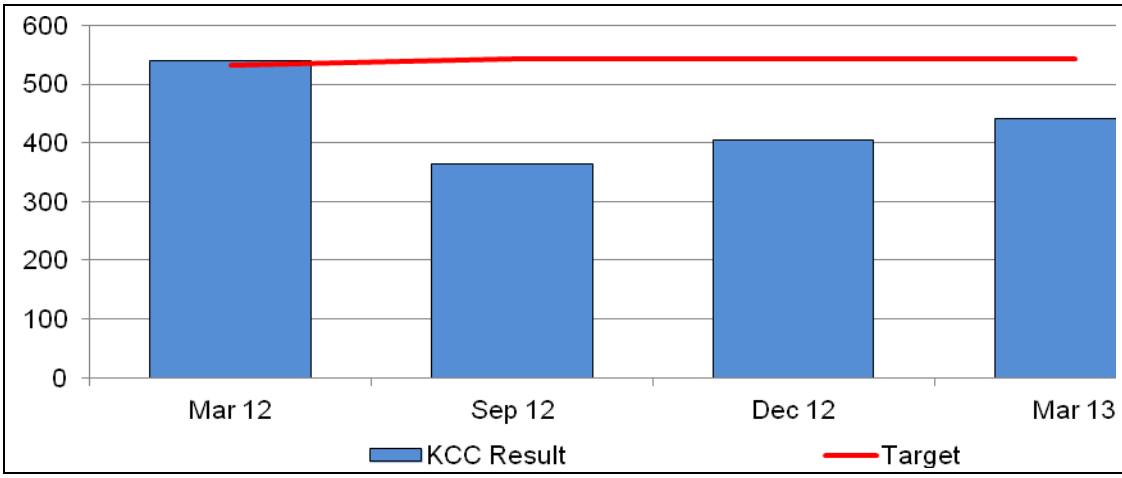
YTD	Year to Date (April to March)	CA's	Core Assessments
Num	Numerator	CIN	Child in Need
Denom	Denominator	CP	Child Protection
R12M	Rolling 12 Months	LAC	Looked After Children
CAF	Common Assessment Framework	IN	Improvement Notice
TAF	Team around Family	IP	Improvement Plan
PEP	Personal Education Plan	SGO	Special Guardianship Order
QSW	Qualified Social Worker	UASC	Unaccompanied Asylum Seeking Children
IA's	Initial Assessments	SS	Snapshot

PERFORMANCE INDICATOR GRAPHS AND CHILD LEVEL DATA

The latest graphs and Child level data are published on the SCS Performance Management website

Indicators	Polarity	Data Period	LATEST RESULT				Target for 12/13	PREVIOUS RESULT		OUTTURN RESULT	
			Latest Result and RAG Status		Num	Denom		Previous Reported Result	DoT from previous to latest result	Outturn (March 12) Result	DoT from outturn to latest result
HOW MUCH ARE WE DEALING WITH ?											
Number of CAFs completed per 10,000 population under 18	T	R12M	75.7	A	2445	322813	77.2	70.7	↑	68.5	↑
Number of Referrals per 10,000 population under 18	T	R12M	442.0	R	14267	322813	543.7	425.9	↑	538.4	↓
NI 68 - Percentage of Referrals going on to Initial Assessment	T	YTD	73.4%	A	10495	14304	69.5%	74.6%	↑	89.8%	↑
Number of Initial Assessments per 10,000 population under 18	T	R12M	325.1	G	10495	322813	342.9	324.5	↑	483.6	↑
Number of New & Updated Core Assessments per 10,000 population under 18	T	R12M	326.8	R	10551	322813	236.0	328.5	↑	456.0	↑
Number of S47 Investigations per 10,000 population under 18	T	R12M	107.6	G	3474	322813	106.4	110.2	↑	202.7	↑
Percentage of S47 Investigations proceeding to Initial CP Conference	T	YTD	35.8%	R	1242	3474	44.5%	35.1%	↑	21.7%	↑
Number of Initial CP Conferences per 10,000 population under 18	T	R12M	42.7	G	1377	322813	42.3	41.3	↑	54.3	↑
Number of CIN per 10,000 population under 18 (includes CP and LAC)	T	SS	287.3	G	9274	322813	280.0	283.3	↓	296.4	↑
Numbers of Children with a CP Plan per 10,000 population under 18	T	SS	30.8	G	994	322813	30.5	29.9	↑	30.6	↓
Children looked after per 10,000 population aged under 18 (Excludes Asylum)	T	SS	50.8	G	1641	322813	47.5	49.9	↓	51.7	↑
Number of Looked After Children with a CP plan.	L	SS	27	G			30	22	↓	36	↑
Numbers of Unallocated Cases for over 28 days (Business)	L	SS	0	G			0	0	→	8	↑
HOW LONG IS IT TAKING US ?											
NI 59 - Percentage of IA's that were carried out within 7 working days of referral	H	YTD	83.3%	G	8743	10495	78.8%	84.1%	↓	76.2%	↑
Initial Assessments in progress outside of timescale	L	SS	94	G			100	120	↑	42	↓
(NI 60) - Percentage of Core Assessments that were carried out within timescale	H	YTD	81.1%	A	8561	10551	83.2%	81.9%	↓	68.7%	↑
Core Assessments in progress outside of timescale	L	SS	142	A			100	184	↑	84	↓
NI 67 - Child protection cases which were reviewed within required timescales	H	YTD	98.5%	G	673	683	98.0%	99.5%	↓	97.1%	↑
NI 66 - Looked after children cases which were reviewed within required timescales	H	YTD	96.7%	A	1604	1658	98.0%	96.0%	↑	94.9%	↑
HOW WELL ARE WE DOING IT ?											
Percentage of open cases with Ethnicity recorded (excludes unborn)	H	SS	99.4%	G	9057	9112	98.0%	98.9%	↑	97.4%	↑
Percentage of Children seen at Initial Assessment (excludes unborn/progress to str	H	YTD	91.8%	A	6842	7454	95.0%	91.7%	↑	61.6%	↑
Percentage of Children seen at Core Assessment (excludes unborn)	H	YTD	98.2%	G	9872	10052	95.0%	98.2%	↓	88.0%	↑
Percentage of Children seen at Section 47 enquiry (excludes unborn)	H	YTD	96.8%	G	3178	3282	95.0%	96.8%	↓	91.3%	↑
Percentage of CP Visits held within timescale (Current CP only)	H	SS	86.9%	A	13131	15109	90.0%	86.2%	↑	65.8%	↑
Percentage of Looked After Children aged 5 to 16 with a Personal Education Plan (P	H	SS	93.6%	A	1031	1101	95.0%	91.0%	↑	81.8%	↑
Participation at Looked After Children Reviews	H	YTD	96.4%	G	3954	4100	95.0%	96.7%	↓	94.1%	↑
Children subject to a CP Plan not allocated to a Qualified Social Worker	L	SS	2	R			0	4	↑	2	→
Looked After Children not allocated to a Qualified Social Worker	L	SS	1	R			0	0	↓	2	↑
ARE WE ACHIEVING GOOD OUTCOMES ?											
Percentage of referrals with a previous referral within 12 months	L	YTD	22.8%	G	3263	14304	25.8%	22.6%	↓	30.4%	↑
NI 65 - Percentage of children becoming CP for a second or subsequent time	T	YTD	19.5%	R	238	1221	13.4%	19.4%	↓	16.6%	↓
Percentage of children becoming CP for a second or subequent time within 12 months		YTD	6.6%		80	1221		6.7%			
NI 64 - Child Protection Plans lasting 2 years or more at the point of de-registratior	L	YTD	7.9%	R	94	1185	6.0%	7.5%	↓	8.0%	↑
Percentage of Current CP Plans lasting 18 months or more	L	SS	8.4%	G	83	994	10.0%	10.2%	↑	14.2%	↑
NI 62 - LAC Placement Stability: 3 or more placements in the last 12 months	L	SS	9.5%	R	174	1831	8.1%	9.5%	↑	11.1%	↑
NI 63 - LAC Placement Stability: Same placement for last 2 years	H	SS	69.0%	A	339	491	75.7%	69.4%	↓	70.3%	↓
Percentage of LAC in Foster Care placed within 10 miles from home (Excludes Asylu	H	SS	61.4%	A	768	1251	65.0%	61.7%	↓	60.6%	↑
LAC Dental Checks held within required timescale	H	SS	90.3%	G	1075	1191	90.0%	90.7%	↓	92.6%	↓
LAC Health assessments held within required timescale	H	SS	93.0%	G	1108	1191	90.0%	92.7%	↑	88.1%	↑
Percentage of LAC placed for adoption within 12 months of agency decision	H	YTD	70.6%	R	101	143	85.0%	72.5%	↓	76.6%	↓
Percentage of Children leaving care who were adopted	H	YTD	11.9%	A	105	879	13.0%	11.4%	↑	8.3%	↑
Percentage of Children leaving care who were made subject to a SGO	H	YTD	7.4%	G	65	879	6.3%	7.3%	↑	4.8%	↑
ARE WE SUPPORTING OUR STAFF ?											
Percentage of caseholding posts unfilled (100% - QSW inc Agency Posts)	L	SS	3.0%	G			10%	3.0%	↑	-0.8%	↓
Percentage of caseholding posts filled by agency staff (Agency Staff ÷ Establishmen	L	SS	15.0%	A	75.4	504.0	10%	15.3%	↑	13.9%	↓
Percentage of caseholding posts filled by QSW (QSW posts exc Agency ÷ Establishm	H	SS	82.0%	A	413.4	504.0	90%	81.6%	↑	87.0%	↓
Average Caseloads of social workers in fieldwork teams	L	SS	18.4	G	488.8	8984	20	18	↓	20.9	↑

Number of Referrals per 10,000 population under 18			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	538.8	364.8	403.6	442.0
Target	533.1	543.7	543.7	543.7
RAG Rating	Green	Red	Red	Red

Performance against this measure has RAG rating of Red as Kent is under the Target set at the beginning of the year. In the early part of 2012/13 an external consultant was commissioned to review the processes within the Central Duty Team, comparing Kent's practice with that of high performing authorities. This work identified that Kent was undertaking a higher proportion of work at the Contact stage which was impacting upon the accuracy of referral rates. Action was taken to address this and a revised process has been operational in the Central Duty Team since August 2012.

This shift in practice has resulted in moving Kent's referral rates back in line with our best performing Statistical Neighbour Average (543.7 in 2010/11) which was the basis of the Target for 2012/13. No further action is required.

Data Notes

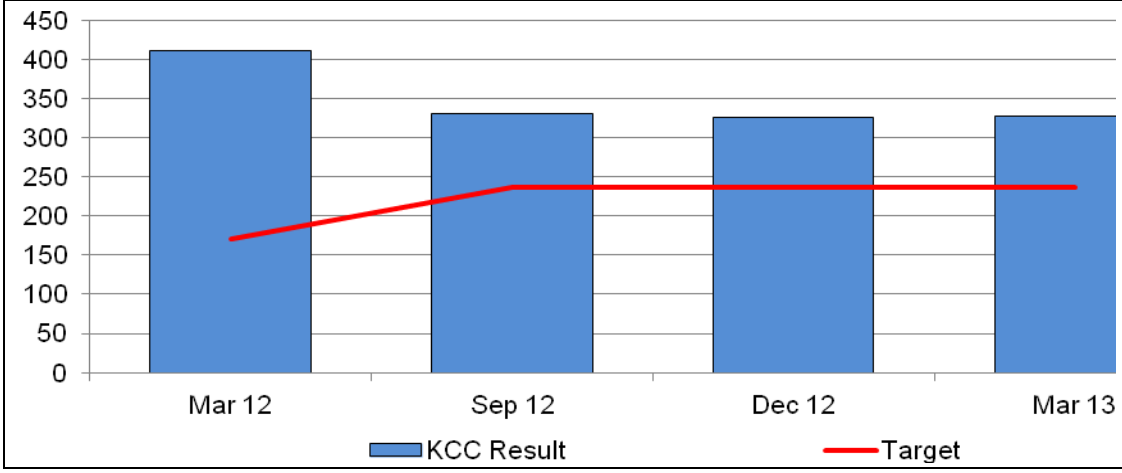
Tolerance: As close to target as possible. Should not be too low or too high

Data is reported as the position at each quarter end (Year-to-date). March 13 data shows the full year result.

Figures shown for March 12 and March 13 are for the full reporting year.

Data Source: Integrated Children's System (ICS)

Number of New and Updated Core Assessments per 10,000 population under 18			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	411.3	331.5	325.9	326.8
Target	170.6	236.0	236.0	236.0
RAG Rating	Green	Red	Red	Red

The high numbers of Core Assessments can, in part, be attributed to the increased recording of updated Core Assessments, and the recording of a Core Assessment when an Initial Case Conference is held on an open case.

The Target set for 2012/13 was based on the Statistical Neighbour average for 2011/12 (latest published information at that point).

Kent has shown increased performance against this measure throughout the year, although the Target set was not achieved. Future monitoring against this measure for 2013/14 will separate out performance against new and updated Core Assessments.

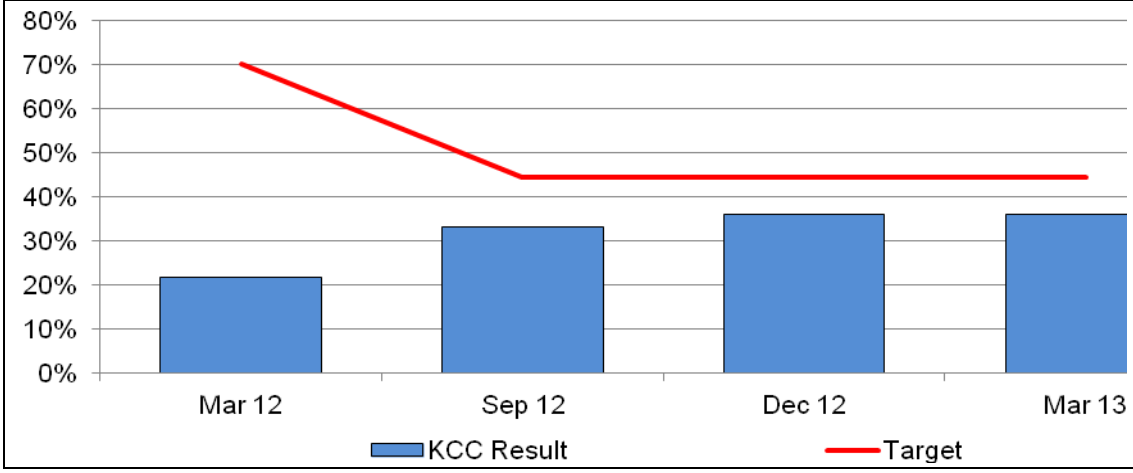
Data Notes

Tolerance: As close to target as possible. Should not be too low or too high

Data: includes both new Core Assessments and updated Core Assessments on open Cases. Data is reported as the position at each quarter end (Year-to-date). Figures shown for March 12 and March 13 are for the full reporting year.

Data Source: Integrated Children's System (ICS)

Percentage of S47 Investigations proceeding to Initial Child Protection Conference			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	21.7%	33.2%	36.0%	35.8%
Target	70.0%	44.5%	44.5%	44.5%
RAG Rating	Red	Red	Red	Red

This is an internal target associated with the conversion rate of Section 47 investigations to Initial Child Protection Conferences. The Target was set as the average of best performing statistical neighbours.

In 2011/12 Kent had a low conversion rate of 21.7%. Throughout 2012/13 Kent's performance has been steadily increasing, culminating in the March out-turn result of 35.8%. This measure will continue to be a focus for improvement during 2013/14.

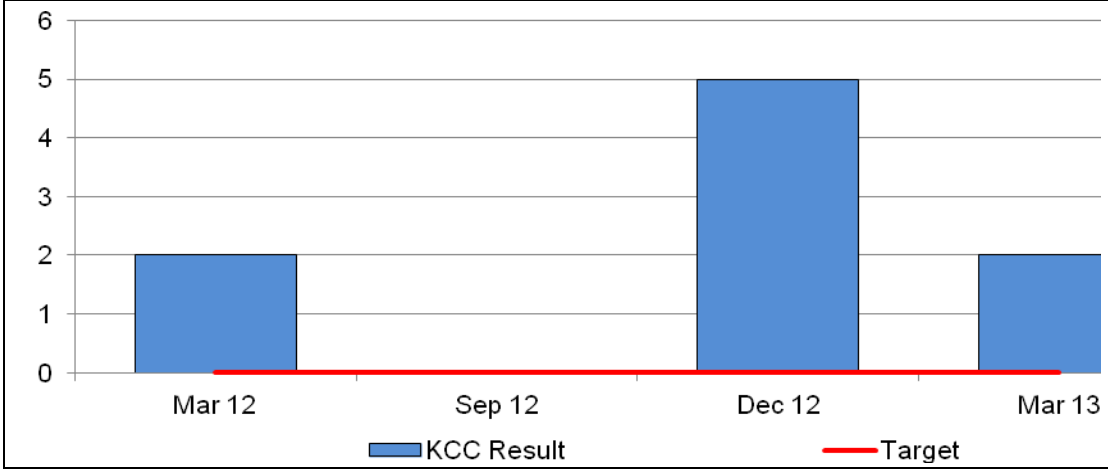
Data Notes

Tolerance: As close to target as possible. Should not be too low or too high

Data is reported as the position at each quarter end (Year-to-date). Figures shown for March 12 and March 13 are for the full reporting year.

Source: Integrated Children's System

Children subject to a Child Protection Plan not allocated to a Qualified Social Worker			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	2	0	5	2
Target	0	0	0	0
RAG Rating	Amber	Green	Red	Red

Performance for this measure as showing as 'Red' as there is zero tolerance set within the Target for unallocated Child Protection cases.

There were two siblings unallocated on the date of the report run. Both children were only unallocated for the one day – the day on which the report was run.

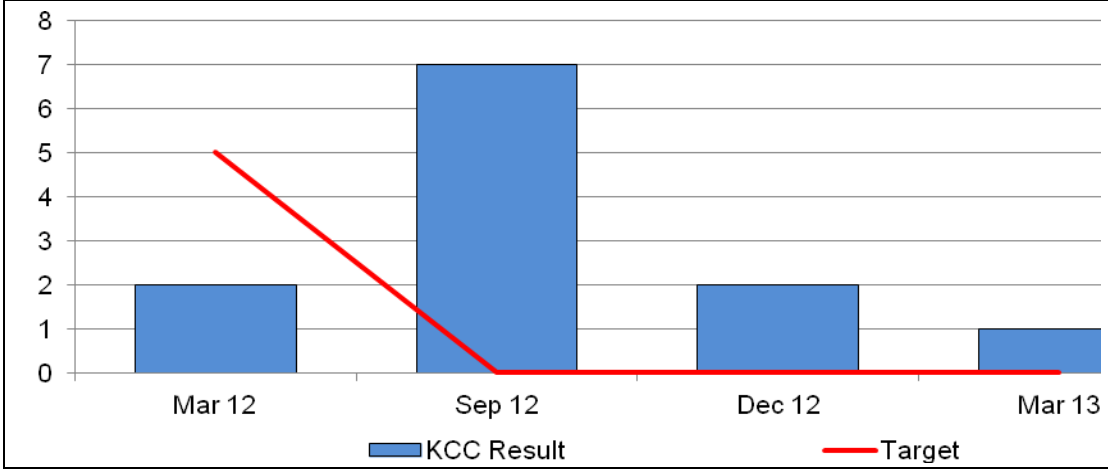
Data Notes

Tolerance: Lower values are better

Data is provided as a snapshot on the day the report was run.

Data Source: Integrated Children's System (ICS)

Looked After Children not allocated to a Qualified Social Worker			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	2	7	2	1
Target	5	0	0	0
RAG Rating	Green	Red	Red	Red

Performance for this measure as showing as 'Red' as there is zero tolerance set within the target for unallocated Children in Care cases.

The one child who was not allocated was within the Children's Disability Service in East Kent and was unallocated for 14 days. During this time the case was managed by the Team Manager.

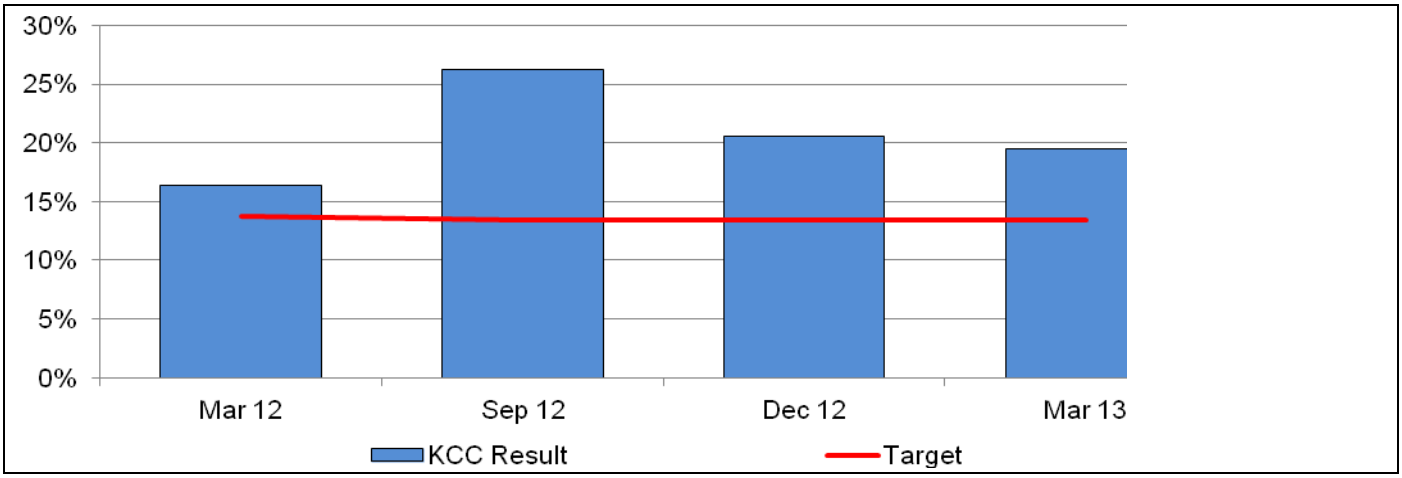
Data Notes

Tolerance: Lower values are better

Data is provided as a snapshot on the day the report was run.

Data Source: Integrated Children's System (ICS)

Percentage of children becoming subject to Child Protection Plan for a second or subsequent time			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	16.4%	26.2%*	20.6%*	19.5%
Target	13.7%	13.4%	13.4%	13.4%
RAG Rating	Red	Red	Red	Red

The percentage of children subject to a Child Protection Plan for a second or subsequent time remains high although the numbers have shown a continual decrease over the last two quarters of the year. The National published figure for 2011/12 was 13.8% and the target of 13.4% was based on the Statistical Neighbour average.

During 2012/13 there were 1221 new Child Protection Plans. For 238 children this was the second or subsequent time that they had been made subject to a Child Protection Plan. However, many of the children becoming subject to a plan for a second or subsequent time had not been subject to a previous plan within the previous two years.

For 2013/14 these children will not be counted under this indicator. Under the new definition only those children who were subject to a subsequent plan within two years will be included. Kent's result for 2012/13 against this definition is 10.8%.

Data Notes

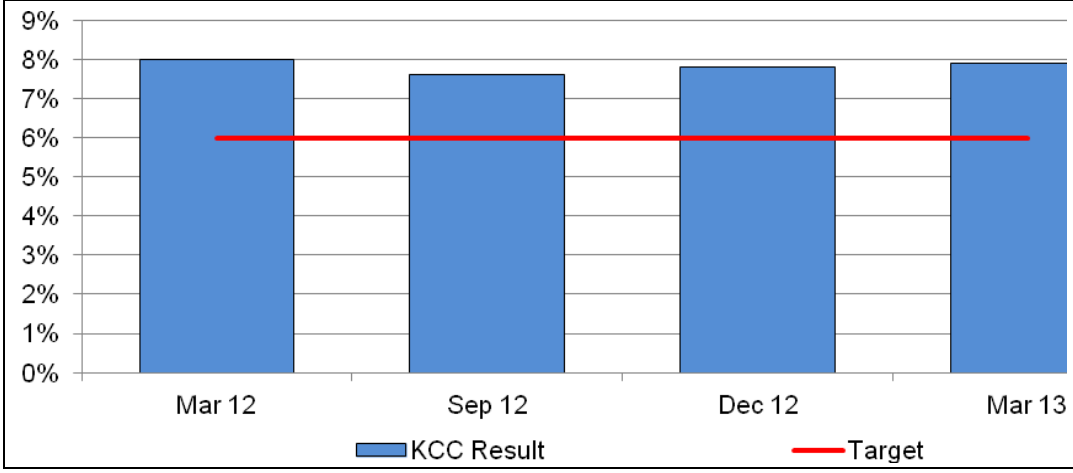
Tolerance: As close to target as possible. Should not be too low or too high.

Data is reported as financial year to date. * These figures are cumulative and as such should not be compared with full year results. March 13 data shows the full year result.

Calculated as the percentage of children commencing a new plan, who had been subject to a previous plan at any time.

Data Source: Integrated Children's System (ICS)

Child Protection Plans lasting 2 years or more at the point of de-registration			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	8%	7.6%*	7.8%*	7.9%
Target	6%	6%	6%	6%
RAG Rating	Red	Red	Red	Red

Although the Target of 6% has not been achieved progress has been made and work continues to review current cases where children have been subject to a child protection plan for over 18 months to try to prevent them moving into the 2 year plus category.

There are now fewer cases where the length of the Child Protection Plan exceeds 2 years: In March 2012, 67 children (7%) had been subject to a Plan for more than 2 years. In March 2013 there were 43 children (4%) had a Plan exceeding 2 years.

Data Notes

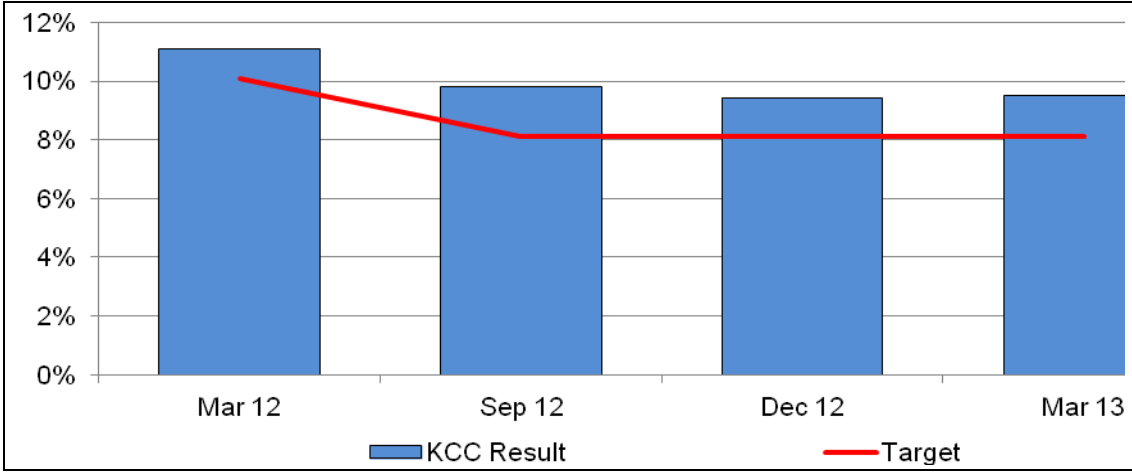
Tolerance: Lower values are better.

Data is reported as financial year to date. * These figures are cumulative and as such should not be compared with full year results. March 13 data shows the full year result.

Calculated as the percentage of children ceasing to be subject to a child protection plan who had been subject to that plan for two or more years.

Data Source: Integrated Children's System (ICS)

LAC Placement Stability: 3 or more placements in the last 12 months			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	11.1%	9.8%	9.4%	9.5%
Target	10.1%	8.1%	8.1%	8.1%
RAG Rating	Red	Red	Red	Red

At 9.5% Kent's performance is above the last reported performance for Statistical Neighbours (8%). Improvements in performance have been demonstrated for 2012/13 and have been achieved by:

- The establishment of Placement Panels which has ensured that all placement moves meet the needs of the child.
- Placement Stability Core Groups have been established to prevent and support potential breakdowns in placements.
- All cases for children who have had two placement moves to date are reviewed at the point of the second placement.
- Detail on those children with three or more moves are discussed with District Management Teams during the Quarterly Deep Dive meetings.

174 children have had three or more moves in placement in the 12 month period. Of these, the Catch22 Service (responsible for children over the age of 16) have the highest percentage. This is to be expected as these moves will include planned changes towards independent living.

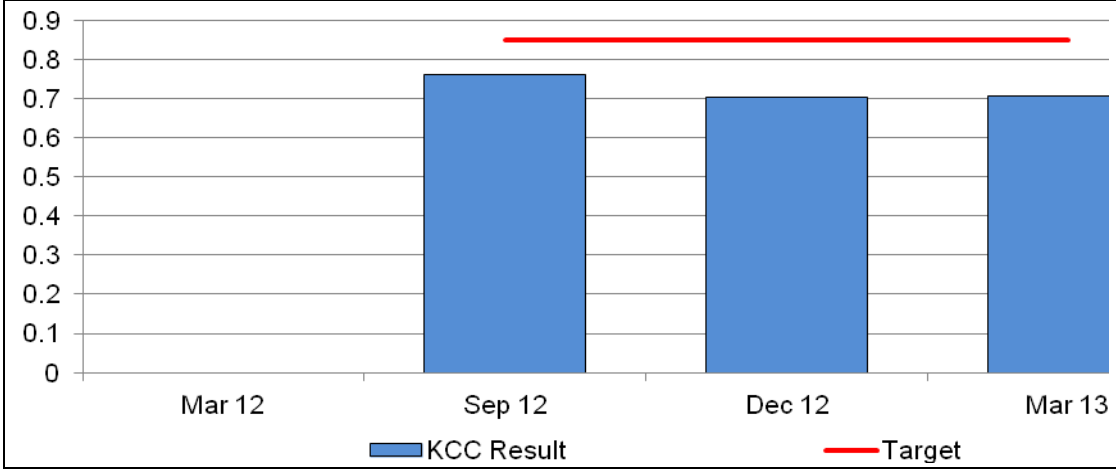
Data Notes

Tolerance: Lower values are better.

Data is reported as a snapshot at each quarter end.

Data Source: ICS

Percentage of LAC placed for adoption within 12 months of agency decision			Red
Cabinet Member	Jenny Whittle	Director	Mairead MacNeil
Portfolio	Specialist Children's Services	Division	Specialist Children's Services



Trend Data – Month End	Mar 12	Sep 12	Dec 12	Mar 13
KCC Result	N/A	76.2%	70.3%	70.6%
Target	N/A	85%	85%	85%
RAG Rating	**N/A**	**Amber**	**Red**	**Red**

Improving performance against this measure during 2012/13 has proved challenging due to the progress made on a number of historical cases which have had an impact upon timescales. During the year there were 11 children placed for adoption who had an Agency Decision for adoption agreed prior to 2011. There remain 20 children who had an Agency Decision for adoption prior to 2012 which will impact upon future performance.

Data Notes

Tolerance: Higher values are better.

Data is reported as year-to-date.

Data Source: ICS

Families and Social Care Directorate – End of Year Business Plan Report 2012/13

Division: Specialist Children's Services

Priority:	Progress
1. Deliver high quality, rigorous and consistent frontline practice to safeguard children and young people.	**Green**
2. Provide a streamlined continuum of early intervention services for children and families.	**Green**
3. Deliver effective corporate parenting and improve outcomes for children in care and care leavers.	**Green**
4. Increase LAC permanency and stability to ensure LAC feel safe and nurtured in a home setting, including reducing the number of adolescents becoming looked after, where appropriate and safe to do so.	**Green**
5. Ensure the most robust and effective child protection arrangements.	**Green**
6. Develop high quality child and family centred services which promote personalisation and respond to the needs of disabled children, young people and their families.	**Amber**
7. Deliver services through a locality cased integrated structure which is fit for purpose, strongly managed, and staffed by experienced and competent social workers.	**Amber**

Key Achievements

- Focus on these priorities has contributed to positive Ofsted inspections this year:
  - Inspection of Local Authority arrangements for the protection of children, judgement of adequate
  - Inspection of fostering agency. Judgement of adequate with good areas
- The establishment of the multi-agency central referral unit (CRU) has improved information sharing, consistency and strengthened decision making at the point of initial contact and referral.
- The fostering service has successfully restructured. Foster care support has become part of the area children in care teams.
- Exceeded target of 140 new foster carers approved
- Increased number of KCC foster carers by 5.1% to a total of 820.
- All 3 Multi Agency Specialist Hub (MASH) buildings in East Kent are operational, with health and education staff.
- Increase in overall provision of short break services for disabled children.
- Early intervention and prevention service providers have been through a robust re-commissioning process to ensure that they are delivering the services required.
- All five short break residential units are delivering a high quality service to children and their families in Kent. This is reflected in the Ofsted Inspections with one unit achieving an "Outstanding" rating and all other units achieving a "Good" rating. The units are delivered in partnership with Health and the revised Health model.
- The ePEP has been introduced and rolled out across the county. Training is in place for schools and social workers and a training manual will be provided to foster carers. Monitoring of the quantity and quality of PEPs remains a priority for VSK
- The OCPYC (our children and young people council) has been established and continues to develop in response to the views of young people. .
- A participation plan is in place, with participation events taking place for children in care during every school holiday. Four activity days have been held in 2013; which had a total

of 121 different children attend with 26 children attending more than one day.

- The VSK Young People's website has been developed and has recently instigated a "you said, we did" page to ensure young people receive feedback.
- Increase in the number of children placed for adoption from 68 in 2011 to 2012 to 143 in 2012 - 2013
- Increase in the number of children adopted from 70 in 2011 - 2012 to 105 in 2012-2013
- Increase in the number of adopters approved from 67 in 2011 -2012 to 87 in 2012-2013.
- The adoption service has established a dedicated family finding team.

Key issues:

- Many of the targets and priorities outlined in the business plan are ongoing, there remains a continued focus on quality, effectiveness and consistency of practice
- Recruitment remains an on-going challenge

Division: Strategic Commissioning

Priority:	Progress
PRIORITY 1: Strategic Commissioning Transformation Programme	Green
PRIORITY 2: Restructure Strategic commissioning	Green
PRIORITY 3: Ensure we provide the most robust and effective public protection - ADULTS	Green
PRIORITY 4: Develop and commission a range of outcome based preventative services to avoid unnecessary family breakdown	Green
PRIORITY 5: Deliver high quality early years services that provide value for money and are targeted at the most vulnerable families in Kent (Children Centre FSO)	Amber
PRIORITY 6: Develop and commission services to improve outcomes for children and young people in care and seek to reduce the number of adolescents becoming looked after where appropriate and safe to do so	Green
PRIORITY 7: Ensure KCC deliver statutory services that offer value for money and support the delivery of efficiency savings	Green
PRIORITY 8 : Improve how we procure and commission services	Green
PRIORITY 9: Advice, information and Guidance	Green
PRIORITY 10: Support for carers	Amber
PRIORITY 11: Review use of residential care – building on prevention, enablement and avoiding long term admissions wherever possible.	Amber
PRIORITY 12: Developing a range and choice of services that support people in the community and help them to be as independent as possible	Green
PRIORITY 13: Accommodation & Housing Solutions	Green
PRIORITY 14: Sensory Services	Amber
PRIORITY 15: Business Continuity	Green
PRIORITY 16: Continuously review performance information and scrutiny to support and improve operational business and outcomes for service users	Green
PRIORITY 17: Support the delivery of FSC key business objectives with timely, relevant, effective information management	Green

Key Achievements

- Priority 1 – Appointment of Efficiency Partner to support implementation and identify levels of savings
- Priority 2 – New Strategic Commissioning Structure implemented with effect 1.10.12
- Priority 3 – The delivery of the Post Winterbourne Conference in March 2013
- Priority 3 – The implementation of the new arrangements for the Deprivation of Liberty (DOLS)
- Priority 4 – Outcome based specifications acknowledged in the peer led improvement review.
- Priority 8 – 2 consortia bids successful as part of the Early Intervention Framework

- Priority 11 – Carer Assessments and Support Services – new contracts let and work is on-going with new providers to embed new contracts and ensure smooth handover for carers from one organisation to another.
- Priority 12 – New Supporting Independence Services Contract in place, with a review in place to respond to feedback from providers about the consequences of new contract.
- Priority 12 – Single Tender Action with current meal delivery provider, with agreed price negotiation to remove bandings and generate savings. Re-let of contract will be part of the Transformation Programme.
- Priority 13 – A Place to Live – Accommodation Strategy being developed in line with Transformation Blue Print – full document due in November with appendices to be developed over the following years
- Priority 16 – have made use of EY Web mandatory, resulting in significant efficiency and cost savings (due to split of Children's Performance Team - now responsibility of ELS)
- Priority 16 – Development of KNet – use of SharePoint for publishing Performance Monitoring reports
- Priority 17 – significant improvements in safeguarding data and performance, through 1:1 support and training with the teams, ensuring staff are aware of safeguarding procedures and the correct data input.
- Priority 17 – allocation of personal budgets has met the new National targets, with on-going support to the teams.

Key issues:

- Priority 3 – Volume of safeguarding alerts has increased significantly, and over 40% of alerts are from residential settings requiring more complex investigations.
- Priority 5 - is reported as Amber due to the complexity of the Children Centre FSO review which has meant that there has been a revised timetable put in place.
- Priority 10 – Short Breaks Commissioning Strategy to be delivered as part of the Transformation Programme
- Priority 11 – will be delivered through the Transformation Programme – Efficiency partners now appointed.
- Priority 12 – Day Opportunities – no new procurement pending commissioning strategy and transformation. Grants now end 2014 (was 2013) to allow this to happen.
- Priority 14 – is reported as Amber due to the delay of the Sensory Commissioning Strategy, which is now expected to be completed October 2013. Procurement of Sensory Services will follow, and commence this year 2013/14

RAG Rating Definition

Red – Project/Action/Milestone is not complete and will not be completed
Amber – Project/Action/Milestone is partially complete or continuing
Green – Project/Action/Milestone has been completed

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

Meradin Peachey Director of Public Health

To: Social Care & Public Health Cabinet Committee - 12th June 2013

Subject: **Health Improvement Performance Report**

Classification: Unrestricted

Electoral Division: Countywide

Summary:

This report updates the Cabinet Committee on performance of the health improvement programmes that are mandated to local authorities under the newly implemented public health reforms, including those specifically prioritised within the NHS Operating Framework – Health Checks and stop smoking services.

Recommendations:

The Cabinet Committee is asked to note and comment on the report.

1. Introduction

1.1 From 1st April this year responsibility for major public health programmes designed to improve the health of the population passed to local authorities. KCC is now responsible for the delivery and performance of those programmes.

1.2 This report shows the performance on the mandated services that KCC has to provide for the final quarter of year ending March 2013.

1.3 The report adopts a dashboard style with individual targets rated as Red, Amber or Green (RAG).

2. Exception Reports

2.1 Smoking Cessation

2.1.1 Delivery of smoking cessation targets has been mixed. In the East of the County 94% of the annual target has, so far, been reached however this is mitigated by an achievement of 76% of the target in West Kent. Overall the target for Kent has been underachieved by 14**%.** The final submission of figures is not required until mid-June; a verbal update will be provided.

2.1.2 Work with the provider of the service, Kent Community Health NHS Trust (KCHT), continues to improve the performance in West Kent including public campaigns and developing the referral rate from clinical staff. Increasing

numbers of community pharmacies should also impact positively as the work we've have done with GPs and the Local Medical Committee in the West of the county.

2.1.3 Of growing concern, from a service delivery point of view, is the increasing popularity of e-cigarettes which are currently not classed as an aid which can be taken into account when determining smoking quits. Currently, we await the National Institute for Health and Care Excellence (NICE) to provide formal national guidance on this.

2.2 Health Checks

2.2.1 Health Checks is a five year rolling programme with the expectation that 20% of the total cohort eligible for a health check will have been offered a health check annually. Thus it will take five years for us to reach the 100% mark

2.2.2 The target that was set for the service with the SHA was challenging for 2012/13 with quarterly projections highest in the first two quarters of the new financial year (these are based on evidence of uptake in longer running programmes). The east of the county very nearly achieved targets for both the number of invitations and the number of health checks received target. In the West of the county work continues to increase the number of GP practices involved. Again, work with the Local Medical Committee has been beneficial in gaining GPs involvement in the West.

2.2.4 As agreed at previous Cabinet Committee, KCHT is now the main provider of NHS Health Checks across the county, with contracts in place with GPs and other providers where necessary.

2.3 Breast Feeding

2.3.1 Performance against target for breast feeding initiation has deteriorated in the final quarter of the year. This is likely to be linked in part to issues around the collection of the data in primary care which are being investigated.

2.3.2 Commissioning proposals are being drawn up to increase investment in breastfeeding support services and a Business Case has been drafted in preparation procure further services service.

2.3.3 Public Health Specialists are prioritising these programmes with district councils. Swale, in particular, is an outlier and focussed work is being undertaken in the community in Sheppey and with Swale CCG and Swale Borough Council.

3. Conclusions

3.1 Performance in delivering smoking quits and therefore the contribution to reducing smoking prevalence remains a concern which Public Health will be monitoring closely with our provider. NHS Health is in a much better position, particularly in the West, and we expect delivery of this year's target to be achieved. Rates of breast feeding initiation will remain as a priority until we can demonstrate improvement in ascertainment coverage and more importantly, uptake.

3.2 Now that Public Health have formally moved to the Kent County Council, we will be ensuring performance management of the Public Health programmes is integrated with wider KCC performance management and will bring to next Cabinet Committee and more inclusive performance report.

4. Recommendation(s)

Recommendation(s):

The Cabinet Committee is asked to note and comment on the report.

5. Contact details

Report Author

- Andrew Scott-Clark, Director of Health Improvement
- 0300 333 5176
- andrew.scott-clark@kent.gov.uk

Relevant Director:

- Meradin Peachey, Director Of Public Health
- 01622 694293
- meradin.peachey@kent.gov.uk

Background documents: *none*

Kent Public Health Department

Public Health Performance Report Dashboard

Programme	Target	Achieved	RAG	
1 Smoking Quits				
Nos of people successfully quitting: Annual Target				
Nos of people successfully quitting: Progress against Q4 Target	9,251	7,908	R	
Service delivered by Kent Community Healthcare NHS Trust, target agreed with Public Health and relates to people who have set a quit date and successfully quit at the four week follow up				Q4 2012/2013 to date
Service runs across the financial year, data runs 10 weeks in arrears				
2 Health Checks				
Number of Invites for Health Checks	91,241	67,992	R	
Number of Health Checks completed		29,845	A	
Service delivered by numerous providers, with GP practices being the fundamental buiding block of the programme. The programme is a five year rolling programme for 40 to 74 year old people who are invited for a vascular health check once every five years, except if they are already on a vascular disease register				Q4 Submission
Service runs across the financial year, data runs six weeks in arrears				
3 Sexual Health				
GUM Access	95%	98%	G	
Chlamydia Screening Uptake rate	35%	26%	R	
Chlamydia Screening Positivity	7%	7%	G	
Access to Genito-Urinary Medicine is an important element in reducing the rise in the incidence and prevalence of sexually transmitted disease; the target is 95% of patients offered an appointment to be seen within 48 hours. Chlamydia screening is an opportunistic screening programme targeting sexually active people aged between 15 and 24 years. Emphasis of the programme has been on Uptake rate with a national target of 35% of the eligible propulation. Emphasis in future years is to be based on positivity ensuring individuals at risk are screened.				progress for Q4 2012/2013
Service runs across the financial year, data runs 8 weeks in arrears.				
4 National Childhood Measurement Programme				
Measurement Reception Year	85%	94%	G	
Measurement Year 6	85%	95%	G	
The National Child Measurement Programme (NCMP) is an annual programme to measure the height and weight of all children in Reception and Year 6. The aim of the programme is to provide the national statistics on obesity within the two cohorts with a target of measuring at least 85% of eligible children, and to provide direct feedback to partents on their children's healthy weight.				2011 to 2012 outturn
The service runs over the acdemic year, with the service uploading to a national data repository				
5 Healthy Schools*				
Achievement of Healthy School Status	98%	97%	A	
Engagement in the enhamcement model	40%	56%	G	
Healthy Schools is undergoing review with the service currently to look at a future model of delivery which supports reduction in teenage conceptions, reduces young people's smoking and substance misuse prevalance, reduction of unhealthy weight together with emotional health and wellbeing*				to Q4 2013/2013
This service runs over the acdemic year.				
6 Breast Feeding Initiation				
Coverage rates (the percentage of ascertainments of breast feeding status)	95%	96%	G	
6-8 week breastfeeding rates (prevalence)	46%	40%	R	
Breastfeeding newborn babies is evidenced to improve long term outcomes, for both mother and baby; this target measures both the ascertainment of breastfeeding status and the prevelance of initiation and maintainance of breastfeeding for 6-8 weeks. The 6-8 week target is relatively new and has required detailed work with midwives, heath visitors and GP practices to ensure robust reporting				Q4 2012/2013
The service runs over the financial year, data runs two months in arrears				
7 Health Trainers				
Number of new contacts	2,500	4,492	G	
The Health Trainers Programme is commissioned to help people in our most deprived communities to develop healthier behaviour and lifestyles. HT's offer practical support to change individual's behaviour to achieve their own choices and goals. This involves encouraging people to: stop smoking, participate in increased physical activity eat more healthily, drink sensibly and/or practice safe sex. The service not only seeks new clients, but ensures existing clients have personalised written care plans and, where appropriate, are signposted to other servies.				to Q4 2012/2013
Service runs arcross the financial year, data runs 6 weeks in arrears				

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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