# SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

**Thursday, 21st March, 2013**

**10.00 am**

**Darent Room, Sessions House, County Hall, Maidstone**

**AGENDA**

# SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

| **Thursday, 21 March 2013, at 10.00 am**<br>**Darent Room, Sessions House, County Hall, Maidstone** | Ask for:<br>Telephone: | **Theresa Grayell**<br>**01622 694277** |
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*Tea/Coffee will be available 15 minutes before the start of the meeting*

**Membership (13)**

Conservative (11): Mr C P Smith (Chairman), Mrs A D Allen (Vice-Chairman), Mr R E Brookbank, Mr N J D Chard, Mrs V J Dagger, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr P W A Lake and Mr A T Willicombe

Liberal Democrat (1): Mr S J G Koowaree

Labour (1) Mr L Christie

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**UNRESTRICTED ITEMS**

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

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

A4 Minutes of the Meeting of this Committee held on 11 January 2013 (Pages 1 - 14)

A5 Minutes of the Meeting of the Corporate Parenting Panel held on 14 December 2012, for information (Pages 15 - 22)

A6 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

B2 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) (Pages 23 - 28)

## 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 13/00001 - 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) (Pages 29 - 56)

## 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 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) (Pages 57 - 74)

D3 13/00024 and 13/00023 - Public Health Transition (Decisions to be taken by the Cabinet Member for Adult Social Care and Public Health) (Pages 75 - 86)

## E. PERFORMANCE MONITORING ITEMS

E1 FSC Directorate Financial Monitoring Report 2012/13 (Pages 87 - 138)

E2 Children's Services Improvement Programme: Progress Update (Pages 139 - 146)

E3 Ofsted Inspection: Protection of Children (Pages 147 - 166)

E4 Update on the Children and Young People's Mental Health Services (CAMHS) (Pages 167 - 176)

E5 Families Services Directorate Performance Dashboard for January 2013 (Pages 177 - 198)

E6 PH Performance Dashboard - Health Improvement Programmes Performance Report (Pages 199 - 202)

**<u>Motion to exclude the press and public</u>**

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.

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

F1 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) (Pages 203 - 204)

Exempt Appendix to Item B2

Peter Sass
Head of Democratic Services
(01622) 694002

**Wednesday, 13 March 2013**

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**KENT COUNTY COUNCIL**

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# 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 Friday, 11 January 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, Mrs V J Dagger, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr S J G Koowaree, Mr P W A Lake 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 MacNeil (Director, Specialist Children's Services), Mr A Scott-Clark (Director of Health Improvement (KCC), NHS Kent and Medway), Ms P Southern (Director of Learning Disability and Mental Health), Mrs A Tidmarsh (Director of Older People and Physical Disability) and Miss T A Grayell (Democratic Services Officer)

**UNRESTRICTED ITEMS**

**58. Minutes of the Meeting held on 9 November 2012**
*(Item A4)*

RESOLVED that the Minutes of the meeting held on 9 November 2012 are correctly recorded and they be signed by the Chairman. There were no matters arising.

**59. FOR INFORMATION - Minutes of the Meeting of the Corporate Parenting Panel held on 26 October 2012**
*(Item A5)*

RESOLVED that the Minutes of the meeting of the Corporate Parenting Panel held on 26 October 2012 be noted.

**60. Oral Updates by Cabinet Member and Director**
*(Item B1)*

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

   - ***Attended the Local Government Information Unit (LGIU) Roundtable Conference on End of Life Care on 30 November 2012,*** at which KCC received good feedback on its end of life care. A report on this issue will be considered at the Health and Wellbeing Board on 30 January.
   - ***Spoke at South East England Councils Ageing South East Workshop on 18 December 2012***
   - ***Market Oversight in Adult Social Care Consultation*** – KCC's response to the consultation needs to be submitted before the next Cabinet Committee meeting on 21 March, and it was agreed that a Member Group be established to comment on a draft response which Mr Gibbens will then sign off and send

on behalf of the Council. *A meeting of this Group was subsequently arranged for 7 February.*

- ***Responding to the Budget*** – the Budget will be challenging again this year, and KCC will need to look carefully at what it provides, while aiming to maintain eligibility criteria at moderate. Budget areas are being managed effectively, despite ongoing challenges. Mrs Tidmarsh and her team were particularly commended on their management of the Older Persons' budget.

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

- ***NHS monies for Social Care*** – KCC is currently working on how to use new health monies from 1 April 2013. KCC is working closely with NHS and has a good relationship with clinical commissioning groups. Key pressures are around hospital discharge and avoiding admissions.
- ***Winter Pressures*** – information on this funding is now available, although actual sums are not yet known. Hospital admissions always rise around Christmas and during severe weather, and the usual pattern is expected this year.

3. The oral updates were noted, with thanks.

**61. 12/01981 - Kent County Council's Annual Report (Local Account) on Adult Social Care for April 2011 to March 2012 (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health)**
*(Item B2)*

*Mrs S Abbott, Head of Performance and Information Management, was in attendance for this item.*

1. Mrs Abbott introduced the report, which had been developed to take account of comments on content and style made at the November meeting of the Committee. A Member briefing since the November meeting had been well attended. As the Local Account process was new in 2012, its engagement process is still evolving, and the 2013 report will start to be prepared and consulted upon earlier in the year, being shared with the Cabinet Committee in June 2013. This new timetable will address some of the concerns Members had in November about the process feeling hurried and the document appearing unfinished.

2. In response to a question about the effectiveness of the assessment process, Mr Ireland explained that it is subject to ongoing monitoring to ensure that it is timely, cost-effective and appropriate, and that efficient and optimal use is made of the self-assessment process. Assessments which are complex or particularly challenging are undertaken by the most experienced staff.

3. RESOLVED that the decision to be taken by the Cabinet Member for Adult Social Care and Public Health, to approve the final KCC Annual Report (Local Account) on Adult Social Care for April 2011 to March 2012, be endorsed, and the revised preparation timetable for the 2013 version be noted.

**62. Oral Updates by Cabinet Member and Director**
*(Item C1)*

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

- ***KCC/Coram Adoption Summit*** was well attended. A map is being launched on 11 January to show 'hotspots' where adoption rates are of particular concern. So far in this financial year, 107 children have been placed with adoptive parents, compared to 68 in the whole of the 2011/12 year.
- ***Ofsted inspection*** outcome will be published on15 January. A further inspection of Adoption, Fostering and Children in Care is expected in late Spring.
- ***Care Leavers' Charter*** - KCC will sign up to the Charter, which includes parts which relate to educational attainment of children in care.
- ***Launch of Sussex Partnership NHS Foundation Trust Children and Young People's Mental Health Services.***
- ***KCC has been invited to speak to the Joint Human Resources Committee on support for Unaccompanied Asylum Seeking Children (UASC)***. There is still a £3m funding gap, so lobbying of the Minister will continue, to keep the issue live.

2. Mrs Whittle responded to comments and questions from Members, as follows:-

a) Members thanked Mrs Whittle and paid tribute to all the work she has done to promote and improve KCC's adoption service and to tackle other issues, such as UASC. They also expressed dismay that the news media still choose to give negative rather than positive coverage. *Although KCC has wanted to improve its Adoption service, it has actually matched the national average in terms of its performance. Having an improvement notice for its safeguarding service drew critical attention to its other services, and because KCC is upfront about its wish to improve (ie by engaging Martin Narey) this can and has drawn negative media attention to its other services. KCC's Adoption service is now performing above the national average, and much work is going on to improve relationships with Courts to speed up the adoption process. Potential new initiatives such as Adoption 'parties', which have been trialled by other local authorities, need to be very carefully thought through before being tried in Kent;*

b) a view was expressed that KCC perhaps needs to be a bit smarter about its public relations approach and try to predict follow-up enquiries and how a statement might be used or misused. Perhaps a new style of press release would help;

c) *the number of children in care has now stabilised and it is hoped that it won't increase further, but it is not realistic to expect it to decrease;*

d) KCC continues to fund services for those young people who have exhausted all rights to stay and are awaiting repatriation. The security of the accommodation used for these young people needs to be reviewed, to protect them from potential traffickers;

e) Members expressed ongoing concern about the number of agency, temporary and interim staff being employed and the need to achieve as many permanent appointments as possible. Members would like to see a plan setting out how this aim will be achieved; and

f) it had been noted, by Members as well as Martin Narey in his review, that all Adoption staff and all the speakers at the recent Adoption summit, are female. Fathers are often the most difficult to convince about adoption, and having some male Adoption staff might start to address this problem. *Mrs Whittle agreed with the observation that Adoption can appear to be a female-only issue and undertook to look into why there are no male staff in the Adoption team and what can be done to address this.*

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

- ***Peer Review and Inspection.*** A second draft peer review letter has now been sent to all Members. The new Children in Care framework will start in Spring 2013. The next inspections will not be pre-announced.
- ***Adoption*** – future work is being carefully planned to ensure that Coram's work continues beyond 2014. Ofsted will be shown the future plan at the next inspection.
- ***Appointment of Area Director for Dartford, Gravesham and Sevenoaks, Mr Philip Segurola.***

4. The oral updates were noted, with thanks.

**63. Short Breaks for Disabled Children**
*(Item C2)*

*Mrs R Henn-Macrae, County Manager for Disabled Children, was in attendance for this item.*

*Mr Ferrin declared an interest in this item as his wife is a member of a voluntary organisation which arranges breaks for children from the Demelza House Hospice.*

1. Mrs Henn-Macrae introduced the report and, with Ms MacNeil and Mrs Whittle, responded to comments and questions from Members. The following points were highlighted:-

a) some parents' groups with which Members work in their local area are not aware of the East Kent service hubs referred to in the report, but better awareness and access to this sort of hub would help them greatly. *The East Kent hubs have been built but not yet launched, and publicity of them will happen when they are fully established. It was hoped that similar hubs in West Kent could be established as soon as possible, but government funding was later withdrawn, so a joined-up service will be provided in West Kent by using whatever premises are already available;*

b) the underspend on the short breaks service is not due to a lack of demand but lack of provision, and children who should be able to access short breaks are unable to. *The underspend is only in relation to day care, not the short breaks service as a whole, and is offset by an overspend in Direct Payments which enables families to make their own choices about short breaks. There is not a barrier to children accessing short breaks in general;*

c) one Member stated that he had been given no choice of whether or not to take up a Direct Payment for his son, and suspected that other parents had had the same experience. In this way, neither the Direct Payment system or the short breaks service is working as it was intended to. *Ms MacNeil and Mrs Whittle undertook to look into the points raised, and added that perhaps the Direct Payment system expects parents to understand and take on too much administration for themselves. The short breaks scheme has arranged some excellent events recently, and Mrs Whittle paid tribute to the team which organises these*;

d) the issue is not of lack of quality but of lack of capacity and ability to reach all the families which could benefit from the service. Provision appears to be uneven across the county. *Mrs Henn-Macrae advised that more overnight breaks were being added to increase the capacity of the scheme. She undertook to supply Members outside the meeting with a breakdown of the geographical use of the service*;

e) the report had originally been requested to explain why the service had shown an underspend, but the content of the report had opened Members' eyes to the running of the service and the value of it;

f) Members re-asserted their concern that Direct Payments must remain a voluntary option and should not become a condition of receiving a service. *Mrs Henn-Macrae advised that the County Council is obliged to offer a Direct Payment as an option, but assured Members that anyone who does not wish to take it up is not compelled to;* and

g) Mrs Whittle was thanked for the personal interest she has taken in developing the short breaks scheme, which is a vital support to the parents who use it.

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

**64. Oral Updates by Cabinet Member and Director**
*(Item D1)*

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

- ***Attended the Kent Stop Smoking Service Annual Conference 2012 on 26 November 2012***
- ***Department for Communities and Local Government Select Committee visit to Kent on 28 November 2012***

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

- ***Public Health Transition to Kent County Council –*** formal consultation with staff moving from the NHS to the KCC will take place from January onwards. The government funding allocation to local authorities for public health services, announced on 10 January, had been more generous than expected, and covers a period of two years, which is welcomed.
- ***Launch of national Stop Smoking campaign***

- ***Local launch of proposals for sexual health/GUM services in north Kent.*** *A report on this issue will come to the Cabinet Committee's next meeting, so Members have the opportunity to comment on a decision to be taken by Mr Gibbens on interim service provision.*
- ***Connecting Communities work in Thanet***, centred on Newington and Cliftonville, is part of a national programme which has run for some 15 years.

3. Mr Gibbens responded to comments and questions from Members, as follows:-

   a) a view was expressed that having a performance target for the number of people encouraged to give up smoking conflicts with the fact that some KCC staff pension funds are invested in tobacco companies. *Mr Gibbens responded that ethical investment is a very broad issue, on which the KCC had made its policy very clear;* and

   b) the budget which accompanies the public health duties transferring to the KCC in April will be listed separately from the Adult Social Care budget, so the two can be distinguished.

4. The oral updates were noted, with thanks.

**65. Families and Social Care Directorate Financial Monitoring 2012/13**
*(Item E1)*

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

1. Miss Goldsmith introduced the report and explained that it had been difficult to make a like-with-like comparison to previous quarters' reports as some Adult Services lines had been added and Early Years is still historically listed as part of the Education portfolio budget.

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

**66. Families and Social Care Performance Dashboards for October 2012**
*(Item E2)*

*Mrs S Abbott, Head of Performance and Information Management, and Mrs M Robinson, Member Information Services Manager, were in attendance for this item.*

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

**67. Children's Services Improvement Plan: Progress Update**
*(Item E3)*

1. Ms MacNeil introduced the report and assured Members that work on the improvement of services was ongoing. She explained that the recent restructure was continuing to bed in and it and work with the Courts to speed up the adoption process were both starting to show some effect. The number of children who are the subject of a Child Protection Plan has decreased.

2. Ms MacNeil, Mrs Whittle and Mr Ireland responded to comments and questions from Members, explaining the following:-

a) the ongoing issue of the number of children in care placed in Kent by other local authorities, and the challenge of finding school places for them, is being addressed by a working group set up by the Department for Education, with representatives from London Boroughs and Kent County Council (Ms MacNeil). KCC has a statutory duty to provide a school place for a child in care placed by another local authority. Some children's homes have their own arrangements for finding places. Some places in pupil referral units are taken by children from other local authorities, displacing Kent's own children in care. Ms MacNeil added that she is not aware of any problem of Kent's own children in care accessing school places;

b) taking a child into care is a very difficult decision to make, and the assessment process is necessarily robust. The child's needs are always paramount, and it is important to make the best possible decision about their future and to place them as soon as possible in a suitable situation. In some cases, it is deemed appropriate to return a child home, but in these cases the decision to take them into care should in no way be viewed as a 'mistake';

c) social workers can only take a child into care with the authority of a Court Order. The application for that Order is very closely scrutinized, and very few applications are refused. Only the Police can remove a child without an Order, for the child's protection;

d) in its self-audit process, KCC is open and clear about its performance and about reviewing its progress. The format of performance reports has so far followed the style and headings in the Improvement Notice, to which they have been responding, but future reports to the Cabinet Committee will be in a different format which responds to the way in which Members and officers would rather see information;

e) the impact of the social worker recruitment campaign launched in September 2012 varies across the county, and Ms MacNeil undertook to advise the questioner outside the meeting on the impact in specific areas;

f) the term 'looked after child/ren' will no longer be used and is being replaced by the preferred term 'child/ren in care'; and

g) the number of children in care in Kent has stabilised at just over 1,600, at a time when the national figure is increasing. In Kent, children stay in care for a shorter time, moving on to a permanent placement such as adoption, or returning home. This is due to the quality of KCC's social work staff and the impact of its early intervention measures.

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

## 68. Health Improvement Programmes Performance Report

*(Item E4)*

1. Mr Scott-Clark introduced the report and explained that smoking quits are currently 93% on target, with the full impact of the 'Stoptober' campaign having yet to show up. KCC is ahead of the national average with the number of health checks completed. Members welcomed the inclusion of 6-8 week breastfeeding rates.

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

## 69. Kent and Medway Safeguarding Vulnerable Adults Annual Report April 2011 - March 2012

*(Item E5)*

*Mr N Sherlock, Head of Adult Safeguarding, was in attendance for this item.*

1. Mr Sherlock introduced the report and corrected a figure shown on page 165 of the meeting papers: that the % change between 2010/11 and 2011/12 should read 17.3% and not 54.3%. He and Mr Ireland responded to comments and questions from Members and the following points were highlighted:-

a) preventative work to reduce the number of safeguarding alerts, and a new monitoring regime, is built into the Directorate's Transformation programme, and the nature of this monitoring regime will be reported to a future meeting of this Committee;

b) Members asked that a pocket-sized card be produced which sets out bullet point guidance and contact information which they can use to report or respond to safeguarding issues locally. *Mr Sherlock undertook to prepare some suitable guidance. The Central Referral Unit is happy to give guidance to Members on what to do to report or respond to safeguarding issues in their area, whether related to adults or children;*

c) concern was expressed about the higher number of referrals arising in East Kent compared to West Kent. *This disparity can be explained by the much greater number of care homes located in East Kent;*

d) Members asked about the possibility of shadowing or accompanying a safeguarding officer to see issues at first-hand, as had proved helpful in the 'shadow a social worker' initiative. *Mr Ireland explained that this would need careful thought as most premises are in the private sector and not in KCC control, which might make Member visits difficult to accommodate, but he and Mr Sherlock undertook to look into how best to approach this*; and

e) there has a been a rise in alerts at premises which cater for people with mental health issues, and a Member with a link to the Kent and Medway NHS and Social Care Partnership Trust (KMPT) undertook to ask the Trust about this increase.

2. Mr Gibbens assured Members that adult safeguarding is his top priority. He commented that the number of alerts had increased in recent years due to the raising of

awareness and understanding of safeguarding issues and people's increased willingness to report their concerns. He stated his intention to work more closely with providers to address the issue and assured Members that good safeguarding practice was not an issue of finance.

3. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks, and the Director of Strategic Commissioning, Mr Lobban, be asked to report to a future meeting on how the new monitoring regime will look.

## 70. Dementia - A New Stage In Life: Select Committee One Year On Report
*(Item E6)*

*Mr M Thomas-Sam, Strategic Business Advisor, Ms E Hanson, Head of Strategic Commissioning, and Ms S Gratton, Head of Learning Disability Commissioning, NHS Kent and Medway, were in attendance for this item.*

1. Mr Thomas-Sam introduced the report and explained that the Select Committee would re-convene for its 'one year on' monitoring meeting on 5 February, at which time it would see the report now being presented to the Cabinet Committee. Ms Hanson and Mrs Tidmarsh responded to comments and questions from Members and the following points were highlighted:-

a) Mr Gibbens was thanked for his efforts in keeping Select Committee Members updated on progress through the past year, in particular the development of memory cafes and the buddy system;

b) a scheme run with Darent Valley Hospital, wherein voluntary partners support patients with Dementia while in hospital, has been very successful;

c) managers of residential and care homes are receiving more training on how to manage issues around Dementia under the Safeguarding Quality and Care agenda;

d) assistive technology can help people with Dementia to remain in their own homes as long as possible, and solutions aimed at addressing specific challenges are being developed, eg a GPS tracking device for someone with a tendency to wander out of their home; and

e) KCC has secured funding of £1.2million to improve provision of services for people with Dementia, and bids for allocation of this funding will be reported to this Committee.

2. RESOLVED that the information set out in the report and given in response to comments and questions, and the reconvening of the Dementia Select Committee on 5 February to review progress on the recommendations, be noted, with thanks.

## 71. Community Children and Young People's Mental Health Services update
*(Item E7)*

*Mr I Darbyshire, Senior CAMHS Commissioning Manager, NHS Kent and Medway, was in attendance for this item.*

1. Mr Darbyshire introduced the report and explained that it had been prepared in response to a request from the Committee to have an update on how the new Mental Health and Emotional Wellbeing contracts, which started on 1 September 2012, were operating. He outlined key strands of work as:-

- the inherited backlog of cases is being addressed and the overall number of young people on waiting lists is being reduced.
- the contractor, Sussex Partnership NHS Foundation Trust (SPFT), is currently liaising with CAMHS staff to introduce a new working model by February 2013.
- training to ensure staff refer young people correctly is taking place, supported by funding from the Strategic Health Authority.

He clarified points of fact and responded to comments from Members, as follows:-

a) pie-charts included in the report are difficult to read and the content of graphs and tables is confusing. From the format of the information given, it is difficult to see how many young people are waiting for 40 weeks, for example, and what progress is being made to address this. *The pie-charts had been supplied by SPFT but Mr Darbyshire undertook to ensure that there are clearer next time they are presented. To clarify the information set out in charts: KCC has not been performing well in terms of waiting lists for some time, and there are long waiting lists for some treatments. Many referrals are for behavioural issues and the appropriateness of this type of referral needs to be investigated;*

b) concern was expressed that, as the services were contracted out to a Trust from Sussex, Kent would have to share its services with Sussex. *Members were assured that this is not the case. KCC sets the contract standards, to which the Trust must adhere, and funding for Kent's services is ring-fenced so cannot be diverted elsewhere;*

c) Kent seems to be losing services from the homeopathic hospital in Tunbridge Wells as this does not appear in the contract. *Provision will not necessarily be delivered from the same premises as used by previous CAMHS services, and will include more services delivered in the community;*

d) concern was expressed about the robustness of the contract and the ability to penalise the contractor in the event of poor performance. *Performance is judged by quality controls built into the contract;*

e) transition from children's to adults' mental health services is not mentioned in the contract but is a major and long-standing concern. *This is a gap in the currant contract which will need to be addressed. Transition could be addressed within the service system rather than within specific services;*

f) there is disparity between East and West Kent in terms of waiting times, and neither clear figures or an explanation is apparent. Fuller figures and information will help give a clearer picture in a number of places in the report;

g) *the 'first appointment' referred to does indeed mean the first face-to-face discussion between a young person and a professional who can assess their condition. The waiting times quoted are for routine referrals; if a case is urgent, an appointment can be arranged the same day if need be. However, not all young people who are referred will need to see a specialist;*

h) *only 1% of young people with Asperger's syndrome have been formally diagnosed as such. Mr Darbyshire undertook to look into delays in the case of a young man with Asperger's syndrome which was referred to in the meeting by the family's local Member;*

i) the new Young Healthy Minds contract started on 3 September 2012, so services should be up and running *before* the end of the current financial year; this seems a long lead-in period but the reason for this is not apparent; and

j) in response to a question, Mr Darbyshire explained that 'ACCENT' stands for Adolescents and Children in Care Emotional Needs Team. This is a CAMHS consultation service for Children in Care and is for foster carers and the children and young people placed with them by KCC. Its purpose is to support placements through helping carers, children and young people and associated professionals to understand mental health issues that may be affecting the child or adolescent and how this may be impacting on the placement's stability.

2. Mr N J D Chard proposed and Mr K A Ferrin seconded that a further report be made to the Cabinet Committee's next meeting which will address the concerns raised by Members during debate, set out above, and that the Chief Executive of the contractor, Sussex Partnership NHS Foundation Trust, be asked to attend the meeting to respond to those concerns.

*Agreed without a vote.*

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) a further report be made to the Cabinet Committee's March meeting which will address the concerns raised by Members, set out above, and the Chief Executive of the contractor, Sussex Partnership NHS Foundation Trust, be asked to attend the meeting to respond to those concerns.

**72. 2013/14 Final Draft Budget**
*(Item F1)*

*Mr A Wood, Corporate Director of Finance and Procurement, and Miss M Goldsmith, FSC Finance Business Partner, were in attendance for this item.*

1. Mr Wood introduced the report and explained that some figures in the budget had been updated since the briefings which were held for each political group. He outlined the key issues as follows:-

- the reduction in KCC's grant allocation from Government had been larger than expected, so the discrepancy to cover is larger, at £15m.

- in addition, spending demands have been updated and have risen by £2m, so the discrepancy to cover is now £17m.
- the final draft budget will be published on 14 January and all party groups will have a further briefing soon after. The budget will then go to Cabinet on 23 January and full Council on 14 February.
- identifying sufficient extra savings within this timeframe will be a great challenge, and there is no time to launch a second public consultation exercise.

He responded to comments and questions from Members, explaining the following:-

a) it had previously been forecast that there would be an 'easier' year and a 'tougher' year, in terms of the level of savings required. 2013/14 was meant to be the 'easier' year, with a savings target of 1.5%, but the factors outlined above had increased this required saving to 4%. This is the third of four years of planned savings and the overall total will be around £350m;

b) there is now no automatic increase in government grant funding to take account of demographic trends, eg an increasingly elderly population. Government funding is instead based on business rates, split between the County and District Councils in a ratio of 20:80%, but the actual spending pattern simply does not reflect this ratio; and

c) a view was expressed that the government funding this year reflected the pattern seen many times before, and the County Council would cope this time as it had coped before. It is clear that Children's Services should be protected from having to find savings, but proposals for adult services raise concern, and whether or not these will deliver sufficient savings. The speaker did not share the pessimism of others as the stock market has risen since September 2012 and there is a new mood of optimism in the business economy.

2. The Committee discussed the need for a further meeting of the Informal Member Group to look again at the budget before the County Council meeting in February. It was asserted that the purpose of an IMG is to inform and strengthen the stance the Cabinet Members should take when supporting their portfolios' budget allocations at County Council, and that the IMG allows Members to look at issues in depth. Others felt that another meeting of the IMG would serve no purpose, as the detail of the budget can be explored at Member briefings. It was pointed out that the role of Member briefings and an IMG are not the same. Mr L Christie then proposed and Mr S J G Koowaree seconded that a further meeting of the IMG be convened.

*Lost, 8 votes to 2*

3. RESOLVED that the information set out in the report and given in response to comments and questions be noted, with thanks, and no further meeting of the budget IMG be convened.

**73. Business Planning 2013/14 - Draft Plans (FSC)**
*(Item F2)*

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

1. Mr Thomas-Sam introduced the report and explained that each Cabinet Committee was being given the opportunity to comment on the draft business plans for its portfolio areas in advance of the final business plans being approved by the Cabinet in March. In response to a question, Mrs Tidmarsh explained that the '3 million lives' initiative listed in the plans is a pilot government scheme to spread assistive technology to reach three million people, rather than the 6,000 people who were the target of the whole system demonstrator. Kent is a pathfinder county for this initiative and there is much work to do around procurement of services in time to start the scheme.

2. The Committee discussed the usefulness of all Members being sent full business plans, and gave views on the length and content of them, as follows:-

a) the great amount of text in business plans is simply not read by many, so the cost of producing and sending a copy to every Member is not justified;

b) previously, one or two copies would be placed in the Members' room at Sessions House for Members to refer to, and it was suggested that this custom be resurrected; and

c) the role of business plans is to justify a directorate's work to the outside world. Staff preparing such documents need guidance on what it is necessary to include, and how to make information clear and concise. Too often, authors resort to including all available information, which is sometimes simply not necessary.

3. RESOLVED that the information set out in the report and its appendices, and given in response to questions be noted, with thanks, and Members' comments, set out above, be taken into account when preparing the final business plans for approval by Cabinet in March.

**74. Business Planning 2013/14 - Draft Plans (PH)**
*(Item F3)*

1. Mr Scott-Clark introduced the report and explained that, at the time of preparing it, the government funding allocation which would support it was unknown, having been announced on the day before this Committee's meeting.

2. RESOLVED that the information set out in the report, and the draft Public Health business plans appended to it, be noted.

**75. Public Health 23 Programmes**
*(Item F4)*

1. Mr Scott-Clark introduced the report and explained that the Cabinet Committee was being asked to support the proposal to roll forward the majority of existing contracts with providers, giving time to prioritise and systematically review each and every contract, following the novation to the Kent County Council. The exceptions to this are the changes which have previously been agreed by this Committee and are set out in the report.

2. RESOLVED that:-

a) the detail of the 23 Public Health programmes and services which become the responsibility of the County Council from April 2013 be noted; and

b) the Cabinet Member's approach to roll existing contracts, with a prioritised and systematic review through 2013/14 and beyond, with the exception of the programmes previously agreed by this Committee, be endorsed.

**76. Meeting Papers**

1. During the meeting, Members referred to the excessive volume of material which had been produced to accompany the agendas for recent meetings, and a discussion ensued about the usefulness of the material produced. Points raised were as follows:-

- the volume of reading is too much to digest and consider in time for the meeting, so the length of agendas and the volume of material produced should be revisited.

- the time of year had partly accounted for the length of the agenda and the amount of accompanying material. There were several large items, such as business plans, which the Committee needed to look at before it could comment on and input into the development of them.

- the cost of producing such large papers, in terms of preparation time, paper, printing and postage, caused concern. It is not necessary to have so much paperwork.

- the agenda is large as there are three major issues included in it, but in such a large agenda Members cannot do justice to any of the items properly. The size of agendas is becoming unworkable.

2. The Chairman undertook to discuss the matter with the Cabinet Members and Directors.

**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 Friday, 14 December 2012.

PRESENT: Mrs A D Allen (Chairman), Mr M J Vye (Vice-Chairman), Mrs T Carpenter, Mrs P T Cole and Mrs J Whittle

IN ATTENDANCE: Ms M MacNeil (Director, Specialist Children's Services), Mr P Brightwell (Performance and Quality Assurance Manager, LAC) and Miss T A Grayell (Democratic Services Officer)

**UNRESTRICTED ITEMS**

**17. Membership - to report that two of the co-opted Members - Anthony Duncan and Graham Razey - have left the Panel.**
*(Item A1)*

1. The Chairman reported that Anthony Duncan and Graham Razey had left the Panel; Mr Duncan as his Apprenticeships with Virtual School Kent had ended and Mr Razey as his changing professional role - eg he is no longer the Chair of the local Young Care Leavers in Post Compulsory Education (YCLPE) Group – had made his membership less relevant.

2. She read a note from Mr Razey saying how much he had enjoyed his time on the Panel and how impressed he had been by the commitment displayed by Panel Members. Members asked to be told how Mr Duncan is getting on, and Mr Brightwell undertook to find out and advise the Panel outside the meeting.

3. RESOLVED that the departures be noted and that replacement Members be sought.

**18. Minutes of the meeting held on 26 October 2012**
*(Item A3)*

RESOLVED that the Minutes of the meeting held on 26 October 2012 are correctly recorded and they be signed by the Chairman. There were no matters arising.

**19. Cabinet Member's Oral Update**
*(Item A5)*

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

- **Adoption Summit in early December:** this had been well attended, and good news stories had arisen recently from media coverage.
- **Our Children and Young People's Council (OCYC) meeting on Saturday 8 December**, which Mrs Whittle had attended with Ms MacNeil. Social worker recruitment is an ongoing issue. The aim is to achieve permanent, qualified social workers making up 90% of the workforce.

Young people with a positive experience of the social work process are helping with the recruitment campaign, and positive media coverage is being sought.

- **Support for Care Leavers:** there will be a TV programme about this issue on 17 December, and Mrs Whittle will also take part in radio coverage of the issue. Care leavers report varying experiences, but social worker recruitment is a shared and ongoing issue. There are 1,000 care leavers in Kent. The average age at which a young person comes into care is 12-and-a-half, so the care period covers the most difficult teen period and many emotional issues.
- **Funding of Boarding School places** will be the subject of focus in the next few months. Three new placements are currently being considered. The scheme needs to catch young people who are on the edge of care, and flexible (eg part-time) fostering is a vital part of this.

2. Mrs Whittle and Ms MacNeil responded to questions and comments from Members and the following points were highlighted:-

- Social worker recruitment – is the pool of social workers with sufficient training too narrow, and how can this be addressed? What on-the-job training is given? *Kent has many good social workers but the 'burn-out' rate is very high, so there is always some turnover. Raising the profile of social work study would help – eg establish a social work 1st degree. Radio Kent did some good work a year ago with a series of sound bites about the role of social workers, foster carers, adopters, etc. KCC needs to feed the media good news stories, otherwise coverage given will be of bad news that the media finds for itself. Children and Families social work is a very difficult job and does not suit everyone. Many students study social work at University but few are interested in Children and Families, and those who are interested may not necessarily prove suitable; they need help to see the reality of the role. Mrs Whittle will meet soon with the University of Kent at Canterbury about their Child Protection course, and in-house training can be refined and developed*. If a change of social worker for a young person cannot be avoided, then a handover period would help, and changes should be avoided at vital times (eg around exams) unless absolutely necessary. Young people get a good service from social workers but it is not consistent.
- Support for Care Leavers – a Foster Carer on the Panel gave examples from her experience: one young man came late into care and has struggled with learning difficulties but has a strong work ethic, while another came into care at the age of 7 and has had a better experience, going through University successfully. The latter is still living with his foster family at 22. Correct support is vital, and needs to be flexible and tailored to the young person – eg supported lodgings can be difficult if a young person is not sufficiently prepared. In Kent's Pledge, care leavers get a higher education study bursary of £1,000 per year for 2 years, and there is also a commitment to support young people in low paid jobs up to the age of 21. Members were reminded of the example quoted at the October Panel meeting - of the support being sought being included in the Pledge but a social worker advising the foster carer that it wasn't. This issue needs to link to good training for social workers so they give correct message and support. *Ms MacNeil repeated her commitment to check social workers' awareness of facts so that foster carers are properly advised*. *The Children's Minister has urged all local authorities to*

*sign up to the Care Leavers' Charter, the principle of which is that local authorities will take a life-long interest in young people previously in their care. The Charter content is good but some areas are a bit vague to commit to, and Kent already exceeds much of what the Charter says. Part of the life-long interest would include support for young people learning about parenting, as many have no good parenting role model. Long-term support needs to be correct and discreet.*

3. The oral updates were noted, with thanks. A written bullet point update on Virtual School Kent, prepared by Mr Doran, was tabled.

**20. Update on Adoption Service**
*(Item B1)*

*Ms Y Shah, Coram/KCC Project Manager, was in attendance for this and the following item.*

1. Ms Shah introduced the report and highlighted key points, as follows:-

a) the report had been prepared using figures taken in October, and figures were updated orally, as follows:-
- the number of children adopted so far this year had risen from 57 to 75
- the number of children placed for adoption in the same period had risen from 73 to 105 (compared to 66 for the whole of 2011/12);

b) children make great progress once they are placed for adoption, and the earlier they can be placed and adopted, the better it will be for them;

c) she thanked the County's Childcare Social Work staff for their positive and constructive approach to working with Coram to improve the Adoption service. Good news stories, such as those in the statistics listed above, should be celebrated;

d) matching children with adopters is an ongoing challenge, and when adopters have a choice of children, it is always those who are older, disabled, from an ethnic minority or with siblings who are last to be placed;

e) Kent has established the innovative Family Finding team. Every child awaiting adoption has an allocated Family Finding worker, and these workers take the family finding role from busy social workers and free them up to work on court proceedings;

f) Kent is the largest local authority in the UK to pilot a scheme which links the KCC to adoption partners, to address the issue of hard-to-place children;

g) although much progress has been made, there is still much work to be done in terms of cultural change. The most experienced social workers can also be the most entrenched; and

h) the aim is to approve 83 new adopters this year (compared to 44 in 2011/12), and this target is achievable.

2. Ms Shah and Ms MacNeil responded to comments and questions, as follows:-

a) Coram's work will continue until 2014, and Members sought assurance that the progress made so far will be sustainable once their work has finished. At every Panel meeting until then, Members should ask about the sustainability of improvements. *Ms MacNeil and Ms Shah assured Members that sustainability was always the aim of the changes currently being put into place, and mechanisms would be left in place to ensure that sustainability;* and

b) it is vital to have permanent managers in place to carry forward the changes and make sure they work. *The interim manager posts which have covered the period of change have helped make the necessary cultural changes. The appointment of good interim managers also avoids posts staying vacant if permanent candidates of suitable quality do not come forward. Kent's large size and diverse nature make its recruiting challenges different from those faced by some smaller local authorities.*

3. Mrs Whittle thanked Ms Shah and Coram for the excellent work they had done to turn around Kent's Adoption service. It had become clear during their work that improvement is not about resources but the way in which those resources are used. 2013 and 2014 will show the outcomes and impact of the improvements made.

4. RESOLVED that:-

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

b) Coram be thanked for the excellent work they have put in to improving Kent's Adoption service, and the progress they have made in a relatively short space of time.

**21. Six-Monthly report by Independent Chairs of Kent's Adoption and Permanence Panels**
*(Item B2)*

1. Ms Shah introduced the report and highlighted key points, as follows:-

a) key weaknesses of the present Adoption Panel system is the style of reporting, quality assurance and the need for reporting to be supported by solid rather than anecdotal evidence;

b) the former 7 Panels will be reduced to 4, but the current total is 5. The outcome of the Panel reduction exercise should be known soon;

c) it is suggested that the membership of Adoption Panels be broadened to include care leavers and a representative of Virtual School Kent, and have links to the CAMHS service and senior childcare managers; and

d) it is suggested that the Panel Chair should write their own reports and be responsible for their own professional development and the Panel's development.

2. Ms Shah and Ms MacNeil responded to Members' comments and the following points were highlighted:-

a) the quality and skill of the Panel Chairman is vital, and the Panel membership needs to have a range of strengths. *A Panel Chairman needs to understand the role of the Panel and its relationship to other bodies (eg the adoption agency), what information each has and how that information is handled;* and

b) *the review has been difficult, with cultural change being required. The Panel system needs to be professional and consistent, with no regional variations.*

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

**22. Update on Trafficking and Unaccompanied Children**
*(Item B3)*

*Ms T Gallagher****,*** *County Manager, Unaccompanied Asylum Seeking Children (UASC), was in attendance for this item.*

1. Ms Gallagher introduced the report and highlighted the following:-

a) the number of young people going missing has reduced since last year, which is to be welcomed;

b) patterns of behaviour can be identified from studying the cases of young people of different nationalities, a summary of which is included in the report, but the key is to find out why the patterns recur and address them;

c) a trafficking assessment calculates the likelihood of a young person having been trafficked, but unfortunately the possibility of trafficking can never be ruled out completely; and

d) KCC is discussing with the UK Border Agency the need to make an immediate referral for any young person who goes missing.

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

a) a new jobskills initiative is being run by partners, including the UK Border Agency, the University of Kent and voluntary organisations, to train those young people who have exhausted all rights (ARE) to stay in the UK. This seeks to make the best use of the time they spend awaiting repatriation as well as improve their chances of finding

employment when they return home. It is hoped that at least half of the current cohort of 27 young people in this category can be signed up and benefit from this initiative;

b) a 'buddy' scheme has been set up to support those who have emotional (but not necessarily mental health) difficulties to cope with the pressures they face. A review of the pilot scheme after 18 months will assess the effectiveness of the support given and see if any other type of support is needed; and

c) Kent is running these initiatives at a local level to address the particular problems that it encounters. Although the immediate effect of these schemes on the national problem might seem limited, they do attract media coverage and generate discussion, which might help and inspire other local authorities to try something similar. The aim is to make the best use of Kent's available resources to address its local problems to the best of its ability.

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) a further update report be made to a future meeting of the Panel.

**23. Performance Scorecard for Children in Care**
*(Item B4)*

1. Mr Brightwell introduced the report and explained that comments made by Panel Members at the previous meeting about the content and style of the scorecard had been taken into account. The format of Kent's scorecard has been admired and the National Children's Bureau has asked to use it as a model of best practice to share with other local authorities. The scorecard is dynamic, responsive and evolving, and Members are asked for ongoing input regarding its content. The priority now is to move from the process of preparing it to focus on the quality of recording, and current challenges are how to reflect young people's views on their care and how to capture the various routes towards permanence. The scorecard can now be accessed by the CAMHS service, and will shortly include the outcomes of exit interviews with young people leaving care.

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

a) frequency of change of social worker should be added to the scorecard, as part of the ongoing review of its content and style;

b) it is difficult to measure and record how Members listen to young people and respond to the points they raise. It is important to get the questions right, but this is difficult to show on a scorecard, although quality assurance reports will show up how the KCC has responded to issues raised;

c) young people could be asked what '10 questions' they would ask if they were the Corporate Parenting Panel;

d) the Apprentice scheme offered by Virtual School Kent could be used as a template for other KCC services to offer work experience to young people, and the value this would add to their CV would help them to compete with their peers. An annual scheme of eight-week placements offers 16- and 17-year olds a chance to gain work experience, and those who shine on this scheme are offered summer work and marked out as good candidates for future Apprenticeships;

e) targets showing red performance ratings show that progress has not been as good as had been wished, and the small number of such targets are subject to close attention and investigation by the Kent Corporate Parenting Group. Kent sets itself very challenging, aspirational targets, so there is always the chance that a few aspects will fall short of the desired level; and

f) many of the targets being measured affect only a small number of young people, so a change affecting only one young person can make a substantial impact on performance figures. Targets can be viewed as a very useful indicator of progress in the long-term.

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) Members' comments and suggestions in paragraphs 2 a) and c) above be taken forward.

**24. CAMHS Update**
*(Item B5)*

*Ms H Jones, Head of Commissioning, Specialist Children's Services and Mr I Darbyshire, NHS Commissioning Manager, were in attendance for this item.*

1. Ms Jones and Mr Darbyshire introduced the report and explained that the new commissioning process and contracts which had started on 1 September 2012 will provide one single pathway to services for the first time ever. This will allow more young people to access mental health services, and some to access them for the first time. There is a predicted backlog and waiting list of young people needing to access services, which is a result of past access problems, but the new contractors are working hard to clear this. Waiting times in East and West Kent differ. In East Kent, the time between referral and first appointment is down to 4 – 6 weeks, with some young people with ADHD and ASD waiting a little longer for a first appointment, while in West Kent the aim is to reduce this same period to 18 weeks by the end of December 2012 and to 4 weeks by the end of the 2012/13 financial year.

2. Ms Jones and Mr Darbyshire responded to comments and questions from Members and the following points were highlighted:-

a) waiting times depend to some extent on the type of treatment needed. For example, there are very few practitioners offering cognitive behavioural therapy, but this treatment, when accessed, is of great benefit to many young people;

b) Kent has had a poor reputation for its CAMHS waiting times, and there is still a way to go to overcome this;

c) many referrals are still received from GPs, although anyone can refer a young person to the CAMHS service. The single pathway for all mental health referrals will include screening and referral either to CAMHS or multi-agency provision;

d) some CAMHS referrals could be a result of poor parenting. Approximately 41% of the waiting list for assessment is made up of young people with 'behavioural problems', and it is important to be able to distinguish what is and isn't a mental health referral and to divert appropriately those which are not. The design of the new system will seek to link CAMHS to mainline services so it is not working in isolation;

e) for some young people, using mental health and wellbeing services still carries a stigma, and they try to avoid becoming labelled. The service seeks to break down this stigma by offering early advice by telephone, to prevent challenges escalating into problems. Educating schools, GPs and Health Visitors about criteria and thresholds can also help them make appropriate referrals;

f) alongside making it easier for young people to access specialists is a drive to assess and optimise the effectiveness of these appointments. While reducing waiting lists, the service also needs to increase the quality of assessments and interventions. To do this, young people's perceptions of the service are assessed at the start, part-way through and at the end of their involvement with it; and

g) transition from CAMHS to adult mental health services is still a challenge, and the Panel could make a recommendation to the Cabinet Member for Adult Social Care and Public Health about the need to improve this transition.

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 further update report be made to a future meeting of the Panel; and

c) the Panel consider making a recommendation to the Cabinet Member for Adult Social Care and Public Health about the need to improve transition from CAMHS to adult mental health services.

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

To: Social Care and Public Health Cabinet Committee – 21 March 2013

Subject: **APPOINTMENT OF A TRANSFORMATION AND EFFICIENCY PARTNER - ADULT SOCIAL CARE TRANSFORMATION PROGRAMME** (Decision number 13/00010)

Classification: Unrestricted

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Summary: This report provides information relating to the key decision to appoint a transformation and efficiency partner to manage the adult social care transformation programme.

Recommendations: Members of the Social Care and Public Health Cabinet Committee are asked to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Adult Social Care and Public Health.

The Cabinet Member for Adult Social Care and Public Health will be asked to:

1. Identify the preferred bidder, as contained within the accompanying exempt report;

2. Agree the award of the contract to that bidder as FSC adult's transformation and efficiency partner; and

3. Delegate Authority to the Corporate Director 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 condition.

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## 1. Introduction

(1) KCC's financial deficit over the next two years (2014-16) is estimated at around £200m and it is clear that public spending will remain under pressure for a number of years. As Adult Social Care is a third of KCC's non-school budget, Families and Social Care is preparing to make significant savings over the coming years. The basis of the Adult Social Care Transformation Programme is that savings of the magnitude that will be needed can only be achieved through transformation (re-designing how social care is delivered). This approach was set out in the Adult Social Care Transformation Programme Blueprint and Preparation Plan which was endorsed by County Council on 17th May 2012.

(2) As transformational changes take time to implement, benefits will take time to grow. The ability to start implementing transformational changes as soon as possible is therefore vital to KCC's ability to manage budgets over the next few years.

(3) In October 2012 an independent efficiency review was undertaken. Based on the considerable amount of detailed analysis, this evidenced that significant opportunities exist for adult social care to transform as well as to help support achieving savings of the order of £18m in the first year.

(4) KCC does not have readily available capacity of appropriate capability to manage a programme as large and as complex as FSC's Transformation Programme.

(5) The expertise of the consultancy used during the review, and the way they worked with KCC staff, was a positive and successful experience. This gave KCC confidence that it was possible to work in partnership with a consultancy. It also gave KCC clarity regarding the added value a transformation and efficiency partner could bring to the implementation stage of the programme and ways of sharing risk.

(6) To identify a suitable efficiency partner a three stage tender process was initiated. The tender process is now complete, a clear leader is identified and we are now in a position to award the contract. Additional information on the outcome is contained in the exempt Appendix A.

## 2. Reasons for appointing a Transformation and Efficiency Partner

(1) Transforming social care will be a complex and time consuming task – taking at least 4 years. This change programme will be resource intensive and require KCC to transform the business, whilst simultaneously ensuring we continue to meet our statutory duties.

(2) The complexity of improving outcomes for vulnerable people in Kent, building a sustainable social care market which is fit for the future, whilst simultaneously working within reduced budgets is a huge challenge. KCC intends to reduce the risks associated with managing a programme of this size and complexity by: a) using a consultancy with enough capacity to support our programme; b) using a consultancy with a high level of expertise and with experience in implementing similar programmes elsewhere.

(3) Without a transformation and efficiency partner KCC's ability to transform adult social care will be severely hindered.

## 3. Tender Process

(1) The tender took place through the Health Trust Europe (HTE) framework via a mini-competition open to 19 organisations that specialise in organisational change. The contract on offer is for 2 years, with an option for KCC to extend by 12 months a maximum of 2 times. A three stage process was designed to ensure that bidders have the relevant skills and experience and that the strongest and best value bid would win the contract.

(2) **Stage One: Track Record.** We received 3 submissions providing evidence of appropriate skills and experience to deliver our programme. All bidders were invited to submit a stage two proposal and, upon signing a Non-disclosure Agreement, were provided with data from the diagnostic.

(3) **Stage Two: Costed Proposal**. All three bidders submitted their proposals detailing proposed changes, resources, estimated benefits, fees and options of how they could share risk with us. Proposals were evaluated based on 4 key criteria (with sub criteria). These were evaluated by a different member of the evaluation team to ensure consistency and fairness in the evaluation process. All three bidders were invited to Stage Three to discuss their proposal in further detail. All bidders were asked to clarify specific issues prior to interview.

(4) **Stage Three: Interview**. Each bidder was interviewed by a panel. Bidders were asked a number of specific questions which tested the robustness of their proposal and checked 'fit' with our organisation and the programme needs. The panel discussed bidders in detail after each interview and scored based on consensus opinion.

(5) **Outcome of the tender process:** At the end of the process Stage Two & Three scores were totalled. One bidder was the clear leader. The lowest scoring bidder was un-awardable due to the poor robustness of their proposal and their poor fit with our organisation. The other two bidders were potentially awardable but further clarification was required to be absolutely certain about what was being offered. Following post-interview clarification, it was agreed that the highest scoring bidder's proposal was awardable, subject to approval of the key decision.

## 4. Policy Context

(1) The Adult Social Care Transformation Programme is crucial to improving outcomes for vulnerable people in Kent at the same time as delivering the £18.8m of transformation savings identified in the 2013/14 budget.

(2) The decision is in accordance with the Policy Framework – specifically the delivery of Bold Steps for Kent.

## 5. Consultation and Communication

(1) There is no requirement to consult or communicate on the identification and appointment of a transformation and efficiency partner.

## 6. Financial Implications

(1) The Transformation Programme will deliver significant savings for the Council over the next few years. As outlined in the KCC Budget, the adult social care transformation programme is required to deliver £18.8m in 2013/2014.

(2) The attainment of a large proportion of both FSC and KCC future savings will be dependent on the success of the adult social care transformation.

(3) Investment in external capacity, expertise and innovation is essential in a time of severe financial pressure to maintain or improve services for Adult Social Care. Not taking action now is likely to increase pressures in the immediate and long-term.

## 7. Legal Implications

(1) Advice has been provided by Corporate Procurement and Legal Services throughout the process to identify and appoint a transformation and efficiency partner.

## 8. Equality Impact Assessments

(1) There is no requirement to carry out an equality impact assessment for the appointment of a transformation and efficiency partner.

## 9. Sustainability Implications

(1) There are no negative sustainability implications to identifying and appointing a transformation and efficiency partner.

## 10. Alternatives and Options

(1) If a transformation and efficiency partner is not appointed – KCC will need to fully resource the programme alone. As KCC does not have enough staff with the composite skills and experience, a significant proportion of this resource will need to be recruited externally. As resources are likely to be recruited individually, it will take time to build a team and for them to get up to speed and work in consistent and co-ordinated way. This will mean a delay to implementation starting and therefore a delay to the realisation of the benefits.  Each month of delay ‘costs’ approximately £1.5m of savings not achieved in 13/14.

## 11. Risk and Business Continuity Management

(1) If transformation is not successfully delivered, adult social care will be unable to operate effectively within the forecast budget – particularly with the expected increase to the over 65 population and rising levels of dementia. Financial and operational pressures have the potential to affect the safeguarding and support of thousands of vulnerable people. These pressures are also highly likely to impact the large provider market in Kent.

(2) There is a financial and reputational risk to the Council if this decision is delayed.

## 12. Conclusion

(1) Using a transformation and efficiency partner to manage the implementation of the adult social care transformation programme will increase our likelihood of successfully delivering improved outcomes to vulnerable people in Kent and of achieving the savings.

(2) Appointing the highest scoring bidder as the adult social care transformation and efficiency partner will enable FSC to start the implementation phase of the transformation programme imminently.

## 13. Recommendation

Members of the Social Care and Public Health Cabinet Committee are asked to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Adult Social Care and Public Health

The Cabinet Member for Adult Social Care and Public Health will be asked to:

1. Identify the preferred bidder, as contained within the accompanying exempt report;

2. Agree the award of the contract to that bidder as FSC adult's transformation and efficiency partner; and

3. Delegate Authority to the Corporate Director 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

## 14. Background Documents

Adult Social Care Transformation Blueprint and Preparation Plan, May 2012

Appendix A – Additional Tender Information (This appendix is exempt on the basis that the contract cannot be awarded without a key decision and therefore is commercially sensitive).

## Contact details

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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

**Date:** 21 March 2013

**Subject:** **EVERY DAY MATTERS: KENT COUNTY COUNCIL'S CHILDREN AND YOUNG PEOPLE'S STRATEGIC PLAN 2013-2016 (Decision no 13/00001)**

**Classification:** Unrestricted

**Summary:** This report presents the draft Kent County Council's Children and Young People's Strategic Plan 2013-2016 to enable Members to inform the final draft document.

Kent County Council's Integrated Children's Services Board commissioned the development of this strategic plan. The draft plan sets out a clear vision for the future direction of children's services in across the County Council. The draft plan was discussed by the Kent Children and Young People's Joint Commissioning Board at its meeting on 31 January 2013. The Board positively endorsed the draft plan and it agreed that work should be done to build on the County Council's overarching framework and produce a multi-agency children and young people's strategic framework for Kent.

**FOR COMMENT**

## 1. Introduction

(1) The purpose of this report is to present the draft Every Day Matters: Kent County Council's Children and Young People's Strategic Plan 2013 -2016 (Appendix 1), for comment before a final draft is produced. Subject to the views of the Cabinet Committee and changes made, the Every Day Matters Strategic Plan will be presented for approval by the Cabinet Member for Specialist Children's Services as soon as possible.

(2) This overarching strategic plan has been developed as a County Council document. However, it should be noted that the Kent Children and Young People's Joint Commissioning Board has agreed that work should be done to develop the County Council document into a multi-agency children and young people's plan for Kent.

(3) The County Council's Integrated Children's Services Board commissioned the development of a children and young people's strategic plan for the authority. Subsequently, Corporate Directors for Families and Social Care, Education, Learning and Skills and Customer and Communities defined the scope of the strategic plan which has culminated into the draft plan presented the Cabinet Committee today.

(4) Every Day Matters was developed against the background of the Local Government Association sponsored peer review in September 2012 and the

Ofsted inspection report of January 2013 regarding KCC's arrangements for the protection of children which judged Kent to be 'Adequate'.

## 2. Policy Context

(1) The County Council's Accountability Protocol has been revised in response to the statutory guidance on the roles and responsibilities, of the director of children's services and lead member for children's services, which was issued by the Secretary of State for Education.

(2) In accordance with amendments to Appendix 2 Part 4 of the Constitution of Kent County Council, the Kent Integrated Children's Services Board has been established to ensure effective leadership and integrated delivery across children's services. It regularly brings together the Leader, Cabinet Members and Corporate Directors for Families and Social Care, Education, Learning and Skills and Customer and Communities to provide a shared understanding of need and performance across the breadth of universal and targeted children's services. It plays a vital role in providing oversight and assurance of frontline delivery, challenge on areas for improvement and identifying opportunities to drive further integration and service transformation across the piece.

## 3. Overview of Every Day Matters Strategic Plan

(1) The draft document describes a clear vision for children's, underpinned by four broad outcomes and five priorities.

The one vision is that:

Every child and young person in Kent achieves their full potential in life, whatever their background.

The four overall outcomes at the heart of the integrated children's services are:

- Keep all children and young people safe
- Promote the health and wellbeing of all children and young people
- Raise the educational achievement of all children and young people
- Equip all young people to take positive role in their community.

(2) The five priorities are as follows:

**Priority 1 - Safeguarding and protection**
- Improving efforts in making sure that children and young people are safe and stay safe in every setting.
- Increasing the awareness and understanding that keeping all children and young people safe is the responsibility of everyone in the community.

**Priority 2- Early help, prevention and intervention**
- Enhancing the responsiveness and inclusivity of universal services that give families the right help early enough to resolve difficulties and reduce the need for further intervention.
- Improving the ability to be proactive in identifying needs of all children and young people.

**Priority 3 - Community ambition, health and wellbeing**

- Improving the consistency and cohesive universal service offer for young people to help support them to make a positive contribution to society
- Ensuring that children and their families have access to timely, effective and responsive health care that gives them the best start in life and resolves health needs as they arise.

**Priority 4 - Learning and achievement**

- Improving the expectations and aspirations for the achievement of all children and young people in all areas of their lives.
- Ensuring all children are ready to succeed at school whatever their background.
- Ensuring that every child or young person has access to a good or outstanding school.

**Priority 5 - Better use of resources**

- Remodelling services and practice to deliver and demonstrate better outcomes for all children, young people and the wider community within available resources.
- Improving the commissioning of effective integrated services that enable families to manage and support them in finding additional help when necessary.

(3) The document is then presented in three sections. Section one, describes where are now and, it provides a high level description of the internal governance arrangements, the breadth of partnerships and a range of underpinning strategies and plans.

(4) Section two, deals with where we need to be in the years ahead. The strategic plan explains the need to strike the right balance between four critical factors of (a) achieving outcomes, (b) skilled and stable workforce, (c) integrated services and (d) evidence of impact.

(5) The third section, describes the steps we will take to deliver the vision and make reality of what 'good looks like'. To deliver better integration and new models of joined up services, require service transformation and plans will be developed based on the defined themes set out in the document.

## 4. Financial Implications

(1) None identified as a direct result of the of strategic plan.

## 5. Legal Implications

(1) In the light of the recent statutory guidance the KCC Accountability Protocol has been revised to ensure that KCC fulfils its statutory requirements in relation to children's services.

## 6. Equality Impact Assessments

(1) The strategic plan complies with the new KCC Equality & Diversity Policy Statement.

## 7. Sustainability Implications

(1) The strategic plan has been assessed against the five principles of sustainability and the evaluation has not identified any negative sustainability implications.

## 8. Alternatives and Options

(1) There are strong reasons for KCC to articulate the strategic direction for children's services in order to avoid the risk of criticism.

## 9. Risk and Business Continuity Management

(1) Reputational risk, if any, relate to the point mentioned in paragraph 8.1 above.

## 10. Conclusion

(1) This report has presented the draft Every Day Matters: Kent County Council's Children and Young People's Strategic Plan 2013 -2016, which has been endorsed by Corporate Directors for Families and Social Care, Education, Learning and Skills and, Customer and Communities and the Kent Children and Young People's Joint Commissioning Board.

(2) The Cabinet Committee is invited to use the opportunity to inform the draft document before a final draft is produced.

## 11. Recommendations

(1) The Cabinet Member for Specialist Children's Services will be asked to take the final decision 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, after taking into account the views expressed by the Cabinet Committee.

(2) Members of the Social Care and Public Health Cabinet Committee are asked to consider and either endorse or make recommendations on the proposed decision to be taken by Cabinet Member for Specialist Children's Services.

## Appendices

Appendix: 1: Draft Every Day Matters: Kent County Council's Children and Young People's Strategic Plan 2013 -2016

## Background Documents

Statutory guidance on the roles and responsibilities of the director of children's services and lead member for children's services, Department for Education, 2012.

Kent County Council Revised Accountability Protocol, July 2012.

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Kent's children and young people

# Every Day Matters

## Kent County Council's Children and Young People's Strategic Plan

2013-2016



Kent County Council
kent.gov.uk

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# Introduction

*Every Day Matters:* Kent County Council's Children and Young People's Strategic Plan 2012 -2015, provides the overarching framework within which Kent County Council's (KCC) children's services work together seamlessly to deliver integrated services and the best possible outcomes for all children, young people, their families and carers in Kent. ***Every Day Matters*** arises from Kent's children's services peer review in September 2012. Peer review is a process whereby an external team acting as a 'critical friend' challenges an organisation and their staff to learn and improve. The recent peer review concluded that child protection agencies in Kent must focus on the child's journey and remember that for children even a day of delay in making decisions about their future can seem like a lifetime.

We have the highest aspirations for all children and young people in Kent and want them to grow up safe and healthy. Every adult and all agencies in Kent have a role to play in protecting all children and young people from harm. We want them to enjoy and benefit from educational and social opportunities. Above all, we want them to make best use of their skills and abilities so that they can reach their full potential as citizens and parents of the future.

KCC's strategic objectives are set out in Bold Steps for Kent, the Medium Term Plan (2010-2013.) The three ambitions of Bold Steps - helping the Kent economy to grow, putting citizens in control and tackling disadvantage, shape what we do to improve services for the people, children and families of Kent.

It is our intention to work with partners that have a crucial role to play in the welfare of children to build on this overarching framework document into a multi-agency framework for children and young people as soon as possible. The diagrams in Appendix 1 show the KCC governance arrangements alongside those of wider partnership and governance architecture.

Ofsted undertook an inspection of KCC's arrangements for the protection of children in December 2012 and judged the service to be 'Adequate.' Inspectors noted the significant improvement since the previous inspection in October 2010, including in early intervention, identification of children at risk and speed of initial assessment. KCC's leadership was praised for the high level of strategic priority and investment that has been dedicated to protecting and improving these services. We recognise that there is still more work to be done and the welfare of children and young people remains KCC's top priority.

We are well placed to implement the Munro principles of enabling social workers to spend more time with children and families and the new 'Working Together' statutory guidance, as well as influencing the Kent education landscape, working constructively with all schools, and making the most of the wide range of universal services that support children, young people and families in Kent.

Whilst we and our partners will face considerable challenges in delivering the outcomes and priorities set out in this plan, we hope that the vision and direction of travel we have articulated will enable all those involved in supporting children, young people and their families to embrace transformation and create future services of which we can all be proud, and enable all children and young people to thrive and succeed.

**Jenny Whittle**
Cabinet Member for
Specialist Children's Services

**Mike Hill**
Cabinet Member
for Communities

**Patrick Leeson**
Corporate Director, Education,
Learning and Skills

**Mike Whiting**
Cabinet Member for Education,
Learning and Skills

**Andrew Ireland**
Corporate Director,
Families and Social Care

**Amanda Honey**
Corporate Director,
Customer and Communities

**March 2013**

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# Kent County Council's Children and Young People's Strategic Plan 2013-2016

**One Vision**
Every child and young person in Kent achieves their full potential in life, whatever their background

**Outcome 1:** Keep all children and young people safe

**Outcome 2:** Promote the health and wellbeing of all children and young people

**Outcome 3:** Raise the educational achievement of all children and young people

**Outcome 4:** Equip all young people to take a positive role in their community

**Priority 1:** Safeguarding and protection

**Priority 2:** Early help, prevention and intervention

**Priority 3:** Community ambition, health and wellbeing

**Priority 4:** Learning and achievement

**Priority 5:** Better use of resources

## Five priorities

Our aspiration is to be a county where all children and young people flourish. Our work is informed by the guiding principle of 'continuum of need' and the determination to provide appropriate and responsive support services. We recognise the need for more integrated provision and we are joining up and transforming services to ensure that no child or young person falls through the gap.

*We will do so by focusing on the following five priorities:*

### Priority 1 Safeguarding and protection

- Making sure that children and young people are safe and stay safe in every setting.
- Increasing the awareness and understanding that keeping all children and young people safe is the responsibility of everyone in the community.

### Priority 2 Early help, prevention and intervention

- Enhancing the responsiveness and inclusivity of universal services that give families the right help early enough to resolve difficulties and reduce the need for further intervention.
- Improving the ability to be proactive in identifying needs of all children, young people, their families and carers.

### Priority 3 Community ambition, health and wellbeing

- Improving the consistency and cohesive universal service offer for young people to help support them to make a positive contribution to society.
- Ensuring that children and their families have access to timely, effective and responsive health care that gives them the best start in life and resolves health needs as they arise.

### Priority 4 Learning and achievement

- Improving the expectations and aspirations for the achievement of all children and young people in all areas of their lives.
- Ensuring all children are ready to succeed at school whatever their background.
- Ensuring that every child or young person has access to a good or outstanding school.

### Priority 5 Better use of resources

- Remodelling services and practice to deliver and demonstrate better outcomes for all children, young people and the wider community within available resources.
- Improving the commissioning of effective integrated services that enable families to manage and support them in finding additional help when necessary.
- Being open to ways of doing things differently to drive effectiveness and ensure resources are used to maximum effect.



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# Section 1 - Where we are now

## Governance

Our directorates with responsibility for children's services are fully committed to seamlessly working together to fulfil our statutory requirements and to achieving the most positive outcomes possible for children, young people, their families and carers.

We have established the Kent Integrated Children's Services Board to ensure effective leadership and integrated delivery across children's services. This meets our statutory requirements and is supported by clear accountability protocols for the roles of the Director and Lead Member for Children's Services. It frequently brings together the Corporate Directors and Cabinet Members that share responsibility for services relating to children, providing a shared understanding of need and performance across the breadth of universal and targeted children's services. It plays a vital role in providing oversight and assurance of frontline delivery, challenge on areas for improvement and identifies opportunities to drive further integration and transformation.

## Working together in partnership to achieve shared priorities

Our five priorities cannot be achieved in isolation, and require responsive, effective internal and external partnership relationships that are focused on delivery. Our partnerships are constantly evolving and responding to a rapidly changing policy and governance landscape due to the significant national changes in education, health and public service reform and the associated impact on community and voluntary services. In times of change it is essential that we have clear governance arrangements at both the strategic and local delivery level to help ensure we maintain a consistent focus on achieving our vision, and as a result raise our performance to the level of the best performing authorities in the country.

Our emphasis is on working better together, and as our transformation programmes progress it will be important that we identify further opportunities to reflect on the appropriateness of our strategic governance and local delivery arrangements to ensure they are fully aligned and fit for purpose.

The diagram in Appendix 1 is not an exhaustive list, but shows the major multi-agency strategic and local partnership governance architecture that support children's services, with the Children and Young People's Joint Commissioning Board as the glue that binds these specific partnership bodies together. The relationships between these bodies are complex and evolving - discussions and consultations are underway on the roles of, and relationships between, the local Children's Trust Boards, the Kent Safeguarding Children Board local multiagency arrangements, the district-level Health Inequalities Groups and the new Health and Wellbeing Boards at the Clinical Commissioning Group level. We are committed to streamlining the number of partnerships and clarifying the relationship between them to ensure that there is clarity about priorities, shared outcomes and targets at Kent-wide and local area level, and an focus on the child's journey.

Two significant current examples of partnership working are:

**Commissioning of Child Health** - During the restructuring of the NHS, we have drawn up transition plans with the main (and future) providers of children's health commissioning, Kent and Medway Commissioning Support (KMCS). We need to develop stronger strategic partnerships with the seven Clinical Commissioning Groups alongside robust engagement in the Kent Health and Wellbeing Board in order to deliver the Child Health Outcomes Framework. Alignment of the health and KCC commissioning processes still needs further work.





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**Kent Safeguarding Children Board (KSCB)** - Improved partnership working over the last 12 months has led to a reduction in Kent's previously high number of children with a child protection plan to a level below the average of our statistical neighbours. The KSCB plans to establish a Young Persons Forum which will sit under the Safeguarding Board, as a way to involve young people in the safeguarding agenda. There has also been significant progress in consolidating the safeguarding partnership, through three key areas – (a) clarifying the KSCB's governance arrangements; (b) ensuring that all professionals working with children understand what are known as thresholds, eligibility and assessment processes for child protection support; and (c) the development of a new quality assurance framework. We are now much better placed to know what works well in protecting children in Kent and the areas that still need improving, e.g. a more consistent approach by all agencies in applying thresholds for further intervention.

## Key strategies

Work around supporting children, young people, their families and carers in Kent is shaped by a number of strategies, policies and plans. Many of these are multi-agency and are developed and owned in partnership. They set out a range of priorities, objectives and measures for improving outcomes for children and young people. All of the strategies play an important role in delivering our five priorities.

However, the strategies, policies and plans in place tend to focus on specific areas. For example, Bold Steps for Education focuses primarily on improving educational outcomes, while Kent's Health and Wellbeing Strategy informed by the Joint Strategic Needs Assessment, includes outcomes focused on improving health from an early age to give children the best start in life. Appendix 2 sets out the main strategies, policies and plans that underpin work with children, young people, their families and carers in Kent, and shows how they contribute to our five priorities.

Although the individual strategies are extremely important, what has been missing is an overarching vision for children and young people, which centres around the child's journey. This vision needs to be the 'golden thread' running through all the work we do to support children, young people, their families and carers. Every Day Matters – Kent County Council's Children and Young People's Strategic Plan 2013-2016 provides that golden thread through the overarching vision, four outcomes and five priorities for children and young people in Kent.

The outcomes and priorities in this strategic plan are based on detailed needs assessments which can be found in the strategies set out in Appendix 2. Only a very high level overview is given in this document. In brief, the main strategic plans include – Vision for Kent, Bold Steps for Kent, Early Intervention and Prevention, Kent Safeguarding and Children in Care Improvement Plan, Youth Justice Plan, Health and Wellbeing Strategy, Mind the Gap and 14 to 24 Learning Employment and Skills Strategy.

## Strengths and challenges

Kent's population (currently 1.4 million) is growing faster than the national average and the rest of the south east. 17% of its 350,000 children are living in poverty, with rates higher than the SE average and a contrast between child poverty rates in some districts in the east (over 20%) of the county compared to the west (only 11%). As our population grows and changes, we need to build on our strengths and continue to tackle the challenges ahead.



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**Safeguarding and protection - priority 1**
Considerable improvements have been made in the management of referrals, timeliness of assessments, and reductions in numbers of children in need and children subject to child protection plans. Children in Kent are safer as a result of this intensive activity. There are still very significant challenges. We need to improve the quality of practice and make it responsive to service user need. We are improving the quality of assessment and planning to ensure that decision making is responsive, timely and child centred. .

**Early help, prevention and intervention - priority 2**
We have re-commissioned a wide range of early intervention and prevention services and created dedicated early intervention teams to better manage care pathways between universal, specialist and preventative services. Universal services play a critical role in early intervention and will work together to identify clear, effective pathways from universal work to more complex preventative interventions. This approach will help us to gain pace and momentum in delivering the Troubled Families programme, embedding the Family Common Assessment Framework process and putting customised support plans and effective delivery in place at a local level.

Supporting this, our local youth offending work is reducing the overall number of young offenders and first time entrants to the youth justice system. Continued improvements are needed to improve participation and engagement with young people, with a particular focus on improving accommodation, employment, education and training outcomes for young offenders. With a high proportion of single homeless people in Kent under 21 years old, the Supporting People Programme will expand early support to vulnerable young people, including those leaving care. It aims to help young people to maintain their housing situation, manage their finances, acquire independent living skills and stay safe, which is also complemented by the specific housing actions for young people in the Kent & Medway Housing Strategy delivery plan.

**Community ambition, health and wellbeing - priority 3**
We have a wide range of universal services to enable children and young people to achieve their full potential. Our Integrated Youth Service has transformed to create a consistent universal offer and locally tailored solutions, built on evidence of local need. We have a strong tradition of promoting young people's participation in sport and positive activities across the county, including the Kent School Games, the Duke of Edinburgh Award scheme and Cultural Olympiad events. We are building on the positive legacy of youth volunteering and Olympic Games Makers and Games Greeters.

One of our strengths is supporting children and young people with issues of substance misuse with preventative outcomes-based commissioning models in place in the Kent Drug and Alcohol Action Team. However, further health and wellbeing challenges remain. The proportion of children with particularly complex and profound disabilities is rising. We have a greater proportion of young people aged 5-19 whose health is varied. We also significantly underperform compared to the England average for smoking cessation in pregnancy and breastfeeding initiation.

**Learning and achievement - priority 4**
Our early years provision is generally good compared to the national average. However only 55% of our primary schools are judged to be good or outstanding. Kent's 62 outstanding primary schools are leading the drive to move Kent from the bottom quartile of Key Stage 2 performance to the top. Although 69% of secondary schools in Kent are good or better, in line with the national average,



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we have wide gaps in performance at Key Stage 4, with the worst gaps amongst those young people who face the greatest disadvantage. Only 28% of pupils on free school meals attained five good GCSEs in 2011, which is well below average, and the achievement of children in care is well below what it should be at Key Stage 2 and Key Stage 4. The number of permanent exclusions in Kent is too high, and we need a particular focus on tackling exclusions for children in care, children with special educational needs, and those from Kent's Gypsy Roma and Traveller communities.

Kent has been a national leader in the delivery of an innovative 14-19 vocational programme.We will continue to redesign the offer to respond to government changes and raising the participation age. We have been successful in engaging young people (16-18) in education and training, and have actively developed and promoted apprenticeships across the county. This has resulted in Kent bucking regional trends by increasing the number of 16 to 24 year olds taking up apprenticeships, despite the current economic downturn. This has included supporting a significant number of vulnerable young people, such as teenage parents, disabled young people, young offenders and care leavers into apprenticeships through our Vulnerable Learners Project. Our proportion of those not in employment, education or training (NEET) is at a relatively low level nationally, however further action is needed with 18 to 24 year olds, particularly given high youth unemployment in the challenging economic climate. In addition, many young people with learning difficulties and disabilities at age 19 have poor opportunities for unemployment and independent living.

**Better use of resources - priority 5**

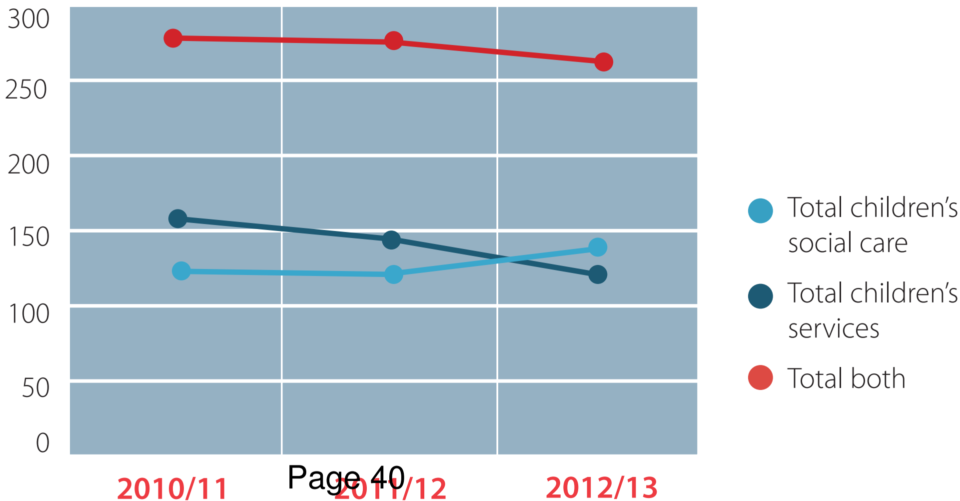
Addressing the challenges set out above can only be achieved through working with children, young people, their families and carers, and with other agencies. As resources are squeezed across the board, it becomes even more important to work seamlessly, communicate effectively, and ensure valuable resources are targeted at those individuals and families where they will have most impact and meet the greatest needs. However, it will be a challenge to shift the balance of overall resources in favour of prevention and early intervention.

## Spending on children's services

A disproportionately high percentage of the budget is spent on a relatively small number of children with complex and acute needs. As a result, KCC has not invested sufficient resources in preventative services to the extent that we need to if we are to succeed in shifting the balance between high level need and preventative services.

The following graph shows net expenditure on children's social care and other children's services.

£m net expenditure





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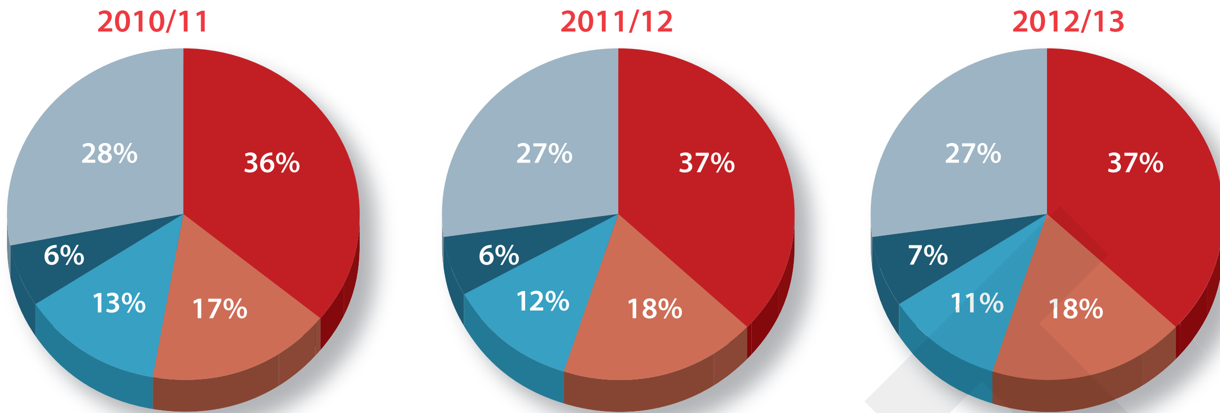
## Children's social care - Net expenditure



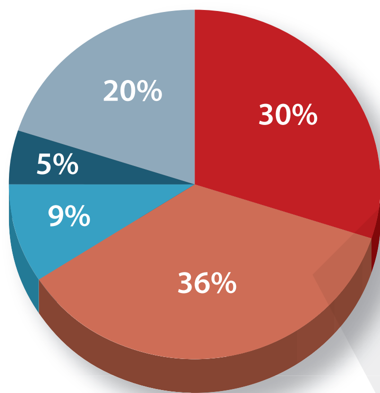
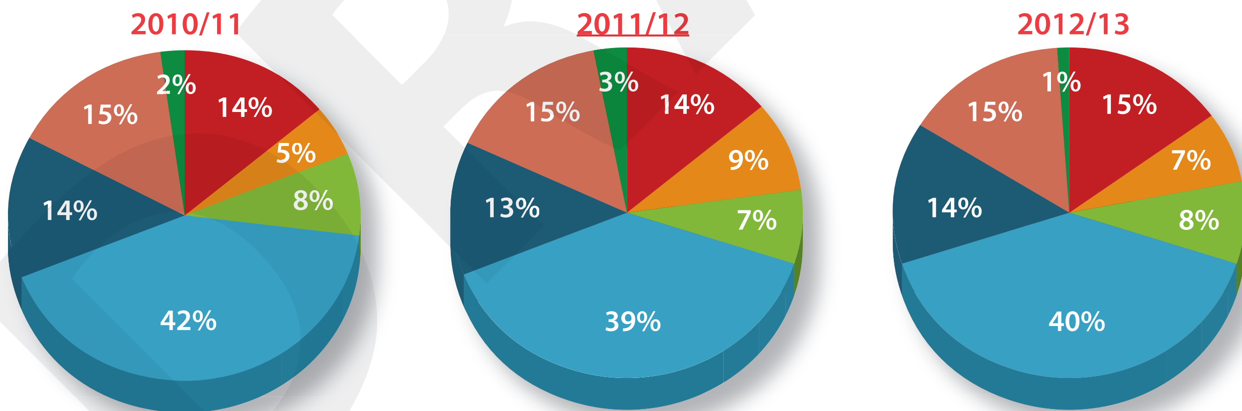




**Illustration of where we want services to be. Shift in funding from high-cost reactive spending to early intervention and prevention**

- Looked after children
- Preventative & family support
- Unaccompanied asylum seekers
- Legal & performance management
- Assessment

## Other children's services - Net expenditure



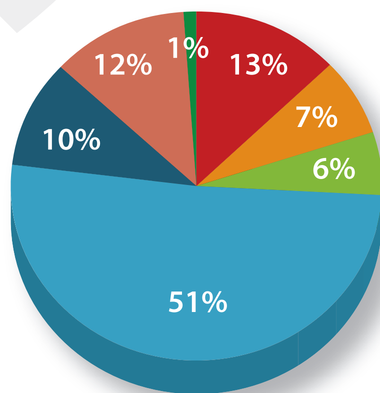




**Illustration of where we want services to be. Shift in funding from high-cost reactive spending to early intervention and prevention**

- School attendance and behaviour service
- Education, careers and personal advice services for young people
- Youth and youth offending services
- Early years
- Children's services
- Special educational needs
- Free school meals

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# Section 2 - Where we need to be

## What does good look like?

This essentially depends on striking the right balance between the following four elements. To achieve lasting change calls for an ambitious programme as a guide for how we will do things differently in order for us to have a positive impact on outcomes.

Success, therefore relies on getting the balance right:

**1. Achieving outcomes for children, young people, their families and carers**

- Achievement gap better than the national average
- Significant reduction in exclusions from school
- More children adopted
- Focus on the child's journey
- Improvement in take-up of employment
- Children are safeguarded
- Improvement in key health outcomes
- Meeting diverse needs

**2. Skilled workforce**

- Improvement in the quality of practice
- Outcome focused practice
- Peer challenge
- Staff confidence to exercise professional judgement
- Confidence in evaluating risk
- Understand their role and that of partners in integrated services

**Children, young people, their families and carers**

**3. Integrated sevices**

- Joined up services
- Joint commissioning
- Users able to shape developments
- Quality of partnership
- Gaps in provision identified and addressed

**4. Evidence of impact**

- Use of resources
- Productivity increase
- Overarching KPIs used for managing risk and performance
- Evidence of return on investment

## Achieving outcomes

Our objective is to have repositioned and transformed children's services across KCC and, working with the broader family of partners, to build sustainable support services. We will achieve demonstrable, positive impact in relation to outcomes for children, young people, their families and carers. As a result:

- Kent children's academic results will be amongst the best compared with our statistical neighbours.
- The achievement gaps at key stages 2 and 4 will be less than the national gap figures and pupils from low income backgrounds, children in care, and pupils with special educational needs and disabilities will be achieving better progress and outcomes than similar groups nationally.
- There will be reductions in exclusions and absence from schools .
- Fewer children will be in care, and more will be adopted.
- The quality of care for children in care will be higher, resulting in improved outcomes for those children.
- More children will be supported through early intervention, leading to reduced numbers of children in need.
- Youth crime and anti-social behaviour will be lower.
- There will be increased engagement of young people in positive activities.





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- Youth unemployment will be lower, and there will be fewer NEETs.
- High need families will have greater stability, resilience and parenting skills.
- Greater participation in 14-19 vocational pathways and take up of employment with training, including apprenticeships.
- Significant improvement in key health indicators around smoking, breast feeding and immunisation.
- Young people with learning and physical disabilities will be better supported in their transition to adulthood, and given greater employment and supported living opportunities.
- A much improved and integrated single assessment process.
- The option of a personal budget, which enables people to have greater control and ability to exercise choice, will be available to all who are eligible.

## Skilled workforce

There will be effective deployment of a more confident and skilled workforce, which has the capacity to respond early and provide appropriate interventions according to different levels of presenting need, and does so without compromising the safety of children. Consequently, we will have strong assessment and risk management expertise. As recommended by the Munro Report, the performance of the workforce will be measured by outcomes instead of by compliance to process measures. An essential component of this is to establish a social work academy.

## Integrated services

We fully subscribe to the clear case put forward by Munro that;

*"The reactive child protection services deal with only a small percentage of the problems that children and young people experience; most formal help is provided by universal services or targeted services. That help, besides improving their wellbeing in general, also significantly reduces the incidence and severity of abuse and neglect"*

**Munro Review of Child Protection Progress Report, 2012**[1]

## Evidence of impact

Appendix 3 sets out the key performance indicators which will provide evidence that this strategic plan is being delivered.

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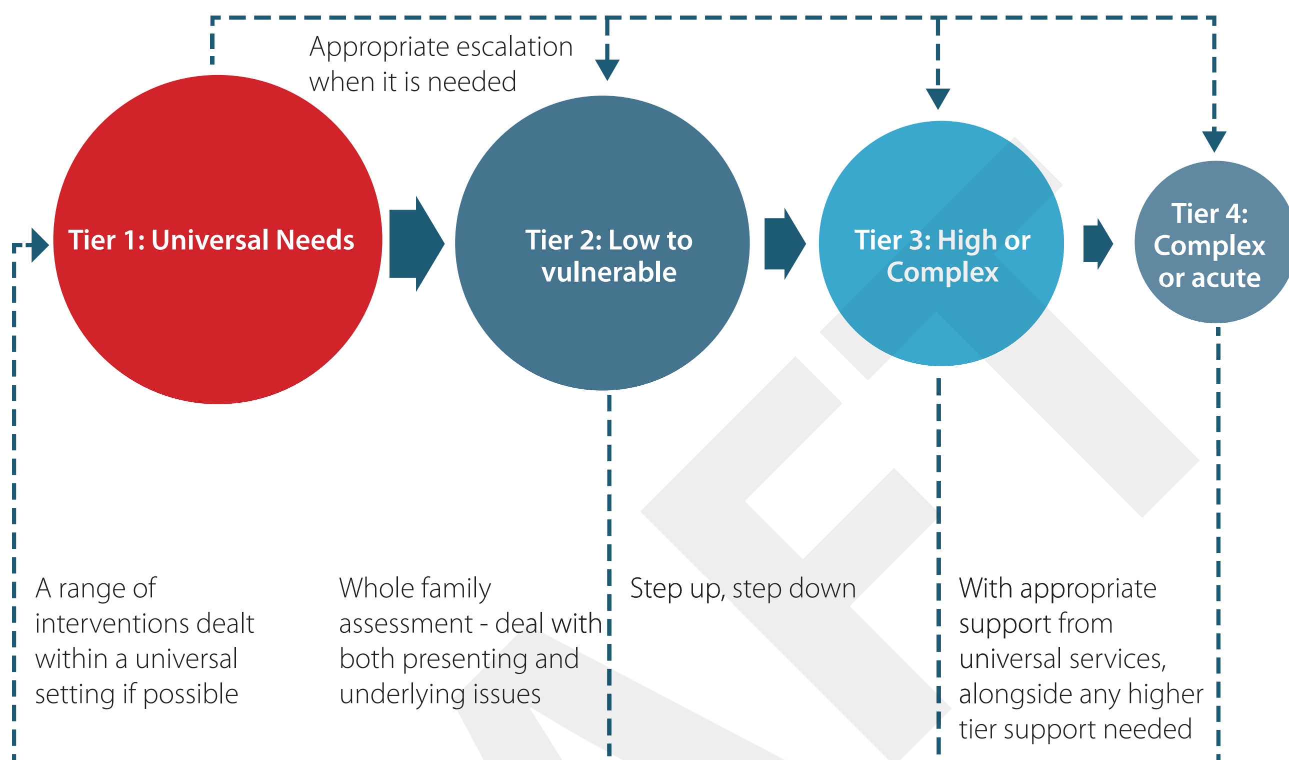
1 The Munro Review of Child Protection - Progress report: Moving towards a child centred system, Professor Eileen Munro, May 2012, www.education.gov.uk/publications/standard/Childrenandfamilies/Page1/DFE-00063-2012

## Good universal services and making the best use of valuable resources

### Right support, Right place, Right time - when needed

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The vast majority of children and young people flourish with the support provided by universal services (universal health provision, children's centres, early learning settings and schools).

From time to time some children may require targeted early help from within their schools to support their achievement or from other universal or targeted services to improve their well being. Where such help is given, the objective must always be to enable the child to do well and achieve without long term support or the need for more intensive intervention.

### Good universal services in Kent will:

- meet the needs of the population they serve well
- quickly recognise those children and families who need additional help/support
- provide additional appropriate support in a timely and effective way.
- swiftly identify those children who reach the threshold for targeted intervention, refer appropriately; and continue to meet the universal needs of those children who are receiving targeted support.

A much smaller number of children may have multiple and complex needs that require dedicated support through specific interventions from a range of agencies, depending upon their specific need. This may include Social Care, Education, Health or Youth Justice. Where this happens it is critical to ensure that children and their families are able to access the specialist help that they need whilst continuing to receive appropriate mainstream support from universal services.

## The child's journey

New models of intervention based on the concept of the 'child's journey' will inform routine practice. The improved provision of 'early help' through better interagency working will be an essential part of remodelled services. It will be common practice for universal service providers to operate in a more inclusive manner. Through integrated working they will be able to assume new responsibilities which will enable them to work with families to help them find solutions to their difficulties early without problems escalating to the point where they may require a more expensive intervention.

*"…each individual child has a range of needs and many will come into contact with more than one part of the system throughout their childhood. That experience should be coherent, consistent and well navigated by the professionals leading at every stage. This means designing and delivering policy initiatives that are child centred, joined up and understood by the workforce who will implement them"*

Debbie Jones – Association of Directors of Children's Services Annual Report, 2011/12[1]

We will focus on ensuring that the children and their families who come into contact with our services are supported in a way that makes sense to them, maximises the opportunity for hearing their voices and listening to their story and minimises the need for repetitive processes and interactions.

To support children, young people, their families and carers through their journey, we need to develop new ways of working that provide local, responsive and seamless service delivery. We are working towards this through the implementation of new models of district working. Running through this work are two cross-cutting themes - prevention and early help for children, young people, their families and carers, and supporting family resilience and resourcefulness. Ways in which we are delivering prevention and early help include identifying named contacts in each area to coordinate service response and commissioning support to provide packages of services around children and families. Increasing and improving our early intervention services will also help to promote family resilience and resourcefulness by identifying needs and providing support earlier. This will build more trust in services and reduce reliance on more complex and expensive forms of care and support.

Always keeping a focus on these cross-cutting themes, we will support children and families through all stages in a child's life as follows:

### Pre-birth

- Ensuring women, and their partners, have access to timely pre-pregnancy advice and support to enable early adoption of healthier lifestyle choices
- Providing a free NHS Information Service for parents which include emails and texts containing NHS-approved advice sent every week from five weeks of pregnancy through to four weeks after the baby's birth. Fathers-to-be can sign up for advice specifically aimed at them

### Early Years

- Delivering targeted support to the most disadvantaged children and their families to narrow the achievement gap for disadvantaged children at the end of the Foundation Stage and prevent escalation of problems

1 Association of Directors of Children's Services Annual Report 2011/12 - Vice President's Report, Debbie Jones, October 2012 http://www.adcs.org.uk/publications/index.html

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- Children's Centres working closely with early years settings and their local Primary Schools to ensure that all children are eager and able to learn well when they start school
- Improving on satisfactory provision in early years

### School

- Aligning resources to districts – bring together professional and practitioners – co-locating wherever possible.
- Supporting schools through local district teams that better understand the needs of local schools and communities.
- Virtual School Kent is working at district level with relevant professionals to ensure all Personal Education Plans (PEP) for children in care are of a high quality, subject to a rigorous monitoring and evaluation process, with impacts and outcomes that are followed up.

### Adolescence

- Introducing a new model of multiagency early intervention and prevention for young people aged 11 to 19 through the Kent Integrated Adolescent Support Service.
- Providing children and young people with a tailored personalised programme that will support their learning, progress and their personal and social development.
- Aligning support and activity through a Framework of Integrated Adolescent Support, along an adolescent pathway so that children, young people, their families and carers access the right services, in the right time, in the right place.

### Transition

- Delivering an integrated multiagency approach enabling young people to be as independent as possible in adulthood.
- Supporting transition due to a move from children's to adults' health and social care services and general support required by young people from adolescence to adulthood which enables them to be as independent as possible.
- Providing support that covers education, training, employment, living arrangements, financial independence, health and social care support and social and leisure opportunities.

### Care leavers

- Working with partners to pay particular attention to the needs of care leavers so that they are equipped with a good start in life to make a positive contribution to society.
- Preventing escalation of problems in adulthood and associated costs for other agencies.

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# Section 3 - How we will deliver service transformation

## Better integration and new models of services

We will create transformation plans based on the following themes. We recognise that implementing an effective change programme depends on our ability to work with partners to define alternative and effective models of intervention, but always coming back to a focus on the child's journey.

**1 Safeguarding intervention**
Prevention, timely multi-agency response to keep children safe.
The responsibility of every agency – safeguarding is everyone's business.

**2 Early help, prevention and early intervention**
Responding to a problem as soon as it is identified, acting quickly to prevent escalation and building family resilience, confidence and empowering people to manage. Children prepared for school, pupil progress tracking, Children's Centres services.

**3 Timely response and crisis intervention**
Target support within schools (pupils, groups and whole school communities). Attendance and behaviour support interventions.

**4 Time-limited intervention**
Step-up and step-down support services to avoid children going into care by enabling families to cope. Short term fostering, SEN support without statement. Integrated Adolescent Support Service, Troubled Families - increase scale and effectiveness to avoid future expensive intervention.

**5 Enduring care intervention**
Adoption, fostering, children with statements. Maximising life chances of looked after children and having high aspirations for them.

**6 Procurement and better use of resources**
Joint commissioning, integrated teams, confident organisations. Evidence based commissioning. Using money wisely. Review agreement with the Courts to facilitate quicker assessment. Workforce development programme to facilitate cultural transformation and valuing staff.

## Shifting the focus of spending

We expect the present spending profile to change in future to reflect the positive impact that comes from successful implementation of cultural and service transformation that will be delivered. As a result of the increased investment in early preventative services and strong and adaptive universal providers, we will be able to make the shift in resources. Working on calculated assumptions, we can illustrate what the changed landscape of spending would look like. Our overall success is very much linked to the extent to which we approach the changes required in partnership with other organisations.

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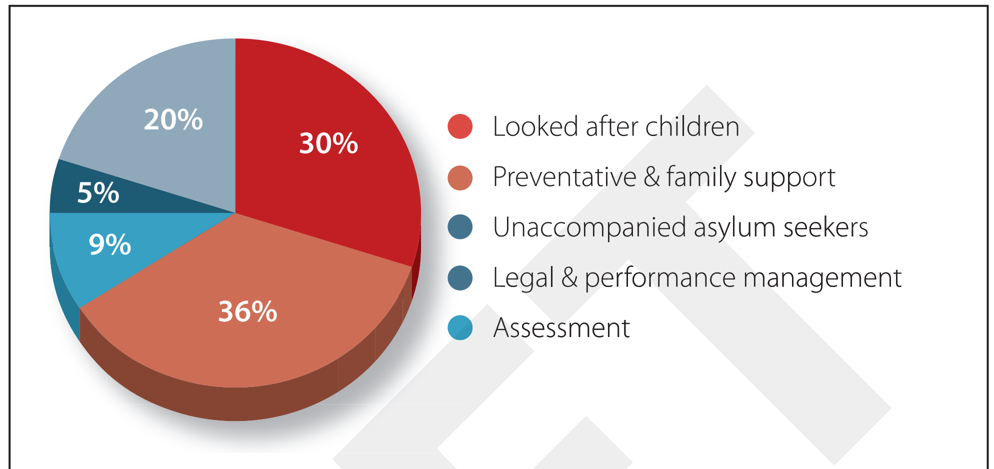
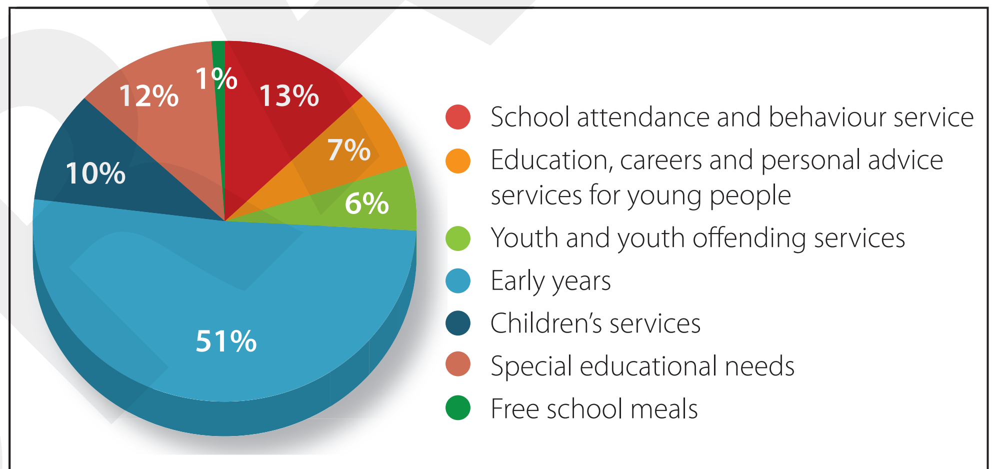
## Children's social care - Net expenditure

**Illustration of where we want services to be**
**Shift in funding from high-cost reactive spending to early intervention and prevention**




## Other Children's Services - Net expenditure

**Illustration of where we want services to be**
**Shift in funding from high-cost reactive spending to early intervention and prevention**



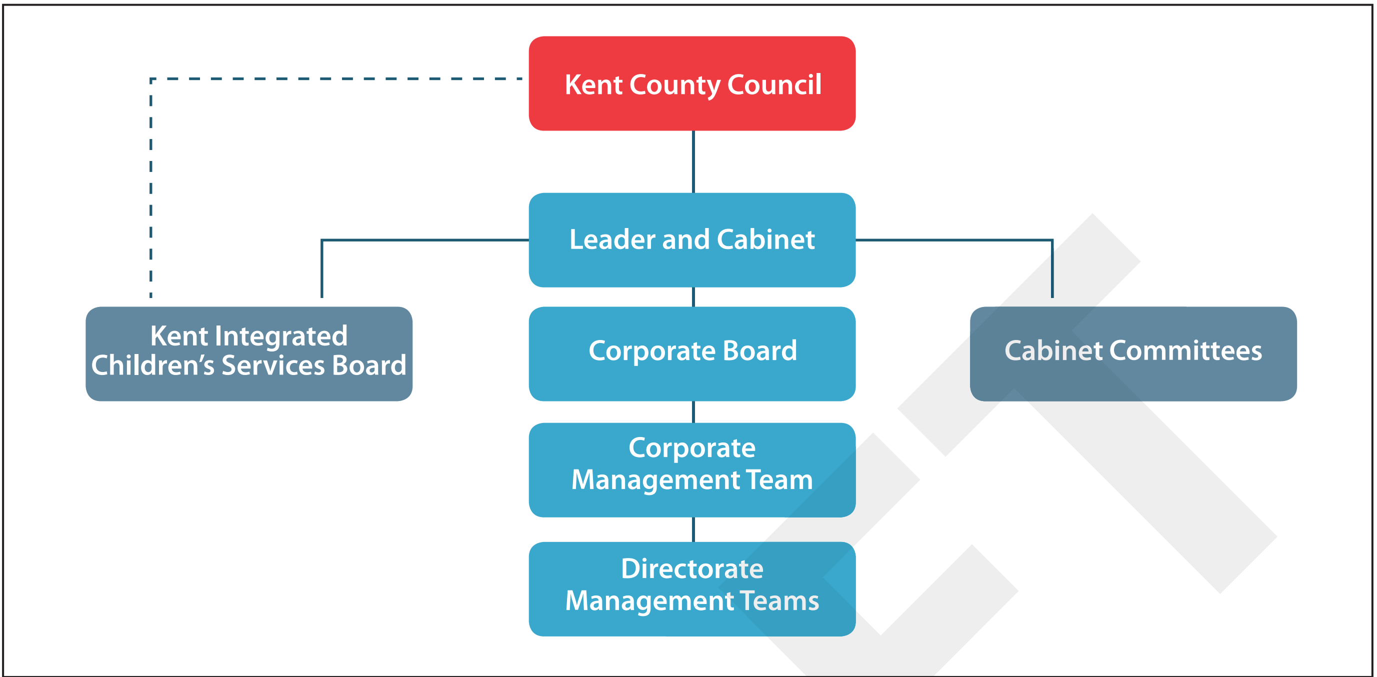

## Reaching for ambitious targets

Finally, to ensure that we are making good progress towards our overarching vision, we have set clear and ambitious targets. These are focused on our five priorities, to provide a holistic view of how our work is supporting children, young people, their families and carers in all the main areas of their lives, and where we need to improve. This will involve bringing together performance information from across KCC directorates and from partners. Shared priorities and measures will support us to work more effectively together to reach our vision.

We have selected a small number of key indicators for each of the five priorities, to focus activity on the areas where we need to see the best outcomes. Underneath this, we have more detailed performance information for specific priorities.

Appendix 3 sets out the key indicators under each of the five priorities that we are monitoring.

## Kent County Council Governance Arrangements




## Partnership Governance Architecture

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# Appendix 2: Strategies that underpin our vision

| Our vision: links and contributions to key strategies and plans | | Our vision: shared priorities | | | | |
|---|---|---|---|---|---|---|
| **Strategy/Policy/Plan** | **What is it?** | **Priority 1:** Safeguarding and Protection | **Priority 2:** Early Help, Prevention & Early Intervention | **Priority 3:** Community Ambition, Health and Wellbeing | **Priority 4:** Learning and Achievement | **Priority 5:** Better Use of Resources |
| **CROSS-CUTTING** | | | | | | |
| **Vision for Kent** | This is the Kent Forum's countywide Sustainable Community Strategy which sets out three ambitions that will guide the direction of public services in Kent from 2012 to 2022. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Bold Steps for Kent** | This is Kent County Council's Medium Term Plan (2010-2013), which sets out our strategic vision for how we will achieve our three ambitions; to grow the Kent economy, to tackle disadvantage and to put the citizen in control. It outlines how we will make Kent a county of opportunity where aspiration rather than dependency is supported, particularly for those who are disadvantaged or vulnerable. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Early Intervention & Prevention Strategy** | This is a Kent County Council strategy, which draws upon and informs prevention and early intervention priorities in other key strategies and plans. It provides a vision for early intervention and prevention for vulnerable children, young people and families living in Kent. It details our model of early intervention and prevention, identifies priority areas and provides an overview of the action we will take over the next 3 years to deliver improved outcomes, and is delivered through a series of annual implementation plans. | ✓ | ✓ | ✓ | | ✓ |
| **Child Poverty Strategy** | It has been agreed by the Kent Integrated Children's Services Board that a robust strategy will be developed which will set out how Kent County Council and its partners can continue to work together to tackle the causes and effects of Child Poverty. This will form the basis of a statutory requirement placed on all Local Authorities under the provisions set out in the Child Poverty Act 2010 and is a key part of discharging our accountability protocol for the Lead Member for Children's Services and the Director of Children's Services. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Child Poverty Needs Assessment** | This is a statutory needs analysis of child poverty in Kent and review of national evidence which provides an evidence base shared by partners in order that we can detail what work has been done to respond to local need, and what outcomes have been achieved to date. This summary of effective practice enables us to understand the actions already taken to improve the circumstances of children and families facing poverty. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Kent Troubled Families Programme Business Case** | The Business Case outlines the proposed approach for Kent's three year (2012-2015) Troubled Families (Community Budget) Programme, endorsed by the Multi-Agency Steering Group. It sets out a vision to create a long-term approach that achieves better value for money and more effective interventions to transform the lives of Kent's most troubled families, through joint commissioning, service re-design and transformation. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Kent Partners' Compact** | The Kent Partners' Compact is a partnership agreement between the Voluntary & Community Sector (VCS) and the public sector in Kent. It is a jointly agreed framework for a mutual working relationship with positive benefit to the Kent community. It includes Codes of Practice on funding and resources, communication and engagement and volunteering, with commitments from the VCS, public sector and joint commitments. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Kent Safeguarding Children Board Strategic Plan and Business Plan 2013-14** | This sets out the Kent Safeguarding Children Board's vision and three strategic priorities that the Board will work in partnership to achieve. These are 1) positive outcomes for children and young people in Kent, including Children in Need and those in care, 2) holding partner agencies to account for their part in collectively improving safeguarding and 3) demonstrating a robust safeguarding partnership that can effectively undertake the work of Kent's Improvement Board. | ✓ | | | | |

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| Strategy/Policy/Plan | What is it? | **Priority 1:** Safeguarding and Protection | **Priority 2:** Early Help, Prevention & Early Intervention | **Priority 3:** Community Ambition, Health and Wellbeing | **Priority 4:** Learning and Achievement | **Priority 5:** Better Use of Resources |
|---|---|---|---|---|---|---|
| **OUTCOME 1: KEEP ALL CHILDREN AND YOUNG PEOPLE SAFE** | | | | | | |
| **Kent Safeguarding and Children in Care Improvement Plan: Phase 3** | This is the third phase of Kent County Council's improvement plan to deliver a whole system approach to managing family pathways from early help to statutory intervention. The Plan continues to focus on quality and sustainability - building on the improvements already achieved - whilst evidencing Value for Money on the investments made. It also functions as a transition document, integrating and embedding Improvement Programme actions into 'Business as Usual' practice. | ✓ | ✓ | | | ✓ |
| **Kent's Looked After Children Strategy** | This strategy was developed by Kent County Council and partners and aims to improve services and outcomes for looked after children and care leavers through good corporate parenting from 2011-2014. It commits to a series of strategic objectives. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Youth Justice Plan** | This is KCC's Integrated Youth Services plan for 2012/13 - the plan is produced on an annual basis to meet statutory requirements. It sets out a series of key actions, projects and milestones for the service including supporting vulnerable children and young people, preventing offending and reducing reoffending. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Community Safety Framework** | The Framework describes the contribution by the wide range of services delivered by KCC that makes a tangible difference in preventing and deterring crime and that provide support to particularly vulnerable households in Kent. It sets out Kent's community safety priorities over the medium term (2012-2015). | ✓ | ✓ | ✓ | ✓ | ✓ |
| **The Kent Police & Crime Plan April 2013 - March 2017** | This is the Kent Police and Crime Commissioner's strategic vision and priorities for policing and community safety over a four-year period. It also sets out the objectives and targets against which the performance of Kent Police will be scrutinised, and priorities for working with partners. | ✓ | | ✓ | | ✓ |
| **OUTCOME 2: PROMOTE THE HEALTH & WELLBEING OF ALL CHILDREN AND YOUNG PEOPLE** | | | | | | |
| **Children's Joint Strategic Needs Assessment** | The children's JSNA (2011) is a joint needs assessment between NHS Kent and Medway and KCC. It identifies issues within the local population which will require future investment and creates a policy context of why specific issues matter. It also identifies other issues necessary to advance improvements in the health and welfare of children and young people. It should inform strategies, plans and the commissioning of both the NHS and KCC. It should help Clinical Commissioning Groups in determining their priorities for local service development that supports children's health. | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Health & Wellbeing Strategy** | The Kent Joint Health and Wellbeing Strategy sets out the overarching direction for the NHS, social care and public health services in Kent. It also describes our aspirations for health and what we can do together to improve health and reduce health inequalities for people in Kent. It is being developed by the Kent Shadow Joint Health and Wellbeing Board on behalf of all local authorities and NHS Clinical Commissioning Groups in Kent. The draft strategy is currently out for consultation. | ✓ | ✓ | ✓ | | ✓ |
| **Mind the Gap: Building Bridges to better health for all - Kent's Health Inequalities Action Planw** | This sets out a three year plan (2012-2015) for how KCC, health, Districts, the third Sector and other partners across Kent will work to reduce the gap in health status between our richest and poorest communities. It sets out a series of objectives across all areas of life, taking a holistic approach to tackling health inequalities. | ✓ | ✓ | ✓ | ✓ | ✓ |

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| Strategy/Policy/Plan | What is it? | **Priority 1:** Safeguarding and Protection | **Priority 2:** Early Help, Prevention & Early Intervention | **Priority 3:** Community Ambition, Health and Wellbeing | **Priority 4:** Learning and Achievement | **Priority 5:** Better Use of Resources |
|---|---|---|---|---|---|---|
| **Live It Well** | Live It Well is the strategy that looks to improve the mental health and wellbeing of people in Kent and Medway from 2010 to 2015. The strategy makes ten commitments, including reducing the number of people with common mental health problems and giving people more choice and more say over their care. | | ✓ | ✓ | | ✓ |
| **Kent Alcohol Strategy** | This is a three year partnership strategy (2010-2013) that is supported by local delivery plans and is overseen by the Kent Action on Alcohol Steering Group. It focuses on tackling the harms from alcohol misuse within our communities as a key priority for the health, social care and criminal justice agencies across Kent. It highlights the need to inform the public of the risks to health and society and change attitudes in a positive way k. It sets out specific priorities for action for children and young people. | | ✓ | ✓ | | |
| **Kent Hidden Harm Strategy** | The three year partnership strategy (2010-2013) aims to address the harms caused by substance misusing parenting. The strategy has been developed and driven through a multi agency Hidden Harm Working Group which feeds into the Kent Safeguarding Board. The delivery plan is overseen by KDAAT. Hidden Harm refers to children and young people whose particular needs are often overlooked; where their parental substance misuse has serious negative effects on their childhood. These children and young people are often in need of protection and support to help them achieve their potential. The strategy promotes cooperation between relevant partners, to improve the well being of children in the area, to ensure they are protected from harm. | ✓ | ✓ | ✓ | | ✓ |
| **Kent Housing Strategy** | The Kent and Medway Housing Strategy is a county-wide document that takes a new radical look at housing and how it is delivered. It is owned by the Kent Forum and is part of KCC's Regeneration Framework. It has been developed collaboratively between KCC, Kent Districts, Medway Council, Kent Partnership, Kent Economic Board, Kent Housing Group and other public and private sector organisations.<br>It focuses on principle of Encouraging and supporting joint working to solve common problems to deliver the ambition to support people with a greater diversity of housing need to fulfil their potential and live a high quality life through the provision of excellent housing and support services | | | ✓ | | ✓ |
| **Kent Supporting People Strategy** | The five year strategy (2010-2015) sets out a framework to enable vulnerable people to maintain their housing situation, manage their finances, co-exist successfully in their community, acquire independent living skills, stay safe, liaise with other agencies, and access training, education, and employment. It focuses on prevention and supporting vulnerable young people affected by issues such as homelessness, substance misuse, offending and domestic violence to remain independent through housing related and floating support. | | ✓ | ✓ | | ✓ |
| **OUTCOME 3: RAISE THE EDUCATIONAL ACHIEVEMENT OF ALL CHILDREN AND YOUNG PEOPLE** | | | | | | |
| **Bold Steps for Education** | This is Kent County Council's vision for the future of education in the county to help improve the lives of thousands of children and young people from 2012-2015. It sets out aspirations for Kent to be the best place for children and young people to grow up, learn, develop and achieve. It contains a host of specific targets designed to improve the educational outcomes for Kent's young people. | | ✓ | ✓ | ✓ | |

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| Strategy/Policy/Plan | What is it? | **Priority 1:** Safeguarding and Protection | **Priority 2:** Early Help, Prevention & Early Intervention | **Priority 3:** Community Ambition, Health Wellbeing | **Priority 4:** Learning and Achievement | **Priority 5:** Better Use of Resources |
|---|---|---|---|---|---|---|
| **14 to 24 Learning Employment and Skills Strategy 2013-2016** | This is a county-wide partnership strategy jointly owned by the Employment, Learning and Skills Partnership Board. The strategy is designed to link the world of learning to the world of work more successfully, and to bring about more rapid transformation in young people's skills, qualifications and employability. It aims to achieve lower youth unemployment, put in place better systems for local employers and learning providers to work in partnership so that we secure the higher levels of skilled young people we need in the key growth sectors relevant to the Kent economy, and have every young person participating in high quality learning or training that is relevant to their needs, until the age of 18, with a good outcome. | | | ✓ | ✓ | ✓ |
| **Involving the whole community: The Kent Approach to Literacy and Reading** | This is Kent County Council's ten year strategy (2011-2021) to achieve its aspiration of 100% literacy in Kent. It identifies15 priority groups including Looked after Children, Young people not in education, employment or training (NEET) and children and young people excluded from school and sets out the barriers to reading. | | ✓ | ✓ | ✓ | |
| **OUTCOME 4: EQUIP ALL YOUNG PEOPLE TO TAKE A POSITIVE ROLE IN THE THEIR COMMUNITY** | | | | | | |
| **Unlocking Kent's Cultural Potential – A Cultural Strategy for Kent** | The Cultural Strategy for Kent 2010 – 2015 is owned by Kent and Medway partners to promote a shared understanding of how the county's cultural offer can enhance the lives of people who live in Kent; to demonstrate how culture can be used to strengthen the individual, collective and economic wellbeing of the county. One of the core aims is to improve participation for all. | | | ✓ | ✓ | |
| **Strategic Framework for Sport** | The Strategic Framework for Sport 2009-2013 is produced by Kent County Council on behalf of the Kent and Medway Sports Board. It outlines the strategic priorities for sport and presents a common voice and vision for sport in Kent. It sets out how sport should play a positive and active role in enhancing community safety, health, community cohesion and positive community relations for young people, by bringing together the diverse communities of Kent. | | ✓ | ✓ | | ✓ |

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### Priority 1: Safeguarding and Protection

- Number of CIN per 10,000 population under 18 (includes CP and LAC)
- Child protection cases which were reviewed within required timescales
- Percentage of children who wait less than 21 months between becoming looked after and being Placed for Adoption
- Percentage children in care in fostering placements
- LAC Placement stability: Same placement for last 2 years

### Priority 2: Early Help, Prevention & Early Intervention

- Percentage of TAFs closed where outcomes achieved or closed to single agency support
- Percentage of SCS cases closed that have been stepped down to CAF/ Preventative Services
- Percentage of children and young people living in poverty
- Number of disabled children whose families receive Direct Payments

### Priority 3: Community Ambition, Health & Wellbeing

- Number of 1st time entrants into the Criminal Justice System, per 100,000 10-17 year olds
- Number of households in temporary accommodation
- % 16-17 year olds known to YOS in suitable accommodation
- Prevalence of breastfeeding at 6-8 weeks from birth (%)
- Percentage MMR1 Vaccinations at 24 months
- Percentage of obese children in Year 6
- Prevalence of smoking during pregnancy (%)
- Conception rate per 1000 females aged 15-17
- Total number of cases waiting - snapshot (CAMHS Needs Assessment)

### Priority 4: Learning and achievement

- Percentage of pupils who are persistently absent from primary schools - all pupils
- Percentage of pupils who are persistently absent from secondary schools - all pupils
- Number of permanent exclusions from school - all children
- Number of permanent exclusions from school - LAC
- Free school meals achievement gap - Percentage of pupils at KS2 achieving L4+ in English & mathematics
- FSM achievement gap - Percentage of pupils at KS4 achieving 5+ A*-C including GCSE English & mathematics
- Percentage of 16-18 year olds not in education, employment or training (NEET)
- Percentage of 18-24 year olds who are unemployed.

### Priority 5: Better Use of Resources

- Defined and monitored by the relevant boards

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Decision No 13/00022

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

Meradin Peachey, Director of Public Health

**To:** Social Care and Public Health Cabinet Committee – 21 March 2013

**Subject:** To identify an interim solution for the Genito-Urinary Medicine service in Darent Valley Hospital

**Classification:** Unrestricted

**Summary**

Commissioning of Genito-urinary services will be the responsibility of the County Council from April 2013.

The current provider of the GUM service for part of Kent (Darent Valley Hospital) have served notice, therefore an interim arrangement has to be identified and implemented before the notice period expires on 1st April 2013.

The most feasible option is to hand over the GUM service to Kent Community Health Trust till the service can be tendered out.

The cost for GUM services at Darent Valley is £1,241,665.

The cost for all sexual health services for all of Kent is estimated to be £13,760,308.

## 1. Introduction

The purpose of this paper to set out the options for an interim arrangement for the Genito-urinary medicine service provided from Darent Valley Hospital (DVH).

## 2. Report Content

### 2.1 Background

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 April 2013. There had been previous discussions on the need to relocate the service as DVH required the premises for acute provision and had requested alternative space be found. This was

not possible in the requested timescale (4 weeks), and so the need to relocate imminently as an interim measure is imperative due to the pressing demands for space at DVH.

A decision was taken by the Director of Public Health to commission MBARC an external consultancy to

- Identify an interim solution for moving the GUM services in DVH to a new location
- Engage with users of the services, professionals and managers to identify views on the quality of services and potential changes

As part of this interim project, MBARC engaged with Key Informants (KI's), including NHS Kent and Medway (NHS K&M), managers and clinical professionals working both in DVH and with other providers, to agree a preference for an interim location, and to explore some recommendations for action. In the stakeholder event the option of relocating the service to the following three venues was discussed:

- Gravesham Community Hospital in Gravesend
- The Grand Health Living Centre in Gravesend
- The Livingstone Hospital in Dartford

The majority of KI's, including those currently working in a variety of sexual health premises at different locations across Kent expressed a preference for Gravesham Community Hospital.

### 2.2 Implications

Sexual Health is one of the mandated services, as outlined in the Health and Social Care Act that Local Authorities will be required to commission from April 2013. These include community contraception services, emergency contraception, pharmacy sexual health provision, GUM services, Local HIV prevention and sexual health promotion.

A lack of a GUM service in the North of West Kent will have huge implications for the HIV patients and other service users. Therefore there is an urgency in identifying an interim solution for the GUM service in DVH as the notice period will expire on 1st April 2013.

### 2.3 Options Appraisal

| Site | Advantages | Disadvantages |
|---|---|---|
| **Gravesham Community hospital (GCH)** | GCH has good transport links and will provide ease of access<br><br>Consultant cover can be provided by the KCHT GUM service lead | The Dartford residents have been used to having a service on their doorstep and moving the service to Gravesend may lead to a drop in the number of patients accessing the service from Dartford. |

| | | |
|---|---|---|
| | The physical space is most suitable out of all the options and available without the need for major refurbishments or unnecessary financial outlays at this stage.<br><br>DVH staff already worked closely with the clinicians as part of a supportive network in the physical absence of a lead clinician.<br><br>A discreet service can be offered from this site<br><br>Kent Community Hospital Trust (KCHT) are willing to accommodate the GUM\HIV service as an interim solution and to work closely with the staff to ensure seamless transition and to offer robust support and partnership working<br><br>KCHT already offer a strong hub and spoke model which could be extended to include GUM/HIV outpatient care (including Dartford)<br><br>offer opportunities to increase the provision of a "one stop shop" approach for service users<br><br>maximise the opportunities for dual trained health professionals to practice across disciplines<br><br>The service will become more accessible for the Gravesend patients | The number of treatment rooms available at Gravesham Community Hospital may not be perceived to be adequate (4) - as there are upwards of 700 patients per month accessing the DVH service and these numbers are unlikely to diminish, even in interim premises. (*currently DVH has 5 treatment rooms)* |
| **The Grand Healthy Living Centre** | Service could be integrated with young persons services<br><br>The service will become more | There would need to be major investment in refurbishment<br><br>The Grand is situated on the high |

| | | |
|---|---|---|
| | accessible as the Grand has good bus routes and train connections<br><br>Offer an opportunity to provide an integrated service as there is already a Contraception and Sexual Health (CASH) clinic provided from the site<br><br>maximise the opportunities for dual trained health professionals to practice across disciplines<br><br>Some patients may prefer a non-clinical setting | street and there may be difficulties in people openly accessing the building due to the perceived "culture" of some service users. Stigma and discrimination has long been recognised as a major barrier to people openly using sexual health services<br><br>A new IT server would need to be set up to support the Lilli System<br><br>Transport of pathology samples will need to be set up<br><br>Infection control may pose a problem<br><br>The Board members at the Grand see this as a take over of the premises by the GUM services<br><br>Patients may perceive that there might be information governance issues |
| **Livingstone Hospital** | The service will remain geographically close to the existing service (half a mile down the road)<br><br>It will provide the anonymity that is required for sexual health services | Livingstone Hospital is a step down for elderly patients (patients who have been discharged from hospital and are awaiting going home because they still require some nursing care) and it will not be appropriate to set up a sexual health clinic from the site<br><br>The physical environment is not contusive to setting up a GUM clinic on the site.<br><br>The cost of refurbishment will be prohibitively high.<br><br>A new IT server would need to be set up to support the Lilli System |

### 2.3.1 Options Appraisal for Providing the Service from Gravesham Community Hospital (GCH)

| Option | Advantages | Disadvantages |
|---|---|---|
| **Kent Community Health Trust to provide accommodation for the GUM service and agree a rent with DVH which DVH will pay directly to KCHT. The consultant cover could be provided through the network or by one of the consultants employed by KCHT . DVH to buy consultant time from KCHT or the network.** | Probably more acceptable to the DVH staff as they can continue to work to existing contracts | The disadvantage of this option is the risk to governance associated by "Network" arrangements or having a consultant from other organisations overseeing / supporting services for a different trust which will have differing policies. |
| **The service is handed over to KCHT in totality and is provided from GCH.** | This option will allow developing a robust governance arrangement (consultant cover)<br><br>The service can be integrated with the contraception service and have close links with outreach work.<br><br>This will be an opportunity to fill in any gaps in service provision | The staff will need to be TUPE over and there will need to be consultation with the staff<br><br>When the service is tendered it means that the staff will have to undergo yet another TUPE if KCHT is not successful in its bid. |
| **DVH subcontract KCHT to provide the service from the GCH site** | The transition will be smooth and the onus will be on DVH to set up a sub contract | This is not a feasible option because if DVH sub contract with KCHT then they will not be TUPEing their staff.<br>KCHT would have to recruit additional staff to cover the service, this will means DVH will have staff surplus to requirements and therefore |

| | | possible high redundancy costs. |
|---|---|---|

**3. Recommendations**

- It is recommended that the GUM service in DVH is handed over to KCHT to provide it from Gravesham Community Hospital as an interim solution. As this is least likely to cause disruption to the service and does not require excessive startup costs. It will also provide an opportunity to fill some of the gaps in the service as outlined in appendix 1.
- This arrangement will be only for a year and the service will be tendered out in 2014.

**4. Contact Details**

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**5. Background documents**

None

Appendix 1

## 1 Key Issues / Gaps Identified at the GUM Service in DVH

During the interviews in the stakeholder engagement, major gaps in provision were also identified which have implications for patients and service users and do not reflect a comprehensive range of sexual health services.

- Clinical governance arrangements currently at DVH are unacceptable as the incumbent consultant is retired and is only able to offer telephone advice and supervision. This is a less than satisfactory arrangement for all concerned, especially during this interim move,
- The current GUM/HIV clinic template is insufficient with no late evening or early morning clinics. There are currently no walk in sessions for DVH patients - all patients attend on an appointment basis and there are high DNA (did not attend) rates.
- No Electronic Patient Records (EPR) are available which disproportionately impacts on already limited administrative time
- No results text service is available which has resulted in the service being closed each day for an hour and a half at lunchtime whilst expensive nursing time is used to offer a results service to patients who phone in.
- No Hep B vaccine service
- No NAAT (nucleic acid amplified testing) testing
- No same day testing (4 Hours)
- No designated young people's services (4YP)

## 2 Issues that Require Addressing

It is highly recommended that these important gaps in provision are addressed by the interim provider and that they are commissioned as part of a comprehensive sexual health package of care for patients.

- A clinical lead must be identified who will be responsible for all clinical governance arrangements for the interim GUM/HIV service. Commissioners should consider funding the maintenance of a clinical network. Even meeting costs with some back up locum costs would be welcomed and supportive during transition. This would ensure that the clinical lead is appropriately supported during the transition and facilitate the development of new relationships as part of the interim provision.
- Review of the overall clinic template to spread sessions is essential and will lead to improved utilisation of the facilities

- Walk in and appointment sessions should therefore be established in order to offer choice to patients and increase access and choice.

- Extending opening to >1900hrs is helpful for access and consideration should be given to increasing this still further, staggering shift patterns and use of the SLOT system. Appointment and /or walk in opportunities for patients to attend the service pre- and post work should be considered as this also increases patient choice.

- Patient flow into and through the service needs to undergo a LEAN exercise to identify unnecessary activity. This should include registration, triage / streaming through to most appropriate staff member, results management and follow-up processes. This will establish the numbers of treatment rooms required.

- A Multi Disciplinary Team (MDT) of staff will be required to service all clinical sessions in order to provide optimum skill mix to meet client's needs, being cognisant of the need to delegate tasks to the lowest appropriately qualified competent practitioner. This can be achieved through a robust system of triage at the point of client contact.

- Given the need to maximise the skills and competencies of dual trained staff, an interim location within the contraceptive service hub would be an excellent opportunity to increase access to an integrated model of care for service users and would improve delivery and access for patients in the interim.

## 3 Essential Steps for a Smooth Transition

The logistics for the following have been identified as requiring urgent attention in interim premises and any new location will need to ensure that these are addressed immediately to ensure seamless access for patients:-

- The commissioners and interim providers will need to ensure that a lead commissioning role is identified within the Public Health team and one at KCHT to lead on the three key commissioning relationships across Public Health (PH), Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs). This will avoid fragmentation, and ensure seamless pathways for patients during transition, particularly for HIV patients. The lead could act as conduit to the bodies responsible for the different elements of provision and ensure robust and transparent processes are in place.

- A clinical and service management representative, working alongside the sexual health commissioning and management team, is advisable to ensure robust communications are established and that patient's views and needs are fully met.

- The PCT could consider the short term interim appointment of a project manager to facilitate the transition and to work closely with, and support,

the current PH lead commissioner (as they await the new appointments to support the commissioning functions).

- The lead commissioner must work closely with the Human Resource Departments at DVH, KCHT and at the PCT to ensure that the TUPE arrangements are consulted on with the relevant staff teams as soon as practical, and that new contracts are in place by the date of transfer of responsibilities (May 1st 2013).

- A short term 'Task and Finish Group' should be established, led by Public Health and attended by the relevant professionals (in HR, Finance, procurement and contracting) to ensure seamless transition for staff and patients alike and to support the transition lead appropriately.

- Finance Directors (or delegates with clear lines of responsibility for GUM and HIV services) at DVH and KCHT must work closely with the commissioners to agree the totality of the budget and to identify cost pressures and additional funding required for the transition.

- The budgets must be organised in a meaningful and transparent way which reflects the new commissioning arrangements for sexual health and is clear at the outset. Working closely with the Finance Directors or delegated managers responsible for the complexity of the new arrangements for sexual health will be imperative during transition both within Public Health commissioning and with the interim provider at KCHT.

- Working closely with the service managers and clinical leads, NHS K&M commissioners should identify overarching priorities for how the interim provision of sexual health services and partnerships will proceed within the new contracting arrangements and current resources.

- IT systems at KCHT will need to be appropriately resourced and in place to monitor the activity data and disaggregate HIV and GUM activity as soon as possible.

- Discuss a basis for payment e.g. block contract versus GUM PbR or integrated sexual health tariff with the new commissioners in PH
*(NB. From April 2013, there will be an expectation on LAs to produce a Public Health Local Authority Contract. This will be used to support LA's in meeting their new public health function and enable LA's to use a standardised approach to contracting. NHS K&M commissioners may consider initiating discussion on the application of a sexual health tariff (although the rate will not be mandatory for public health).*

- Ensure disaggregated data for the HIV patients

- Look at level of investment in IT and new technologies including telehealth solutions

- Ensure staff and service user engagement at all levels

- There is a need for improved communications between the DVH clinic staff team, KCHT as the interim provider and the Transition Lead for sexual health at PH. This is of particular importance during transition to ensure that there is clarity for staff being transferred, and reassurance for the new commissioning partners on the quality of service provision and the need to secure that provision for a vulnerable target population. The involvement of elected members will add a new dimension to the commissioning process.

- The relationship between the management team of the interim provider and commissioners will require an agreed code of transparency to ensure clarity of purpose, direction of travel and achievement of strategic and public health outcomes. This will be particularly important during transition to the new commissioning arrangements to ensure a "Business as Usual" approach and the continued standard of provision of care to patients. In theory, patients should not notice a difference. This will be crucial for governance arrangements.

- A formalised network or forum led by public health for these discussions is recommended. Data sharing with the relevant partners is essential to provide the evidence-base and ensure the allocation of appropriate resources. NHS K&M commissioners will therefore need to develop a robust performance management framework for the interim provision, with transparent access to data for commissioners and providers.

- An advertising budget must be identified to ensure that patients and future service users are well informed as to the new location, opening times and service availability and that a centralised booking number is established and widely advertised (including to GPs, VCOs and community groups etc.) to ensure that this happens.

- Human Resource issues must be resolved as a matter of urgency re: vacant clinical and health advising posts, extended sickness and backfilling of posts. The current timetable is inadequate and staff stretched.

- There should be a review of the interim multidisciplinary team, its structure, roles responsibilities, skills and abilities to ensure the workforce is skilled to deliver a seamless, integrated sexual health services as part of the interim provision.

- Consideration should be given to strengthening nurse leadership through reorganisation to create a lead role for the strategic direction for nursing and oversee a seamless nursing and (to develop) a health advising team. There also appears to be historic staff working patterns that are not conducive to improved service delivery, and need to be addressed as part of the workforce review for the interim provision.

- There are currently no Health Advisor roles within the existing GUM service although the Clinical Manager has been juggling this role with numerous other tasks. A Health Adviser role should play a pivotal role in the management of on-going risk, screening and crucially partner management but who provides these aspects should be explored. These skills along with enhanced behavioural interventions such as Motivational Interviewing should enable the team to robustly support the clinical services. Cross working and being independent in core skills such as phlebotomy, asymptomatic screening would enable a health adviser role to further embed their skills into the MDT.

- Priority should be given to identifying and skill-shifting aspects of asymptomatic screening and results management to HCA and administrative staff to free-up highly skilled nurses and health advisers to undertake more complex episodes of care. In tandem to this, medical and nursing staff could expand risk assessments of high-risk users as part of holistic care as sending all Men who have Sex with Men (MSM), Commercial Sex Workers (CSW), those with endemic risks and young people to a Health Adviser are historic ways of working. An effective triage system is required to ensure that this is workable.

- A triage form is recommended to identify service users who can be fast tracked rather than relying on referral from medical and nursing colleagues.

- The role of nursing and health advising needs to be working to a standard that is within the national guidance available from the Society for Sexual Health Advisers (SSHA), British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH), thus ensuring that robust clinical governance is evident and provides the public with assurances of quality. Educational development utilising the national programs such as BASHH – STIF FSRHC – Course of Five & the British HIV Association (BHIVA) / National HIV Nurses Association (NHIVNA) competencies in tandem with local Higher Education Institutions support will allow the workforce to be educated to a standard that the professions deem as required. This underpinned with routine and regular audit of practice will demonstrate the importance of MDT working whilst providing the commissioners with assurance of quality with patient focused outcomes.

- Support staff competent in phlebotomy and public relations could undertake well person screening with minimal intervention. Their role could also be cross trained to include reception skills flexing the team to manage supply and demand and in doing so support the professional staff providing more interventional screening and assessment. The role of the HCA could be further extended to offer 'XpressCHECKOUT' asymptomatic screening clinics where medical support is not required.

- Training, education and competency based assessments / reviews of practice are essential criteria in this interim solution. This needs to be service led – not staff preference led. A draft template of future staffing and skill mix requirements then needs to be drawn up, to ensure appropriate and adequate clinic cover at the reviewed opening times.

- The interim sexual health service will need to liaise with Higher Education Institution providers locally to develop integrated sexual health education courses, which encompass competency based outputs, within an academic framework. Where Higher Education Institutions do not provide local integrated sexual health education, partnership working to develop them should be fostered. However, service providers may be required to tender out such training if not available locally as these will be essential to the future success of the integrated sexual health model.

- There are major issues relating to inadequate support for the reporting requirements, management of clinic data and IT systems across the service. Whilst statutory data reporting requirements have been met, there has been a long history of inefficient provider support and lack of appropriate levels of IT funding. This has led to delays in implementing electronic patient records (EPR) and lack of timely service level data. Data management and reporting have been challenging as a result of these inadequate systems, and reporting mechanisms both internally and to commissioners were less robust as a result. HIV and GUM activity is not disaggregated.

- Given the protracted history in the development of an appropriate and updated IT infrastructure for the service, this needs to be rectified as soon as possible to ensure that a solid evidence base of activity at locality level is fit for purpose for the new interim location and contract arrangements with LA and HIV specialist commissioners.

- Additional IT support to ensure that the data requirements are up to date and can be provided in a timely manner, and without using expensive nurse time!

- A short term IT project role at KCHT to ensure that transfer of the IT systems from DVH to KCHT and to ensure support for all the different reporting requirements are met.

- The new reporting mechanism for HIV (HARS) should be an immediate priority as the coding has to be entered at diagnoses to ensure the relevant funding is allocated as well as the relevant reporting.

- Texting results is cost effective. The introduction of a text service should be a priority.

- Progressing the implementation of Electronic Patient Records (EPR) is essential to ensure best use of staff resources and a quality patient experience. It will also reduce the need for costly storage space.

## 4 Financial Consequences

Sexual health is one of the biggest Public Health budgets moving to the local authority. The cost of the GUM service in DVH is based on a payment by results (PbR) basis. The tariff for new appointments is £152.92 and for follow up appointments it is £116.13.

| **2011** | | |
|---|---|---|
| New Appointments | 6954 | £1,063,405 |
| Follow Up Appointments | 1535 | £178,259 |
| | **Total** | **£1,241,665** |

It is envisaged that the service will be handed over to KCHT at the 2013/14 tariff.

There will be some costs linked to IT and setting up the service at GCH

# Sexual Health Services Factsheet

## What are the services?

Local authorities will become responsible for commissioning comprehensive, accessible and confidential contraception and sexually transmitted infections (STIs) treatment services.

The sexual health service for Kent includes the following:

- CASH (Contraceptive and Sexual Health Services) – 37 clinics
- GUM services (Genitourinary Medicine including HIV services)
- EHC (Emergency Hormone Contraception) schemes through pharmacies – 130 services
- School-based sexual health clinics
- C-Card (condom registration and access points) – 222 services
- Outreach work.

## Who are they for?

For the benefit of people across all age groups in Kent.

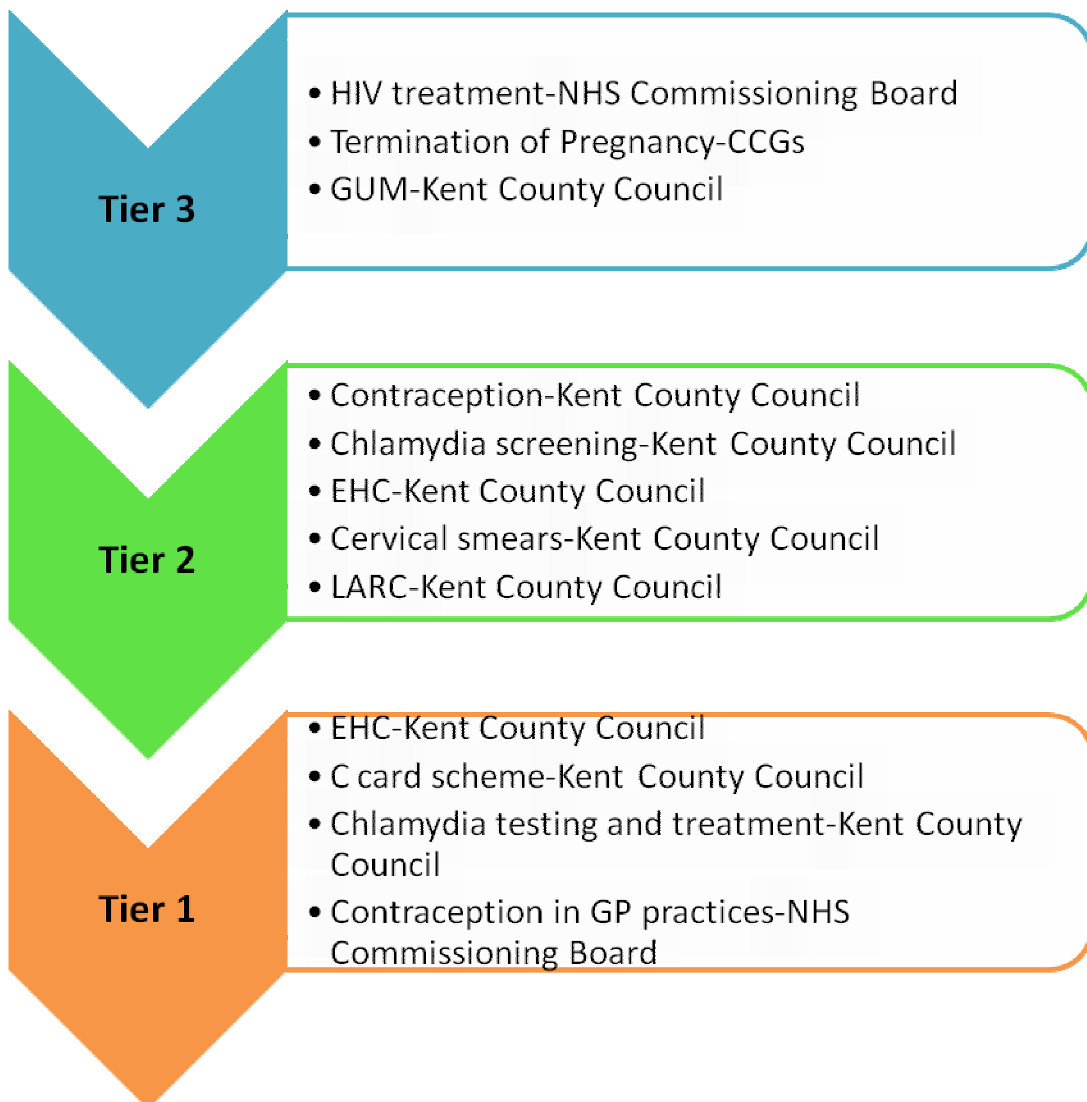
## Who is the contracted provider or providers?

There are a number of providers commissioned for sexual health services across Kent.

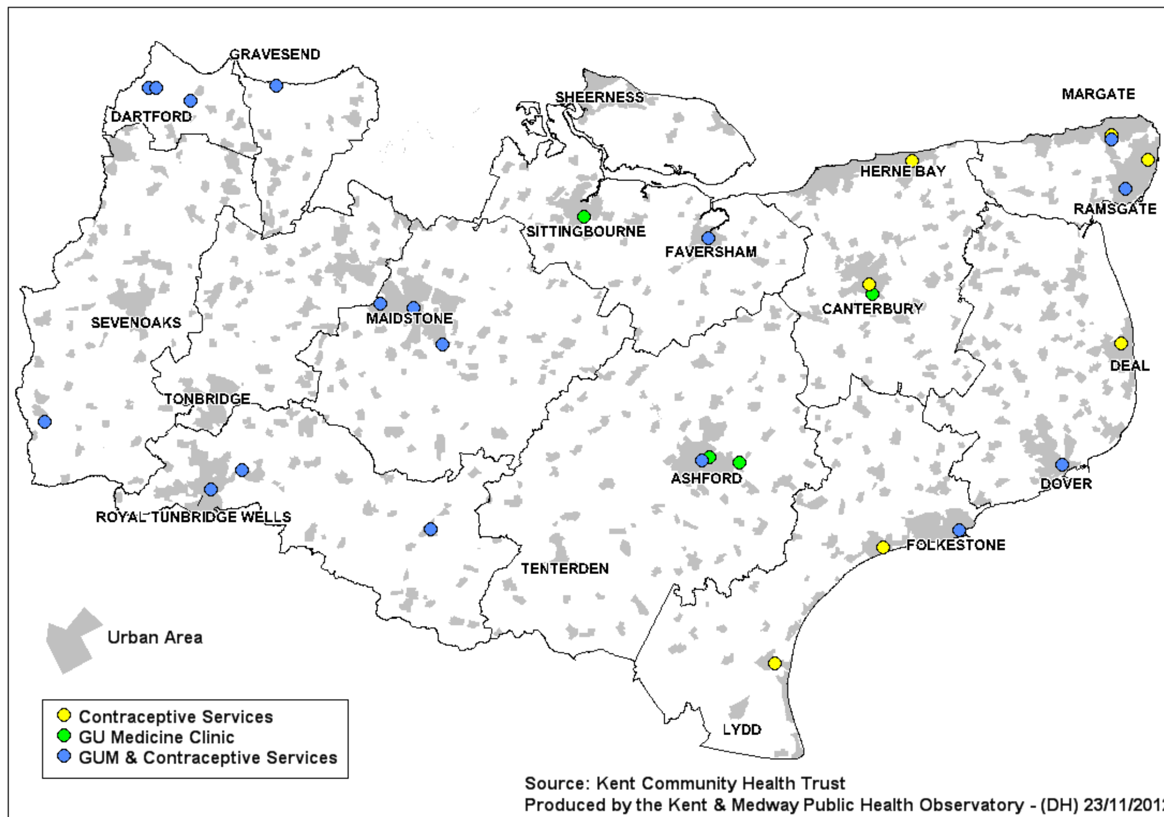
| Provider name | Funding(£) |
|---|---|
| Darent Valley Hospital (DVH) | £950,171 |
| Maidstone and Tunbridge Wells NHS Trust (MTW) | £1,369,781 |
| Medway Foundation Trust (MFT) | £570,781 |
| East Kent Hospitals University Foundation Trust (EKHUFT) | £248,927 |
| Kent Community Healthcare Trust (KCHT) | £9,500,000 |
| Total | £13,513,736 |

- All the CASH clinics in Kent are provided by Kent Community Health Trust
- Contracts are all annual with a 6-month notice period.

(Please see the diagram overleaf for an overview of how sexual health services are commissioned.)




The map below shows the location of the CASH [Contraceptive and Sexual Health Clinics] and the GUM [Genitourinary medicine] services.




**The evidence background**

Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV. DH, July 2001-Refreshed 2008 by the Independent Advisory Group for Sexual Health (http://www.dh.gov.uk/assetRoot/04/07/44/86/04074486.pdf)

Choosing health: Making healthier choices easier. Department of Health, 16/11/04, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550

*UK National Guidelines for HIV Testing 2008* www.bhiva.org

MEDFASH Recommended Standards for Sexual Health Services 2005, and MEDFASH Recommended Standards for HIV Services 2004 http://www.medfash.org.uk?

HIV in Primary Care 2004 http://www.medfash.org.uk?

NICE guidance Prevention of sexually transmitted infections and under 18 conceptions 2007 - http://www.nice.org.uk/PHI003?

**Targets and outcomes**

**National Outcome Measures**
**3.2 Chlamydia diagnosis (15-24 year olds)**
**3.4 People presenting with HIV at a late stage of infection**

**Sexual Health Targets**

**48-hour access to GUM services – 100%**

**Chlamydia diagnosis 15 -24 year olds**

Chlamydia screening is recommended for all sexually active people under 25, annually and on partner change. The Health Protection Agency (HPA) recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,400 per 100,000(2.4%) population

For Kent this would mean diagnosing approximately **4,414** 15 to 24 year olds. Public Health Outcomes Framework baseline 2010 was **1,562** diagnoses per 100,000 population 15 to 24 years.

- Late diagnosis of HIV is defined as a CD4 count of less than 350. Late diagnosis has been mentioned in the Public Health Outcomes Framework but it hasn't been decided nationally what the target will actually look like

**Issues , gaps and opportunities**

- HIV commissioning will be the responsibility of the National Commissioning Board (NCB)
- GUM and CASH services will be the responsibility of Local Authorities
- Termination of pregnancy will be the responsibility of Clinical Commissioning Groups.

The challenge will be to ensure that the population of Kent receives the best sexual health outcomes in a consistent and equitable way.

GUM attendances are increasing yearly. We need to cap costs as the increase can no longer be funded within NHS contracts.

DVH have given notice that they no longer want to provide GUM services. This is an opportunity to review the strategic direction of sexual health services in West Kent, focus on transformation of young people services alongside youth services and develop community based services.

**What it costs and what do we get for the money?**

The sexual health budget is estimated to be £13,760,308.
This money pays for the provision of sexual health services detailed above.

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**Decision No** 13/00024

**Decision No** 13/00023

**From:** **Graham Gibbens, Cabinet Member for Adult Social Care & Public Health**
**Meradin Peachey, Director of Public Health**

**To:** **Social Care and Public Health Cabinet Committee**

**Date:** **21 March 2013**

**Subject:** **Public Health Transition**

**Classification: Unrestricted**

**Summary**: On the 1 April 2013 the County Council will assume statutory responsibility for the delivery of significant elements in Kent of the new Public Health system for England. This paper updates this Committee on the progress made during this transition year in preparing for these changes. This includes ensuring that there is an appropriate level of assurance in the delivery of the new system.

**Recommendations:**

The Cabinet Member for Adult Social Care and Public Health will be asked to take two separate decisions:

- Decision number 13/00024 - To agree for the County Council to take over responsibility for the existing National Health Service contracts that are used to deliver those Public Health programmes for which the Authority will have responsibility for from 1 April 2013.
- Decision number 13/00023 - To agree that KCC shall take on responsibility for the relevant existing National Health Service (NHS) Assets and Liabilities that relate to the previous delivery of Public Health programmes for which the Authority will have responsibility for from the 1 April 2013.

**Members of this Committee are asked to:**

1. Note the contents of this report
2. Consider and either endorse or make further recommendations on the proposed decisions to be taken by the Cabinet Member

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

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

## 1. Introduction

1.1 This Committee has received frequent updates on the transfer of the locality-led element of the new national Public Health system to the County Council in April 2013. This report provides a final update for Members and seeks this Committee's views and comments on the assurance mechanisms in place to ensure the safe delivery of the new system. Members' views are also sought on two decisions the Cabinet Member intends to take to support the transition process. As a reminder the new system for public health in England will consist of four elements:

- National Commissioning Board
- Public Health England (PHE)
- Clinical Commissioning Groups
- Upper Tier Local Authorities

## 2. Contracts

2.1 The work that will be transferred will include the shaping and delivery of some 23 Public Health (PH) programme/ services. See appendix 1 for full list. The PH team currently commission external providers to deliver the majority of these programmes. These contracts are currently let by the NHS. These will need to be re-let by KCC on the 1 April 2013 to ensure service and business continuity in to the new financial year.

2.2 KCC's procurement team have been working through the details of the existing contracts, conducting the appropriate due diligence tests. Following this work the intention is for KCC to take direct responsibility for these contracts in its own right. This will need to be a decision to be taken by the Cabinet Member. The collective value of these contracts is approximately £37m placed with 10 primary providers[1]. There is a further £2m of Locally Enhanced Agreements.

2.3 The budget allocation that will be provided to the County Council for PH work in 2013/14 is sufficient to meet the costs of these contracts.

2.4 The disaggregation of NHS contracts and the identification of which part of the new National Health Service will take forward the responsibility from 1 April has been a difficult and complex process.

[1] This does not take into account the number of locally enhanced service providers, CVS providers for alcohol and substance misuse contracts or district councils

Whilst every effort has been taken to maximise KCC's best interests in this regard it is important to say there is an anticipation that unexpected issues may arise after April. Although it is not expected to be significantly financially, work is in to develop contingency plans to manage any unanticipated issues.

## 3. Assets and Liabilities

3.1 As part of the legal steps underpinning the new PH infrastructure there is a need to identify existing NHS Primary Care Trust (PCT) assets and liabilities and to transfer these, as appropriate, to the new 'receiver' organisations. For certain aspects of PH this will be KCC. The transfer scheme is drawn up by the NHS and signed by the Secretary of State. If an organisation is named on a transfer scheme they cannot refuse not to receive those assets and liabilities identified. That said it still requires the Cabinet Member to take a formal decision to accept any asset or liability. The transfer of NHS Personnel is subject to a separate transfer scheme and this is being considered by the Personnel Committee at it March 2013 meeting.

3.2 KCC does not intend to receive any physical assets (such as computers or furniture).

3.3 KCC's Legal Services team is conducting due diligence on the draft transfer order relating to KCC and at the time of writing are still waiting for clarification on a couple of points. The latest draft transfer order identifies only a limited number of assets and liabilities (such as the transfer of Personnel records and the transfer of a web site) and the current expectation, subject to the completion of the due diligence process, is that this transfer is probably a simple legal formality. However, this is a statutory process and it is important to report this to Members. A further update will be provided at the meeting of this Committee.

## 4. Health Protection

4.1 Health protection includes (but is not confined to) infectious disease, environmental hazards and contamination, and extreme weather events.

4.2 The statutory responsibility to protect the health of the population transfers from the Health Protection Agency (HPA) to the Secretary of State for Health on 1 April 2013. The Secretary of State's responsibilities will mainly be discharged through Public Health England (PHE). However, there are also some specific delegated powers to Local Authorities under the 2012 regulations. These are to give information and advice on appropriate health protection arrangements within their local area to every responsible person and relevant body. This means that KCC will be responsible for disseminating information about severe weather events like heat wave

planning as we approach summer. KCC will also be responsible for advice on Health Care Acquired Infection. Specialist nursing resource will be available in the public health team to do this.

4.3 PHE will be responsible for providing the specialist health protection functions currently carried out by the HPA including the specialist response to incidents.

4.4 As part of the Local Authority's responsibilities the Director of Public Health (DPH) has a duty to prepare for and lead the Local Authority's response to incidents that present a threat to the public's health. This would include severe weather events, chemical and environmental hazards and pandemics like swine flu. In KCC this means that all emergency responses will need public health advice. The Council's emergency plan will need to be amended. We will retain a 24 hour public health consultant rota which will be available to members, emergency planners and officers for public health advice. The DPH will remain a member of the Kent Resilience Forum (KRF) to ensure that KCC can provide appropriate advice to all agencies on public health issues.

4.5 District and Unitary Authorities also have defined responsibilities in respect of environmental health, which are discharged in a variety of different ways in different geographical areas. For example, some Districts combine their environmental health capacity across a wider area with DPH leadership from the County; some Unitary Authorities have environmental health within the DPH's leadership responsibilities, whilst in others they are entirely separate. In Kent there have been no discussions with District Councils about changing their current responsibilities for environmental health.

4.6 The DPH is a statutory member of the Health and Wellbeing Board. The function of Health and Wellbeing Boards is to ensure leaders from health and care systems and the public work together to improve the health and wellbeing of their local population and reduce health inequalities. Board members will work together to ensure public engagement and input to joint strategic needs assessments and to health and wellbeing strategies. Boards will also ensure that commissioners work collaboratively to meet the health and wellbeing needs of the community.

<u>DPH and PHE relationship</u>

4.7 The DPH has a duty to prepare for and lead the Local Authority's response to incidents that present a threat to the public's health. PHE has a duty to deliver the specialist health protection response. These roles are complementary and both are needed to ensure an effective response. In practice this will mean that there must be early and on-going communication between the organisations regarding emerging

health protection issues to discuss and agree the nature of response required.

4.8 In Kent we are establishing a Health Protection Committee that will bring together not only PHE and KCC but also the National Commissioning Board (NCB) as all 3 organisations have responsibilities in Health Protection. This committee will address the following:

1. Health Care Acquired Infection
2. Public Health Emergency Planning
3. Management of incidents and outbreaks
4. Surveillance of infectious diseases including sexual transmitted diseases
5. Immunisations and screening

This Committee is an opportunity for the Directors of Public Health for Kent and Medway to ensure appropriate action is taken to keep residents safe.

PHE Delivery

4.9 PHE continues to deliver the specialist health protection functions described in the HPA's previous work on the "model health protection unit". These are:

- Responding to and managing outbreaks and incidents
- Responding to cases, enquiries and providing advice
- Surveillance and epidemiology study
- Health protection leadership/stakeholder relationship management
- Contributing to and influencing HPA Programme Board activities and other internal work streams
- Research and development
- Underpinning activities (management, governance arrangements etc.)

This includes the provision of PHE support for the DPH addressing issues of environmental health planning applications (e.g. for waste incinerators)

Health and Wellbeing Boards

4.10 Local Authorities, with their Health and Wellbeing Boards (HWBs), and through their DPH will wish to assure that acute and longer term Health Protection responses and strategies delivered by PHE are delivered in a manner that properly meets the health needs of the local population. Public Health England Centres and Directors of Public Health will agree the reporting of health protection arrangements to Health and Wellbeing Boards to include local agreement of health protection

priorities on an annual cycle and any ad hoc reporting for serious incidents or areas of concern.

4.11 PHE is not expected to be represented on the HWB but to attend for specific health protection related discussions. Attendance would be primarily in support of the DPH who is the local leader for health in the Local Authority.

Mobilising Resources for Incidents

4.12 The DPH with their local health leadership role will work with colleagues from PHE to establish arrangements for mobilising resources to respond to incidents and outbreaks. This will include advice to Clinical Commissioning Groups, discussions with the Area Teams of the NHS Commissioning Board and particularly through the joint chairmanship arrangements of the Local Health Resilience Forum.

Communications, Information and Concerns

4.13 The PHE Centre and the DPH will develop a shared understanding around communications about health protection concerns. The PHE Centre will keep the DPH informed about health protection issues and of the action being taken to resolve them.

4.14 PHE will provide to Local Authorities, via their DPH, the information, evidence and examples of best practice to support the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies. There needs to be a clear programme of engagement at national and local level to determine what form this information can most helpfully be provided in.

4.15 PHE will support transparency and accountability across the public health system including the provision of information and discussions with local authorities in relation to achievement of public health outcomes.

4.16 PHE will also highlight issues of concern to local authorities, for example if there is no system for Environmental Health Officer support to respond to outbreaks of infection.

Workforce and Training

4.17 PHE will support the DPH in providing development and educating Health and Wellbeing Boards on issues of relevance to the health of the local population. Public Health England will support Local Authorities to develop a trained and knowledgeable public health workforce, including in the area of health protection.

Scientific Technical and Advisory Cell

4.18 This is a statutory part of emergency planning whereby the police gold commander can call upon scientific advice when needed. In the absence of clear advice from PHE the DPH will continue to ensure that when needed a group of experts will be called and clear advice is given to the gold commander

Health Service Emergency Planning Response

4.19 The NCB has established a Local Health Resilience Partnership in each Local Resilience Forum area. The Director of Public Health is the joint chair of the Kent and Medway Local Health Resilience Partnership on behalf of both Kent and Medway Councils. The constitution of these partnerships has been prescribed by the National Commissioning Board. This is an opportunity for KCC to provide its statutory advice to NHS providers and to ensure that NHS emergency planning response planning is appropriate.

4.20 A public health rota will continue so that KCC has 24 hour access to expert public advice for any potential or actual incidents. The DPH will continue to attend the KRF as expert public health advice

## 5. Quality Assurance

KCC Commissioned Services

5.1 Quality indicators will be developed for contracted providers and performance managed by the Public Health business unit and will be reported by exception as part of KCC procedures.

5.2 The Public Health team will develop an internal Quality Committee to review and monitor the quality of PH services provided. This should include patient experience, serious untoward incidents, risk management, data collection, staff development, effectiveness, especially picking up National Institute of Clinical Excellence (NICE) PH guidance and implementation, as well as clinical effectiveness, and broader NICE where it applies to our clinical services.

NCB Quality Committee

5.3 The NCB is establishing quality committees in every Local Area Team. The terms of reference are determined nationally and specifically exclude social care. This committee includes all those with a commissioning responsibility or input into the quality of health services. KCC is a member as well as CCGs, CQC and monitor. It is here that KCC can ensure that NICE guidance and other national standards are implemented and an opportunity to raise members concerns about quality of health services.

## 6. Public Health Professional standards

6.1 Public Health professionals need to maintain registration and fulfil the new requirements for revalidation and all the current requirements for CPD. KCC's Human resources function will monitor compliance with professional qualifications. A public health consultant with additional training in educational standards will be designated as the training lead to ensure public health registrars receive the appropriate training. KCC is waiting to hear about authorising KCC as a site for Public Health trainees.

## 7. Public Health Memorandum of Understanding with Clinical Commissioning Groups

7.1 A Memorandum of Understanding has been agreed by the Cabinet member and Clinical Commissioning Groups (CCG) chairs describing the role of public health advice. This will be monitored 6 monthly with CCG chairs by the DPH.

## 8. Reporting on Public Health Outcomes and Spend

8.1 The Department of Health has advised Local Authorities how it wants public health spend notified yearly. This includes a signed statement by the chief executive or equivalent that the public health budget has been appropriately spent. KCC will use the same categories on the finance system to report to members.

8.2 A public health outcomes framework, with details of the indicators has been published. PHE has not yet described how it wants to monitor these. KCC public health has already reported on these outcomes to the Health and Well-Being Board and will report the same to the relevant cabinet committee.

## 9. Public Health Commissioning

9.1 The Head of Public Health Commissioning within the KCC Public health team will manage a business unit that will:

- develop and monitor a risk register and contribute to the corporate risk register
- utilise the oracle finance systems and report the budget progress to the cabinet committee and liaise with the finance business partner
- report performance to the cabinet committee and performance committee
- report to the procurement board as services will be considered for re procurement over the next few years
- develop business continuity plans in liaison with the emergency planning team

## 10. Community Safety

10.1 Currently Public Health represents the Primary Care Trusts on 12 Community Safety Partnerships. The Cabinet Member for Customer and Communities, in his role as the chair of the Kent Community Safety Partnership has written to Kent and Medway CCGs asking them how they would like to be represented on the Kent Community Safety Partnership in their new role.

10.2 The DPH has a key role in working with the Police and Crime Commissioner to improve health and reduce the impacts of crime and disorder. The DPH will implement these responsibilities as a member of the Kent Community Safety Partnership and through the provision of crime and disorder strategic needs assessment relevant to public health issues.

## 11. Conclusion

11.1 From the 1 April 2013 the County Council will take forward a direct and key role in protecting and improving the health of the local population. Rightly this comes with the associated responsibilities and accountabilities. The County Council is well placed to build on the success of the Kent Public health team to date and to fully reflect the fundamental principles of localism in future strategy and delivery. The organisational changes within the NHS means that new systems and processes have either been developed or being finalised to provide oversight and assurance within Public Health. This is a period of dynamic change and I will continue to report to this Committee on how these new systems are embedded in to both KCC and into wider partnership structures.

## 12. Recommendations:

12.1 The Cabinet Member for Adult Social Care and Public Health will be asked to take two separate decisions:

- Decision number 13/00024 - To agree for the County Council to take over responsibility for the existing National Health Service contracts that are used to deliver those Public Health programmes for which the Authority will have responsibility for from 1 April 2013.
- Decision number 13/00023 - To agree that KCC shall take on responsibility for the relevant existing National Health Service (NHS) Assets and Liabilities that relate to the previous delivery of Public Health programmes for which the Authority will have responsibility for from the 1 April 2013.

Members of this Committee are asked to note the contents of this report and Consider and either endorse or make further recommendations on the proposed decisions to be taken by the Cabinet Member

- Decision number 13/00024 - To agree for the County Council to take over responsibility for the existing National Health Service contracts that are used to deliver those Public Health programmes for which the Authority will have responsibility for from 1 April 2013.
- Decision number 13/00023 - To agree that KCC shall take on responsibility for the relevant existing National Health Service (NHS) Assets and Liabilities that relate to the previous delivery of Public Health programmes for which the Authority will have responsibility for from the 1 April 2013.

**Background Documents**

None

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**Appendix 1**

## Public Health Services Transferring to KCC

| | Service |
|---|---|
| 1 | Tobacco control and smoking cessation services |
| 2 | Drug misuse services |
| 3 | Alcohol misuse services |
| 4 | Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) school nursing |
| 5 | The National Child Measurement Programme |
| 6 | Interventions to tackle obesity such as community lifestyle and weight management services |
| 7 | Locally-led nutrition initiatives |
| 8 | Increasing levels of physical activity in the local population |
| 9 | NHS Health Check assessments |
| 10 | Public mental health services |
| 11 | Dental public health services |
| 12 | Accidental injury prevention |
| 13 | Population level interventions to reduce and prevent birth defects |
| 14 | Behavioural and lifestyle campaigns to prevent cancer and long-term conditions |
| 15 | Local initiatives on workplace health |
| 16 | Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes |
| 17 | Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention) |
| 18 | Local initiatives to reduce excess deaths as a result of seasonal mortality |
| 19 | The local authority role in dealing with health protection incidents, outbreaks and emergencies |
| 20 | Public health aspects of promotion of community safety, violence prevention and response |
| 21 | Public health aspects of local initiatives to tackle social exclusion |
| 22 | Needs Assessment and commissioning advice to CCGs |
| 23 | Needs assessment and commissioning advice to NCB |

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**TO:** Social Care & Public Health Cabinet Committee – 21st March 2013

**BY:** Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
Jenny Whittle, Cabinet Member for Specialist Children's Services
Andrew Ireland, Corporate Director - Families and Social Care

**SUBJECT:** Families & Social Care Directorate (Adult Social Care & Public Health Portfolio & Specialist Children's Services Portfolio) Financial Monitoring 2012/13

**Classification:** Unrestricted

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**Summary:**

Members of the Cabinet Committee are asked to note the third quarter's full budget monitoring report for 2012/13 reported to Cabinet on 21 March 2013.

**FOR INFORMATION**

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## 1. Introduction:

1.1 This is a regular report to this Committee on the forecast outturn for Families & Social Care Directorate (Adult Social Care & Public Health Portfolio & Specialist Children's Services Portfolio)

## 2. Background:

2.1 A detailed quarterly monitoring report is presented to Cabinet, usually in September, December and March and a draft final outturn report in either June or July. These reports outline the full financial position for each portfolio and will be reported to Cabinet Committees after they have been considered by Cabinet. In the intervening months an exception report is made to Cabinet outlining any significant variations from the quarterly report. The third quarter's monitoring report for 2012/13 is attached.

## 3. Families & Social Care Directorate/Portfolio 2012/13 Financial Forecast - Revenue

3.1 There are no exceptional revenue changes since the writing of the attached quarter 2 report.

3.2. The table below shows a summary of the overall forecast position for the FSC directorate at the end of the second quarter of 2012-13:

| Portfolio | Forecast Variance £m |
|---|---|
| Specialist Children's Services (excl EY)* | +9.063 |
| Adult Social Care & Public Health | -1.619 |
| **Directorate Total** | **+7.444** |

3.3. The table below summarise the forecast variances for Specialist Children's Services.

| | Variance £m |
|---|---|
| Looked After - Residential Care | +2.353 |
| - Fostering | +3.070 |
| - Legal Costs | +1.010 |
| Adoption | +0.635 |
| Children's Staffing | +1.282 |
| Safeguarding | +0.000 |
| Preventative Services | -1.352 |
| Leaving Care | -0.029 |
| Directorate Mgt & Support | -0.267 |
| Asylum | +3.082 |
| Children's Centres | -0.788 |
| Specialist Children's Service Total | +9.063 |

The detail and reasons of these variances can be found in the full monitoring report (Annex 2) attached, between pages 4 and 20.

3.4 The table below summarise the forecast variance for Adult Social Care and Public Health.

| | Variance £m |
|---|---|
| Older People | -0.482 |
| Physical Disability | -0.997 |
| Learning Disability | +0.395 |
| Mental Health | -0.240 |
| Assessment of Vulnerable Adults | -0.206 |
| Safeguarding | 0.000 |
| Directorate & Management Support | -0.074 |
| Public Health | -0.015 |
| Adult Social Care & Public Health Total | -1.619 |

The detail and reasons of these variances can be found in the full monitoring report (Annex 3) attached, between pages 21 and 51.

## 4. Families & Social Care Directorate/Portfolio 2012/13 Financial Forecast - Capital

4.1 There are no capital movements from the attached quarter 3 report.

4.2 The table below shows a summary of the overall forecast position for the FSC directorate at the end of the third quarter of 2012-13:

| | Portfolio | | |
|---|---|---|---|
| | Adult Social Care & Public Health £m | Specialist Children's Services £m | **TOTAL** **£m** |
| Unfunded variance | 0.000 | +1.107 | +1.107 |
| Funded variance | +0.007 | 0.000 | +0.007 |
| Variance to be funded from revenue | 0.000 | +0.006 | +0.006 |
| Project underspend | 0.000 | -0.017 | -0.017 |
| Re-phasing (beyond 2012/15) | -1.418 | 0.000 | -1.418 |
| **Total variance** | **-1.411** | **+1.096** | **-0.315** |

## 5. Social Care Debt Monitoring

5.1 The latest position on social care debt can be seen in Annex 3 attached (Pages 50 – 51)

## 6. Recommendations

6.1 Members of the Social Care & Public Health Cabinet Committee are asked to note 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.

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# FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
# CHILDREN'S SERVICES SUMMARY
# DECEMBER 2012-13 FULL MONITORING REPORT

## 1. FINANCE

### 1.1 REVENUE

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

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits for the A-Z service analysis have been adjusted since the quarter 2 report to reflect the centralisation of the ICT budgets to BSS directorate (see annex 6), and the transfer of the Service Level Agreements for transport related services to the new Transport Operations A-Z budget within the EH&W portfolio (see annex 4), following the transfer of the Transport Integration Unit to E&E directorate from Commercial Services. There have also been a number of other technical adjustments to budget.
- The inclusion of a number of 100% grants (ie grants which fully fund the additional costs) awarded since the budget was set. These are detailed in Appendix 1 to the executive summary.

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

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **Specialist Children's Services portfolio** | | | | | | | |
| Strategic Management & Directorate Support Budgets | 3,448 | -175 | 3,273 | -267 | | -267 | Staff vacancies |
| Children's Services: | | | | | | | |
| **- Education & Personal** | | | | | | | |
| - Children's Centres | 17,650 | -139 | 17,511 | -660 | -128 | -788 | Release of uncommited budget, various underspends across 97 centres |
| - Early Years & Childcare | 0 | 0 | 0 | 179 | -155 | 24 | Additional PVI income, corresponding spend |
| - Virtual School Kent | 2,683 | -704 | 1,979 | 89 | -10 | 79 | |
| | 20,333 | -843 | 19,490 | -392 | -293 | -685 | |
| **- Social Services** | | | | | | | |
| - Adoption | 8,310 | -49 | 8,261 | 635 | | 635 | Increase in placements, SGO |
| - Asylum Seekers | 14,901 | -14,621 | 280 | 64 | 3,018 | 3,082 | forecast shortfall in funding, awaiting resolution with Govt |
| - Childrens Support Services | 2,538 | -1,043 | 1,495 | -124 | 88 | -36 | OOH team staffing |
| - Fostering | 34,302 | -237 | 34,065 | 3,061 | 9 | 3,070 | Increase in demand, change in unit cost, reduced demand for Kinship Non LAC, increase demand for related foster payments |
| - Leaving Care (formerly 16+) | 5,123 | 0 | 5,123 | -29 | | -29 | |
| - Legal Charges | 6,315 | 0 | 6,315 | 1,010 | | 1,010 | Increased demand |

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| - Preventative Children's Services | 20,560 | -4,369 | 16,191 | -1,544 | 192 | -1,352 | Reducation in S17 payments, MASH lease, re-phasing of strategies relating to early intervention & prevention, increased demand for Direct payments |
| - Residential Children's Services | 13,749 | -2,144 | 11,605 | 2,010 | 343 | 2,353 | Increase in weeks/ lower unit cost, specialist placements, increased costs of respite care for disabled children due to complexity of needs |
| - Safeguarding | 4,598 | -316 | 4,282 | 0 | | 0 | Staff vacancies |
| | 110,396 | -22,779 | 87,617 | 5,083 | 3,650 | 8,733 | |
| Assessment Services | | | | | | | |
| - Children's Social Care Staffing | 39,099 | -819 | 38,280 | 1,282 | 0 | 1,282 | Staffing |
| | | | | | | | |
| **Total SCS portfolio** | **173,276** | **-24,616** | **148,660** | **5,706** | **3,357** | **9,063** | |
| | | | | | | | |
| **Assumed Management Action** | | | | | | | |
| **- SCS portfolio** | | | | | | **0** | |
| | | | | | | | |
| **Forecast after Mgmt Action** | | | | **5,706** | **3,357** | **9,063** | |

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

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

## Specialist Children's Services portfolio:

1.1.3.1 Strategic Management & Directorate Support: Gross -£267k
This variance is predominantly due to a staffing underspend within the Performance & Information Management unit of -£190k, which is mainly due to unfilled vacancies.

1.1.3.2 Children's Centres: Net -£788k (-£660k Gross, -£128k Income)
An underspend of -£300k has been forecast on the Early Years, Children's centre development team from the release of uncommitted budget to offset pressures elsewhere within SCS.

There is a further gross underspend on Children's Centres of -£488k which is due to various small underspends spread over the 97 centres. There is also a further gross pressure of +£128k which has a corresponding income variance -£128k, which relates to where the centres receive income for shared costs, rental of rooms, activities etc, all of which also incur expenditure.

1.1.3.3 Early Years & Childcare: Net +£24k (+£179k Gross, -£155k Income)
There is a forecast income variance of -£155k due to additional income being received by the Early Years nurseries in respect of 2, 3 & 4 year old funding. This results in additional spend and a corresponding gross pressure of +£155k has been forecast. There are also other small gross variances of +£24k relating to the three KCC run nurseries which are transferring to ELS.

1.1.3.4 Adoption: Gross +£635k

The current forecast variance of +£635k includes a pressure of +£192k for an increase in the cost of placements. In addition, there is a pressure of +£386k relating to special guardianship orders (SGO); this is due to the need to secure a permanent placement for a child where adoption is not suitable or required. There are also other small gross pressures of +£57k.

1.1.3.5 Asylum Seekers – Net +£3,082k (+£64k gross, +£3,018k income)

We are now forecasting a potential net pressure of £3,082k against the Asylum Service. This pressure is in respect of both unaccompanied asylum seeking children and those eligible under the care leaving legislation.

A separate report on this issue was presented to Cabinet on 18 March.

1.1.3.6 Children's Support Services: Net -£36k (-£124k Gross, +£88k Income)

There is a forecast underspend on staffing of -£65k which is for the Out of Hours team, there are also other small gross variances of -£59k, and a small income variance of +£88k.

1.1.3.7 Fostering: Net +£3,070k (+£3,061k Gross, +£9k Income)

There is a forecast gross pressure of +£801k on Non-related fostering (in house) as a result of the forecast number of weeks of service being 1,851 higher than the affordable level of 54,872, this generates £707k of the current pressure. Additionally, the unit cost being +£1.71 higher than previously estimated when setting the cash limit, has increased the pressure by +£94k.

A gross pressure of +£2,532k is forecast for Independent fostering. Again this is as a result of an increase in weeks support, which is 3,376 higher than the affordable level of 6,152 and results in a pressure of +£3,088k. However, the average weekly cost is -£90.35 lower than budgeted, and this reduces the total pressure by -£556k.

A gross underspend of -£677k is forecast on Kinship non LAC which is due to reduced demand. (This reduction in spend has resulted in an increase in the SGO forecast of +£386k in section 1.1.3.4 above) and +£317k on related foster payments (see below), and other small gross variances of +£26k.

There is also a gross pressure of +£317k on related foster payments due to an increase in demand resulting from the drive to move children from Kinship to Related foster payments (and SGO see section 1.1.3.4).

The county fostering team is forecasting a gross pressure of +£88k, due to an increase in the number of staff following the restructure. There is also a small income variance of +£9k.

1.1.3.8 Leaving Care (formerly 16+): Gross -£29k

An underspend of -£457k is forecast on leaving care/Section 24. This is partly due to more young people opting to remain with their foster carers, and also stricter controls around S24 payments (*assistance provided to a child aged 16+ who leaves local authority care*). There is also a forecast pressure of +£295k due to a VAT liability dating back to 2009 relating to the contract with Catch 22. In addition there are other small variances totalling +£133k.

1.1.3.9 Legal Charges: Gross +£1,010k

There is a pressure forecast on the legal budget of +£1,010k, of which +£860k is due to demand being greater than that budgeted for and +£150k is spend which has moved from the Section 17 budget (see section 1.1.3.10)

1.1.3.10 Preventative Children's Services: -£1,352 k (-£1,544k Gross, +£192k Income)

There is a forecast underspend of -£570k on the Section 17 *(Provision of services for children in need, their families and others)* budget. -£150k of this is due to spend being re-classified as legal costs, previously been classified as Section 17. These costs are now included in section 1.1.3.9. A further underspend has been forecast of -£420k due to management action and more detailed guidance being issued to district teams on when they can make Section 17 payments. There is also a small income variance of +£55k

There is a forecast underspend of -£249k on Independent sector day care and short breaks as a result of renegotiated day care costs.

Independent sector day care and short breaks for disabled children has a forecast underspend of -£308k, of which there is an underspend of -£496k on core activity as a result of a shift to providing direct payments instead (see below). In addition there is a forecast pressure of +£188k due to lease charges on the MASH (Multi Agency Specialist Hubs).

There is a forecast pressure of +£319k for Direct payments, which is due to the number of forecast weeks being 4,660 higher than budgeted, and the forecast rate being £10.60 higher than the budgeted rate. There is also a small income variance of +£13k.

Due to some re-phasing of the strategies relating to early intervention and prevention a -£500k underspend is forecast. There is a further gross underspend of -£150k and corresponding income variance of +£150k, which reflects a number of renegotiated commissioned services, which have also resulted in some loss of joint funding. There is also a further small income variance of +£8k on the prevention strategy budget.

There are also various other small gross variances totalling -£86k, and an income variance of -£34k.

1.1.3.11 Residential Children's Services: Net +£2,353k (+£2,010k Gross, +£343k Income)

Of the pressure within residential services, +£1,851k (+£1,478k Gross, +£373k Income) relates to non disabled independent sector residential provision. The forecast number of weeks of service is 680 higher than the affordable level of 1,892, which generates +£2,011k of current pressure. Additionally the unit cost being -£281.66 lower than previously estimated when setting the cash limit has reduced this pressure by -£533k. The income variance of +£373k is due to a reduction in income for placements from health.

The budget for independent residential care for disabled children is showing a pressure of +£474k (+£450k Gross, +£24k Income). This is due to an increase in costs of specialist placements of +£350k, and a pressure of +£100k due to an increase in the overall number of placements. There is also a small income variance of +£24k.

There is a forecast net pressure of +£110k relating to KCC respite care for disabled children reflecting the complexity of the children's needs, which comprises a gross pressure of +£166k and a small income variance of -£56k.

There is a small net underspend on Residential care for Non-LAC of -£38k, comprising of a gross underspend of -£40k and an income variance of +£2k

There is also a small underspend forecast on secure accommodation of -£44k

1.1.3.12 Assessment Services – Children's Social Care Staffing: Gross +£1,282k

Following a more in depth monitoring process this quarter including greater engagement of finance staff, service managers and Area Directors, we are now in a position to provide a more accurate reflection of the financial position on this budget. This is producing a gross pressure of +£1,282k on staffing costs.

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

(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| SCS | Fostering - Gross - Independent - forecast weeks higher than budgeted | +3,088 | SCS | Fostering - Gross - Independent - forecast unit cost lower than budgeted | -556 |
| SCS | Asylum - forecast shortfall in funding, awaiting resolution with Government | +3,082 | SCS | Residential - Gross - Non Dis Independent Sector - forecast unit cost lower than budgeted | -533 |
| SCS | Residential - Gross - Non Dis Independent Sector - forecast weeks higher than budgeted | +2,011 | SCS | Preventative Children's services - Gross - re-phasing of strategies relating to early intervention and prevention | -500 |
| SCS | Children's social care staffing - Gross - Additional staffing costs | +1,282 | SCS | Preventative Children's services - Gross - Independent sector day care disability - reduction in core activity due to a shift to direct payments | -496 |
| SCS | Legal Charges - Gross - increased demand | +860 | SCS | Children's centres - Gross - Various small underspends across 97 centres | -488 |
| SCS | Fostering - Gross - Non-related in house - forecast weeks higher than budgeted | +707 | SCS | Leaving care - Gross - decrease in demand as 16-18 yr olds remaining in foster care, stricter controls around S24 payments | -457 |
| SCS | Adoption - Gross - Increase in Special Guardianship Orders | +386 | SCS | Preventative Children's services - Gross - management action and more detailed guidance on Section 17 payments | -420 |
| SCS | Residential - Income - Non Dis Independent Sector - reduction in income for placements from Health | +373 | SCS | Fostering - Gross - Kinship non LAC - move to SGO | -386 |
| SCS | Residential - Gross - Dis Independent Sector - Increase in specialist placements | +350 | SCS | Fostering - Gross - Kinship non LAC - move to related fostering | -317 |
| SCS | Preventative Children's services - Gross - Direct Payments - Forecast weeks/unit costs higher than budgeted (shift from Ind day care disability) | +319 | SCS | Early Years - Gross - Children's centre development team - release of uncommitted budget | -300 |
| SCS | Fostering - Gross - Related foster payments - drive to move children from Kinship to Related Fostering | +317 | SCS | Preventative Children's services - Gross - Independent sector day care non disability- renegotiated day care rate | -249 |
| SCS | Leaving care - Gross - VAT liability | +295 | SCS | Strategic Management & Directorate Support - Gross - Vacancies within Performance & Information Management unit | -190 |
| SCS | Adoption - Gross - Increase in cost of placements | +192 | SCS | Early Years - Gross - additional income for increased payments for 2, 3 & 4 year olds | -155 |
| SCS | Preventative Children's services - Gross - increased cost of MASH due to lease changes | +188 | SCS | Preventative Children's services - Gross - Costs re-classified as legal costs | -150 |
| SCS | Residential - Gross - In house respite care for disabled children - complexity of needs | +166 | SCS | Preventative Children's Services - Income - loss of joint funding from health | -150 |

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| SCS | Early Years - Gross - additional costs due to increased payments for 2, 3 & 4 year olds | +155 | SCS | Children's centres - Income - Various income for utilities, activities etc | -128 |
| SCS | Legal Charges - Gross - costs moved from S.17 | +150 | | | |
| SCS | Preventative Children's Services - Gross - renegotiated commissioned services | +150 | | | |
| SCS | Children's centres - Gross - Various spend on utilities, activities etc | +128 | | | |
| SCS | Residential - Gross - Disability Independent Sector - increase in the overall number of placements | +100 | | | |
| | | | | | |
| | | +14,299 | | | -5,475 |

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

Controls have been put in place which we believe are helping to reduce the financial pressures on Specialist Children's Services during the year, these include:

- *Access to Resource Panels chaired by Assistant Directors, to ensure that there is consistent decision making with regard to new placements for children in care.*
- *Placement Panels to review the status and placement of current children in care.*
- *New guidance and expenditure limits applied to Section 17 expenditure and transport costs.*
- *New commissioning framework being drawn up to reduce the costs of Independent Fostering placements.*
- *Recruitment of more in-house foster carers and potential adopters.*
- *Better contract management.*
- *Improved joint working with Legal through a Service Level Agreement.*

Structural changes are being implemented which will ensure that there are smaller teams with better management oversight, and clearer delineated accountability for case work decisions. New Access to Resources Team is being established, which will help maximise commissioning potential, and ensure best value.

In addition to the above, new commissioning frameworks have been developed for Early Intervention Services and Disabled Children's Services which will enhance early intervention, and therefore reduce the need for ongoing higher costs.

1.1.5 **Implications for MTFP**:

The current year pressures have been addressed in the recently approved 2013/15 MTFP

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

None

1.1.7 **Details of proposals for residual variance**: *[eg roll forward proposals; mgmt action outstanding]*

None

## 1.2 CAPITAL

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

1.2.2 Specialist Childrens Services
The Specialist Childrens Services portfolio has an approved budget for 2012-15 of £0.703m (see table 1 below). The forecast outturn against this budget is £1.799m, giving a variance of +£1.096m. After adjustments for funded variances and reductions in funding, the revised variance comes to +£1.090m.This is made up of an unfunded variance of +£1.107m and project underspends of -£0.017m (see table 3).

1.2.3 Tables 1 to 3 summaries the portfolio's approved budget and forecast.

1.2.4 Table 1 – Revised approved budget

| | £m |
|---|---|
| Approved budget last reported to Cabinet | 0.769 |
| Approvals made since last reported to Cabinet | -0.066 |
| Revised approved budget | 0.703 |

1.2.5 Table 2 – Funded and Revenue Funded Variances

| Scheme | Portfolio | Amount £m | Reason |
|---|---|---|---|
| **Cabinet to approve cash limit changes** | | | |
| | | | |
| | | | |
| **No cash limit changes to be made** | | | |
| Ashford, Thanet & Swale MASH | SCS | 0.006 | Revenue Cont-as previously reported |
| | | | |
| Total | | 0.006 | |

1.2.6 Table 3 – Summary of Variance

| | Amount £m |
|---|---|
| **Unfunded variance** | **1.107** |
| Funded variance (from table 2) | |
| Variance to be funded from revenue | 0.006 |
| Project Underspend | -0.017 |
| **Rephasing (beyond 2012-15)** | |
| Total variance | 1.096 |

1.2.7 **Main reasons for variance**

Table 4 below, details each scheme indicating all variances and the status of the scheme. Each scheme with a Red or Amber status will be explained including what is being done to get the scheme back to budget/on time.

Table 4 – Scheme Progress

| Scheme Name | Total approved budget | Previous Years Spend | 2012-15 approved budget | Later Years approved budget | 2012-15 Forecast Spend | Later Years Forecast Spend | 2012-15 Variance | Total Project Variance | Status |
|---|---|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m | £m | |
| Approval to Spend | | | | | | | | | |
| Ashford, Thanet and Swale MASH | 15.826 | 15.843 | -0.017 | 0.000 | 1.096 | 0.000 | 1.113 | 1.113 | Amber - Overspend |
| TSB2 Short Breaks Pathfinder Programme | 0.532 | 0.117 | 0.415 | 0.000 | 0.415 | 0.000 | 0.000 | 0.000 | Green |
| Early Years & Children's Centres | 41.955 | 41.901 | 0.054 | 0.000 | 0.037 | 0.000 | -0.017 | -0.017 | Green |
| Self Funded Project (Quarryfields)(tr to ELS) | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | Green |
| Service Redesign | 0.251 | 0.000 | 0.251 | 0.000 | 0.251 | 0.000 | 0.000 | 0.000 | Green |
| | 58.564 | 57.861 | 0.703 | 0.000 | 1.799 | 0.000 | 1.096 | 1.096 | |



1.2.8 Status:
Green – Projects on time and budget
Amber – Projects either delayed or over budget
Red – Projects both delayed and over budget

1.2.9 Assignment of Green/Amber/Red Status

1.2.10 Projects with variances to budget will only show as amber if the variance is unfunded, i.e. there is no additional grant, external or other funding available to fund.

1.2.11 Projects are deemed to be delayed if the forecast completion date is later than what is in the current project plan.

**Amber and Red Projects – variances to cost/delivery date and why.**

1.2.12 MASH - Latest MASH estimates show a forecast variance of £1.113m in 2012-13. This reflects a continuing pressure and has not changed since last reported to Cabinet. £0.006m of the overspend is to be funded from a revenue contribution, and there is anticipated external funding of £0.800m which is awaiting confirmation from the NHS. If this is forthcoming there remains an unfunded variance of £0.307m, the funding of which is yet to be resolved.

**Other Significant Variances**

1.2.13 **Quarry Fields – Self funded Project –** The cash limit and spend for this project has been moved to the ELS portfolio in alignment with the responsibilities for Early years.

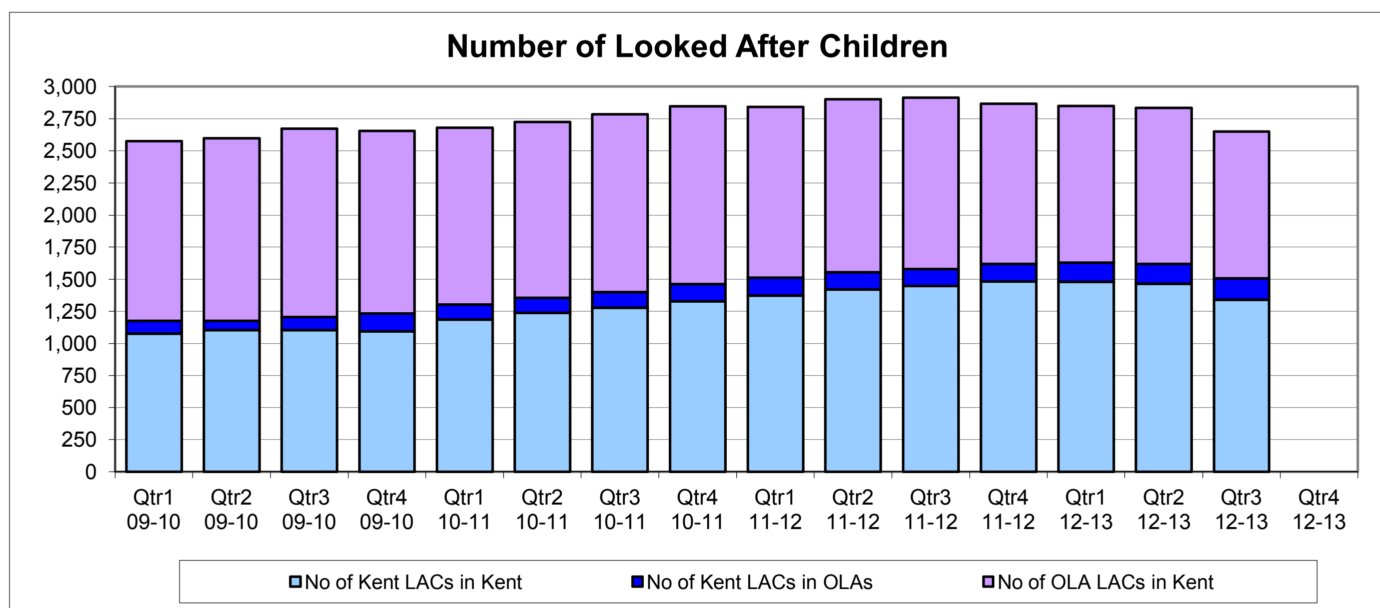
**Key issues and Risks**

1.2.14 MASH – until the funding of £0.800m is confirmed from the NHS there is a risk around this.

## 2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

### 2.1 **Numbers of Looked After Children (LAC)** (excluding Asylum Seekers):

| | No of Kent LAC placed in Kent | No of Kent LAC placed in OLAs | TOTAL NO OF KENT LAC | No of OLA LAC placed in Kent | TOTAL No of LAC in Kent |
|---|---|---|---|---|---|
| **2009-10** | | | | | |
| Apr – Jun | 1,076 | 100 | **1,176** | 1,399 | **2,575** |
| Jul – Sep | 1,104 | 70 | **1,174** | 1,423 | **2,597** |
| Oct – Dec | 1,104 | 102 | **1,206** | 1,465 | **2,671** |
| Jan – Mar | 1,094 | 139 | **1,233** | 1,421 | **2,654** |
| **2010-11** | | | | | |
| Apr – Jun | 1,184 | 119 | **1,303** | 1,377 | **2,680** |
| Jul – Sep | 1,237 | 116 | **1,353** | 1,372 | **2,725** |
| Oct – Dec | 1,277 | 123 | **1,400** | 1,383 | **2,783** |
| Jan – Mar | 1,326 | 135 | **1,461** | 1,385 | **2,846** |
| **2011-12** | | | | | |
| Apr – Jun | 1,371 | 141 | **1,512** | 1,330 | **2,842** |
| Jul – Sep | 1,419 | 135 | **1,554** | 1,347 | **2,901** |
| Oct – Dec | 1,446 | 131 | **1,577** | 1,337 | **2,914** |
| Jan – Mar | 1,480 | 138 | **1,618** | 1,248 | **2,866** |
| **2012-13** | | | | | |
| Apr – Jun | 1,478 | 149 | **1,627** | 1,221 | **2,848** |
| Jul – Sep | 1,463 | 155 | **1,618** | 1,216 | **2,834** |
| Oct – Dec | 1,340 | 165 | **1,505** | 1,144 | **2,649** |
| Jan – Mar | | | | | |



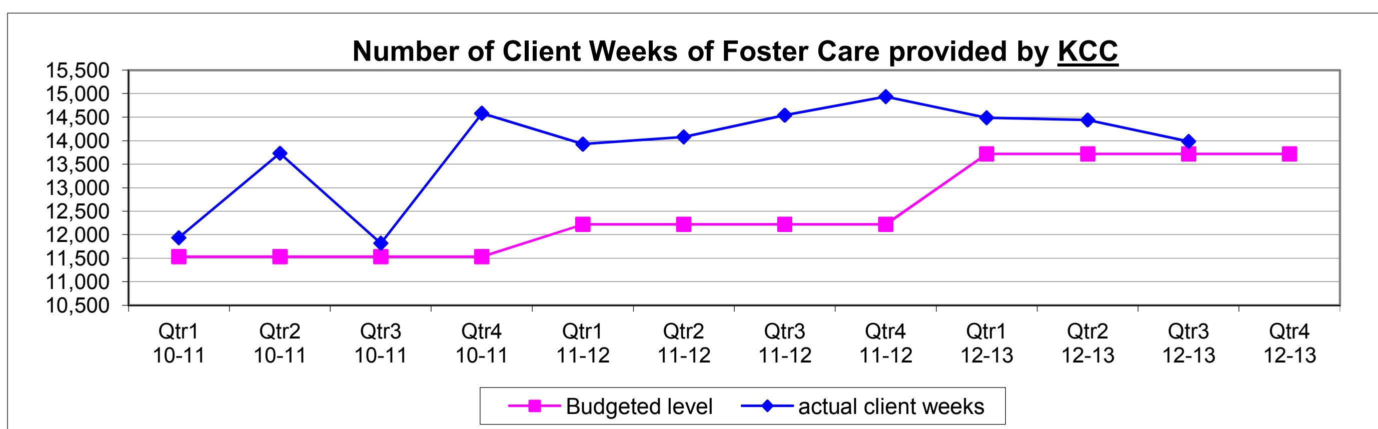

Comments:

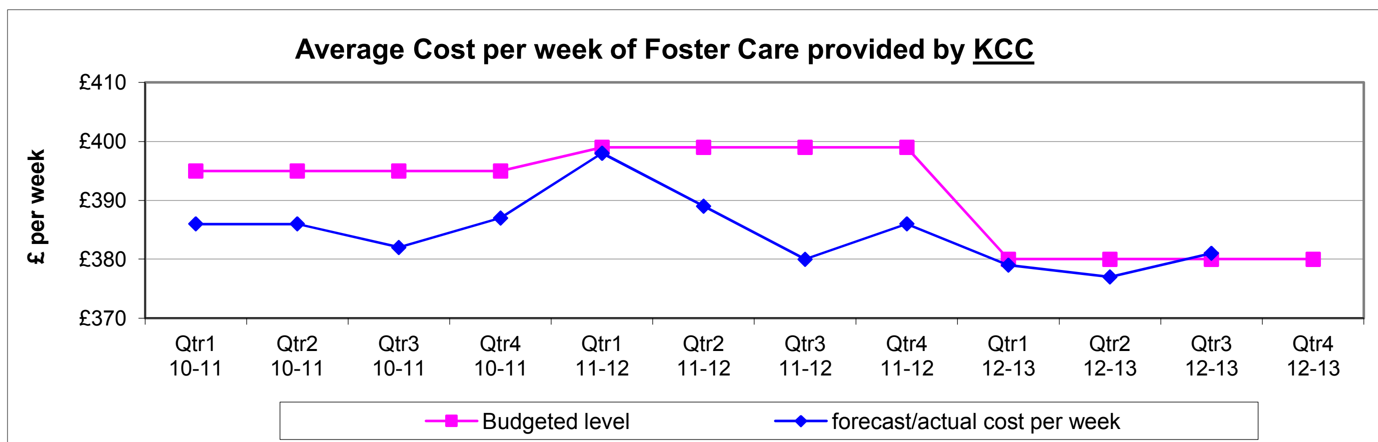
- Children Looked After by KCC may on occasion be placed out of the County, which is undertaken using practice protocols that ensure that all long-distance placements are justified and in the interests of the child. All Looked After Children are subject to regular statutory reviews (at least twice a year), which ensures that a regular review of the child's care plan is undertaken.
- The number of looked after children for each quarter represents a snapshot of the number of children designated as looked after at the end of each quarter, it is not the total number of looked after children during the period. Therefore although the number of Kent looked after children has reduced by 113 this quarter, there could have been more (or less) during the period.
- The increase in the number of looked after children for the first half of 2012-13 compared to when the 2012-13 budget was set (Q3 11/12) has placed additional pressure on the services for looked after children, including fostering and residential care.

- The OLA LAC information has a confidence rating of 62% and is completely reliant on Other Local Authorities keeping KCC informed of which children are placed within Kent. The Management Information Unit (MIU) regularly contact these OLAs for up to date information, but replies are not always forthcoming. This confidence rating is based upon the percentage of children in this current cohort where the OLA has satisfactorily responded to recent MIU requests.

2.2.1 **Number of Client Weeks & Average Cost per Client Week of Foster Care provided by KCC**:

| | **2010-11** | | | | **2011-12** | | | | **2012-13** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No of weeks | | Average cost per client week | | No of weeks | | Average cost per client week | | No of weeks | | Average cost per client week | |
| | Budget Level | actual | Budget level | actual | Budget level | actual | Budget level | actual | Budget level | actual | Budget level | forecast |
| Apr - June | 11,532 | 11,937 | £395 | £386 | 12,219 | 13,926 | £399 | £398 | 13,718 | 14,487 | £380 | £379 |
| July - Sep | 11,532 | 13,732 | £395 | £386 | 12,219 | 14,078 | £399 | £389 | 13,718 | 14,440 | £380 | £377 |
| Oct - Dec | 11,532 | 11,818 | £395 | £382 | 12,219 | 14,542 | £399 | £380 | 13,718 | 13,986 | £380 | £382 |
| Jan - Mar | 11,532 | 14,580 | £395 | £387 | 12,219 | 14,938 | £399 | £386 | 13,718 | | £380 | |
| | **46,128** | **52,067** | **£395** | **£387** | **48,876** | **57,484** | **£399** | **£386** | **54,872** | **42,913** | **£380** | **£382** |




Comments:

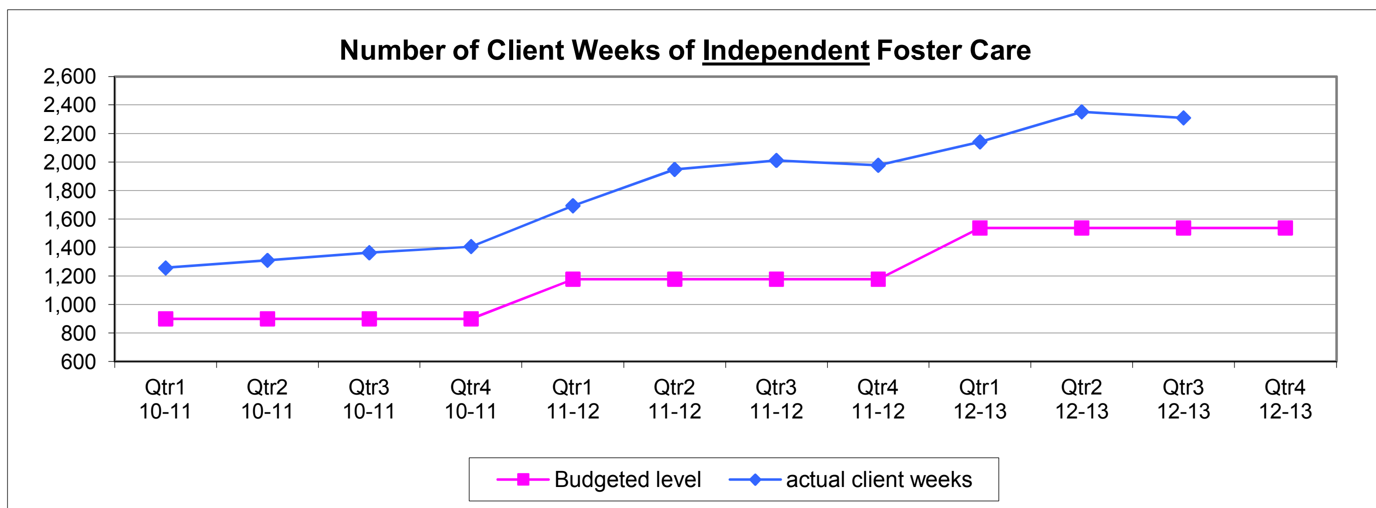
- The actual number of client weeks is based on the numbers of known clients at a particular point in time. This may be subject to change due to the late receipt of paperwork.
- The budgeted level has been calculated by dividing the budget by the average weekly cost. The average weekly cost is also an estimate based on financial information and estimates of the number of client weeks and may be subject to change.
- In addition, the 2012-13 budgeted level represents the level of demand as at the 2011-12 3rd quarter's full monitoring report, which is the time at which the 2012-13 budget was set and approved. However, since that time, the service has experienced continued demand on this service.
- The forecast number of weeks is 56,723 (excluding asylum), which is 1,851 weeks above the affordable level. This forecast number of weeks is lower than the YTD activity would suggest due to an

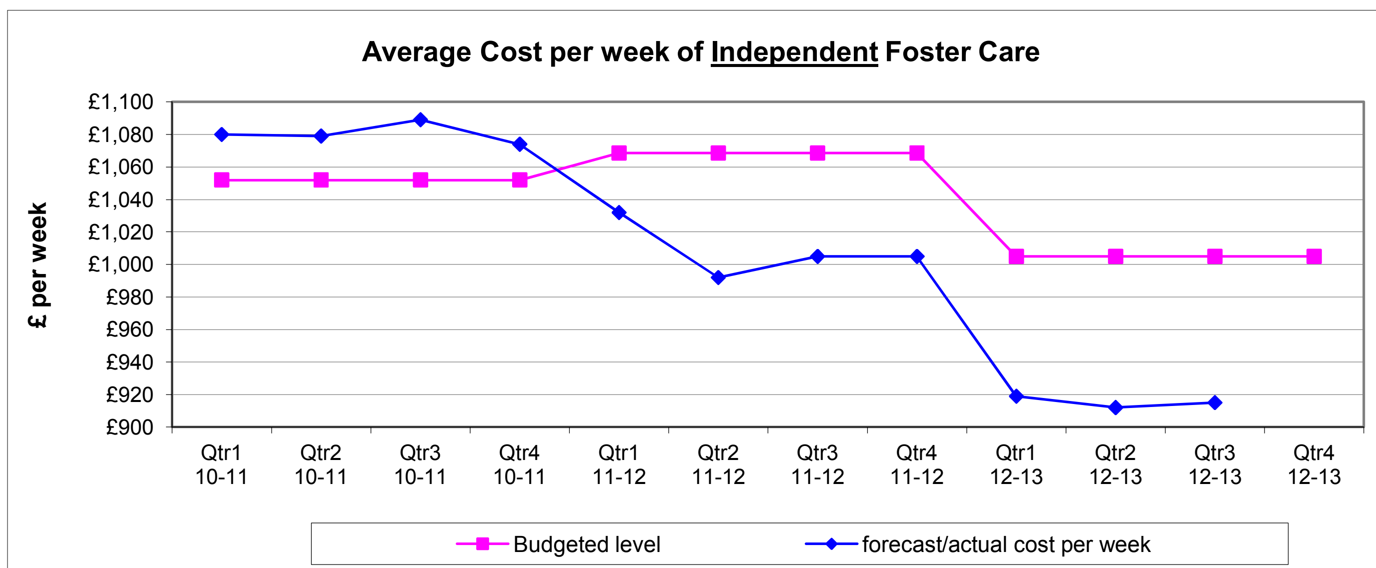
anticipated reduction in the number of children in in-house fostering for the remainder of the year in response to the controls put in place to help reduce the pressures on the SCS budgets (see section 1.1.4), and problems finding suitable in-house placements. At the forecast unit cost of £381.71 per week, this increase in activity gives a pressure of £707k.

- The forecast unit cost of £381.71 is +£1.71 above the budgeted level and when multiplied by the budgeted number of weeks, gives a pressure of +£94k.
- Overall therefore, the combined gross pressure on this service for both under and over 16's (and those with a disability) is +£801k (£707k + £94k), as reported in section 1.1.3.7.

2.2.2 **Number of Client Weeks & Average Cost per Client Week of Independent Foster Care**:

| | **2010-11** | | | | **2011-12** | | | | **2012-13** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No of weeks | | Average cost per client week | | No of weeks | | Average cost per client week | | No of weeks | | Average cost per client week | |
| | Budget Level | actual | Budget level | actual | Budget level | actual | Budget level | actual | Budget level | actual | Budget level | forecast |
| Apr - June | 900 | 1,257 | £1,052 | £1,080 | 1,177 | 1,693 | £1,068.60 | £1,032 | 1,538 | 2,141 | £1,005 | £919 |
| July - Sep | 900 | 1,310 | £1,052 | £1,079 | 1,178 | 1,948 | £1,068.60 | £992 | 1,538 | 2,352 | £1,005 | £912 |
| Oct - Dec | 900 | 1,363 | £1,052 | £1,089 | 1,177 | 2,011 | £1,068.60 | £1,005 | 1,538 | 2,310 | £1,005 | £915 |
| Jan - Mar | 900 | 1,406 | £1,052 | £1,074 | 1,178 | 1,977 | £1,068.60 | £1,005 | 1,538 | | £1,005 | |
| | **3,600** | **5,336** | **£1,052** | **£1,074** | **4,710** | **7,629** | **£1,068.60** | **£1,005** | **6,152** | **6,803** | **£1,005** | **£915** |



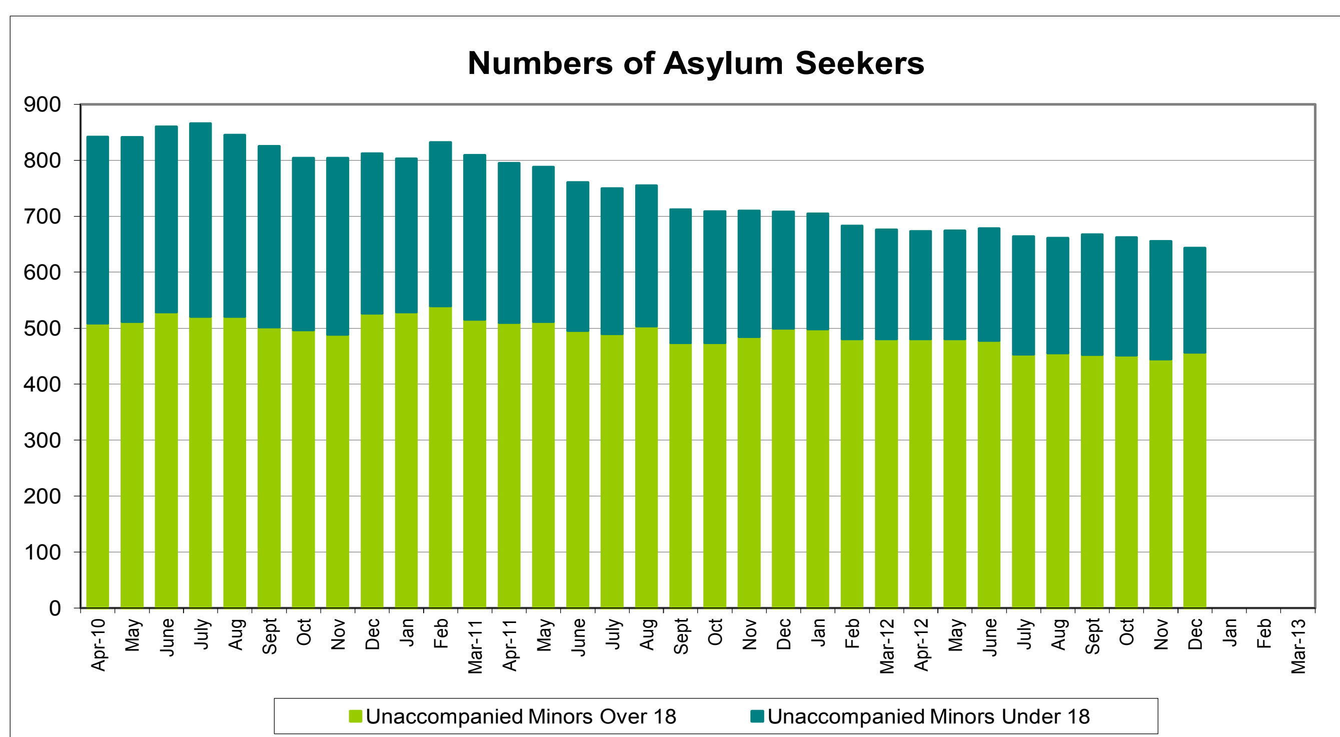



Comments:

- The actual number of client weeks is based on the numbers of known clients at a particular point in time. This may be subject to change due to the late receipt of paperwork.
- The budgeted level has been calculated by dividing the budget by the average weekly cost. The average weekly cost is also an estimate based on financial information and estimates of the number of client weeks and may be subject to change.
- For the 2012-13 budget further significant funding has been made available based on the actual level of demand at the 3rd quarter's monitoring position for 2011-12, the time at which the 2012-13 budget was set and approved. However, since that date the service has experienced continued demand on this service.
- The forecast number of weeks is 9,528 (excluding asylum), which is 3,376 weeks above the affordable level. The forecast number of weeks is higher than the YTD activity would suggest due to an increase in the number of IFA placements reflecting the difficulty in finding in-house placements. At the forecast unit cost of £914.65, this increase in activity give a pressure of £3,088k.
- The forecast unit cost of £914.65 is an average and is -£90.35 below the budgeted level and when multiplied by the budgeted number of weeks gives a saving of -£556k
- Overall therefore, the combined forecast gross pressure on this service and is +£2,532k (+£3,088k increased demand and -£556k lower unit cost), as reported in sections 1.1.3.7.

## 2.3 Numbers of Unaccompanied Asylum Seeking Children (UASC):

| | 2010-11 | | | 2011-12 | | | 2012-13 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Under 18 | Over 18 | **Total Clients** | Under 18 | Over 18 | **Total Clients** | Under 18 | Over 18 | **Total Clients** |
| April | 333 | 509 | **842** | 285 | 510 | **795** | 192 | 481 | **673** |
| May | 329 | 512 | **841** | 276 | 512 | **788** | 193 | 481 | **674** |
| June | 331 | 529 | **860** | 265 | 496 | **761** | 200 | 478 | **678** |
| July | 345 | 521 | **866** | 260 | 490 | **750** | 210 | 454 | **664** |
| August | 324 | 521 | **845** | 251 | 504 | **755** | 205 | 456 | **661** |
| September | 323 | 502 | **825** | 238 | 474 | **712** | 214 | 453 | **667** |
| October | 307 | 497 | **804** | 235 | 474 | **709** | 210 | 452 | **662** |
| November | 315 | 489 | **804** | 225 | 485 | **710** | 210 | 445 | **655** |
| December | 285 | 527 | **812** | 208 | 500 | **708** | 186 | 457 | **643** |
| January | 274 | 529 | **803** | 206 | 499 | **705** | | | |
| February | 292 | 540 | **932** | 202 | 481 | **683** | | | |
| March | 293 | 516 | **809** | 195 | 481 | **676** | | | |

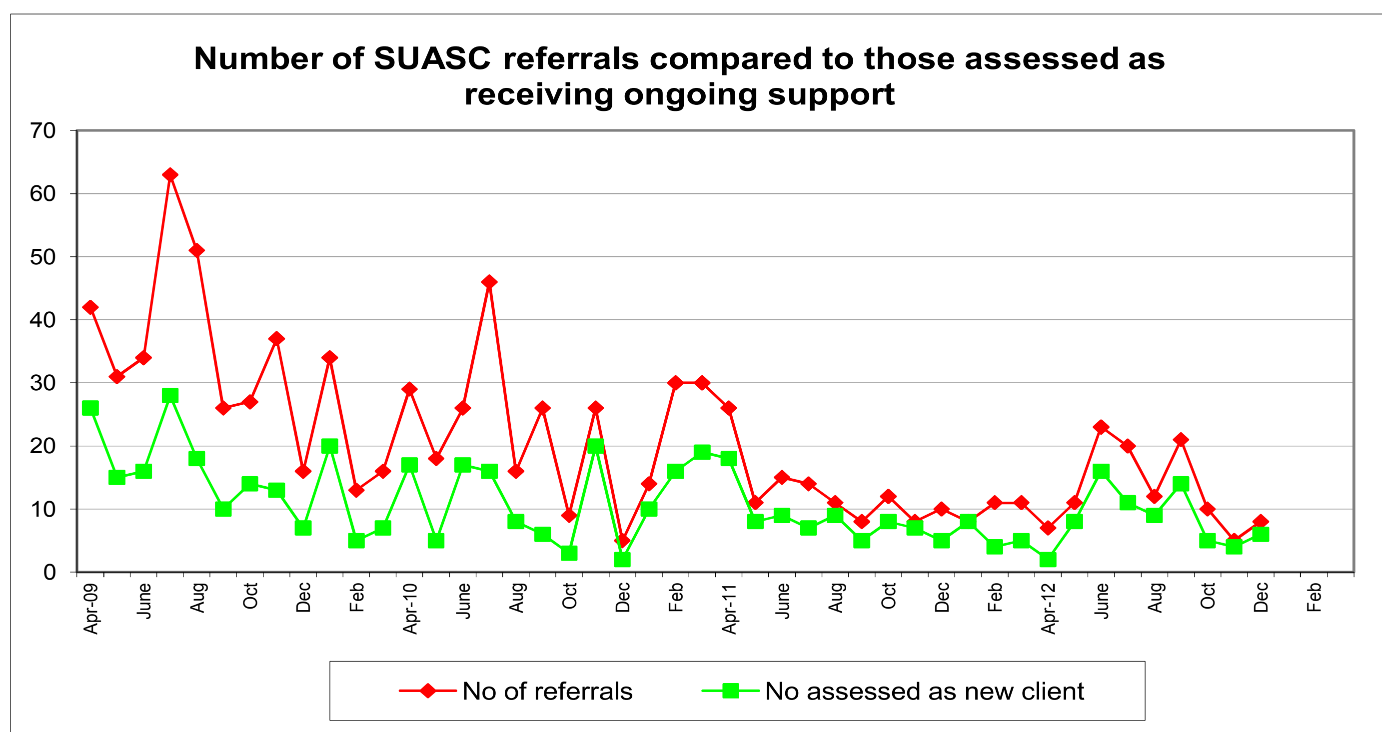



Comment:

- The overall number of children has remained fairly static so far this year. The current number of clients supported is below the budgeted level of 690.
- The budgeted number of referrals for 2012-13 is 15 per month, with 9 (60%) being assessed as under 18.
- Despite improved partnership working with the UKBA, the numbers of over 18's who are All Rights of appeal Exhausted (ARE) have not been removed as quickly as originally planned.
- In general, the age profile suggests the proportion of over 18s is decreasing slightly and, in addition, the age profile of the under 18 children has increased
- The data recorded above will include some referrals for which the assessments are not yet complete or are being challenged. These clients are initially recorded as having the Date of Birth that they claim but once their assessment has been completed, or when successfully appealed, their category may change.

2.4 **Numbers of Asylum Seeker referrals compared with the number assessed as qualifying for on-going support from Service for Unaccompanied Asylum Seeking Children (SUASC) ie new clients**:

| | 2009-10 | | | 2010-11 | | | 2011-12 | | | 2012-13 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | No. of referrals | No. assessed as new client | % | No. of referrals | No. assessed as new client | % | No. of referrals | No. assessed as new client | % | No. of referrals | No. assessed as new client | % |
| April | 42 | 26 | 62% | 29 | 17 | 59% | 26 | 18 | 69% | 7 | 2 | 29% |
| May | 31 | 15 | 48% | 18 | 5 | 28% | 11 | 8 | 73% | 11 | 8 | 73% |
| June | 34 | 16 | 47% | 26 | 17 | 65% | 15 | 9 | 60% | 23 | 16 | 70% |
| July | 63 | 28 | 44% | 46 | 16 | 35% | 14 | 7 | 50% | 20 | 11 | 55% |
| Aug | 51 | 18 | 35% | 16 | 8 | 50% | 11 | 9 | 82% | 12 | 9 | 75% |
| Sept | 26 | 10 | 38% | 26 | 6 | 23% | 8 | 5 | 62% | 21 | 14 | 67% |
| Oct | 27 | 14 | 52% | 9 | 3 | 33% | 12 | 8 | 67% | 10 | 5 | 50% |
| Nov | 37 | 13 | 35% | 26 | 20 | 77% | 8 | 7 | 88% | 5 | 4 | 80% |
| Dec | 16 | 7 | 44% | 5 | 2 | 40% | 10 | 5 | 50% | 8 | 6 | 75% |
| Jan | 34 | 20 | 59% | 14 | 10 | 71% | 8 | 8 | 100% | | | |
| Feb | 13 | 5 | 38% | 30 | 16 | 53% | 11 | 4 | 36% | | | |
| Mar | 16 | 7 | 44% | 30 | 19 | 63% | 11 | 5 | 45% | | | |
| | **390** | **179** | **46%** | **275** | **139** | **51%** | **145** | **93** | **64%** | **117** | **75** | **64%** |



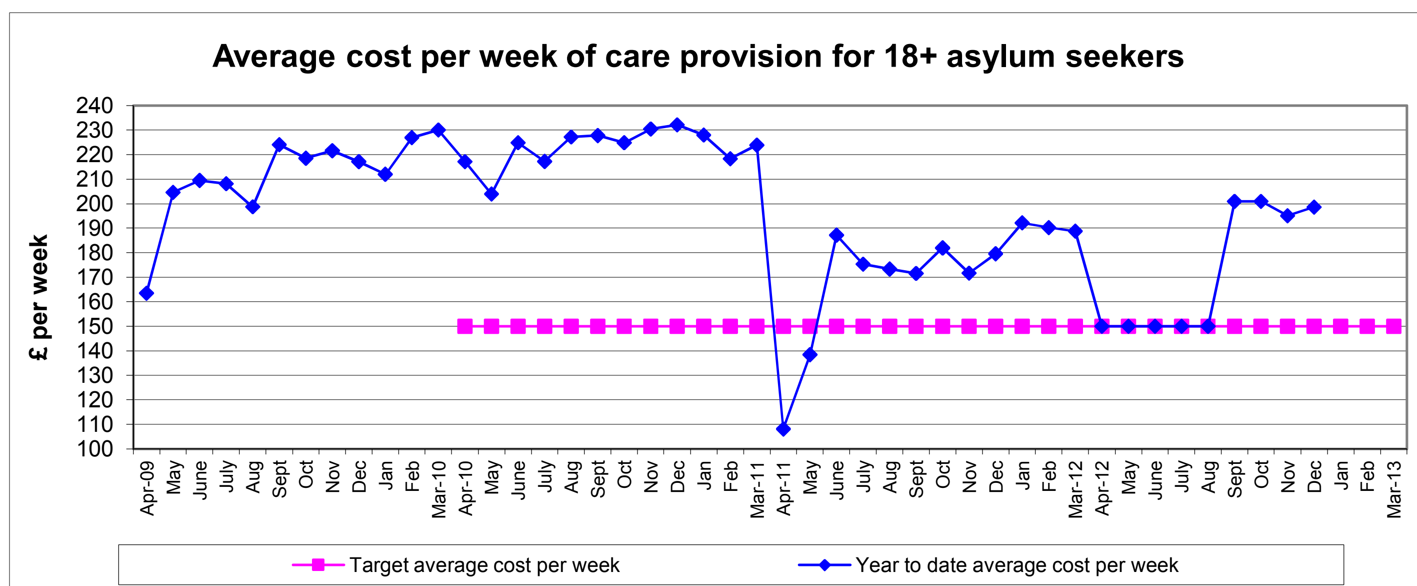

Comments:

- In general, referral rates have been lower since September 2009 which coincides with the French Government's action to clear asylum seeker camps around Calais. The average number of referrals per month is now 13, which is below the budgeted number of 15 referrals per month.
- The number of referrals has a knock on effect on the number assessed as new clients. The budgeted level is based on the assumption 60% of the referrals will be assessed as a new client. The average number assessed as new clients is now 64%.
- The budget assumed 9 new clients per month (60% of 15 referrals) but the average number of new clients per month is currently 8 i.e a 10% decrease.
- The number of referrals assessed as a new client has been revised for the period April 12 to August 12 due to a more accurate definition of criteria.

- Where a young person has been referred but not assessed as a new client this would be due to them being re-united with their family, assessed as 18+ and returned to UKBA or because they have gone missing before an assessment has been completed.

2.5 **Average monthly cost of Asylum Seekers Care Provision for 18+ Care Leavers:**

| | 2009-10 | | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|---|---|
| | Target average weekly cost £p | Year to date average weekly cost £p | Target average weekly cost £p | Year to date average weekly cost £p | Target average weekly cost £p | Year to date average weekly cost £p | Target average weekly cost £p | Year to date average weekly cost £p |
| April | | 163.50 | 150.00 | 217.14 | 150.00 | 108.10 | 150.00 | 150.00 |
| May | | 204.63 | 150.00 | 203.90 | 150.00 | 138.42 | 150.00 | 150.00 |
| June | | 209.50 | 150.00 | 224.86 | 150.00 | 187.17 | 150.00 | 150.00 |
| July | | 208.17 | 150.00 | 217.22 | 150.00 | 175.33 | 150.00 | 150.00 |
| August | | 198.69 | 150.00 | 227.24 | 150.00 | 173.32 | 150.00 | 150.00 |
| September | | 224.06 | 150.00 | 227.79 | 150.00 | 171.58 | 150.00 | 200.97 |
| October | | 218.53 | 150.00 | 224.83 | 150.00 | 181.94 | 150.00 | 200.97 |
| November | | 221.64 | 150.00 | 230.47 | 150.00 | 171.64 | 150.00 | 195.11 |
| December | | 217.10 | 150.00 | 232.17 | 150.00 | 179.58 | 150.00 | 198.61 |
| January | | 211.99 | 150.00 | 227.96 | 150.00 | 192.14 | 150.00 | |
| February | | 226.96 | 150.00 | 218.30 | 150.00 | 190.25 | 150.00 | |
| March | | 230.11 | 150.00 | 223.87 | 150.00 | 188.78 | 150.00 | |




Comments:

- The local authority has agreed that the funding levels for the Unaccompanied Asylum Seeking Childrens Service 18+ grant agreed with the Government rely on us achieving an average cost per week of £150, in order for the service to be fully funded, which is also reliant on the UKBA accelerating the removal process. In 2011-12 UKBA changed their grant rules and now only fund the costs of an individual for up to three months after the All Rights of appeal Exhausted (ARE) process if the LA carries out a Human Rights Assessment before continuing support. The LA has continued to meet the cost of the care leavers in order that it can meet it statutory obligations to those young people under the Leaving Care Act until the point of removal.
- As part of our partnership working with UKBA, most UASC in Kent are now required to report to UKBA offices on a regular basis, in most cases weekly. The aim is to ensure that UKBA have regular contact and can work with the young people to encourage them to make use of the voluntary methods of return rather than forced removal or deportation. As part of this arrangement any young person who does not report as required may have their Essential living allowance discontinued. As yet this has not resulted in an increase in the number of AREs being removed.

The number of AREs supported has continued to remain steady, but high. Moving clients on to the pilot housing scheme was slower than originally anticipated, however all our young people, who it was appropriate to move to lower cost accommodation, were moved by the end of 2010-11. However there remain a number of issues:

- For various reasons, some young people have not yet moved to lower cost properties, mainly those placed out of county. These placements are largely due to either medical/mental health needs or educational needs.
- We are currently experiencing higher than anticipated level of voids, properties not being fully occupied. Following the incident in Folkestone in January 2011, teams are exercising a greater caution when making new placements into existing properties. This is currently being addressed by the Accommodation Team.
- We are still receiving damages claims relating to closed properties.

- As part of our strive to achieve a net unit cost of £150 or below, we will be insisting on take-up of state benefits for those entitled.

# FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
# ADULTS SERVICES SUMMARY
# DECEMBER 2012-13 FULL MONITORING REPORT

## 1. FINANCE

### 1.1 REVENUE

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

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits for the A-Z service analysis have been adjusted since the quarter 2 monitoring report to reflect the centralisation of the ICT budgets to BSS directorate (see annex 6), and the transfer of the Service Level Agreements for transport related services to the new Transport Operations A-Z budget within the EH&W portfolio (see annex 4), following the transfer of the Transport Integration Unit to E&E directorate from Commercial Services. There have also been a number of other technical adjustments to budget.
- The inclusion of a number of 100% grants (ie grants which fully fund the additional costs) awarded since the budget was set. These are detailed in Appendix 1 of the executive summary.

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

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **Adult Social Care & Public Health portfolio** | | | | | | | |
| Strategic Management & Directorate Support Budgets | 9,903 | -1,066 | 8,837 | -40 | -34 | -74 | Estimated legal charge pressure; staffing vacancies |
| Adults & Older People: | | | | | | | |
| **- Direct Payments** | | | | | | | |
| - Learning Disability | 12,769 | -547 | 12,222 | -505 | 247 | -258 | Lower than budgeted activity & unit cost offset by one-off payments; income charge lower than budgeted level |
| - Mental Health | 708 | 0 | 708 | -8 | -8 | -16 | |
| - Older People | 6,924 | -787 | 6,137 | -453 | -76 | -529 | Activity below budgeted level offset by unit cost above budgeted level |
| - Physical Disability | 9,580 | -374 | 9,206 | -175 | -107 | -282 | Activity below budgeted level offset by unit cost above budgeted level plus more one-off payments; unit income charge higher than budgeted level |
| Total Direct Payments | 29,981 | -1,708 | 28,273 | -1,141 | 56 | -1,085 | |

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **- Domiciliary Care** | | | | | | | |
| - Learning Disability | 5,261 | -1,532 | 3,729 | 323 | 306 | 629 | Unit cost above budget level & activity below budget level; additional pressure on extra care housing clients; under-recovery of income received by Independent Living Service |
| - Mental Health | 350 | -114 | 236 | -83 | 26 | -57 | |
| - Older People | 44,586 | -12,669 | 31,917 | -1,687 | 1,529 | -158 | Activity for P&V & in-house below budgeted level; savings on block contract; Shortfall in income due to reduced activity |
| - Physical Disability | 7,403 | -595 | 6,808 | 186 | -93 | 93 | Activity lower than budgeted level & unit cost above budget level |
| Total Domiciliary Care | 57,600 | -14,910 | 42,690 | -1,261 | 1,768 | 507 | |
| **- Nursing & Residential Care** | | | | | | | |
| - Learning Disability | 75,667 | -6,456 | 69,211 | 819 | 175 | 994 | Activity & unit cost above budget level for IS; activity below budget level and unit cost above budget level for preserved rights; delay in review of in-house units; |
| - Mental Health | 7,243 | -692 | 6,551 | 274 | -41 | 233 | Unit cost higher than budget level |
| - Older People - Nursing | 46,868 | -24,730 | 22,138 | 1,599 | -1,050 | 549 | Activity & unit cost above budget level; income charge higher than budget level; RNCC costs to be recharged to health |
| - Older People - Residential | 85,686 | -36,724 | 48,962 | -2,585 | 1,845 | -740 | Activity lower than budget level; higher unit cost; in-house staffing pressure; release of contingency; income activity & unit charge lower than budget level |
| - Physical Disability | 13,813 | -1,969 | 11,844 | -669 | 197 | -472 | Activity lower than budget level; higher unit cost; |
| Total Nursing & Residential Care | 229,277 | -70,571 | 158,706 | -562 | 1,126 | 564 | |

**Annex 3**

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **- Supported Accommodation** | | | | | | | |
| - Learning Disability | 33,366 | -3,645 | 29,721 | -1,184 | 702 | -482 | Unit cost below budget level; transfer from reserve; Supporting Independence Service Pressure; underspend on group homes; income charge lower than budgeted |
| - Physical Disability/Mental Health | 2,986 | -279 | 2,707 | -238 | -137 | -375 | Savings from the Supporting Independence Service; income charge higher than budget level |
| Total Supported Accommodation | 36,352 | -3,924 | 32,428 | -1,422 | 565 | -857 | |
| **- Other Services for Adults & Older People** | | | | | | | |
| - Contributions to Vol Orgs | 15,570 | -1,655 | 13,915 | 14 | 80 | 94 | |
| - Day Care | | | | | | | |
| - Learning Disability | 13,200 | -237 | 12,963 | 74 | 49 | 123 | Staffing savings due ot in-house modernisation strategy & reduction in activity; Independent Sector pressure |
| - Older People | 3,313 | -59 | 3,254 | -685 | 32 | -653 | Re-commissioning strategies |
| - Physical Disability/Mental Health | 1,320 | -5 | 1,315 | -38 | -2 | -40 | |
| Total Day Care | 17,833 | -301 | 17,532 | -649 | 79 | -570 | |
| - Other Adult Services | 13,629 | -17,857 | -4,228 | 285 | -262 | 23 | Transfer of clients to the Provider Managed Services Pilot; Increased unit cost on meals provision; learning disability development fund staffing & commissioning underspend; telehealth/telecare additional costs offset from health income |
| - Safeguarding | 1,071 | -196 | 875 | -50 | 50 | 0 | |
| Total Other Services for A&OP | 48,103 | -20,009 | 28,094 | -400 | -53 | -453 | |
| **- Assessment Services** | | | | | | | |
| - Adult's Social Care Staffing | 41,314 | -4,316 | 36,998 | -391 | 185 | -206 | vacancies; various minor income pressures |
| Community Services: | | | | | | | |
| - Public Health Management & Support | 374 | 0 | 374 | 38 | -53 | -15 | |
| - Public Health (incl Local Involvement Network) | 106 | -57 | 49 | -38 | 38 | 0 | |
| | | | | | | | |
| **Total ASC&PH portfolio** | **453,010** | **-116,561** | **336,449** | **-5,217** | **3,598** | **-1,619** | |

| Budget Book Heading | Cash Limit | | | Variance | | | Comment |
|---|---|---|---|---|---|---|---|
| | G | I | N | G | I | N | |
| | £'000s | £'000s | £'000s | £'000s | £'000s | £'000s | |
| **Business Strategy, Performance & Health Reform portfolio** | | | | | | | |
| - Public Health (LINk, Local Healthwatch & Health Reform) | **758** | **-60** | **698** | **16** | **-16** | **0** | |
| **Total FSC ADULTS controllable** | **453,768** | **-116,621** | **337,147** | **-5,201** | **3,582** | **-1,619** | |
| **Assumed Management Action** | | | | | | | |
| **- ASC&PH portfolio** | | | | | | **0** | |
| **- BSP&HR portfolio** | | | | | | **0** | |
| **Forecast after Mgmt Action** | | | | **-5,201** | **3,582** | **-1,619** | |

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

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

## Adult Social Care & Public Health portfolio:

1.1.3.1 Strategic Management & Directorate Support Budgets -£74k (-£40k Gross & -£34k Income)
The gross and income variances are less than £100k but within this is a pressure on legal costs (+£133k), which assumes similar levels of activity as in 2011-12, offset by underspends on various staffing lines including -£162k within the performance & information unit due to vacancies during the year.

1.1.3.2 **Direct Payments -£1,085k (-£1,141k Gross & +£56k Income):**

a. Learning Disability -£258k (-£505k Gross & +£247k Income)
The forecast underspend against the gross service line of £505k is generated as a result of the forecast activity weeks being 2,221 (-£540k) lower than the affordable level, along with the forecast unit cost being lower than the affordable by £1.27 (-£66k). The underspend on longer term direct payments is offset by a net pressure of +£131k where the number of one-off payments has not been offset by the recovery of surplus funds from existing direct payment clients (periodically we recover unspent funds from long term direct payment clients). The remaining gross variance of -£30k relates to under spending on payments to carers.

This service is forecasting an under recovery of income of +£247k, as the actual average unit income being charged is £4.48 lower than the budgeted level resulting in a shortfall of +£234k plus a minor variance due to the reduced level of activity (+£13k).

b. Older People -£529k (-£453k Gross & -£76k Income)
The budget is forecast to under spend by -£453k on gross expenditure. The number of weeks is forecast to be 8,682 fewer than budgeted, generating a saving of -£1,278k, which is partially offset by the unit cost being higher than budgeted by £15.38 and therefore generating a pressure of +£803k. The balance of the variance relates to minor pressures on one-off payments and payments to carers (+£22k).

The lower than budgeted number of weeks leads to a shortfall in income of +£164k, however this is more than offset by unit income being £4.84 higher than budgeted resulting in a saving of -£240k.

c. Physical Disability -£282k (-£175k Gross & -£107k Income)
The forecast number of weeks of care provided is 2,841 lower than anticipated generating a forecast under spend of -£521k, this is partially offset by the unit cost being higher than budgeted by £2.73 (£145k) and the number of one-off payments being in excess of the budgeted level (+£200k) along with minor pressure on payments to carers (+£1k).

The lower than budgeted number of weeks leads to a shortfall in income of +£27k however this is more than offset by a £2.53 higher than budgeted unit income resulting in a saving of -£134k.

1.1.3.3 **<u>Domiciliary Care +£507k (-£1,261k Gross & +£1,768k Income):</u>**

a. <u>Learning Disability +£629k (+£323k Gross & +£306k Income)</u>
The overall forecast is a pressure against the gross of +£323k, coupled with an under recovery of income by +£306k. The number of hours is forecast to be 63,618 lower than the affordable level, generating a -£873k forecast under spend. The forecast unit cost is £4.22 higher than the affordable level, increasing the forecast by +£1,017k. The remaining variance of +£179k against gross, is comprised of a pressure on Extra Care Sheltered Housing of +£144k and other minor variances less than £100k each (+£35k).

The income variance is mainly due to of +£306k is mainly due to the under-recovery of income of +£337k within the Independent Living Service due to the placing of fewer clients where income is received from the supporting people service and Health.

b. <u>Older People -£158k (-£1,687k Gross & +£1,529k Income)</u>
The overall forecast is an under spend against gross of -£1,687k, coupled with an under recovery of income of £1,529k. The number of hours is forecast to be 67,409 lower than the affordable hours generating a -£1,003k forecast under spend. The forecast unit cost is £0.13 higher than the affordable level, partially offsetting this initial forecast underspend by +£311k.

The Kent Enablement at Home (KEAH) in house service is forecasting a gross under spend of -£580k, which is the cumulative effect of less hours of service than budgeted being forecast, and resultant savings in staffing costs. This is in contrast to the purchase of externally provided enablement services where a pressure of +£174k is currently being forecast. A saving of -£354k is also forecast against block domiciliary contracts, as a result of savings on non-care related costs, and where negotiations to have an element of unused hours refunded have been successful, along with a underspend of -£202k for those clients in Sheltered Accommodation.

The remaining gross variance relates to the estimated contribution to the bad debt provision (+£200k) resulting from the increase in outstanding client debt this financial year reported in section 3, offset by a drawdown from the NHS Support for Social Care reserve (-£139k) and release of unrealised creditors of -£94k.

The income variance of +£1,529k reflects the under-recovery of client income of +£1,562k which is largely due to the reduced activity, marginally offset by minor variances of -£33k.

c. <u>Physical Disability +£93k (+£186k Gross & -£93k Income)</u>
The gross variance is caused by a forecast of 17,719 hours below the affordable level, creating a -£245k saving, which is offset by a unit cost variance of £0.80 greater than affordable level, causing a pressure of +£416k. The remaining gross pressure (+£15k), and income variance (-£93k) are due to variances on a number of other budgets within this heading, all below £100k.

1.1.3.4 **<u>Nursing & Residential Care +£564k (-£562k Gross & +£1,126k Income):</u>**

a. <u>Learning Disability +£994k (+£819k Gross & +£175k Income)</u>
A gross pressure of +£819k, coupled with an under recovery of income of -£175k generates the above net forecast variance. The forecast level of client weeks is 823 higher than the affordable level generating a +£1,016k forecast pressure. The gross unit cost is currently forecast to be £4.46 higher than the affordable level, which generates a +£176k forecast pressure. The forecast activity for this service is based on known individual clients including provisional and transitional clients. Provisional clients are those whose personal circumstances are changing and therefore require a more intense care package or greater financial help. Transitional clients are children who are transferring to adult social services.

There are variances on the preserved rights budgets where activity is forecast to be 1,532 weeks lower than affordable creating a saving of -£1,359k offset by a unit cost variance totalling +£868k. In addition, a further saving of -£87k has been generated from a release of a provision no longer required.

There is a +£192k pressure resulting from delays in the review of in-house units and a consequential delay in delivering the budgeted savings. The balance of the gross pressure relates to additional nursing care to be recharged to health (Registered Nursing Care Contribution - RNCC) (+£13k).

The forecast income variance of +£175k is due to a number of compensating variances within residential care. The additional forecast client weeks for residential care add -£72k of income, and the actual income per week is higher than the expected level by £8.97 which generates a further over-recovery in income of -£353k.

The reduction in client weeks compared to the affordable level for preserved rights residential care creates a loss of +£146k of income, coupled with a lower actual income per week than the expected level of £15.05 which generates an under-recovery in income of +£435k.

The remaining income variance of +£19k relates to in house provision and RNCC.

b. Mental Health +£233k (+£274k Gross & -£41k Income)
The forecast gross pressure of £274k is primarily due to the residential care gross unit cost being £19.25 higher than the budgeted level creating a pressure of £199k, along with a proposed contribution towards the S117 provision of £77k for future cases.

c. Older People - Nursing +£549k (+£1,599k Gross & -£1,050k Income)
There is a forecast pressure of +£1,599k on gross and an over recovery of income of -£1,050k, leaving a net pressure of +£549k. The forecast client weeks is 1,751 higher than the affordable level, which generates a pressure of +£829k coupled with the unit cost forecast to be £7.54 higher than budget, which gives a gross pressure of +£613k. The remaining gross variance relates to additional nursing care to be recharged to health (RNCC) of +£471k partially offset by a drawdown from the NHS Support for Social Care reserve of -£279k along with other minor variances on preserved rights and unrealised creditors (-£35k).

The increased activity in nursing care has resulted in a -£356k over-recovery of income, along with an increase in the average unit income being recouped from clients totalling -£254k. Forecast reimbursement from health for RNCC of -£471k along with minor variances on preserved rights (+£31k) form the balance of the income variance.

d. Older People - Residential -£740k (-£2,585k Gross & +£1,845k Income)
This service is reporting a gross under spend of £2,585k, along with an under recovery of income of £1,845k. The forecast level of client weeks is 3,435 lower than the affordable levels, which generates a forecast under spend of -£1,359k. This is partially offset by the unit cost being £1.74 higher than the affordable levels creating a +£267k pressure.

A gross underspend is also forecast for Preserved Rights of -£415k which is mainly due to a lower than affordable level of activity of 1,114 weeks creating a -£488k under spend, offset by a +£73k minor pricing pressure.

A gross variance of +£609k is forecast against the In-house provisions, including Integrated Care centres (ICC). The pressure on this service is mainly due to the use of agency staff to cover staff absences and vacancies (+277k), along with costs associated with the integrated care centres which are due to be recharged to the PCT (+£332k, see below for compensating income variance).

Contingency funding was held against this service to help compensate for possible volatility in the forecast for both residential and nursing care because of the impact of the Modernisation agenda. This funding has now been released, resulting in a -£1,344k underspend, to help offset the increases seen in nursing care, as detailed above. In addition, a drawdown from the NHS Support for Social Care reserve of -£279k has also been forecast. The balance of the underspend relates to unrealised creditors totalling -£64k.

On the income side, the reduction in activity results in a +£742k shortfall in client income, along with a lower than budgeted average unit income being charged which has increased this shortfall by +£871k. In addition, there is a forecast under recovery of client income of +£677k for the In-house service, mainly due to less permanent clients being placed in the homes because of the OP Modernisation Strategy. The remaining income variance predominately relates to the

recharge of costs associated with the integrated care centres to the PCT (-£332k) along with other smaller variances each below £100k (-£113k).

e. Physical Disability -£472k (-£669k Gross & +£197k Income)
A gross under spend of £669k, along with an under recovery of income of £197k, is reported for this budget. The forecast level of client weeks of service is 941 lower than the affordable level, giving a forecast under spend of -£816k. The forecast unit cost is currently £13.01 higher than the affordable level, which reduces that under spend by +£184k. The balance is due to other minor underspends totalling -£37k relating the Preserved Rights service, RNCC clients and unrealised creditors.

The reduced activity results in a reduction in income of +£99k, along other minor pressures on income totalling +£98k.

1.1.3.5 **Supported Accommodation -£857k (-£1,422k Gross & +£565k Income):**

a. Learning Disability -£482k (-£1,184k Gross & +£702k Income)
A gross underspend of -£1,184k, offset with an under recovery of income of £702k generates the above net variance. The gross underspend is predominately due to the expected net draw down of -£902k from the Social Care Supported Living costs reserve following a review of potential liabilities relating to ordinary residence along with a further -£100k from the release of unrealised creditors. In addition, the gross unit cost for supported accommodation is currently forecast to be -£9.54 lower than the affordable level, which generates a saving of -£257k and a forecast underspend of -£216k is reported against group home budgets as part of the modernisation of learning disability services. These underspends are slightly offset by the Supporting Independence Service which is forecasting a pressure of +£285k as this new contract arrangement is established and the transfer of clients from other LD service lines is completed. The balance of the gross underspend (+£6k) is due to minor other variances (including a +£28k pressure as a result of forecast activity being 30 weeks above budgeted level).

The under recovery of income is mainly due to the average unit income being lower than budgeted so creating a +£709k under recovery of income. The reduction in unit income is partly due to a reduction in expected income from continuing health care i.e. those clients funded by health.

b. Physical Disability / Mental Health -£375k (-£238k Gross & -£137k Income)
Mental health supported accommodation services are forecasting a gross underspend of £200k due to savings relating to the introduction of the Supporting Independence Service (-£128k) along with reduction in the number of weeks being supported (-£72k). The balance of the gross underspend relates to physical disability (-£38k). The is a small over recovery of income of -£137k forecast for both Physical Disability and Mental Health primarily due to a higher than budgeted weekly income per client.

1.1.3.6 **Other Services for Adults & Older People -£453k (-£400k Gross & -£53k Income):**

a. Day Care -£570k (-£649k Gross, +£79k Income)
A reduction in staffing levels due to the continued non-recruitment and re-deployment to posts in preparation for modernisation and a reduction in client numbers results in an under spend of -£317k for Learning Disability in-house provision. This is more than offset by a pressure on the commissioning of external learning disability day care services (+£391k). The balance of the gross under spend is mainly due to a number of re-commissioning strategies for in-house and independently provided services across the Older People client group (-£685k) and other minor variances across the other client groups (-£38k). The income pressure of +£79k results from a reduction in health contributions based on the current client profile.

b. Other Adult Services +£23k (+£285k Gross, -£262k Income)

The gross pressure of +£285k is due to a number of variances, of which those over £100k are detailed below. The income variance of -£262k is primarily due to additional health contributions from health towards the telecare/telehealth budget.

There is a pressure of +£198k resulting from the transfer of older people clients from OP Domiciliary Care to the Provider Managed Services Pilot. This is a formal agreement whereby an approved service provider is appointed to hold and spend someone's Personal Budget for him or her on the understanding that it will be spent according to his or her individual support plan outcomes, this is in contrast to traditional case management. The costs for this service include the cost of care provision.

The number of hot meals provided to older people has continued to fall over the past few years as clients chose alternative methods to receive this service (and can be funded through a direct payment). The unit cost paid per meal is linked to the number of meals provided (under the current contract the more meals provided, the lower the unit cost) and the fall in demand for meals during this year has resulted in a pressure of +£180k due to the resultant increased unit cost associated with current numbers of meals. Negotiations with the existing supplier are taking place in respect of the unit costs for 2013-14, prior to the re-letting of the contract.

The learning disability development fund is currently forecasting a gross under spend of -£182k due to contracts with organisations being reviewed or renegotiated, along with the redeployment of staff following the recent FSC restructure of strategic commissioning and operational support.

The telecare/telehealth budget is currently forecasting a gross pressure of +£162k along with additional income contributions of -£258k. These services have been primarily funded from the whole system demonstrator grant however this grant is coming to an end and the current equipment commitments have exceeded the remaining grant available by +£175k although this is partially offset by the redeployment of staff associated with the project (-£148k). The balance of the gross pressure relates to the purchase and licence of a new server (+£135k). The PCT have agreed to fund the purchase of the new server along with a contribution towards the existing equipment commitment totalling -£258k.

The balance of both the gross and income variances (-£73k and -£4k respectively) relates to a number of minor variances on other budget lines.

1.1.3.7 **Assessment Services – Adult's Social Care staffing -£206k (-£391k Gross & +£185k Income):**

The gross underspend of -£391k reflects the current staffing forecast, representing 1% to the overall budget for assessment staffing services, and results from the delay in recruitment to known vacancies. The forecast reduction in income of +£185k is due to many minor variances all individually less than £100k.

**Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER**
(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Domiciliary Care - Older People Income: under-recovery of client income due to reduced activity | +1,562 | ASCPH | Residential Care - Learning Disability Gross: preserved rights number of weeks forecast to be lower than affordable level | -1,359 |
| ASCPH | Domiciliary Care - Learning Disability Gross: forecast unit cost higher than affordable level | +1,017 | ASCPH | Residential Care - Older People Gross: forecast number of weeks lower than affordable level | -1,359 |
| ASCPH | Residential Care - Learning Disability Gross: forecast number of weeks greater than affordable level | +1,016 | ASCPH | Residential Care - Older People Gross: release of contigency to help fund pressures on nursing care | -1,344 |
| ASCPH | Residential Care - Older People Income: forecast unit charge lower than affordable level | +871 | ASCPH | Direct Payments - Older People Gross: forecast number of weeks lower than affordable level | -1,278 |
| ASCPH | Residential Care - Learning Disability Gross: preserved rights unit cost forecast to be higher than affordable level | +868 | ASCPH | Domiciliary Care - Older People Gross: forecast number of hours lower than affordable level | -1,003 |
| ASCPH | Nursing Care - Older People Gross: forecast number of weeks higher than affordable level | +829 | ASCPH | Supported Accommodation - Learning Disability Gross: expected net drawdown from social care supported living costs reserve | -902 |
| ASCPH | Direct Payments - Older People Gross: forecast unit cost higher than affordable level | +803 | ASCPH | Domiciliary Care - Learning Disability Gross: forecast number of hours lower than affordable level | -873 |
| ASCPH | Residential Care - Older People Income: forecast number of weeks lower than affordable level | +742 | ASCPH | Residential Care - Physical Disabiltiy Gross: forecast number of weeks lower than affordable level | -816 |
| ASCPH | Supported Accomodation - Learning Disability Income: forecast unit charge lower than affordable level | +709 | ASCPH | Day Care - Older People Gross: savings from re-commissioning strategies in both in-house & external services | -685 |
| ASCPH | Residential Care - Older People Income: lower income resulting from the placing of less permanent clients in in-house units | +677 | ASCPH | Domiciliary Care - Older People Gross: Savings from the Kent Enablement at Home service as a result of forecast activity below budgeted level | -580 |
| ASCPH | Nursing Care - Older People Gross: forecast unit cost higher than affordable level | +613 | ASCPH | Direct Payments - Learning Disability Gross: forecast number of weeks lower than affordable level | -540 |
| ASCPH | Nursing Care - Older People Gross: additional nursing care to be recharged to health (RNCC) | +471 | ASCPH | Direct Payments - Physical Disability Gross: forecast number of weeks lower than affordable level | -521 |
| ASCPH | Residential Care - Learning Disability Income: preserved rights unit charge forecast is lower than affordable level | +435 | ASCPH | Residential Care - Older People Gross: preserved rights forecast number of weeks lower than affordable level | -488 |

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Domicilary Care - Physical Disability Gross: forecast unit cost higher than affordable level | +416 | ASCPH | Nursing Care - Older People Income: additional nursing care to be recharged to health (RNCC) | -471 |
| ASCPH | Day Care - Learning Disability Gross: pressure on the commissioning of external day care services | +391 | ASCPH | Assessment Adult's Social Care Staffing Gross: delay in recruitment to known vacancies | -391 |
| ASCPH | Domiciliary Care - Learning Disability Income: changing client profile in the Independent Living Service leading to reduced levels of support for those clients in receipt of external funding | +337 | ASCPH | Nursing Care - Older People Income: forecast number of weeks higher than affordable level | -356 |
| ASCPH | Residential Care - Older People Gross: integrated care centre health costs to be recharged to the PCT | +332 | ASCPH | Domiciliary Care - Older People Gross: savings on block contracts | -354 |
| ASCPH | Domiciliary Care - Older People Gross: forecast unit charge higher than affordable level | +311 | ASCPH | Residential Care - Learning Disability Income: forecast unit charge greater than affordable level | -353 |
| ASCPH | Supported Accomodation - Learning Disability Gross: Establishment of new supporting independence service & further transfer of clients from other LD services | +285 | ASCPH | Residential Care - Older People Income: integrated care centre health costs to be recharged to the PCT | -332 |
| ASCPH | Residential Care - Older People Gross: staffing pressure on in-house units due to absences and vacancy cover | +277 | ASCPH | Day Care - Learning Disability Gross: staffing savings on in-house service from modernisation strategy & reduced client numbers | -317 |
| ASCPH | Residential Care - Older People Gross: forecast unit cost higher than affordable level | +267 | ASCPH | Residential Care - Older People Gross: Drawdown from NHS support for social care reserve | -279 |
| ASCPH | Direct Payments - Learning Disability Income: forecast unit charge lower than affordable level | +234 | ASCPH | Nursing Care - Older People Gross: Drawdown from NHS support for social care reserve | -279 |
| ASCPH | Direct Payments - Physical Disability Gross: one-off payments in excess of budgeted level | +200 | ASCPH | Other Adult Services Income: PCT contributions towards purchase of new telecare/telehealth server & equipment | -258 |
| ASCPH | Domicilary Care - Older People Gross: estimated contribution to the bad debt provision to cover rising client debt levels | +200 | ASCPH | Supported Accommodation - Learning Disability Gross: forecast unit cost lower than budgeted level | -257 |
| ASCPH | Residential Care - Mental Health Gross: unit cost forecast to be higher than affordable level | +199 | ASCPH | Nursing Care - Older People Income: forecast unit charge higher than affordable level | -254 |
| ASCPH | Other Adult Services Gross: transfer of clients from OP Domiciliary Care to the Provider Managed Services Pilot | +198 | ASCPH | Domicilary Care - Physical Disability Gross: forecast number of hours lower than affordable level | -245 |
| ASCPH | Residential Care - Learning Disability Gross: delay in the review of in-house units | +192 | ASCPH | Direct Payments - Older People Income: forecast unit charge higher than affordable level | -240 |

| Pressures (+) | | | Underspends (-) | | |
|---|---|---|---|---|---|
| portfolio | | £000's | portfolio | | £000's |
| ASCPH | Residential Care - Physical Disabiltiy Gross: forecast unit cost is higher than affordable level | +184 | ASCPH | Suppported Accommodation - Learning Disability Gross: underspend on group home budgets as part of the modernisation of Learning disability in-house services | -216 |
| ASCPH | Other Adult Services Gross: higher unit cost paid per meal resulting from drop in number of meals provided | +180 | ASCPH | Domiciliary Care - Older People Gross: savings on the provision of domi care to clients within sheltered accommodation | -202 |
| ASCPH | Other Adult Services Gross: current telecare/telehealth equipment commitments are higher than grant available | +175 | ASCPH | Other Adult Services Gross: Learning Disability Development Fund underspend resulting from review of payments to organisations and redeployment of staff | -182 |
| ASCPH | Residential Care - Learning Disability Gross: forecast unit cost higher than affordable level | +176 | ASCPH | Strategic Management & Directorate Support Gross: vacancies within the performance & information unit. | -162 |
| ASCPH | Domiciliary Care - Older People Gross: pressure on the provision of enablement services by external providers | +174 | ASCPH | Other Adult Services Gross: redeployment of staff within the telecare/telehealth service | -148 |
| ASCPH | Direct Payments - Older People Income: forecast number of weeks lower than affordable level | +164 | ASCPH | Domilicary Care - Older People Gross: Drawdown from NHS support for social care reserve | -139 |
| ASCPH | Residential Care - Learning Disability Income: preserved rights number of weeks forecast to be lower than affordable level | +146 | ASCPH | Supported Accommodation - Physical Disability/Mental Health Income: forecast unit charge higher than affordable level | -137 |
| ASCPH | Direct Payments - Physical Disability Gross: forecast unit cost higher than affordable level | +145 | ASCPH | Direct Payments - Physical Disability Income: forecast unit charge higher than affordable level | -134 |
| ASCPH | Domiciliary Care - Learning Disability Gross: pressure on Extra Care Sheltered Housing | +144 | ASCPH | Supported Accommodation - Mental Health Gross: savings resulting from introduction of Supporting Independence Service | -128 |
| ASCPH | Other Adult Services Gross: costs associated with purchase of new server & licence for telecare/telehealth service | +135 | ASCPH | Supported Accommodation - Learning Disability Gross: Release of unrealised creditors set up in 2011/12 | -100 |
| ASCPH | Strategic Management & Directorate Support Gross: estimated legal charges pressure based on 11-12 outturn. | +133 | | | |
| ASCPH | Direct Payments - Learning Disability Gross: one-off direct payments higher than recovery of surplus funds from long term clients | +131 | | | |
| | | | | | |
| | | | | | |
| | | +16,339 | | | -17,682 |

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

None

1.1.5 **Implications for MTFP**:

All pressures and savings have been addressed in 2013-15 MTFP approved by County Council on 14th February 2013.

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

None.

1.1.7 **Details of proposals for residual variance**: *[eg roll forward proposals; mgmt action outstanding]*

The forecast underspend for Adult Services is -£1.619m as shown in table 1, which is contributing towards the £5m underspend from 2012-13 being used to support the overall 2013-14 KCC budget, as approved by County Council on 14th February 2013.

## 1.2 CAPITAL

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

1.2.2 Adult Social Care and Public Health
The Adult Social Care and Public Health portfolio has an approved budget for 2012-15 of £88.371m, reduced to £21.571m excluding PFI (see table 1 below). The forecast outturn against this budget is £20.160m, giving a variance of -£1.411m. After adjustments for funded variances and reductions in funding, the revised variance comes to -£1.418m (see table 3).

1.2.3 Tables 1 to 3 summaries the portfolio's approved budget and forecast.

1.2.4 Table 1 – Revised approved budget

| | £m |
|---|---|
| Approved budget last reported to Cabinet excl PFI | 21.498 |
| Approvals made since last reported to Cabinet | 0.073 |
| Revised approved budget | 21.571 |

1.2.5 Table 2 – Funded and Revenue Funded Variances

| Scheme | Portfolio | Amount £m | Reason |
|---|---|---|---|
| **Cabinet to approve cash limit changes** | | | |
| Folkestone Activities, Respite & Rehabililtation Care Centre | ASC&PH | 0.007 | Additional Developer Contributions |
| | | | |
| **No cash limit changes to be made** | | | |

1.2.6 Table 3 – Summary of Variance

| | Amount £m |
|---|---|
| **Unfunded variance** | **0.000** |
| Funded variance (from table 2) | 0.007 |
| Variance to be funded from revenue | 0.000 |
| Project underspend | 0.000 |
| **Rephasing (beyond 2012-15)** | **-1.418** |
| Total variance | -1.411 |

1.2.7 **Main reasons for variance**

Table 4 below, details each scheme indicating all variances and the status of the scheme. Each scheme with a Red or Amber status will be explained including what is being done to get the scheme back to budget/on time.

**Annex 3**

Table 4 – Scheme Progress

| **Scheme name** | **Total cost** | **Previous spend** | **2012-15 approved budget** | **Later Years approved budget** | **2012-15 Forecast spend** | **Later Years Forecast spend** | **2012-15 Variance** | **Total project variance** | **Status Red /amber /green** |
|---|---|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m | £m | |
| | (a) = b+c+d | (b) | (c) | (d) | (e) | (f) | (g) = (e-c) | (h)=(b+e+f)-a | |
| | | | | | | | | | |
| Modernisation of Assets (Adults) | 0.810 | 0.437 | 0.373 | 0.000 | 0.373 | 0.000 | 0.000 | 0.000 | Green |
| Home Support Fund | 9.456 | 4.312 | 3.532 | 1.612 | 3.532 | 1.612 | 0.000 | 0.000 | Green |
| Tunbridge Wells Respite (formerly Rusthall Site) | 0.217 | 0.167 | 0.050 | 0.000 | 0.050 | 0.000 | 0.000 | 0.000 | Green |
| Bower Mount Project | 0.072 | 0.060 | 0.012 | 0.000 | 0.007 | 0.000 | -0.005 | -0.005 | Green |
| MH Strategy | 0.547 | 0.283 | 0.264 | 0.000 | 0.264 | 0.000 | 0.000 | 0.000 | Green |
| Public Access | 1.700 | 0.516 | 1.184 | 0.000 | 1.184 | 0.000 | 0.000 | 0.000 | Green |
| Bearsted Dementia Project | 0.025 | 0.025 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | Green |
| Folkestone Activities, Respite and Rehabilitation Care Centre | 0.031 | 0.001 | 0.030 | 0.000 | 0.037 | 0.000 | 0.007 | 0.007 | Green |
| IT Strategy (formerly IT Infrastructure Grant - IT Related Projects) | 3.121 | 0.924 | 2.197 | 0.000 | 2.197 | 0.000 | 0.000 | 0.000 | Amber - Delayed |
| Dartford TC - OP Strategy - Trinity Centre, Dartford | 1.194 | 0.122 | 1.072 | 0.000 | 1.072 | 0.000 | 0.000 | 0.000 | Green |
| OP Strategy - Specialist Care Facilities - (formerly Int. Care Ctr & Dorothy Lucy Ctre). | 5.088 | 0.000 | 5.088 | 0.000 | 5.088 | 0.000 | 0.000 | 0.000 | Green |
| PFI Excellent Homes for all - Development of new Social Housing | 66.800 | 0.000 | 66.800 | 0.000 | 66.800 | 0.000 | 0.000 | 0.000 | Green |
| LD Modernisation - Good Day Programme | 6.779 | 0.427 | 6.352 | 0.000 | 6.357 | 0.000 | 0.005 | 0.005 | Green |
| Community Care Centre - Thameside Eastern Quarry / Ebbsfleet | 1.418 | 0.000 | 1.418 | 0.000 | 0.000 | 1.097 | -1.418 | -0.321 | Amber - Delayed |
| | | | | | | | 0.000 | 0.000 | |
| **TOTAL Adults Social Care and Public Health** | **97.258** | **7.274** | **88.372** | **1.612** | **86.961** | **2.709** | **-1.411** | **-0.314** | |

1.2.8 Status:
Green – Projects on time and budget
Amber – Projects either delayed or over budget
Red – Projects both delayed and over budget

1.2.9 Assignment of Green/Amber/Red Status

1.2.10 Projects with variances to budget will only show as amber if the variance is unfunded, i.e. there is no additional grant, external or other funding available to fund.

1.2.11 Projects are deemed to be delayed if the forecast completion date is later than what is in the current project plan.

**Amber and Red Projects – variances to cost/delivery date and why**

1.2.12 Information Technology Strategy/Modernisation of Assets - As a result of the decision to postpone the implementation of the Adults Integration Solution (AIS) workstream to all localities, pending further conclusive outcomes, coupled with an over-arching strategic review scheduled to be carried out by the Authority's Director of ICT, the Directorate has decided to show prudency and delay elements of this project into 2013/14.

1.2.13 Community Care Centre – Thameside Eastern Quarry/Ebbsfleet - There is re-phasing of £1.418m to 2015/16. This is due to the housing development relating to this project not progressing at the expected rate. There has also been a budget adjustment to the Ebbsfleet project resulting in a reduction of £0.321m to the cash limit in 2015-16.

**Other Significant Variances**

1.2.14 There are no other significant variances to report

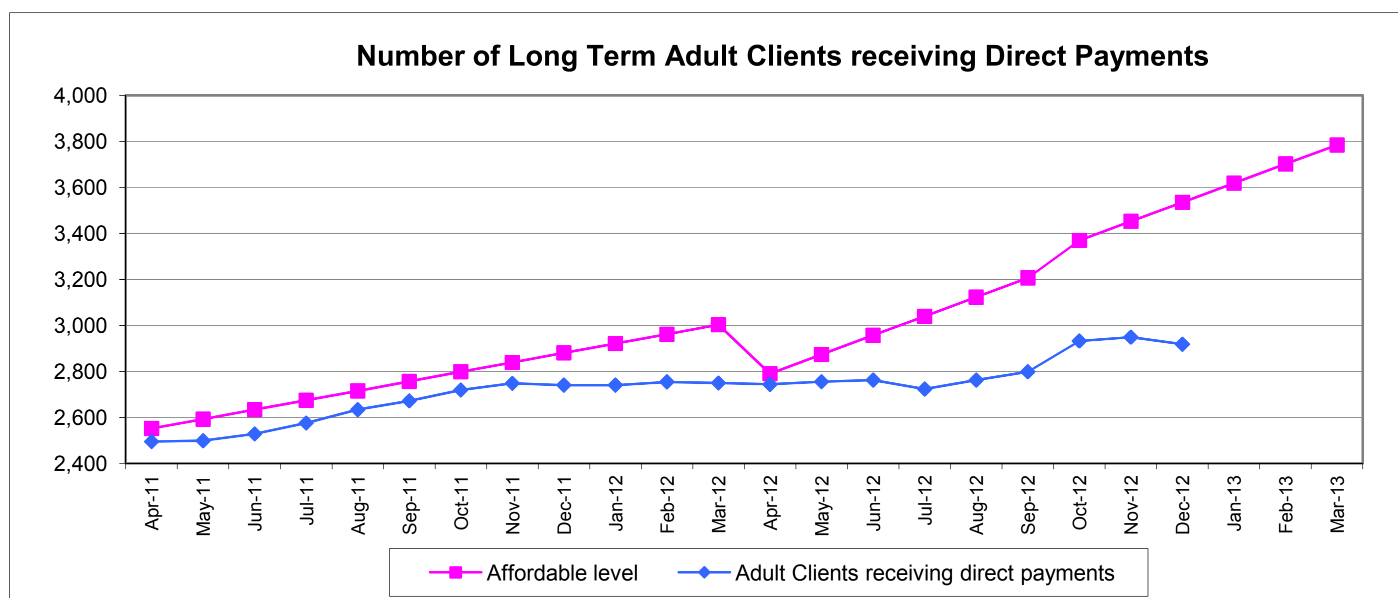
**Key Issues & Risks**

1.2.15 None to report

## 2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

### 2.1 Direct Payments – Number of Adult Social Services Clients receiving Direct Payments:

| | 2011-12 | | | 2012-13 | | |
|---|---|---|---|---|---|---|
| | Affordable Level for long term clients | Snapshot of long term adult clients receiving Direct Payments | Number of one-off payments made during the month | Affordable Level for long term clients | Snapshot of long term adult clients receiving Direct Payments | Number of one-off payments made during the month |
| April | 2,553 | 2,495 | 137 | 2,791 | 2,744 | 169 |
| May | 2,593 | 2,499 | 89 | 2,874 | 2,756 | 147 |
| June | 2,635 | 2,529 | 90 | 2,957 | 2,763 | 133 |
| July | 2,675 | 2,576 | 125 | 3,040 | 2,724 | 156 |
| August | 2,716 | 2,634 | 141 | 3,123 | 2,763 | 167 |
| September | 2,757 | 2,672 | 126 | 3,207 | 2,799 | 147 |
| October | 2,799 | 2,719 | 134 | 3,370 | 2,933 | 185 |
| November | 2,839 | 2,749 | 122 | 3,453 | 2,949 | 119 |
| December | 2,881 | 2,741 | 111 | 3,536 | 2,919 | 76* |
| January | 2,921 | 2,741 | 130 | 3,619 | | |
| February | 2,962 | 2,755 | 137 | 3,702 | | |
| March | 3,003 | 2,750 | 117 | 3,785 | | |
| | | | **1,459** | | | **1,299** |



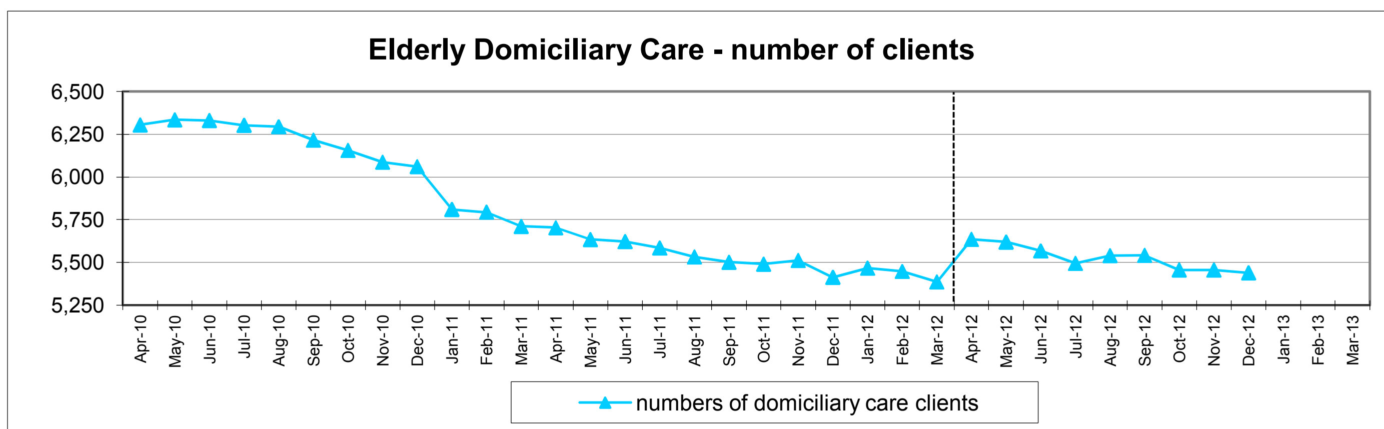

Comments:

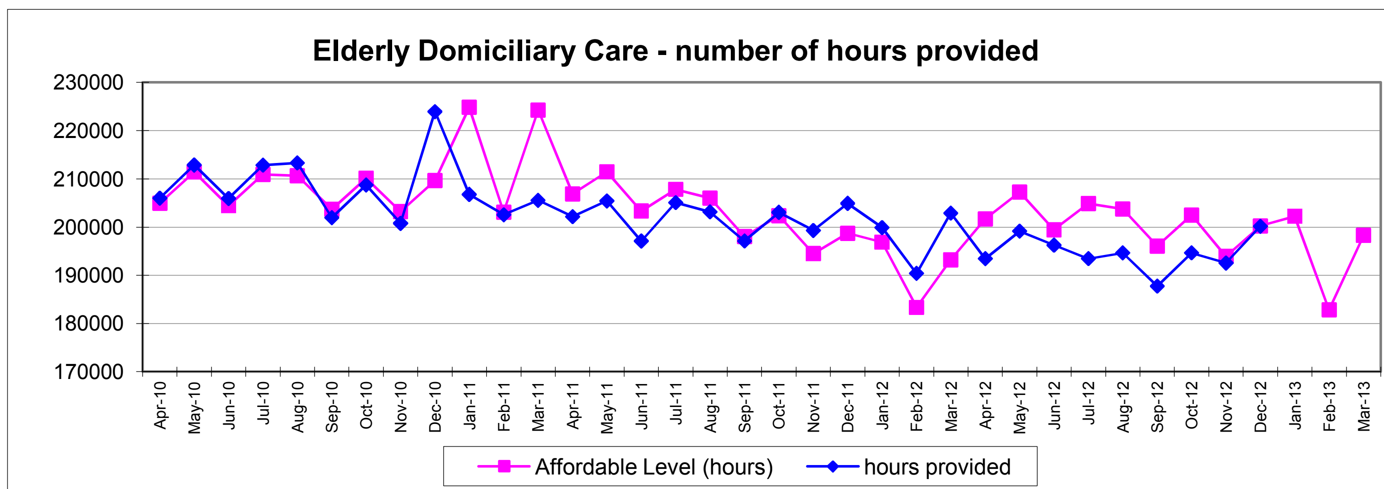
- The presentation of activity being reported for direct payments changed in the Q2 report in order to separately identify long term clients in receipt of direct payments as at the end of the month plus the number of one-off payments made during the month. Please note a long term client in receipt of a regular direct payment may also receive a one-off payment if required. Only the long term clients are presented on the graph above.
- Please note that due to the time taken to record changes in direct payments onto the client database the number of clients and one-off direct payments for any given month may change therefore the current year to date activity data is refreshed in each report to provide the most up to date information.
- *The low number of one-off payments in December may be due to delays in recording payments and will be updated in the outturn report reported to Cabinet in July.
- The drive to implement personalisation and allocate personal budgets has seen continued increases in direct payments over the years. There will be other means by which people can use their personal budgets and this may impact on the take up of direct payments. Whilst the overall numbers of Direct Payments are gradually increasing this is at a slower rate than the budget can afford, leading to a forecast gross under spend of -£1.141m as shown in section 1.1.3.2. It is important to note, the

current forecast is based on known clients only and does not factor in future growth in this service. This service received a significant amount of monies in the 2012-13 Budget (£3.5m) for the predicted growth in this service.

## 2.2.1 Elderly domiciliary care – numbers of clients and hours provided in the independent sector

| | 2010-11 | | | 2011-12 | | | 2012-13 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Affordable level (hours) | hours provided | number of clients | Affordable level (hours) | hours provided | number of clients | Affordable level (hours) | hours provided | number of clients |
| April | 204,948 | 205,989 | 6,305 | 206,859 | 202,177 | 5,703 | 201,708 | 193,451 | 5,635 |
| May | 211,437 | 212,877 | 6,335 | 211,484 | 205,436 | 5,634 | 207,244 | 199,149 | 5,619 |
| June | 204,452 | 205,937 | 6,331 | 203,326 | 197,085 | 5,622 | 199,445 | 196,263 | 5,567 |
| July | 210,924 | 212,866 | 6,303 | 207,832 | 205,077 | 5,584 | 204,905 | 193,446 | 5,494 |
| August | 210,668 | 213,294 | 6,294 | 206,007 | 203,173 | 5,532 | 203,736 | 194,628 | 5,540 |
| September | 203,708 | 201,951 | 6,216 | 198,025 | 197,127 | 5,501 | 196,050 | 187,749 | 5,541 |
| October | 210,155 | 208,735 | 6,156 | 202,356 | 203,055 | 5,490 | 202,490 | 194,640 | 5,456 |
| November | 203,212 | 200,789 | 6,087 | 194,492 | 199,297 | 5,511 | 193,910 | 192,555 | 5,455 |
| December | 209,643 | 223,961 | 6,061 | 198,704 | 204,915 | 5,413 | 200,249 | 200,178 | 5,439 |
| January | 224,841 | 206,772 | 5,810 | 196,879 | 199,897 | 5,466 | 202,258 | | |
| February | 203,103 | 202,568 | 5,794 | 183,330 | 190,394 | 5,447 | 182,820 | | |
| March | 224,285 | 205,535 | 5,711 | 193,222 | 202,889 | 5,386 | 198,277 | | |
| **TOTAL** | **2,521,376** | **2,501,274** | | **2,402,516** | **2,410,522** | | **2,391,092** | **1,752,059** | |




Comment:

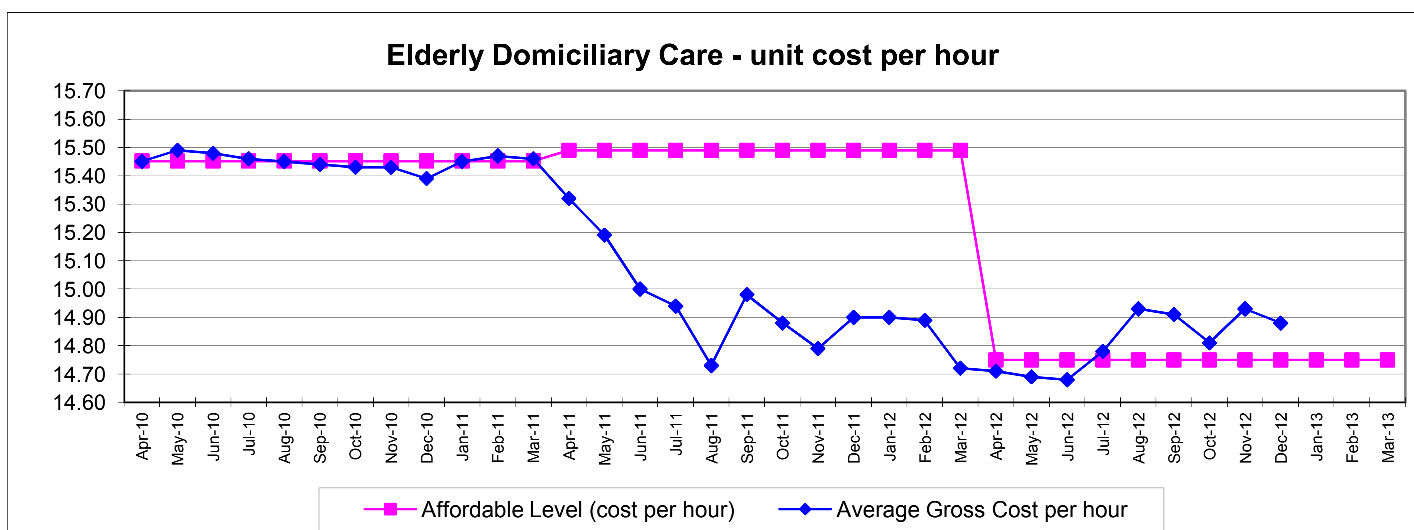
- Figures exclude services commissioned from the Kent Enablement At Home Service.
- The current forecast is 2,323,683 hours of care against an affordable level of 2,391,092, a difference of -67,409 hours. Using the forecast unit cost of £14.88 this reduction in activity reduces the forecast by -£1,003k, as highlighted in section 1.1.3.3.b.
- To the end of December 1,752,059 hours of care have been delivered against an affordable level of 1,807,737 a difference of -55,678 hours.
- Please note, from April 2012 there has been a change in the method of counting clients to align with current Department of Health guidance, which states that suspended clients e.g those who may be in hospital and not receiving a current service should still be counted. This has resulted in an increase in

the number of clients being recorded. For comparison purposes, using the new counting methodology, the equivalent number of clients in March 2012 would have been 5,641. **A dotted line has been added to the graph to distinguish between the two different counting methodologies, as the data presented is not on a consistent basis and therefore is not directly comparable**.

- Domiciliary for all client groups are volatile budgets, with the number of people receiving domiciliary care decreasing over the past few years as a result of the implementation of Self Directed Support (SDS). This is being compounded by a shift in trend towards take up of the enablement service.
- Please note the affordable level of client hours has been updated from 2,373,183 included in the Q2 monitoring report to Cabinet in December to 2,391,092 to reflect the allocation of winter pressures monies for domiciliary care.
- Please note the year to date activity for 2012-13 has been updated to reflect known delays in the updating of cases on the client database due to the continually changing nature of these care packages. For comparison, in the Q2 monitoring report to Cabinet in December the total number of client hours to September was 1,184,828 and is now 1,164,686.

2.2.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Hour) | Average Gross Cost per Hour | Affordable Level (Cost per Hour) | Average Gross Cost per Hour | Affordable Level (Cost per Hour) | Average Gross Cost per Hour |
| April | 15.452 | 15.45 | 15.49 | 15.32 | 14.75 | 14.71 |
| May | 15.452 | 15.49 | 15.49 | 15.19 | 14.75 | 14.69 |
| June | 15.452 | 15.48 | 15.49 | 15.00 | 14.75 | 14.68 |
| July | 15.452 | 15.46 | 15.49 | 14.94 | 14.75 | 14.78 |
| August | 15.452 | 15.45 | 15.49 | 14.73 | 14.75 | 14.93 |
| September | 15.452 | 15.44 | 15.49 | 14.98 | 14.75 | 14.91 |
| October | 15.452 | 15.43 | 15.49 | 14.88 | 14.75 | 14.81 |
| November | 15.452 | 15.43 | 15.49 | 14.79 | 14.75 | 14.93 |
| December | 15.452 | 15.39 | 15.49 | 14.90 | 14.75 | 14.88 |
| January | 15.452 | 15.45 | 15.49 | 14.90 | 14.75 | |
| February | 15.452 | 15.47 | 15.49 | 14.89 | 14.75 | |
| March | 15.452 | 15.46 | 15.49 | 14.72 | 14.75 | |

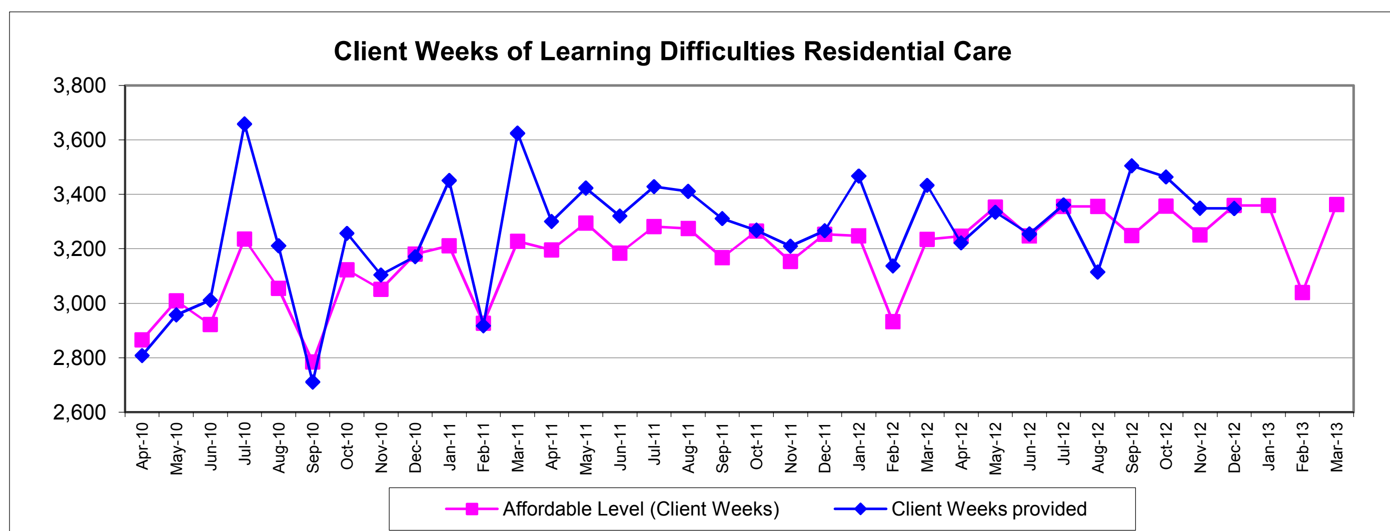



Comments:

- The unit cost has been showing an overall general reducing trend due to current work with providers to achieve savings however, the cost is also dependent on the intensity of the packages required.
- The forecast unit cost of £14.88 is higher than the affordable cost of £14.75 and this difference of +£0.13 increases the forecast by £311k when multiplied by the affordable hours, as highlighted in section 1.1.3.3.b.

2.3.1 **Number of client weeks of learning disability residential care provided compared with affordable level (non preserved rights clients):**

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided | Affordable Level (Client Weeks) | Client Weeks of LD residential care provided |
| April | 2,866 | 2,808 | 3,196 | 3,300 | 3,246 | 3,222 |
| May | 3,009 | 2,957 | 3,294 | 3,423 | 3,353 | 3,334 |
| June | 2,922 | 3,011 | 3,184 | 3,320 | 3,247 | 3,254 |
| July | 3,236 | 3,658 | 3,282 | 3,428 | 3,355 | 3,361 |
| August | 3,055 | 3,211 | 3,275 | 3,411 | 3,356 | 3,115 |
| September | 2,785 | 2,711 | 3,167 | 3,311 | 3,249 | 3,505 |
| October | 3,123 | 3,257 | 3,265 | 3,268 | 3,357 | 3,464 |
| November | 3,051 | 3,104 | 3,154 | 3,210 | 3,251 | 3,349 |
| December | 3,181 | 3,171 | 3,253 | 3,266 | 3,359 | 3,348 |
| January | 3,211 | 3,451 | 3,248 | 3,467 | 3,359 | |
| February | 2,927 | 2,917 | 2,932 | 3,137 | 3,039 | |
| March | 3,227 | 3,624 | 3,235 | 3,433 | 3,362 | |
| **TOTAL** | **36,593** | **37,880** | **38,485** | **39,974** | **39,533** | **29,952** |

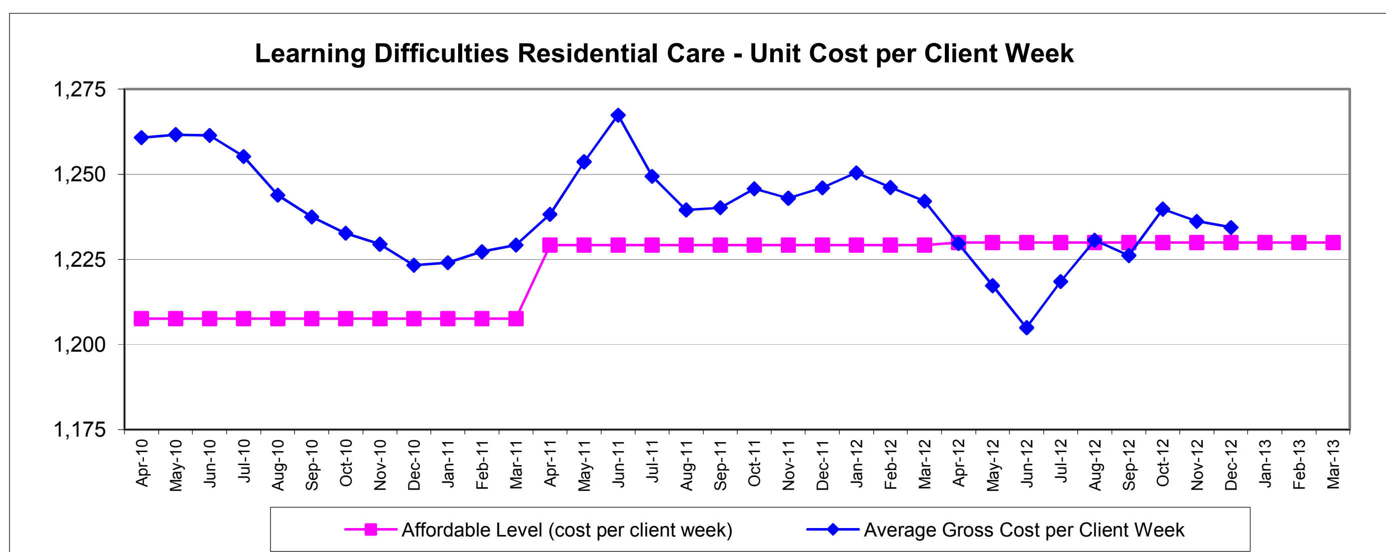



Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2010-11 was 713, at the end of 2011-12 it was 746 and at the end of December 2012 it was 751. This includes any ongoing transfers as part of the S256 agreement with Health, transitions, provisions and Ordinary Residence.
- The current forecast is 40,356 weeks of care against an affordable level of 39,533, a difference of +823 weeks. Using the forecast unit cost of £1,234.39 this additional activity adds £1,016k to the forecast, as highlighted in section 1.1.3.4.a.
- To the end of December 29,952 weeks of care have been delivered against an affordable level of 29,773, a difference of +179 weeks. The current year to date activity suggests a lower pressure however the forecast also includes 233 additional weeks of transition and provision clients (as described in section 1.1.3.4.a) i.e. clients expected to transfer to this service during this financial year. In addition, the current year activity is understated due to delays in the processing of short term beds on the activity database. The forecast includes the full costs of all non permanent block contracts and assumes full occupancy of these beds within the activity forecast. Additional resources have been allocated to clear this backlog of cases and the year to date activity will be restated in the Outturn Report to Cabinet in July.

2.3.2 **Average gross cost per client week of learning disability residential care compared with affordable level (non preserved rights clients)**:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 1,207.58 | 1,260.82 | 1,229.19 | 1,238.24 | 1,229.93 | 1,229.69 |
| May | 1,207.58 | 1,261.67 | 1,229.19 | 1,253.68 | 1,229.93 | 1,217.30 |
| June | 1,207.58 | 1,261.46 | 1,229.19 | 1,267.40 | 1,229.93 | 1,204.91 |
| July | 1,207.58 | 1,255.21 | 1,229.19 | 1,249.41 | 1,229.93 | 1,218.46 |
| August | 1,207.58 | 1,243.87 | 1,229.19 | 1,239.50 | 1,229.93 | 1,230.65 |
| September | 1,207.58 | 1,237.49 | 1,229.19 | 1,240.17 | 1,229.93 | 1,226.14 |
| October | 1,207.58 | 1,232.68 | 1,229.19 | 1,245.76 | 1,229.93 | 1,239.77 |
| November | 1,207.58 | 1,229.44 | 1,229.19 | 1,242.97 | 1,229.93 | 1,236.19 |
| December | 1,207.58 | 1,223.31 | 1,229.19 | 1,246.05 | 1,229.93 | 1,234.39 |
| January | 1,207.58 | 1,224.03 | 1,229.19 | 1,250.44 | 1,229.93 | |
| February | 1,207.58 | 1,227.26 | 1,229.19 | 1,246.11 | 1,229.93 | |
| March | 1,207.58 | 1,229.19 | 1,229.19 | 1,242.08 | 1,229.93 | |



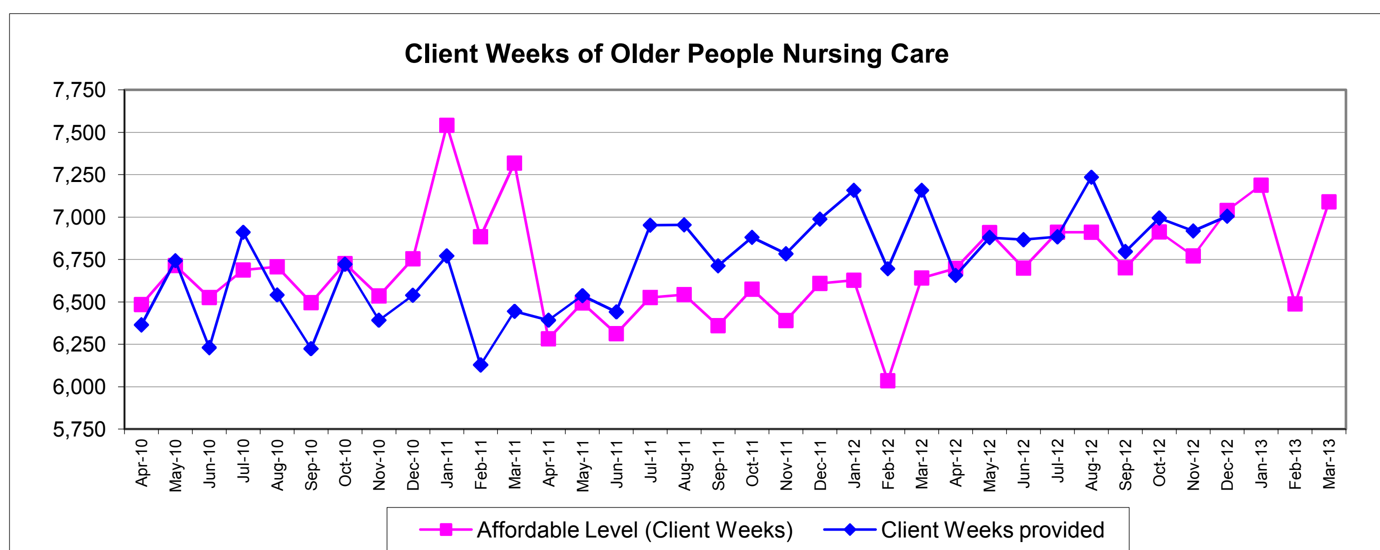

Comments:

- Clients being placed in residential care are those with very complex and individual needs which makes it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,200 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high cost – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases. The general increase in the average cost per week due to the complexity of clients has been offset this financial year by the price savings forecast to be achieved as part of the 2012-13 budget.
- The forecast unit cost of £1,234.39 is higher than the affordable cost of £1,229.93 and this difference of +£4.46 adds £176k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.a.

- The rise in the forecast unit cost between June and September reflects the current assumption that the service will not be able to make all of the budgeted procurement savings, with a shortfall of approx. £370k currently anticipated.

2.4.1 **Number of client weeks of older people nursing care provided compared with affordable level:**

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided | Affordable Level (Client Weeks) | Client Weeks of older people nursing care provided |
| April | 6,485 | 6,365 | 6,283 | 6,393 | 6,698 | 6,656 |
| May | 6,715 | 6,743 | 6,495 | 6,538 | 6,909 | 6,880 |
| June | 6,527 | 6,231 | 6,313 | 6,442 | 6,699 | 6,867 |
| July | 6,689 | 6,911 | 6,527 | 6,953 | 6,911 | 6,884 |
| August | 6,708 | 6,541 | 6,544 | 6,954 | 6,912 | 7,235 |
| September | 6,497 | 6,225 | 6,361 | 6,713 | 6,701 | 6,797 |
| October | 6,726 | 6,722 | 6,576 | 6,881 | 6,913 | 6,995 |
| November | 6,535 | 6,393 | 6,391 | 6,784 | 6,772 | 6,918 |
| December | 6,755 | 6,539 | 6,610 | 6,988 | 7,039 | 7,005 |
| January | 7,541 | 6,772 | 6,628 | 7,159 | 7,189 | |
| February | 6,885 | 6,129 | 6,036 | 6,696 | 6,489 | |
| March | 7,319 | 6,445 | 6,641 | 7,158 | 7,090 | |
| **TOTAL** | **81,382** | **78,016** | **77,405** | **81,659** | **82,322** | **62,237** |

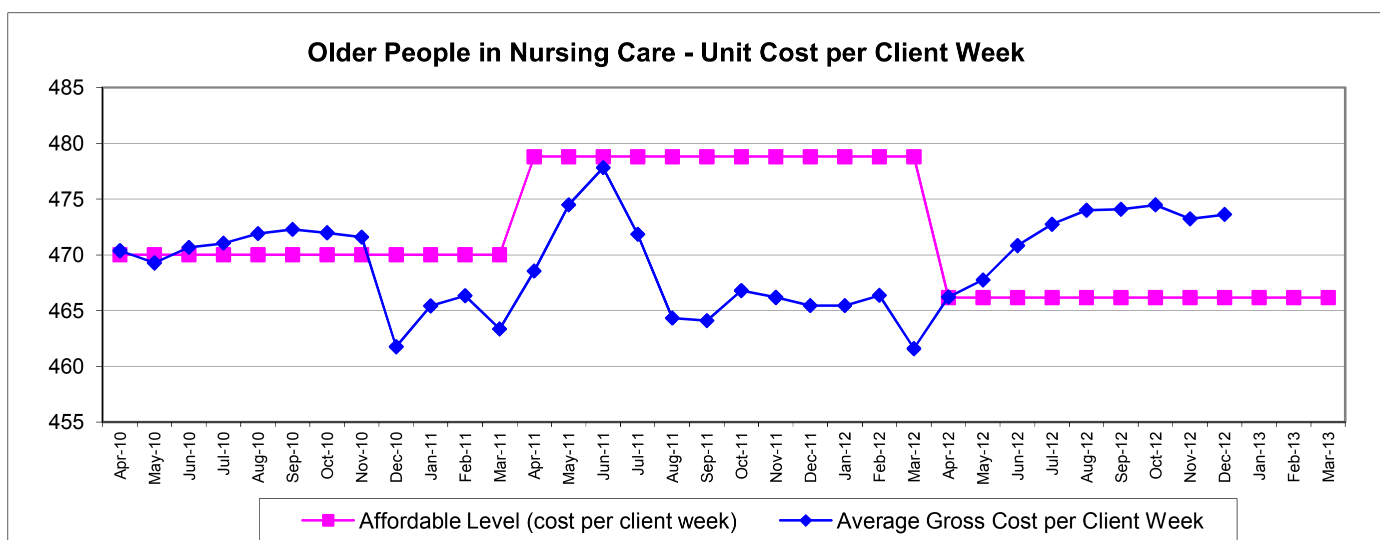



Comment:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2010-11 was 1,379, at the end of 2011-12 it was 1,479 and at the end of December 2012 it was 1,497.
- The current forecast is 84,073 weeks of care against an affordable level of 82,322, a difference of +1,751 weeks. Using the actual unit cost of £473.61, this additional activity adds +£829k to the forecast, as highlighted in section 1.1.3.4.c.
- To the end of December 62,237 weeks of care have been delivered against an affordable level of 61,554, a difference of +683 weeks. Current year to date activity suggests the forecast should be lower for this service however, the current year to date activity is understated due to delays in the processing of short term beds on the activity database. The forecast includes the full costs of all non permanent block contracts and assumes full occupancy of these beds within the activity forecast. Additional resources have been allocated to clear this backlog of cases and the year to date activity will be restated in the Outturn Report to Cabinet in July.
- Please note the affordable level of client weeks has been updated from 81,474 included in the Q2 monitoring report to Cabinet in December to 82,322 to reflect the allocation of winter pressures monies for nursing care.

2.4.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** | **Affordable Level (Cost per Week)** | **Average Gross Cost per Client Week** |
| April | 470.01 | 470.36 | 478.80 | 468.54 | 466.16 | 466.20 |
| May | 470.01 | 469.27 | 478.80 | 474.48 | 466.16 | 467.74 |
| June | 470.01 | 470.67 | 478.80 | 477.82 | 466.16 | 470.82 |
| July | 470.01 | 471.03 | 478.80 | 471.84 | 466.16 | 472.74 |
| August | 470.01 | 471.90 | 478.80 | 464.32 | 466.16 | 473.99 |
| September | 470.01 | 472.28 | 478.80 | 464.09 | 466.16 | 474.09 |
| October | 470.01 | 471.97 | 478.80 | 466.78 | 466.16 | 474.47 |
| November | 470.01 | 471.58 | 478.80 | 466.17 | 466.16 | 473.23 |
| December | 470.01 | 461.75 | 478.80 | 465.44 | 466.16 | 473.61 |
| January | 470.01 | 465.40 | 478.80 | 465.44 | 466.16 | |
| February | 470.01 | 466.32 | 478.80 | 466.36 | 466.16 | |
| March | 470.01 | 463.34 | 478.80 | 461.58 | 466.16 | |



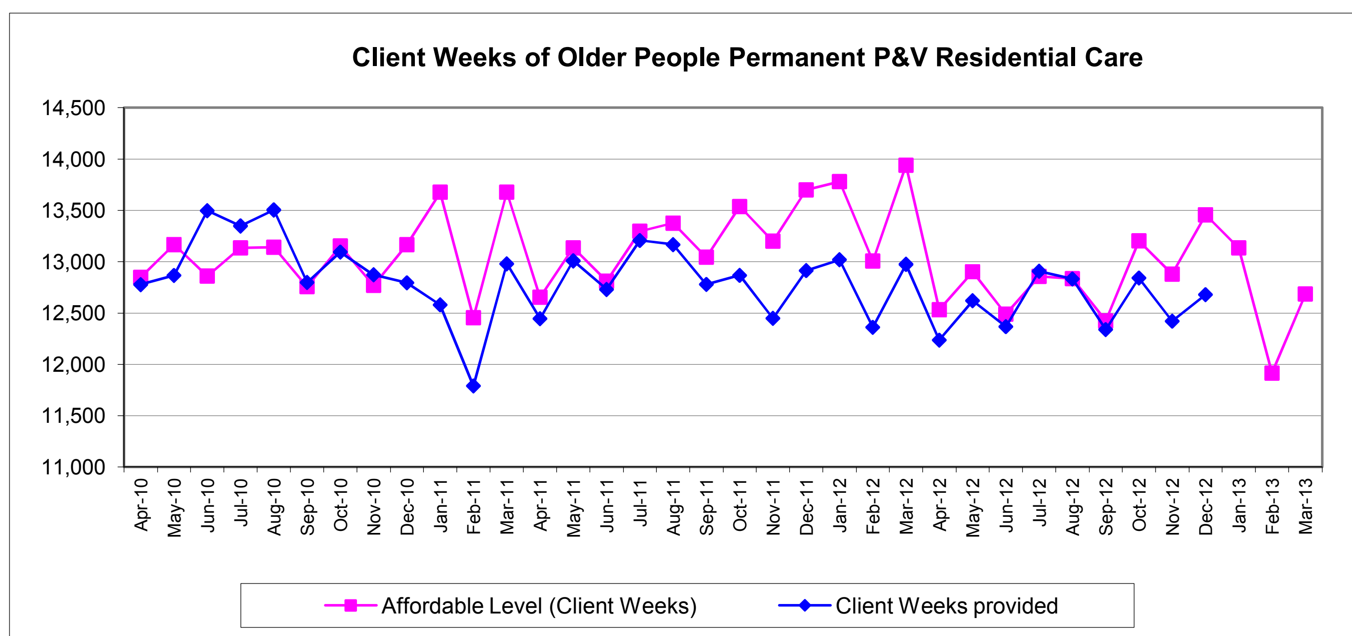

Comments:

- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care, which is why the unit cost can be quite volatile and in recent months this service has seen an increase of older people requiring this more specialist care.

- The forecast unit cost of £473.61 is higher than the affordable cost of £466.16 and this difference of +£7.54 adds +£613k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.c.

**2.5.1 Number of client weeks of older people permanent P&V residential care provided compared with affordable level:**

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of older people permanent P&V residential care provided | Affordable Level (Client Weeks) | Client Weeks of older people permanent P&V residential care provided | Affordable Level (Client Weeks) | Client Weeks of older people permanent P&V residential care provided |
| April | 12,848 | 12,778 | 12,655 | 12,446 | 12,532 | 12,237 |
| May | 13,168 | 12,867 | 13,136 | 13,009 | 12,903 | 12,621 |
| June | 12,860 | 13,497 | 12,811 | 12,731 | 12,489 | 12,369 |
| July | 13,135 | 13,349 | 13,297 | 13,208 | 13,858 | 12,908 |
| August | 13,141 | 13,505 | 13,377 | 13,167 | 12,836 | 12,832 |
| September | 12,758 | 12,799 | 13,044 | 12,779 | 12,424 | 12,339 |
| October | 13,154 | 13,094 | 13,538 | 12,868 | 13,203 | 12,842 |
| November | 12,771 | 12,873 | 13,200 | 12,448 | 12,880 | 12,422 |
| December | 13,167 | 12,796 | 13,700 | 12,914 | 13,358 | 12,679 |
| January | 13,677 | 12,581 | 13,782 | 13,019 | 13,135 | |
| February | 12,455 | 11,790 | 13,007 | 12,361 | 11,916 | |
| March | 13,678 | 12,980 | 13,940 | 12,975 | 12,786 | |
| **TOTAL** | **156,812** | **154,909** | **159,487** | **153,925** | **153,320** | **113,249** |




Comments:

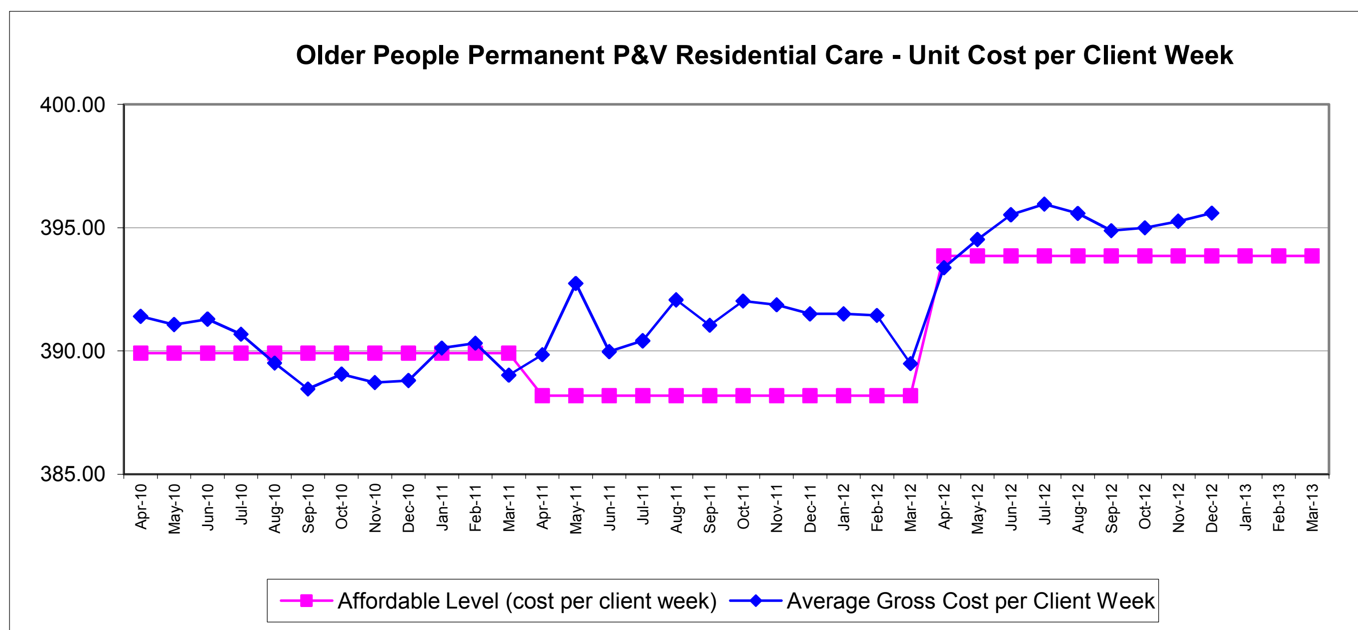
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2010-11 it was 2,787, at the end of 2011-12 it was 2,736 and by the end of December 2012 it was 2,707. It is evident that there are ongoing pressures relating to clients with dementia who require a greater intensity of care.
- It is difficult to consider this budget line in isolation, as the Older Person's modernisation strategy has meant that fewer people are being placed in our in-house provision, so we would expect that there will be a higher proportion of permanent placements being made in the independent sector which is masking the extent of the overall reducing trend in residential client activity.
- The current forecast is 149,885 weeks of care against an affordable level of 153,320, a difference of -3,435 weeks. Using the forecast unit cost of £395.59 this reduced activity saves -£1,359k from the forecast, as highlighted in section 1.1.3.4.d.
- To the end of December 113,249 weeks of care have been delivered against an affordable level of 115,483, a difference of -2,334 weeks. Current year to date activity suggests the forecast could be

slightly higher for this service however the forecast assumes the level of non-permanent care services falls marginally by the end of the year.

- Please note the affordable level of client weeks has been updated from 150,914 included in the Q2 monitoring report to Cabinet in December to 153,320 to reflect the allocation of winter pressures monies for residential care.

2.5.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 389.91 | 391.40 | 388.18 | 389.85 | 393.85 | 393.37 |
| May | 389.91 | 391.07 | 388.18 | 392.74 | 393.85 | 394.52 |
| June | 389.91 | 391.29 | 388.18 | 389.97 | 393.85 | 395.52 |
| July | 389.91 | 390.68 | 388.18 | 390.41 | 393.85 | 395.95 |
| August | 389.91 | 389.51 | 388.18 | 392.07 | 393.85 | 395.58 |
| September | 389.91 | 388.46 | 388.18 | 391.04 | 393.85 | 394.88 |
| October | 389.91 | 389.06 | 388.18 | 392.02 | 393.85 | 394.99 |
| November | 389.91 | 388.72 | 388.18 | 391.87 | 393.85 | 395.26 |
| December | 389.91 | 388.80 | 388.18 | 391.50 | 393.85 | 395.59 |
| January | 389.91 | 390.12 | 388.18 | 391.50 | 393.85 | |
| February | 389.91 | 390.31 | 388.18 | 391.44 | 393.85 | |
| March | 389.91 | 389.02 | 388.18 | 389.48 | 393.85 | |

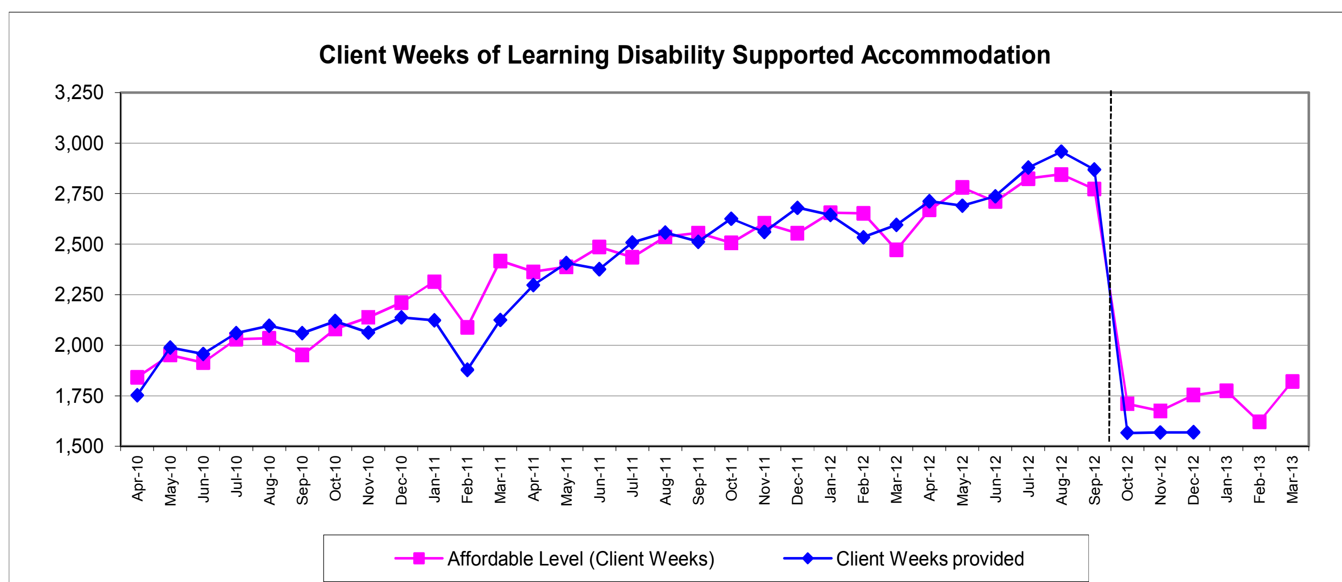



Comments:

- The forecast unit cost of £395.59 is higher than the affordable cost of £393.85 and this difference of +£1.74 adds +£267k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.d. This higher average unit cost is likely to be due to the higher proportion of clients with dementia, who are more costly due to the increased intensity of care required, as outlined above.

## 2.6.1 Number of client weeks of learning disability supported accommodation provided compared with affordable level:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided | Affordable Level (Client Weeks) | Client Weeks of LD supported accommodation provided |
| April | 1,841 | 1,752 | 2,363 | 2,297 | 2,670 | 2,712 |
| May | 1,951 | 1,988 | 2,387 | 2,406 | 2,781 | 2,690 |
| June | 1,914 | 1,956 | 2,486 | 2,376 | 2,711 | 2,737 |
| July | 2,029 | 2,060 | 2,435 | 2,508 | 2,824 | 2,879 |
| August | 2,034 | 2,096 | 2,536 | 2,557 | 2,845 | 2,958 |
| September | 1,951 | 2,059 | 2,555 | 2,512 | 2,773 | 2,869 |
| October | 2,080 | 2,119 | 2,506 | 2,626 | 1,710 | 1,566 |
| November | 2,138 | 2,063 | 2,603 | 2,560 | 1,675 | 1,568 |
| December | 2,210 | 2,137 | 2,554 | 2,680 | 1,753 | 1,569 |
| January | 2,314 | 2,123 | 2,655 | 2,644 | 1,774 | |
| February | 2,088 | 1,878 | 2,652 | 2,534 | 1,621 | |
| March | 2,417 | 2,125 | 2,472 | 2,595 | 1,820 | |
| **TOTAL** | **24,967** | **24,356** | **30,204** | **30,295** | **26,957** | **21,548** |



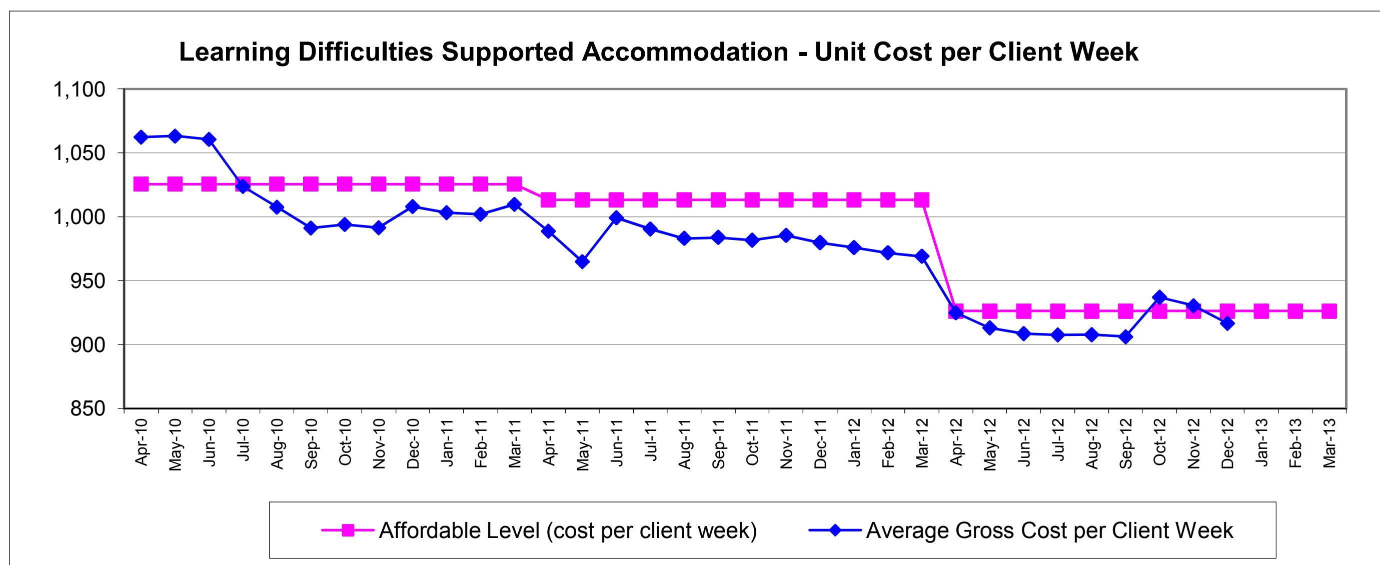

Comments:

- The affordable level for 2012-13 was amended in quarter 2 because from 1st October 2012 the Supporting Independence Service (SIS) was introduced and as a result a significant number of clients previously receiving supported accommodation services have transferred to this new arrangement and are no longer forecast under this activity indicator. This is represented by the significant drop in budgeted level from October 2012 onwards. The Supporting Independence Service clients are reported separately within the Supported Accommodation A-Z budget and are not recorded as part of the activity above. We will be reviewing the way we report supported accommodation for next year to see whether it is possible to combine both services within a single measure. **A dotted line has been added to the graph to illustrate the introduction of the new Supporting Independence Service, and the consequent transfer of clients from Supported Accommodation, as the data presented either side of the dotted line is not on a consistent basis and is therefore not directly comparable.**

- The above graph reflects the number of client weeks of service provided. The actual number of clients in LD supported accommodation at the end of 2010-11 was 491 of which 131 were S256 clients, at the end of 2011-12 it was 607 of which 156 were S256 clients, and at the end of December 2012 it was 284 (of which 114 are S256). This drop in clients reflects the transfer to the new SIS service explained above.
- The current forecast is 26,987 weeks of care against an affordable level of 26,957, a difference of +30 weeks. Using the forecast unit cost of £916.62 this increase in activity provides a pressure of +£28k, as reflected in section 1.1.3.5.a.
- To the end of December 21,548 weeks of care have been delivered against an affordable level of 21,742, a difference of -194 weeks. Current year to date activity suggests the forecast should be lower for this service however, the forecast includes approximately 196 weeks of expected transition and provision clients, therefore there is expected to be an increased pressure on this service in the final three months of the financial year.
- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people, it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that more and increasingly complex and unique cases will be successfully supported to live independently.

2.6.2 **Average gross cost per client week of learning disability supported accommodation compared with affordable level (non preserved rights clients)**:

| | 2010-11 | | 2011-12 | | 2012-13 | |
|---|---|---|---|---|---|---|
| | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week | Affordable Level (Cost per Week) | Average Gross Cost per Client Week |
| April | 1,025.67 | 1,062.38 | 1,013.18 | 988.73 | 926.16 | 924.87 |
| May | 1,025.67 | 1,063.22 | 1,013.18 | 964.95 | 926.16 | 912.93 |
| June | 1,025.67 | 1,060.59 | 1,013.18 | 999.24 | 926.16 | 908.53 |
| July | 1,025.67 | 1,023.90 | 1,013.18 | 990.45 | 926.16 | 907.44 |
| August | 1,025.67 | 1,007.58 | 1,013.18 | 983.09 | 926.16 | 907.63 |
| September | 1,025.67 | 991.20 | 1,013.18 | 983.85 | 926.16 | 906.09 |
| October | 1,025.67 | 993.92 | 1,013.18 | 981.78 | 926.16 | 936.95 |
| November | 1,025.67 | 991.56 | 1,013.18 | 985.45 | 926.16 | 930.40 |
| December | 1,025.67 | 1,007.95 | 1,013.18 | 979.83 | 926.16 | 916.62 |
| January | 1,025.67 | 1,003.21 | 1,013.18 | 975.90 | 926.16 | |
| February | 1,025.67 | 1,001.98 | 1,013.18 | 971.85 | 926.16 | |
| March | 1,025.67 | 1,009.82 | 1,013.18 | 969.09 | 926.16 | |




Comments:

- The forecast unit cost of £916.62 is lower than the affordable cost of £926.16 and this difference of -£9.54 provides a saving of -£257k when multiplied by the affordable weeks. The forecast unit cost assumes £94k of the £854k procurement saving is still to be achieved before the end of the financial year.
- There are three distinct groups of clients: Section 256 clients, Ordinary Residence clients and other clients. Each group has a very different unit cost, which are combined to provide an average unit cost for the purposes of this report.
- The costs associated with these placements will vary depending on the complexity of each case and the type of support required in each placement. This varies enormously between a domiciliary type support to life skills and daily living support.
- Please note, from 2012-13 the unit cost has been recalculated to exclude spend associated with better homes active lives accommodation as these clients are not included in the client weeks reported in section 2.6.1 above. For comparison the revised March 2012 unit cost would have been £936.81 per client per week. In addition, the budgeted unit cost has been further lowered to reflect the procurement savings in the 2012-15 MTP.

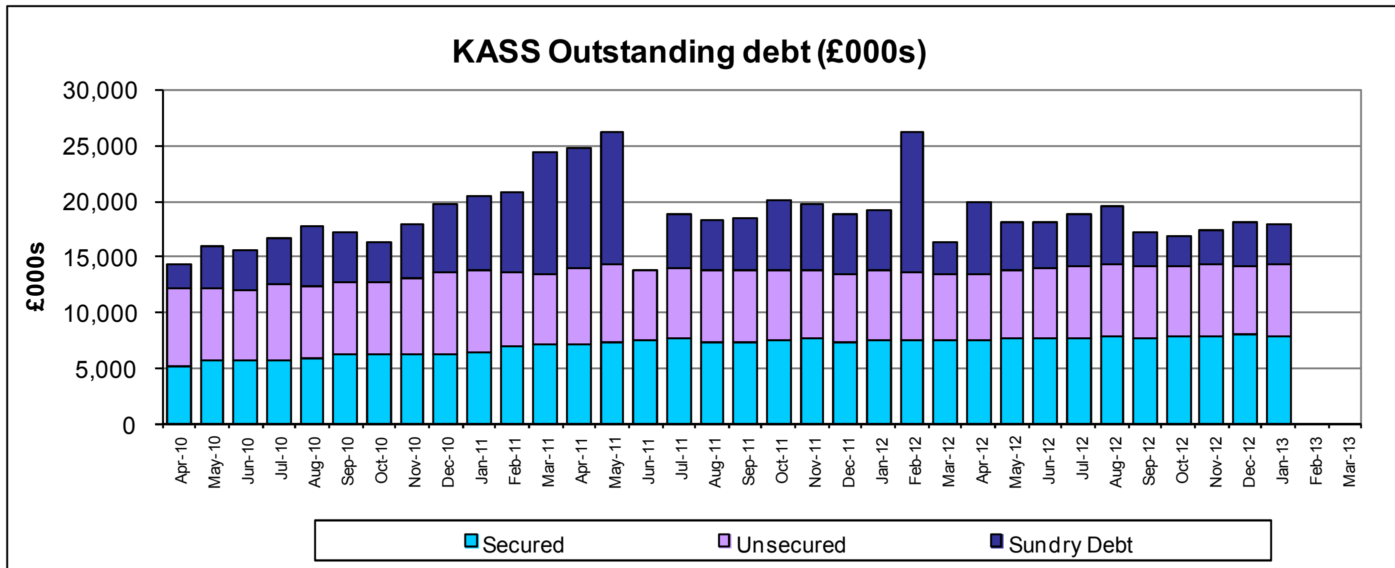
## 3. SOCIAL CARE DEBT MONITORING

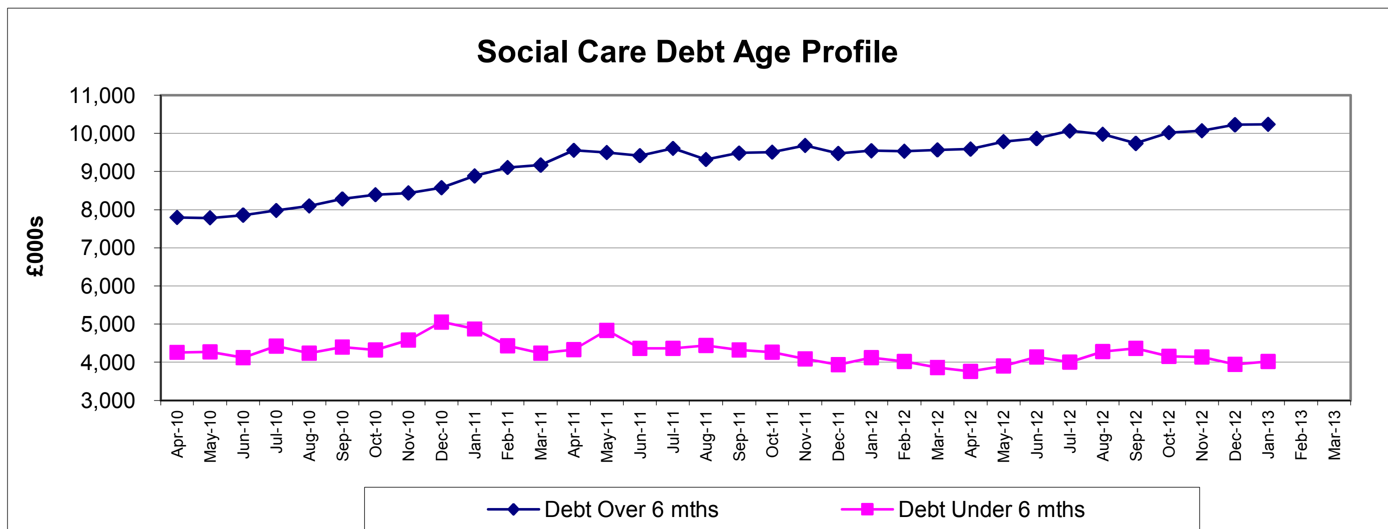
The outstanding debt as at the end of January was £17.965m compared with October's figure of £16.747m (reported to Cabinet in December) excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this figure is £3.711m of sundry debt compared to £2.574m in October. The amount of sundry debt can fluctuate for large invoices to health. Also within the outstanding debt is £14.254m relating to Social Care (client) debt which is a small increase of £0.081m from the last reported position to Cabinet in December. The following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year. The sundry debt figures are based on calendar months.

| | | | Social Care Debt | | | | |
|---|---|---|---|---|---|---|---|
| **Debt Month** | **Total Due Debt (Social Care & Sundry Debt) £000s** | **Sundry Debt £000s** | **Total Social Care Due Debt £000s** | **Debt Over 6 mths £000s** | **Debt Under 6 mths £000s** | **Secured £000s** | **Unsecured £000s** |
| **Apr-10** | **14,294** | **2,243** | 12,051 | 7,794 | 4,257 | 5,132 | 6,919 |
| **May-10** | **15,930** | **3,873** | 12,057 | 7,784 | 4,273 | 5,619 | 6,438 |
| **Jun-10** | **15,600** | **3,621** | 11,979 | 7,858 | 4,121 | 5,611 | 6,368 |
| **Jul-10** | **16,689** | **4,285** | 12,404 | 7,982 | 4,422 | 5,752 | 6,652 |
| **Aug-10** | **17,734** | **5,400** | 12,334 | 8,101 | 4,233 | 5,785 | 6,549 |
| **Sep-10** | **17,128** | **4,450** | 12,678 | 8,284 | 4,394 | 6,289 | 6,389 |
| **Oct-10** | **16,200** | **3,489** | 12,711 | 8,392 | 4,319 | 6,290 | 6,421 |
| **Nov-10** | **17,828** | **4,813** | 13,015 | 8,438 | 4,577 | 6,273 | 6,742 |
| **Dec-10** | **19,694** | **6,063** | 13,631 | 8,577 | 5,054 | 6,285 | 7,346 |
| **Jan-11** | **20,313** | **6,560** | 13,753 | 8,883 | 4,870 | 6,410 | 7,343 |
| **Feb-11** | **20,716** | **7,179** | 13,537 | 9,107 | 4,430 | 6,879 | 6,658 |
| **Mar-11** | **24,413** | **11,011** | 13,402 | 9,168 | 4,234 | 7,045 | 6,357 |
| **Apr-11** | **24,659** | **10,776** | 13,883 | 9,556 | 4,327 | 7,124 | 6,759 |
| **May-11** | **26,069** | **11,737** | 14,332 | 9,496 | 4,836 | 7,309 | 7,023 |
| **Jun-11** | **13,780** | * | 13,780 | 9,418 | 4,362 | 7,399 | 6,381 |
| **Jul-11** | **18,829** | **4,860** | 13,969 | 9,608 | 4,361 | 7,584 | 6,385 |
| **Aug-11** | **18,201** | **4,448** | 13,753 | 9,315 | 4,438 | 7,222 | 6,531 |
| **Sep-11** | **18,332** | **4,527** | 13,805 | 9,486 | 4,319 | 7,338 | 6,467 |
| **Oct-11** | **20,078** | **6,304** | 13,774 | 9,510 | 4,264 | 7,533 | 6,241 |
| **Nov-11** | **19,656** | **5,886** | 13,770 | 9,681 | 4,089 | 7,555 | 6,215 |
| **Dec-11** | **18,788** | **5,380** | 13,408 | 9,473 | 3,935 | 7,345 | 6,063 |
| **Jan-12** | **19,180** | **5,518** | 13,662 | 9,545 | 4,117 | 7,477 | 6,185 |
| **Feb-12** | **26,218** | **12,661** | 13,557 | 9,536 | 4,021 | 7,455 | 6,102 |
| **Mar-12** | **16,310** | **2,881** | 13,429 | 9,567 | 3,862 | 7,411 | 6,018 |
| **Apr-12** | **19,875** | **6,530** | 13,345 | 9,588 | 3,757 | 7,509 | 5,836 |
| **May-12** | **18,128** | **4,445** | 13,683 | 9,782 | 3,901 | 7,615 | 6,068 |
| **Jun-12** | **18,132** | **4,133** | 13,999 | 9,865 | 4,134 | 7,615 | 6,384 |
| **Jul-12** | **18,816** | **4,750** | 14,066 | 10,066 | 4,000 | 7,674 | 6,392 |
| **Aug-12** | **19,574** | **5,321** | 14,253 | 9,977 | 4,276 | 7,762 | 6,491 |
| **Sep-12** | **17,101** | **3,002** | 14,099 | 9,738 | 4,361 | 7,593 | 6,506 |
| **Oct-12** | **16,747** | **2,574** | 14,173 | 10,020 | 4,153 | 7,893 | 6,280 |
| **Nov-12** | **17,399** | **3,193** | 14,206 | 10,069 | 4,137 | 7,896 | 6,310 |
| **Dec-12** | **17,996** | **3,829** | 14,167 | 10,226 | 3,941 | 7,914 | 6,253 |
| **Jan-13** | **17,965** | **3,711** | 14,254 | 10,237 | 4,017 | 7,885 | 6,369 |
| **Feb-13** | **0** | | 0 | | | | |
| **Mar-13** | **0** | | 0 | | | | |

* It should be noted that the Sundry debt reports were not successful in June 2011, and hence no figure can be reported, the problem was rectified in time for the July report, but reports are unable to be run retrospectively.

In addition the previously reported secured and unsecured debt figures for April 2012 to July 2012 were amended slightly between the Quarter 1 and Quarter 2 reports following a reassessment of some old debts between secured and unsecured.



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

Andrew Ireland, Corporate Director of Families and Social Care

To: Social Care & Public Health Cabinet Committee - 21 March 2013

Subject: Children's Services Improvement Programme: Progress Update

Classification: Unrestricted

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**Summary**

This report provides Cabinet with an update on progress regarding the Children's Services Improvement Programme.

Members are also asked to **NOTE** the very significant progress that has been made.

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**1. Introduction**

1.1 This is the sixth report to Cabinet Committee, outlining progress made in improving Specialist Children's Services (SCS). This paper is constructed differently to previous reports, which focused primarily on performance issues and the Improvement Notice targets. Instead, this report acts as a broad position statement - setting out where we believe the Service to be, and the direction of travel throughout 2013 and beyond.

**2. Key Developments**

2.1 Peer Review & Safeguarding Inspection

In September 2012, SCS was subject to a Peer Review of its services. The Review was not an inspection – rather a supportive but challenging 'critical friend', assisting KCC and partner agencies to identify our strengths and areas requiring further development. The key purpose of the Review was to stimulate local discussion about how Children's Services can become more effective in delivering improved safe outcomes for children and young people. The Review was both properly challenging and appropriately helpful, corroborating our understanding of Kent's improvement journey i.e. where we are in the process of improvement, and where our strengths and weaknesses lie. Actions were put in place to address recognised areas of vulnerability, and a series of staff briefings were subsequently held to define how best to respond to the feedback received across business operations. See Appendix 1 for more details.

2.2 Between 26th November and 5th December 2012, Ofsted conducted an inspection of KCC's child protection arrangements; the inspection report was subsequently published on 17th January 2013 (see Appendix 2). The inspection was unannounced (as prescribed in the new inspection regime), and Ofsted made judgements in four key areas. Their findings were:

- Quality of Practice: Adequate.
- Effectiveness of Help and Protection: Adequate.
- Leadership and Governance: Adequate.
- Overall Effectiveness: Adequate.

2.3 This is clearly a key milestone since we began our improvement process in October 2010, and reflects well on the substantial developments made since that time.

2.4 The Peer Review and Inspection reports, when taken together, give us a very comprehensive and detailed picture about the quality and effectiveness of current service provision. Both also offer useful and, in many ways, similar views and recommendations about the future developments needed to deliver the kind of quality provision that is expected by us and which local children and families need.

2.5 It is perhaps most pleasing that neither report highlighted any areas of development not already known to us. Ofsted in particular commented on the fact that SCS is a service that knows itself, that is proactively identifying areas of weakness and putting in place robust actions to improve upon them. It is perhaps this facility more than any other that can give some confidence about the next stage of the improvement journey.

2.6 Both the Peer Review Team and Ofsted commented positively on the improvement programme undertaken thus far and were able to see the reason for, and benefits of, the three phase approach we have adopted. The Peer Review was helpful in identifying the need for a further phase to this process - moving from improvement to transformation.

2.7 There is no complacency in the service. Children's Services do not aspire to be adequate and the Service is aware there is still much to do. However, we believe that the core building blocks needed to deliver a safe service are in place and increasingly the focus must be on the quality and effectiveness of our work.

**3. Current Position**

3.1 It is worth capturing the key headlines from the Peer Review, Ofsted and our continuing self assessment of the Service.

3.2 Vision – From Improvement to Transformation

The need to shift the vision from a remedial response to the 2010 inspection to something more aspirational and far-reaching was a point particularly made by the Peer Review Team. The point is well made and has been embraced in the Council. This is described in more detail below (para 5.2).

## Practice

There remains too much variability in the standards of practice across the County. We have some excellent practitioners doing excellent work, but equally some whose work is not yet at the required level. More generally, there is an evident need to engender a form of practice that makes more of a difference to children and their families. In too many instances, even where children are being regularly visited and cases supervised, there is insufficient impact to and change in the child's circumstances.

## Children in Need

There is a need to make significant progress in our work with Children in Need (CIN). Again, this is an area that SCS is already sighted on, and a considerable amount of work is already underway to improve quality in this area. All the Areas (North, South, East and West) are in the process of reviewing and improving their work with CIN; however, there remains more to do and work with CIN will form a key focus of our second Practice Improvement Programme for 2013 - see 4.6, below.

## Outcome Focus

A key point made explicitly by the Peer Review and implicitly in much of the Ofsted feedback was the fact that there has been considerable focus on 'process and rule-bound practice'. This was necessary and indeed inevitable in an organisation in intervention. It is important that we do not lose the internal discipline that this focus engenders, but we now need to move to ensure that all our work - whether a social work visit, a supervision session or a case conference - has a clear and explicit outcome-focus with a particular emphasis on bringing about change in each child's circumstances.

## KSCB

Both the Peer Review and Inspection reports comment on the KSCB, and it is clear that the Board needs to develop so that it can at some point assume the responsibilities of the Improvement Board in the future.

The KSCB Chair has increased her time commitment to the County and has assumed the chairing of the Quality and Effectiveness Sub-group (which had not previously delivered what was required of it). The interim AD, Safeguarding has also joined the group and a new QA Framework and refreshed data set will be constructed to drive forward the work of the group. The first round of multi-agency audits has been completed and these will be used to help inform future inter-agency practice developments. The Chair called a Safeguarding Summit in early December 2012 to ensure the necessary senior manager commitment from across the agencies to the Board, and to its scrutiny and challenge responsibilities. A Section 11 Audit has been commissioned and will be used as the core part of a refreshed Business Plan for the Board. Finally, the KSCB Business Unit has been restructured and streamlined to ensure more focussed support to the Board and to maintain the drive of the Board's work outside of the formal meeting structure.

## Early Help

Ofsted spoke positively about the new construction of early help services (redesigned as part of the new service structure) whilst rightly commenting on their relative newness. Both Ofsted and the Peer Review described continuing challenges in the embedding of CAF and its intended use. SCS has conducted its own evaluation of our early help offer and John Coughlan, DCS in Hampshire, is leading a Peer Review of this area in February 2013. We will therefore be in a position to comment in more detail about progress in this area in future reports.

3.3 SCS has constructed a more detailed Action Plan to respond to the Ofsted recommendations (see Appendix 3). This has been built alongside the Improvement Plan to preserve as far as possible its centrality as the Plan which drives our overall improvement. The Ofsted Action Plan relates to those areas not covered in the Improvement Plan and/or highlights where swifter action is required to meet the required timescales.

## 4. Current Position

4.1 Firstly, we are anticipating a further inspection visit from Ofsted – see point 11, p.8 for more details. Kent is one of only three local authorities judged inadequate in its work to safeguard children *and* in its' provision of services to Children in Care. Services to Children in Care were not inspected by the recent Ofsted inspection, nor were they a major line of enquiry for the Peer Review (although they did helpfully comment on some aspects of those services).

4.2 Secondly, there is, in our view, a need to review some of the specific contents of the Improvement Notice. The Notice is due to be "finally reviewed" in April 2013 and the contents of the Peer Review and the Ofsted Judgements will help inform that review.

4.3 The review of the Notice will take place between the Council, the DFE and the Board through the Chair. However, we believe we can now evidence:

- ✓ That work to develop preventative and early intervention has been completed.
- ✓ That threshold documentation is agreed, disseminated and subject to regular multi-agency training.
- ✓ There are now no unallocated cases within the social care service, although a small number of assessments remain out of timescale.
- ✓ That we have a performance management and quality assurance framework in place and that specifically file auditing is regular and frequent (our file audit methodology and audit programme are both being updated as a consequence of the Inspection and will include the Peer Review feedback on our file auditing processes.)
- ✓ The number of initial assessments has now increased in-line with statistical neighbours, and there is now a consistent conversion from referrals to initial assessments.
- ✓ That a comprehensive Child in Care Strategy has been developed and is being implemented.

- ✓ Significant success has been achieved in improving education outcomes and health and dental checks for children in our care

4.4 We accept that some elements of the Improvement Notice are not fully delivered and this was echoed by either the Peer Review and/or Ofsted. Areas requiring further work include:

- The need to continue to reduce the number of children subject to repeat Child Protection Plans.
- Continue to implement our recruitment and retention strategy with an initial focus on the hard-to-recruit-to areas in the Service.
- Maintain and develop the training for practitioners and supervisors.
- Continue our work to ensure Children in Care can voice their views and contribute to the development of the Service.
- Continue the improvements in the numbers and rate at which children become adopted.

4.5 It is worthy of note that work on all of the above are now embedded in “business as usual” in the Service and are subject to regular and routine management and practitioner attention. The continuation and development of the Practice Improvement Programmes (PIPs) and the Deep Dive Programme will ensure they receive the necessary attention.

Practice Improvement Programme (PIP)

The PIP was a key response to the practice failings identified by Ofsted in 2010. A small team of experienced and expert practitioners was constructed and spent time in each district throughout 2012, working alongside practitioners, auditing and working with Social Workers on cases, providing mentoring and coaching and running training workshops. This very direct ‘hands-on’ approach was welcomed by staff and local managers and the reports produced after each PIP have been used to continue the drive to sustain improvements in the Districts. SCS managers have agreed that there is a need for a PIP 2 in 2013 and agreement has been reached with the Regional Adviser of the Children’s Improvement Board that some of the funding available through that source will be used to contribute to its future implementation.

The specific focus of PIP 2 will be negotiated between each Area and the Safeguarding Unit to ensure the Programme addresses their requirements; there will also be room for a ‘lighter touch’ in those Districts where there is an evidence base to show they are moving forward quickly and successfully. In all cases PIP 2 will have a focus on Children in Need work and on management and supervision since we recognise these are our two overarching areas of vulnerability.

Deep Dives

Deep dives will be maintained throughout 2013 and will be informed by a richer set of data, bringing together: the (revised) scorecard; feedback from Conference Chairs and IROs; outcomes from file and themed audits; and the results of PIP 2 as it is rolled out.

It is increasingly clear that local managers have a much greater grip on the work of their teams, and that they are demonstrating a much greater sense of ownership of the outcomes for children. There is also strong evidence that local managers are aware of performance at a child-by-child level. The last round of Deep Dives clearly showed both improvements in performance and - perhaps more importantly - showed management teams in the new structure driving through changes and being able to relate work with individual children to the higher level data on the scorecards.

Andrew Ireland continues to Chair these performance surgeries and they are prioritised by both the Director of SCS and AD for Safeguarding. The Deep Dives are also an important communication channel with Area-based managers. Each Deep Dive is an important 'testing ground' to explore the extent to which services are moving from 'improvement to transformation'

**5. Service, KCC and Partner Changes**

5.1 The service is now increasingly looking to the future, building on the successful improvement work undertaken over the last two years. In particular, Phase 3 of the Improvement Plan is building on, and developing, the whole system approach to managing family pathways. It continues to focus on quality and sustainability, whilst embedding the efficiency and effectiveness of improved service provision into everyday working practice. The Plan also lays the foundations for cultural change. Senior officers from KCC's Education, Learning & Skill (ELS) directorate, Families & Social Care (FCS) and Communities and Customers (C&C) directorates have been working together to construct a transformational vision and strategic plan for all children and all services in the County. The "Every Day Matters" Strategy covers the whole range of provision from universal to the very specialist, and seeks to set out a set of fundamental changes that will improve outcomes for all.

5.2 Underneath - but connected to - this work is a strategy to transform social care practice in-line with the model set out in the Munro report. A Social Work Contract is being developed which will build on:

a. the recent structural changes

b. the improved stability of staffing

c. the major investments in ICS changes

d. substantial management and supervision training inputs

e. emerging improvements in practice

This Contract sets out a programme of change that will enable (and expect) practitioners to become more effective in their work with children and families, and to ensure that the necessary organisational and infrastructure changes are in place to support them in that work. This Contract will set out more explicit roles for the Principle Social Work posts (which will be recruited to in early 2013) and will form the basis for our response to the new flexibilities expected in the revised version of 'Working Together'.

5.3 This report has already described some of the emerging changes within the KSCB and it is clear that many of the improvements still needed in outcomes for children can only be delivered through improved partnership working - both at a strategic and operational level. "Every Day Matters" will ultimately require

multi-agency ownership if it is to deliver the transformational changes required. Equally, the improvements required for Children in Need will require the same kind of commitment and input from partner agencies as do those subject to a Child Protection Plan.

**6. Financial Implications**

£749K has been allocated to support the improvement programme in the 2013/14 financial year.

An additional grant of £70K has been sought from the Children's Improvement Board, to pay for further improvement works (e.g. the Phase 2 Practice Improvement Programme).

**7. Bold Steps for Kent and Policy Framework**

Improving Children's Services continues to be one of the Council's top priorities, following the Ofsted Inspection in August 2010.

**7. Legal Implications**

The Secretary of State has the power to issue a statutory intervention notice if he or she deems this is required to secure the necessary improvements within a failing service.

**8. Equality Impact Assessments**

There are no issues to report on this.

**9. Risk and Business Continuity Management**

A risk register has been established and maintained, and is reported regularly to the external Improvement Board.

Key strategic risks we need to mitigate against are:

- A failure to recruit and retain experienced social care staff and managers to KCC
- Numbers of Children in Care may continue to increase with impacts on staffing resources and outcomes for children
- That the capacity and skill set of the quality assurance and evaluation sub group is sufficient to meet the needs and demands of the KSCB
- Delay to the implementation of the new ICS system to the revised timescales, and/or related issues arising following implementation
- Untoward safeguarding incidents

**10. Consultation and Communication**

The programme will continue to communicate with staff, managers, KCC Members, the Children's Service Improvement Panel, KCSB and the External Improvement Board on improvement achievements and challenges.

## 11. Children in Care Inspection

Ofsted are currently constructing a new inspection regime, which will look at all services to Children in Care. The service is anticipating a Children in Care inspection later in 2013. As with the Safeguarding inspection, this inspection will focus on the quality of front-line practice and as such, inspectors will track the child's journey through social care provision. Staff are being asked to prepare for the forthcoming inspection accordingly.

As a consequence of the delay in the new inspection regime being implemented, Ofsted are continuing the inspection of adoption services under the current regime. At the time of publication of this report, Ofsted have informed the Adoption Service that will inspect the service from 18 to 22 March.

It is very much hoped that the findings of both the Adoption and Children in Care inspections will reflect the significant progress which has been made over the past 29 months, as has the recent inspection of our Safeguarding services.

## 12. Conclusion

The Peer Review and the Ofsted Inspection have been important milestones in Kent's journey of improvement since the 2010 inspection. They have both described the considerable progress made – and the amount of improvement still required. This report has set out in headline terms how that future improvement work will be delivered and progress on this work will form the basis of future reporting.

## Recommendations

Members are asked to NOTE this report.

Background Documents: None

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**From:** 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 – 21 March 2013

**Subject:** **Ofsted Inspection of Protection of Children**

**Classification:** Unrestricted

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**Summary:** Ofsted inspected Kent County Council's arrangements for the protection of children and reported in January 2013 that these were now adequate in all areas.

**Recommendation:** Members are asked to NOTE and COMMENT on Ofsted's inspection report.

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1. Following Ofsted's previous inspection in 2010 of Safeguarding and Looked After Children, the inspection regime has been changed. The new inspection regime for protection of children was introduced in April 2012 with the intention of raising standards.

2. Ofsted inspected the arrangement for the protection of children in Kent between 26 November and 5 December 2012. Ofsted's inspection report was published on the 15 Jan, and confirmed that arrangements in Kent are now adequate in all areas.

3. The ongoing work by Kent County Council and its' partners to build on this finding are set out in the separate, Children's Services Improvement Programme: Progress Report to the Cabinet Committee

**Recommendations**

4. Members are asked to NOTE and COMMENT on Ofsted's inspection report.

Andrew Ireland
Corporate Director for Families & Social Care
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Appendix 1: Inspection of local authority arrangements for the protection of children, Kent County Council

Background documents: none

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Ofsted
raising standards
improving lives

# Inspection of local authority arrangements for the protection of children

## Kent County Council

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**Inspection dates:** **26 November – 5 December 2012**
**Lead inspector** **Simon Rushall**

**Age group:** All

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# Inspection of local authority arrangements for the protection of children

## The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

| | |
|---|---|
| Outstanding | a service that significantly exceeds minimum requirements |
| Good | a service that exceeds minimum requirements |
| Adequate | a service that meets minimum requirements |
| Inadequate | a service that does not meet minimum requirements |

## Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Kent County Council is judged to be **adequate**.

## Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Kent, the local authority and its partners should take the following action.

**Immediately:**

- audit child in need cases to ensure that purposeful work is taking place and there are no unidentified risks
- the Kent Safeguarding Children Board should ensure that the audit that was underway at the time of the inspection under section 11 of the Children Act (2004) is completed, analysed robustly and used to support improvements.

**Within three months:**

- ensure that all child in need cases have an up to date assessment of need and a plan which addresses identified needs and contains specific and measurable objectives with timescales
- ensure that children removed from child protection plans are provided effective continuing support that addresses identified needs and that these are formulated within a specific and measurable child in need plan with clear contingency arrangements
- review the current approach to conducting child protection conferences so that they are not unduly long for parents and that

they enable the full contribution to risk assessment and planning of all participants

- clarify decision-making processes within the central duty team (CDT) to eliminate the scope for confusion and duplication that currently exists.

- take action to improve the quality of assessments and plans carried out under the common assessment framework (CAF) so that interventions are focused on achieving specific and measurable objectives

- take action to improve the quality of supervision and management oversight and direction in casework.

**Within six months:**

- ensure that children in need referrals requiring assessment are promptly transferred from the CDT to the family support teams as soon as there is sufficient information to determine that an assessment is required

- ensure that partner agencies understand and carry out their shared responsibilities for supporting children in need and their families.

# About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI) and a Seconded Inspector.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

# Service information

9. Kent has approximately 323,000 children and young people under the age of 18 years. This is 22% of the total population. Some 17% of those under 18 are living in poverty. The proportion of children and young people entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for 9.4% of the total population, compared with 16.3% in the country as a whole. The proportion of pupils with English as an additional language (10%) is below the national figure of 16%. Kent's population is largely of white ethnic origin, with approximately 6.3% estimated to be of minority ethnic origin. The largest minority ethnic group is formed by people of Indian origin at about 1.5% of the total population. In addition there are significant local populations of Roma people of East European origin.

10. The council and its partners have refocused the arrangements for providing early help to children, young people and families. This is now delivered through 97 children's centres and a very recently commissioned range of services delivered largely by private and voluntary sector organisations. These include family advice workers, an intensive family support service, intensive adolescent support, the healthy minds project and a domestic abuse service to support children. A recent reorganisation has brought together the coordination of early help and children's social care services under common management structures in order to improve responsiveness.

11. Initial contacts with children's social care services are managed by the council's central duty team (CDT) which is located within the multi-agency contact and referral unit (CRU). Those children identified as requiring further social care assessment are transferred to a locally based assessment and intervention team (AIT). Children who need a period of continuing social work intervention, for example through a child protection or child in need plan, subsequently transfer to a family support team. An emergency duty team, located in the CRU, responds to children and young people who require support or protection out of normal office hours.

## Overall effectiveness

12. The overall effectiveness of arrangements to protect children in Kent is judged to be adequate. Senior leaders within the council, supported by strong and well-informed political leadership, have delivered a significantly improved response at the point of referral to children's social care services

from an earlier low baseline. In consequence, children who are at risk of harm are protected by effective initial screening and prompt subsequent action by the council and police services. Children are almost always seen and seen alone in child protection investigations and both initial and core assessments. A workforce development strategy has reduced vacancy rates through a range of initiatives including overseas recruitment and a 'grow our own' policy. While there remain significant difficulties in recruiting suitably qualified and experienced staff to some posts and some areas, the council has adopted an appropriately determined stance, preferring to employ good locum staff rather than appointing weak candidates to permanent posts. It has also taken a robust stance on poorly performing staff, a number of whom have now moved on from their posts. Children requiring protection receive a more assured initial response than previously, with risk identified in a timely and effective way. However, child protection planning and review need further improvement. Children on child protection plans are seen and seen alone, but plans too often lack specific and measurable improvement goals. This leads to unfocused interventions and makes progress hard to evidence. A significant number of child protection plans end after three to six months before improvements are seen to be embedded and sustainable. No children were seen to be exposed to immediate risk as a result but remaining welfare needs are not always fully mitigated by effective step-down planning and intervention and there is a high rate of children experiencing repeat child protection plans.

13. A recently introduced new approach to conducting child protection conferences aims at improving the extent to which parents, children and young people contribute to and influence their own plans. The council's own survey suggests some success, with parents and children reporting that they understand the reason for the concerns and have helped shape plans. However, a small number of conferences seen by inspectors were excessively long and did not consider sufficiently the views of the full range of professionals in evaluating risk.

14. Planning for children in need is weak, characterised by superficial assessments and a lack of specific and measurable objectives and contingency plans. This means that too often interventions lack focus and there is drift and delay. Inspectors saw child in need cases where visits were not made, children were not seen for long periods and reviews were not held in a timely way.

15. There has been a recent reconfiguration of early help services. A range of services has been commissioned and council early intervention teams including common assessment framework (CAF) coordinators are now located within the same management structures as children's social care services. This has improved the accessibility and responsiveness of help and is leading to improvements in communications between agencies, the coordination of help and the use of the CAF to identify and respond to

need. However, there are still weaknesses in the quality of too many CAFs which often lack effective analysis and objective-setting.

16. The council has a good understanding of its strengths and areas for improvement. It has used the improvement plan that followed the notice to improve issued in 2010 to prioritise and focus improvement activities. It has a comprehensive approach to gathering and analysing performance data and has used this to drive improvements, for example in the timeliness of assessments. It has also conducted a wide range of practice audits, for example of child protection enquiries that do not progress to initial child protection conferences. However, the overall programme of audits is unfocused and not clearly guided by any overarching priority framework, and there is only very limited evidence that their findings are used systematically to drive progress. Complaints are analysed in detail and discussed in the annual report, with lessons learnt explicitly identified.

17. Kent Safeguarding Children Board (KSCB) has historically been weak and has not secured sufficient commitment from some partner agencies in key aspects of its business. These include the failure of some agencies to complete individual management reviews in serious case reviews, which has compromised the partnership's capacity to learn and respond to lessons that arise from them. While recent improvements are in evidence, such as stronger challenge to partners over their level of engagement and the fact that KSCB is now meeting its obligations under statutory guidance, it is not yet fully effective. For example, it has not yet completed a recent audit of partner agencies' safeguarding measures.

## The effectiveness of the help and protection provided to children, young people, families and carers

### Adequate

18. The effectiveness of the help and protection provided is adequate. During the inspection no children were identified who were left at risk of, or suffering from, significant harm as a result of systemic weaknesses in management or action.

19. The establishment in May 2012 of a multi-agency CRU that includes the children's social care CDT has improved communication and information sharing. As a result, responses and decision-making for new contacts and referrals are now sounder and more consistent than previously. Strategy discussions in most cases are timely with the involvement of relevant partner agencies and effective decision-making and action planning. This leads, where necessary, to prompt child protection enquiries and means that children referred with child protection concerns now receive an assured response.

20. A well-established out of hours service that provides emergency intervention is located within the CRU. This enables prompt communication and information sharing with day services and immediate access to the children's electronic case records. Staff schedules overlap with day time services which facilitates effective information sharing between them.

21. In some cases where children do not meet the threshold for a child protection response, inspectors saw unnecessary delay in the CDT in reaching decisions about whether further assessment was needed. This means that children in need of help short of protection can experience delays in transfer to the assessment and intervention teams and in the provision of services to meet their needs. The CDT is still in development and has yet to be fully embedded. Systems for management oversight of cases lack clarity, and in some cases several senior practitioners or managers are involved in case direction or oversight of the same case and this is confusing and contributes to delay.

22. The KSCB has recently introduced new processes for conducting child protection conferences and core groups and report that partner agencies feel that this has improved information exchange and the involvement of parents. The new structures for conducting child protection conferences were informed by consultation with parents and have brought an increased focus on their active involvement. The council's own surveys suggest that parents say they have been able to influence their child protection plans and know what needs to change. However, child protection conferences observed by inspectors were not effectively managed or focused and were repetitive. They were longer than the circumstances of the cases required and did not sufficiently engage all professionals present. As a result, child protection plans were not drawn up in a way that reflects analysis of a full range of views and they lacked specific and measurable goals.

23. Inspectors examined a number of cases where child protection plans had recently ended. While no children were left at risk as a result of the plans ending, in some cases there was a lack of analysis of risk in conference reports and minutes and in consequence the rationale for concluding that reductions in risk were embedded and sustainable was not always clear. This was particularly evident in some cases where child protection plans had been in place for a long period. In almost all cases seen where a child protection plan ended, subsequent child in need plans were not sufficiently specific and measurable and did not always address the continuing needs identified at the final conference. Contingency plans were superficial and formulaic, for example simply indicating that a further conference should be considered if new concerns arose. These weaknesses are evident in the rate of children being made the subject of repeat child protection plans. According to the council's own data, this has increased in a year from 14.7% in September 2011 to 26.2% in

September 2012, which is considerably higher than comparable authorities.

24. Interventions aimed at protecting and supporting children on child protection plans are proportionate and sufficient to reduce risks identified. Agencies work together appropriately to provide support to children and families subject to child protection plans. However, their effectiveness is reduced by a lack of specific and measurable goals. Parents told inspectors that recent improvements in the services they receive mean they now feel well supported by their social workers.

25. Interventions and support for children on child in need plans are not as effectively supported. A significant number of such cases seen by inspectors lacked coherent child-focused assessments and clear planning and this led to drift and delay in achieving desired outcomes for the welfare and support of children. In a small number of open child in need cases seen by inspectors, a lack of rigour in intervention, re-assessment and review meant that emerging problems of neglect were not identified as potential child protection concerns early enough. As a result, children continued to live in potentially harmful environments for too long.

26. A range of new early help services has been commissioned very recently. Early intervention teams have been established in each of the 12 districts in September 2012 and each team has early intervention workers who act as CAF lead professionals and deliver parenting programmes. CAF coordinators have been placed within each of the teams and have regular contact with CAF coordinators located within the CRU and this ensures prompt notification and tracking of cases where a CAF is required.

27. The restructuring of early intervention has led to some improvements in the way the CAF is used to identify the needs of children and families. Emerging evidence of the impact of the re-structuring indicates that the quality of services is beginning to improve. Staff told inspectors that there is now clarity about roles and responsibilities, communication with children’s social care is better and there is increasing understanding about the CAF. Parents spoken to by inspectors were positive about the early help they have received and the use of the CAF to identify their needs. They felt that they had been promptly referred to a range of services which met their needs. Young parents told inspectors that they are provided with access to a range of valued services through the Young Able Parents early intervention programme and that this has helped to improve their parenting skills. Staff in this service are readily available to give support and advice and signpost them to other services. However, the quality of CAFs seen during the inspection is only just adequate overall. Many lack depth and pay insufficient attention to identifying strengths and needs. As a result, priorities and action plans are not specific enough about desired outcomes and how and when they should be achieved. The

council and KSCB are aware of these weaknesses and they are being tackled, but substantial further work is needed.

28. The council and its partners have recognised the need to meet the needs of an increasingly diverse population. Where required, appropriate use is made of interpreters and key documents are translated into the user's first language. Appropriate steps have been taken to ensure that the Equality Act 2010 is met. There is a range of support for different minority ethnic groups. For example, targeting has led to increased access to early help among groups from Traveller and Eastern European communities, with an increase in one year from 500 to 3000 families from minority ethnic groups taking up early help services in one part of the county. In children's social care and CAF assessments, basic information about diversity, including ethnicity, disability and communication needs, is routinely recorded. In some cases there is sensitive assessment and intervention that reflects and responds to diversity factors. However, this was not the norm and in most cases, needs in relation to culture and ethnicity were superficially considered and not addressed adequately in planning and interventions.

## The quality of practice

29. The quality of practice is adequate. Clear written thresholds for referral are in place and screening at the central referral unit ensures that the right children are getting services. Decision making at this stage is consistent and there are examples of effective and systematic multi agency processes, which safeguard and protect children at risk of significant harm. Transfer to assessment and intervention teams (AIT) works well. The timeliness of initial and core assessments has improved, and all children in child protection processes have an allocated social worker. Children in need services are insufficiently developed to ensure effective action in all cases and the council has recognised this though remedial action is not yet fully implemented. Early help services are not yet fully embedded but are beginning to show an impact for children whose needs can be met by the common assessment framework (CAF) process.

30. The route to escalate cases from the CAF is effectively applied in most cases, and where there are child protection concerns these are recognised and addressed. Professionals are able to consult with qualified social workers to discuss and consider whether to make a referral. In most cases partner agencies communicate and exchange information or concerns appropriately and have established close working relationships. However a small number of examples were seen where partner agencies did not take prompt and appropriate action in response to potential risk to children. These included a delay of two weeks in the referral of domestic abuse where there were young children in the household; and the failure by acute health services to refer a very young child with suspicious injuries.

Children's social care services took appropriate action once they were made aware of these cases.

31. All new referrals are dealt with promptly by the CDT. New contacts, including re-referrals, are screened and appropriately addressed or redirected with a minimum of delay in most cases. Domestic abuse referrals are initially screened by the police, and where they are high priority they are immediately addressed. However, some domestic abuse cases were seen where there had been a delay in their being passed to the CDT for action. In some child in need work, inspectors saw delays in engaging both adult and children's mental health services where these services were needed.

32. Managers and staff understand the need to focus on children and young people, to ensure that interventions are timely, effective and avoid drift. The extent to which children and families understand the role of social workers is not routinely evident from the case records, but in some offices information packs for families are provided. In almost all initial assessments and child protection cases children and young people are seen and seen alone and their wishes and feelings are considered and reflected in casework. In child in need cases the picture is more mixed. There are some examples of direct work where effective relationships have been developed which have influenced the child's plan. However inspectors have seen cases in which the level of engagement with children and young people was less robust. Some examples of child in need cases were reviewed where children and young people had not been seen by social workers for several months. While children were not exposed to risk of significant harm in these cases, their welfare needs were not fully assessed and met. Overall the quality and effectiveness of assessments and interventions to support children and to minimise risk is too variable, and the quality of practice is just adequate.

33. Social workers regularly and appropriately seek advice and guidance from managers and seniors, who are visible and accessible to staff. In some cases managers chair child in need meetings and core groups. Decisions made by managers are regularly recorded on case files. However managers' effectiveness in driving forward casework by monitoring action taken and progress made is too variable. Inspectors saw cases where weak planning and a lack of rigour in management oversight led to drift and delay in meeting the welfare needs of children in need.

34. Most supervision records show evidence of monthly meetings. Although some contained a staff appraisal on file, these were limited and there is little evidence of how the professional development needs of staff are being met. Most supervision records seen are brief, with little evidence of reflective discussion and challenge and little rationale for decisions made, though a minority of records were good and did include these elements. Children's files do include supervision discussions and decisions and some

of these include a rationale for decisions. There is evidence of formal quality assurance feedback from child protection conference chairs on some supervision files and these are discussed with staff to inform professional development.

35. Enquiries made under section 47 of the Children Act 1989 are undertaken by suitably qualified social workers. Background checks are carried out and in most cases assessments and outcomes of enquiries clearly recorded. In the CDT, findings and actions from initial strategy discussions are clear. However while child protection enquiries are triggered effectively in new cases referred via the CDT, emerging child protection concerns in open child in need cases do not always receive a sufficiently prompt response.

36. Most core assessments identify risk and protective factors and reflect relevant historical information about children and families. Some demonstrate effective analysis to inform future planning but too many do not explicitly identify the actual or potential impact on children of the relevant risk factors. Reports for child protection conferences also reflect a tendency to list risks rather than analyse or weigh them. In most cases, social workers share their reports with families in advance of the child protection conference. A majority of CAF assessments are timely, and families understand the reasons for agency involvement but not all assessments identify clear priorities. This has a detrimental effect on the planning process, with outcomes not always spelt out sufficiently clearly and progress measures often ill-defined.

37. Most child protection and child in need plans seen by inspectors are too general and are insufficiently explicit about how the actions will reduce risk and improve outcomes for children. Few include timescales for improvement. Actions are not often prioritised or differentiated. Too many child in need plans in particular are poorly formulated, and some are not routinely reviewed, leaving children without purposeful involvement to meet their assessed needs.

38. The electronic social care record has been improved over the past year, enabling social workers to identify quickly relevant records and have access to key decisions made. However significant limitations remain and this results in social workers keeping documents on parallel files. This is being addressed by the council, which has procured and is due to launch a new electronic social care system in May 2013.

39. Case recording on child protection files is generally up to date, although the rationale for decisions is not always clearly identified on case records. In many cases seen the purpose of the work in relation to plans is not clear. On child in need cases, plans and meeting records are not stored on children's electronic files, making it more difficult for managers to audit and assure the quality of the work. The quality of chronologies is variable.

Although the transfer protocol requires every case to have a chronology at the point of transfer, some are too detailed to be of value. The council has recognised this and action is being taken, but it is too early to see significant impact.

40. In the majority of cases reviewed, multi-agency conferences, strategy meetings and core groups include a range of professional participants. Records of these meetings show that while risks and protective factors are identified sufficiently to lead to appropriate decision-making, they are not always fully evaluated to assist planning. This reduces the quality of child protection plans. Compliance with child protection plans is monitored, but it is not clear how outcomes for children are changed or improved. In one core group observation, there was insufficient challenge to parents and professional agencies to address the lack of improvement in meeting the objectives of the plan. Agencies were not held to account, and this lack of transparency presented a confusing message to the parents. Some children and young people attend their child protection conferences, though this is a small minority of cases. Although good examples were seen of the use of advocates to support children with disabilities in attending their conferences, advocacy services are not yet routinely available. The council has very recently recognised this and is beginning to take action to remedy this weakness.

## Leadership and governance

### Adequate

41. The judgment for leadership and governance is adequate. Elected members and senior managers have consistently given a high level of strategic priority to protecting and improving services to Kent's most vulnerable children. Following judgments of inadequate in a safeguarding and looked after children inspection in October 2010, Kent was given a notice to improve in March 2011. The council has taken an appropriate phased and prioritised approach to the improvement task. In the first 12 months up till October 2011 remedial work focused on successfully clearing the backlog of unallocated and incomplete assessments. A development programme was introduced to bring control over referral levels and workflow. Work to reduce high caseloads was initiated along with a programme of auditing to develop an understanding of strengths and deficits in casework practice. The council also launched its workforce strategy to deal with high staff turnover and identified weaknesses in the capability of some staff.

42. A second, consolidation, phase followed between October 2011 and August 2012 and was marked by the appointment of a new Director of Children's Services and two reorganisations to develop clearer lines of accountability and responsiveness. This included the establishment of the

CRU as a multi-agency single point of access, and within it, the CRT as well as in-house early intervention teams. An early intervention strategy was launched including a quality assurance framework as well as further work to improve the CAF process through a rolling programme of training. There has been significant investment in early help services. Similarly, and because of an unsatisfactory child and adolescent mental health service (CAMHS), robust action was taken to terminate the existing contract and re-let the contract. The new range of CAMHS provision started in September 2012 and is now becoming established. A new electronic social care record system has been procured to replace the current inefficient system and is due to be launched in May 2013. During this phase there have been significant performance improvements around the responsiveness to initial referrals as well as child protection enquiries. However, the council acknowledges that the pace of improvement and prioritisation in the consistent application of appropriate thresholds, assessment, planning, multi-agency engagement and supervision for children in need remains insufficient.

43. The council has a range of strategies and initiatives to improve services and help and protect children. These include the Practice Improvement Programme (PIP) which has used performance and audit data to identify areas for improvement and has focused on raising supervision, increasing consistency in the quality of practice and improving managerial oversight and leadership across the county. The council has achieved a high level of awareness of this programme among first line managers and practitioners as well as a strong commitment to it. While this has contributed to clear improvements in important aspects of services, the council itself acknowledges that much work remains to be done. The council's governance structure has recently changed with the removal of the Chief Executive role. However, there are clear accountabilities and responsibilities between the KSCB, the Children's Joint Commissioning Board, the Improvement Board, the Lead Member for children's services and the Council Leader.

44. The KSCB largely meets its statutory responsibilities and has established a generally adequate business and training plan although it is not as yet clearly able to demonstrate the impact of its work. KSCB members acknowledge that it has delivered insufficient challenge, due in part to a longstanding variation in the commitment of partner agencies to the importance of the Board's work. The Board has only recently commenced a section 11 audit which was scheduled for completion shortly after the end of the inspection. There is duplication and confusion between the roles of various sub groups and task and finish groups.

45. Performance management information is routinely collated and analysed at all levels. A scorecard of key performance data is effectively scrutinised and reported to senior managers, the KSCB and council members. Performance scorecards indicate wide variations for some indicators

between the best and worst performing districts. One example of this is the high level of children who are subject to a child protection plan for a second or subsequent time. The council acknowledges that some child in need planning for those removed from child protection plans was not sufficiently outcome focused and has taken steps to improve this. It recognises that although there has been a high level of qualitative auditing, this has not always been well focused with clear pathways from lessons learnt to action. Work has very recently begun to develop a more effective model with a clearer improvement focus.

46. Senior and middle managers have been largely effective in ensuring robust oversight and tackling weaknesses in child protection practice and systemic barriers to improvement. For example a number of staff have been subject to formal performance and capability measures and a significant number have moved out of the service when they have not met required standards. However, the consistency and quality of work remains a significant issue and the council accepts that much more in particular is required to be done to improve the quality of assessment, planning and provision for children in need.

47. Some analysis has taken place of user feedback on services provided. An externally commissioned survey of staff engagement in March 2012 which sampled 67% of staff in children's social care services found the majority of staff felt enabled and supported with high job satisfaction scores but that only 44% felt confident in senior management. However, the inspection found consistently good morale among social workers, based on confidence that managers understand the front line and have introduced safer systems of casework management. Social workers report that formal supervision occurs regularly and newly qualified social workers report positively on the support and protection they receive in their first year. Despite this the inspection has found significant inconsistency in the quality and recording of supervision. The council recognises this and has already started to deliver a programme of reflective supervision training which will be concluded for all relevant managers by mid-2013.

48. There is some evidence in reports of an active approach to seeking the views of children, young people and parents about child protection and early help services. Changes made reflect to some extent the views obtained, for example a report format for parents to present their views to meetings is now in use. Feedback suggests some progress in ensuring parents are clearer about what needs to change in child protection cases, although casework examined during the inspection shows this is limited. It also suggests that most children and young people feel that child protection conference chairs help them express their views and that social workers explain to them why people are concerned. Staff report that they have opportunities to express their views about the improvement agenda.

49. There is evidence of the use of a range of sources to create an active learning environment. This is particularly evident in the council's commissioning of a peer review in September 2012 and acceptance of its findings as well as the consideration and review of information from complaints. However, the inspection has not found evidence that learning from serious case reviews or research is established in casework practice.

50. Workforce planning is adequate. Kent has some significant and difficult challenges in relation to workforce development. It has reduced its social worker vacancy levels and pursues a 'grow your own' policy as well as recruiting social workers from abroad. There remains variation in the balance between experienced and less experienced workers in teams across the county. There are also specific recruitment problems related to some geographical locations. The council has invested in ensuring the recruitment of good quality staff with additional pay incentives in place to address particular staff shortages, and has also deployed staff in a flexible manner to cover gaps. There remain key first line manager and social worker posts that are not filled by permanent staff. However, the council does not compromise on the calibre of staff and retains good quality locum staff rather than appoint social workers who do not met the required standard. In some cases, supernumerary locum staff have been engaged to help respond to peaks of demand. As a result of these activities, social workers' caseloads are maintained at a manageable level.

# Record of main findings

| **Local authority arrangements for the protection of children** | |
|---|---|
| Overall effectiveness | Adequate |
| The effectiveness of the help and protection provided to children, young people, families and carers | Adequate |
| The quality of practice | Adequate |
| Leadership and governance | Adequate |

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| | |
|---|---|
| By: | Jenny Whittle, Cabinet Member for Specialist Children's Services<br>Andrew Ireland, Corporate Director, Families and Social Care |
| To: | Social Care and Public Health Cabinet Committee – 21 March 2013 |
| Subject: | **Update on the Children & Young People's Mental Health Service (CAMHS)** |
| Classification: | Unrestricted |

Summary: The purpose of this report is to inform and update Members about the implementation and progress of the new Community Children and Young People's Mental Health Service (CAMHS).

## 1. Introduction

1.1 At the previous meeting on 11 January 2013, Members expressed concern that there is a substantial waiting list for the Community Children and Young People's Mental Health Service (CAMHS) and requested a further update on progress made since the start of the current contract on 1 September 2012, with the new provider Sussex Partnership NHS Foundation Trust (SPFT)

1.2 Lorraine Reid, the Chief Operating Officer and Simone Button, Service Director for the SPFT will attend the meeting to answer members' questions about the how the service is progressing and to provide the latest figures on waiting times. This report provides a brief background and update along with the revised action plan.

## 2. Background

2.1 On 1 September 2012 following a procurement process, SPFT commenced delivery of the CAMHS, with NHS Kent and Medway PCT as lead commissioner. KCC commissioned the Emotional Health and Well-being Service which commenced on the 3rd September 2012 (Young Healthy Minds). Each element of the service has been aligned to ensure clear pathways for children and young people between the different tiers of need.

2.2 Following the establishment of the Early Intervention and Prevention (EIP) Framework there is now a range of early intervention services to meet the emotional health and well-being needs of children and young people. An early intervention Emotional Health and Well-being Service is provided by consortia under the umbrella of Young Healthy Minds (YHM)[1]. Access to this service is via the Common Assessment Framework (CAF). YHM engage individual children and young people who are experiencing, or at risk of experiencing, low-level emotional difficulties and will offer time-limited group or 1-1support.

[1] Kent Children's Fund Network, Family Action, CXK, Stepahead support

## 3. Progress since contract implementation

3.1 Since the 1 September 2012, SPFT have been actively engaged in a mobilisation process to introduce and embed the new service model called 'Right from the Start', which will deliver high quality, easily accessible and timely support and interventions consistently across Kent and Medway.

3.2 This mobilisation process has included:

- The TUPE of 287 staff from the 6 previous organisations providing CAMHS in Kent,
- Embedding strong governance with clear and effective interim management and professional leadership structures,
- A staff consultation process to enable the introduction of the new management and governance structures, appropriate skill mix and deployment of staff resource across Kent and Medway,
- The development of strong partnership working with a range of stakeholders in particular including the providers of Emotional Wellbeing services (KCC), CAMHS Tier 4 (inpatient services), Adult Mental Health providers as well as children, young people and their families,
- The establishment of an out of hours service so that all children, young people and families presenting in crisis out of hours are responded to,
- A newsletter, which will be distributed monthly, sent to GPs and other professionals and information in the schools bulletin.

## 4. Key operational issues

4.1 At the point of the new contract commencing in September 2012, there were significant numbers of children and young people on lists waiting to receive a service. This was a particular issue in west Kent. In total 1,688 children and young people were waiting for a CAMH service at October 2012.

4.2 At December 2012, the CAMH service was working with 6,814 cases. SPFT have triaged all children and young people on the waiting list and 389 cases have been assessed as appropriate for the YHM service to meet their emotional health and wellbeing needs.

4.3 In west Kent the average waiting times for routine referrals have been reduced from 24 to 22 weeks and in east Kent from 7.5 to 2.4 weeks. The discrepancy between east and west largely lies within the fact that the historic level of staff was low compared to demand and the service provider has been unable to move staff around to meet demand until after staff consultation and restructuring of the service is completed.

4.4 SPFT confirm that the waiting times for assessment and first appointment across Kent will be reduced to 4 – 6 weeks by July 2013. Further recruitment of staff could see this achieved by April 2013. See trajectory attached in appendix 1.

4.5 An action plan (see Appendix 1) to address the waiting lists has been put in place and includes the following:

- Identify a staff team of 10 from other parts of the service to target teams with waiting list pressures,
- A new discharge checklist added to all team meetings to ensure proactive discharge of cases where appropriate,
- Weekend and evening assessment clinics established ,
- Introduction of new assessment paperwork created by SPFT to speed up the assessment process,
- Staff to consider necessity of attendance at all meetings and avoid duplicate attendance,
- East Sussex staff approached regarding additional working hours,
- Clinics to be closed one week in February and one week in March for all but emergency appointments so whole teams can focus on assessments.

**5. Children in Care**

5.1 The current Children in Care (CIC) element of the service is the Adolescent and Children in Care Emotional Needs team (ACCENT), which is only providing a service to 7% of CIC. SPFT has reviewed this service and proposed a new model that will reach 30% of Kent's CIC at any one time. The CAMH service will be for Children in Care and Adopted Children providing a range of evidence-based mental health clinical interventions, as well as support, consultation, training and in-reach to social care.

5.2 Consultation with staff in the current CIC service commenced on 20.2.13. The new model will be in place on 1.4.13. There is a fast track process in place to ensure that CIC referred to the service are prioritised.

5.3 At January 2013 SPFT were working with 237 CIC across Kent and Medway. (Medway figures are being disaggregated).

**6. Recommendation**

Members are asked to NOTE the contents of the report.

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*Background Documents:* CAMHS Update to Social Care and Public Health Cabinet Committee, 11 January 2013

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Sussex Partnership NHS
NHS Foundation Trust

# Waiting List Action Plan

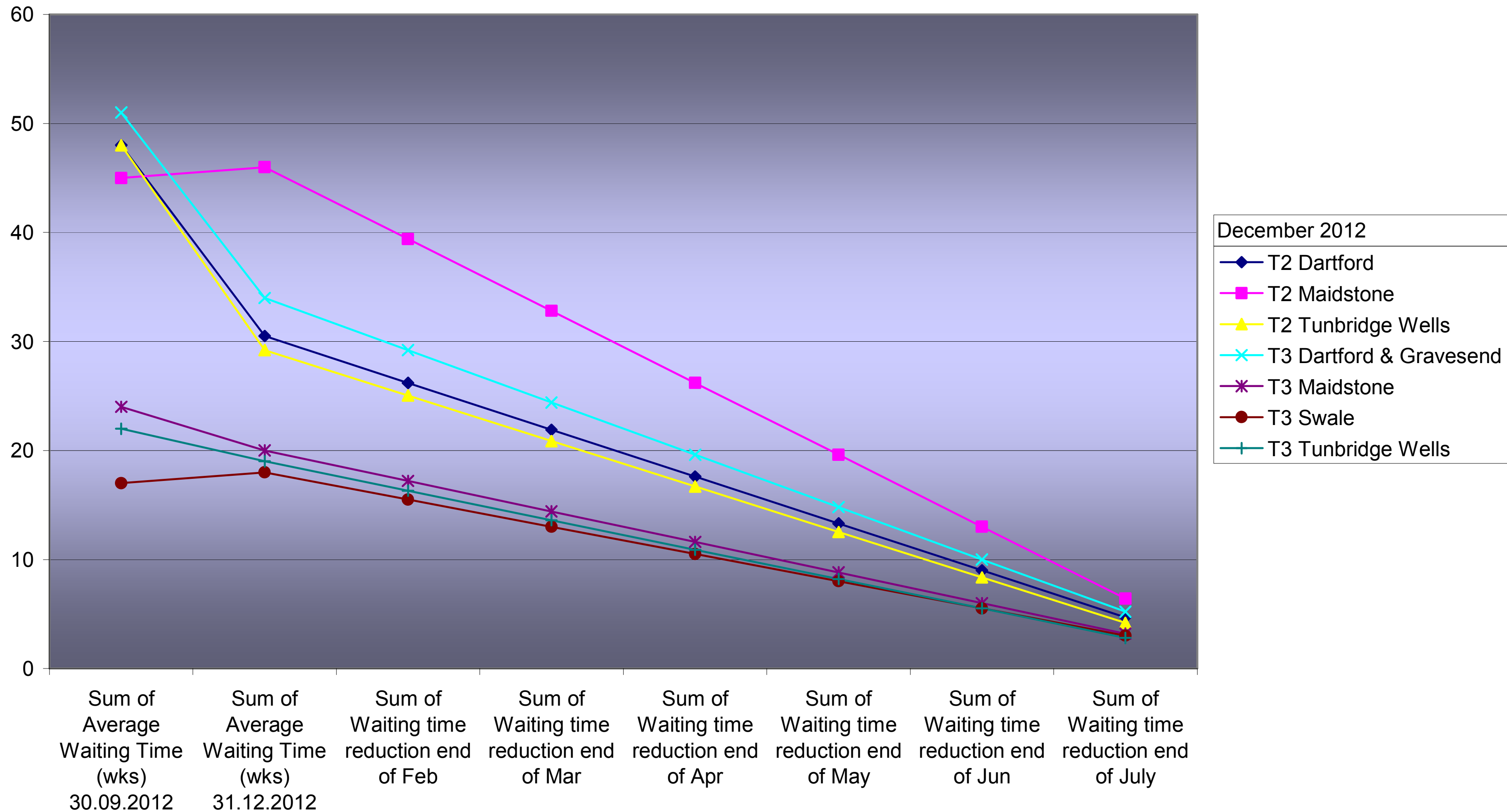
| Action | Milestones | Lead | Target date | Achieved/ update comment |
|---|---|---|---|---|
| All teams to have a standard approach to acceptance of referrals | New referral criteria circulated to all teams and used for screening referrals | Peter Joyce/ Managers | October 2012 | achieved |
| Achieve clarity regarding real numbers of families waiting for a service | All families waiting for longer than 3 months contacted | Managers | October 2012 | achieved |
| Increase staff capacity and recruitment to vacancies to focus on waiting lists whilst ensuring this does not disadvantage KM staff ahead of outcome from consultation process | • Recruit to clinical bank<br>• Recruit to vacancies – largely through fixed term contracts | Managers | End October 2012 | 11 staff recruited to bank but includes work on OOH service<br><br>Only partial achievement leading to difficulties meeting set waiting time trajectory |
| Joint working with other agencies to support appropriate referral allocation and build relationships | • Active attendance of local SPA meetings<br>• Establish single point of access/ CAP in each referral base (coterminous with hubs when in place)<br>• Establish regular practice forums between wider tier 2 and tier 3 | Clinical leads/ local managers | End November<br><br>End November | Achieved<br><br>CAPs in Thanet; C'bury; F'stone; Dover; Maidstone (for T/Wells and M'stone)<br>Further work required to further support SPA in Medway |

| | | | | |
|---|---|---|---|---|
| Ensure good caseload management systems in place to encourage throughput and increase capacity | • Robust and audited Clinical and management supervision to evaluate content and size of caseload and ensure cases where appropriate are discharged and closed<br>• Audit to identify reduction in service caseload | Clinical leads/ managers<br><br>Interim business manager – AK-L | November | ongoing<br><br>audit showed reduction from 8,603 to 6,814. |
| Monitoring systems in place | • Action plan formally monitored through leadership meeting monthly and management meetings fortnightly<br>• Performance report discussed with commissioners monthly in performance contract meeting | KMLT<br><br>AK-L/ SB | Monthly<br><br>monthly | Ongoing<br><br>ongoing |
| Introduction of CAPA to all teams | • Team based training on CAPA<br>• Implement team action plan for CAPA including individual and team job plans<br>• All staff to complete a skills audit | PJ<br><br>PJ<br><br>SB | April 2013<br><br>April 2013<br><br>Dec 2012 | Cannot be fully actioned until correct staffing skill mix in place<br><br>Achieved as part of staff consultation exercise regarding skill mix |
| Implement additional actions to create capacity to enable waiting list reduction. **NB This action is a consequence of slower progress than had been anticipated on w/list reduction in West** | • Identify staff from other parts of service to work some hours in teams with w/list pressures<br>• New discharge checklist added to all team meetings to ensure proactive discharge of cases where appropriate<br>• Calculation of number of | PJ/ PH<br><br>PJ/ PH | Jan 2013<br><br>Jan 2013 | A minimum of 10 additional staff identified as well as some capacity from OOH staff<br><br>**NB these actions will** |

| | | | | |
|---|---|---|---|---|
| | assessment and treatment appointments needed to clear waiting list to provide trajectory<br>• Weekend and evening assessment clinics established<br>• Introduction of new assessment paperwork created by SPFT to speed up the assessment process<br>• Staff to consider necessity of attendance at all meetings and avoid duplicate attendance<br>• East Sussex staff approached regarding additional working hours<br>• Clinics to be closed one week in Feb and one week in March for all but emergency appointments so whole teams can focus on assessments | PJ<br><br>PJ/<br>Managers<br><br>PJ<br><br>Managers/<br>clinical leads<br><br>PJ | Jan 2013/<br>ongoing<br><br>Jan 2013<br><br>Ongoing<br><br>Jan 2013 | **deliver a waiting list of no greater than 4-6 weeks by end July 2013.**<br><br>**Should the service be able to recruit a further 5 wte then this reduction can be achieved by April 2013.** |

# Trajectory of Recovery

## 6 month trajectory of average assessment waiting time reduction for Kent

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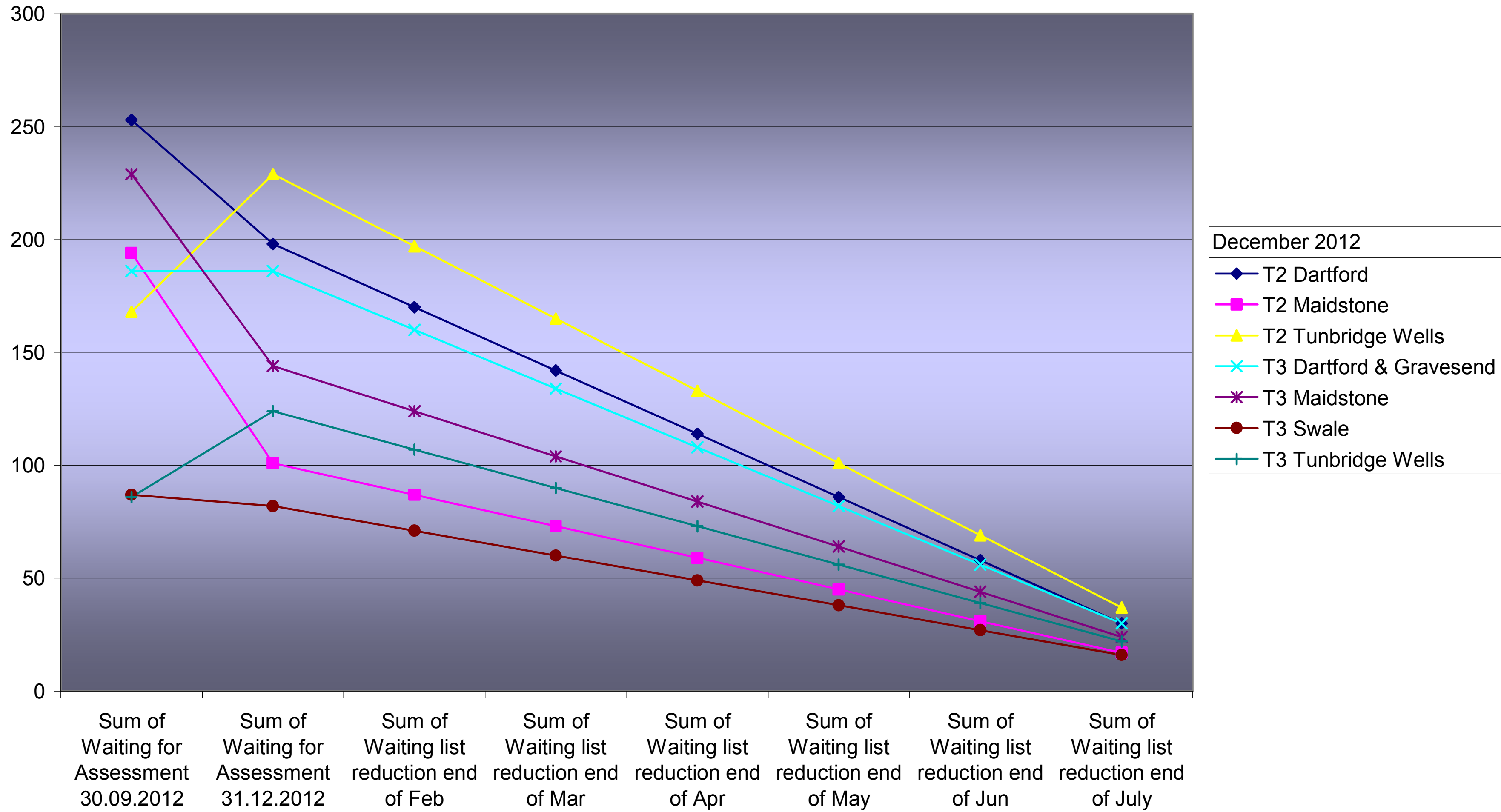
# Trajectory of Recovery

## 6 month trajectory of assessment waiting list totals reduction for Kent



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**From:** Graham Gibbens, Cabinet Member for Adult Social Care & Public Health
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 – 21 March 2013

**Subject:** Families and Social Care Performance Dashboard for January 2013

**Classification:** Unrestricted

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

**Recommendation:** Members are asked to REVIEW the Families & Social Care performance dashboard.

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**Introduction**

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**

3. There are two main elements of the Report which members are asked to consider:

   - The Children's Social Care dashboard report found at **Appendix A**
   - The Adult's Social Care dashboard report found at **Appendix B.**

4. In particular members are asked to note that both dashboards are used within the Directorate. The children's dashboard is used to support the Improvement Board, and the adult's dashboard is in a transition phase, and will be amended in line with the priorities and objectives of the transformation programme in the next few months.

5. A subset of these indicators is used within the quarterly performance report, which is submitted to Cabinet.

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

**Performance dashboard**

7. The draft Families and Social Care performance dashboards includes latest available results for the key performance and activity indicators.

8. 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 may evolve for Adults Social Care as the transformation programme is shaped. 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.

9. Where frequent data is available for indicators the results in the dashboard are shown either with the latest available month (in most cases January) and a year to date figure, or where appropriate as a rolling 12 month figure.

10. 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.

11. It should be noted that for some indicators where improvement is expected to be delivered steadily over the course of the year, this has been reflected in phased targets. Year End Targets are shown in the dashboards but full details of the phasing of targets can be found in the Cabinet approved business plans.

**Recommendations**

12. Members are asked to:
    REVIEW the Families & Social Care performance dashboards

**Contact Information**

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Background documents: none

# Scorecard - Kent, inc UASC

**Jan 2013**

| Indicators | Polarity | Data Period | LATEST RESULT | | | | | PREVIOUS RESULT | | OUTTURN RESULT | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Latest Result and RAG Status | | Num | Denom | Target for 12/13 | 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 | 67.0 | A | 2163 | 322813 | 77.2 | 64.9 | ↑ | 68.5 | ↓ |
| Number of Referrals per 10,000 population under 18 | T | R12M | 411.8 | R | 13293 | 322813 | 543.7 | 403.5 | ↑ | 538.4 | ↓ |
| NI 68 - Percentage of Referrals going on to Initial Assessment | T | YTD | 75.4% | A | 8611 | 11418 | 69.5% | 76.8% | ↑ | 89.8% | ↑ |
| Number of Initial Assessments per 10,000 population under 18 | T | R12M | 326.1 | G | 10528 | 322813 | 342.9 | 330.3 | ↓ | 483.6 | ↑ |
| Number of New & Updated Core Assessments per 10,000 population under 18 | T | R12M | 324.2 | R | 10467 | 322813 | 236.0 | 325.0 | ↑ | 456.0 | ↑ |
| Number of S47 Investigations per 10,000 population under 18 | T | R12M | 111.1 | G | 3587 | 322813 | 106.4 | 114.5 | ↑ | 202.7 | ↑ |
| Percentage of S47 Investigations proceeding to Initial CP Conference | T | YTD | 36.0% | R | 1015 | 2823 | 44.5% | 36.6% | ↓ | 21.7% | ↑ |
| Number of Initial CP Conferences per 10,000 population under 18 | T | R12M | 40.6 | G | 1310 | 322813 | 42.3 | 39.3 | ↑ | 54.3 | ↑ |
| Number of CIN per 10,000 population under 18 (includes CP and LAC) | T | SS | 287.1 | G | 9268 | 322813 | 280.0 | 283.8 | ↓ | 296.4 | ↑ |
| Numbers of Children with a CP Plan per 10,000 population under 18 | T | SS | 29.1 | G | 938 | 322813 | 30.5 | 29.3 | ↓ | 30.6 | ↓ |
| Children looked after per 10,000 population aged under 18 (Excludes Asylum) | T | SS | 49.7 | G | 1604 | 322813 | 47.5 | 50.2 | ↑ | 51.7 | ↑ |
| Number of Looked After Children with a CP plan. | L | SS | 30 | G | | | 30 | 43 | ↑ | 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 | 84.9% | G | 7307 | 8611 | 78.8% | 86.1% | ↓ | 76.2% | ↑ |
| Initial Assessments in progress outside of timescale | L | SS | 80 | G | | | 100 | 110 | ↑ | 42 | ↓ |
| (NI 60) - Percentage of Core Assessments that were carried out within timescale | H | YTD | 82.3% | A | 7037 | 8546 | 83.2% | 82.9% | ↓ | 68.7% | ↑ |
| Core Assessments in progress outside of timescale | L | SS | 186 | R | | | 100 | 164 | ↓ | 84 | ↓ |
| NI 67 - Child protection cases which were reviewed within required timescales | H | YTD | 99.1% | G | 568 | 573 | 98.0% | 99.0% | ↑ | 97.1% | ↑ |
| NI 66 - Looked after children cases which were reviewed within required timescales | H | YTD | 96.0% | A | 1579 | 1644 | 98.0% | 96.3% | ↓ | 94.9% | ↑ |
| **HOW WELL ARE WE DOING IT ?** | | | | | | | | | | | |
| Percentage of Case File Audits judged adequate or better | H | YTD | 72.9% | R | 537 | 737 | 85.0% | 72.5% | ↑ | 64.1% | ↑ |
| Percentage of open cases with Ethnicity recorded (excludes unborn) | H | SS | 98.9% | G | 9014 | 9111 | 98.0% | 98.4% | ↑ | 97.4% | ↑ |
| Percentage of Children seen at Initial Assessment (excludes unborn/progress to strat) | H | YTD | 91.5% | A | 5688 | 6216 | 95.0% | 91.4% | ↑ | 61.6% | ↑ |
| Percentage of Children seen at Core Assessment (excludes unborn) | H | YTD | 98.1% | G | 7968 | 8123 | 95.0% | 98.2% | ↓ | 88.0% | ↑ |
| Percentage of Children seen at Section 47 enquiry (excludes unborn) | H | YTD | 95.8% | G | 2552 | 2665 | 95.0% | 96.9% | ↓ | 91.3% | ↑ |
| Percentage of CP Visits held within timescale (Current CP only) | H | SS | 85.9% | A | 11568 | 13472 | 90.0% | 86.8% | ↓ | 65.8% | ↑ |
| Percentage of Looked After Children aged 5 to 16 with a Personal Education Plan (PEP) | H | SS | 90.7% | A | 1005 | 1108 | 95.0% | 87.2% | ↑ | 81.8% | ↑ |
| Participation at Looked After Children Reviews | H | YTD | 95.8% | G | 3241 | 3383 | 95.0% | 96.5% | ↓ | 94.1% | ↑ |
| Children subject to a CP Plan not allocated to a Qualified Social Worker | L | SS | 0 | G | | | 0 | 5 | ↑ | 2 | ↑ |
| Looked After Children not allocated to a Qualified Social Worker | L | SS | 0 | G | | | 0 | 2 | ↑ | 2 | ↑ |
| **ARE WE ACHIEVING GOOD OUTCOMES ?** | | | | | | | | | | | |
| Percentage of referrals with a previous referral within 12 months | L | YTD | 22.6% | G | 2585 | 11418 | 25.8% | 22.9% | ↑ | 30.4% | ↑ |
| NI 65 - Percentage of children becoming CP for a second or subsequent time | T | YTD | 18.9% | A | 188 | 994 | 13.4% | 20.5% | ↑ | 16.6% | ↓ |
| Percentage of children becoming CP for a second or subequent time within 12 months | | YTD | 6.5% | | 65 | 994 | | 7.1% | | | |
| NI 64 - Child Protection Plans lasting 2 years or more at the point of de-registration | L | YTD | 7.6% | R | 77 | 1011 | 6.0% | 6.9% | ↓ | 8.0% | ↑ |
| Percentage of Current CP Plans lasting 18 months or more | L | SS | 11.6% | A | 109 | 938 | 10.0% | 12.4% | ↑ | 14.2% | ↑ |
| NI 62 - LAC Placement Stability: 3 or more placements in the last 12 months | L | SS | 9.7% | R | 172 | 1778 | 8.1% | 9.4% | ↓ | 11.1% | ↑ |
| NI 63 - LAC Placement Stability: Same placement for last 2 years | H | SS | 68.9% | A | 332 | 482 | 75.7% | 68.7% | ↑ | 70.3% | ↓ |
| Percentage of LAC in Foster Care placed within 10 miles from home (Excludes Asylum) | H | SS | 61.2% | A | 744 | 1215 | 65.0% | 60.7% | ↑ | 60.6% | ↑ |
| LAC Dental Checks held within required timescale | H | SS | 89.9% | A | 1129 | 1256 | 90.0% | 88.4% | ↑ | 92.6% | ↓ |
| LAC Health assessments held within required timescale | H | SS | 93.0% | G | 1168 | 1256 | 90.0% | 91.4% | ↑ | 88.1% | ↑ |
| Percentage of LAC placed for adoption within 12 months of agency decision | H | YTD | 74.3% | R | 75 | 101 | 85.0% | 74.0% | ↑ | 76.6% | ↓ |
| Percentage of Children leaving care who were adopted | H | YTD | 11.5% | R | 88 | 768 | 13.0% | 11.6% | ↓ | 8.3% | ↑ |
| Percentage of Children leaving care who were made subject to a SGO | H | YTD | 7.0% | G | 54 | 768 | 6.3% | 7.0% | ↑ | 4.8% | ↑ |

**PERFORMANCE SUMMARY**

As at 31/01/2013, Kent has 20 indicators rated as Green, 12 indicators rated as Amber and 9 indicators rated as Red. When comparing performance from last month to this month, 25 indicators have shown an improvement, 1 indicator has remained the same and 15 indicators have shown a reduction. When comparing performance from outturn (March 12) to this month, 32 indicators have shown an improvement, 0 indicators have remained the same and 9 indicators have shown a reduction.

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# Adult Social Care Dashboard

# January 2013

**Key to RAG (Red/Amber/Green) ratings applied to KPIs**

APPENDIX B

| | |
|---|---|
| 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 January 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 B

## Summary of Performance for our KPIs

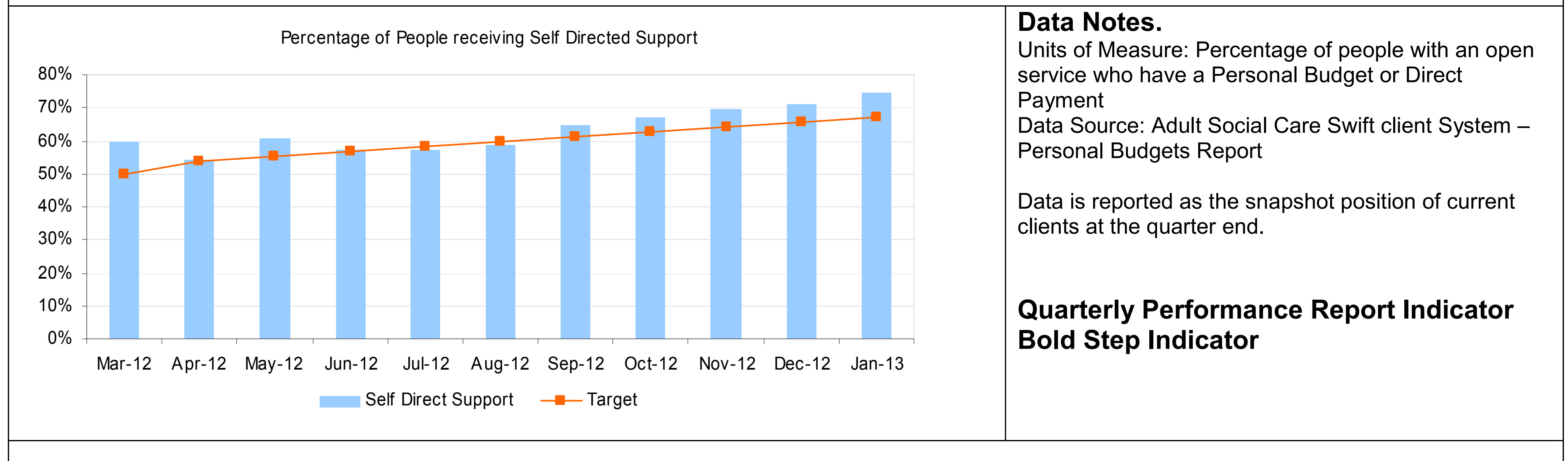
| Indicator Description | Bold Steps | QPR | 2011-12 Out-turn | 2012-13 Target | Current Position | Data Period | RAG | Direction of Travel |
|---|---|---|---|---|---|---|---|---|
| 1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment | Y | Y | 59% | 70% | **74.4%** | 12M | **GREEN** | ↑ |
| 2. Proportion of personal budgets given as a direct payment | Y | | 24.13% | | **21.3%** | 12M | **See Page 5** | |
| 3. Number of adult social care clients receiving a telecare service | Y | Y | 1032 | 1300 | **1497** | Cumulative | **GREEN** | ↑ |
| 4. Number of adult social care clients provided with an enablement service | Y | Y | 612 | 700 | **679** | Month | **AMBER** | ↑ |
| 5. Percentage of adult social care assessments completed within six weeks | | Y | 76.68% | 75% | **78.4%** | 12M | **GREEN** | ↑ |
| 6. Percentage of clients satisfied that desired outcomes have been achieved at their first review | | Y | 73.6% | 75% | **73.7%** | 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 | **5.74** | 12M | **AMBER** | ↓ |
| 9. Admissions to Permanent Residential Care for Older People | | | 164 | 145 | **135** | 12M | **GREEN** | ↑ |
| 10. People with Learning Disabilities in residential care | Y | | 1288 | 1260 | **1266** | Month | **AMBER** | ↑ |
| 11. Proportion of adults in contact with secondary Mental Health in settled accommodation | Y | | 62.0% | 75% | **85.3%** | Quarterly | **GREEN** | ↑ |

APPENDIX B

| 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** | **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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage | 59.70% | 54.30% | 60.90% | 57.50% | 57.20% | 58.90% | 64.90% | 67.20% | 69.7% | 71.20% | 74.40% |
| **Target** | **50%** | **54%** | **55%** | **57%** | **58%** | **60%** | **61%** | **63%** | **64%** | **66%** | **67%** |
| Client Numbers | 11416 | 10132 | 10549 | 10256 | 10453 | 10865 | 10612 | 11541 | 11595 | 11732 | 12192 |
| RAG Rating | GREEN | GREEN | GREEN | GREEN | AMBER | AMBER | GREEN | GREEN | GREEN | GREEN | GREEN |

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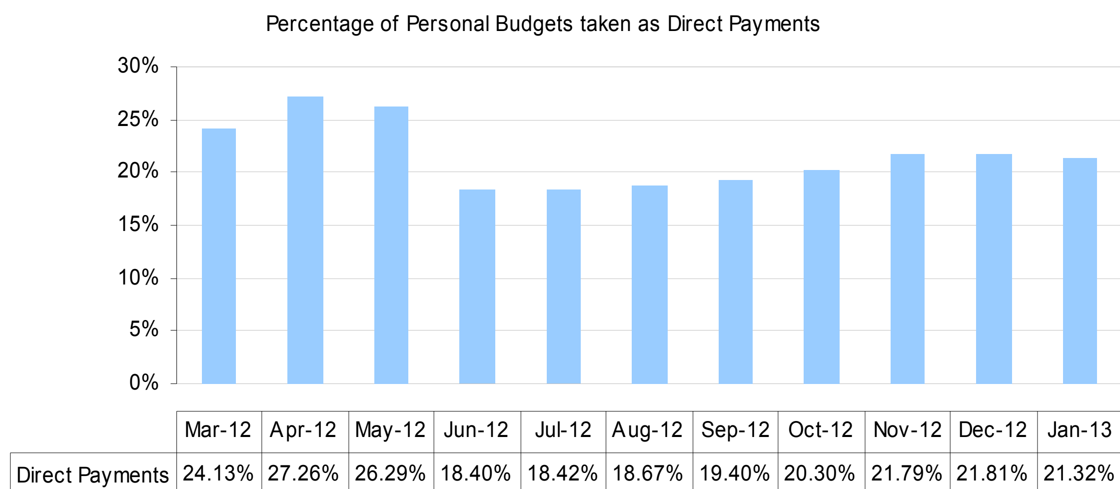
APPENDIX B

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Direct Payments | 24.13% | 27.26% | 26.29% | 18.40% | 18.42% | 18.67% | 19.40% | 20.30% | 21.79% | 21.81% | 21.32% |

**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

The National target for personal budgets has been announced by the new Care Services Minister for April 2013, which has been based on feedback from Councils, including Kent, highlighting the real fact that not all people are eligible for personal budgets. For example, people who receive enablement services and return home with no further support, or equipment only will not have a personal budget.

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.

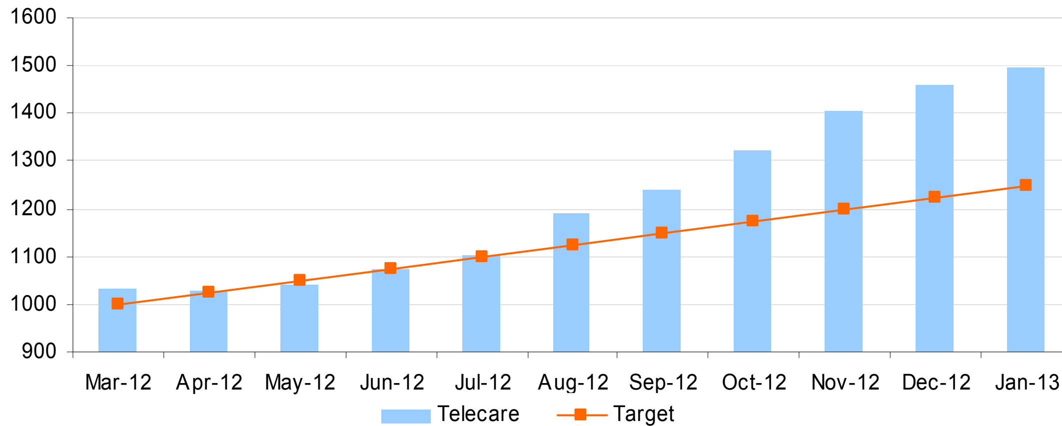
Continued emphasis and local monitoring of progress will continue, which will also ask Managers to raise training needs for both operational practice and system input in their teams so that this can be dealt with quickly.

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.

| 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**

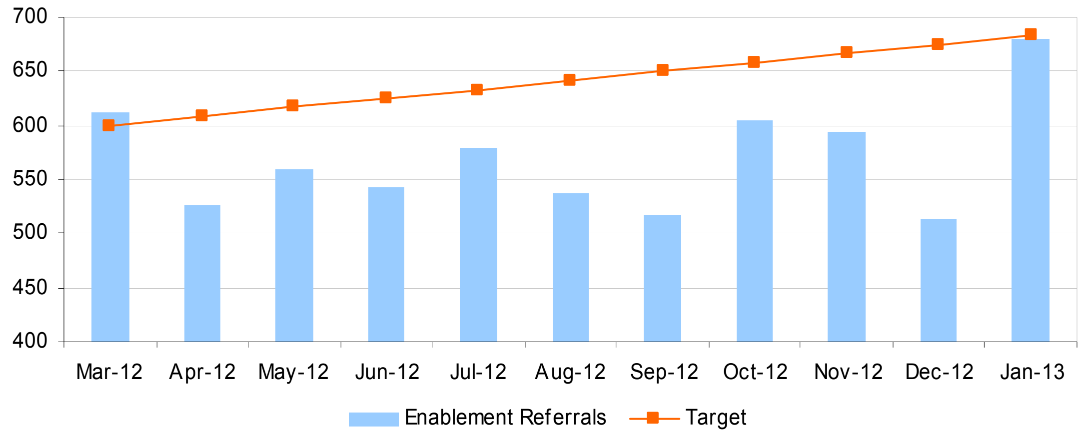
APPENDIX B

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

## 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**

APPENDIX B

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

| Commentary |
| --- |
| 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. The mapping of all these services will be undertaken to determine the impact of these interdependencies in the next couple of months and will be reported back to committee.<br>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.<br>The target for 2012/13 is for 700 people per month to received enablement. |

| 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 |

Assessments for New People completed w ithin 42 Days



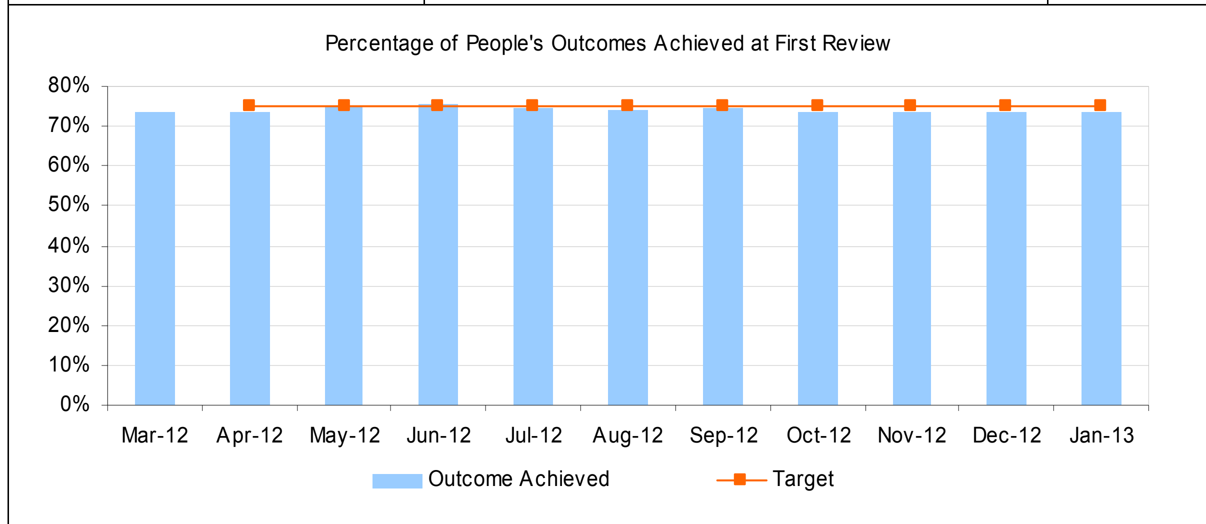
**Data Notes.**
Units of Measure: Percentage of assessments completed within 42 Days
Data Source: Adult Social Care Swift client System – Open Referrals without Support Plan Report

**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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Completed | 76.7% | 76.3% | 76.8% | 77.2% | 77.5% | 78.0% | 78.2% | 78.4% | 78.27% | 78.14% | 78.41% |
| **Target** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** |
| RAG Rating | 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.<br>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.<br><br>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,<br><br>or who were pushing people through the assessment process too quickly.<br>Factors affecting this indicator are linked to waiting lists for assessments, assessments not being carried out on allocation and some long standing delays in Occupational Therapy assessments. There are also appropriate delays due to people going through enablement as this process takes up to six weeks and the assessment can not be completed until the enablement process is completed<br><br>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. |
| |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Achieved | 73.6% | 73.6% | 75.0% | 75.3% | 74.7% | 74.0% | 74.6% | 73.6% | 73.7% | 73.8% | 73.7% |
| **Target** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** |
| RAG Rating | AMBER | AMBER | GREEN | GREEN | AMBER | AMBER | AMBER | AMBE R | AMBE R | 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 January 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 |

Achieving Independence through Intermediate Care

**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% | 82% |
| **Target** | **85%** | **85%** | **85%** | **85%** | **85%** | **85%** | **85%** | **85%** | **75%** | **75%** |
| 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 400 referrals a month which are supported from hospital and into intermediate care. Performance has been lower in recent months, particularly in the west of the county, where there has been a reduction in the number of intermediate care beds. This position 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, I

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| People | 5.04 | 5.28 | 5.28 | 5.26 | 5.23 | 5.36 | 5.35 | 5.4 | 5.62 | 5.74 |
| **Target** | **5.40** | **5.40** | **5.40** | **5.40** | **5.40** | **5.40** | **5.40** | **5.4** | **5.4** | **5.4** |
| RAG Rating | GREEN | GREEN | GREEN | GREEN | GREEN | GREEN | GREEN | GREEN | 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.

| 9. Admissions to Permanent Residential Care for Older people | | | GREEN ⇧ |
|---|---|---|---|
| **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 |

Admissions to Residential Care

180
160
140
120
100
80
60
40
20
0

Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13

Admissions Target

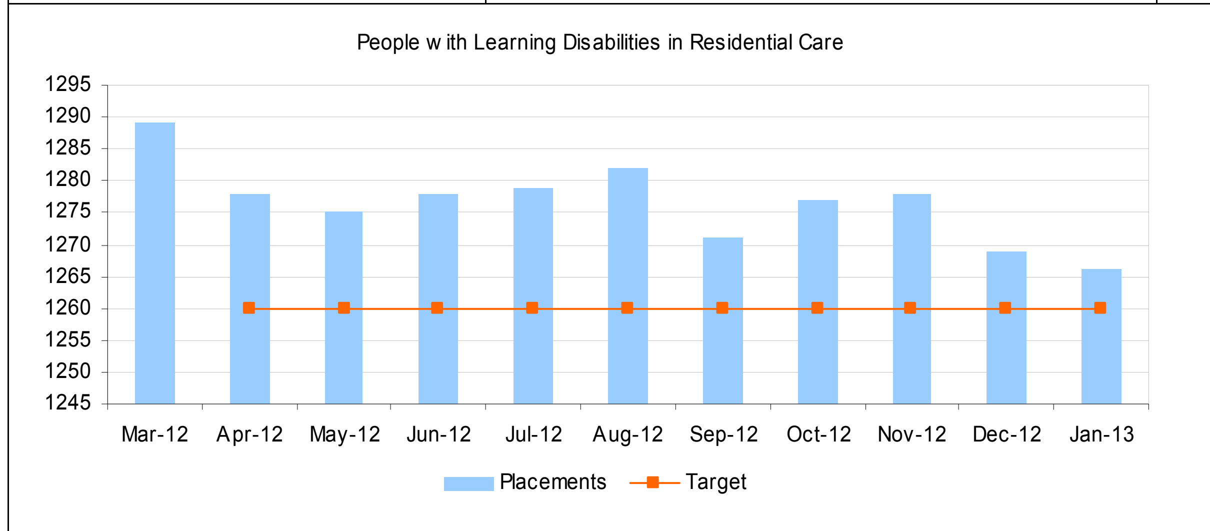
**Data Notes.**
Units of Measure: Older People placed into Permanent Residential Care per month.
Data Source: Adult Social Care Swift client System – Residential Monitoring Report

| Trend Data | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Admissions | 164 | 115 | 137 | 118 | 149 | 150 | 137 | 151 | 99 | 132 | 135 |
| **Target** | | **145** | **145** | **145** | **145** | **145** | **145** | **145** | **145** | **145** | **145** |
| RAG Rating | | GREEN | GREEN | GREEN | AMBER | AMBER | GREEN | AMBE R | GREEN | GREEN | GREEN |

**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.

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Placements | 1,289 | 1,278 | 1275 | 1278 | 1279 | 1282 | 1271 | 1277 | 1278 | 1269 | 1266 |
| **Target** | | **1260** | **1260** | **1260** | **1260** | **1260** | **1260** | **1260** | **1260** | **1260** | **1260** |
| RAG Rating | AMBER | AMBER | AMBER | AMBER | AMBER | AMBER | AMBER | AMBE R | AMBE R | 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 form the majority of the new residential placements. |

| 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 |

Percentage of People receiving Secondary MH Services Living Independently

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12
Percentage
Target

**Data Notes.**
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

**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 |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage | | | 85.9% | 83.1% | 84.5% | 84.7% | 84.5% | 82% | 82.3% | 85.3% |
| **Target** | | | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** | **75%** |
| RAG Rating | | | 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.

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

Meradin Peachey Director of Public Health

**To:** Social Care and Public Health Committee – 21 March 2013

**Subject:** Health Improvement Programmes Performance Report

**Classification:** Unrestricted

---

**Summary: This performance report provides an update of Public Health performance, particularly on the two programmes highlighted specifically in the NHS Operating framework (Health Checks and Stop Smoking Services) and also the services that are mandated.**

## 1. Introduction

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

This report shows performance to date on the majority of Public Health: Health Improvement programmes which will move to Kent County Council from 1st April 2013

The report is presented in a dashboard style, with the individual performance targets RAG (red, amber, or green rated)

## 2 Exception Reports

### 1. Smoking Quits

Data presented is for progress to date for Quarter three of this financial year. Although performance has improved considerably in the East of the county, the service is behind schedule in the West

Work continues with the provider Kent Community Health NHS Trust (KCHT) to get the number of quits back on track. Extensive local advertising campaigns, work with clinical staff to increase referrals and an increase in the number of community pharmacists providing the service are all in place to push the numbers up in quarter 4.

A verbal update will be given on progress to date.

## 2. Health Checks

The target set for the service with the SHA continues to be 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 are now achieving both the number of invites target and the number of health checks received target, the west continue to work to get the number of practices involved and started.

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

Full investment by both NHS Eastern and Coastal Kent and NHS West Kent for 2012/13 means that we should reach the target agreed with the SHA.

Nationally, the England average of 11.7% of the cohort invited in Q3, in Kent the average is 10.4%, with East Kent at 16% and West Kent at 5.2%.

## 3. Breast Feeding Initiation

The gradual improvement from Q2 has continued in the recording of breastfeeding initiation rates for Q3. In both East and West of the county we are above the 95% ascertainment threshold of 95% with initiation rates at 42%.

## 3. Recommendations

Members are asked to note the report

**Contact details** – Andrew Scott-Clark
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Andrew.scott-clark@eastcoastkent.nhs.uk

**Background information** Nil

**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 Q3 Target | 5,863 | 5,254 | 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 suceesfully quit at the four week follow up* | Q3 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 | 68,431 | 48,700 | R |
| | Number of Health Checks completed | | 20,276 | A |
| | *Service delivered by numerous providers, with GP practices being the fundamental building 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* | Q3 Submission | | |
| | *Service runs across the financial year, data runs six weeks in arrears* | | | |
| 3 | **Sexual Health** | | | |
| | GUM Access | 95% | 97% | G |
| | Chlamydia Screening Uptake rate | 35% | 20% | A |
| | 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 population. Emphasis in future years is to be based on positivity ensuring individuals at risk are screened.* | progress for Q3 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 parents 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 enhancement model | 40% | 55% | 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 susbstance misuse prevalence, reduction of unhealthy weight together with emotional health and wellbeing* | to Q3 2012/13 | | |
| | *The 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% | 42% | A |
| | *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 maintainence of breastfeeding for 6-8 weeks. The 6-8 week target is relatively new and has required detailed work with midwives, health visitors and GP practices to ensure robust reporting* | Q3 2012-2013 | | |
| | *The service runs over the financial year, data runs two months in arrears* | | | |
| 7 | **Health Trainers** | | | |
| | Number of new contacts | 1,875 | 2,728 | G |
| | *The Health Trainers Programme is commissioned to help people in our most deprived communities to develop healthier behaviour and lifestyles. HTs offer practical support to change individual's behaviour to achieve their own choices and goals. This involve 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 appropraite, are signposted to other services.* | to Q3 2012-2013 | | |
| | *Service runs across the financial year, data runs 6 weeks in arrears* | | | |

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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