ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 11th July, 2014

9.30 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 11 July 2014 at 9.30 am
Darent Room, Sessions House, County Hall, Maidstone

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

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

Membership (13)

Conservative (8):	Mr C P Smith (Chairman), Mr G Lymer (Vice-Chairman), Mrs A D Allen, MBE, Mr A H T Bowles, Mr R E Brookbank, Mrs P T Cole and Mrs V J Dagger
UKIP (2)	Mr H Birkby and Mr A D Crowther
Labour (2)	Mrs P Brivio and Mr T A Maddison
Liberal Democrat (1):	Mr S J G Koowaree

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UNRESTRICTED ITEMS

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Membership - to report that Mr P Oakford has left the Committee and there is a vacancy

A3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

A4 Declarations of Interest by Members in items on the Agenda

To receive any declarations of interest made by Members in relation to any matter on the agenda. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared

A5 Minutes of the meetings held on 2 May 2014 and 12 June 2014 (Pages 9 - 24)

To consider and approve the minutes as a correct record

A6 Verbal updates (Pages 25 - 26)

To receive verbal updates from the Cabinet Member for Adults Social Services and Public Health and the Corporate Director of Social Care, Health and Wellbeing

B - Key or Significant Cabinet/Cabinet Member Decisions for Recommendation or Endorsement

B1 Health Check Programme Update (Pages 27 - 32)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Acting Director of Public Health that outlines the background to the health check services, details the current service provision and discusses the options for future service delivery

B2 Tendering for Postural Stability Classes (Pages 33 - 40)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Acting Director of Public Health that provides information about the process undertaken to procure community based postural stability classes across the County, to ensure a consistent and equitable service.

B3 Updating the Kent and Medway Suicide Prevention Strategy (Pages 41 - 50)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Acting Director of Public Health that outlines the process for updating the Kent and Medway Suicide Prevention Strategy, as well as providing details of changes in national policies and local structures which will influence the content of the updated strategy.

B4 Home Support Fund Policy (Pages 51 - 64)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and Corporate Director for Social Care, Health & Wellbeing that provides information on the consultation on the Home Support Fund Policy and makes recommendations for the policy to be unified for both Adults and Children.

B5 Update on the Swale Learning Disability Day Service (Good Day Programme) Consultation. (Pages 65 - 66)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and Corporate Director for Social Care, Health & Wellbeing that provides an update on the consultation and an activity summary, including any significant changes to support the summary briefing.

B6 Temporary Financial Assistance (Pages 67 - 72)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and Corporate Director for Social Care, Health & Wellbeing that seeks a formal change to the rule whereby residents are only eligible for KCC Temporary

Financial Assistance (TFA) for residential care (providing they do not qualify for Deferred Payments) if their liquid capital has decreased to £3,000. It is recommended that this rule be substituted by one which states that a resident will only be eligible for TFA once their liquid capital and income can only support their care costs for three months.

B7 KCC Accommodation Strategy - Better Homes: Greater Choice (Pages 73 - 82)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing and to endorse or make a recommendation to the Cabinet Member on the development and implementation plans of the Accommodation Strategy with specific focus on Older Person's services; extra care and intermediate care. The Strategy was launched on 2 July 2014.

B8 Older Persons Residential and Older Persons Nursing Contract re-let - award of contract (Pages 83 - 102)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing seeking agreement to confirm new guide prices for Older Persons residential and nursing care.

C - Other items for comment/recommendation to the Leader/Cabinet Member/Cabinet or officers

C1 Healthy Living Pharmacy Programme (HLP) (Pages 103 - 130)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Acting Director of Public Health on the Healthy Living Pharmacy Programme in Kent.

C2 Kent Health and Wellbeing Strategy (Pages 131 - 170)

To receive a report from the Cabinet Member for Education and Health Reform on the revised Health and Wellbeing Strategy before the final draft is presented to the Kent Health and Wellbeing Board on 16th July for approval.

C3 Preparation for the Care Act 2014 (Pages 171 - 190)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director for Social Care, Health & Wellbeing that sets the preparatory work for the implementation of the Act and the current assessment of the main financial and other implications.

C4 Adult Social Care Transformation - Building Community Capacity Programme and Presentation (Pages 191 - 216)

C5 Kent Support and Assistance Service (Pages 217 - 220)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director for Social Care, Health & Wellbeing that sets out the current position with regard to the Kent Support and Assistance Scheme (KSAS) and options for the future.

D - Monitoring of Performance

D1 Public Health Performance - Adults (Pages 221 - 230)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Acting Director of Public Health that provides an overview of Public Health key performance indicators which specifically relate to adults.

D2 Adult Social Care Performance Dashboard for February 2014 (Pages 231 - 248)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing that provides Members with progress against targets set for key performance and activity indicators for May 2014 for Adult Social Care.

D3 Risk Management - Strategic Risk Register (Pages 249 - 306)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing that presents the strategic risks of relevance to the Adult Social Care & Health Cabinet Committee, in addition to the risks featuring on the corporate risk register for which the Corporate Director is the designated 'risk owner'. The paper also explains the management process for review of key risks.

D4 Work Programme 2014/2015 (Pages 307 - 312)

To receive a report from the Head of Democratic Services that details the proposed work programme and seeks suggestions for future topics for consideration by the Adult Social Care and Health Cabinet Committee.

Motion to Exclude the Press and Public for Exempt Items of Business

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.

EXEMPT ITEM

E1 Older Persons Residential and Older Persons Nursing Contract re-let - award of contract (exempt appendix to item B8) (Pages 313 - 336)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and Corporate Director for Social Care, Health & Wellbeing containing information pertaining to Item B8 that is exempt from publication owing to it containing financial information that is commercially sensitive at this time.

Peter Sass
Head of Democratic Services
(01622) 694002

Thursday, 3 July 2014

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

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 2 May 2014.

PRESENT: Mrs A D Allen, Mr H Birkby, Mr A H T Bowles, Mrs P Brivio, Mr R E Brookbank, Mrs P T Cole, Mr A D Crowther, Mr S J G Koowaree, Mr G Lymer, Mr T A Maddison, Mr P J Oakford and Mr C P Smith

ALSO PRESENT: Mr G K Gibbens

IN ATTENDANCE: Mr A Ireland (Corporate Director, Social Care, Health & Wellbeing), Mr A Scott-Clark (Acting Director of Public Health), Mr M Lobban (Director, Commissioning), Ms P Southern (Director, Learning Disability & Mental Health), Mrs A Tidmarsh (Director, Older People & Physical Disability) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Apologies and Substitutes
(Item 2)

1. Apologies had been received from Mrs V J Dagger for absence and Mr H Birkby, Mrs P Brivio and Mr G Lymer for expected lateness due to the closure of the M20.

2. Mr S C Manion was to be present as a substitute for Mrs V J Dagger but did not attend.

2. Election of Chairman
(Item 3)

Mr P Oakford proposed and Mr A H T Bowles seconded that Mr C P Smith be elected Chairman of the Committee. There were no other nominations and it was AGREED that Mr Smith be elected.

Mr Smith thereupon took the Chair

3. Election of Vice-Chairman
(Item 4)

Mr C P Smith proposed and Mr A H T Bowles seconded that Mr G Lymer be elected Vice-Chairman of the Committee. There were no other nominations and it was AGREED that Mr Lymer be elected.

4. Declarations of Interest by Members in items on the Agenda
(Item 5)

No declarations of interest were made at this time.

5. Minutes of the final meeting of the former Social Care and Public Health Cabinet Committee, held on 16 January 2014
(Item 6)

RESOLVED that these be noted.

6. Meeting dates for the remainder of 2014
(Item 7)

1. RESOLVED that the meeting dates reserved for this Committee for the remainder of 2014 be noted, as follows:-

Friday 11 July – *9.30 am*
Friday 26 September
Thursday 4 December

All meetings would normally commence at 10.00 am at County Hall, Maidstone, but it was subsequently agreed that the July meeting commence at 9.30 am.

7. Verbal Updates by the Cabinet Member and Directors
(Item 8)

Adult Social Care

1. Mr Gibbens gave a verbal update on the following issues:-

A number of key decisions had been taken since the final meeting of the former Social Care and Public Health Cabinet Committee in January 2014, which were listed in a report for Members' information at the end of the agenda pack. He highlighted the following three issues:-
Home Care Contract Award – this was a significant area of work for the County Council. The number of providers had been much reduced, which would give the County Council more scope for control and supervision.
Proposed revision of rates payable and charges levied for adult services in 2014/15
Swanley Learning Disability Day Service – this was a good news story, and service users were happy with the new services.
6 February attended 'Time to Change' event at the Angel Centre in Tonbridge ('Time to Change' pledge) – this campaign aimed to reduce stigma around mental health issues. It was known that one in four adults in the UK would experience some kind of mental illness at some point in their lifetime.
17 February Kent Older People's Senior Forum at Sessions House
11 March attended LGA Health & Social Care Integration in the South East Conference in London

2. Mr Gibbens, Mr Lobban and Mr Ireland responded to comments and questions from Members, as follows:-

a. the effect upon care workers of the home care contract award would be beneficial as it would allow visits to clients to be organised on a more

sensible, geographical basis, thus reducing care workers' travel time and allowing them more time to spend with each client;

b. engaging with a smaller number of providers would allow better monitoring and make it easier to forecast and deal with any issues before they became problems;

c. all providers with whom the County Council contracted for home care services had an office in Kent and employed local people, although some were larger national organisations with a branch in Kent;

d. the tendering and selection process was rigorous and was run by the County Council's procurement team. An external organisation called Neuven was engaged to undertake an audit of all potential providers at the stage at which they expressed an interest;

e. previously, the County Council had not been allowed to take past contractual performance into account when assessing the suitability of potential contractors. However, procurement legislation had since changed to allow local authorities to take into account past performance;

f. the County Council could not have taken account of the most recent Care Quality Commission (CQC) reports when assessing contractors, as some contractors had not been inspected by CQC since 2012, making it impossible to compare potential providers on a like-for-like basis. The benefit of the audits by Neuven was that all were undertaken recently within the same, short timescale, and each bidder was assessed against the same data set; and

g. Mr Gibbens emphasised that he would always prefer that issues such as those listed above should come to the Committee for discussion. He pointed out that it was only the larger than usual gap between meetings and the need for arrangements to be made by the end of the financial year that had necessitated the decisions listed being taken between meetings.

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

Better Care Fund – this was £120million of Department of Health funding, delivered via clinical commissioning groups and targeted at specific areas of transformed services.
Association of Directors of Social Services (ADASS) Spring Seminar – this useful network had debated the provisions of the Care Bill and other current issues.
Independent Living Fund - the administrative set-up of this had changed and was currently uncertain. *It was agreed that a report on this issue be made to the July meeting of this Committee.*
Integration Pioneer – this was linked to the Better Care Fund. Kent had been chosen as a pioneer due to the quality of its bid and its size and diversity. Mr Ireland had recently met with Department of Health sponsors.

Adult Public Health

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

Two of the key decisions taken since the final meeting of the former Cabinet Committee were to extend contracts, with ***Kent Community Health Trust*** *and* ***Maidstone and Tunbridge Wells NHS Trust****, to deliver sexual health services.*
4 February attended Annual Public Health Conference in Birmingham
7 February attended a 'HOUSE on the move' celebration event at Lenham Community Centre. HOUSE was a service which offered young people advice and support on issues such as drugs and alcohol use and sexual health issues. Permanent HOUSE facilities were located in Ashford, Dover, Canterbury and Sevenoaks and a mobile service moved around other areas of the county.

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

Award for Margate Taskforce. The GP and JobCentre Plus staff of Margate Taskforce had won an award which celebrated joint working between the GP and JobCentre Plus team. This was awarded by the Public Health Minister, Jane Ellison.
Anti-virals for Influenza. Anti-virals were not as ineffective as recent media had suggested, so the County Council's pandemic flu plan would continue to recommend their use to treat flu and flu-like illnesses, as they were nationally.

6. The oral updates were noted, with thanks.

8. Outcome of formal consultation on the closure/variation of service of Dover Learning Disability Service (14/00010)
(Item 1)

Ms P Watson, Commissioning Manager, Accommodation Solutions, was in attendance for this item.

1. Ms Southern and Ms Watson introduced the report and explained that the changes proposed for Dover were part of the countywide programme of improvements to day services for people with learning disabilities, similar improvements having already been made in several other districts. The services to be updated were run by the County Council and were used by a total of 78 people, with an average daily attendance of 54 on the two days on which they operated. Feedback from service users and their families had been good. In response to comments and questions from Members, the following points were highlighted:-

a) it was planned that two community hubs would be established – in Dover and Deal – and three potential sites were currently being investigated to accommodate them; Dover Leisure Centre, Deal Library and the Landmark Centre. Informal negotiations to use these sites were currently underway, and the use of any site was not guaranteed until negotiations had been satisfactorily concluded. Use of the Well Resource Centre and others, such as the YMCA, would be occasional only, when they hosted an activity which was suitable for users of day services; and

b) Members were assured that, although the number of questionnaires returned seemed to be a very small percentage of the number of people consulted, most of the 78 current service users were asked their views via interviews and group sessions, so had not been asked to complete questionnaires.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and confirmed that he would take account of them when taking the final decision. He emphasised that, as had been the case when modernising day services in other areas, no current services would be closed until new hubs were open and operational.

3. RESOLVED that, following a 14-week period of public consultation, the Cabinet Member for Adult Social Care and Public Health give approval to proceed with moving the Dover Learning Disability Day Service from its existing base and to continue the service as a more inclusive, accessible, community-based service, operating from community hubs.

9. 13/00094 - Alcohol Strategy for Kent, 2014 - 2016
(Item 2)

1. Mr Scott-Clark introduced the report and responded to comments from Members, as follows:-

a) the increase in alcohol misuse seemed to have caused the greatest deterioration in quality of life in Kent and the UK over the last 40 years;

b) measures which sought to address the issue seemed to treat the symptoms of alcohol misuse rather than its causes;

c) patterns of alcohol consumption had changed. The decline of community pubs, in which friends and neighbours could see and discourage excessive consumption, meant that alcohol was now purchased mainly in supermarkets and consumed at home, in the street or in other public places;

d) the 'future actions' listed in Pledge 3 of the Strategy included ensuring that amendments to the Licensing Act were understood. However, what was needed was more than understanding; the County Council needed to commit to having a positive input;

e) it was suggested that those presenting at hospital accident and emergency departments with alcohol-related injuries should be required to pay for the costs of the ambulance and their hospital treatment;

f) the report of the County Council Select Committee on Alcohol Misuse, published in March 2008, could helpfully be reviewed to see what had happened in implementing its recommendations since progress was last reviewed in March 2009;

g) there needed to be a balance between licensing and legislation and the County Council's public health responsibility; and

h) in Europe, where many children would be introduced to wine-drinking at an early age, there did not seem to be as visible an alcohol problem in later years as there was in the UK.

2. Mr Scott-Clark agreed with the concerns expressed about the patterns and impact of alcohol misuse and the need to address these nationally, for example by price control. He undertook to respond to a speaker outside the meeting about future trends. Although experimenting with alcohol was part of youth culture, educating young people about alcohol and the dangers of its misuse was part of the Healthy Schools Programme, and had a dedicated service, the KCA. It was known, however, that the majority of young people acquired alcohol from adults. Enforcement had improved over the years, to stop off-licences from selling alcohol to children. The suggestion in Pledge 6 of the Strategy that children should be at least 15 years of age before being allowed to drink alcohol was based on the professional view of the Chief Medical Officer, with the aim of minimising damage while their livers were still forming. Addiction to alcohol was present in Europe, but was not as visible in public areas as it was in the UK.

3. The Cabinet Member, Mr Gibbens, thanked Members for their comments and supported the suggestion that the Select Committee report be revisited. He said that the way in which the County Council approached the issue of alcohol use and misuse would be a good test of its public health role, via which he hoped it would take the opportunity to increase its impact. He undertook to monitor progress on the implementation of the Strategy and make regular reports back to the Cabinet Committee.

4. RESOLVED that the proposed decision by the Cabinet Member for Adult Social Care and Public Health, to approve the Alcohol Strategy, be endorsed.

10. Adult Healthy Weight Review (14/00011)
(Item 3)

Ms M Gibbon, Consultant in Public Health, was in attendance for this item.

1. Ms Gibbon introduced the report and she and Mr Scott-Clark responded to comments and questions from Members, as follows:-

a) historic differences in service delivery in east and west Kent had led to east Kent having a better record of service. The aim was to achieve more consistency across tier 1 and tier 2 services; and

b) diabetes, in both adults and children, was a large and increasing problem. Mr Scott-Clark said that a review of children's public health issues would be undertaken shortly and *a report on childhood obesity submitted to the Children's Social Care and Health Cabinet Committee.*

2. RESOLVED that:-

a) the commissioning of a universal (tier 1 and tier 2) adult healthy weight service for Kent be agreed; and

b) a report on childhood obesity be submitted to the Children's Social Care and Health Cabinet Committee.

11. 14/00048 - Tendering for Community Sexual Health Services
(Item 4)

1. The Chairman asked Members of the Committee if, in discussing the report, they wished to make reference to the information set out in the exempt appendix to it, which was included at the end of the agenda, at item F1. Some Members confirmed that they wished to ask questions about some of the information in the appendix.

2. Accordingly, it was RESOLVED that discussion of this item take place in closed session. It is recorded below, in Minute 18.

12. New Legal Framework for Adult Social Care
(Item 1)

Mr M Thomas-Sam, Strategic Business Adviser, Policy and Strategic Relationships, Ms C Grosskopf, Policy Manager, and Ms M Stirrup, Change Implementation Manager, were in attendance for this item.

1. Ms Grosskopf presented a series of slides which set out key aspects of the new legislation and the effects of the changes upon delivery of, and charging for, social care services. *Copies of the slides were tabled.* There would be two phases of change - in April 2015 and April 2016 – and the main elements of each phase were summarised in the slides. Some detail of changes coming in April 2015 was not yet available but would become clear later in May 2014. Not all changes would be new to Kent but would formalise some best practice which Kent already followed. Mr Thomas-Sam and Mr Ireland responded to comments and questions from Members, as follows:-

a) the importance of a client having an initial assessment of their care needs and eligibility was emphasised, so that suitable care, if required, could be planned and funded, either by the client or by the County Council. This would help avoid a client entering care of their own volition as a self-funder, perhaps earlier than was necessary, and then finding that this compromised their eligibility for County Council support at a later date. The County Council would not be responsible for refunding the costs of care already incurred if that care was purchased without the client first having had a care assessment;

b) the new system would commence in April 2015, and clients entering care at that time would be assessed under the system described above. The care package and funding arrangements for those already in care at that time would not change;

c) there was no threshold, for example, of age or financial resources, to a client requesting a care assessment, as any client was entitled to ask for such an assessment. There would be a national system to resolve any dispute by a client wishing to challenge their assessment;

d) the provisions of the new Care Act would be supported by government funding. Although the costs of this had not yet been fully quantified, the estimated cost in the first few years would be approximately £2.5 billion, nationally. Both the Local Government Association and the Association of Directors of Social Services (ADASS) had expressed concern that, should government funding fall short, particularly with an ageing population, local authorities would have to make up the shortfall; and

e) the costs to Kent were expected to be confirmed during the summer. Kent was known to spend more per head on adult care than many other local authorities, and had a large number of self-funders. Members expressed concern that Kent may not be able to retain its 'moderate' eligibility criteria, which it had protected for years, if it were forced to supplement government funding.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and said he shared the concerns expressed. He had always believed that it was important and correct for Kent to keep its eligibility criteria at 'moderate' and to support people to live independently in their own homes for as long as possible, giving them better quality of life and avoiding larger care costs later in their life. He reminded Members that the Care Act represented the largest and most fundamental change to social care provision since 1948. Today's social care was delivered in a very different environment to that of 1948, with many more of the population living for much longer than, and thus developing care needs not experienced by, previous generations.

3. RESOLVED that the main provisions of the Care Bill be noted and Members' comments on it and the outline implementation plan be noted.

13. Adult Social Care Transformation and Efficiency Partner update
(Item 2)

Mr S J G Koowaree declared an interest in this item as he had a relative who was receiving a direct payment from the County Council.

1. Mr Lobban introduced the report, which set out progress since the County Council's efficiency partner, Newton Europe, started working with the Council in early May 2013. He reported that good progress had been made and that the Council was on target to achieve the target of £30million annualised savings. Mr Ireland added that the County Council's 'efficiency' programme was focussed on enhancing and developing independence for clients and delivering better outcomes with less work.

2. Mr Lobban and Mrs Tidmarsh responded to comments and questions from Members, as follows:-

a) Mr Lobban explained to Members who had joined the County Council since the appointment of Newton Europe that, following a competitive tendering exercise, Newton Europe, a company of independent consultants, had been appointed as an efficiency partner to work alongside the County Council on its transformation programme. He emphasised that neither party could have achieved the savings without the support of the other;

b) although many clients applied to have a direct payment and wished to use this method to purchase their care, every applicant for a direct payment would be assessed to check that they were indeed able to take on the responsibility of managing and budgeting their own funds;

c) Members expressed concern that, when a service provider's contract was cancelled to reduce the number of providers, clients would miss out on the continuity of care provided by care staff with whom they had become familiar. They asked if staff could continue to work for the County Council by transferring to a provider whose contract was being renewed, and if such a transfer would be subject to TUPE rules. Mr Lobban confirmed that TUPE rules would apply in this situation but emphasised that the County Council was not the only purchaser of care in the county; and

d) telecare had previously been part of the whole system demonstrator, for which Kent had been a pilot. It could be delivered as part of a care package, after an assessment, in which case its cost to the client would depend on means testing, but if a client required telecare only, many chose to purchase the service themselves by subscribing to one of several 'lifeline' services available.

3. RESOLVED that the information set out in the report be noted and that further reports be made on a six-monthly cycle, the next one being to the September meeting of this Committee.

14. Draft 2014-15 Social Care, Health and Wellbeing Directorate Business Plan (Strategic Priority Statement)
(Item 1)

Mr M Thomas-Sam, Strategic Business Adviser, Policy and Strategic Relationships, was in attendance for this item.

1. Mr Thomas-Sam introduced the report and highlighted key areas of the new Business Plan. Members made the following comments and the content and style of the Plan:-

a) Members asked that more detail of the Better Care Fund be included;

b) the typeface in some sections of the plan was very small and could be difficult for some users to read comfortably; and

c) the lighter-coloured type in which some of the text was presented could be difficult for some users to see clearly.

2. RESOLVED that the draft 2014-15 Directorate Business Plan (Strategic Priority Statement) for the Social Care, Health and Wellbeing directorate be noted, in advance of the final version being approved by the relevant Cabinet Members and the Corporate Director.

15. Adult Social Care Performance Dashboard for February 2014
(Item 2)

Ms K Webb, Performance Manager, was in attendance for this item.

1. Ms Webb introduced the report and Mrs Tidmarsh and Mr Ireland responded to a question about the use of direct payments. The percentage of clients taking up a personal budget and/or a direct payment was currently rated red against its target. Due to the changes in practice which would arise from the transformation agenda and the Care Bill, the target would need to be adjusted to retain its relevance to the new, transformed services.

2. RESOLVED that the performance reported in the dashboard be noted.

16. Public Health Performance - Adults
(Item 3)

Mr M Gilbert, Commissioning and Performance Manager, and Ms K Sharp, Head of Commissioning, were in attendance for this item.

1. Ms Sharp introduced the report and said the County Council was seeking to establish a broader range of performance indicators to reflect a fuller picture of activity and outcomes across its transformed services. Mr Gilbert set out the background to, and context of, the current set of performance indicators. Mr Scott-Clark responded to comments and questions from Members, as follows:-

a) the set of indicators used to measure performance was a standardised set which was applied and used nationally, so that patterns across the country could be compared. The age of 75 was used in national indicators as it was believed by health professionals that most deaths under that age were preventable;

b) there was currently no national indicator to measure substance misuse, but it would be good to add one to Kent's dashboard. Work was in hand to add such an indicator for the next report, for this Committee's July meeting;

c) similarly, there was currently no national indicator in the Public Health Outcomes Framework related to clinical depression, but clinical commissioning groups (CCGs) collected local prevalence data and this could be included as a measure in future reports; and

d) the current set of performance indicators had been established while the public health function was part of the NHS, and the County Council would potentially identify new sets of indicators as its reviewed the 23 public health programmes which it had inherited from the NHS.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and undertook to take forward their concerns. Performance on some areas of public health work – for example, smoking cessation - was not as good in Kent as he would like it to be, and the Healthchecks programme was the subject of concern and attention from the Secretary of State.

3. RESOLVED that:-

a) the performance reported in the dashboard be noted;

b) the additional public health indicators, set out in paragraph 2.10 of the report, be agreed, with the addition of an indicator for substance misuse; and

c) an additional indicator for the weight management service be also added, once the new service had been commissioned.

17. Reports of Decisions taken outside the Cabinet Committee meeting cycle, for Members' information:
(Item E1)

Details of the decisions listed below, which had been taken since the final meeting of the former Social Care and Public Health Cabinet Committee on 16 January 2014, were noted.

14/0009 – Home Care contract award
14/00025 – Contract Extension for Maidstone and Tunbridge Wells NHS Trust
14/00026 - Contract Extension for Kent Community Health Trust
14/00030 – Review of Rates Payable and Charges Levied for Adult Services
14/00031 – Thomas Place nomination agreement
14/00032 – Wylie Court nomination agreement
14/00033 – Swanley Learning Disability Day Service

EXEMPT ITEMS

(OPEN ACCESS TO MINUTES)

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

18. Tendering for Community Sexual Health Services (Appendix to item B4 - 14/00048)
(Item F1)

Mr M Gilbert, Commissioning and Performance Manager, and Ms K Sharp, Head of Commissioning, were in attendance for this item.

1. Ms Sharp introduced the report and explained that the purpose of reviewing sexual health services in Kent was to address the consistency and accessibility of services. The unrestricted report set out the process for procurement and the award of contract, including the division of the service into seven lots on which interested parties would bid, and the exempt appendix to it listed those bidders who had submitted satisfactory pre-qualification questionnaires and had thus been invited to tender. Some slippage of the intended timescale of the review had been caused by the need to first prepare a report in response to concerns about service provision

expressed by the British Association for Sexual Health and HIV Services. Ms Sharp responded to comments and questions from Members, as follows:-

a) as part of the pre-qualification questionnaire process, bidders were asked to supply case studies to demonstrate their ability to deliver services similar to those for which they intended to bid in Kent. Those who were unable to supply satisfactory case studies would be recorded as having 'failed' against one or more of the lots and would not be invited to tender;

b) of the seven lots, lots 1 and 2 were by far the largest and, due to their size and complexity, may be ultimately delivered by a lead provider supported by a number of smaller providers. This model would allow the involvement of a combination of providers of a range of sizes and from a range of sectors; and

c) the contract length, an initial two years with an optional two-year extension, had been chosen to be long enough to engage the interest and commitment of good-quality providers while also allowing the opportunity to review performance. This contract length would allow the County Council optimum flexibility.

2. RESOLVED that:-

a) the identities of the providers invited to tender for community sexual health services be noted; and

b) the proposed decision to be taken by the Cabinet Member for Adult Social Care and Public Health, to identify the preferred bidder/s from amongst those listed, and to agree the award of the contract/s to those bidder/s, to deliver Community Sexual Health services, be endorsed.

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Thursday, 12 June 2014.

PRESENT: Mr C P Smith (Chairman), Mr G Lymer (Vice-Chairman), Mrs A D Allen, MBE, Mr H Birkby, Mr A H T Bowles, Mrs P Brivio, Mrs P T Cole, Ms C J Cribbon (Substitute for Mr T A Maddison), Mr A D Crowther, Mrs V J Dagger, Mr S J G Koowaree, Mr R J Parry (Substitute for Mr R E Brookbank) and Mrs P A V Stockell (Substitute for Vacancy)

ALSO PRESENT: Mr G K Gibbens

IN ATTENDANCE: Mr M Lobban (Director of Commissioning), Mr A Scott-Clark (Acting Director of Public Health), Mr M Walker (Head of Service, Learning Disability, West Kent), Ms G Walton (Change Implementation Officer), Mrs L Whitaker (Democratic Services Manager (Executive)) and Ms A Evans (Democratic Services Officer)

UNRESTRICTED ITEMS

19. Apologies and Substitutes
(Item A2)

(1) Members were asked to note that Mr Oakford had taken over from Mrs Whittle as Cabinet Member for Specialist Children's Services from 2 June 2014 which had created a vacancy on the Committee. For this meeting the vacancy was being substituted by Mrs Stockell.

(2) Mr Brookbank and Mr Maddison had both sent apologies and were substituted by Mr Parry and Ms Cribbon respectively.

20. Declarations of Interest by Members in items on the Agenda
(Item A3)

(1) Ms Cribbon declared an interest in Item B1, Gravesham Social Education Centre (GSEC) as the Chairman of Gravesham Borough Council's Planning Committee and as the local County Member who had written in response to the consultation.

(2) Mr Parry declared an interest in Item B2, Medway Integrated Substance Misuse Service. As the Chairman of the Scrutiny Committee he had, along with the Corporate Director for Social Care, Health and Wellbeing, been party to agreeing the use of the urgency procedure.

21. Chairman's announcements

The Chairman stated at this point that it was his intention to take items B2 and C1 together in Part 2 of the meeting to allow Members to debate the matter fully. He asked if Members were agreeable to this and it was agreed that, after item B1, the meeting would go into closed session.

22. Gravesend Social Education Centre (GSEC)

(Item B1)

(1) The Cabinet Committee received a report of the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing which contained an update on the refurbishment of the Gravesend Social Education Centre (GSEC) building and further development of community opportunities for the consideration of the Committee. Mark Walker, Assistant Director, Learning Disability – West Kent, and Gina Walton, Change Implementation Officer, were in attendance to introduce the report and in particular referred to the following:

(2) In 2013 a feasibility study was carried out to consider how best to provide services for people with Learning Disabilities in the Gravesham area. As part of this review the Good Day Programme (GDP) looked at modernising in house day services to ensure they were delivered in a more flexible and community based way. GDP aimed to overcome people with learning disabilities feeling isolated and segregated and process centre planning was one way of doing this. Take up of the GDP had been better in West Kent than in East Kent.

(3) The modernisations at GSEC also provided an opportunity to link into New Ways of Working (NWoW) as the lease on Joynes House, Gravesend was due to expire and new office accommodation was required for the Community Learning Disability Team. The placement of this team within GSEC would ensure an improved, more community based service for GSEC service users and realise leasehold savings from Joynes House in the longer term. As well as co-locating services at the GSEC site options for a community hub within the Gravesend area were being explored.

(4) The Cabinet Member had held cross-party briefings with Members in January 2014 and a formal consultation took place with CSEC service users, carers and staff following these briefings. Responses to the consultation were positive with people glad that the building was being retained and money was going to be spent on it.

(5) The total budget available for construct, refurbishment and furniture and equipment was £800k, the Good Day Programme contribution was £500k and NWoW was £300k.

(6) The contract was ready to be signed and it was expected that construction would commence in late June 2014 and be completed by the end of January 2015.

(7) In response to questions raised and comments made the Committee received the following further information from officers:

(8) The tender had been project managed by NWoW and four suitable contractors had tendered. Harpers had been identified as the winner and the contract was with Legal.

(9) The GDP contribution came from ring fenced money being reinvested from changes to in house services which had been agreed several years ago. The NWoW contribution would be money invested in GSEC rather than rent and rates for Joynes House.

(10) Concerns about parking and mature trees had been addressed with a proposed reconfiguration of the car park. One option included off-site parking in local car parks close to the site while a second option with changes to the car park configuration addressed concerns that had been raised about the mature trees.

(11) The large office space (on the plan attached to the report) included 26 desks which would be shared between 49 staff moving to GSEC from Joynes House including care managers of service users who would benefit from them being onsite.

(12) The Cabinet Member thanked Members of the Committee and gave the assurance that no changes to services would be made until replacements were up and running.

(13) RESOLVED that Members of the Adult Social Care and Health Cabinet Committee endorse the proposed decision and the Cabinet Member for Adult Social Care and Public Health be asked to agree to the refurbishment of the Gravesend SEC and further development of community opportunities.

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

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

23. Medway Integrated Substance Misuse Service - Contract Award and Performance Management
(Item B2)

(1) The Cabinet Committee received a report of the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing which contained detailed information that the Cabinet Member for Adult Social Care and Public Health had considered prior to making the decision.

(2) Mark Lobban, Director of Strategic Commissioning, introduced the report and answered Members' questions.

(3) RESOLVED that the information be noted and that Members endorse the Cabinet Member to make the decision.

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By: Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health

Mr A Ireland, Corporate Director for Social Care, Health and Wellbeing

Mr A Scott-Clark, Acting Director for Public Health

To: Adult Social Care and Health Cabinet Committee – 11 July 2014

Subject: **Verbal update by the Cabinet Member and Corporate Directors**

Classification: Unrestricted

The Committee is invited to note verbal updates on the following issues:-

Cabinet Member Update

Adult Social Care:

Key Decisions
1. Gravesend SEC Modernisation – 12 June
2. Dover LD Day Services – 16 May

Events
1. 09 May attended South East Mental Health Commissioning Network in Guildford
2. 24 June attended South East Care Bill consultation event in London
3. 27 June attended Voluntary Sector Conference in Lenham
4. 02 July attended Accommodation Strategy Launch in Hollingbourne

Public Health:

Key Decisions
1. Kent Alcohol Strategy 2014-16 – 16 May
2. Contract Award for Medway Adult Substance Misuse Treatment Services – 13 June

Events
1. 04 June attended Public Health Champions celebration event in Maidstone
2. 17 June attended West Kent Healthy Business Launch in Brands Hatch
3. 17 June attended Healthy Living Programme event in Wrotham
4. 9 July will attend Children and Young People's Emotional Wellbeing summit in Gravesend

Corporate Director of Families and Social Care, Health and Wellbeing
- Health Integration Update including national recognition of the work in Kent and Norman Lamb's visit
- Launch of the Accommodation Strategy
- Engagement with the third sector on Community Services

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

Andrew Scott-Clark, Acting Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 11th July 2014

Subject: Health Check Programme Update

Classification: Unrestricted

Summary:

Kent County Council inherited a number of commissioned services when public health responsibilities transferred into the authority. As a part of a structured programme these services are being systematically reviewed prior to re-commissioning.

This paper outlines the background to the health check services, details the current service provision and discusses the options for future service delivery.

Next steps in the process of developing service specifications are discussed.

Recommendations:

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

1. Note the current position of the programme

2. Agree to this committee receiving a paper in September outlining the recommended approach to future delivery

1. Introduction

1.1. Background

1.1.1. The *Global burden of disease* report (2013) highlighted the need to reverse the growing trend in the number of people dying prematurely from non-communicable diseases. Since 1990, the number of people dying from ischemic heart disease and diabetes has risen by 30% and a high body-mass has been attributed as the most important cause of premature mortality and disability.

1.1.2. The Secretary of State for Health has prioritised reducing premature mortality with a focus on improving prevention and early diagnosis; the NHS Health Check programme is a key element in supporting this ambition.

1.1.3. The Department of Health published *Living well for longer:* a *call to action on avoiding premature mortality* and the *Cardiovascular disease (CVD) outcomes strategy* on 5 March 2013. Both identify the NHS Health Check programme as a vehicle for delivering ambitions.

1.2. What is the Health Check Programme?

1.2.1. The NHS Health Check programme is a national cardiovascular disease (CVD) risk assessment programme that became a mandated responsibility for the NHS in 2012. This responsibility transferred from the NHS to Kent County Council with Public Health in April 2013.

1.2.2. It is a five year rolling programme that targets people aged between 40 and 74. People in this age range are invited every five years to receive a Health Check to assess their risk of CVD. CVD includes heart disease, stroke, diabetes, kidney disease and vascular dementia. Patients already diagnosed with any of these conditions, or who have hypertension, or are already on a statin medication to control cholesterol, or are receiving palliative care are not eligible and are therefore excluded from the invitation process.

1.2.3. To enable a structured approach for a five year programme that allows for an equalised number of patients per year, patients are targeted for invitation in the financial year that they will turn a centennial age. (I.e. age will end in a '0' or a '5').

1.3. What does a Health Check consist of?

1.3.1. The check takes about 20-30 minutes and comprises simple questions on:

- age
- sex
- ethnicity
- family history
- smoking status
- amount of exercise
- Alcohol consumption.

Recording of:

- height, weight, Body Mass Index (BMI)
- blood pressure
- cholesterol levels

1.3.2. For people over 65 years old, there is also an element on dementia awareness and signposting.

1.3.3. A formula is then applied to give an indication of the risk of developing cardio-vascular disease which is then discussed with the patient and further investigatory referral made for those identified as high risk. Referrals are made to health improvement services dependent on results.

2. Current Service

2.1. Current provision of the service

2.1.1. Currently the Health Checks Programme commission is worth approximately £2.1m per annum (dependent on performance – for example poor performance by the provider in the first three quarters of 2013/14 resulted in a claw back of circa £700,000) and is held by Kent Community Health Trust (KCHT), who sub-contract with GP practices, and pharmacies to deliver the programme on their behalf.

2.1.2. There are two key elements to the service – the invitation to receive the check, and the delivery of the check.

2.1.3. There are 197 GPs practices who provide the service, and only eight practices who are not engaged in the programme delivery. Of these, 157 practices offer the invitation and the check, whilst 40 practices offer the invitation only.

2.1.4. There are approximately 19 community pharmacy providers, and Kent Community Health trust organises clinics for practices that are not offering the service. They also undertake outreach checks, including at some employers and in offender institutions

2.1.5. An important part of the service is the implementation of a software system that allows collection and interrogation of data.

2.2. Target population

2.2.1. Using 2011 ONS statistics, the total number of people in Kent eligible for a Health Check between 2013-2019 is 444,482. The number of people who were due to be invited in 2013/14 was 91,241, with a target that 50% of those invited will receive a check.

2.2.2. For next year, 2015/16, the Public Health England aspiration is to achieve 66% (60,826) uptake of checks.

2.3. Current performance

2.3.1. The two key elements of the programme (number of invites and subsequent uptake) are measured and reported via the Public Health Outcomes Framework.

2.3.2. The performance for the past two years is shown in the table below, and the impact of the effective contract management (and enforcement of penalties) can be seen by the increase in performance in the fourth quarter of 2013/14. This has meant that the target for invites was met for the year, whilst performance for the number of people receiving health checks was approaching the required levels in the final three months of the year.

Trend Data – by quarter	2012/13		2013/14				
	Q4 (Jan-Mar)	Full 2012/13	Q1 (Apr -Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)	Full 2013/14
Target Offers	22,811	91,241	22,810	22,810	22,810	22,811	91,241
Actual offers	19,292	67,992	19,761	18,996	27,608	28,639	95,004
Target receive	11,406	45,621	11,405	11,405	11,405	11,406	45,621
Actual receive	9,569	29,845	6,455	8,836	6,924	10,709	32,924
% of target offers received	42.0%	32.7%	28.3%	38.7%	30.4%	46.9%	36.1%
RAG Rating	Amber	Red	Red	Red	Red	Amber	Red
National %	48.2%	40.4%	37.4%	45.3%	42.6%	-	-

3. Developing options for future service delivery

3.1. The current model of delivery (and contract with KCHT) was inherited as a part of the transfer of responsibilities from the NHS to local authorities, and it is therefore important that it is reviewed to understand if it is an effective model, or if there could be improvements.

3.2. It is also important to recognise that a new programme on this scale (with an eligible customer base of over 440,000 people), could take time to establish itself, and for people to recognise the value of the service.

3.3. Improvements in recent performance should also be recognised when developing an appropriate short and medium term plan of action, although improvements will need to be carefully monitored.

3.4. Different possibilities for the commissioning of this service are:

- Prime provider – sub-contracting to primary care providers, e.g. GPs and community pharmacies. The prime provider will co-ordinate services, including paying sub-contractor to deliver outreach. **(This is the current model).**

- Single provider – involves commissioning a single provider or consortium to deliver NHS health checks. This will include both the invitation and the check.

- Any qualified provider model - this will contract directly with GPs, pharmacies and outreach providers to deliver NHS health checks and payment will be based on numbers delivered.

- Primary care based model with additional outreach which will contract directly with primary care (GPs and community pharmacy) and additional outreach will be commissioned separately.

- Partial in house delivery - KCC could administer the invite dimension of the programme through the Kent Primary Care Agency database and contract out the health checks.

4. Next Steps

4.1. The Public Health Commissioning team will review all options to determine the recommended model for the delivery of health checks, prior to returning to committee in September. The focus will be how to improve performance particularly with key groups vulnerable to poor health outcomes.

4.2. Different models of delivery will be evaluated including a review of the approach with other areas nationally, and exploring where innovation in the approach may be needed to improve performance.

Recommendation(s):

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

1. Note the current position of the programme

2. Agree to this committee receiving a paper in September outlining the recommended approach to future delivery.

5. Background Documents

5.1 None

6. Contact Details

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

Andrew Scott-Clark, Acting Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 11th July 2014

Subject: Tendering for Postural Stability Classes

Classification: Unrestricted

Summary

Programmes to reduce falls in older people are a key priority for Kent Public Health, particularly because fall rates are comparatively high across the County. Evidence suggests that a course of Postural Stability classes are effective in improving balance and confidence, and in strengthening muscles, and therefore reduce the rate of falls in vulnerable groups.

This paper provides information about the process undertaken to procure community based postural stability classes across the County, to ensure a consistent and equitable service.

Members of the Committee are asked to:

a) Endorse the commissioning approach and service model outlined in the paper.

Introduction

1.1 The purpose of this paper is to outline the joint Public Health and Social Care proposals to commission a series of evidence based postural stability classes across Kent to reduce risk of falls among older people in Kent.

2 Background

2.1. Falls and fractures among older people are significant public health issues and represent substantial costs for the health and social care system[1]. In July 2013, the Kent Health Wellbeing Board approved proposals to establish a consistent and effective framework for preventing falls across Kent. The framework is illustrated at Appendix A. The falls framework is at different stages of implementation across CCGs and there is varying levels of service provision in different areas of the county.

2.2. A key component of the falls framework is the provision of evidence based 36-week postural stability classes in the community. The current provision is commissioned by Public Health and Social Care and is delivered by a range of providers including Kent Community Health Trust and voluntary sector providers.

[1] Kent Health & Wellbeing Board Paper, 17 July 2013

2.3. The provision is inconsistent across the county and in most areas only offers a shorter duration (12 week) course rather than the recommended 36-week programme. The contracts and grant agreements for the current services are also due to expire in September 2014.

2.4. This paper outlines proposals for jointly commissioning a more comprehensive range of 36-week courses across the county to enable the agreed falls framework to operate effectively leading to fewer falls related admissions to hospital and residential / nursing care.

3 Commissioning Approach

3.1. Public Health and Social Care commissioners have agreed a clear service specification for postural stability classes in Kent. The specification is based upon NICE guidance[2] and best practice for classes and has been informed by the Equality Impact Assessment for the service. The high level service outcomes are listed at Appendix B. The classes will need to operate in a changing environment as the wider falls framework develops.

3.2. Public Health, Social Care, CCGs and other partners are working collaboratively to ensure integration at local level. Key initiatives relating to the wider falls framework include:

a) Wider use of screening tools by agencies who may have contact with older people at risk of falls (e.g. Fire and Rescue Service, Alcohol Advice and Information Services)

b) Expansion or consolidation of falls rehabilitation services in all CCG areas

c) Delivery of Identification and Brief Advice within postural stability classes for to reduce alcohol related falls among increasing risk and higher risk drinkers

3.3. A recent market engagement exercise identified a broad level of interest from NHS providers and providers in the voluntary and community sector. This wider context and relatively diverse market has required a careful consideration of the most suitable commissioning approach. The commissioning approach must be:

a) flexible and scalable – must allow for additional capacity to be commissioned to meet future increases in demand

b) accessible to a wide range of providers including small, voluntary sector providers

c) good value for money.

3.4. The Falls and Postural Stability Steering Group considered a range of commissioning options. A summary options appraisal is included at Appendix C. The Steering Group selected the Dynamic Purchasing System (DPS) as a preferred commissioning approach with caveats on minimum contract length and effective operation of an independent referral service.

[2] NICE CG161 Falls: assessment and prevention of falls in older people

3.5. The DPS will allow Public Health and Social Care to commission a block of postural stability classes on a 2-year contract to offer the minimum coverage across the county but will also allow for additional classes to be commissioned as the framework develops further to create demand for additional classes.

3.6. The DPS will operate as an approved provider list as all providers will have been assessed to ensure they meet the minimum requirements. Approved providers will be invited to tender a price for a specified class, or range of classes when the need is identified. The DPS is also flexible so new providers can join as the market develops.

3.7. Public Health intends to invite tenders for the service in Autumn 2014 and will award contracts to successful providers, following this process. .

4 Service Model

4.1. The commissioning approach outlined above may lead to postural stability classes being delivered by different providers in different locations. In order to reduce the risk of service fragmentation and confusion among service users and referrers, Public Health will commission the KCC Access to Resources Team (ART) to act as a central referral point for any partner agency seeking make a client referral for postural stability.

4.2. The information governance and data requirement for Better Care Fund (such as the NHS no's.) will be included as part of this.

5 Financial Implications

5.1. Public Health has committed to invest up to £453k per annum in provision of postural stability classes across Kent up to 2017/18. Public Health and Social Care are working closely to review the level of funding available and ensure alignment with joint priorities.

5.2. The flexibility of the DPS will mean that the core provision can be commissioned relatively quickly with additional capacity commissioned at a later date to meet local Better Care Fund objectives.

6 Conclusion

6.1. Falls and fractures among older people are significant public health issues and represent a substantial cost to the health and social care system. The Kent Health and Wellbeing Board have approved plans to develop and more comprehensive falls framework across Kent including provision of evidence based postural stability classes.

6.2. Public Health and social care have developed a new approach to commissioning the classes across in a way that will be scalable, affordable and accessible for small VCS providers. The approach will involve setting up a DPS and tendering for providers to deliver classes in line with local need. The DPS will allow additional capacity to be added as the wider framework develops and creates additional demand for postural stability classes.

7 Recommendations

7.1. Members of the Committee are asked to:

a) Endorse the proposed commissioning approach and service model outlined in the paper.

Background documents

Kent Health & Wellbeing Board Paper, 17 July 2013

Postural Stability Classes – Service Specification

Postural Stability Classes – Equality Impact Assessment

NICE clinical guideline 161 - Falls: assessment and prevention of falls in older people

Report Prepared by

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Appendix A – Kent Falls Framework
Reduce second box & simplify

Appendix B – Postural Stability Classes – Draft Service Outcomes

1. The Provider will engage with the target age group within the community (older people aged 65 and over), social care and health practitioners and other partners/local organisations to positively contribute towards the outcomes listed below:
    - improved balance strength, mobility and confidence leading to reduced risk (reduction) of falling;
    - increased knowledge & awareness of causes of (injury from) falls, and the benefits of exercise and good nutrition;
    - a reduction in acute hospital admissions due to falls prevention and fallers referred directly to programme.

2. The Provider must also:
    - provide the opportunity to socialise by providing an environment that is attractive, inclusive and welcoming;
    - provide alcohol Initial Brief Advice (IBA) and screening and signpost clients to additional as appropriate;
    - signpost or refer to other relevant services or activities to address other health issues such as weight loss or isolation;
    - raise awareness of other relevant Public Health programmes;
    - liaise with GPs, Social Services and/or other carers (referrers) to ensure client attendance can be accommodated;
    - deliver and co-ordinate 3 successive programmes of Postural Stability classes for 1.5 hours per week for 36 weeks (including 15-20 minutes for information sharing and signposting other public health interventions and programmes).

Appendix C – Commissioning Approach – Options Appraisal

Option	Advantages	Disadvantages/Risks
a) Prime provider model – Single provider operates has responsibility for ensuring provision of postural stability classes in required locations on the required dates	• Simplicity – fewer providers to contract manage • Commissioners will not need to spend time organising times and locations of particular classes➔ more time to focus on evaluation of programme • Allows for smaller organisations to be engaged through sub-contracting or consortium arrangements • Prime provider will have flexibility to source new/ alternative providers quickly, at short notice without having to follow complex procurement procedures	• Prime provider management and overhead costs will still need to be met from the postural stability budget • Risk that poor performance of prime provider may have knock-on effect across the county as they will be the only provider. • Less competition - market for prime provider is more limited than smaller scale contracts. There may only be 2 or 3 potential providers
b) Framework Agreement – A range of suitably qualified providers are available to run postural stability classes in the county. Commissioners run a mini-competition or reverse auction to agree individual contracts for each 36-week programme for each location. Mini-competitions will be run 3-6 months ahead of the start of the programme to allow mobilisation time for the appointed provider.	• Increased competition – more providers available as they will not all need to provide county wide or year round coverage. • Public Health may benefit from lower costs/overheads of smaller organisations.	• Public Health will still have on-going responsibility for regularly inviting bids for classes every 3 months. • More complex contract management ➔ potentially several different providers to contract manage • No provision for new providers to run classes even where they may be cheaper and/or better quality
c) Dynamic Purchasing System Similar to framework agreement but allows new providers to apply to join	• Commissioners and service users able to benefit from new providers with lower costs and/or higher quality than	• Potentially complex procedure for advertising and awarding contracts – requirement to advertise each call-off contract

Option	Advantages	Disadvantages/Risks
the pool of providers available to deliver the programmes.	providers available at the start of the programme	through EU website.

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

Andrew Scott-Clark, Acting Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: **11th July 2014**

Subject: Updating the Kent and Medway Suicide Prevention Strategy

Classification: Unrestricted

Summary:

Kent County Council is a lead partner within the Kent and Medway Multi-Agency Suicide Prevention Strategy Group. The Group is responsible for the oversight and implementation of the current Kent and Medway Suicide Prevention Strategy which runs from 2010-2015.

In 2012 the Government introduced a new national suicide prevention strategy, and in 2013, published the first annual progress report which contained six new areas of focus for suicide prevention work at a local level.

This paper outlines the process for updating the Kent and Medway Suicide Prevention Strategy, as well as providing details of changes in national policies and local structures which will influence the content of the updated strategy.

Recommendation(s):

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

1. Endorse the timescale for updating the Kent and Medway Suicide Prevention Strategy

2. Endorse the direction of travel in relation to new areas of focus within the updated Strategy

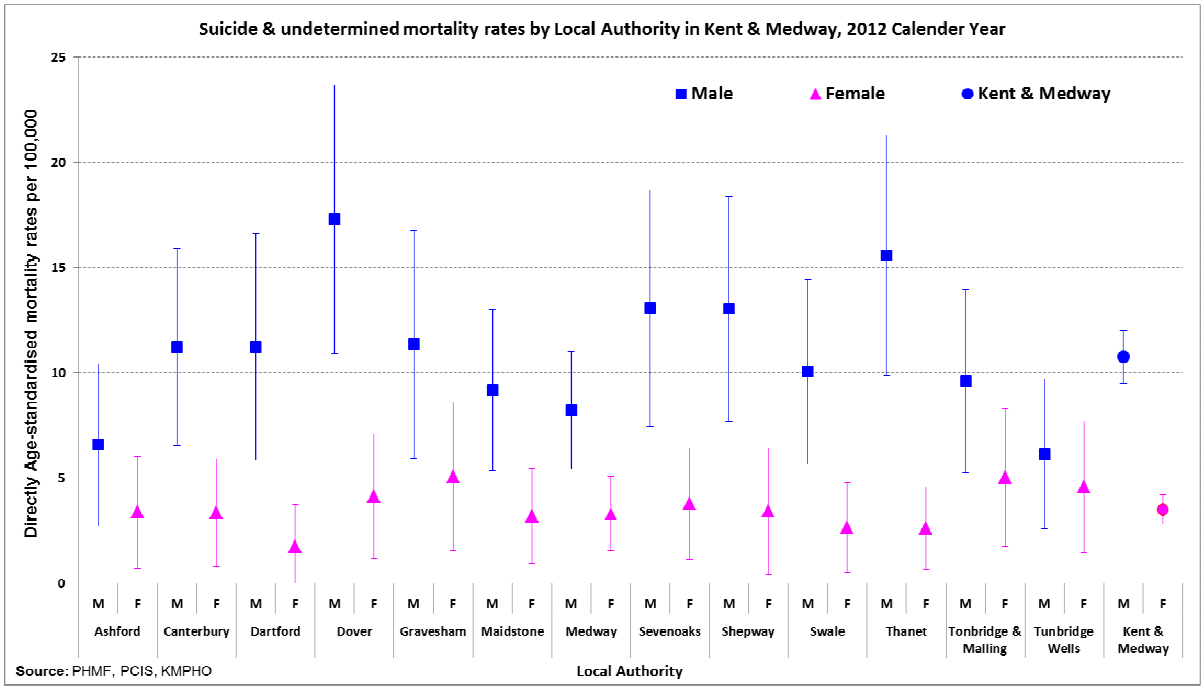
1.0 Introduction

1.1 The effect of someone committing suicide is devastating for families and friends of the individual concerned. The impact can be felt across the whole community.

1.2 Suicide rates in Kent are higher than the national average, and it is the largest cause of death amongst people aged 25-44. In 2013 there were 147 suicides

or deaths by undetermined causes[1] in Kent (116 men and 31 women). This is an increase from 121 in 2012[2]. Most suicides in Kent are committed by men aged between 30 and 60. (Please note: The 2013 figures have only just become available and a detailed analysis is currently being undertaken).

1.3 The following figure uses the average annual standard mortality rates from 2010-2012 to illustrate the difference in suicide rates between men and women in every local authority within Kent.



1.4 While every person that commits suicide has their own reasons for doing so, statistics from the Kent and Medway NHS and Social Care Partnership Trust (KMPT) show that between 2009 and 2011, 26% of individuals who committed suicide in Kent had been in contact with mental health services within one year prior to death. Therefore KMPT and other agencies will need to continue to work together to support this particularly vulnerable group.

1.5 However, it is important to note that the same statistic means that 74% of individuals who committed suicide in Kent between 2009 and 2011 had not been in recent contact with mental health services. Therefore, it is imperative that suicide prevention activity also aims to improve the mental health and well-being across the whole Kent population, as well as within a number of other high risk groups.

2.0 The Kent and Medway Suicide Prevention Strategy 2010-15

[1] Undetermined cause is a category of coroner verdict that is counted along with suicide by the Office of National Statistics and is regarded as 'probable suicide'

[2] Figures provided by KMPHO

2.1 Reducing the number of suicides is an indicator within the draft *2014-17 Joint Health and Wellbeing Strategy for Kent*[3] as well as the *Live It Well Strategy* for improving the mental health and wellbeing of people in Kent and Medway[4].

2.2 Kent County Council is a lead partner within the *Kent and Medway Multi-Agency Suicide Prevention Strategy 2010-15*[5]. The strategy has five strategic priorities;

1) To reduce the risk of suicide in key high risk groups
2) To promote well-being in the wider population
3) To reduce the availability and lethality of suicide methods
4) To improve reporting of suicidal behaviour in the media
5) To monitor national suicide statistics and progress towards national targets, ensure appropriate audit and support research

2.3 More details on progress and activity related to these priorities can be found in Appendix 1.

2.4 Although the current strategy is due to run to the end of 2015, it is felt that due to a new national strategy, changes in local circumstances (ie Public Health moving into Kent County Council) and emerging good practice from around the country, it is appropriate to update the Kent strategy now.

3.0 National policy and good practice

3.1 Since the publication of Kent's suicide strategy in 2010, the Coalition Government has published the *Preventing Suicide in England*[6] national strategy in 2012 and a '*One Year On'* progress report in January 2014[7]. The priorities contained within the 2012 national strategy match the strategic priorities within the *Kent and Medway Suicide Prevention Strategy 2010-15* very well, however the '*One Year On'* national progress report identified six further priority areas which will need further examination in a Kent and Medway context. These areas are;

- Self-harm
- Supporting mental health in a financial crisis
- Helping people affected or bereaved by suicide
- Middle aged men
- Children and young people
- Working with coroners

3.2 Other relevant policy developments have included Public Health England publishing the *Public Health Outcomes Framework 2013-2016*[8] in November 2013 (which includes indicators on both suicide and self-harm), and the

[3] *Joint health and wellbeing strategy: Outcomes for Kent 2014-17*
[4] *Live It Well: The strategy for improving the mental health and wellbeing of people in Kent and Medway 2010-2015*
[5] *Kent & Medway Suicide Prevention Strategy 2010-2015*
[6] *Preventing suicide in England; A cross-government outcomes strategy to save lives*
[7] *Preventing suicide in England: One year on*
[8] *Public Health Outcomes Framework 2013-2016*

National Institute for Health and Care Excellence (NICE) issuing new guidance on self-harm in June 2013[9].

3.3 In April 2014, the Coalition published an update to its mental health strategy[10]. It seeks 'Parity of Esteem' for people with mental health disorders and recommends that public services should reflect the importance of mental health in their policy planning by putting it on a par with physical health.

3.3 An informal review of national good practice has indicated that the *Kent and Medway Suicide Prevention Strategy and Action Plan* already contains many of the indicators of good practice as published by the Department of Health[11]. The review also uncovered that Brighton and Hove is aiming to become the first UK city to be given Suicide Safer City status. More details below.

Brighton and Hove – Suicide Safer City

Brighton and Hove is aiming to become the UK's first 'Suicide Safer City' (a designation given by LivingWorks Education). A suicide Safer City has the following characteristics;

- A leadership committee and an action plan to guide progress towards suicide-safer status
- Significantly improved access to suicide intervention and suicide bereavement services
- 1% of the local population is trained in suicide prevention skills
- Local organisations have trained their staff in suicide alertness and intervention skills
- A significant number of community members have taken a pledge to talk openly and directly about suicide if they are concerned for someone else, or themselves
- A plan for mental health promotion in the general population
- Every year the community gathers to mark World Suicide Prevention Day and celebrate progress

Brighton has developed a *'Tell Me'* suicide prevention pledge and is aiming that 5% of the city's adult residents take the pledge. Their figures show that one in twenty of their residents, or 5%, will consider suicide in any two week period. They want each person in Brighton & Hove who thinks about suicide, to know that there is a nominal person somewhere else in the city who has taken the pledge.

4.0 Updating the Kent and Medway Suicide Prevention Strategy

4.1 Following its move into the County Council, Kent Public Health is now able to play an enhanced role in shaping and co-ordinating the activities of partners. In turn this may enable the Strategy to go further in some areas than has previously been possible.

4.2 In addition to ensuring that the Strategy reflects new national policy and emerging best practice, early discussions have identified the following areas which provide opportunities for potential improvement:

[9] *NICE Guidance Quality Standard 34 self-harm*
[10] *Making mental health services more effective and accessible*
[11] *Department of Health Prompts for local leaders on suicide prevention*

- Increased commitment to achieve parity of esteem for individuals with mental health disorders
- Enhanced links with the Coroner's Court and increased monitoring at a local level to identify trends
- Improved working with agencies such as Kent Police and Kent and Medway Partnership Trust
- A detailed examination of the rates of self-harm in Kent and the links to future suicide attempts
- A greater understanding and a better response to individuals with a dual diagnosis (ie individuals with a mental health illness and a history of alcohol or other substance misuse) – this is being led by the Dual Diagnosis Steering Group
- Publicity campaigns and training for front line staff to reduce the stigma of mental illnesses such as Mental Health First Aid Training and KCC's Happier@Work pilot developed in partnership with NHS South London and Maudsley (SlaM)
- Continued investment and programmes targeting men's mental health e.g. Kent SHEDs which seeks to support men, particularly those aged 30 to 60 and ex service personnel in particular
- Suicide prevention training and awareness – Mental Health First Aid Training will be offered to public sector, voluntary and community sector employers and small businesses across Kent
- An examination of the role of the media (including social media and the internet) in influencing suicide and parasuicide (especially amongst young people).

4.3 Kent Public Health will work with partners and stakeholders to prepare an updated Kent and Medway Suicide Prevention Strategy, with the aim of bringing it to this Committee for comment and approval in February or March 2015. In doing so, it may also be appropriate to make recommendations to refresh fundamental aspects of the Kent 'Live it Well' Strategy 2010-2015.

4.4 Proposed timescale;

- June - July 14 National policy and best practice review
- June – Aug 14 Evaluation of current strategy and latest statistics
- June – Dec 14 Consultation with partners and stakeholders
- Jan – Feb 15 Drafting updated strategy
- Feb – March 15 Return to Committee for consideration prior to Cabinet

Member decision to approve and sign off strategy

Recommendation:

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

1. Endorse the timescale for updating the Kent and Medway Suicide Prevention Strategy
2. Endorse the direction of travel in relation to new areas of focus within the updated Strategy

5. Background Documents

Kent and Medway Suicide Prevention Strategy 2010-15

6. Contact Details

a. Report Authors

- Jess Mookherjee, Public Health Consultant
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b. Relevant Director

- Andrew Scott-Clark, Acting Director of Public Health
- 0300 33 6459
- Andrew.scott-clark@kent.gov.uk

Appendix 1 – June 2014 Update on Priorities with Kent and Medway Suicide Prevention Strategy

Priority	Actions taken/population affected	Status /activities
1. Reducing risk in high risk groups	High risk groups include: • those with mental illness • those who self-harm • offenders • older people • unemployed • those abusing substances	• Appropriate suicide prevention plan is in place in Kent and Medway Partnership Trust. • Mandatory training of staff in suicide prevention and risk assessment continues within Kent and Medway Partnership Trust • Ligature audits completed & recommendations implemented in Kent and Medway Partnership Trust • KDAAT are now part of the Suicide Prevention Strategy Steering Group • Self-harm audit in A&Es carried out in East & West Kent & findings widely disseminated including in all councils • Recommendations made to extend Liaison Psychiatric service in West Kent to 12 midnight every day (to follow the established practice in East Kent) • A tender process to procure a significant programme of Mental Health First Aid training is being undertaken during summer 2014
2. Promoting wellbeing in the wider population	• Those in financial difficulties • Those bereaved through suicides • Those misusing substances.	• The Six Ways to Wellbeing Campaign has been launched across Kent. All details and further information available on www.liveitwell.org.uk • Community sign-posting now available through several avenues like One Stop shop, voluntary organisations, Liveitwell.org.uk etc • KMPT supporting better access to information for those bereaved by suicide • KDAAT is a member of the Suicide Prevention Strategy steering group
3. Reducing availability & lethality of methods	• Those deliberately dying by bridges & train stations • Those taking an overdose of prescribed drugs	• Suicide attempt hot spots have been identified using data shared by Police and Network Rail. Partners (including the Samaritans) have installed posters and signage in appropriate places. • Network Rail have produced an analysis of all recent incidents and have budget available to increase safety measures
4. Improving reporting of suicides in media	The media (including internet sites) could influence the decision of some population groups, such as young people to take their own lives through copycat action	• Reporting monitored on an on-going basis through cuttings of press reporting and TV programmes
5. Monitoring of suicide statistics	Police, KMPT & other agencies sharing information collected with group.	• There is regular local monitoring of suicide trends in Kent and Medway by the KMPHO and other agencies • Baseline information has also been obtained on the trend of self-

		harming behaviour • Coroners have agreed to give regular updates to the KMPHO

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By:	Graham Gibbens, Cabinet Member for Adult Social Care & Public Health Andrew Ireland, Corporate Director for Social Care, Health & Wellbeing
To:	Adult Social Care & Health Cabinet Committee – 11 July 2014
Decision:	14/00083
Subject:	**HOME SUPPORT FUND POLICY**
Classification:	Unrestricted

Summary:	Provides information on the consultation on the Home Support Fund Policy and makes recommendations for the policy to be unified for both Adults and Children.
Recommendation:	The Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to: agree the revised Home Support Fund Policy as set out in the attached appendix 1.

Introduction

1. (1) The Home Support Fund plays a crucial role in helping the most vulnerable individuals in Kent remain in their own home and reduces the need for nursing/residential care. It supports disabled individuals by creating an adapted environment, which enables them to carry out everyday activities, maximising their independence so that they can continue to work, or carry out their role as spouse/parent. Children are given the best opportunity to be as independent as possible and their parents/carers supported to care for them.

(2) The Home Support Fund (capital budget) is a discretionary pot of money used for major adaptations and fixed equipment over and above the DFG

- Provide finance (grant or loan) to support major adaptation/DFG process in individual cases where there is financial hardship
- For Provision of major equipment
- For Assistance with moving and handling
- For Ceiling track Hoists

(3) Currently for Children the fund is used to top up a DFG where the costs of the work is over the maximum grant of £30k. This is offered in the form of a grant up to £15k and thereafter a legal charge is applied to the family property on a taper until the child is 18 or for ten years. No repayment is required unless the parents/carers cease to care for the child during that time.

(4) The situation is different for adults in that DFGs are means tested and often a 'notional loan' i.e. contribution is required from the individual. The test of resources applied by the local council is determined by government and does not generally take into account outgoings e.g. mortgage payments. Where the disabled individual has been assessed through the test of resources as having to make a contribution to the costs of works, they will usually be expected to make their own arrangements to pay this amount.

(5) The effect of this is that many individuals cannot afford to take out a loan. As a result FSC carry out a financial assessment and based on the result an interest free loan is made with the individual repaying, some, all or none of the money over a five year period. In addition it may be necessary to provide top up on the differential between the DFG and the cost of the work, or to fund the whole adaptation where the individual is not eligible for a DFG.

Revised Policy

2. (1) We are proposing a consistent policy that will:

- Create a single policy for children and adults across Kent.
- Provide consistency of application of the policy between adults and children
- Provide clear guidance for staff, partner agencies, individuals and their families.
- Be clear about the amount of funds available and any legal process that may apply.

(2) This will be on the basis of the first £1,000 being a grant. Where a disabled individual can demonstrate that they are unable to find the necessary funds from savings or a loan from a bank or building society an interest free loan will be applied for the additional funding up to £9,000 with a signed loan agreement. If the adaptation requires funding over £10K a legal charge (interest free) will be placed on the property up to a maximum of £30,000 so that in effect the Home Support Fund will, if required, match fund the maximum amount of DFG.

Financial Implications

3. (1) Currently parents/carers of children do not repay the loan unless they cease to care for the child. In future the policy will require repayment of the loan either over a 5 year period or when the home is sold. Repayment of adult loans is minimal and no legal charge is applied.

(2) The table below shows the difference financially between the existing and proposed policy over a three year period.

Expenditure and Number of Service Users/ 3 year period		
	£	**No.**
Adult's Services (OPPD):	527,815	90
Children's Services (DCS):	780,887	61
CUMULATIVE EXPENDITURE:	**1,308,702**	151
Existing Policy Income		

Adults - repayments	29,225	13
Childrens – legal charges secured income	647,105	19
TOTAL:	**676,330**	
Proposed Policy - Potential additional repayments / secured income		
Adults	91,782	77
Childrens	421,590	42
TOTAL:	**513,372**	

(3) The table above shows that there is potential to secure further funds for KCC. However, it is not possible to estimate the amount of income as a result of repayment and that which would be secured through a legal charge as this is dependent on the cost of the adaptation and so any income would be irregular.

(4) All applications for funding are scrutinised at Housing Adaptations Panel and the most modest solution is agreed. Occupational Therapists encourage individuals to move if a property is unadaptable on the grounds of feasibility or cost. However as there is no limit to the amount of money that can be requested from the Home Support Fund, KCC is open to challenge. In addition within the DFG legislation a grant cannot be refused on the grounds of cost alone.

Alternatives and Options

4. (1) Maintain status quo – this does not address the differences between the current Childrens and Adults polices.
(2) Introduce a tapered legal charge in adult services to match that of children services, but this would impact on the income to KCC as there would be no return on the investment.

Progress to Date

5.

- Briefed relevant Cabinet Members and their deputies on 26th March and received agreement to proceed with the consultation.
- Eight week period of customer, staff and colleague engagement. In general the responses received were that the proposals were clear with one or two minor changes and that the policy provided greater equity and consistency. As a result, we amended the policy as attached.
- Final draft of policy and report to DMT on 11th June 2014. Agreed to recommend the revised policy to Cabinet Committee.

Legal Implications

6. (1) There is currently a legal charge process in place for children. KCC Legal Services have now formulated a consistent process for both adults and children.

Personnel and Training Implications

7. (1) Once the policy is approved Procedural Guidance will be produced and training offered to the Occupational Therapists in both Adults and Children's services.

Property Implication

8. (1) None

Customer Impact Assessment

9. (1) An Equality Impact Assessment has been prepared and the risk is determined as low. A questionnaire has been sent to service users, local council colleagues and staff who are potentially impacted by changes for their feedback. This feedback has been incorporated into the revised policy.

Implementation Proposals

10.

- Report to be taken to Cabinet Committee 11th July 2014
- Cabinet Member decision – 17th July 2014
- Production of operational guidance – August 2014
- Roll out of training across the OT services – September 2014
- Implementation of Policy – 1st October 2014

Recommendation

11. (1) The Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to:

agree the revised Home Support Fund Policy as set out in the attached appendix 1.

Background Documents
Appendix 1 – Draft Home Support Fund Policy for Major Adaptations
Appendix 2 – Proposed Record of Decision, 14/00083 – Home Support Fund Policy

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DRAFT

Social Care Health and Wellbeing

Home Support Fund Policy for Major Adaptations

Issue Date:	Draft version 0.3 - 26June 2014
Review Date:	**March 2015**
Owner:	Anne Tidmarsh Director of Older People and Physical Disability Social Care Health and Wellbeing 3rd Floor, Brenchley House Maidstone ME14 1RF

Home Support Fund Policy for Major Adaptations
Social Care Health and Wellbeing

1. BACKGROUND

1.1 The Occupational Therapist following an assessment of need under the NHS and Community Care Act 1990, may make recommendations for the provision of adaptations to people's homes under section 2 of the Chronically Sick and Disabled persons Act 1970, where that person has a permanent and substantial disability as defined by the Act.

1.2 The local authority has a statutory duty under Section 2 of the Chronically Sick and Disabled Persons Act 1970 to 'make arrangements for home adaptations or for the provision of any additional facilities designed to secure their greater safety, comfort or convenience' but only where their needs have been determined to be eligible under the Fair Access to Care Services (FACS) Guidance on eligibility criteria for Adult Social Care England 2010.

1.3 There is a statutory duty for district councils to provide mandatory Disabled Facilities Grants (DFG) for disabled people under the Housing Act 1989 for essential home adaptations. This provision was revised through The Housing Grants, Construction and Regeneration Act 1996 which provides the current legislative framework.

1.4 The current maximum grant available under the DFG is £30,000 in England and is subject to a nationally determined means test which applies to those aged 18 and over to establish their contribution to the cost of the works. Those service users aged under 18 are not means tested for the DFG and therefore do not have a contribution.

1.5 The local authority has responsibility to support the disabled person to make arrangements for the provision of financial assistance in two ways:

- Where the cost of the agreed adaptation exceeds the maximum DFG
- Where the applicant for the DFG has difficulty meeting their assessed contribution determined by the means test and seeks financial assistance.

2. SOCIAL CARE FUNDING

2.1 Client contribution to DFG – Adults. Where the disabled adults has been assessed through the test of resources as having to make a contribution to the costs of works, they will generally be expected to make their own arrangements to pay this amount.

2.2 However, where a disabled adult or the parents of a disabled child can demonstrate that they are unable to find the necessary funds from savings or a loan from a bank or building society they can approach Social Care for financial support from the Home Support Fund. This is either for their assessed contribution or for top up above £30,000 DFG limit. The offer of support will be made through a loan with an upper limit of £10,000 (see section 3 for funding above this amount). This offer will be made, subject to the availability of funding, in the following way:

- a grant up to or for the first £1,000
- a loan, interest free, for the additional funding required up to £9,000 with a signed loan agreement. The repayment period should be over a period no longer than 5 years

2.3 The policy to offer a loan for the figure not greater than £9,000 provides a clear and fair approach to offering financial support where an assessed contribution has been identified through the Disabled Facilities Grant test of resources. This approach negates the need for a further financial assessment given that one has been completed through the grant process.

2.4 Flexibility will be available in terms of the repayment period should this be required to assist affordability. The decision to extend the repayment period beyond those mentioned above will need authorisation by a Senior Manager.
(Repayment table for loans, see appendix 1)

2.5 Loans offered will be subject to a signed loan agreement. Loans offered can only be considered for the assessed contribution and not for any other sum required to complete the adaptation.

2.6 Loans can only be offered subject to funding being available within the capital budget and authorisation being granted from the monthly Housing Adaptations Panel. (See appendix 2)

2.7 Where a disabled person has a contribution above £10,000, financial support can only be offered for the first £10,000, as outlined above.

2.8 If a disabled person defaults on repayments a review of their financial situation will be undertaken and adjustments made to their repayment plan to reflect their current circumstances. The Council reserve the right to charge interest on non paid loans. Legal proceedings may be pursued in the event of wilful refusal to reach agreement or to pay.

2.9 This element of the policy would apply to any disabled person who qualifies for a disabled facilities grant regardless of the tenure of their property.

2.10 Where a disabled person has a financial contribution, which is greater than the cost of the works it would be expected that the DFG process would be followed and a nil grant approval received prior to the works funded through the Home Support Fund commencing.

3 Works exceeding the DFG limit of £30,000 – Legal Charge Adults and Children

3.1 When the cost of the adaptations exceeds the DFG limit of £30,000, funding from Social Care could be offered where it has been agreed by the Housing Adaptations Panel that the adaptation is a cost effective way to meet the person's eligible needs. This offer of financial support will be made as an interest free loan secured by legal charge against the property and repayable when the property is sold.

3.2 In many cases the funding requested above the DFG level to complete the adaptation would be in the region of £10,000 or less (see section 2) . However, in exceptional cases a maximum loan of up to £30,000 may be considered, which in conjunction with a DFG of £30,000, makes a total of £60,000 available if necessary to meet assessed eligible needs.

3.3 All offers of financial support will be subject to agreement by the Housing Adaptations Panel and the responsible Corporate Director, or delegated nominee.

3.4 A loan secured by legal charge can only be offered for the sum required to complete the adaptations above the £30,000 DFG ceiling and not for any other ineligible works for the home. The loan should be repaid if the service user no longer lives at the property or the property is sold. Should the loan not be repaid this will usually attract interest and will be charged on the loan from the date that the service user no longer requires the adaptation. The interest rate will be in line with the prevailing government guidance.

3.5 All offers of financial assistance are subject to acceptance of a legal charge being placed against the property.

3.6 Should the disabled person live in rented property in the first instance the landlord would be approached to provide the financial top up to the DFG. The decision on any level of funding to be provided will be subject to agreement by the Housing Adaptations Panel and the responsible Corporate Director or their delegated nominee.

3.7 Where the top up applies to a child the legal charge would be placed on the property where the child lives, subject to the agreement of the owner of the property. If the child is in foster care paid for by KCC, then the Legal Charge process will still apply but the capital sum will not be repayable unless they cease to care for the child within an agreed period.

4 Client Contribution to DFG and Work exceeding DFG Limit

4.1 In adult cases there are occasions when the client contribution is required and the top up for the works exceeding the DFG limit. This offer of financial support would only be made where funding is available and is approved by the Housing Adaptations Panel and the designated Senior Manger.

5 Further Considerations

5.1 Where a property is unsuitable for adaptations either for technical or financial reasons, financial assistance towards the moving costs of a grant up to £1,000 can be made where an alternative property is being purchased. The property being purchased must be deemed suitable for the needs of the disabled person by the Occupational Therapist although it is recognised that further adaptations may be required once the move has taken place. Should it be necessary to provide financial assistance to a level greater than the £1,000 an additional amount could be considered and offered subject to a loan agreement as detailed in section 2. However, it should be noted that if the property purchase falls through the service user would need to meet the costs incurred relating to the moving process. Moving costs could include estate agents fees, removal costs and legal fees.

6 Review date

6.1 The Care Act 2014 will mean that there will be significant changes in how social care will be provided. However some of the regulations setting out these changes in subsequent years have not yet been released. Consequently this policy will need reviewing in March 2015 to ensure it remains compliant with the Care Act and its associated regulations.

Home Support Fund Policy for Major Adaptations
Social Care Health and Wellbeing

Appendix 1

REPAYMENT TABLE FOR LOANS UPTO £9000

These are weekly amounts. Service users will be invoiced every 4 weeks. 4 times the figure below.

AMOUNT OF LOAN	6 MONTHS	1 YEAR	2 YEARS	3 YEARS	4 YEARS	5 YEARS	6 YEARS	7 YEARS	8 YEARS	9 YEARS	10 YEARS
£ 100.00	£ 3.85	£ 1.92	\\\\\\\\\\\\\\	\\\\\\\\\\\\\\	\\\\\\\\\\\\\\	\\\\\\\\\\\\\\	\\\\\\\\\\\\\\				
£ 500.00	£ 19.25	£ 9.60	£ 4.80	£ 3.20	£ 2.45	£ 1.91	\\\\\\\\\\\\\\				
£1,000.00	£ 38.46	£ 19.23	£ 9.62	£ 6.41	£ 4.81	£ 3.85	\\\\\\\\\\\\\\				
£2,000.00	£ 76.92	£ 38.46	£ 19.26	£ 12.82	£ 9.62	£ 7.70	\\\\\\\\\\\\\\				
£3,000.00	£ 115.38	£ 57.69	£ 28.88	£ 19.23	£ 14.43	£ 11.55	\\\\\\\\\\\\\\				
£4,000.00	£ 153.84	£ 76.92	£ 38.52	£ 25.64	£ 19.24	£ 15.40	\\\\\\\\\\\\\\				
£5,000.00	£ 192.30	£ 96.15	£ 48.14	£ 32.05	£ 24.05	£ 19.25	\\\\\\\\\\\\\\				
£6,000.00	£ 230.77	£ 115.38	£ 57.69	£ 38.46	£ 28.85	£ 23.08	£ 19.23	£ 16.48	£ 14.42	£ 12.82	£ 11.53
£7,000.00	£ 269.23	£ 134.62	£ 67.31	£ 44.88	£ 33.65	£ 26.92	£ 22.44	£ 19.23	£ 16.83	£ 14.96	£ 13.46
£8,000.00	£ 307.69	£ 153.85	£ 76.92	£ 51.28	£ 38.46	£ 30.77	£ 25.64	£ 21.98	£ 19.23	£ 17.09	£ 15.38
£9,000.00	£ 346.15	£ 173.08	£ 86.54	£ 57.69	£ 43.27	£ 34.62	£ 28.85	£ 24.73	£ 21.63	£ 19.23	£ 17.31

Appendix 2

KENT COUNTY COUNCIL

HOUSING ADAPTATIONS FUNDING APPLICATION FORM

CLIENT NAME:	ID no.
ADDRESS:	D.O.B
Worker's name	Date:

PROPOSED ADAPTATION:

	ESTIMATED FIGURES	FINAL FIGURES FOLLOWING DFG APPROVAL
TOTAL COST OF WORKS		
CLIENTS ASSESSED CONTRIBUTION		
DFG EXPECTED (minus client contribution)		
CLIENTS AGREED CONTRIBUTION		
HOUSING ADAPTATIONS GRANT (up to £1000)		
HOUSING ADAPTATIONS LOAN towards client contribution		
HOUSING ADAPTATIONS TOP UP for works over £30k		

PREDICTED DATE OF GRANT APPROVAL ……..

PREDICTED DATE OF COMPLETION/PAYMENT ……

APPROVED: **DATE:**

SENIOR PRACTITIONER OT	
HOUSING ADAPTATIONS PANEL	

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Home Support Fund Policy	14/00083

For publication

Subject:
Home Support Fund Policy for Major Adaptations

Decision:

As Cabinet Member for Adult Social Care and Public Health, I agree to:

i) The Home Support Fund Policy for Major Adaptations, as set out in the accompanying report and appendix.

ii) Delegate authority to implement the policy to the Corporate Director for Social Care, Health and Wellbeing or other suitably nominated officer.

Reason(s) for decision:
The Home Support Fund plays a crucial role in helping the most vulnerable individuals in Kent remain in their own home and reduces the need for nursing/residential care. The revised policy:

- Creates a single policy for children and adults across Kent.
- Provides consistency of application of the policy between adults and children
- Provides clear guidance for staff, partner agencies, individuals and their families.
- Is clear about the amount of funds available and any legal process that may apply.

Cabinet Committee recommendations and other consultation:
To be entered after the 11 July 2014 Adult Social Care & Health Cabinet Committee and to be considered by the Cabinet Member when taking the decision.

Any alternatives considered:
Alternatives considered were:

1. To maintain status quo of existing policies, however this does not address the differences between the current Children's and Adults' polices.
2. Introduce a tapered legal charge in adult services to match that of children services, however this would impact on the income to KCC as there would be no return on the investment.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

None

..... signed

..... date

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

Andrew Ireland, Corporate Director for Social Care, Health & Wellbeing

To: Adult Social Care and Health Cabinet Committee - 11 July 2014

Decision: **14/00082**

Subject: Update on the Swale Learning Disability Day Service (Good Day Programme) Consultation.

Classification: Unrestricted

Recommendation: The Cabinet Committee is asked to note the ongoing consultation and that a decision report will come to the 26 September Cabinet Committee

1. Introduction

(1) This briefing statement for the Good Day Programme Swale Day Service Consultation provides an update on the consultation and an activity summary, including any significant changes to support the summary briefing.

(2) The 14 week consultation was launch on 6th May 2014 and will end on 12th August 2014.

We are consulting with	How are we consulting
KCC Member's and Local Councillors Service Users – with full support from Advocacy Service. Staff and Unions Parent/Family carers People who might use the services in the future Other organisations, including District Partnership Groups Health. Other Stakeholders	Consultation Briefing Meetings on the proposals Information Workshops A range of individual and group Meetings A questionnaire - hard copy and online questionnaire. Staff team meetings and individual meetings.

2. Latest Developments

(1) 437 questionnaires have now been distributed. 7 completed questionnaires have been received by post. The number of online completed questionnaires is not available until the end of the consultation period.

(2) Three consultation Information Workshops have taken place on 9th May 2014 (Sittingbourne), 4th June 2014 (Faversham) and 10th June 2014 (Sheerness) with a cumulative attendance of 19 people from a variety of stakeholder groups.

(3) The advocacy service started working with service users on 9th May 2011with workshops, group and 1:1 sessions. All people attending the Crawford Day Centre have had an opportunity to complete a questionnaire with an advocate. The advocacy will continue to carry out workshops, group and 1:1 sessions with the other people who use Swale day services until the end of the consultation period.

(4) Family/parent Carer 1:1 time slots were made available, with 1 family arranging a 1:1 meeting.

(5) Comments received to date are overall positive towards the changes:

> "To know that I had transport. To mix with the friends and socialise I am now used to. I like the staff at the day centre and hope I will still see them." [person attending the service]
>
> "I like meeting my friends, my art lessons, going out bowling, indoor bowls, dancing. I like trips out to see places and cups of tea." [person attending the service]
>
> "Our present centre is old and falling apart, we need new premises. New sites needed to improve enthusiasm and enjoyment of service users and staff." [staff member]
>
> "Brilliant! A breath of fresh air. The building in Faversham is awful, it was bad when the service moved there, it is even worse now. The other one is Sheerness is a bit better but so detached from the centre of the community." [anonymous]
>
> "I would like to be involved in finding new hubs. . . [family carer]

3. Next stages

(1) The consultation ends on the 12th August 2014 with the consultation outcome taking the following proposed timeline for a Key Decision.

27 August 2014	DMT
18 September 2014	Consultation report published
26 September 2014	Adult Social Care and Health Cabinet Committee
2 October 2014	Cabinet Member for Adult Social Care and Public Health can take the decision
10 October 2014	Implement Decision

4. Recommendation

(1) Cabinet Committee is asked to note the ongoing consultation and that a decision report will come to the 26 September Cabinet Committee

5. Background Documents - None

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

Andrew Ireland, Corporate Director, Social Care Health & Wellbeing

To: Adult Social Care and Health Cabinet Committee – 11 July 2014

Decision: 14/00015

Subject: **TEMPORARY FINANCIAL ASSISTANCE FOR RESIDENTIAL CARE - CHANGE TO THE ELIGIBILITY CRITERIA**

Classification: Unrestricted

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

Recommendation: The Adult Social Care Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to:

Change the policy on Temporary Financial Assistance (TFA) to state that a resident will (providing they meet the other criteria) be eligible for TFA once their liquid capital and income can only support their care costs for three months.

Introduction

1. (1) Kent County Council currently operates a Temporary Financial Assistance scheme for Residential Care for people who have capital over the capital limit (currently £23,250) but whose liquid capital has reduced to £3,000. This is normally because their other capital is tied up in their former home. There are (as at June 2013) currently 64 people being provided with assistance via this scheme.

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

Policy Context

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

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

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

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

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

- There must be no outstanding mortgage or loan already secured on the property.

- The cost of the residential/nursing home must be no more than our current guidelines for Deferred Payments (exceptions have to be agreed with the Assistant Director for the relevant locality)

- The resident must not have more than £23,250 in capital (e.g. savings), other than the value of their home.

- The resident must either not wish to sell their home or not be able to sell it quickly enough.

- The resident must solely own their former home

- The former home must have sufficient equity in it to fund the required care. We expect there to be enough equity to fund a minimum of 5 years in a residential home and a minimum of 3 years in a nursing home.

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

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

Policy change required

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

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

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

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

(5) Consultation with Finance colleagues has led to the conclusion that the policy be changed to state that Temporary Financial Assistance can be applied for when an individual/their representative can demonstrate that they only

possess sufficient liquid capital and income to fund their own care for three months. It must be stressed that this is only one of the criteria necessary for TFA to be granted. Others include the agreement to having a legal charge placed on the former home. If this is jointly –owned, all co-owners must agree to this charge, although the accruing debt will only ever be repaid from the resident's portion.

Financial Implications

4. (1) There are currently about 64 people being provided with assistance via the Temporary Financial Assistance scheme according to a report run by Finance in June 2013.

(2) It is not possible to predict accurately the financial implications of the proposed change to the policy. Finance believe it will provide a longer period to arrange for a charge to be placed on the resident's property before KCC begins funding. This is a good thing as it ensures our debt is secure.

Legal Implications

5. (1) The legal position is outlined in section 2 above.

(2) Legal services have not been consulted on this specific issue. However they were heavily involved in drawing up the new procedures for Temporary Financial Assistance. They are aware of our current policy in relation to the £3,000 and were made aware of our concerns and the fact that we would be seeking a change to the policy if possible.

Recommendations

6. (1) The Adult Social Care Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to:

Change the policy on Temporary Financial Assistance (TFA) to state that a resident will (providing they meet the other criteria) be eligible for TFA once their liquid capital and income can only support their care costs for three months.

Background Documents

Appendix 1 - Proposed Record of Decision, 14/00015 – Temporary Financial Assistance

Lead Officer/Contact: Chris Grosskopf, Business Strategy
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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TAKEN BY	DECISION NO.
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	14/00015

If decision is likely to disclose exempt information please specify the relevant paragraph(s) of Part 1 of Schedule 12A of the Local Government Act 1972

Subject: : Temporary Financial Assistance for Residential Care – Change to the Eligibility Criteria

Decision:

As Cabinet Member for Adult Social Care and Public Health, I AGREE:

To change the policy on Temporary Financial Assistance (TFA) to state that a resident will (providing they meet the other criteria) be eligible for TFA once their liquid capital and income can only support their care costs for three months.

Any Interest Declared when the Decision was Taken None

Reason(s) for decision, including alternatives considered and any additional information
Kent County Council's (KCC) currently operates a Temporary Financial Assistance scheme for Residential Care for people who have capital over the capital limit but whose liquid capital has reduced to £3,000. This is normally because their other capital is tied up in their former home. When the scheme was initially set up (over ten years ago) £3,000 would usually last long enough for KCC to make the necessary arrangements and take over the contract with the care home. This is no longer the case, although this will depend on the resident's weekly income.

Background Documents:
Report from Corporate Director to Cabinet Member

Cabinet Committee recommendations and other consultation:
Decision was supported at 5 Dec 2013 Social Care & Public Health Cabinet Committee

Any alternatives considered:
The only alternative is to maintain the current policy with an increasing number of discretion exceptions in cases of significant hardship.

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

....
signed date

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Decision Referred to Cabinet Scrutiny			
YES		NO	

Cabinet Scrutiny Decision to Refer Back for Reconsideration			
YES		NO	

Reconsideration Record Sheet Issued			
YES		NO	

Reconsideration of Decision Published

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

Andrew Ireland, Corporate Director – Social Care, Health and Wellbeing

To: Adult Social Care & Health Cabinet Committee - 11 July 2014

Subject: KCC Accommodation Strategy – Better Homes: Greater Choice

Classification: Unrestricted

Electoral Division: All

Summary: To inform Cabinet Committee on the development and implementation plans of the Accommodation Strategy with specific focus on Older Person's services; extra care and intermediate care. The Strategy was launched on 2 July 2014

Recommendations:

Cabinet Committee is asked to:

i) NOTE the launch of the Accommodation Strategy on the 2 July

ii) ENDORSE the current position and directions attached in Appendix 1.

1. Introduction

1.1 Kent County Council, the Clinical Commissioning Groups and the District/Borough Councils have agreed an integrated strategy for developing accommodation services for vulnerable people. This Strategy was formally launched on 2 July 2014.

1.2 The Accommodation Strategy is required to provide strategic direction to the market who are developing various care services, all that potentially attract KCC revenue funding if the person is eligible for care. KCC previously has been unable to provide any definitive support regarding need or service type in particular locations and this strategy aims to provide that direction and management to a growing care market.

1.3 In the past 18 months, 28 different organisations have discussed developments with Strategic Commissioning including different financing models and options for development. The existing care sector have been provided with key messages regarding future purchasing through the contract re-let; some of which will require a re-modelling of their current services. The innovative sector of the market is ready and waiting for strategic direction and discussions on how to take forward particular developments.

1.4 Whilst the Accommodation Strategy will be the over-riding Market Position Statement for Kent, a series of local statements will need to be developed to detail particular areas that require developing.

2. Financial Implications

2.1 Looking specifically at older person's services, implementing a shift from residential provision and developing more extra care services, early analysis of the evidence base shows that by developing an additional 2,542 units of extra care by 2021 would cost £6.8m less than placing people in standard residential care.

2.2 It is expected that once the Strategy has been published, the market will respond as it is waiting for the document to be published. Direct intervention may be required in some areas of the County

2.3 Consideration should be made to the Kent economy given the drive for capital projects either through re-modelling or new build.

3. Bold Steps for Kent and Policy Framework

3.1 There are a number of strategies and frameworks within Kent that this Accommodation Strategy will have links with, form the evidence base for and support, these include the following:

- KCC Adult Social Care Transformation Programme
- Bold Steps for Kent – all three themes; to help the Kent economy grow, to put the citizen in control and to tackle disadvantage
- Facing the Challenge: Delivering Better Outcomes
- Kent and Medway Housing Strategy – Better Homes: localism, aspirations and choice
- Kent Telecare Strategy
- Better Homes: Housing for the Third Age Protocol
- Better Homes: Accessible Housing Protocol
- Supporting People Commissioning Plan 2014-2017
- KCC's 16 – 24 Vulnerable Young People Strategy
- Care leavers strategy
- Valuing People Now

3.2 It is likely that there will be a future requirement to formally consult on changing or varying services managed by KCC, however this will be undertaken carefully once any proposal is defined.

4. Why develop an accommodation strategy?

4.1 Adult Social Care spends £180m per year on residential and nursing care across all client groups. Research and evidence shows that there are greater

efficiencies and better outcomes for people if they live in their own accommodation.

4.2 The right type of accommodation in the right place - Kent has a growing care market with planning applications being submitted frequently for care homes or housing with support schemes for all client groups. To date this has been largely uncoordinated and has been market led.

4.3 Stimulate the market or directly intervene – identify areas that have over/under provision and issue local statements. See how the market responds prior to developing business cases in the event KCC needs to directly intervene.

4.4 Inform planning applications and work with District Councils in relation to making the case for the new types of services and accommodation required.

4.5 Address issues of quality and safeguarding where the physical environment does not promote good services. For instance, the room sizes could be too small for the service type and equipment may not safely be used within the service.

5. Impact on other agencies

5.1 KCC does not have the statutory duty to provide housing and has a long standing relationship with District/Borough councils in successfully delivering housing with care and support schemes either individually or through the large PFI schemes. This strategy must have approval from the Kent Housing Group and the Joint Policy and Planning Group (Housing) in order to successfully deliver the objectives.

5.2 Working much more closely with Health towards health and social care integration means that the provision of intermediate care, and continuing health care, must be taken into account. The review of the community hospitals that provide beds to older people and the commissioning intentions on use of the private and voluntary sector is a consideration and therefore a programme of engagement with CCG's is taking place.

6. Conclusions of the Strategy

6.1 Phase one of Facing the Challenge undertook a review of the KCC owned residential care homes. This required a particular focus on all older persons provision in Kent and workshops were held to review the evidence base, forecasting options and determine a district profile looking at national ratios of data and applying known profiling data. The outcome across Kent for older people is to:

- Increase the provision of nursing care, particularly for those with dementia
- Increase the provision of extra care housing
- Reduce the provision of residential care

- Remodel services to be better geared up to accommodating people with dementia
- Complete bed utilisation reviews for intermediate care

6.2 Analysis of the size of a care home has shown some areas of concern in the County. The average size of a care home registering with CQC is 57 beds and de-registering is 27 beds. The average size of a care home in Kent is 35 beds (40 in West Kent and 32 in East Kent). This raises questions regarding ongoing sustainability of the homes. Furthermore, there is a question over the design and physical fabric of some care homes. KCC will be welcoming new developments of larger care homes meaning to a certain extent the market will adjust itself. The impact on the Kent economy could be significant.

6.3 Further focused work is required for people with a learning disability, physical disability and mental health needs. It is expected that this piece of work will be completed by the end of the year.

6.4 The current position and future direction for each client group is documented in summary at Appendix One.

6.5 The conclusions as documented in the Strategy are that KCC and its partners want to see:

- Responsible, flexible and integrated commissioning of services to respond to current and future need
- More people residing in accommodation that meets their individual accommodation and care and support needs, evidenced by cross agency needs assessments
- More Extra Care Housing, exploring the opportunities to develop mixed tenure models of extra care housing
- More Supported Accommodation (learning disability, mental health needs and those with an autistic spectrum disorder)
- A reduction in the reliance on care home settings
- A greater focus on preventative services designed to keep people at home longer
- Regular review of placements into care homes when this is the immediate appropriate accommodation solution
- Flexible business models in both care homes and housing to adapt to the need for short and long term re-enablement needs
- A range of housing options available for all the adult social care client groups

- A commitment to avoid isolation and ensure integration within a community

- A commitment to review existing provision across all accommodation types, to re-model/develop to more specialised provision where required, undertaking cross agency needs assessments

- Innovative design and technology ready accommodation

- Partnership working and delivery of accommodation solutions across District and Borough Council boundaries and Clinical Commissioning Groups

7. Document design and areas covered

7.1 The Strategy is dynamic with reviews built in and updates to the District Profiles as and when projects are developed. This will mean that the market will be able to see the developments required and openly discuss plans at an early stage with the commissioning team.

7.2 It is an on-line document with links to other documents and strategies. The scope for this type of strategy is far reaching as the expected units of accommodation are based on the whole preventative nature and other services and organisations have responsibilities to delivering specific outcomes. For instance, if community services are more effective in peoples own homes, what would be the number of people requiring purpose built accommodation?

7.3 The strategy is supported by an in depth Evidence Base, a number of case studies, some initial findings by user group, a look at the financial impact, district profiles, design principles and land issues and funding opportunities. It is designed to be a document that a developer could pick up and look at what it is like to work in Kent, in a particular district or for a particular client group.

7.4 With the direct links to the district and borough councils through both Housing and Planning, the document has been presented using district boundaries. However, when the focused work is undertaken through the workshops, the data is cut to look at Clinical Commissioning Group boundaries. This provides a cross cutting view for commissioning and clearly identifies responsibilities for progressing the implementation and delivery of projects.

8. Forecasting for older persons

8.1 As stated in 6.1, the initial focus of developing the strategy has been on older people's services. There is more information available about the need for services for older people which has meant that it has been easier to develop the strategy in this area. There are also national ratios identified through various forecasting tools developed by the Housing Learning Improvement Network (LIN).

8.2 It is not possible to simply apply projected population forecasts to previous placement data. Through the various Transformation Programmes and review of commissioning activity across organisations, different assumptions have been applied.

8.3 For older persons, indicative figures have been projected which will be used to target priority areas. The numbers will need to be periodically reviewed and adjusted in line with the performance of enhanced community services.

8.4 In order to determine the indicative forecasts, existing provision has been reviewed, the research undertaken that there are approximately 30% of people in residential care that could be accommodated in different types of services should that be available, apply the population forecasts and impact of known growth, placement patterns where people are not being accommodated in their local community due to availability of accommodation, a market appraisal and the impact of community services.

9. Findings

9.1 The detailed work undertaken through the analysis of the evidence base and the workshops produced the District Profiles. These are presented in the Strategy by district. The overall picture for Kent is shown as follows:

Older People	EXISTING (2013)	2021	+/-	Known
Residential Care including Dementia	8200	5730	-2470	70
Nursing Care including Dementia	3730	5661	+1931	170
Extra Care Housing	490	3032	+2542	946
Sheltered Housing	17950	17706	-244	0
	30370	32129	+1759	1186

9.2 In order to prioritise the work programme and to ensure these opportunities are secured a series of “candidate projects” will be identified in each district area.

9.3 The term ‘candidate projects’ is used to describe potential projects which will be defined based upon the information provided at meetings with partners who are at different stages with regards to determining their strategies.

9.4 Feasibility work and option appraisals need to take place before project briefs can be agreed. The programme will need to be flexible and, as strategies are developed and projects become defined, other projects will emerge.

10. Intermediate Care

10.1 Intermediate care is defined as a range of integrated services to promote faster recovery from illness and maximise independent living - (Halfway Home 2009). Intermediate care services should be targeted at older people who would

otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care or long term residential care. It should be time-limited, normally no longer than six weeks and frequently as little as one to two weeks.

10.2 Intermediate Care is largely delivered in community hospitals or integrated care centres. Many community hospitals are not fit for the future. All CCG's are reviewing the efficiency and effectiveness of the services to focus more on rehabilitation. The outcome of this work, along with the focused projects for the Accommodation Strategy, will identify how many beds are required and where they will be delivered. Re-provision of a service from a community hospital could mean a Public Private Partnership of some description or block purchased beds in a private development. The business cases will be developed along with the consultation and communications plans for each project area.

11. Next Steps

11.1 A series of local statements will be developed and published and KCC will see if and how the market responds prior to determining any intervention steps needed.

11.3 Projects will be identified, prioritised and sequenced with approval through DMT and/or the Adults Transformation Board.

11.4 Options appraisals and business cases will be developed along with establishing the consultation route.

11.5 Focused work will take place on all other service user groups where it is intended the same process will be followed and partners engaged throughout.

12. Equalities and Health Impact Assessments

12.1 An Equalities Impact Assessment has been undertaken and identifies no discrimination to any groups.

12.2 Public Health commissioned a Health Impact Assessment which sought to identify potential health issues and gaps, investigate potential distributions and magnitude of outcomes and provide evidenced based recommendations. The final report confirms that there is no need to progress to a full Health Impact Assessment. Equalities were also considered in this review and the initial findings confirmed that the Strategy does not discriminate.

13. Recommendations

Recommendation(s):

Cabinet Committee is asked to:

i) NOTE the launch of the Accommodation Strategy on the 2 July

ii) ENDORSE the current position and directions attached in Appendix 1

14. Contact details

Christy Holden – Head of Commissioning – Social Care, Health and Wellbeing
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Mark Lobban – Director of Commissioning – Social Care, Health and Wellbeing
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Background Documents:

- Accommodation Strategy – Better Homes: Greater Choice
- Evidence Base
- District Profiles
- Design Principles
- Maps of Provision
- Confidential Workshop notes
- Equalities Impact Assessment
- Health Impact Assessment

Appendix One:

Current Position and Direction

Through the development of this Strategy, evaluation of the Evidence Base and engagement with key stakeholders, there have been a number of emerging themes which have formed the conclusions of this Strategy. A summary of the current position and future direction across Kent is detailed below, however there will be local variations and therefore the District Profiles and emerging Market Position Statements will provide greater information:

Client Group	Current Position	Future Direction
Older People including Dementia	• Over-provision of residential care • Under-provision of nursing care, specifically for people with dementia • Under-provision of extra care • Average size of a care home in Kent is 40 beds • Evidenced efficiencies through extra care housing • Community hospital provision older and smaller not getting best value • Inefficient rehabilitation and enablement model for intermediate care	• Increase provision of extra care housing and other models • Increase provision of nursing and dementia care homes • Increase fit for purpose modern care homes and as a result reduce older converted care home provision • Investment in Community Services, both health and social care, to prevent reliance on long term residential services • Greater use of tele-technologies across all provision
Learning Disability	• Growing care home market that is not supported strategically by KCC • Other local authorities placing people in Kent providing issues for ordinary residence • Varying availability of supported accommodation • Lack of choice and availability of alternative provision resulting in the only option for people to be placed in residential care • Needs of individuals not clearly understood • Needs of people in residential care currently range from very low to very high	• Provision of some specialist residential provision targeted to move people into independent living • Undertake detailed review of the needs of individuals to determine whether they are in the best place for them • Understand and make provision for the range of needs of people in care homes • Undertake detailed commercial understanding of sector • Develop provision as an alternative to residential care • Greater use of tele-technologies across all provision
Physical Disability	• Some specialist residential provision across the County • Varying waiting lists for DFG's	• Through development contributions, increase the supply of wheelchair accessible housing • Undertake detailed review through

	across the County • Wide ranging needs of individuals difficult to predict • Specialist provision developed for access across the Country means local provision is impacted	workshops on the current activity and models and research service provision around the country for best practice • Promote use of tele-technologies across all provision
Mental Health	• The market believes there is a need to develop more residential care, this is not supported strategically by KCC • Some interest from the market to develop large supported accommodation schemes, determined as more than 12 units, this is not supported strategically by KCC • Supported accommodation with assured shorthold tenancies effectively working to progress people through services	• Develop more supported accommodation in some areas of the County • Adequate provision of supported accommodation in some areas at the current point in time, will need a further focus as the move to decommission further residential care provision is appropriately managed • Undertake a review of the care and support provision to make sure best value is achieved
Autistic Spectrum Disorder	• Insufficient provision for those that challenge services • Continued use of services for people with learning disabilities or mental health needs as a lack of alternative suitable services	• Develop more supported accommodation with specialist design and tailored care and support services
Children	• Over use of bed and breakfast accommodation	• Promote the need for younger people to hold tenancies

Agenda Item B8

From: **Graham Gibbens. Cabinet Member for Adult Social Care and Public Health**

Andrew Ireland, Corporate Director for Social Care, Health and Wellbeing

To: **Adult Social Care and Public Health Cabinet Committee Meeting 11th July 2014**

Decision No: **14/00064**

Subject: **OLDER PERSONS RESIDENTIAL TENDER STAGE ONE ANALYSIS AND GUIDE PRICE RECOMMENDATION**

Decision No: **14/00065**

Subject: **NURSING RESIDENTIAL TENDER STAGE ONE ANALYSIS AND GUIDE PRICE RECOMMENDATION**

Classification: **Unrestricted**

Electoral Division: **All**

Summary: This report provides the results of the stage one tender process, which includes our analysis of the market by home type and the considerations for understanding the actual, and determining the fair cost of care for these services in Kent.

In accordance with Local Authority Circular (2004) 20, the Council is obliged to pay due regard to the actual cost of care provision. This report details how we have conducted that analysis and includes officer recommendations for how these professional judgements should be applied in order to ensure we have a sustainable market place that is in line with our future residential requirements as detailed in the Accommodation Strategy.

Attached to this report is Appendix One which contains information that is Exempt from publication as contains commercially sensitive information

The 2014-15 budget for these services was approved by the Council on 13th February 2014 with a provision for price pressures. This paper seeks to demonstrate how this budget allocation might most fairly and appropriately be allocated against our identified bands of care, taking into account the actual cost of that care provision and other local factors including the preferred future shape of the care sector in Kent.

Upon approval of this report, and in line with our governance process, stage two of the tender process will commence with new contracts coming into effect on 6th October 2014.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to:

Agree the proposed recommendations contained in the recommendation report and exempt appendix and to confirm the new guide prices for these categories of care.

1. Context

The Council spends over £100m on residential and nursing care for older people. Following the decision in December 2013 to competitively tender these services a report was presented to Procurement Board in January 2014. This paper outlined the procurement options available in order to re-let the older persons residential and nursing care contracts and the requirement for any price review based for the financial year 2014/15.

In order to ensure compliance with the Choice Directive, appropriate competition within the market and our support of new market entrants, the decision was taken to re-let the contract using a Dynamic Purchasing System (DPS).

Strategic Sourcing and Strategic Commissioning have worked closely together and progressed through a competitive tender process led by the Procurement team. Full market participation was a key requirement to ensure the success of the procurement exercise. This was achieved by holding several market engagement events and enabled the market to be fully prepared for the tender process and to understand the importance of registering for and completing the documentation and our online cost model.

Older Persons Residential and Older Persons Nursing Care have been tendered separately but in order to consider the overall impact on the budget and our allocation of any price increases the outcome of stage one of both tenders are provided in this report.

2. Description of Service

Older persons' (usually, but not limited to, those over 65 years of age) residential care in Residential Care Homes and Nursing Homes situated within the administrative area of Kent County Council.

3. Background

The Council has not been out to tender for older persons' residential care since 2002, with current framework agreements awarded in 2003.

In order to comply with Local Authority Circular (2004) 20, the Council has had to consider annually how the cost of providing older persons' residential care has fluctuated and has had to conduct an appropriate fee review each financial year. The table below shows the 'usual rates' payable each year since 2004/05 in respect of the various categories of care:

OLDER PERSONS RESIDENTIAL					
Year	Fee Increase for Existing Clients	Guide/Usual Price			
		Residential (Area 1)	Residential (Area 2)	EMI (Area 1)	EMI (Area 2)
2013/14	1%	£336.93	£351.29	£404.44	£440.30
2012/13	1%	£333.00	£348.01	£400.44	£436.00
2011/12	0.5%	£330.29	£344.56	£396.48	£431.62
2010/11	0%	£328.65	£342.85	£396.48	£431.62
2009/10	2.5%	£328.65	£342.85	£396.48	£431.62
2008/09	2.5%	£320.63	£334.49	£386.61	£421.09
2007/08	£9.56	£312.81	£326.33	£377.38	£410.82
2006/07	2.5%	£303.25	£316.77	£367.82	£401.26
2005/06	3%	£295.85	£309.04	£358.85	£391.47
2004/05	2.5%	£287.23	£300.04	£348.40	£380.07

OLDER PERSON WITH NURSING			
Year	Fee Increase for Existing Clients	Guide/Usual Price	
		Nursing area 1	Nursing Area2
2013/14	1%	429.26	480.22
2012/13	1%	425.01	475.47
2011/12	0%	420.80	470.76
2010/11	0%	420.80	470.76
2009/10	2.5%	420.80	470.76
2008/09	3.53%	410.54	459.28
2007/08	2.47%	396.54	445.28
2006/07	2.5%	386.98	435.72
2005/06	3%	377.54	410.16
2004/05	2.5%	366.54	398.21

In preparation for the 2013/14 review the Council undertook formal consultation with the Kent market, supported by the Trade Associations, to investigate how the cost of older persons' residential care had altered throughout the course of 2012/13. The consultation did not receive a large response, many providers being unwilling to share information about their costs. Re-tendering the contract in 2014 gave the Council the ability to request accounts as part of the tender exercise in order to clarify providers' costs and income. This information enabled us to carry out a full cost analysis in order to ensure our compliance with Circular (2004) 20 and minimise the prospects of successful legal action against the Council.

Responses were received from approximately 60% of the Kent market for this tender. The high level of responses has provided confidence that the data provides an adequate picture of the sector upon which to base the analysis on which we have calculated the new guide prices.

In more general terms the information enabled the Council to gain a better understanding of the Kent market, including different home types and their relative efficiency. The data has also helped to demonstrate the importance of the Accommodation Strategy in clearly stating our purchasing strategy for residential placements in order to ensure there is a sustainable and cost efficient market as we move towards the implementation of the Care Act and the residential market for 2016.

4. Procurement Route

The Dynamic Purchasing System (DPS) was selected to ensure that all providers who wished to participate, and who met the basic criteria, were invited to join the contract.

The strategy for this procurement is to facilitate as much choice as possible for those older persons who require accommodation in an older persons' residential or nursing home. The DPS therefore encourages as many potential suppliers to apply to join the DPS.

The DPS is a two stage process as follows:

- **Stage One** – Pre-Qualification Questionnaire (including the submission of an online cost model for each care home situated within the administrative area of Kent County Council); and
- **Stage Two** – Technical and Commercial Response.

All individual placements will be advertised under the new contract, and we are proposing placing a regular notice on the portal to ensure that any new market entrants, or existing providers with new capacity, are able to apply to join. Providers will express their interest to tender for placements and submit their real price, which is based on their occupancy/availability at the time of placement and reflect the needs of the client. They will not be able to exceed their tendered maximum indicative cost submitted at stage two. Third

party top ups will be clearly defined and explained at the start as will any other financial implications for the service user. This should reduce the confusion for individuals, their families and providers and should subsequently reduce officer time responding to complaints and enquiries.

As part of this process it is our intention not to initially place any clients with providers who are not registered on the DPS, which providers currently account for 38% of the available beds for standard and EMI care. This is until such time as these providers have signed up to our Terms and Conditions and agree to deliver to our specification, conducted through the DPS procurement route. There may however need to be arrangements in place to allow such placements in order to comply with the Choice Directive and so individual contractual process arrangements are being developed.

5. The Process

As part of their response to stage one of the tender process, suppliers were required to complete and submit a separate Cost Model and Pre-Qualification Questionnaire for each older persons' Residential and Nursing Home situated within the administrative area of Kent County Council.

The model was completed in accordance with published instructions to ensure that all data were measured in the same way, so as to prevent any distortion of the figures and to ensure that we were able to undertake a proper analysis and comparison of the data. To this end providers' accounts were considered and the analysis endeavoured to identify, clarify, rectify and/or remove any obvious anomalies in the evidence submitted by suppliers.

As part of KCC's obligation to pay due regard to the actual cost of care, the Council is committed to understanding the cost of older persons' residential and nursing care, and only once this understanding is satisfactory will the Council be able to set a fair guide/usual price for the duration of the DPS, based on our budget allocation for the corresponding financial period. This guide price will also be the basis for applying any increase for existing residents from 6th October 2014.

The information is also crucial to understand the potential implications of the Care Act as the Council will be exposed to the costs charged to the self-funded individuals. The majority of changes being introduced to the residential market through the Care Act will become effective in April 2016.

The agreed usual/guide price will be published as soon as the decision is implementable as part of the documentation of stage two of this tender process. Tenderers will therefore be able to submit an indicative price as part of stage two knowing what, if any implications will arise for Third Party Top-Ups.

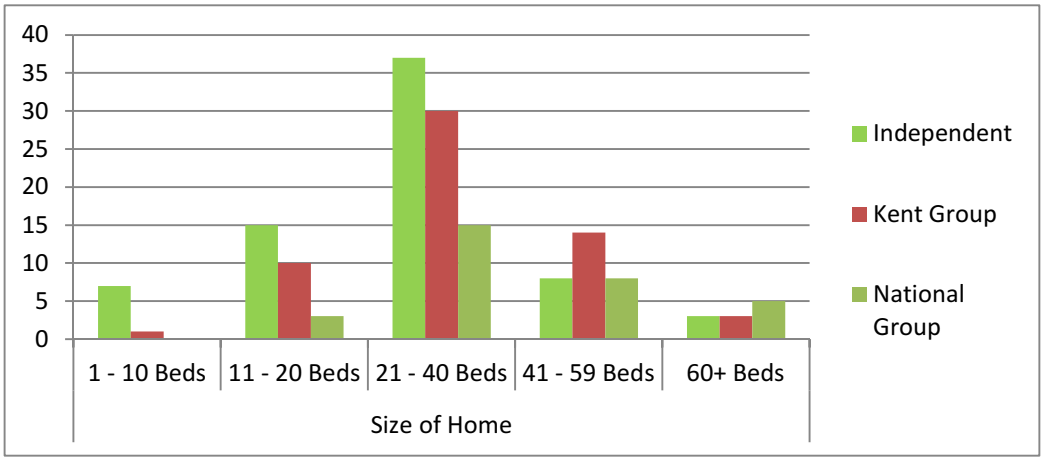
In order to simplify the current guide prices and in an attempt to reduce any confusion with providers and service users, it was our intention to remove the geographical bands and replace these with one band per category of care, regardless of the geographical location. However, this has not been possible at this stage and there is commitment that this should be addressed in future.

6. Evaluation Methodology

In total, cost models were received for 144 older persons' residential care homes and 68 nursing homes situated within the administrative area of Kent County Council.

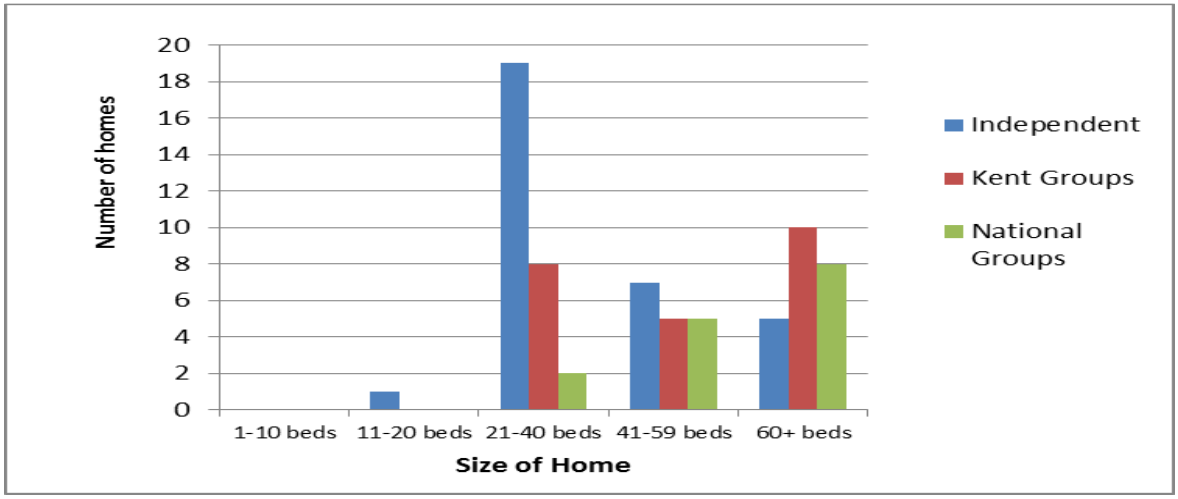
The level of data received provides further weight to the Accommodation Strategy and will support Strategic Commissioning in order to focus their attention on certain areas of the market that require further support, direction and encouragement.

Older Persons Standard Residential – Provider Overview

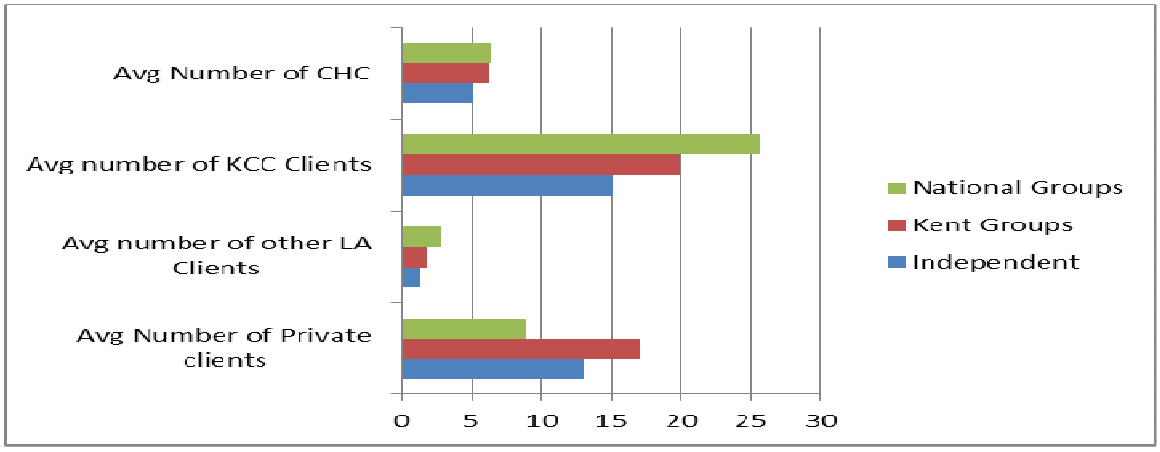


- 40 of 159 care homes DO NOT have a mortgage on their property.
- Build year range:
  - Independent 1800 to 2013;
  - Kent Group 1750 to 2011;
  - National Group 1676 to 2011.
- Total number of beds across all responses **5237.** CQC registered number of beds **8200**

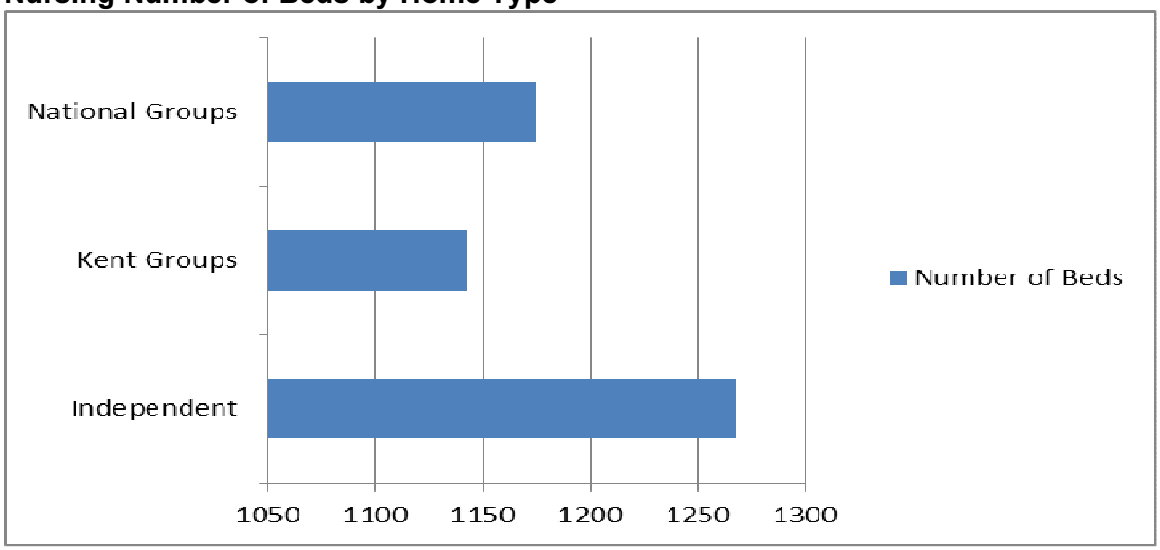
Nursing Care – Provider Overview



- 28 of 68 care homes DO NOT have a mortgage on their property.
- Build year range:
  - Independent **1700 > 2011**;
  - Kent Group **1800 > 2011**;
  - National Group **1810 > 2009**.
- Total number of beds across all responses **3960.**



Nursing Number of Beds by Home Type



The data submitted and analysed was based upon a forecast cost for 12 months, providers being asked to provide:

- average occupancy level (forecast and actual);
- variable hotel and management costs;
- fixed hotel and management costs;
- resource costs; which included total number of staff, forecast and actual cost for staff,
- costs for capital
- forecasted profit.

Procurement then analysed the average cost of care across Kent, including the average cost of care across the different types of organisations, the different CCG areas within Kent and the different sizes of homes.

To ensure that the data used was correct, there was an ongoing clarification process to review and cleanse all information. An audit trail has been kept on all changes made and providers will be informed, as part of stage two, of assumptions made.

The data enabled us to determine the most cost efficient home size to ensure that, in paying due regard to the actual cost of care, account could be taken of unnecessary inefficiencies in the system. As part of this process the following steps needed to be taken:

- providers' type of organisation classification were reviewed against the published criteria within the qualification questionnaire.
- CQC Fee's information was recalculated against the new fee structure published by CQC and a standard approach applied.
- occupancy levels across all of the 3 types of homes, both the average and the mode (most common), were measured. They came out at 90% for Residential and an average of 91% for Nursing. It is important to note that this does not account for any beds that cannot be utilised due to quality issues. In a snapshot survey undertaken for the Accommodation Strategy, the vacancy level was 3%.
- based on the data received, resource costs (staffing) were calculated as a percentage of the total operating costs (an average of **61.24%** for Residential and EMI and **66.16%** for Nursing across the county of Kent).
- based on the data received, corporate overheads were calculated as a percentage of the total operating costs (an average of **6.14%** for Residential and **4.82%** for Nursing across the county).

7. Data Analysis

Residential
The analysis is based upon cost data collected from the market for a total of **144** homes, managed by **93** different organisations, including both national and Kent group as well as independently owned homes:

		Number of Organisations	Number of Homes	Number of Beds
	TOTAL	**93**	**144**	**4794**
Type of Organisation	**Independent Homes**	65	65	1820
	Kent Groups	18	56	1837
	National Groups	8	23	1137

Nursing
The analysis is based upon cost data collected from the market for a total of **68** homes, managed by **45** different organisations, including both national and Kent group as well as independently owned homes:

		Number of Organisations	Number of Homes	Number of Beds
	TOTAL	**45**	**68**	**3583**
Type of Organisation	**Independent Homes**	**25**	**32**	**1267**
	Kent Groups	**12**	**21**	**1142**
	National Groups	**8**	**15**	**1174**

All organisations provided a breakdown of the following information for each of their care homes in Kent; the data provided is based upon a forecast for 12 months from 1st October 2014:

- Average occupancy level (forecast and actual)
- Variable hotel and management costs
- Fixed hotel and management costs
- Resource costs

7.1 Occupancy Levels

The data shows the Council that across all types of organisations, homes of different sizes and locations in different areas in Kent, the average and most common occupancy levels for

Residential is 90% and for Nursing is 91%. It must be noted that, in some care homes, short term care services are offered which means that occupancy data is lower due to the turnover of residents. This in turn provides a reduction of the occupancy rate when long term care is calculated.

The following factors have been taken into account in order to consider the most appropriate percentage occupancy level:

- The analysis of the cost model feedback for residential care determined that in Kent there is a 90% occupancy rate for Residential and 91% for Nursing. This rate includes short term bed activity which, by its very nature, means that there are additional vacancies included in this data. Care homes deliver a mix of long and short term services, some more than others which means this data is not reliable to determine a set model.
- The market consultation events held as part of the pre-tender process activity, the market fed back that occupancy could be anywhere between 60% and 98%
- The Association of Directors of Adult Social Services (ADASS) model recommends a rate of 94%
- Research from other local authorities shows a rate between 90% and 95% occupancy in residential and nursing homes.
- In preparation for the Accommodation Strategy a spot survey found that only 3% of the current vacancies were accessible. This was due to quality issues where contract sanctions have been applied, thus resulting in some beds not being accessible.

Recommendation in Appendix One (2)

7.2 Variable and Fixed Hotel and Management Costs

All organisations submitted data which reflect the cost per resident per week based upon 100% occupancy. The only exception to this is the cost of CQC registration, which was provided as an annual value per care home; the Council has therefore calculated the equivalent of the average cost per resident per week based upon these annual figures.

7.3 Corporate Overheads

The Council calculated the cost of corporate overheads based upon the average percentage of the cost of corporate overheads in relation to the total operational costs of running a care home in Kent.

The Charter Institute of Purchasing and Supply (CIPS) define overheads as “the fixed costs that are not product-related to the goods or services produced by the business”.[1] On this basis, the Council considers the following costs to be corporate overheads:

- insurance;
- CQC Registration;
- recruitment; and
- training.

Recommendation in Appendix One (3)

7.4 Resource Costs (staffing)

The Council calculated the average resource cost based upon the average percentage of the resource cost in relation to the total operational costs of running a care home in Kent.

Twenty nine providers for Residential and eight providers for Nursing submitted an incoherent value for the annual staff costs. In the main the Council has been able to identify where these errors had occurred and recalculated the values accordingly. However, in one case, where the care home has a total of 58 staff and 59 beds, the organisation input a value of £45.04 for the annual total for staff costs. This organisation also failed to provide any accounts from which the Council would have been able to retrieve an actual value. In order to ensure this data did not impact on the analysis these costs were discounted for the purpose of this exercise.

Recommendation in Appendix One (4)

7.5 Costs for Capital

For the purpose of this exercise we have separated profit and a return to the cost of capital. Therefore there is no specific consideration of profit allocated in this section of the report.

Cost of Capital reflects the of cost financing assets. For example interest on a loan. Cost of Capital is relevant to the all of the sector, as at the very least modernisation and, and general improvements will be required in order to meet and maintain the standards required in our specification and in line with the Accommodation Strategy and CQC requirements. A key example being the provision of en-suite facilities, not all homes have this facility and will be required to borrow money to modernise in this way. This is of course on the assumption that the property can be converted and does not make the home unviable in doing so.

The data shows that a cost for capital does not apply to 41.61% for residential and 42.65% for nursing care homes. However, it is prudent and standard practice to reflect the cost of capital. For example with regards to future enhancements required to meet the standards. The data is so varied (presented differently as a cost per resident, weekly cost, annual cost, proportionate cost, etc.). We do recognise that capital costs are applicable more widely than for home improvements. We therefore recommend that a percentage based on the average net asset value is applied to reflect the cost of capital.

The following considerations have been taken into account when considering the percentage cost of capital:

- The Kent property market has seen a significant boom in the last year, with a further rapid increase in the price of land and buildings expected in the near future. Between April 2012 and June 2014, the average property price in Kent has risen from 1.4% to 7.5%. Although this is likely to be offset slightly by a potential hike in interest rates, the overall increase in property values goes some way to provide a return to capital for providers

- We also considered the actual cost of homes in Kent and the impact our cost of capital calculation would have. The table below shows the variance in home value to bed size and rate. The sale prices show the indicative value of homes.

District	Type of Property	For Sale Price	No of beds	Turnover	Rates being obtained
Mid kent	Nursing Home	4,000,000.00	50	1.6m	496.00 - 765.00
Coastal	Standard Resi	2,500,000.00	75	1m	

		for both	50	850k	336.93 to £535
South east Kent	Dementia	1,300,000.00	25	528k	
North kent coast	Standard Resi	1,050,000.00	25	489k	330.00 to 550.00
Mid kent	Dementia	995,000.00	18	418k	
North kent coast	Dementia	850,000.00	21	509k	440.00 to 600.00
Tunbridge wells	Standard Resi	820,000.00	14	275.k	342.00 to 525.00
Maidstone	Standard Resi	710,000.00	16	259k	
Folkestone	Dementia	675,000.00	20	not provided	336.00 to 610.00
Margate	Standard Resi	560,000.00	18	310k	
Folkestone	Standard Resi	499,950.00	20	258k	320.00 to 437.00
Canterbury	Dementia	450,000.00	16		440.00 to 600.00

Recommendation in Appendix One (5)

7.6 Profit

In analysing the data and applying our consideration for an appropriate level of profit, the Council were clear that we wanted to apply a separate value of profit to the cost of capital. As previously stated our Accommodation Strategy clearly states our intention to depart from purchasing ordinary residential care with a stronger focus on extra care housing and EMI residential provision.

By applying profit as a separate value, this also enabled us to apply a different level to each band, which would signal to the market the areas we wished to invest in.

Residential

A significant amount of the data the Council received from the market regarding the forecasted profit (%) was questionable. According to the data received, 11 care homes aim to break even only, forecasting 0% profit; 6 care homes forecast making a loss, forecasting less than 0% profit; and 6 care homes failed to input a forecasted figure. A further 15 care homes input an actual value, rather than a % figure as instructed (ranging from £52.71 to £582,029). Of the remaining 106 care homes, on average, the forecasted profit is 13.56% (ranging from 1.5% to 35%):

	Forecast >13.56% Profit	Forecast <13.56% Profit	Forecast 0% Profit	Forecast <0% Profit	Actual Value	No Data
Number of Care Homes	56 (38.89%)	50 (34.72%)	11 (34.72%)	6 (4.16%)	15 (10.42%)	6 (4.16%)

Nursing

A significant amount of the data the Council received from the market regarding the forecasted profit (%) is also questionable. According to the data received, 7 care homes aim

to break even only, no homes are expecting to make a loss and only 2 care homes failed to input a forecasted figure. Of the remaining 59 care homes, on average, the forecasted profit is 13.13% (ranging from 4% > 35%):

	Forecast >13.13% Profit	Forecast <13.13% Profit	Forecast 0% Profit	Forecast <0% Profit	Actual Value	No Data
Number of Care Homes	29 (48.52%)	30 (44.11%)	7 (4.69%)	0	0	2 (2.94%)

Due to the cross subsidisation of private and local authority clients, there is an appreciation that providers make most of their profit from their private clients and this is not usually expected in the same measure from the local authority.

Although ADASS recommends a range of between 6-8% for profit, this covers all client groups and it is also important to note that these are difficult austere times and normal levels of profit should not be expected.

The following factors have been taken into account in order to consider the most appropriate percentage profit level:

- the analysis of the cost model feedback for residential care determined that the data on profit is incoherent with providers forecasting profit from less than 0% to over 30%
- Laing and Buisson profit it is combined within the return of capital investment of 12%
- IN 2010 ADASS assume a figure of 6-8% across all client groups, however we are now in austere times and all parts of the commercial market are having to adjust. ***Recommendation in Appendix One (6)***It is recognised that our neighbouring authorities pay more for their cost of care and Kent has a buoyant private market of self funders, which helps to sustain sufficient margins.
- Some private organisations have separate charging schedules for private payers, health and other local authorities. In some circumstances, KCC understands that the private payer is likely to be paying in excess of 50% more than the local authority price. Regardless of the charge, the individual will receive the same standard of care and the same food from the same staff group. Additional charges are made based on the provider's judgment of a better positioned larger room and additional facilities.
- KCC's current terms and conditions make working with the local authority beneficial to the market due to the Council a) being a gross payer and accepting the debt risk, b) paying two weeks in advance and two weeks in arrears, meaning that there is regular cash flow for organisations and c) providing strategic direction for business planning and supporting the home to meet their regulatory function with CQC
- The Accommodation Strategy seeks to address the lack of market direction by developing Market Position Statements. KCC knows that there will need to be more EMI residential, more nursing and more EMI nursing.

Recommendation in Appendix One (7)

7.7 The Cost of Older Persons' Residential Care

Residential

The Council analysed the average cost of care across Kent. In addition, the Council analysed the average cost of care across the different types of organisation (i.e. independent

homes, Kent groups and national groups), the different CCG areas within Kent and the different sizes of homes. In addition, the Council analysed the average cost of care across the different types of organisation (i.e. independent homes, Kent groups and national groups), the different locations within Kent (by CCG area) and the different sizes of homes.

On average, national groups appear to be running their care homes in Kent more efficiently than either those owned by Kent groups or that are independently owned. However, on average, national groups appear to spend proportionally more on staffing than either Kent groups or independently owned. Whilst, on average, care homes owned by Kent groups are run with proportionately less staff but with higher hotel and management costs.

There were a few instances in which the data received from organisations, indicating the type of organisation responsible for each care home, appeared to be incorrect based upon the published criteria. The Council, therefore using the data provided in section one of the online qualification questionnaire, reclassified the type of organisation responsible for some care homes in accordance with the following criteria:

- **Independent Homes** are providers, which are responsible for only one care home, which is located in the county of Kent.

- **Kent Groups** are providers, which are responsible for more than one care home, or under a holding organisation, located in the county of Kent.

- **National Groups** are organisations, which are responsible for care homes, which are located both in and outside the county of Kent.

Nursing
The Council analysed the average cost of care across Kent. In addition, the Council analysed the average cost of care across the different types of organisation (i.e. independent homes, Kent groups and national groups), Kent and the different sizes of homes. In addition, the Council analysed the average cost of care utilising 3 models:

1. Data received complete (including the full range of submitted data).
2. Revised data (including clarifications and anomalies removed)
3. Cleansed data (removal of all nursing homes that contain anomalies)

On average, national groups appear to be running their care homes in Kent more efficiently than either those owned by Kent groups or that are independently owned. However, on average, national groups appear to spend proportionally more on staffing than either Kent groups or independently owned. Whilst for residential, on average, care homes owned by Kent groups are run with proportionately less staff but with higher hotel and management costs, however, for nursing Kent groups have a higher staffing cost, but lower hotel and management costs.

There were a few instances in which the data received from organisations, indicating the type of organisation responsible for each care home, appeared to be incorrect based upon the published criteria. The Council, therefore using the data provided in section one of the online qualification questionnaire, reclassified the type of organisation responsible for some care homes in accordance with the following criteria:

- Independent Homes are providers, which are responsible for only one care home, which is located in the county of Kent.

- Kent Groups are providers, which are responsible for more than one care home, or under a holding organisation, located in the county of Kent.

- National Groups are organisations, which are responsible for care homes, which are located both in and outside the county of Kent.

7.8 Location

The Council does not have an equal distribution of data from care homes across each of the different CCG areas in Kent. The data shows no tangible difference between the costs of running a care home based upon where it is located within Kent. Whilst, on average, the cost of running a care home, which is situated in Medway or out of county, appears to be significantly greater, this assumption would be based upon data from Residential three out of county care homes (i.e. two in East Sussex and one in Bexleyheath) and only four care homes situated in Medway. The data used in residential is from the original data set and has not been revised based on new clarifications/analysis. The data from Nursing showed two out of county homes.

Residential

	Number of Organisations	Number of Homes	Number of Beds	Independent Homes	No. of Homes owned by Kent Groups	No. of Homes owned by National Groups
Ashford CCG	5	5	160	4	1	0
Canterbury & Coastal CCG	19	23	697	10	7	2
Dartford, Gravesham & Swanley CCG	13	17	509	8	2	3
South Kent Coast CCG	27	38	1094	14	9	4
Swale CCG	9	12	492	5	2	2
Thanet CCG	19	23	699	14	5	0
West Kent CCG	20	31	1143	11	3	6

Nursing

CCG	Number of Organisations	Number of Homes	Number of Beds	Independent homes	No of Homes owned by Kent Groups	No of Homes owned by National Groups
Ashford	7	7	460	4	3	1
Canterbury & Coastal	7	10	416	9	0	1
Dartford Gravesham & Swanley	5	8	508	2	2	4
South Kent Coast	6	9	423	4	5	0
Swale	2	2	133	0	1	1
Thanet	5	7	277	6	1	0
West Kent	17	21	1273	6	8	7

7.9 Size of Home

Residential

On average, care homes with 11 – 20 beds are run with proportionately less staff, but with higher hotel and management costs; care homes with 11 – 20 beds are the least efficient, with the highest average operating cost.

On average, care homes with 41 – 51 beds are run with proportionately more staff, but with relatively low hotel and management costs. However, on average, care homes with 60+ beds are marginally more efficient overall, with the lowest average operating cost.

As stated previously, the average number of care homes de-registering with CQC is 27 beds and the average size registering is 57 beds.

Nursing
11 – 20 beds - information has been clarified.

On average 21 – 40 beds range is run with less staff, however cost per resident is greater than the 41 - 59 range, but hotel costs are less than the 41-59 range

On average the 41 – 59 beds range is run with a greater number of staff than the 21 – 40 range. This range of Providers has the greatest hotel costs per resident of all the ranges.

On average the 60+ bed range is run with more staff than the other ranges, with the lowest cost per resident for hotel costs, but highest staff costs per resident.

As stated previously, the average number of care homes de-registering with CQC is 27 beds and the average size registering is 57 beds.

8. Quality Audit

Residential
Strategic and Corporate Services Projects Team have undertaken a review of the calculations, assumptions and processes in order to provide quality assurance to the process. They have provided some recommendation on how to enhance the quality of the data presented by revisiting some of the formulas used. Where appropriate these recommendations have been built into the final analysis.

Nursing
This has not been carried out for the Nursing Data, however the same principles and process as residential was used for nursing.

On the request of the Cabinet Member external auditors have also reviewed our analysis and are happy with our process.

9. Financial Implications

The Council is required to give three months' notice to terminate all existing framework agreements for this service, as they will all become obsolete from 6th October 2014. The Council's Accommodation Commissioning Group agreed the following regarding existing clients:

- If a supplier applies to join the DPS and is successful **AND** the Council has current contractual placements with the supplier, the current contractual arrangements for these placements will automatically be renewed under the DPS. This means that the new guide/usual price shall apply from 6 October 2014.

- If a supplier does not apply to join the DPS **AND** the Council has current contractual placements with the supplier, the Council shall offer to renew current contractual arrangements for these placements, in accordance with the terms and conditions of the DPS. However, the guide/usual price shall remain the same for all existing clients placed with this supplier, until the supplier has successfully joined the DPS.

- If a supplier applies to join the DPS and is unsuccessful **AND** the Council has current contractual placements with the supplier, the Council shall need to investigate the reasons why the supplier failed the process. Unless the Council needs to terminate the placement/s and move clients (in extreme cases based on quality and safeguarding), the Council shall offer to renew current contractual arrangements for these placements, in accordance with the terms and conditions of the DPS. However, the guide/usual price shall remain the same for all existing clients placed with this supplier, until the supplier has successfully joined the DPS.

10. Legal Implications

When agreeing the Council's new guide/usual price, the Council must pay due regard to the actual cost of providing older persons' residential and nursing care within the county of Kent. Paying such regard does not in our view require the Council to pay for market inefficiency or over supply. In determining the relationship between the actual cost of care provision and the price the Council is prepared to pay for such care (the 'usual cost'), the Council is entitled to take into account considerations of efficiency and Kent's Accommodation Strategy.

To this end, the cost of care has been calculated on the basis of 31+ beds for Residential, because such homes are more efficient and account for over 48% of the available beds in the responses received.

For Nursing, using cleansed data with a reduced population of returns, the most efficient homes have between 31 & 45 beds. When using the uncleansed data and abridged data the most efficient homes have 60+ beds.

The Council is keen to ensure we have fulfilled our obligations within our available budget and have demonstrated our commitment to showing due regard to the fair cost of care.

11. Equality Impact Assessments

An EQIA has been completed by Strategic Commissioning in order to consider and address any implications of the recommendations. This is provided in the exempt appendix 2.

12. Sustainability Implications

By agreeing a new usual/guide price, with due regard to the cost of providing older persons' residential and nursing care within the county of Kent which has been determined through thorough analysis of cost data provided by the market, the Council should be helping to ensure sustainable provision. The new guide/usual price pays due regard to the actual cost of care and reflects a fair price which should sustain all suppliers providing older persons' residential care within the county of Kent.

Fee increases shall no longer be a solution for any issues raised regarding the sustainability of a care home; instead the Council shall work collaboratively with suppliers to identify why a care home is having financial difficulty; for instance, low occupancy, etc.

The flexibility of the DPS shall allow the Council to attract new suppliers if more provision is required. The flexibility and call-off process of the DPS shall also encourage the market to operate more efficiently and to continuously improve the required service.

13. Alternatives and Options

As the Council decided to tender these services, rather than conduct a price review, there would be a significant legal risk of any other option, rather than concluding the tender process.

14. Conclusion

The Council must show due regard to the cost of providing older persons' residential care within the county of Kent. This process has enabled the Council to understand in more detail what these costs should be and what accounts for any differences.

As previously stated our intention was to remove the geographical bands within each category of care and this intention was further supported by our analysis which showed that there is no distinguishable difference between the cost of provision across different geographies. Supply, however, is still an issue in certain parts of the County.

Analysis and Recommendation in Appendix One (8)

15. Recommendation

The Adult Social Care and Health Cabinet Committee is asked to consider and endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the decision to:

Agree the proposed recommendations contained in the recommendation report and exempt appendix and to confirm the new guide prices for these categories of care.

Analysis for the Recommendation in Appendix One (9)

16. Background Documents

Appendix 1 Exempt Analysis supporting the recommendations.
Appendix 2 Exempt Equality Impact Assessment
Both Appendix 1 and 2 are exempt from publication under S12A of the Local Government Act 1972 as they contain pre-contract information and are commercially sensitive.

Appendix 3 Proposed Record of Decision – 14/00064
Appendix 4 Proposed Record of Decision – 14/00065

17. Contact details

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Graham Gibbens **Cabinet Member for Adult Social Care and Public Health**	14/00064

Exempt from publication

Key decision

Yes – Number of people affected and size of budget affected both exceed the Key Decision limit

Subject: OLDER PERSONS RESIDENTIAL TENDER STAGE ONE ANALYSIS AND GUIDE PRICE RECOMMENDATION

Decision:

As Cabinet Member for Adult Social Care and Public Health, I:

1) Agree the proposed recommendations contained in the recommendation report and exempt appendix and to confirm the new guide prices for these categories of care.
2) Delegate to the Corporate Director of Social Care, Health and Wellbeing, or other suitable nominated officer, responsibility to take all steps that are necessary to implement the decision.

Reason(s) for decision:

Having reviewed the report and the data and analysis provided, I support the recommendations to apply a varied increased to the current guide prices for these different categories of care.

In accordance with our requirements under the Local Authority Circular (2004)20, this process has allowed us to robustly consider the actual costs of care and enabled us to apply an increase, where appropriate to our current guide prices.

Application of these guide prices will form part of stage 2 of the tender process and facilitate a new contract to commence from 6th October 2014.

Cabinet Committee recommendations and other consultation:

The Adult Social Care & Public Health Cabinet Committee is meeting on the 11th July 2014 to consider the recommendation report and make comments to the Cabinet Member.

SCHWB DMT and the Corporate Director for Social Care, Health and Wellbeing have been consulted and confirm the recommendations in the report.

Any alternatives considered:

As part of the planning process, DMT considered various options on how these services could be delivered. It was felt that a further price review would not best suit the needs of the council, service users or providers and it was felt that competitively tendering these services would give us the required transparency in order to carefully consider the actual cost of care provision across Kent.

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

....
signed date

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY: Graham Gibbens Cabinet Member for Adult Social Care and Public Health	DECISION NO: 14/00065

Exempt from publication

Key decision

Yes – Number of people affected and size of budget affected both exceed the Key Decision limit

Subject: OLDER PERSONS NURSING TENDER STAGE ONE ANALYSIS AND GUIDE PRICE RECOMMENDATION

Decision:

As Cabinet Member for Adult Social Care and Public Health, I:

1) Agree the proposed recommendations contained in the recommendation report and exempt appendix and to confirm the new guide prices for these categories of care.
2) Delegate to the Corporate Director of Social Care, Health and Wellbeing, or other suitable nominated officer, responsibility to take all steps that are necessary to implement the decision.

Reason(s) for decision:

Having reviewed the report and the data and analysis provided, I support the recommendations to apply a varied increased to the current guide prices for these different categories of care.

In accordance with our requirements under the Local Authority Circular (2004)20, this process has allowed us to robustly consider the actual costs of care and enabled us to apply an increase, where appropriate to our current guide prices.

Application of these guide prices will form part of stage 2 of the tender process and facilitate a new contract to commence from 6th October 2014.

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Any alternatives considered:

As part of the planning process, DMT considered various options on how these services could be delivered. It was felt that a further price review would not best suit the needs of the council, service users or providers and it was felt that competitively tendering these services would give us the required transparency in order to carefully consider the actual cost of care provision across Kent.

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

....
signed date

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
	Andrew Scott-Clark, Acting Director of Public Health
To:	Adult Social Care and Health Cabinet Committee
Date:	11 July 2014
Subject:	Healthy Living Pharmacy Programme (HLP)
Classification:	Unrestricted

Summary

The Healthy Living Pharmacy Programme is a national voluntary programme supported by Public Health England and is aimed at improving the quality and range of services available in community pharmacies; accredited pharmacies will be recognised by a quality 'kitemark'.

In Kent the programme has been adapted and sees pharmacies agree to a range of eligibility conditions, workforce and business developments in order to gain a 'quality kitemark'.

By ensuring a consistent 'quality platform' across pharmacies, the range and quality of services should be assured and a platform created from which to expand the types of services which could be offered in pharmacies in the future. These developments will also increase and improve the access of the public to treatment and lifestyle services and help reduce health inequalities.

A re- launch of the programme and a supporting e-learning package started in June across three Kent venues. Pharmacies can register to become a Healthy Living Pharmacy at any time, and currently 53% of all Kent pharmacies are participating in the scheme.

Recommendations

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

Comment on and endorse the Healthy Living Pharmacy Programme in Kent.

1. Introduction

1.1 The Healthy Living Pharmacy programme recognises that pharmacies are important healthcare assets that are based in the heart of their communities. It is a programme that aims to instil a recognised standard in participating venues so that they can support the health of their community beyond the issuance of pharmaceuticals. The standard is aimed at ensuring that each pharmacy:

- Has a skilled team to pro-actively support and promote behaviour change, and subsequently improving health and wellbeing
- Has premises that are fit for purpose
- Engages with the local community, other health professionals (especially GPs), social care and public health professionals and Local Authorities

1.2 Community pharmacies wishing to become HLPs are required to consistently deliver a range of services based on local need, and commit to and promote a healthy living ethos within a dedicated health-promoting environment

2. Background

2.1 The Healthy Living Pharmacy programme has been through a staged development process as outlined below:

2008 White paper states vision for pharmacies to become Healthy Living Centres

2009 NHS Portsmouth and County Council develop the concept with stakeholders

2010 Portsmouth delivers positive results

2011 Pathfinder national programme launched

2013 Evaluation shows results can be replicated, are cost-effective and have high levels of public approval

2.2 Kent participated in the national pathfinder work in 2011, with 47 pharmacies participating.

2.3 The aims of the programme are:

- To recognise the significant role pharmacies have in the community and encourage proactive pharmacy leadership and multi-disciplinary working
- To deliver consistent and high quality health and wellbeing services linked to outcomes
- To reduce health inequalities
- To provide proactive health advice and interventions – 'make every contact count'
- To create healthy living 'hubs' and engage with the local community
- To meet commissioners' needs

2.4 The intention is that as pharmacies develop their expertise in providing public health interventions they will be able to be commissioned to provide public health services through three levels of increasing complexity and required expertise, with pharmacies aspiring to go from one level to the next.

3. The Programme in Kent

3. The Healthy Living Pharmacy Programme in Kent

3.1 The Kent programme was reviewed and revised in the first part of 2014 with new conditions introduced, including the requirement that a pharmacy works towards achieving the Kent Healthy Business Award. The full eligibility conditions can be found in Appendix 1, Section 4.

3.2 A grant of £50,000 has been secured from 'Health Education Kent, Surrey, Sussex - Technology Enhanced Learning Fund' to deliver a bespoke Kent e-learning programme to support pharmacies to achieve the development aims of the programme. It will also be made available to opticians and dentists later in the year. This e-learning course will also incorporate learning for brief interventions for alcohol and smoking amongst others.

3.3 By May of this year, 146 pharmacies in Kent have registered on the programme, with 100 of those registering in 2014 alone. This represents 53% of all pharmacies in Kent. Pharmacies are able to join the programme at any time.

4 Financial Implications

4.1 Funding of £50,000 has been set aside to support this programme. This will cover the training of two 'champions' per pharmacy. It is anticipated that going forward the pharmacies will self-fund any ongoing staff training via arrangements with the Local Pharmacy Committee.

4.3 As detailed above, a £50,000 grant was secured to develop an innovative e-learning solution.

5. Conclusion

5.1 The Healthy Living Pharmacy programme is a well-recognised, evaluated and successful national programme which continues to evolve.

5.2 The programme has the potential to substantially increase the capacity of community based pharmacies, and subsequently allow public health interventions to be increased in local settings that are easily accessible for members of the public.

5.3 A further evolution of the programme could extend the reach to include dentistry and optical outlets also.

6. Recommendations

6.1 The Adult Social Care and Health Cabinet Committee is asked to:

Comment on and endorse the Healthy Living Pharmacy Programme in Kent.

7. Background Documents

Appendix 1 – Healthy Living Pharmacy Prospectus

Appendix 2 – What Can Pharmacy Do for Your Local Community

8. Contact Details

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Relevant Director

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Kent Healthy Living Pharmacy Programme

Prospectus

20014/15

Linda.smith2@kent.gov.uk

DOI: May 2014

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1. Accreditation summary

Please see full eligibility criteria for more information.

1. Agree to meet eligibility criteria
2. Satisfactory pharmacy site assessment visit
3. Successfully complete training:
   - The Kent Healthy Living Pharmacy e-learning course / leadership:

     Evidence prior learning of leadership and / or undertake the e-learning programme. Should be a pharmacist or manager; see eligibility conditions, point 5.
   - Champion training (x2) per pharmacy[1]. Presently, two champion places are being funded per pharmacy.

2. Revalidation

Revalidation will be every three years, and is anticipated to be in line with services contract renewal. Consideration to revalidate Healthy Living Pharmacy status will be based upon the following factors:

- Evidence of ongoing compliance with eligibility conditions
- Pharmacy site audit
- Portfolio evidence review

[1] Dependent upon pharmacy size, more may be required. Please see eligibility criteria for more information.

- Satisfying contractual obligations

3. Background

2008 White paper states vision for pharmacies to become Healthy Living Centres

2009 NHS Portsmouth and County Council develop the concept with stakeholders

2010 Portsmouth delivers positive results

2011 Pathfinder national programme launched

2013 Evaluation shows results can be replicated, are cost-effective and have high levels of public approval (= new commissioning framework)

Aims

- To recognise the significant role pharmacies have in the community
- To deliver consistent and high quality health and wellbeing services
- To reduce health inequalities
- To provide proactive health advice and interventions
- To create healthy living 'hubs'
- To meet commissioners' needs

Commissioner need	Community Pharmacy	Healthy Living Pharmacy
Deliver services that address local health needs	□	□
Consistency and reliability in delivery	□	□
Cost effective solutions	?	□

Evidence of high quality delivery linked to outcomes	☐	☐
Engagement with the local community	☐	☐
Make every contact count	?	☐
Effective multidisciplinary working	☐	☐
Proactivity and local leadership	?	☐

4. Eligibility conditions

Pharmacies will:

4.1 Have key policies such as training staff, confidentiality and data management including an NHS email account and up-to-date pharmacy profile on NHS Choices

Notes:
NHS email will be the primary and preferred mode of contact to Healthy Living Pharmacy pharmacies. It has the benefit of being accessible from non-network, public computers; is a secure route for sensitive information if required; is carbon-saving

It is also anticipated that for those operating within a larger organisation, communications will be managed via Regional Management using intranet

An up-to-date profile on NHS Choices is essential for the both public and commissioner information, for contact details and what services the pharmacy offers

4.2 Premises must meet GPhC[2] standards and have an accessible and confidential consultation room

4.3 Pharmacy staff must adhere to and align service development and practice to the Professional Standards of Public Health Practice for Pharmacies Appendix 3

4.4 All staff providing Public Health services must have evidence of accreditation either via a Declaration of Competence (for Pharmacists and Pharmacy Technicians) or within an individual's portfolio (for pharmacy staff) Appendix 3

4.5 Be committed to:

i. Having a minimum of two members of staff trained as Health Champion to co-ordinate the delivery of Healthy Living Pharmacy interventions

ii. The pharmacist or manager to undertake leadership training. (If previously undertaken evidence of leadership training directly related to Healthy Living Pharmacy will be required).

iii. Identify one suitable staff member as a Public Health Lead for the pharmacy

Notes:

[2] General pharmaceutical Council

Please be mindful when selecting suitable members of staff for training i.e. do they have the opportunity to interact with the public / do they have the necessary aptitude to successfully provide health champion interactions? What is the skill mix?

It is recognised that it may be difficult for some pharmacies to have more than one member of staff being trained at one time. Therefore it is acceptable to have other staff working towards completion of training as long as one is undertaking the training in the first instance.

The expectation is that during pharmacy opening times, there will be appropriately trained staff available to provide Champion interventions. Accordingly, the numbers trained will vary dependant on the size of the pharmacy and should be determined by each pharmacy.

4.6 Be committed to participating in CPD activities and local campaign launch events *Appendix 3*

4.7 Champions and leaders should be able to demonstrate evidence of Continuous Personal Development allied to Healthy Living Pharmacy service activities and criteria as appropriate. CPD / self-reported evidence will be required as part of the revalidation process. *Appendices 3, 4*

4.8 You must notify Public Health Kent[3] in the event that you cannot fulfil any aspect of the Healthy Living Pharmacy eligibility criteria with particular reference to Champion(s) and /or leader no longer being available for any reason or a significant period of time. [4]

4.9 Be delivering other services such as Medicines Use Reviews and New Medicines Service – particularly important for older people and people living with long term conditions

4.10 Provide Health Promotion Services according to local health needs and in liaison with Public Health Commissioners; be supportive of the Public Health Responsibility Deal *Appendix 3*

4.11 Provide evidence of good working relationships with the wider multi-disciplinary Health and Care teams, e.g. GPs, residential homes, community groups, schools, medicines management; participate in risk-profiled multi-disciplinary meetings

This evidence will also be used as part of the revalidation process at three yearly intervals via portfolio submission.

4.12 Be committed to principles of sustainable Healthcare and work towards achieving the Kent Healthy Business Award (Excellent level), as the framework to comply with the *NHS Standard Contract 4 NHS England, 2014 (2014/15).*

Notes:

[3] Programme lead/administrator as publicised.
[4] For example staff changes.

http://www.kent.gov.uk/business/news_and_events/kent_healthy_business_awards.aspx

The Kent Healthy Business Awards are self-assessment standards that provide a guide and general overview to help keep your business sustainable. Appendix 5

This evidence will also be used as part of the revalidation process at three yearly intervals via portfolio review.

4.13 All Healthy Living Pharmacy activities should be operated in a manner which is compliant with the 'You're Welcome' guidelines; further details may be found at http://www.nya.org.uk/you-re-welcome

5. Training

5.1 Kent Healthy Living Pharmacy e-learning programme Appendix 1

This e-learning course is open to all pharmacy staff and is particularly recommended to pharmacists and managers to meet the **leadership training requirement** of the Healthy Living Pharmacy accreditation process.

This programme has been developed by CPPE bespoke to Kent which extends over 8 weeks, with an expected time commitment of 4 to 5 hours per week.

Aim

The overall aim of this course is to equip participants with an understanding of the purpose and scope of the Healthy Living Pharmacy initiative and to equip participants with the key knowledge, skills and behaviours to support the pharmacy team to successfully implement a Healthy Living Pharmacy service.

Evidence of completion/learning gained will be via self-reports; anticipated to be part of a pharmacy's Healthy Living Pharmacy portfolio of evidence to support accreditation and revalidation.

5.2 Health Champion: Level 2 Award in Understanding Health Improvement (The Royal Society of Public Health) Appendix 2

This is an **essential** requirement of becoming accredited as a Healthy Living Pharmacy. Training will be delivered as 'face-to-face' sessions to be conducted over two half-days in various venues across Kent.

6. Implementation and Support

Things you may find of use and the e-learning course will also help with the following:

- **Identify and match local need via**
  - Pharmacy Needs Assessments (what services are offered; *NHS Choice profile*)
  - Joint Strategic Health Needs Assessment (JASNA)
  - identified local community needs / service provision required
  - the pharmacy will be responsible for identifying and ordering their own health promotional and patient information materials *Appendix 3*

- **Engage and Communicate**
  - with other organisations and professional groups
  - with the public
  - with commissioners *(plus NHS email)*
  - signpost to other services[5]
  - Healthy Living Pharmacy support platforms *(e.g. training, webpage, newsletters, CPD networks, local networks and local campaign launch days)*

[5] Locality referral units/access points for service referral will be supplied

- **Quality Assurance and Improvement**
  - Meeting eligibility and revalidation conditions
  - Meeting commissioned performance requirements
  - Promoting the ethos and practice of Healthy Living Pharmacies

7. Appendices

Appendix 1 E-learning course

Kent Healthy Living Pharmacy e-learning programme

This programme has been developed by CPPE and uses course sites as the platform to deliver an e-learning course, which extends over 8 weeks, with an expected time commitment of 4 to 5 hours per week.

Aim

The overall aim of this course is to equip participants with an understanding of the purpose and scope of the Healthy Living Pharmacy (Healthy Living Pharmacy) initiative and to equip you with the key knowledge, skills and behaviours to support them and the pharmacy team to successfully implement a Healthy Living Pharmacy service.

Learning outcomes

By working through this course, participants should be able to:

· discuss the key features and benefits of Healthy Living Pharmacies
· compare local health needs and health inequalities with those in the rest of England
· analyse the Healthy Living Pharmacy development framework and match pharmacy services to local health needs
· use the Healthy Living Pharmacy quality criteria to develop an action plan for implementation of the service
· apply the principles of effective change management to communicate the impact of Healthy Living Pharmacies to your team
· develop an action plan to support team members to undertake personal development appropriate to their role.

Who has this programme been developed for?

This programme has been developed for pharmacists, pharmacy technicians and pharmacy staff with an interest in Healthy Living Pharmacy, whether they intend to

apply for accreditation as part of the local initiative or they just want to find out more about what is involved.

This programme will provide a structured approach to learning about Healthy Living Pharmacy and will give the opportunity to deliver a quality patient-focussed service. Participants will have the opportunity to have online discussions with colleagues to share experiences and problem solve together.

The programme structure:

The first week of the programme takes participants through the Healthy Living Pharmacy journey, from understanding the background and where it fits into the national pharmacy contract through to understanding the benefits it has delivered in early adopter sites.

- During week **2** participants will consider how to use local health needs to influence key stakeholders and commissioners.
- During weeks **3 to 5** participants will concentrate on leadership, including time management and delegation, as this has been key to the successful implementation of Healthy Living Pharmacy in other areas.
- Weeks **6 and 7** focus on behaviour change and brief advice.
- Finally in week **8** participants will focus on measuring the impact of their service and sustaining the change over the longer term.

Appendix 2 Health Champion Information

Health Champion Information April 2014

Figure 1 Training overview

*Recent feedback from pharmacy staff that undertook this course was not positive about the relevance of this qualification to the community pharmacy context

Appendix 3 Information and Resources

1. http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/
2. http://www.pharmacynorthamptonshire.co.uk/downloads/Healthy Living PharmacyFRAMEWORKv3.pdf
3. http://www.kentlpc.org.uk/healthy-living-pharmacy
4. https://responsibilitydeal.dh.gov.uk/about/
5. http://www.cppe.ac.uk/learning/programmes.asp?format=&ID=115&theme=30
   Free modules – Healthy Living Pharmacy and general CPD
6. http://sustainablehealthcare.org.uk/
7. https://www.rsph.org.uk/
8. Local Pharmacy Council Healthy Living Pharmacy section
9. NHS Choices http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10
10. https://www.gov.uk/government/publications/health-and-wellbeing-introduction-to-the-directorate
11. http://www.patient.co.uk/wellbeing
12. Patient information literature and resources: http://www.patient.co.uk/pils.asp
13. 'You're Welcome' guidelines: http://www.nya.org.uk/you-re-welcome
14. Declaration of Competence:

    www.cppe.ac.uk/services

    http://psnc.org.uk/our-news/declaration-of-competence-doc-framework-for-locally-commissioned-services/
15. http://www.kent.gov.uk/business/news_and_events/kent_healthy_business_awards.aspx
16. http://www.rpharms.com/unsecure-support-resources/professional-standards-for-public-health.asp

17. http://www.networks.nhs.uk/nhs-networks/Healthy Living Pharmacy-pathfinder-sites

Appendix 4 CPD Guidance for Champions

Continuing Practice Development (CPD)

Guidance for Healthy Living Pharmacy Champions

1. **The purpose** of keeping a record of your CPD is to:
   - Help you think about what you do in your work and how you do it
   - Helps you to keep up with the latest information and developments
   - Helps to show that you provide high quality care and advice
   - Document each learning activity you do within the three year period

2. **Things to record.** There is no right or wrong way to do this but please see the tips below:
   - List and describe your workplace and your role during the last three years and link your role(s) to your learning activities. You should also link them to the four areas you learned about in your Level 2 Understanding Health Improvement course. You could also link them to the services you provide in the pharmacy or any learning you do in preparation of providing new services in the pharmacy.
   - Describe what you did with dates and how long you engaged in the learning activity for (e.g. how many hours you spent)
   - Give details of what you actually did. How did you come to do your learning activity; was it a planned activity or did you seek out the learning and why?
   - What did you learn from it? How did you put this into practice? What difference did it make? Will you do things differently in the future?
   - Get into the habit of keeping any documents or certificates from any learning including things like appraisals or emails about the work you done

3. **More information and guidance** on recording CPD can be found at the General Pharmaceutical Council - http://www.pharmacyregulation.org

   (The information is aimed at pharmacists and technicians but has much useful information you could use).

- http://www.pharmacyregulation.org/education/continuing-professional-development/recording-cpd
- http://www.pharmacyregulation.org/sites/default/files/GPhC%20Plan%20and%20Record%20g.pdf

Appendix 5 Kent Healthy Business Award

The Kent Healthy Business Awards are self-assessment standards that provide a guide and general overview to help keep your business sustainable.

Why take part in the awards?

- To showcase your people, services and skills
- to help build your reputation for commitment to best practice in health, safety and wellbeing
- to assist in business development and tendering activity
- The awards offer support in developing policies and procedures and demonstrating your compliance with current laws and regulations.

Award categories

The standards are divided into three levels:

Commitment

The Commitment award is for those businesses that may have just started to engage with the 'Health and Work' idea and who wish to discover what it might mean for their business and people.

Achievement

The Achievement award is for those businesses who have already made some inroads into Health and Work for their staff and business and who are now actively encouraging employees to improve their lifestyle.
These businesses will be putting basic interventions in place to raise awareness among staff.
For example, arranging smoking cessation training within the workplace, or signposting people to the help they need about debt advice, domestic abuse and health conditions.

Excellence

The Excellence award is for those businesses that have not only made information easily accessible to their staff, but have publicised and actively promoted it and the leaders of the business are fully engaged.
The leaders show commitment to their staff by providing intervention programmes and support mechanisms that will help prevent ill health, help people stay in work, and return to work as soon as possible.
Each level focusses on leadership, culture and communication, and is broken down into the themes below:

- Leadership
- Attendance Management

- Health and Safety Requirements
- Mental Health and Wellbeing
- Smoking and Tobacco
- Physical Activity
- Healthy Eating
- Alcohol and Substance Use
- Environment

There are four options which indicate which standard your business is at:

- **Fully Met (FM)** - every aspect of the standard has been met or exceeded and you can evidence this both by documented and practical examples
- **Partially Met (PM)** - Some or most of the Standard has been met and can be evidenced. This option could be selected if the business undertakes activities but cannot evidence it or have not yet communicated with employees about it, but the intention is there
- **Not Met (NM)** - None or very little of the Standard has been met. This option should be selected if activities, procedures or systems are still under development or have not been implemented
- **Not Applicable (NA)** - The Standard covers an area that does not relate to the business due to the nature of activities, location or other practical reason


Charter Resources Commitement 10.02.1


Charter Resources Achievement 10.02.14


Charter Resources Excellence 10.02.14 V

Appendix 6 Registration form

HLP registration form Master.docx

Please return by email to: Dawn.Williams@kent.gov.uk

Please, no later than **31st May 2014.**

Thank you.

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PHARMACY
the Heart of our Community

What can pharmacy do for your **local** community?

Community pharmacies straddle the ground where the local authority and NHS worlds meet. They are 'an integral part of the NHS'[1], a 'vital local service' and a 'community facility'[2].
The recent transfer of responsibilities for public health into local government and the new arrangements for local authority oversight of health commissioning, mean that ties between councillors and healthcare professionals such as community pharmacists need to grow.

Pharmacy basics

- There are over 11,400 community pharmacies in England, situated in high-street locations, in supermarkets and in residential neighbourhoods
- 96% of the population – even those in the most deprived areas – can get to a pharmacy within 20 minutes by walking or using public transport[4]
- 84% of adults visit a pharmacy every year[4]
- Excluding those who report never visiting a pharmacy, on average an adult visits a pharmacy 16 times a year, of which 13 visits are for health related reasons[4]
- An estimated 1.6 million visits to community pharmacies take place daily of which 1.2 million are for health related reasons[4]
- Pharmacies provide a convenient and less formal environment for those who cannot easily access or do not choose to access other kinds of health service[4]
- Most pharmacies (>85%) have private consultation areas
- Of all health professionals, pharmacists have the most comprehensive education and training in the use of medicines for the prevention and treatment of disease

Three strands of the shared local authority - community pharmacy agenda

Public health - central government has recognised pharmacy as 'a valuable and trusted public health resource'[1]. Community pharmacies have a track record in delivering public health services – helping people to stop smoking, manage their weight, practise safe sex and reduce/stop their use of illegal drugs.

Support for independent living - pharmacies provide services that help people remain independent for longer, by helping them understand and manage their medicines.

Social capital - a community pharmacy is one of the core businesses which can make a difference between a viable high street and one that fails commercially – thereby sustaining communities and building social capital[3].

Public Health

Community pharmacies are providing a growing range of public health services (see overleaf) that are producing positive outcomes, notably for people in deprived or vulnerable circumstances.

As community pharmacies are uniquely well positioned to reach out to the population – including 'apparently well' people – on a large scale, there is considerable public health benefit to be gained by extending the range and reach of these services.

What can pharmacy do for your **local** community?

PHARMACY
the Heart of our Community

A new concept highlighted in the Government's Public Health White Paper is the 'Healthy Living Pharmacy', which brings together a number of these public health services in one location. This has been successfully piloted in Portsmouth[5] and further tested in more than twenty sites around the country[6].

Support for independent living

Community pharmacies provide a range of services to support people to live independently in their own homes, including support with re-ordering repeat medicines / the NHS repeat dispensing service; home delivery of medicines to the housebound; appropriate provision of multi-compartment compliance aids and other interventions such as reminder charts to help people remember to take their medicines; reablement services following discharge from hospital; falls assessment / reduction services; and signposting patients or their carers to additional support and resources related to their condition or situation.

Community pharmacy and social capital

Community pharmacies fulfil a social function by providing a space for individuals to develop networks of trust and mutual support. For example, for many older people who live alone, a visit to a pharmacy constitutes valued social interaction.

Secure health infrastructure is important to maintain resilient communities, notably in remote, rural locations. Community pharmacists have made a commitment to their local community by virtue of their financial investment, and present a sustainable asset.

Pharmacies provide employment for local people and contribute to the economic prosperity of their local community by preserving local shopping access[3].

For these reasons, the Overview and Scrutiny Committees of some local authorities have taken a keen interest in the viability of their local community pharmacy network.

Health and Wellbeing Boards now have the responsibility to develop, update and publish local Pharmaceutical Needs Assessments (PNAs), which identify plans for improving health, and which aid NHS England's decision making on the granting of new NHS contracts to community pharmacies.

Visit www.psnc.org.uk for more information on community pharmacy services.

Public Health

Examples of community pharmacy services

- **6 health promotion campaigns** carried out in community pharmacies annually for NHS England
- **Substance misuse services:** needle and syringe services; supervised consumption of medicines to treat addiction, e.g. methadone; Hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations
- **Sexual health services:** emergency hormonal contraception services; condom distribution; pregnancy testing and advice; Chlamydia screening and treatment; other sexual health screening, including syphilis, HIV and gonorrhoea; contraception advice and supply (including oral and long acting reversible contraception)
- **Stop smoking services:** proactive promotion of smoking cessation through to provision of full NHS stop smoking programmes
- **NHS Health Checks for people aged 40-74 years:** carrying out a full vascular risk assessment and providing advice and support to help reduce the risk of heart disease, strokes, diabetes and obesity
- **Weight management services:** promoting healthy eating and physical activity through to provision of weight management services for adults who are overweight or obese
- **Alcohol misuse services:** providing proactive alcohol brief intervention and advice with referral to specialist services for problem drinkers
- **Pandemic and Seasonal 'Flu services:** providing continuity of dispensing of essential medicines, provision of antiviral medicines; 'flu vaccination services

Examples of local community pharmacy services can be found at: www.psnc.org.uk/database

Partnership with your local pharmacies – steps you can take now

Links with community pharmacists leading the development of services can be made via the Local Pharmaceutical Committee (LPC). A visit to a local community pharmacy can also be arranged to demonstrate how services are provided for local people.

Contact details for your LPC can be found at www.psnc.org.uk.

References
1. A Vision for Pharmacy for Pharmacy in the New NHS. Department of Health, 2003
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3. Improving shopping access for people living in deprived neighbourhoods: a paper for discussion. Department of Health, 1999
4. Pharmacy in England: building on strengths – delivering the future. Department of Health, 2008
5. Healthy lives, healthy people: Our strategy for public health in England. Department of Health, 2010
6. Evaluation of the Healthy Living Pharmacy pathfinder Work Programme 2011-2012, RPS, CCA, NPA, PSNC

By: Roger Gough, Cabinet Member for Education and Health Reform

To: Adults Social Care and Health Cabinet Committee - 11th July 2014

Subject: **Kent Health and Wellbeing Strategy**

Classification: Unrestricted

Summary

The Kent Health and Wellbeing Board is required to ensure that a Health and Wellbeing Strategy for the Kent area is produced and that it reflects the issues identified in the Joint Strategic Needs Assessment. The current Health and Wellbeing Strategy was agreed by the Shadow Kent Health and Wellbeing Board at its meeting of 30th January 2013 as a one year strategy, recognising that in a time of great change to the health and wellbeing system this would be an interim measure prior to developing a full strategy in subsequent years.

The Kent Health and Wellbeing Strategy is therefore now due for renewal and work is underway to complete a final strategy for presentation to the Kent Health and Wellbeing Board on 16th July for approval. This timescale will allow the final strategy to be endorsed in time to inform the next round of commissioning intentions for all parties that will commence in the Autumn.The revised version of the strategy has taken into account feedback from stakeholders workshop which highlighted a clearer strategic alignment across the system; the identification of priorities and their connection with outcomes; the need to be more specific about children's issues and a clear statement of the case for change.

As a result some of the key changes to the revised strategy has clearer links with Better Care Fund providing a strategic platform for change across the system; a revision to the wording of Outcome 5 to reflect holistic support for people with dementia and the stronger connections between outcomes and priorities.

The revised proposed version also takes into account the views of Kent residents about the changes they would expect such as: timely access to support; and improvements to professional communication. Additionally, the revised proposed strategy introduces an increased emphasis on key groups of vulnerable children and young people within Outcome 1.

The initial draft of the revised strategy has been issued for public comment and is attached to this report.

Recommendation:

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

Consider the revised Joint Health and Wellbeing strategy for Kent and to Comment accordingly.

1. Introduction

(a) The original Health and Wellbeing Strategy was based on the Joint Strategic Needs Assessment of 2012/13. The strategy is built around 4 priorities designed to deliver 5 key outcomes through 3 main approaches:

The Priorities:

1. Tackle key health issues where Kent is performing worse than the England average
2. Tackle health inequalities
3. Tackle the gaps in provision
4. Transform services to improve outcomes, patient experience and value for money

Relevant priority outcomes:

1. Every child has the best start in life
2. Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
3. The quality of life for people with long-term conditions is enhanced and they have access to good quality care and support
4. People with mental ill health issues are supported to 'live well'
5. People with dementia are assessed and treated earlier, and are supported to 'live well'.

The Approaches:

- Integrated Commissioning
- Integrated Provision
- Person Centred

(b) In revising the strategy, it has been recognised that although much progress has been made in many areas it is unlikely that these outcomes have been fully achieved, or the priorities completely addressed, during the 12 months that the strategy was in operation. Whilst the Joint Strategic Needs Assessment has been refreshed and updated, these key elements of the strategy remain relevant to the population of Kent today. For all these reasons it is proposed that the original strategy continues to articulate the priorities and outcomes that are still relevant and that they should be retained as the basis for the new document.

The revised strategy is designed to give definition to the improvements that will be necessary to ensure that health and wellbeing priorities of the residents of Kent are properly addressed and the aspirations contained within the "I statements" are made a reality.

(c) The Better Care Fund (BCF) and its associated planning has also been a significant factor in the renewal of the strategy. The BCF is intended to promote large scale system wide changes to health and social care services to deliver an integrated health and social care system at greater pace and scale than hitherto envisaged. The potential impact of the BCF on all aspects of the health

and social care system within the remit of the Health and Wellbeing Board is so great that the production of the new strategy has been purposely delayed in order that these implications can be reflected in the new document. In essence the BCF supports the main principles and aspirations of the existing strategy.

(d) The three approaches highlighted in the strategy are entirely reflected in the principles underpinning the BCF, the aims of the BCF cannot be delivered without addressing the four priorities, and the majority of the five outcomes are directly related to those of the BCF itself, (the exceptions being Every child has the best start in life and Effective prevention of ill-health by people taking greater responsibility for their health and wellbeing. These two outcomes are outside the specific scope of the BCF but are still of great importance in their own right). The renewed strategy is therefore designed to reflect the principles and aspirations of the BCF to improve public understanding of the changes that will be taking place.

(e) Beyond this, the relationship between the outcomes and priorities has been reshaped. The outcomes have also been considered and Outcome 1 – Every child has the best start in life – has been redesigned. This is to recognise that whereas the other outcomes mainly reflect different aspects of health and wellbeing for adults, all children's issues are put together in Outcome 1. The revised strategy will introduce an increased emphasis on key groups of vulnerable children and young people.

(f) The revised strategy was discussed at the Kent Health and Wellbeing Board at its meeting of the 28th May 2014. The Board agreed that the draft has been published for public comment until 27th June and responses will be incorporated into a final draft of the strategy to be presented to the Kent Health and Wellbeing Board on 16th July. Also included in the final draft will be comments from Health and Wellbeing Board discussion relating to a greater emphasis on the patient experience and quality of care. The links to the JSNA could also be made more explicit.

2. Communication and Engagement

(a) Engagement and consultation with the public and stakeholders is crucial to the acceptance of the strategy as the basis for health and social care commissioning in Kent. So far the principles and basic structure of the new strategy have been discussed in a variety of forums including local Health and Social Care Integration Programme meetings and a major workshop to which c. 120 representatives of organisations including the voluntary and private sectors attended. (For information a table summarising key points raised at the workshop is appended to this report). From all these meetings there has been general agreement to the approach for developing the new strategy, subject to a full engagement and consultation programme prior to final agreement from the Kent Health and Wellbeing Board. A communications and engagement group that includes representation from KCC, Districts, Healthwatch and the NHS has been established and a plan for communications and engagement developed. The approach recognises that the decision to delay refreshing the strategy to take account of the BCF and other developments somewhat curtails the time available and also that the new strategy is based in large part on the previous document which was also subject to consultation and wider engagement.

(b) The BCF informs the strategy but the substance of the BCF plans is not part of the public engagement for the strategy as it is contained within the CCG commissioning plans, and CCGs will have their own communication strategies. However, greater public understanding of the implications of the BCF will be critical to the successful transformation of health and social care services and engagement around the strategy needs to reflect this. Whilst the substance of the strategy remains from the previous edition, the pace and scale of change has been increased and the strategy can be a vehicle for engaging the public, patients and users of services in the debate about how these changes will be implemented. Much of this engagement will be required following the issuing of the final strategy and local health and wellbeing boards provide a useful mechanism to achieve this. it is proposed that the Kent Health and Wellbeing Board tasks the local boards to report back in November 2014 on how they are engaging local populations in the discussions concerning implementation of the strategy in their local areas. This should complement other activity such as the Public Health communications strategies, especially concerning Outcome 2.

(c) The engagement plan will include the development of key messages.

(d) The communications and engagement plan recognises that this process will continue after the strategy has been finally published to ensure that it is properly promoted and understood.

(e) To date the revised strategy has been warmly welcomed by the professional organisations that have responded. There has been limited response from local media and the general public apart from an article on the "Your Canterbury" website.

3. Links to other documents

(a) The Joint Health and Wellbeing Strategy shows a direct link to the priorities identified in the Joint Strategic Needs Assessment. It should also be clearly driving the commissioning plans of the CCGs, Public Health and Social Care including the BCF plans.

(b) While the Strategy has been based on priorities identified in the JSNA, there will inevitably be key needs for specific populations at a local level, which are not explicitly set out in the Strategy. However, the principles set out in the Strategy can be applied to the development of policies and plans across areas falling under the wider determinants of health, such as housing, or dealing with specific population groups, such as gypsies and travellers, and there is an expectation that the Strategy would be used to inform these.

4. Measurement and Metrics

(a) The existing strategy contains a number of measures that were designed to demonstrate whether progress has been made in achieving the desired outcomes. Whilst these seemed very reasonable at the time experience has shown that there are a number of issues associated with the suite of indicators adopted. Data for some of the measures is not easily collated, there is a mixture of performance indicators and measurement of activity, and some measures are very aspirational and not easily quantifiable.

(b) These issues have been considered by a wide range of stakeholders at a recent workshop where it was agreed that a new set of indicators should be incorporated that are more clearly designed to reflect progress against the outcomes. Work has also been progressing with the Board to develop an assurance framework and the revised strategy has incorporated some of these measures to promote greater consistency.

(c) Another intention for the revised strategy is that it should be easier to relate to smaller populations within the county. Given the size and complexity of Kent, it is a challenge to make the strategy relevant at district, CCG and care economy (north, east and west) levels but if the strategy is to be more than a reference document it must be capable of translation into all of these.

5. Local Action

Given the size and complexity of Kent, and the scale of the health and care system, it is very difficult for any strategy to provide answers at district, Clinical Commissioning Group and health/care economy (north, east and west) levels. Therefore, local Health and Wellbeing Boards will be encouraged to develop their own action plans designed to achieve the outcomes in ways most relevant to their own populations supported by data and information aggregated to the appropriate level.

6. Review and Monitoring of Progress

(a) Ongoing monitoring of the indicators associated with the strategy will be provided through the regular assurance report to the Kent Health and Wellbeing Board.

6. KCC Committee cycle

(a) The revised Health and Wellbeing Strategy is scheduled to be considered at a number of KCC Cabinet committees and the Health Overview and Scrutiny Committee as well as returning to the Health and Wellbeing Board for final approval. These committees meet on the following dates:

Health Overview and Scrutiny	**18th July 2014**
*Cabinet Committees***:**	
Children's Social Care and Health	**9th July 2014**
Adult Social Care and Health	**11th July 2014**
Education and Young People's Services	**23rd July 2014**

7. Recommendation

The Adults Social Care and Health Cabinet Committee is asked to consider the revised Joint Health and Wellbeing Strategy for Kent and to comment accordingly.

Appendices:

Strategy Development Workshop: Issues

Communications and engagement plan

Background Documents

Kent Joint Health and Wellbeing Strategy – Outcomes for Kent Report to Kent Health and Wellbeing Board 30th January 2013

Kent Joint Strategic Needs Assessment - http://www.kmpho.nhs.uk/

Kent "Mind the Gap" – Health Inequalities Action Plan http://www.kmpho.nhs.uk/

Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategy and Timeline – Report to Kent Health and Wellbeing Board 17 July 2013

Better Care Fund plans – report to the Kent Health and Wellbeing Board 26 March 2014

CCG Commissioning Plans - report to the Kent Health and Wellbeing Board 26 March 2014

Kent Health and Wellbeing Strategy – report to the Kent Health and Wellbeing Board 28th May 2014.

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Appendix 1 - Strategy Development Workshop: Issues

The stakeholder conference said	We responded
The measures in the original document were not specific or robust enough to demonstrate whether we had succeeded in achieving our outcomes or not.	The metrics in the new strategy are much more closely aligned with those of the Assurance Framework being developed for the Health and Wellbeing Board and the National Outcomes Frameworks for the NHS, Adult Social Care and Public Health
The strategy needs to be more relevant at a local level of District Council, Clinical Commissioning Group, and Care Economy.	The measurements should be easier to translate into a local context so that local progress can be seen more clearly. The application of the 4 Priorities to a local level should be clearer and the emphasis on achieving outcomes rather than doing the same thing everywhere should enable more local interpretation.
Priority 4 Transform services to improve outcomes, patient experience and value for money, is not given enough prominence.	The implementation of the Better Care Fund will require these improvements to be demonstrated in all the plans and proposals concerned. All three go hand in hand to deliver the aspirations of properly integrated services that will benefit the people who need them.
What are “priorities” anyway?	We have redefined the relationship between outcomes and priorities in the new strategy. It should be much more explicit as to how the 4 Priorities will contribute to the achievement of the 5 Outcomes.
Children’s issues need to be identified more specifically. In the original document all of them are put together in Outcome 1 and all the measures concern preventative measures rather than medical issues.	The new document differentiates the issues for children and young people in Kent and the measures we need to judge progress more fully.
The case for change needs to be stated more clearly	The main reasons for the changes that will be necessary – the NHS Call to Action and The Better Care Fund - are described in the new document.

What will these changes mean for people involved? The strategy needs to be clear about what can be directly influenced by those organisations represented on the Health and Wellbeing Board and those which cannot.	The “I statements” that are driving the improvement of services and describe how things should change are included in the new strategy. The actions and targets under the four priorities have been reviewed. The strategy does take into account the wider national context and to gain a full picture of the health and wellbeing of the people of Kent, this information is useful. The strategy will also be used to inform the decision making of a wider range of organisations than are formally represented on the Health and Wellbeing Board.

Milestones	Actions	Timescale	Lead(s)
Develop draft-for-consultation version of the Strategy	Draft the strategy document.	by 14th May	P&SR
	Artwork document	14 – 19 May	Comms
	Publish draft "for consultation" document with Board papers	19 May	Democratic Services
Agree version of Health and Wellbeing Strategy to go out for consultation	Draft considered by the Health and Wellbeing Board, with feedback / amendments provided	28 May	P&SR
	Changes to document made.	28-30 May	Comms
Complete equality impact assessment	Complete initial assessment to assist with identifying potential stakeholders and methods	By 2/6/14	P&SR
Identify key stakeholders	Complete mapping exercise of stakeholders	By 2/6/14	P&SR
Public consultation starts	Press and media - press release	w/c 2/6/14	Press Office
	Press briefings with Roger Gough	w/c 2/6/14	Press Office
	Publication of draft Health and Wellbeing Strategy for Kent on kent.gov.uk	w/c 2/6/14	Comms
	Social media activity (Twitter) to inform public.		Comms
Publish survey to gather stakeholder feedback on the draft strategy	Draft survey based on key questions identified by public health.	By 2/6/14	P&AR & Consultation
	Survey to be made available on-line and hard copies available in key public areas (tbc)	From 2/6/14	Comms

	Circulate questionnaire to stakeholders: • CCG leads (will require direct targeting and personal approach) • District/Borough council • Providers • Healthwatch Kent • Voluntary & Community Sector (VCS) • KCC • Patient/service user and carer groups • Specific interest groups	From 2/6/14	To confirm
	Work with CCGs to promote through surgeries and other health settings.		P&SR and Comms
Attend public meetings to promote draft strategy and gather feedback	Raise at existing meetings, including patient and user groups across health and social care subject to timescales.	From 2/6/14	tbc
Maximise use of internal/external newsletters	Communicate via existing newsletters, including Healthwatch Kent	From 2/6/14	tbc
Closing date of consultation	Issue reminder press release a week before consultation closes.	w/c 16 June	Press Office
	Increase Twitter activity	w/c 16 June	Comms
Data analysis	Analyse responses from consultation – analyst to be identified	From 1/7/14	tbc
Consultation report	Full report completed and published, alongside final version of HWB Strategy	By 16/7/14	tbc

2014 – 2017

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

Draft

Published by Kent County Council on behalf of the Kent Health and Wellbeing Board

Kent County Council
kent.gov.uk

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Foreword

I have been pleased with the progress that the Kent Health & Wellbeing Board has made since its launch in April 2013 – bringing together GPs, County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from the Local Healthwatch. We have collectively settled into our role, and the Board provides an effective body where commissioners, patient representatives and elected officials can come together to take an overview of the health and care system in Kent. We continue to align our work, and share our commissioning plans and good practice. This stands us in good stead to tackle the challenges of, and seize the opportunities offered by, the changes that will face us over the coming years.

Just over twelve months ago the Kent Health and Wellbeing Board agreed its first strategy, identifying the outcomes that we, as a health economy in Kent, would collectively be looking to deliver, and we identified the priorities that we felt would enable us to achieve our aims. We took the decision that in a rapidly changing health and social care landscape that it would be prudent to revisit our strategy after twelve months to assess whether it was still applicable, and whether we had started to make progress. It is fair to say that in twelve months the major challenges facing Kent haven't changed a great deal, and for that reason, the board and our colleagues across the health and care system agreed to retain the five outcomes and four priorities we agreed last year.

As you will see over the following pages, the growing pressure of demographic change, generating increased need for health and social care services, at a time of financial stringency is still with us. We have to change, and to work together more effectively, if we are to achieve better health outcomes for the people of Kent while staying within the financial resources budget. The past year has seen the advent of the 'Better Care Fund' which offers us the opportunity to increase the scale of change that we identified was needed in last year's strategy. Kent is also an Integration Pioneer, giving us opportunity to be innovative and develop joined up services faster.

During the development of the refreshed strategy it became clear that one of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff, with general services provided in the community or at a local hospital as clinically appropriate. This may mean an increase in journey times to access specialist provision for some people, but conversely allowing people to access much more of the care they need in community settings. It is the job of the Health and Wellbeing Board, and its constituent members to begin the conversation with the public, ensuring that they understand the implications, and that they can influence the long term decision making to the same extent that they currently influence specific service developments.

The Joint Kent Health & Wellbeing Strategy will only be effective if the plans of GP-led Clinical Commissioning Groups, the County and District Councils and other partners align with the outcomes and priorities identified here, using them as a set of core values by which to design system and service development.

Signed by Roger Gough
Chair of the Shadow Kent Health and Wellbeing Board

Summary

People's need for care, and their lives, has changed radically. But the health service largely operates as it did decades ago, when the predominant need/ expectation was treating episodic disease and injury rather than providing long-term, often complex care. The health and care system needs to redesign services so that care becomes more integrated, person-centred, coordinated, community-based, and focused on supporting people's well-being and preventing crises. The 2015 Challenge Declaration – NHS Confederation

The challenge to the health system is clear. Kent, like the rest of England, has an ageing population that will put increasing demands on the system, and will require long-term complex care. This, along with unhealthy lifestyle behaviours, and the rising cost of technology means that nationally the NHS faces a £30bn funding gap by 2021, unless the system of health and social care can be transformed.

To meet this challenge in Kent, the Health and Wellbeing Board have developed this strategy to lead the system as it changes over the coming three years. The constituent members of the Health and Wellbeing Board will use this strategy to guide their plans, and will also use the strategy as a way to start a conversation with the public about the major changes that will be taking place over the coming years.

They will need to build an understanding about the changes that will happen to large hospitals when 15% of their business moves to community based settings. These changes will see some hospitals become more specialised and the journey times for some treatments may increase to provide this specialist care. Some hospital and care settings may, become smaller, with services redesigned to provide care closer to home. These changes will provide the opportunity to build person centred, integrated services and the advantages of these changes need to be communicated over the coming years.

To realise the full potential of these opportunities and to benefit the people of Kent it is paramount that all constituent agencies in the system (i.e. social care, acute hospitals, ambulance services etc.) work together and develop a common vision and complimentary strategies to address these challenges. Collaborative work between agencies will allow the people of Kent to get a complete service and not just one individual service.

Within Kent County Council, the Adult Social Care Transformation portfolio is putting a stronger emphasis on prevention, early intervention and integrated service delivery and commissioning as a way to realise the vision of a sustainable model of integrated health and social care by 2018. This will improve outcomes for people across Kent by maximising people's independence and promoting personalisation. It will involve KCC working with partner organisations across the public health, health, housing and social care economy. For instance from September 2015 the Council will also be responsible for commissioning of health visitors which will provide increased opportunities to undertake integrated commissioning.

We have tested last year's Joint Health and Wellbeing Strategy (JHWS) against the many developments over the past twelve months, namely the challenges arising from the failures in care at Mid-Staffordshire Hospital and Winterbourne View, alongside the Call to Action, the resulting Better Care Fund, and Kent's status as an Integration Pioneer. The vision, outcomes, priorities and approaches that were developed are still appropriate, and our vision is just as relevant. Therefore we have developed this strategy to achieve our vision :

To improve health outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services, and ensure that the individual is involved and at the heart of everything we do.

To deliver our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment (JSNA), are:

- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to live well

Each of these outcomes is discussed in detail over the coming pages, with each one being examined through the prism of our four identified priorities which are to:

1. Tackle key health issues where Kent is performing worse than the England average
2. Tackle health inequalities
3. Tackle the gaps in provision
4. Transform services to improve outcomes, patient experience and value for money

In all of the work that takes place over the coming years, all developments should test themselves against the three approaches that we identified last year, namely that we should ensure that all services are **Person Centred,** that they are part of **Integrated Provision,** delivered by **Integrated Commissioning.**

So that we know we are on track to delivering our strategy, we have identified existing measurements that we will monitor. These are identified in the Outcome sections, and have been adjusted from last year, so that they truly measure how we are delivering against our priorities in each outcome.

Given the size and complexity of Kent, and the scale of the health and care system, it is very difficult for any strategy to provide answers at district, Clinical Commissioning Group and health/care economy (north, east and west) levels. Therefore it is important that Local Health and Wellbeing Boards develop their own action plans, using the vision and values laid out in this strategy, to achieve the outcomes in ways most relevant to their own populations supported by data and information relevant at their local area level.

Context

Overall, it is a positive message that people are living longer, but unfortunately not all are enjoying good health and many suffer from one or more long-term conditions. Often the causes of long term conditions are related to the lifestyles we live and are largely preventable. The increasing number of long term conditions has changed the nature of the need for health and social care, which has meant that the needs of our population are often complex, requiring agencies to work in partnership to provide a desired outcomes for our population. This strategy embraces these challenges and provides strategic direction to address the issues facing our population in Kent.

Demographics

Kent has the largest population of all of the English counties, with just over 1.46 million people. Just over half of the total population of Kent is female (51.1%) and 48.9% is male. Across the population there are diverse outcomes. Life expectancy is higher than the England average for both men and women. However, life expectancy is significantly lower in deprived areas, with a man in a deprived area living on average 8.2 years less, giving him a life expectancy of 70.9 years and a woman living on average 4.5 years less, with a life expectancy of 78.2 years (based on average aggregated Kent data for people living in all the deprived areas of Kent).

Over the past 10 years Kent's population has grown faster than the national average, growing by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%). Kent's population is forecast to increase by a further 10.9% between 2010 and 2026.

Overall the age profile of Kent residents is similar to that of England. However, Kent does have a greater proportion of young people aged 10-19 years and of people aged 45+ years than the England average and just under a fifth of Kent's population is of retirement age (65+). However looking ahead, Kent has an ageing population and forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged below 65 is only forecast to increase by 3.8%. This will mean that Kent will have a relatively smaller population aged 20-49 years and considerable pressures on health and social care services as a result of services required for an aging population.

What has changed in the past 12 months

Although the challenges we face as we transform the health and care system are not new, the past year has seen several developments which will help us bring about this change.

April 2013 marked the beginning of a new era of public health within local government. Moving responsibility for the public's health out of the National Health Service (NHS) into local government offers a greater opportunity to focus on preventing ill health, by building on the partnerships developed within the NHS and concentrating on the primary factors that can change an individual's ability to live a healthy life.

The Health and Wellbeing Board has settled into its role, and started to lay the foundations for the integration of the health and social care system. Broadly speaking there are two main work streams of the Health and Wellbeing Board which are not mutually exclusive, namely prevention of ill health and integration of the health and care system. Public health activity is embedded throughout partner plans including KCC business plans, district plans including Mind the Gap, Clinical Commissioning Group and NHS England strategic plans. Public Health activity is also a core part of both the Better Care Fund and Integration Pioneer programmes. Kent County Council is now responsible for commissioning of public health programmes and these are an integral part of whole system activity to improve the health of the population of Kent.

We have created local Health and Wellbeing Boards that mirror the boundaries of local clinical commissioning groups, bringing together partners at that level to influence local delivery. These groups are complemented by Integrated Commissioning Boards that bring together the people in those areas

who decide how the available money is spent on health services. The commissioning plans are also considered by the countywide Health and Wellbeing Board

Failures of care

Sadly there have been some very public failures of care in England, and the reports into Mid Staffordshire Hospital and Winterbourne View have led to widespread agreement that fundamental changes are required across health and social care. There is a greater focus on quality of care with the experience of the patient or service user necessarily being at the centre of everything we do. As a result of the report into Winterbourne View, a series of changes have been made to improve the quality of care for vulnerable people, specifically for people with learning disabilities or autism who also have mental health conditions or behavioural problems.

The Francis Report, examining the tragic events at Mid-Staffordshire Hospital Trust, contained 290 recommendations covering everything from organisational culture to the role of patient and public representative bodies. One of the key warnings arising from the report was the danger of prioritising finance and targets over the quality of care. A lot of work is being taken forward locally and nationally in response to these reports, including Sir Bruce Keogh being asked to conduct an investigation into hospitals with the highest mortality rates (which included one of the main hospitals serving people in Kent) and the Berwick Report into NHS patient safety. This strategy will look to ensure the lessons learnt from this work are incorporated into its delivery.

Call to Action

In July 2013, NHS England published *The NHS belongs to the people: a call to action*. This paper set out a range of challenges facing the NHS. This included the fact that more people are living longer and often have more complex conditions. This increases costs for the NHS at a time when funding remains flat but expectations as to the extent and quality of care continue to rise. As things are, a funding gap of £30 billion has been predicted between 2013/14 and 2020/21; this is on top of the £20 billion of efficiency savings the NHS is already working towards meeting.

After the report was published, specific work developing different strands within the Call to Action has been commenced with work on improving general practice, community pharmacy services, dental services and others.

The key point of the Call to Action is that the health and care system needs to do things differently and challenge the status quo. There is a need to embrace new technologies and treatments, but there is a cost attached and thought needs to be given to delivering services in a different way with less focus on buildings and more on patients and services. Kent's participation in the Integration Pioneer programme and Better Care Fund are examples of how different approaches are being developed to meet the challenge locally, and more broadly this strategy shares the same goals as the Call to Action.

Also important is Sir Bruce Keogh's review into transforming urgent and emergency services, arising out of NHS England's Everyone Counts: Planning for Patients 2013/14. The end of phase 1 report was published in November 2013. This report supported the idea that people with urgent but non-life threatening needs must be provided with effective and personalised services outside of hospital. The report also proposes two levels of hospital based emergency care – 'Emergency Centres' and 'Major Emergency Centres' with those patients with the most serious needs being seen in specialist centres. To support the substantial shift of care out of hospitals, new services will be created but some old services will no longer be required.

Parity of Esteem

In February 2011, the Government published its mental health strategy, No Health Without Mental Health. This emphasised giving equal weight to both physical and mental health, with mental health outcomes being seen as central to the three outcomes frameworks. The implementation framework of the strategy suggested local mental

health needs needed reflecting in JSNAs and JHWSs. The idea of parity of esteem between physical and mental health is not new, but was made an explicit duty on the Secretary of State through the Health and Social Care Act 2012. In March 2013, the Royal College of Psychiatrists published a report into achieving parity, writing that a "parity approach should enable NHS and local authority health and social care services to provide a holistic, 'whole person' response to each individual, whatever their needs."

Against this backdrop, the Mental Health Crisis Care Concordat was launched in February 2014 with the aim of making certain that people experiencing a mental health crisis get as good a response from an emergency service as those in need of urgent and emergency care for physical health conditions.

Integration Pioneer & Better Care Fund

Following the 'call to action', the Better Care Fund was created, supporting the full integration of services by 2018, with challenging targets to be achieved by 2016. This has accelerated the pace and scale of integration that KCC had already begun and will continue through our Pioneer work. Through the Kent Better Care Fund proposal, a pooled fund of £127 million from existing resources has been identified to support integration in the county.

The majority of current commissioning and provision of services is standalone and although efforts are made to align services to benefit service users, there is still room for improvement. Single commissioning, and service provision, creates a very complex system for users to navigate often, leaving them dissatisfied. Through the Boards' work we aim to improve the experience for our service users.Kent was chosen as a Pioneer area in the Department of Health's Integration Pioneer Programme, which aims to establish new ways of delivering coordinated care. Through the Pioneer work, over the next five years, we aim to re-design models of care to put the citizen more in control of their health and make a real difference to the way people experience health and social care in Kent. By bringing together CCGs, KCC, District Councils, acute services and the voluntary sector, the aim is to move to care provision that will promote greater independence for patients, whilst reducing hospital and care home admissions. In addition, a new workforce with the skills to deliver integrated care will be recruited and developed.

The integration of service will mean that people get the care they need at the right time and in right place and where possible closer to home. Shifting care closer to home will have an impact on the way hospitals operate, and they may not stay the same size, with more specialist work being centralised on fewer sites.

Patients will have access to 24/7 community based care, ensuring they are looked after well closer to home and do not need to go to hospital. A patient-held care record will ensure the patient is in control of the information they have to manage their condition in the best way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services. We will use innovative approaches to identify those who are at a higher risk of hospital admission and new ways of identifying payment mechanisms such as 'Year of Care' commissioning for long-term conditions. Through better integration we can deliver comprehensive, 24/7 community health services, reducing demand on hospitals. By shifting just 10% of funding from acute to community care in Kent, we can free up £170 million a year to invest in community services.

Integrated intelligence

A key element in delivering a joined up health and social care system is ensuring that every partner is working towards common outcomes, and that they are informed by a consistent intelligence that is drawn from as wide a range of information sources as possible. We are embarking upon developing an Integrated Intelligence capability that will enable Kent stakeholders (service users, commissioners and providers) to understand user experiences and outcomes as they journey through the health, social and care system. The purpose of this capability will be to understand how to improve value (outcomes) for money and link these efforts to the priorities and focus of commissioners, providers and patients. This capability will be grounded within an enhanced approach to Integrated Commissioning that will enable multiple agencies to make well-informed, well-supported, practical decisions on how to evolve integration of services. Accordingly, the Integrated Intelligence capability will also allow us to monitor the effectiveness and efficiency of on-going improvements from the perspective of patients and their outcomes.

Specifically, this capability will allow us to:

- truly understand the impact of all health and well-being services, their interplay, and behaviours on the outcomes for individuals
- think across agencies and across agency budgets to identify the most effective ways of driving efficiency and value for money in creating the best short, medium and long term outcomes
- understand behaviour of service users and adapt the whole system to enable them to participate in their optimal outcomes

Applying and demonstrating these capabilities will be done at an aggregated/whole population level. This will generate more accurate and robust information for commissioners to design and create higher value models of care to enable whole system transformation.

It was in light of these developments that we assessed the 2013/14 strategic vision, outcomes, priorities and approaches. We feel that they still fit the challenge, and provide the common values that should be applied by all commissioners, providers and organisations that impact upon peoples' health and social care. It is important that all partners support these principles and align their plans to the Health and Wellbeing Strategy for Kent, as illustrated in Figure 1.

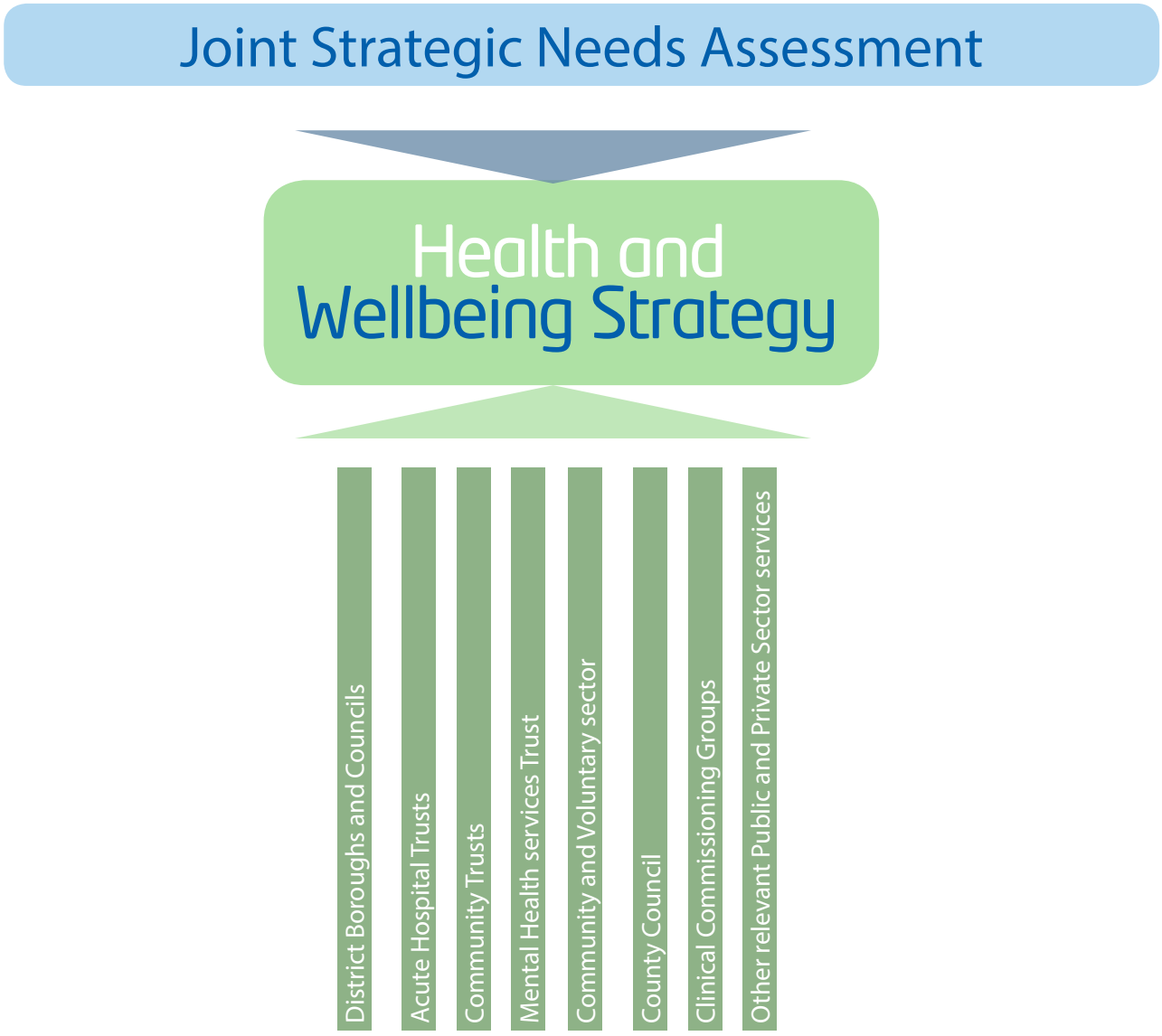


Figure 1

Our vision:

As outlined above our vision has not changed and we are still determined to improve health outcomes, deliver better coordinated quality care, improve the public's experience of integrated health and social care services and ensure that the individual is involved and at the heart of everything we do.

Outcomes

To achieve our vision the outcomes we seek, as informed by the Joint Strategic Needs Assessment, are:

- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to 'live well'

Each of these outcomes is discussed in detail over the coming pages, and the diagram below shows how we will apply our approaches and priorities to each of these outcome areas.

The outcomes will be delivered by focusing on our priorities within each of the outcome areas, whilst ensuring that any intervention is informed by the three approaches, i.e. that it is centred around the person (see diagram below to understand what person centred care would look like as described by our citizens receiving care), that it is provided in a joined up way, and where appropriate it is jointly commissioned.

Joint Health and Wellbeing Strategy

Outcome 1	Outcome 2	Outcome 3	Outcome 4	Outcome 5
Every child has the best start in life	Effective prevention of ill health by people taking greater responsibility for their health and wellbeing	The quality of life for people with long term conditions is enhanced and they have access to good quality care and support	People with mental ill health issues are supported to live well	People with dementia are assessed and treated earlier, and are supported to live well

Approach: Integrated Commissioning

Approach: Integrated Provision

Approach: Person Centered

Priority 1	Priority 2	Priority 3	Priority 4
Tackle key health issues where Kent is performing worse than the England average	Tackle health inequalities	Tackle the gaps in provision	Transform services to improve outcomes, patient experience and value for money

What should good, person centred, care feel like

We asked the people of Kent and this is what they told us

"I have the information and support I need in order to remain as independent as possible and manage my own conditions."

"I tell my story once. I have one first point of contact. They understand both me & my condition(s). I can go to them with a question at any time."

"I can decide the kind of support I need and when, where and how to receive it."

"I feel safe, I can live the life I want and I am supported to manage any risks. I know what is in my care & support plan and I know what to do if things change or go wrong."

"I have as much control of planning my care & support as I want."

"I am in control of planning my care and support. I can decide the kind of support I need & how to receive it."

"All my needs as a person are assessed & taken into account; I am listened to about what works for me, in my life."

"I am not left alone to make sense of information. I have help to make informed choices if I need and want it."

"Information is given to me at the right times. It is appropriate to my condition & circumstances. And is provided in a way that I understand."

"I have good information and advice on the range of options for choosing my support staff."

"I feel that my community is a safe place to live and local people look out for me and each other."

"I have considerate support delivered by competent people. They help me to make links in my local community."

"I have a clear line of communication, action and follow up. When something is planned, it happens."

I am supported to understand my choices & to set & achieve my goals."

"I have access to easy-to-understand information about care and support, which is consistent, accurate, and accessible, up to date. I am supported to use it to make decisions & choices about my care & support".

"I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS)."

"I have care and support that is directed by me, I am as involved with discussions & decisions about my care support & treatment, and it is responsive to my needs."

"I have regular reviews of my care & treatment including comprehensive reviews of my medicines, & of my care & support plan."

"I can speak to people who know something about care and support and can make things happen. I am told about the other services that are available to someone in my circumstances, including support organisations."

"I can get access to the money quickly without having to go through over-complicated procedures."

"I have help to make informed choices if I need & want it; my family or carer is also involved in these decisions as much as I want them to be.

"I can plan ahead and have systems in place to keep control in an emergency or crisis."

"I know where to get information about what is going on in my community."

"I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."

"I always know who is coordinating my care."

"I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

"My support is coordinated, co-operative and works well together. The professionals involved with my care talk to each other. We all work as a team."

"I work with my team to agree a care & support plan; my care plan is clearly entered on my record."

"My carer/family have their needs recognised & are given support to care for me."

"I feel valued for the contribution that I can make to my community."

When I use a new service, my care plan is known in advance & respected.

"I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."

"I have a network of people who support me – carers, family, friends, community and if needed paid support staff."

"The professionals involved with my care talk to each other. We all work as a team; I am kept informed about what the next steps will be."

"I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."

I can see my health & care records at any time. I can decide who to share them with. I can correct any mistakes in the information."

Outcome 1

Every child has the best start in life

The early years of a child's life are critical for ensuring they develop well and they do not fall behind in a way which means they have poorer outcomes throughout life. The focus will be on supporting families, communities and universal settings within local districts to support all children and young people to do well and to stay safe. The aim will be to provide additional local services that can be accessed easily, at the right time in the right place, to ensure more targeted early help is available to meet the needs of children and young people in a way that avoids problems becoming more serious.

Our Vision is that every child and young person, from pre-birth to age 19, who needs early help services will receive them in a timely and responsive way, so that they are safeguarded, their educational, social and emotional needs are met and outcomes are good, and they are able to contribute positively to their communities and those around them now and in the future, including their active engagement in learning and employment.

Whilst developing this refresh, one area where there was a consensus of opinion was that there is a need to recognise that just as outcomes 2-5 deal with different levels of need of the adult population, it was necessary to deal with the population of young people in a similar way. The identification of needs is based on an assessment of the child and family's circumstances. The three agreed multi-agency 'Levels of Need' are:

Level 1: Universal, where needs are met through engagement with universal services such as schools, GP services, youth clubs and where prevention is a priority.

Level 2: Targeted, where early help is available to address emerging or existing problems which, if not addressed, are likely to become more serious and need more specialist input.

Level 3: Specialist, where needs have become serious and there is a greater likelihood of significant harm, requiring the intervention and protection of statutory services.

We will work across the system to improve educational, health and emotional wellbeing outcomes for all of Kent's children and young people, whilst taking account of the additional needs of those young people who are disabled, or who have Special Educational Needs (SEN).

Over the coming years we will also see a much greater integration in services for children from pre-birth to 19. In October 2015 Health visitors will become a part of the public health responsibilities of Kent County Council, and will complement the responsibility to support breast feeding, and reduce smoking in pregnancy. KCC is in the process of developing a joined up preventative services approach for 0-19 year olds. Meanwhile, a new School Health service specification is currently being developed with the intention that a new service is in place by April 2015.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

In order to tackle key health issues in this outcome we need to deliver:

- Reduction in the number of pregnant women who smoke at time of delivery
- Increasing breastfeeding Initiation rates
- Increasing breastfeeding continuance 6-8 weeks
- Decrease the proportion of 10-11 year olds with excess weight

Priority 2 – Tackle health inequalities

The UK is one of the richest OECD countries but one of the most unequal in health terms, which has a direct impact on children's wellbeing. We have seen a rapid rise in mental health problems in children, an increase in teenage pregnancies and sexually transmitted diseases and an epidemic of childhood obesity. Inequalities in health and emotional wellbeing are striking. Poorer children are more likely to be born too early and too small, and are less likely to be breastfed or immunised.

To address health inequalities for children and young people in Kent we will:

- Improve Breast feeding rates by promoting Unicef's Baby Friendly accreditation and implementing the infant feeding action plan in place. This requires partnership working through maternity units, hospitals, children centres, midwives and Health Visitors in a range of medical and community settings
- Prevalence of obesity in children is higher in more deprived areas. We will promote healthy weight for all children, particularly in areas where the need is greater; working with families to promote healthy eating and increase physical activity
- reduce smoking in pregnancy by strengthening midwifery and smoking cessation resources and provide a whole systems approach to engaging with and supporting pregnant smokers.
- ensure vulnerable and disadvantaged children access and participate in good quality childcare and education and achieve good outcomes.

Priority 3 – Tackle the gaps in service provision

The delivery of Speech and Language Therapy is critical to children and young people accessing and benefiting universal, targeted and specialist services. Speech and Language Therapy (SALT) implementation has system wide benefits. During the life of this strategy we will be working towards implementation of the SALT Framework)

The Common Assessment Framework (CAF) will continue to be a key tool for carrying out an early help assessment and planning the necessary actions to improve children's outcomes and support their additional needs. There is also support for parents experiencing physical and mental health issues.

We will continue to work towards strengthening our commissioning and provision of child and adolescent emotional health and mental health services so that we can achieve greater availability of support for emotional resilience and treatment where needed.

The Children's Health and Wellbeing Board will shortly be developing an Emotional Health and Wellbeing (EMHW) Strategy for 0-25 year olds in Kent to support this outcome

Priority 4 – Transform services to improve outcomes, patient experience and value for money

It is essential that the universal, targeted and specialist levels are seen as being parts of a continuum of support available to meet assessed need, and at any particular point in time. Children, young people and their families have different levels of need and their needs change over time depending on their circumstances. The services will be working with universal and specialist provision,

ensuring that targeted support is available to those who need it, in whichever setting, and when they need it most. The service will be helping to ensure that children and families have a well-coordinated experience throughout the pathways of care and support they receive.

The services will aim to provide families with information, advice and support to prevent their needs escalating and to enable them to be supported at the lowest level of need, and where possible to become more self-reliant.

Agencies in the health and care system will work collaboratively to implement the Kent Integrated Family Support Services (KIFSS) for pre-birth to 11 years' services and Kent Integrated Adolescent Support Services (KIASS) for 11-19 years' services. These key services include Children's Centres, Early Intervention Teams and Family Support workers, Attendance and Inclusion services, Connexions workers to provide targeted support for NEETs, Youth Offending workers, Troubled Families workers, Adolescent Social Work Assistants, Pupil Referral Units and Alternative Curriculum Provision, agencies involved in CAF and commissioned support services and health services for children and young people and Gypsy, Roma, Traveller and minority outreach workers. Schools, children's centres and early years settings are at the heart of this new way of working at district level. By establishing a 'team around the school', it is expected that children, young people and their families will be able to access services in a more timely, effective and appropriate manner so that early help activity agreed will significantly improve outcomes for the child, young person and their family.

Keeping track of our progress in delivering Outcome 1

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- A reduction in the number of pregnant women who smoke at time of delivery
- An increase in breastfeeding Initiation rates
- An increase in breastfeeding continuance 6-8 weeks
- A reduction in conception rates for young women aged under 18 years old (rate per 1,000)
- An improvement in MMR vaccination uptake two doses (5 years old)
- An increase in school readiness: all children achieving a good level of development at the end of reception as a percentage of all eligible children
- A reduction in the proportion of 4-5 year olds with excess weight
- A reduction in the proportion of 10-11 year olds with excess weight
- An increase in the proportion of SEN assessments within 26 weeks
- A reduction in the number of Kent children with SEN placed in independent or out of county schools
- A reduction in CAMHS average waiting times for routine assessment from referral
- A reduction in the number waiting for a routine treatment CAMHS
- An appropriate CAMHS caseload, for patients open at any point during the month
- A reduction in unplanned hospitalisation for asthma (primary diagnosis) people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for diabetes (primary diagnosis) people aged under 19 years old (rate per 100,000)
- A reduction in unplanned hospitalisation for epilepsy (primary diagnosis) people aged under 19 years old (rate per 100,000)

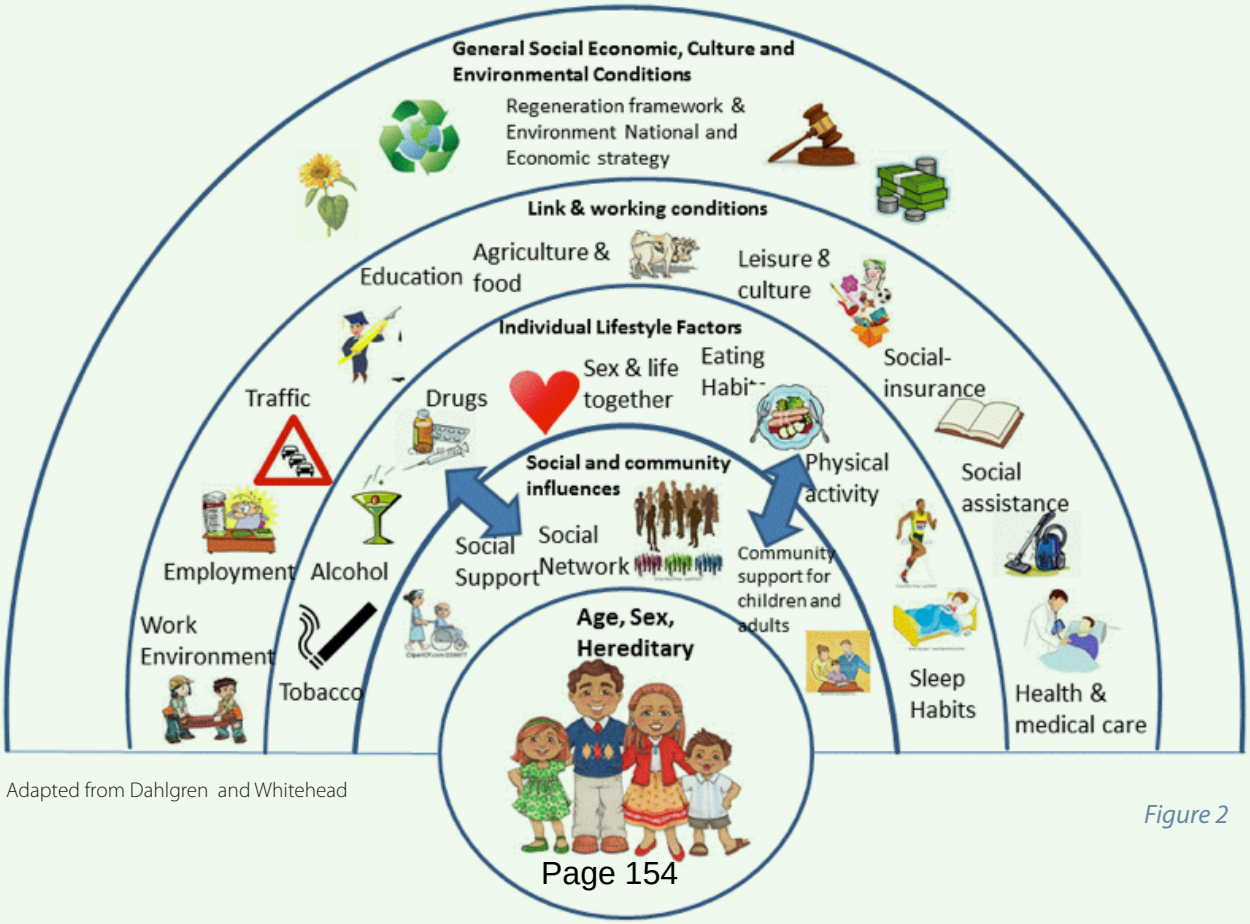
Outcome 2

Effective prevention of ill health by people taking greater responsibility for their health and wellbeing

To improve people's long term health we have to improve healthy lifestyles, encourage healthy eating in adults, and reduce levels of smoking. In addition to this, we will need to look at how we improve people's knowledge of the symptoms of various diseases such as cancer and what they can do prevent them, for example by encouraging physical activity.

A sustainable health and care system requires an integrated approach. It should consider the economic, social and environmental impacts of our decision making to ensure that the delivery of health and social care in Kent is sustainable and equitable, with outcomes benefitting residents now and into the future.

Figure 2 illustrates how we see the health and care system working in collaboration to support local communities. It is acknowledged that for a robust delivery of the strategy wider factors affecting short and long term physical and mental health need to be considered, such as access to green space, climate change resilience, air quality, housing, transport, inequality and employment . To address this, Kent partners have developed a Sustainability Needs Assessment as part of the Joint Strategic Needs Assessment (JSNA). The recommendations identified, in combination with ongoing delivery of the Kent Environment Strategy, underpin our approach to ensuring a sustainable health and care system Through a joined-up, or integrated, approach Kent County Council will make sure that the people of Kent have access to a good standard of education, a clean, safe and sustainable environment in which to live, with good employment opportunities, and will work with local businesses to ensure good workplace health.



Adapted from Dahlgren and Whitehead

Figure 2

The local level Health and Wellbeing Boards provide opportunities for colleagues in Primary Care, Clinical Commissioning Groups and District Councils to work collaboratively to promote prevention of ill health and reduce health inequalities. Figure 3 illustrates the role and contribution needed across the entire system, to promote prevention of ill health and how health inequalities are effectively reduced over the short, medium and long term. For instance in the short term Primary Care services have a major role to play in reducing the risk of people dying prematurely through interventions that control high blood pressure and high blood cholesterol.

To influence medium term interventions we will ensure that commissioning of public health programmes deliver a transformed and integrated approach to public health, ensuring locally appropriate services and campaigns. Services will be based on "proportionate universalism" principles to ensure that there is the right balance of

- Whole population approaches that inspire citizens to take a much more active part in their immediate and long term health and wellbeing
- Effective screening of the population to identify intervention needs at the earliest time.
- Interventions which are targeted to small populations of high risk groups, particularly in relation to unhealthy behaviours such as, smoking, drinking and being physically inactive.

To influence long term interventions we will work with our colleagues in District Councils, Education system, Local Businesses etc. to support our local communities. Communities play an important part in our health and wellbeing and are crucial to people because fundamentally we are social creatures that thrive on social interactions. The influences on people's health are diverse and through this strategy we aim for the health and care system to support individuals and communities by providing an environment to make healthier choices as easier choices. For instance Kent, the Garden of England, with miles of coastline, many country parks and green spaces, provides opportunities for improving physical activity, helping people feel connected with the environment that they live in. Public health traditionally assesses need by looking at what we lack – be it health or access to services. In Kent we want to focus on an 'asset' approach turns this on its head and which looks at all the positive and useful things available to us – from buildings, services, communities and networks that we can use along our health journey.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

Within this outcome the areas we need to focus on are:

- Reducing the proportion of adults with excess weight
- Increasing take up of NHS Health Checks

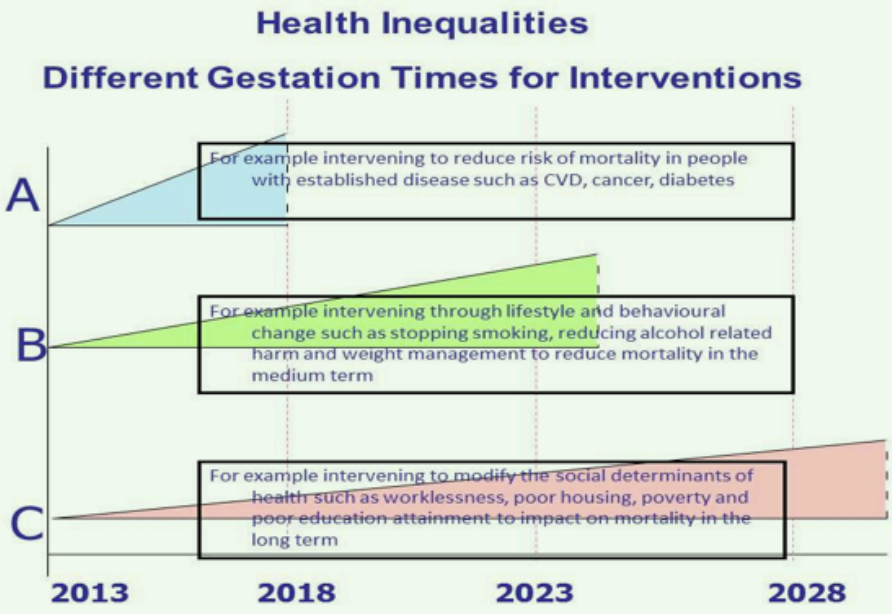


Figure 3
(adapted from C Bentley)

Priority 2 – Tackle health inequalities

The partners in the health and care system acknowledge far-reaching and expansive contribution that District Councils, community enterprises, voluntary sector and other statutory agencies make to improve healthy lifestyles and promote mental and emotional wellbeing among the Kent population, particularly in deprived communities and to the most vulnerable in society. Tackling health inequalities remains at the heart of preventative work, and we have published 'Mind the Gap', Kent's health inequalities action plan, which is driving improvements in all areas that affect people's health, including work, housing, access to health services and a healthy start for all children. It has excellent support from partners and has been complemented by a series of District level plans. . Kent has also developed a specific action plan 'Think Housing First' to address housing related health inequalities.

Local Health and Wellbeing Boards will continue to work with partners in the system to address health inequalities.

Priority 3 – Tackle the gaps in service provision

The introduction of integrated commissioning groups to support the work of each local Health and Wellbeing board has created a joint space where local plans can be discussed to ensure that they are joined together and can identify where gaps exist. The Public Health team are working to review all the services delivered by the Public Health grant to ensure that they are complimentary to other interventions, working to ensure that the patient journey is seamless.

.All partners in the local health and care system have a role to play in prevention of ill health and we will continue to work across the system to understand areas that require improvement. For instance the Area Team and CCGs are collectively responsible for commissioning services provided through general practice that can make a difference to the early deaths in the 'at risk' groups. There are short term interventions which can be influenced chiefly by primary care and assist in reducing health inequalities. Examples of the improvements needed to these services include:

- A reduction in differences across practices in Kent on how patients with high blood pressure are effectively identified on a register and managed
- A reduction in differences across practices in the number of patients that are known to have diseases compared to those who are expected to have a disease for certain conditions such as diabetes, blood pressure and respiratory diseases (Chronic Obstructive Pulmonary Disease)
- Maximising access to, and use of treatment, for managing clinical conditions such as high blood cholesterol, high blood sugar in the case of known diabetics.

Priority 4 – Transform services to improve outcomes, patient experience and value for money

We will locally translate principles recommended by Professor Chris Bentley (former national lead for the National Support Team for Health Inequalities). This would mean that we will work across the system to understand needs of our local population (CCG and district level) and industrialise evidence based cost effective interventions. For instance brief interventions for smoking and alcohol are both evidence based and cost effective and working through partners in the system we will work towards implementing 'every contact counts'

Keeping track of our progress in delivering Outcome 2

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

An increase in Life Expectancy at Birth

- An increase in Healthy Life Expectancy
- A reduction in the Slope Index for Health Inequalities
- A reduction in the proportion of adults with excess weight
- An increase in the number of people quitting smoking via smoking cessation services
- An increase in the proportion of people receiving NHS Health Checks of the target number to be invited
- A reduction in alcohol related admissions to hospital
- (Breast Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous 3.5 or 5.5 years on 31st March
- (Cervical Cancer Screening) An increase in the proportion of eligible women screened adequately within the previous 3 years on 31st March
- A reduction in the rates of deaths attributable to smoking persons aged 35+ (rate per 100,000)
- A reduction in the under-75 mortality rate from cancer (rate per 100,000)
- A reduction in the under-75 mortality rate from respiratory disease (rate per 100,000)
- A reduction in the under-75 mortality rate from cardiovascular disease (rate per 100,000)

Outcome 3

The quality of life for people with long term conditions is enhanced and they have access to good quality care and support.

Nearly 16.5% of Kent's population live with a limiting long term illness, and in most cases they have multiple long term conditions (Figure 3), and need complex support and treatment.The numbers of those affected by multiple long term conditions are set to grow sharply. To improve outcomes for our population we need to shift our focus from treating individual illnesses to addressing the needs of the person as a whole person. This requires a rethinking of how care is commissioned and provided.

Care is often still organised according to 'physical healthcare' and 'social care', with each often delivered by separate organisations and groups of professionals. People do not recognise these distinctions, frequently have need of all … forms of support, and often end up required to do all the work as their own 'service integrator'.

The 2015 Challenge Declaration – NHS Confederation

There is widespread agreement across the health and social care system that things need to change, and that an integrated approach to care is needed if we are to meet this challenge. The journey has begun, and through the Better Care Fund, and Kent's status as an Integration Pioneer, we are in an excellent place to deliver. During the course of this strategy we will begin to see the emergence of a team around the patient with the GP taking the lead for their patient, treating the whole person, rather than each separate ailment. Delivery will generally be in community hubs, with technology increasingly playing a role in linking patients to their care providers, whilst allowing everybody involved, including the patient to see and adjust the same information.

Priority 1 – Tackle Key Health Issues where Kent is performing worse than the England average

Within this outcome, recent data highlights that in Kent we need to:

- Increase the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)
- Increase early identification of diabetes
- Reduce the number of hip fractures for people aged 65 and over (rate per 100,000)

Priority 2 – Tackle health inequalities

From *Mind the Gap, Kent Health Inequalities Action Plan* the following areas have been identified as those in which inequalities have an impact on people's health. Under this priority we will:

- Support older people to live safe, independent and fulfilled lives and support disabled people to live independently at home
- Support self-management of long term conditions
- Deliver effective local services for falls, falls prevention and fractures and reduce the incidence of hip fractures in people aged 65 and over.
- Support people with Learning Disabilities with housing, employment, access to health services and leisure activities.
- Provision of adaptations and equipment to the home to prevent accidents with associated costs, and improve quality of life of recipients and carers.

The graph below shows that the top 0.5% (Band 1) of the Kent population who have been identified as having the highest risk of re-hospitalisation are patients who have at least 3 or more long term conditions, indicating that multi morbidity is the norm, not the exception. For example, only 5% of patients with dementia had only dementia, and only 1% of patients with COPD had only COPD.

Number of conditions experienced by band 1 patients with long Term Conditions in Kent, 2010/11

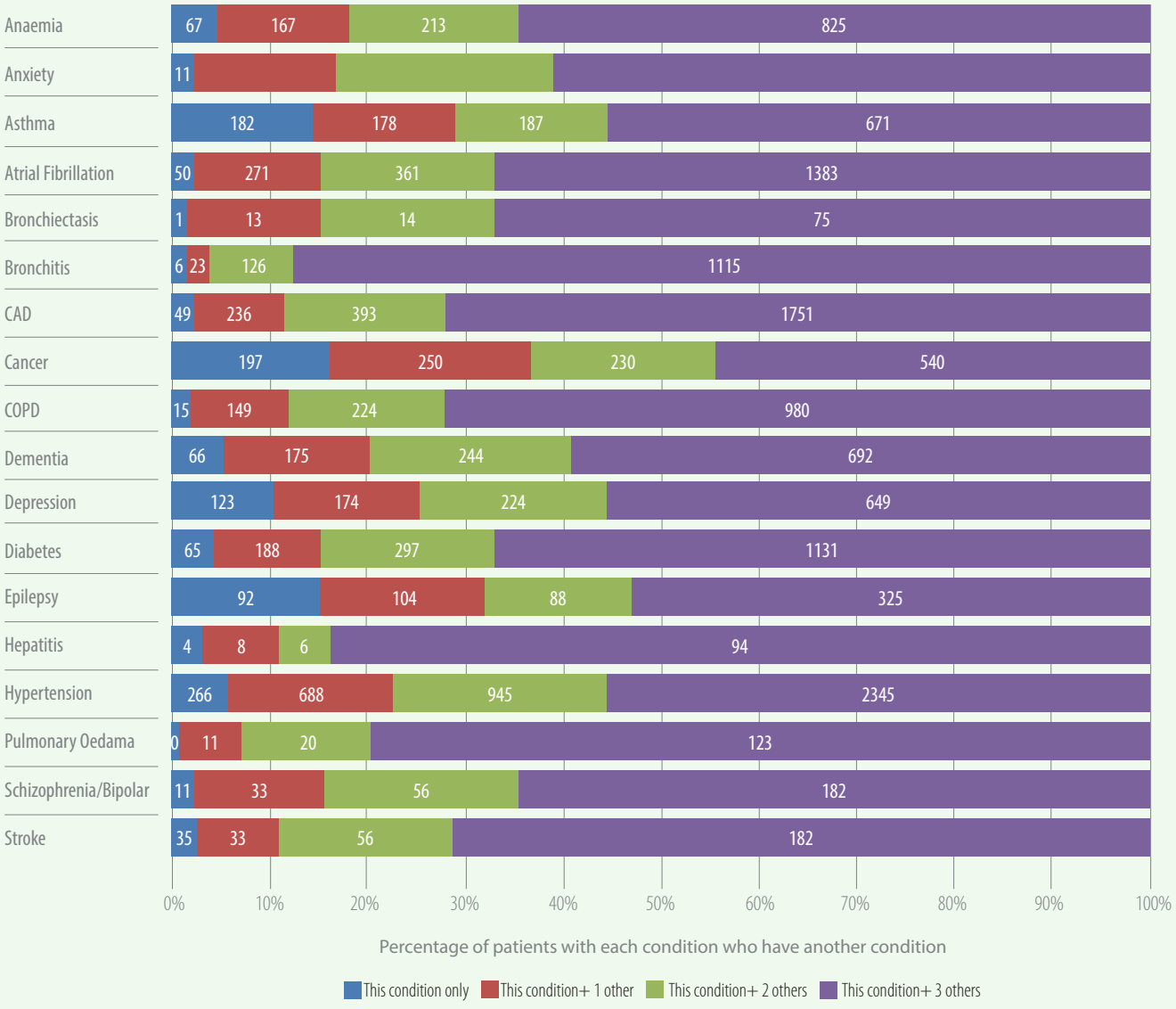


Figure 4

In this outcome the overriding delivery of Priorities 3 and 4 will be focussed around the work on the Better Care Fund

Kent will continue to be bold in developing new and different solutions to the challenges facing health and social care and as Integrated Care and Support Pioneers continue to work through partnerships that support integrated commissioning and deliver the provision of integrated services. The Kent approach has been to look at whole system integration. Rather than working in one area and then moving on to others we have developed a comprehensive programme which supports integration across the entire health and social care economy.

To reflect the complex picture of health and social care within Kent the Better Care Fund is built up from the local level, with 7 area plans, across 3 care economies – giving a complete Kent plan. We will use the Better Care Fund to continue providing us with the opportunity to go further faster and start the longer programme of transformation provided by being a Pioneer. It will drive forward our integration programme, developing more community based services alongside the re-design and commissioning of new systems-wide models of care that ensure the financial sustainability of health and social care services; a proactive, rather than a reactive model that improves outcomes for people and means the reduction of hospital and care home admissions.

Priority 3 – Tackle the gaps in service provision

Falls and fractures continue to be a significant public health issue particularly as individuals age, and it is estimated that one in three people aged 65+ will fall each year and one in two people aged 80+ will fall each year. We will continue to work with our partners to address gaps in service commissioning and provision of falls prevention and management.

Another example is that of people with learning disabilities. They have poorer health outcomes than other population groups, as they may not be accessing routine screening or health support as consistently as the mainstream population. To address low uptake of annual health checks for people with Learning Disability everyone known with Learning Disability will be offered a baseline Health Profile and a Health Action Plan will be developed.

For people with learning disability each GP surgery we will have a link LD Nurse who will support them to understand the needs of people with a learning disability and support an annual health check.

Many people with learning disability also have difficulties with communication and may need Speech and Language Therapy support to work with carers to teach them different methods of communication.

Priority 4 – Transform services to improve outcomes, patient experience and value for money

We know that our population is ageing and is living longer; we will aim to focus on not just adding years to life, but also adding life to years. We will work with health and social care providers in hospitals, primary care (General Practitioners, Community Pharmacists) and in the community to develop 24/7 access and community based health and social care services, ensuring that the good quality right services are delivered in the right place, at the right time. We will work with our partners to create a health and care system that supports people to live as independently as possible at home and are receiving good quality end of life care as and when needed. We want to ensure that people using services have as much choice and control as possible when building their support package and are able to access services

at the right time and place. We will work with our statutory partners and with community and voluntary sector partners to create systems to empower our citizens to be in control so that they are able to make informed choices about when, how and where to get their support. We want to ensure that services to our citizens are easily accessible, tailored to individual's needs , proactive and designed to support self-management; for instance through the use of telecare.

For people with learning disability the aim of the integrated service is to provide quality services in a personalised way so that individuals (and carers) can receive the support they need in a way that enhances their independence. The teams will continue to support people with learning disabilities to live full and active lives within their local communities. We will ensure that everyone who needs it will have a person centred support plan and help to find the best support to meet their individual needs. Everyone who has social care needs will have a personal budget and will be offered a Direct Payment.

Keeping track of our progress in delivering Outcome 3

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- An increase in clients with community based services who receive a personal budget and/or direct budget
- An increase in the number of people using telecare and telehealth technology
- An increase in the proportion of older people (65 and older) mostly at risk of long term care and hospital admission, who were still at home 91 days after discharge from hospital in reablement/ rehabilitation services
- A reduction in admissions to permanent residential care for older people
- An increase in the percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family (Persons/Male/Female)
- An increase in the percentage of adults (age 18-69) who are receiving secondary mental health services on the Care Programme Approach recorded as living independently, with or without support. (Persons/Male/Female)
- A reduction in the gap in the employment rate between those with a learning disability and the overall employment rate
- An increase in the early diagnosis of diabetes.
- A reduction in the number of hip fractures for people aged 65 and over (rate per 100,000).

Outcome 4

People with mental ill health issues are supported to 'live well'

Mental Health can be described in two parts, Common Mental Health Disorders and Severe Mental Health Disorders. Common Mental Health conditions are depression are generalised anxiety disorder. Severe mental disorders include psychosis and bi-polar disorder. People with illness related to mental health often have other conditions that can further affect their mental wellbeing. Our focus will be to prevent mental illness and promote positive mental "wellbeing".

We will achieve the outcome through:

Priority 1. Tackle areas where Kent is performing worse than the England average:

In Kent we need to deliver:

- A reduction in the number of suicides (rate per 100,000)
- An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.

Priority 2. Tackle health inequalities

To tackle inequalities in mental health:

- We will improve health & wellbeing and resilience for the people of Kent by promoting the Six ways to wellbeing, particularly to the most deprived communities
- We will reduce the numbers of hospital stays for self-harm by supporting programmes that work with young people who self-harm or who are at risk of self-harm.
- We will work in partnership to improve access to psychiatric services for people with learning disabilities and for those living in deprived areas.
- We will promote the mental wellbeing impact assessment toolkit and deliver the toolkit in key locations to ensure that the mental wellbeing agenda is addressed across all major services.

Priority 3. Tackle the gaps in provision and quality

Nearly one third of GP consultations are related to mental health problems and approximately one in four people will have a common mental illness such as anxiety and depression during their lifetime and one in six people will have a mental health problem at any given time (point prevalence). One in seven people will have two or more mental health problems at any point in time. We will address this through working across the health and care system including voluntary and community sector. The wellbeing approach set out in this Joint Health and Wellbeing Strategy focusses on holistic wellbeing, and emphasises assets such as an individual's strengths and abilities (rather than deficits) and the networks and associations in communities that people draw on that can grow their mental wellbeing and prevent mental illness. There is evidence to suggest that poor mental wellbeing has impact on physical health. Conditions like heart problems, diabetes are exacerbated by mental health. Therefore in addition to preventing ill health, Primary Care Based services to address problems early will be

a focus of growth this year as we seek to reduce urgent referrals to secondary services and provide a coordinated way for those whose long term condition can be managed closer to home.

Priority 4. Transform services to improve outcomes, patient experience and gain value for money

A key pillar of our approach is the Six Ways to Wellbeing Campaign which seeks to share the knowledge of the six themes for positive action. Kent Public Health aspires to help the population to adopt behaviours that can improve and sustain their mental wellbeing; these behaviours fall into the following themes of the Six Ways to Wellbeing campaign:

© SLaM

Promoting Six Ways to Wellbeing

1. Connect with the people around you
2. Be Active
3. Give
4. Keep Learning
5. Take Notice
6. Grow your World

Keeping track of our progress in delivering Outcome 4

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- An increased crisis response of A&E liaison within 2 hours – urgent
- An increased crisis response of A&E liaison, all urgent referrals to be seen within 24 hours

- An increase in access to IAPT services
- An increase in the number of adults receiving treatment for alcohol misuse
- An increase in the number of adults receiving treatment for drug misuse
- A reduction in the number of people entering prison with substance dependence issues who are previously not known to community treatment
- An increase in the successful completion and non-representation of opiate drug users leaving community substance misuse treatment
- An increased employment rate among people with mental illness/those in contact with secondary mental health services
- A reduction in the number of suicides (rate per 100,000)
- An increase in the percentage of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey
- An increase in the percentage of adult carers who have as much social contact at they would like according to the Personal Social Services Carers survey
- An increase in the percentage of respondents who, according to the survey, are satisfied with their life, who are not feeling anxious, and who feel their life is worthwhile.

Outcome 5

People with dementia are assessed and treated earlier and are supported to live well.

In Kent we will support people to live well with dementia. We know that the majority of people wish to live within their own home in their community for as long as possible; that they wish to be treated with dignity and respect and value the care and support they receive from their families and carers most highly. We will work with partner agencies to recognise this and work together to ensure this is achieved.

We are entering the second year of a programme to support Kent to become more Dementia Friendly, which focuses on improving the quality of life for people living with dementia along with their family, friends, and carers. Raising awareness and understanding is a key element of the work; to this end Dementia Champions are trained to go on and deliver Dementia Friends training. We have at least 27 Dementia Champions in Kent who have delivered training and recruited over 1,000 Friends.
Another key element of our approach to develop Kent to be more Dementia Friendly has been the establishment of a Kent Dementia Action Alliance. We will continue to promote the development of Alliances across the 12 Districts in Kent. We will ensure that the local and county Health and Wellbeing Boards regularly have Dementia Friendly Communities on their agendas to consider the themes from local Action Alliance member's action plans.

Priority 1 Tackle areas where Kent is performing worse than the England average

The national diagnosis rate for expected number of dementia cases is 48% and in Kent it is around 42%. One of our key objectives is to increase this rates to 67% by 2015. The two areas with the lowest levels of diagnosis are South Kent Coast CCG at 39% and Thanet CCG at 34.5%. We will be working with partners in the health and cares system to improve our diagnostic rates.

Priority 2 Tackle Health Inequalities

We will work with GP colleagues to address health inequalities through the use of the GP dementia enhanced scheme, which prioritises the assessment of people from high risk groups:

- Patients aged 60 and over with cardiovascular disease, stroke, peripheral vascular disease or diabetes;
- Patients aged 40 and over with Down's syndrome;
- Other patients aged over 50 with learning disabilities;
- Patients with long term neurological conditions e.g. Parkinson's Disease.

Due to the high incidence among people with Down Syndrome the community learning disability teams will screen people for dementia from the age of 30.

Priority 3: Tackle the Gaps in Provision and Quality

We will

- Address gaps in service provision of community Dementia Nurses.
- Ensure that dementia crisis service is available across the county.
- Continue to work with carers' organisations to monitor and refine joint health and social services investment in carers support
- Continue to train and up skill the workforce across all sectors.
- Ensure all acute trusts have trained dementia volunteer schemes to support people in hospital with social activities.
- Ensure all acute and community trusts have improved their hospital environments to make key areas in their hospital more dementia friendly.

Priority 4: Transform services to improve outcomes, patient experience and gain value for money

We will achieve this by:

- Continuing a person-centred and integrated approach to care planning in hospital
- Improving access to diagnosis - the memory assessment pathway has been reviewed and updated and changes will be implemented during 2014-15 to bring closer working between primary and secondary care, making it easier to get a diagnosis.
- Improving Integration of Care - Kent is an Integration Pioneer and all CCGs have contracted for an integrated care pathway in 2014-15 to provide joined up and integrated care plans, including a crisis plan. Ensuring people are well supported following diagnosis and have access to appropriate support when required to avoid crisis admissions.
- Improving Urgent Care – a dementia crisis service has been introduced to help avoid unplanned admissions and help people through urgent care situation whilst maintaining people in their own homes.
- Ensuring Better Support for Carers – Kent County Council and all Kent CCGs have significantly increased funding into Carers Assessment and Support including a new rapid access to support for carers introduced across all CCGs to improve the health and wellbeing of carers, will be further developed and expanded in 2014.
- Improving discharge from hospital – support various schemes around discharge across the county using not for profit organisations including a bridging scheme provided by Alzheimer's and Dementia Support Services to support Darent Valley discharges and a Crossroads supported discharge scheme in all East Kent acute hospitals to support people to be discharged in a safe and timely manner and reduce excess bed days.

Keeping track of our progress in delivering Outcome 5

We will measure our progress by monitoring the following indicators from the national dataset to determine whether there is:

- An increase in the reported number of patients with Dementia on GP registers as a percentage of estimated prevalence
- A reduction in the rate of admissions to hospital for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the rate of admissions to hospital for patients older than 74 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- A reduction in the total bed-days in hospital per population for patients older than 64 years old with a secondary diagnosis of dementia, rate per 1000
- An increase in the proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who
  a. have been identified as potentially having dementia
  b. who have been identified as potentially having dementia, who are appropriately assessed
  c. who have been identified as potentially having dementia, who are appropriately assessed, referred on to specialist services in England (by trust)
- A reduction in the proportion of people waiting to access Memory Services - waiting time to assessment with MAS.
- An increase in the proportion of patients diagnosed with dementia whose care has been reviewed in the previous 15 months
- A reduction in care home placements

What is the Health and Wellbeing Board?

The Kent Health and Wellbeing Board was established by the Health and Social Care Act 2012. With effect from 1 April 2013 it became a committee of Kent County Council.

The board brings together GPs, County and District Councillors, senior officers from the NHS Area Team, Clinical Commissioning Groups, Social Care and Public Health, as well as representation from the Local Healthwatch. It provides an effective body where commissioners, patient representatives and elected officials can come together to take an overview of the health system in Kent, align their work, and share commissioning plans and good practice.

The Board's statutory functions are to:

- Prepare a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.
- Encourage integrated working between health and social care commissioners including making arrangements under Section 75 of the National Health Service Act 2006

Prior to April 2013 the Health and Wellbeing Board operated in a shadow form.

The Health and Wellbeing Board has established a series of sub-committees known as local Health and Wellbeing Boards. The local Health and Wellbeing Boards lead and advise on the development of Clinical Commissioning Group level integrated commissioning strategies and plans, ensure effective local engagement and monitor local outcomes. They focus on improving the health and wellbeing of people living in their CCG area through joined up commissioning across the NHS, social care, district councils, public health and other services to secure better health and wellbeing outcomes in their areas and better quality of care for all patients and care users.

Further information about the Health and Wellbeing Board, including its membership, can be found here: https://democracy.kent.gov.uk/mgCommitteeDetails.aspx?ID=790

Kent Joint Health and Wellbeing Strategy

Outcomes for Kent

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

Andrew Ireland, Corporate Director for Social Care, Health & Wellbeing

To: Adult Social Care & Health Cabinet Committee – 11 July 2014

Subject: **PREPARATION FOR THE CARE ACT 2014**

Classification: Unrestricted

Past pathway: CMT - 3 June 2014
Corporate Board - 23 June 2014
Cabinet – 7 July 2014

Future pathway: None

Electoral Division: All

Summary: The Care Act 2014, which received Royal Assent on 14 May 2014, will establish a new legal framework for adult care and support services. It marks the biggest change to care and support law in England since 1948 and will replace over a dozen pieces of legislation with a single consolidated modern law. The new framework will come into effect from April 2015 but some of the key reforms (including the cap on care costs) only take effect from April 2016. This report sets out the work underway to prepare for the implementation of the Act and the current assessment of the main financial and other implications.

Recommendations: Cabinet Committee is asked to:

(a) **DISCUSS** the contents of this report and the extra information provided in the PowerPoint presentation which will be delivered on the day.

(b) **NOTE** that a full implementation plan will be presented to the Adults Transformation Board on 23 July 2014 after the draft regulations and guidance have been analysed. This will be made available to Cabinet Members.

1. Introduction

1.1 The Care Act 2014 received Royal Assent on 14 May 2014. The changes to be implemented will overhaul and modernise the complex system of care and support that has evolved over the last sixty years. The changes will have significant implications for Kent residents and Kent County Council.

1.2 Although commencement dates for the different sections have not yet been confirmed, it is expected that the majority of changes to the legal framework will come into effect from April 2015. The main exceptions are what are referred to as the 'Dilnot' reforms which will come into effect in April 2016. This includes the cap on care costs (£72,000 for people over pension age) and the increase in the capital threshold for people in residential care whose former home is taken into account (from the current £23,250 to £118,000).

1.3 The regulations and guidance which outline the reforms in further detail were only issued on 6 June 2012 (in draft form) and they only cover the changes to be introduced from April 2015. They are subject to a 10 week consultation period (closing date of 15

August 2014) and the final versions are expected to be issued in October 2014. The regulations and guidance covering the 'Dilnot' reforms (to be introduced in April 2016) are expected to be released later this year.

2. Key implications and possible decisions required

2.1 **Eligibility criteria:** The Act replaces the current four-level criteria (low, moderate, substantial and critical) with a single national minimum from April 2015. Councils will be able to meet needs at a lower level if they so wish, however it will only be needs assessed as meeting the national minimum that will count towards the cap. Although previous information from Government has suggested the new minimum would be set at a level close to the current 'substantial', the draft regulations just released indicate a wider definition. Early indications are that this may mean KCC does not need to tighten its criteria if it wishes to only provide for needs assessed as meeting the national minimum. This would mean that the current 26% of service users currently assessed as having 'moderate' needs (approximately 2,600) can be passported to the new national minimum. It would also mean that anyone who would be assessed as eligible under our current system would also meet the criteria under the new system. If however the final regulations do end up equating more to the current 'substantial' level, KCC will need to decide if they wish to continue to provide more generous entitlement. In this scenario there would be an impact on the budget. Currently providing services to the 26% of service users assessed as "moderate" equates to 10% of the allocated budget.

Decision may be required on: whether to only meet needs at the national minimum level (by September 2014).

2.2 **Carers:** From April 2015 there is a significant extension of carers' rights. In addition to the duty to assess, local authorities will have a duty to provide carers' services to those who are eligible. On top of the carers' assessments carried out in-house, we currently commission a number of third sector organisations to carry out these assessments. It is believed by Strategic Commissioning that there is sufficient flexibility in the contract to enable them to cope with the expected increase in demand. The costs associated with the extra assessments and services are currently being modelled.

2.3 **Assessments:** There is likely to be a significant increase in the number of people coming forward for care and financial assessments. This is likely to have the most significant impact from October 2015 in anticipation of the 'Dilnot' reforms in April 2016. This will require that the necessary capacity (workforce and systems) is in place and that any decisions relating to the delegation powers have been taken. The estimated increase in activity is provided in the PowerPoint presentation on the day.

2.4 **Delegation powers:** The Act gives local authorities the power to delegate nearly all of its social care functions to third parties, although legal responsibility will still rest with Kent County Council. This power can be used from April 2015 but is most likely to be needed for the 'Dilnot' changes in 2016. In view of the long lead in time for procurement, decisions will need to be taken at an early stage about the use of this power. Options are currently being considered including working with providers and the Kent voluntary sector. It would be possible to delegate all functions except (1) safeguarding adults at risk of abuse or neglect, (2) promoting integration with health services, (3) decision on which services to charge for and, (4) cooperating with relevant partners. The advantages of delegation may include greater flexibility, cost effectiveness and partnership working. It also fits with the strategic direction towards becoming a commissioning authority. Risks to this approach include the fact that KCC would still be legally responsible for any delegated functions, the need to have in place

robust contract management, systems issues concerning transfer of data and concerns about the current capacity of the market to deliver.

Decision may be required on: the extent to which these powers should be exercised (by December 2014 in time for the 2016 changes).

2.5 **Market price for care:** There is the potential for an impact on the market price for care as many more self-funders and former self-funders may have their care arranged by the local authority. This will be due to the increase in the capital threshold (from April 2016) and also because of the right for self-funders to ask the local authority to make the arrangements for their care (expected to be introduced from April 2015). This is most likely to affect the residential care market and has the potential to put significant pressure on the price KCC has to pay for care. The Department of Health has stated that this will lead to greater transparency in the prices paid by local authorities and "will change the care and support market, although it is not clear whether pressure may fall on commissioners, care and support providers or both".[1] Of relevance in this context is the fact that the current residential care contract work makes it clear that the new rates of care will only apply until April 2016. This is so that any changes necessitated by the Care Act can be taken into account."

2.6 **Cap on care costs and change in capital threshold:** For people over pension age the cap will be set at £72,000 from April 2016, after which the local authority must pick up the care costs (but not daily living/hotel costs in residential care). It is expected that the cap for people between 18 and 64 will be lower but this has not yet been confirmed. At the same time, local authority care will become available to people with capital below a limit of £118,000 (as compared with £23,250 now). It has been estimated that the combined effect of these measures for people 65 and over will cost KCC £11.9 million in 2016/17, rising to £13.4 million by 2020/21. The effect for people aged 18-64 is thought likely to cost £4-5 million per annum. People who develop their care needs before the age of 18 will receive free lifetime care for these needs and this is expected to cost about £280,000 per annum.

2.7 **Ordinary Residence:** Currently, when a local authority places an individual in a care home in another area, that individual retains Ordinary Residence in the area of the placing authority. If that individual later begins living in the community (either because they leave their care home or via deregistration) their Ordinary Residence passes to the authority in which they live. This poses particular problems for Kent's Learning Disability service as we are a "net importer" of such placements (one national provider with 182 residents in Kent has 101 of these placed by other local authorities). Under the Care Act the current rules applying to residential care are due to be extended to Shared Lives and Supported Living settings. This will benefit KCC to some extent but will not solve the underlying problem as individuals moving into other non-residential settings will still become the responsibility of Kent.

2.8 **Charging policy:** From April 2015 the existing legislation underpinning charging will be replaced by a power to charge under section 14 of the Act. It is probable that in order simply to maintain the status quo (for example that we charge for residential and domiciliary care) fresh key decisions will be needed. Legal advice is being obtained on this point.

[1] DH 'Caring for our future: Consultation on reforming what and how people pay for their care and support', July 2013

Decisions may be required on: the extent to which the power to charge should be exercised (by January 2015).

2.9 **Opportunities for more prevention and early intervention work:** In addition to there being clear duties in this regard in the Act, the Care Costs Cap will mean that many more people are likely to come forward for an assessment at an earlier stage in order to take advantage of the new system. Whilst this will help to support the drive to keep people independent for longer (as early advice and support can be provided), it clearly has the potential to increase the number of people coming into the formal care system.

2.10 **ICT systems:** In order for the reforms to operate effectively changes will be required to the ICT client database systems (Swift, AIS, Oracle). This is required particularly for the 2016 changes when the ability to create a Care Account for all individuals (including self-funders) will be needed. In addition, it is believed that optimal use should be made of supported self-assessment options (as part of a triage system) and e-market solutions to enable people to manage their own care and support needs. Discussions are currently underway with Northgate to determine if their proposals for the changes are sufficient and will be delivered in time. This issue is currently considered a major risk to the implementation of the programme.

Decisions required: Although procuring a whole new system before 2016 (when Northgate's current contract runs out) is not thought to be feasible, certain additional functionality will be required. Decisions will be needed on whether Northgate's proposals are considered adequate or whether we will need to procure these "add-ons" (e.g. for the Care Account, Supported Self-Assessment) from elsewhere in order to be ready for the 2016 changes (by August 2014).

2.11 **Public understanding:** There are significant challenges in ensuring that the public understand the reforms. It is considered that the communication from Central Government has so far not sufficiently explained how the new system will work and more importantly how individuals will be affected. However, a draft local communication strategy and plan has been developed in response to the changes.

2.12 **Debt recovery:** The Act removes the current power under section 22 of the Health and Social Services and Social Security Adjudication Act 1983 to place a charge on a person's property who is in residential care and has outstanding debts to the council (this did not need the client's permission providing a debt existed). Under the Care Act, escalated debt procedures appear to be being limited to action through the County Court. There is concern that this will increase the amount of debt that is not able to be secured. As at the end of March this year KCC had 56 section 22 charges in places securing debt amounting to £887,770. The Deferred Payments duties and powers are being widened but, crucially, any charge placed on a property under this section of the Care Act requires the client to consent.

2.13 **Paying providers Gross or Net:** The current approach to paying providers (i.e. Gross) will need to be reviewed to determine if it remains the most effective mechanism once the Care Account is introduced in April 2016 alongside the likely extension of direct payments in care home settings from April 2016.

Decision may be required on: whether to continue to pay providers Gross once the current residential contract ends in 2016.

2.14 **Funding:** There is concern that Government may not fully fund the cost of the implementation thereby raising the issue of affordability for local authorities. Significant work has already taken place (including through ADASS and the County Council Network) to estimate the costs involved. See section 3 below.

3. Financial Implications

3.1 The Government has to date made the following funding announcements:

- 2014-15: £19 million to help local authorities prepare for the changes. It has been confirmed that Kent will receive about £0.125 million of this. Every local authority has been given the same grant money.

- 2015-16: £335 million from DCLG/DH for new burdens (new entitlement for carers, national minimum eligibility, deferred payments, better information/advice and safeguarding and other measures). It is understood that this is top-sliced from the main Revenue Support Grant settlement rather than being new money. Kent's indicative funding is about £8.6 million of this (using the normal funding formula).

- 2015-16: £135 million identified out of the £3.8 billion Better Care Fund. This is earmarked for new burdens under the Care Act. According to Kent BCF plans, this translates to £3.5 million for Kent.

3.2 Further announcements are expected in the next Spending Review.

3.3 The impact of the Care Act will be wide ranging, many activities will be affected and estimating cost impacts is dependent on the forecasts of changes to activity levels. Activity in the various service areas will be affected partly by the detailed provisions of the Act, partly by the reaction of the public and the market, and decisions to be taken locally in relation to the implementation of the Act.

3.4 Some costs will impact in 2015-16 and some in 2016-17 and the years after. The main impact in 2015-16 is for costs related to the assessment and provision of support to carers and the introduction of the national minimum eligibility criteria. In 2016-17 the main impacts will be on the assessment and review of service users particularly self-funders, associated financial assessments and then the increased provision of services due to the increased capital thresholds. In later years, cost will increase because of the lifetime cap on care costs. The exact details of how the provisions of the Act will be implemented are to be confirmed, costings at this stage can only provide a general idea of the likely costs rather than a detailed forecast.

3.5 Increased capital thresholds and introduction of a cap on lifetime care contributions will have the biggest cost impact in 2016-17 and beyond. A standard model provided via ADASS is being used to estimate the cost of these changes, supplemented by local information. As detailed in 2.6 above, the aggregate costs it predicts in the two years mentioned (2016/17 and 2012/21) are £16.6m and £19.3m respectively.

3.6 The costs outlined in 3.5 above do not include the costs associated with the extra assessments, impact on the care market and other costs, such as IT, Training, information advice and guidance, advocacy, deferred payments scheme, safeguarding, and the introduction of direct payments in care homes. These costs will be included in cost estimates as more information is known and decisions taken. This should be confirmed at the meeting of the Adults Transformation Board on 23 July.

3.7 Data from the DH national impact assessments has been used to identify the likely number of service users that will need to be assessed, under the provision of the Act coming into effect in April 2016. It is expected that this increase in activity will begin in October 2015, so these costs will arise partly in 2015-16. For the cost of carrying out each assessment KCC's own staff costs have been used.

4. Programme management and governance

4.1 The Care Act Preparation Programme is a separate programme within the Adults Transformation Change Portfolio set up under 'Facing the Challenge'. Whilst the preparations for the Care Act do warrant a separate programme, there will be strong links to the other programmes in the portfolio to ensure that they are "Care Act proof".

4.2 The Care Act programme is being overseen by the Adults Transformation Board and on a more day to day basis by the Care Act Programme Board. The latter includes representatives from the operational service, policy, finance, strategic commissioning, HR, ICT, Children's Services and Newton Europe. In addition specific reference groups are being set up including for Mental Health, Learning Disabilities and service users.

4.3 A detailed programme plan is currently being developed with the workstream leads and will be completed once the draft regulations and guidance have been released and analysed. This will then be submitted for approval by the Adults Transformation Board on 23 July 2014.

4.4 It should be noted that the preparation for the Care Act is taking place at the same time as other significant changes, for example the move to Business Service Centres and operational restructuring.

6. Recommendations

6.1 Cabinet Committee is asked to:

(a) **DISCUSS** the contents of this report and the extra information provided in the PowerPoint presentation which will be delivered on the day.

(b) **NOTE** that a full implementation plan will be presented to the Adults Transformation Board on 23 July 2014 after the draft regulations and guidance have been analysed. This will be made available to Cabinet Members.

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PREPARATION FOR THE CARE ACT 2014

Adult Social Care & Health Cabinet Committee

11 July 2014

Michael Thomas-Sam, Strategic Business Adviser, SC
Policy & Strategic Relationships

New legal framework April 2015...(2)

1. **New National Minimum Eligibility Criteria:** Based on needs caused by a physical, mental impairment or illness that have significant impact on specified outcomes and well-being of an adult

2. **New Rights for Carers:** New duties to provide support to carers additional to existing legal duty to carry out assessment

3. **Universal Deferred Payments:** Nationally defined universal deferred payments to be administered by local authorities

4. **Prevention:** Legal duties on local authorities to provide information & advocacy to plan and prevent care needs

5. **Statutory Safeguarding Adults Board:** Mandated to fulfil specified duties

6. **Delegation of Social Services Functions:** Power for local authorities to delegate social care functions except safeguarding, decisions on charging, integration and direct payments

7. **Prisoners:** New duties on local authorities to meet the care and support needs of prisoners and people in approved premises

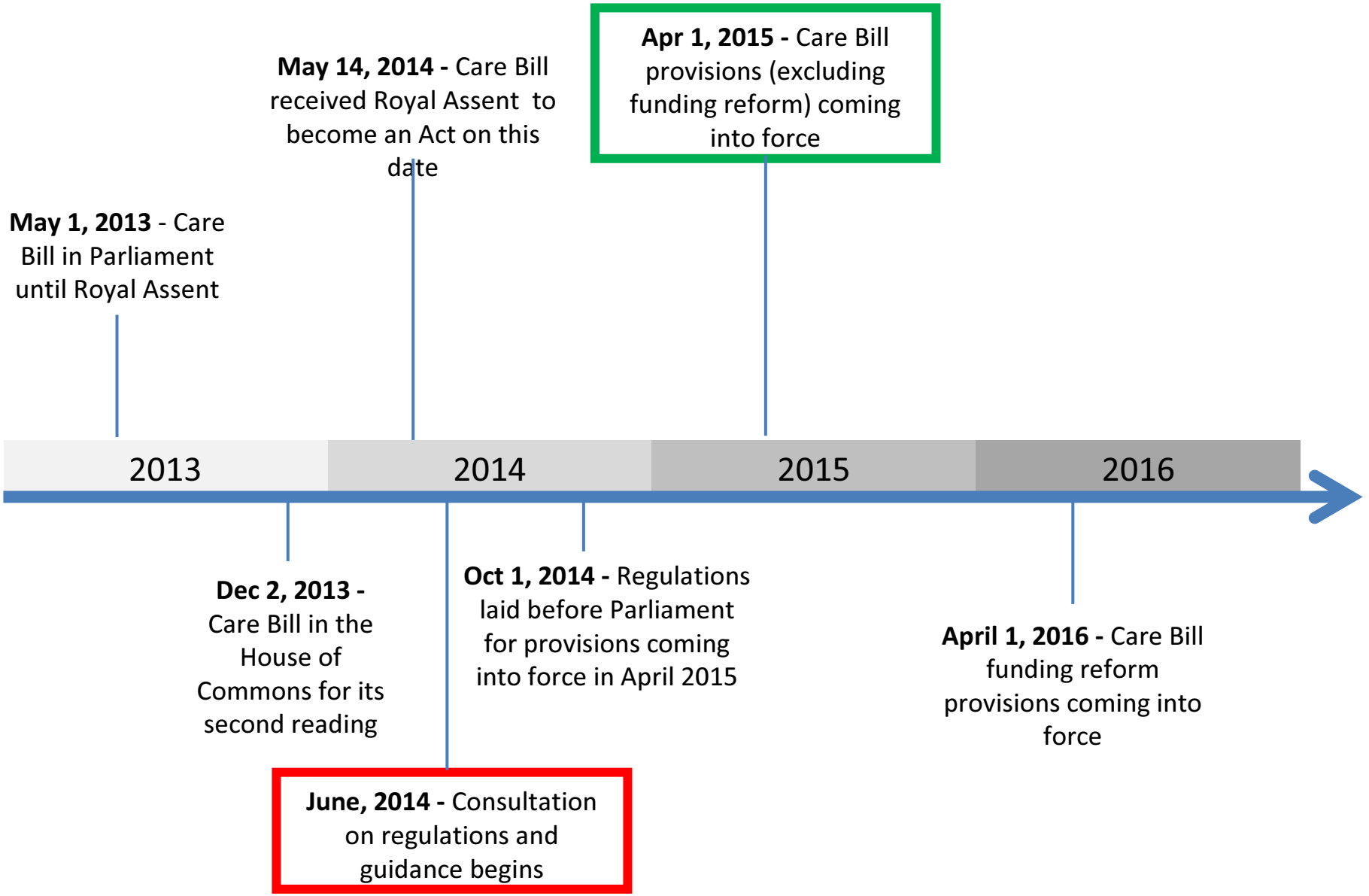
New legal framework April 2016...(3)

1. **Lifetime Cap on Care Costs:** first ever cap on care costs of £72,000 for over 65s (excluding living costs); caps for younger people still to be set; free care if needs develop before age 18.

2. **Residential means-test threshold:** rising from £23,250 to £118,000 for people in care homes where property is taken into account (otherwise £27,000 where the home is not counted)

3. **Extension of Direct Payments:** Care home residents will be able to use direct payments for some or all of their care and support

Timelines for implementation...(5)



Key national and local challenges…(6)

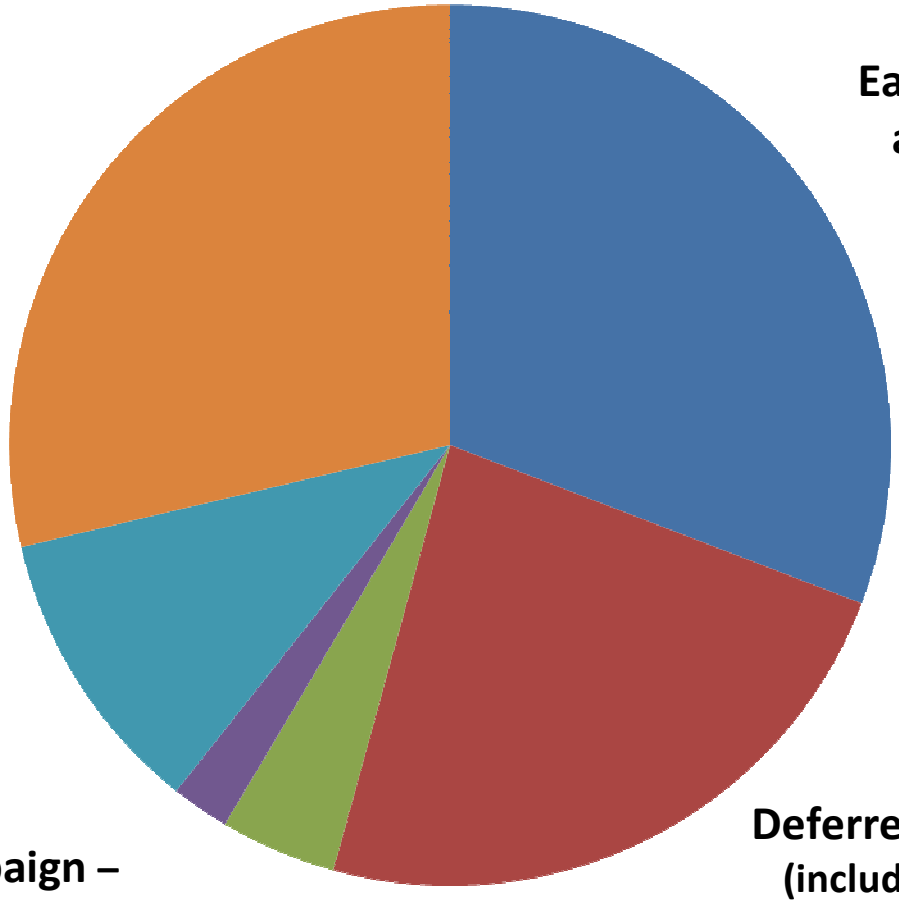
- Affordability of the reforms (cap on care costs, carers and self-funders)
- Working out the true costs of the reforms
- Timeliness of changes to IT & Finance systems
- Clear and accurate communication to inform the public
- Workforce capacity and training implications
- Commissioning and ensuring diverse range of services

National key assumptions & risks...(7)

"Many impacts on local authorities cannot be considered until regulations have been made and hence further impact assessments will be required"

Source: Care and Support Legal Reform (Part 1 of the Care Bill) IA No. 6107, DH December 2013

‘New burdens’ funding 2015/16…(8)



Other costs Included within Better Care Fund - £135m

Early Assessment and Reviews - £145m

Capital Investment (included in Better Care Fund) – £50m

Information Campaign – £10m

Deferred Payment (including cost of administering loans) - £110m

Capacity Building (including recruitment and training of staff) - £20m

Government funding...(9)

Govt. funding	England £	Kent £
2014/15 Confirmed funding for Kent	£19m	£125k
2015/16 DCLG/DH BCF Total Govt. funding	£335m £135m _____ £470m	Subject to local govt. settlement
2016/17	Subject to CSR	

Potential additional activity...(10)

Activity	Additional Activity			Date Expected to Commence
	Low	Best	High	
Carers Assessment	5,130	6,900	7,500	April 2015
Carers Support	3,150	3,300	3,900	April 2015
Deferred Payments	200	310	1,160	April 2015
Needs Assessments (from Oct 2015) (figure in brackets equals the 70% likely to require financial assessment)	4,600 (3,220)	6,900 (4,830)	9,200 (6,460)	Oct 2015
Needs Assessment/reviews (from April 2016) (figure in brackets equals the 70% likely to require financial assessment)	13,800 (9,660)	20,700 (14,490)	27,600 (19,320)	April 2016

Programme management & governance (11)

Sponsoring Group:

- Adults Transformation Board

Care Act Programme Board:

- Representatives from Operational service, Policy , Finance, Internal Audit
- Strategic Commissioning, HR, ICT , Children's Services and Newton Europe

Individual Projects:

- Communication
- Assessment, Eligibility and Cap on Care Costs
- Financial Assessment and Charging
- Safeguarding
- Workforce Development
- ICT issues
- Workforce Capacity
- Commissioning
- Costs modelling

Policy choices... (12)

- Whether to meet needs at the national minimum level or at a lower level (by September 2014)
- Extent to which the delegation of social care functions should be exercised (by December 2014)
- Extent to which the power to charge should be exercised (including consideration of adopting a charging policy based on 'net' payment (by December 2014)
- Extent to which technology should be maximised to support the implementation (by August 2014)

The guidance: chapter by chapter…(4)

Ch	Topic	
1	Promoting wellbeing	
2	Preventing, reducing or delaying needs	☆
3	Information and advice	
4	Market shaping and commissioning	
5	Managing provider failure	☆
6	Assessment and eligibility	☆
7	Independent advocacy	☆
8	Charging and financial assessment	☆
9	Deferred payment agreements	☆
10	Care and support planning	
11	Personal budgets	☆

Ch	Topic	
12	Direct payments	☆
13	Review of care and support plans	
14	Safeguarding	
15	Integration, cooperation and partnerships	☆
16	Transition to adult care and support	☆
17	Prisons and approved premises	
18	Delegation of local authority functions	
19	Ordinary residence	☆
20	Continuity of care	☆
21	Cross-border placements	☆
22	Sight registers	☆
23	Transition to the new legal framework	

☆ *Areas with related draft regulations*

Next steps… (13)

- Continue costs modelling work to estimate the full costs of the implementation
- Assess the implications of and respond to the consultation on the draft regulations and policy guidance
- Complete the Programme Implementation Plan
- Commence awareness raising campaign
- Report to the Cabinet Committee on 11 July 2014); Adults Portfolio Transformation Board on 23 July 2014

End

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

Andrew Ireland, Corporate Director for Social Care, Health and Wellbeing.

To: Adult Social Care and Health Cabinet Committee – 11 July 14

Subject: **Adult Social Care Transformation - Building Community Capacity Programme**

Classification: **Unrestricted**

Past Pathway: DMT May 2014

Electoral Division: Whole Kent Programme

Summary:

This report explains the approach being taken in Adult Social Care to engage with the voluntary sector and ensure it is strategically aligned to the council's aims and objectives in the Adult Social Care Transformation Programme.

Recommendation:

The Cabinet Committee is asked to:

i) CONSIDER the proposed approach, and
ii) ENDORSE the planning and delivery of the Community Capacity Building Programme.

1. Introduction

1.1 In May 2012 Kent County Council set a blueprint for the Transformation of Adult Social Care, and in doing so established the key foundations for transformation:

- A determined focus on prevention and targeted intervention, ensure that services respond rapidly and are more effective.
- To encourage and empower individuals to do more for themselves and ensure greater support is available to carers
- And importantly to this programme that we would develop a new deal with both voluntary and independent providers; one that is based upon trust and incentivisation

1.2 Adult Social Care faces fundamental choices to ensure that there is a sustainable model of social care fit for the future and we are able to continue to meet the needs of the most vulnerable in our communities. A different approach is needed if we are to succeed in a context of increasing demand,

rising public expectations and less funding. Along with other measures this means adopting an asset based approach which empowers individuals, families/carers and communities to meet their own needs outside of a social care model of support.

1.3 This report introduces the planned Community Capacity Building Programme, the objective of which is to support the transformation of adult social care and ensure the council is able to respond fully to the requirement of the Care Act.

1.4 The Community Capacity Building Programme will require the decommissioning and recommissioning of current voluntary sector services to deliver a consistent menu or 'core offers' of services. All services need to support independence, resilience, self-care and wellbeing, diverting people away from formal social care systems and providing an alternative to, or supplementing, traditional care packages.

1.5 Services will be generic where possible and specialist where proven necessary. We are looking initially to deliver a new approach to information, advice and advocacy, an older person's core offer and a mental health core offer. As the programme develops it will also encompass sensory services, services for adults with learning or physical disabilities.

1.6 The programme will be built on the principles of self-care and self-management, which are intrinsic to the council's Integration Pioneer Programme and we are working to secure joint investment from Public Health and Kent Clinical Commissioning Groups.

2. Financial Implications

2.1 Adult Social Care spends £18m on voluntary/community based services to support vulnerable adults, £14m via grants and £4m via contracts. This includes services for older people, people with mental health issues, learning disabilities and physical disabilities.

2.2 The programme will be funded via decommissioning historic grants and moving to outcome focussed contracts. This will require reprofiling the current investment to ensure it is equitably allocated and strategically focused to meet the directorate's aims and objectives. We will also look to secure through robust business cases joint investment with Public Health and Clinical Commissioning Groups.

3. Bold Steps for Kent and Policy Framework

3.1 KCC's commitment to supporting the voluntary sector is outlined in the following documents:

- Bold Steps
- Kent Compact
- KCC Volunteer Charter
- Facing the Challenge

3.2 All services need to be strategically aligned to KCC vision for adult social care which is that by 2018, we will have a sustainable model of integrated health and social care which offers integrated access, provision and commissioning. We will have improved outcomes for people across Kent by maximising people's independence and promoting personalisation. We will have maximised value for money by optimising our business, managing demand and shaping the market through strategic engagement with key suppliers.

4. Relevant History

4.1 Current voluntary sector services have developed over years without a consistently agreed strategic framework, support services were commissioned locally not strategically. There are examples of great practice and innovation but services are not consistent leading to a postcode lottery of access and availability. It is difficult to justify current patterns of resource allocation for example, why do we spend £18m in voluntary/community support and £160m in care home provision? Going forward we must re-engineer our existing system to better reflect the needs, wishes and aspirations of vulnerable adults.

4.2 Mapping by Strategic Commissioning has shown that the type of support available, the quality and the level of investment in these services vary across the county. Furthermore many of the services, especially those for older people, are delivered via traditional models, which do not reflect the changing needs of our population. This programme offers unique opportunities to commission and procure services that are fit for the future and which provide equity of investment, access and excellent return on investment.

4.3 In some instances the nature of our funding has contributed to a dependency on KCC and a lack of sustainability within the voluntary provider market. Inevitably this programme will involve moving some services from annual grants into longer term funding arrangements. The outcome focussed contracts will be used to promote stability and sustainability in the market and enable us to create a culture of performance management all of which will require a transformation in the way we work with the voluntary sector.

4.4 There has been some frustration about the rolling nature of grant funding but this is a complex and important piece of work that requires carefully planning, co-production and must be properly aligned to the overall adult transformation programme. We need to plan consult, reflect and take the sector with us as we transform community services.

5. Supporting transformation in meeting need/managing demand

5.1 In repeated consultations with people who use our services and those who choose not to, we been told that ……. ***people want a life not a service***. However, our current case management model has developed over years to be primarily about supporting people to access care package services. This programme of community capacity development is central and crucial to transformation in two key ways:

- By providing a range of community based services that support independence and wellbeing, diverting people away from formal social care systems (cost avoidance)
- By providing a range of quality, value for money services that provide an alternative to, or supplement traditional care packages (cost savings)

5.2 The commissioning of these services supports both the pathway and optimisation work streams of adult social care transformation by ensuring that individuals who are supported post enablement to maintain their levels of independence and that the right services are in place to support people in their communities.

5.3 Newton Europe our efficiency partner completed a mini diagnostic assessment focused on current provision with the voluntary sector. The diagnostic showed that there was scope for greater use of the voluntary sector as our care pathways are redesigned to direct people to find different solutions in the community. The Community Capacity Building Programme is a key feature of programme two of our transformation programme and we will be working with our efficiency partner to developed robust analysis to underpin out approach.

5.4 The future strategy will be designed to promote community connectivity and resilience. We will look to support localism and bottom up sustainable change which recognises the assets within communities and encourages community development.

6. Care Act Compliance

6.1 Adopting a Community Capacity Building approach will ensure that we are able to meet the requirement of the Care Act, where there is a renewed focus on wellbeing and prevention. The Act requires local authorities to ensure the provision or arrangement of services, facilities or resources to help prevent, delay or reduce the development of needs for care and support. This prevention duty extends to all people in a local authority's area, including carers, regardless of whether they have needs for care and support, or whether someone has had a needs or carer's assessment.

6.2 Information and advice is fundamental to enabling people, carers and families to take control of and make well-informed choices about their care and support. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support. The Act requires local authorities to establish and maintain an information and advice service in their area. The information and advice service must cover the needs of all its population, not just those who are in receipt of care or support which is arranged or funded by the local authority.

6.3 The Act introduces a new duty for local authorities to create a diverse market of high quality providers, be aware of changes in demand and ensure that

services are sustainable. In doing so local authorities must give particular attention to ensure sufficient services that enable participation in *work, education and training*. In line with the Care Act, services will also deliver our statutory responsibility to provide early intervention and prevention services that will reduce, delay or prevent support needs of both adults and carers.

6.4 The Community Capacity Building Programme will seek put people at the centre of their care, is designed to support independence and resilience, creating a network of relationships around them, supported by community services with statutory services being the last option.

7. Social Value Act

7.1 The Social Value Act and other related national guidance place an onus on public sector organisations to give full consideration to the added social value that the voluntary sector bring to service provision. Further, there is a responsibility placed on the public sector to make procurement processes proportionate and accessible to the voluntary sector.

8. Market Development

8.1 Recent findings indicate that the voluntary sector in Kent is ill-prepared for wide scale procurement activity and this a risk to KCC. The need for county wide coverage along CCG boundaries will necessitate the formation of consortia or partnership arrangements and both the scale and value of a contract to provide a core offer is likely to attract larger organisations to bid. In order to prepare and support the voluntary sector in Kent through these processes a market and development service has been commissioned. This will help up skill the sector, encourage the development of networks and provide support through the commissioning process.

9. Options considered – including maintaining the status quo

Option	Options Appraisal
1 Do Nothing	**Risks:** • Services are not strategically realigned, they do not support adult social care transformation and we do not achieve best value from our significant investment. • Inability to comply with the Care Act • Voluntary sector market will remain unstable due to annual funding. • Access to support and investment in services will remain inequitable. • Reputational risk to KCC when status quo to voluntary sector is maintained during a time of radical transformation. This option conveys a mixed message to the whole social care market where one part is protected and the rest is not.

	Opportunities: • Avoids disruption to individuals and market
2 End all Grants	**Risks:** • People without services that support them to be independent • Inability to comply with the Care Act • Increased demand to social care and health due to lack of investment in preventative community services **Opportunities:** • Historic investment contributes to savings
3 Commission at one time whole Kent approach	**Risks:** • Impact on commissioning resources to deliver complex programme of change **Opportunities:** • Entire associated budget can be realigned to equalise funding according to levels of need and deprivation. • Funding can be realigned based on true cost of delivering specific elements of the core offer. For example, levels of investment in Information, Advices and Advocacy can be increased to deliver the 'right' model • Ensures Care Act compliance • Supports Adult Social Care Transformation
4 Commission via a phased approach one CCG cluster at a time.	**Risks:** • Investment will have to stay within existing boundaries and cannot be equalised across the county • Some services are commissioned across district, CCG and county boundaries and money for specific areas cannot be easily extracted from those arrangements in a phased manner. • Some projects (for example, IAG) will be delayed in order for sufficient funding to be released to commission the service • Barrier to county wide solutions that may give KCC better return on investment **Opportunities:** • Enables learning from initial area to inform remainder of programme • Commission alongside CCG's that are ready and avoids waiting for CCG's that are not • Ensures Care Act compliance • Supports Adult Social Care Transformation

10. Legal implications

10.1 The design of new outcome focused contracts may require specialist legal advice.

11. Equalities implications

11.1 An Equality Impact Assessment (EqIA) has been completely for the overarching programme. A specific EqIA will be completed as part of developing the business case for the older person's core offer; the mental health core offer has an EqIA which has been approved by the Diversity team.

11.2 In addition some specific grants may require Equalities Impact Assessments, specifically those that will be ended and where equitable services will not be re-commissioned.

12. Property implications

12.1 Some voluntary sector providers operate out of KCC properties as the programme develops all property implications will be assessed and evaluated with full involvement of appropriate colleagues.

13. Formal decision making

13.1 If there is a move to commission services then there will need to be formal decisions to the award the necessary contracts. These will be taken by the Cabinet Member for Adult Social Care and Public Health.

14. Conclusion

14.1 The Community Capacity Building Programme will support the transformation of adult social care and ensure the council is able to respond fully to the new requirements of the Care Act. We need a more robust and strategically commissioned range of community based services designed to promote independence and wellbeing and control, which keep people healthy, well, support recovery and reablement and delay of negate the need for more expensive care managed support.

14.2 The planning and delivery of this approach is complex and will be central to programme two of our Adult Social Care Transformation and our Integration Pioneer Programme. Services which prevent or delay entry into social formal care systems are essential to support the transformation of adult social care. As our Community Capacity Building Programme we will devise mechanisms, methods and measures to evidence impact of investment and explore means of understanding and assessing the wider social return on investment (SROI).

15. Recommendation:

The Cabinet Committee is asked to:

i) CONSIDER the proposed approach, and

ii) ENDORSE the planning and delivery of the Community Capacity Building Programme.

16. Background Documents - None

17. Contact details

Report Author

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Building Community Capacity

Cabinet Committee
July 11th 2014

Mark Lobban, Director of Commissioning
Emma Hanson, Head of Commissioning
CMM 12th May 2014

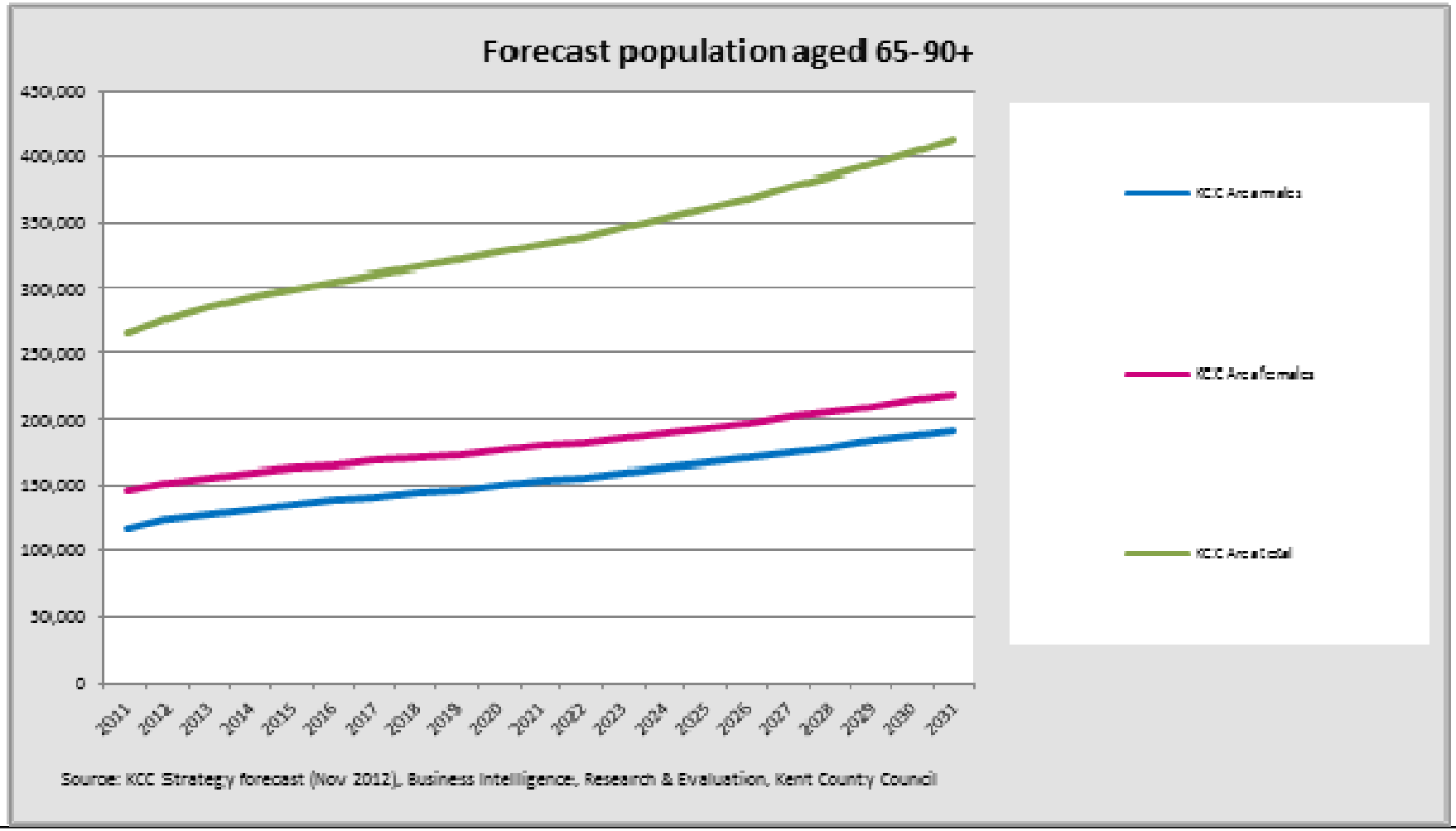
Kent County Council
kent.gov.uk

Challenge on an Unprecedented Scale

- Budget reductions are tougher than any seen before
- at the same time, demand for services continues to increase
- LGA, National Audit Office and Public Accounts Committee have stated that some councils will not survive

Delivering efficiencies will no not be sufficient to meet the challenge… it is the toughest test we have faced

Rising Demand – Kent Picture



Kent County Council kent.gov.uk

Additional Social Issues

- Health inequalities and rise of multiple long term conditions
- Impact of Welfare Reforms
- Rising cost of living - fuel and water poverty
- Care Act requirements

Local authorities face choices

Public services, especially local authorities, face fundamental choices about how they respond to the current climate. These might be characterised as follows:

1 Managed decline

Reducing the scope and role of councils; public services retrenching to becoming providers of last resort; delivering only statutory provision; 'unfunded mandates'. Public services are no longer able to play a role shaping place and supporting livelihoods.

2 Redefining relationships

Between citizens, communities, and services; between different service providers and arms of government; and between businesses, voluntary sector organisations, government and community. This requires give and take on all sides. Demand management is a core part of this package.

To some extent, councils may combine elements of both the responses outlined here: cutting back on some service provision while also seeking to develop a new settlement between citizens and the state as part of a longer term strategy. But any successful strategy will have to have demand management at its core.

Strategic Aims

- Get the best possible outcomes within the resources we have available
- Develop a system that is both affordable and sustainable
- Improve outcomes for vulnerable people within Kent County Council
- Encourage growth and diversification of the provider and voluntary sector market

Transformation of Adult Social Care

- Optimise our internal systems and work practices
- Improve care pathways to ensure they are more accessible and efficient
- Improve commissioning and procurement practices, deliver - Homecare and Care Home re-lets

KCC to become a ***'Commissioning Authority'***

A Life not a Service !

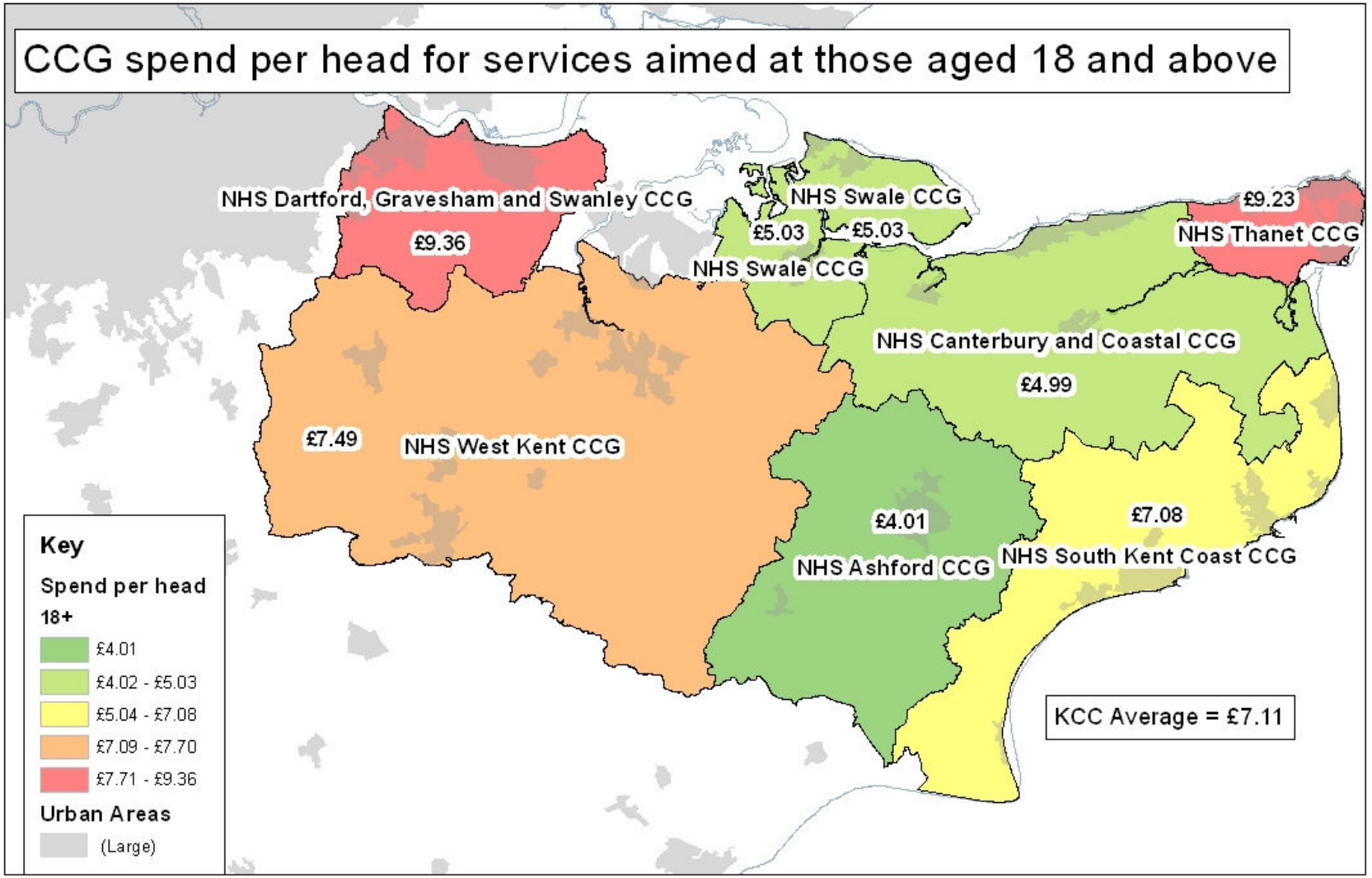
Voluntary Sector Role in Transformation

- Key partner in the transformation of adult social care
- Integral to building Community Capacity
- Ideally placed to deliver and respond to a local need, know their community
- Innovative responsive services
- Add social value

Community Capacity Building Programme

Where we are;

- £14m grants and £4m contracts in community based services
- Not fully aligned to KCC strategic outcomes/priorities
- Provided via a range of voluntary sector partners
- Historically grown different services in different areas, equals inequity of access and a postcode lottery
- Lack of performance management
- Services not consistently networked together



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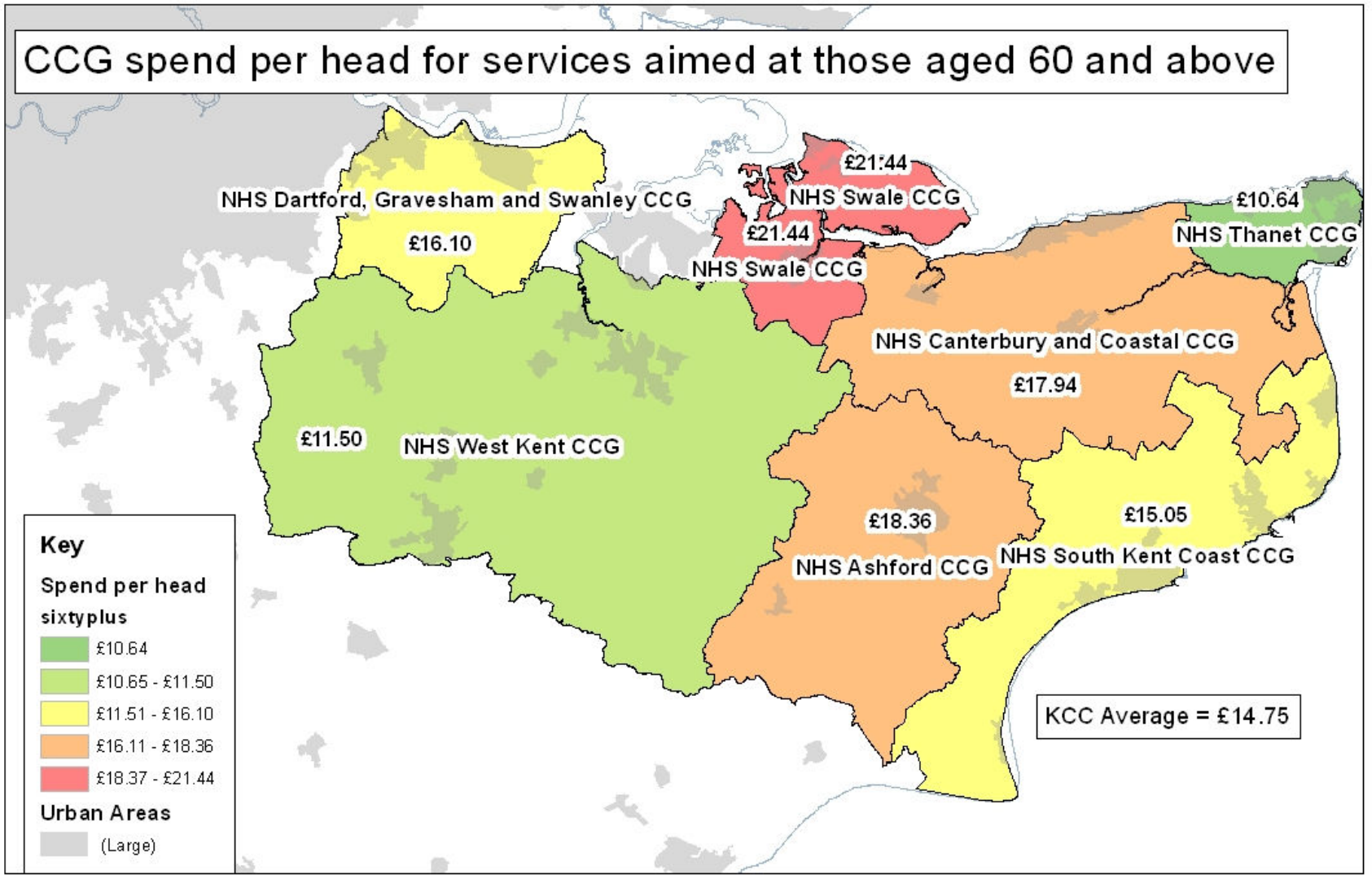
CCG spend per head for services aimed at those aged 60 and above
NHS Dartford, Gravesham and Swanley CCG
£16.10
£21.44
NHS Swale CCG
£21.44
NHS Swale CCG
£10.64
NHS Thanet CCG
NHS Canterbury and Coastal CCG
£17.94
£11.50
NHS West Kent CCG
£18.36
NHS Ashford CCG
£15.05
NHS South Kent Coast CCG
KCC Average = £14.75
Key
Spend per head sixtyplus
£10.64
£10.65 - £11.50
£11.51 - £16.10
£16.11 - £18.36
£18.37 - £21.44
Urban Areas
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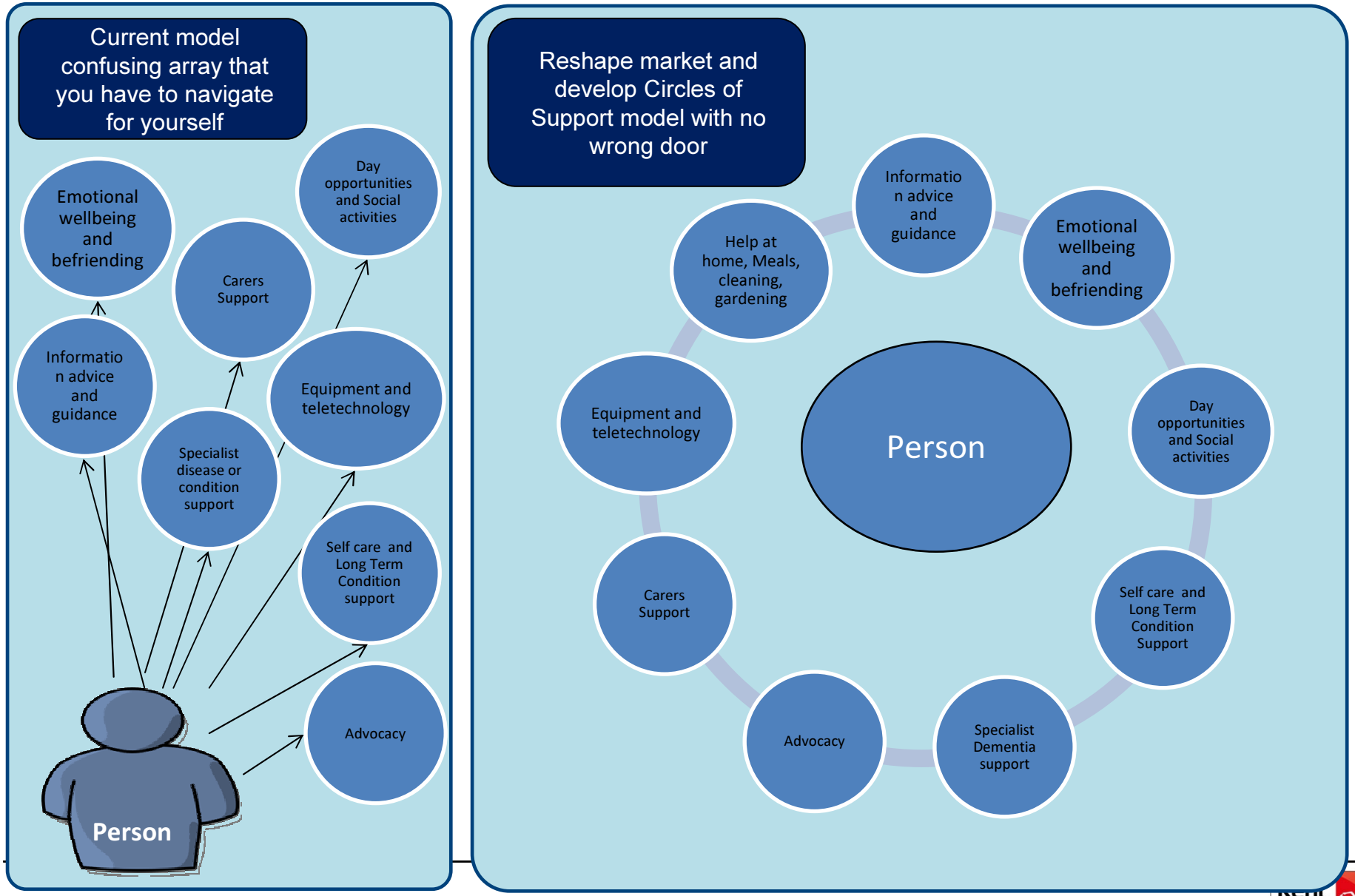
The Vision - Person Centred Community Based Services



Community Capacity Building Programme

Where we need to be:

- Develop core offer or menu of services to support independence, wellbeing, self management and tackle social isolation
- Alternative support to assessed care packages that supports:
  - Demand management via service substitution and therefore cost avoidance
- built on community development principles and connectivity – ***a life not a service***
- Proportionate performance management, focus on outcomes
- Generic where possible specialist where proven necessary

Case Example

- Carers Assessment and Support, new outcome focused contract delivered via 4 vol sector partners
- Evened out historic spend with a funding allocation formula
- Ended years of grant funding 37 grants and 13 organisations
- Embedded culture of performance management, via intelligent and collaborative commissioning
- Know what we are getting and can evidence SROI
- Using outcome star to show impact on carers resilience and ability to care/cope
- Makes service more sustainable in tough times

Commissioning Approach

- **Outcomes**: shifting thinking and practice towards outcomes the positive change that results from an activity
- **Social value**: using methods such as Social Return on Investment to evaluate outcomes
- **Well-being**: capturing and using well-being evidence the 'Six Ways to Well-being' and Outcome star methodology
- **Prevention**: a systemic approach to pushing resources 'upstream' and understanding how prevention can be evidenced
- **Co-production**: developing skills and awareness to truly co-produce working in equal partnership, bringing in the expertise, time and skills of people who use and deliver services, and developing an assets based approach to support

Towards Excellence in Commissioning

- Every **pound** spent benefits our residents and is value for money for Kent taxpayers
- All our activity is focused on the delivery of our strategic **outcomes**
- All decisions taken, and services commissioned, are based on a strong **understanding of customer need**
- Every option considered for the delivery of services is done so on the basis of a full **understanding of true costs**
- **The strengths of the voluntary, community and private sectors in Kent are fully utilised**
- Tough decisions, including when to **decommission** services, are taken in an appropriate and timely manner.

Next Steps

- Continue to deliver programme one of transformation
- Programme two assessment and design with our efficiency partner July – August
- Develop business cases to support Mental Health and Older Person's core offers
- Engage, engage and engage – in order to co-produce model and required outcomes with wide range of stakeholders including those who don't currently use services
- Plan programme and prioritise and sequence projects

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

Andrew Ireland, Corporate Director for Social Care, Health and Wellbeing

To: Adult Social Care and Health Cabinet Committee – 11 July 2014

Subject: Kent Support and Assistance Service

Classification: Unrestricted

Summary
The report sets out the current position with regard to the Kent Support and Assistance Scheme (KSAS) and options for the future.

Recommendation

Cabinet Committee is asked to:

i. NOTE the report and the need for a future formal decision on the service.

ii. ENDORSE or COMMENT on the preferred option of providing a sustainable solution by further investigating option 8.3, possibly via a Voluntary Sector Organisation.

1 Introduction

1.1 Prior to 1 April 2013, the Department for Work and Pensions (DWP) ran a national scheme providing Community Care Grants to support people to remain in or move into independent living accommodation; and Crisis Loans to support people faced with an emergency situation who have no recourse to other funding. These two funding schemes were part of the discretionary Social Fund.

1.2 The Social Fund was designed to give cash awards and loans to people based on a telephone application process.

1.3 The provision of the Social Fund was devolved to upper-tier and unitary local authorities with the intention that they design their own local scheme to better meet the needs of the local population.

1.4 The **£2.85m** funding received was lower than previously available to the DWP and local authorities were expected to concentrate the funding on those facing greatest difficulty in managing their income and to create a more flexible response to local need.

2 KSAS Delivery Model

2.1 It was proposed to run a county-wide assistance pilot scheme commencing 2 April 2013 which would run for one year commissioned by Customer and Communities Directorate. This was subsequently extended to two years.

2.2 Applications could be made via an online form available on Kent.gov or by telephone using a designated 0300 number. Referrals into the scheme would be from other agencies as well as self-referrals.

2.3 Eligibility is restricted to Kent residents over 18 who are in receipt of certain means-tested benefits or those who have a low income.

2.4 The support KSAS offers falls under three broad headings:

- Information and Signposting – this is the most important part of the scheme as it offers long term help and support from agencies around the county. Information is provided on a variety of themes including the DWP Budgeting Advance schemes, Discretionary Housing Benefits Payments, debt management support, advocacy or access to help with employment and training.
- Emergency Support – provision of grocery products, reconnection of fuel supply charges, travelling expenses etc. The grocery products are delivered through a partnership with ASDA who deliver a grocery pack to last for seven days. Energy vouchers, travel vouchers and cash (in very exceptional circumstances) are delivered through the PayPoint Network.
- Non-emergency Support – provision of household items such as furniture, white goods and cookers most of which is delivered via the Kent Furniture Re-use Sector.

2.5 This service model was intended, and has proved to provide a real opportunity for developing working relationships with a range of agencies/stakeholders. It has also helped to improve the existing arrangements to deliver a more integrated preventative service that not only meets the presenting need but also addresses any other underlying circumstances or causal factors to prevent reoccurrences.

3 Staffing

3.1 As this was a new scheme the demand was uncertain and conservative staffing levels were initially mobilised. It soon became clear that to meet the realistic demand staffing levels would need to increase.

3.2 The current staffing level of 15 and the introduction of a new IT system is meeting the current demand.

4 Demand

4.1 For the year 2013/14:

- **9,601** applications received, involving **22,408** total individuals (**9,601** applicants & **12,807** dependants);
- **11,315** awards granted to **6,133** households across Kent;
- **8,466** children (under 16 years of age) feature in applications;
- **4,223** young children (under 5 years-of-age) feature in applications;
- **3,302** applications received featuring mental health issues within the household;
- **216 a**pplications received from ex-armed forces personnel.

4.2 The KSAS programme actual spend in 2013-2014 was £1,140,911 resulting in an underspend of **£1,722,089** for financial year 2013-2014. The overall position of the KSAS programme is one of increasing volumes and the value of awards has increased on a quarterly basis.

5 Evaluation

5.1 An evaluation of the first twelve months was completed in May 2014.

5.2 The analysis of the available quantitative and qualitative data shows that KSAS is generally a well-designed service which meets its objectives.

5.3 When considering the first objective – whether KSAS is supporting to meet or is meeting an immediate short-term need in a crisis or emergency – the evidence shows that the prompt processing of high-risk applications for support, and the goods and services offered, meet the needs of particularly vulnerable residents in a crisis in Kent.

5.4 With regard to its second objective – the extent to which KSAS is supporting to meet or meeting a need for support to stay in the community rather than going into care or an institution – the available evidence is limited, but it indicates that KSAS may be helping particularly vulnerable people to stay in the community. It is clear that the service is enabling people to move on from higher care settings such as supported housing and women's refuges.

5.5 With regard to its third objective – the impact that signposting is having on alleviating applicant's hardship – the available evidence suggests that KSAS's engagement with other agencies is supporting people in crisis.

5.6 KSAS has played a pivotal role in alleviating the distress caused by the floods in December 13 and January 14. KSAS was able to offer both immediate and longer term support to the victims displaced by the floods as it had in previous civil emergencies such as a fire outbreak in a house of multiple occupation.

5.7 A protocol detailing how KSAS can be used in civil emergencies is in place with emergency planning services.

5.8 Feedback from professionals also indicates that a key strength of the service is that it is an easily identifiable and accessible service with a single point of contact that can promptly co-ordinate the provision of different goods and services to meet the needs of people in crisis.

6 KSAS Achievements

6.1 KSAS was set up within a very short timeframe and quickly established a good reputation with partners and other agencies as a service of first and last resort when Kent residents are faced with a crisis or have no other recourse.

6.2 The signposting part of the service has dealt with 34,000 enquiries and KSAS has assessed the health and wellbeing needs of over 20,000 people in Kent of which 8,000 were children. It has successfully provided goods and services to 9,600 households in Kent dealing with emergencies with an immediacy not catered for by any other council services .

6.3 In the first twelve months the demography of the service changed from 70% applicants aged 18-34 and single to over 62% applications from households with children. KSAS had the flexibility to recognise the change and adopt a risk matrix to ensure all applications involving children were prioritised.

6.4 KSAS has been used by districts and KCC as part its civil emergency response providing support to families displaced by fires and delivering tangible support in

the KCC response to flooding in Yalding. The actions of KSAS were recognised with a Chairman's Commendation Award presented to the service in March 2014

6.6 Case studies indicate that the service has enabled residents of Kent to recover from a crisis and get on with their lives without any further help.

7. Conclusion

7.1 There will be no further ring-fenced grants available to the county council to deliver the service from 2015 onwards. As the evaluation shows, stakeholders have expressed concern about a future without the service.

7.2 In common with other authorities, the county council must decide how it envisages that this need should be met in future.

8. Options

8.1 Do nothing and allow the KSAS pilot to end March 2015. Risk of increased demand for other services that KCC provide.

8.2 Continue service for year 3 (15/16) using underspend from 2013/14 and 2014/15. This extends the service for a further year but is not a sustainable solution and may not be the best use of resource.

8.3 Commission a new service focussing on information and signposting. This fits strategically with KCC's wider responsibility for providing Advice, Information and Guidance and could provide a sustainable solution.

9. Recommendation

9.1 Cabinet Committee is asked to:

i. NOTE the report and the need for a future formal decision on the service.

ii. ENDORSE or COMMENT on the preferred option of providing a sustainable solution by further investigating option 8.3, possibly via a Voluntary Sector Organisation.

10. Background Documents - None

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

Andrew Scott-Clark, Acting Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 11th July 2014

Subject: Public Health Performance - Adults

Classification: Unrestricted

Summary: This report provides an overview of Public Health key performance indicators which specifically relate to adults.

Community Sexual Health services continue to provide required levels of access to their services and Health Trainers continue to engage expected numbers of new clients. There were improvements in the NHS Health Check Programme in Q4 for both invites sent and checks received.

Despite concerns with levels of performance of the commissioned programmes, it is encouraging that all five indicators have improving performance during the year and is progressing in the right direction. Significant concerns with smoking cessation services remain.

Due to national publication dates, figures for Chlamydia Positivity have not been updated since the previous report, but local figures have been provided as a temporary measure.

Wider Public Health Indicators have been included to provide an understanding of the wide reaching impact of Public Health.

Recommendation(s): The Adult Social Care and Health Cabinet Committee is asked to note the current performance and actions taken by Public Health

1. Introduction

1.1 This report provides an overview of the key performance indicators for Kent Public Health which relate to services for adults; the report includes a range of national and local performance indicators.

1.2 There are a wide range of indicators for Public Health including the indicators contained in the Public Health Outcomes Framework (PHOF). This report will focus on the indicators which are presented to KCC Cabinet, and which are relevant to this committee.

2 Performance Indicators

2.1 The table below sets out the performance indicators for the key public health commissioned services which deliver services primarily for adults. A more detailed analysis of the performance is included at Appendix A.

Indicator Description	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Direction of Travel[1]
Prescribed and non-prescribed Data Returns						
NHS Health Checks - Proportion of target offers received a Health Check	42.0%	28.3%	38.7%	30.4%	46.9%	⇧
Community Sexual Health Services – Proportion of clients accessing GUM offered an appointment to be seen within 48 hours	98.5%	97.8%	96.6%	97.4%	99.9%	⇧
Community Sexual Health Services – Chlamydia positivity rate per 100,000	1,507	1,292	1,679	Not currently available	Not currently available	⇧
Stop Smoking Services – Number of people successfully quitting having set a quit date	2,541	1,536	1,454	1,488	1,653	⇧
Local Indicator						
Health Trainers – Proportion of new clients against target	163%	77%	109%	95%	109%	⇧

2.2 The provider of NHS Health Checks sent out the target number of invites for 2013/14, in total to just over 95,000 eligible Kent residents. Although the target number of Kent residents to receive a health check was not met, there was an increase on the previous year with 32,924 having a NHS Health check, 10,709 of which were received in Q4.

2.3 Public Health has been working this year to provide active feedback to Clinical Commissioning Groups (CCGs) on local results. Alongside this work Public Health will also be appraising future delivery options with a view to contracts being awarded in December in time for start in April 2015. The target remains to achieve 50% uptake rate this financial year.

2.4 GUM (Genitourinary Medicine) clinics in Kent consistently offer the majority of clients an appointment within 48 hours, performing above the high target of 95%. GUM service is open access, available to all ages. This indicator is being monitored in quarterly performance monitoring meetings with the commissioned providers. Community sexual health services, including GUM and Chlamydia testing, are currently out for tender but the access targets will be included in the new contracts.

2.5 The Chlamydia positivity rate remains below the target level of 2,300 per 100,000 of population. The provider has implemented an action plan to tackle the shortfall of including public health campaign activity, radio messaging, promotional materials and the establishment of improved and focused internal performance measures and targeting of at risk groups/communities.

[1] Key to direction of travel arrows is at Appendix A

2.6 Provisional figures for the full year 2013/14 on chlamydia positivity indicate a possible 2,095 rate per 100,000; this is an improvement on previous performance however would have Kent still below the nationally set target.

2.7 The number of people successfully quitting smoking also remains below the target. Smoking rates in the county have declined in recent years but approximately 1 in 5 adults in Kent smoke with significantly higher rates in particular parts of the county. Public Health has recently commissioned a review of the current Stop Smoking Services which will inform commissioning plans for the future.

2.8 Although the full year 2013/14 figures for smoking cessation did not met the targeted 9,249 quits, quarter 4 did experience an increase in the number of quitters compared to all other quarters within the year at 1,653.

2.9 The health trainer service continues to engage new clients and work with those in the most deprived areas of Kent; Public Health is working with the provider to move from activity-based metrics towards outcome-focussed indicators.

2.10 Not all of the indicators have met the targets set, although performance in four of the five indicators has improved and is moving in the right direction. This needs continuous review and focus to sustain improved performance.

3 Annual Public Health Outcomes Framework (PHOF) Indicators

3.1 At the previous Committee meeting on 2nd May 2014 it was agreed to include a wider range of indicators to reflect the breadth of the Public Health Agenda. Indicators on alcohol, substance misuse and depression have been presented below in line with requests at the previous Committee. It should be noted that these are annual statistics and will not change for every meeting.

Annual PHOF Indicators	2006-08	2007-09	2008-10	2009-11	2010-12	DoT
Under 75 mortality rates for:						
Cardiovascular diseases considered preventable per 100,000	61.2	59.8	57.4	55.9	52.3	⇧
Cancer considered preventable per 100,000	85.6	84.3	83.7	82.6	80.5	⇧
Liver disease considered preventable per 100,000	12.8	12.4	12.1	12.0	12.4	⇩
Respiratory disease considered preventable per 100,000	16.8	17.4	17.4	17.6	16.6	⇧
Suicide rate (all ages) per 100,000	8.4	8.4	7.7	8.4	8.1	⇧
Proportion of people presenting with HIV at a late stage of infection (%)	Not available	Not available	Not available	49.0	46.8	⇧
	2008	2009	2010	2011	2012	
Percentage of adults classified as overweight or obese	Not available	Not available	Not available	Not available	64.6	-
Prevalence of smoking among persons aged 18 years and over (%)	Not available	Not available	21.7	20.7	20.9	⇩
Opiate drug users successfully leaving treatment and not re-presenting within 6 months (%)	Not available	Not available	14.6	14.6	10.9	⇩

	2008/09	2009/10	2010/11	2011/12	2012/13	
Alcohol related admissions to hospital per 100,000. All ages	Not available	Not available	574	557	565	⇩
Proportion of adult patients diagnosed with depression (%)	Not available	Not available	Not available	Not available	5.57	-

3.2 Rates of premature mortality in Kent are all showing as either better or similar to national rates. Although cardiovascular disease is showing as similar to the national rate, the rate is continuing to decrease

3.3 With some changes in direction across some of the rates during the time frames under review, all are at lower rates in the most recently available time period of 2010/12 when compared to 2006/08.

3.4 Late diagnosis of HIV is the most important predictor of morbidity and mortality among those with HIV infection; the earlier the diagnosis the better for both the person and the impact on wider services. There are two time periods currently available via the PHOF, Kent is at similar levels to national and is currently decreasing.

3.5 Excess weight in adults is a new indicator and currently 2012 is only available. Kent is very similar to national levels and other authorities in the South East. Milton Keynes is the only authority in the South East showing worse than national at 72.5%.

3.6 The depression indicator is sourced from the Health & Social Care Information Centre (HSCIC). It measures the number of patients on the depression register against the estimated number of GP registered patients aged 18 and over. Figures for Kent have been aggregated from CCG's. In Kent for 2012/13 there were 66,089 patients on the depression register with the highest percentage occurring in Ashford CCG (7.3%).

4. Conclusions

4.1 Public Health commissioned programmes continue to be regularly evaluated in performance monitoring meetings and where concerns are identified have been escalated to the Head of Commissioning and Interim Director of Public Health

5. Recommendation(s)

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee are asked to note the current performance and actions taken by Public Health

6. Background Documents

6.1 None

7. Contact details

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Relevant Director:

- Andrew Scott-Clark: Interim Director of Public Health
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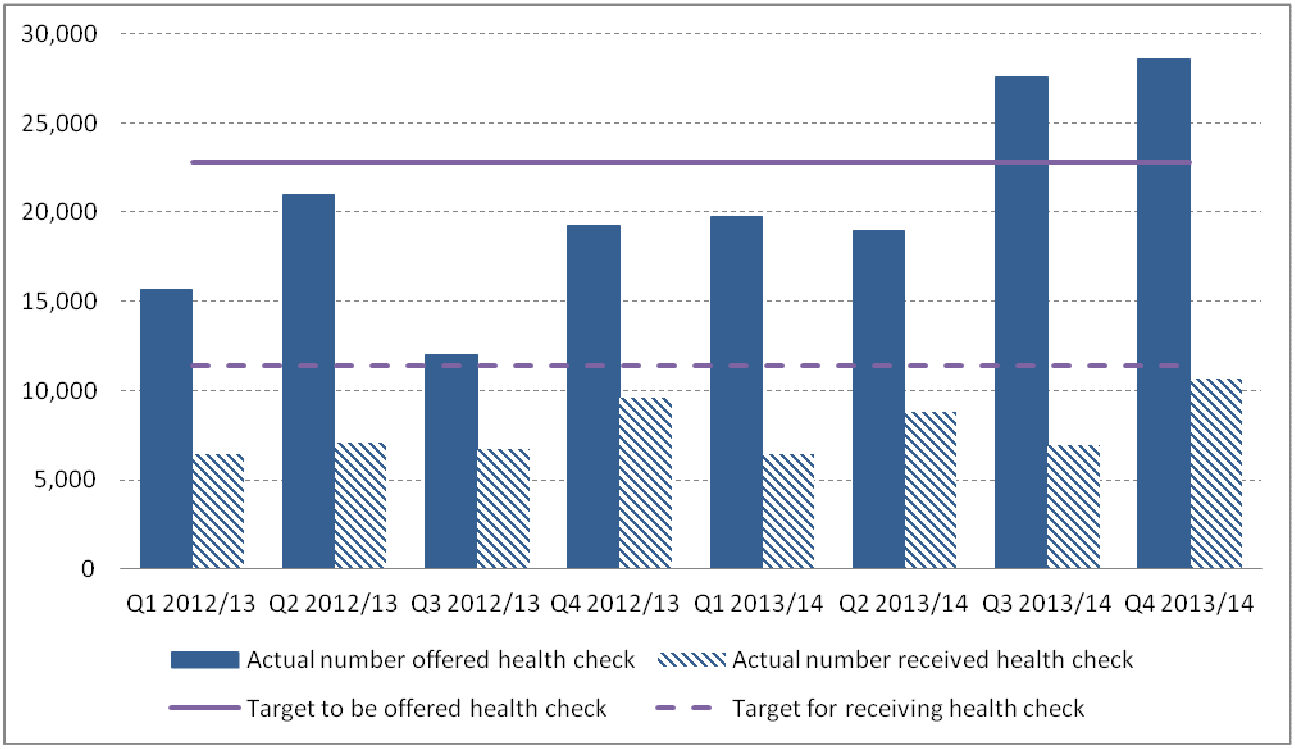
Appendix 1:
Key to KPI Ratings used:

GREEN	Target has been achieved or exceeded the current National Performance
AMBER	Performance at acceptable level or no difference to the National Performance
RED	Performance is below a pre-defined Floor Standard
⇧	Performance has improved relative to targets set
⇩	Performance has worsened relative to targets set
⇔	Performance has remained the same relative to targets set

Data quality note**:** Data included in this report is provisional and subject to later change. This data is categorised as management information.

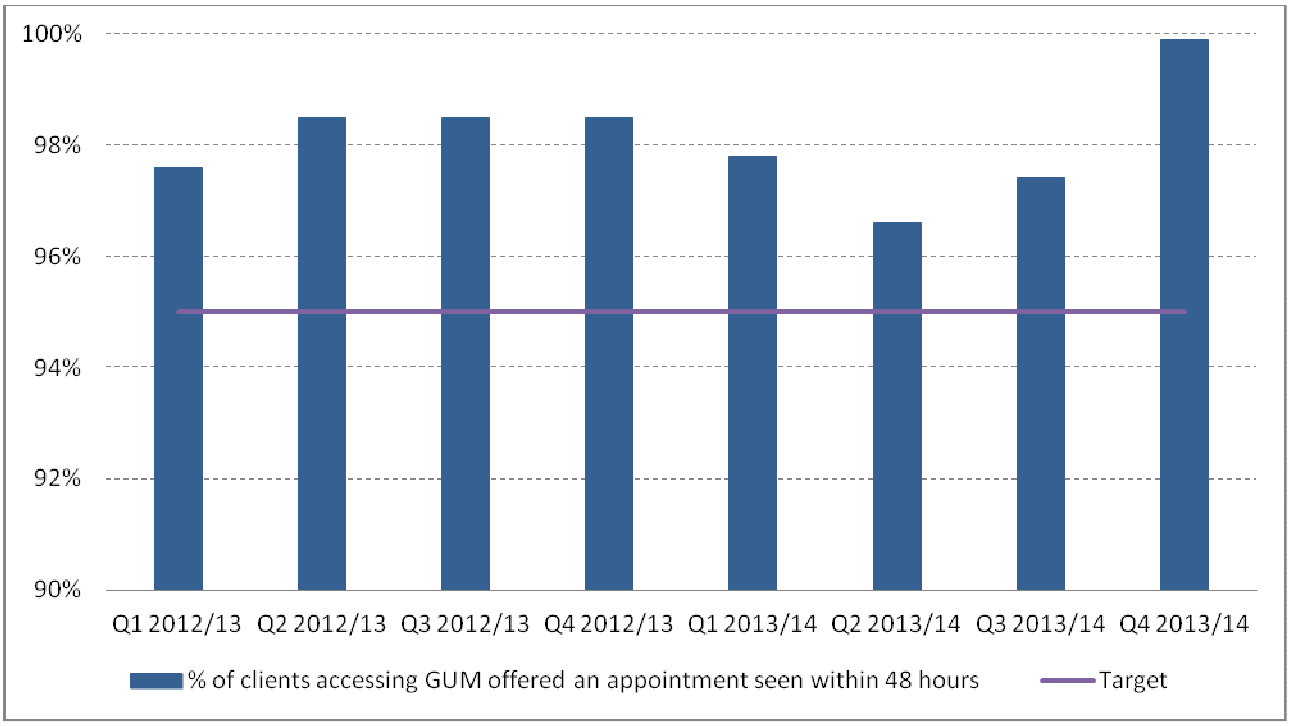
NHS Health Checks: Proportion of Target offers receiving an NHS Health Check	AMBER ⇧



Trend Data – by quarter	2012/13		2013/14				
	Q4 (Jan-Mar)	**Full 2012/13**	Q1 (Apr -Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	**Q4 (Jan-Mar)**	Full 2013/14
Target Offers	22,811	**91,241**	22,810	22,810	22,810	**22,811**	91,241
Actual offers	19,292	**67,992**	19,761	18,996	27,608	**28,639**	95,004
Target receive	11,406	**45,621**	11,405	11,405	11,405	**11,406**	45,621
Actual receive	9,569	**29,845**	6,455	8,836	6,924	**10,709**	32,924
% of target offers received	42.0%	**32.7%**	28.3%	38.7%	30.4%	**46.9%**	36.1%
RAG Rating	**Amber**	**Red**	**Red**	**Red**	**Red**	**Amber**	**Red**
National %	48.2%	**40.4%**	37.4%	45.3%	42.6%	**-**	-

Commentary
The provider of NHS Health Checks sent out the target number of invites for 2013/14, in total to just over 95,000 Kent residents. Although the target number of Kent residents to receive a health check was not met, there was an increase on the previous year with 32,924 having a NHS Health check, 10,709 of which were received in Q4. Public Health will be working this year to provide active feedback to CCGs and local Health & Wellbeing Boards on local results. Alongside this work Public Health will also be appraising future delivery options with a view to contracts being awarded in December in time for start in April 2015. The target remains to achieve 50% uptake rate this financial year. Health checks are the Public Health Outcomes Framework Indicators 2.22i and 2.22ii.
Data Notes: Higher values and percentages are better. Source: KCHT. Indicator Reference: PH/AH/01

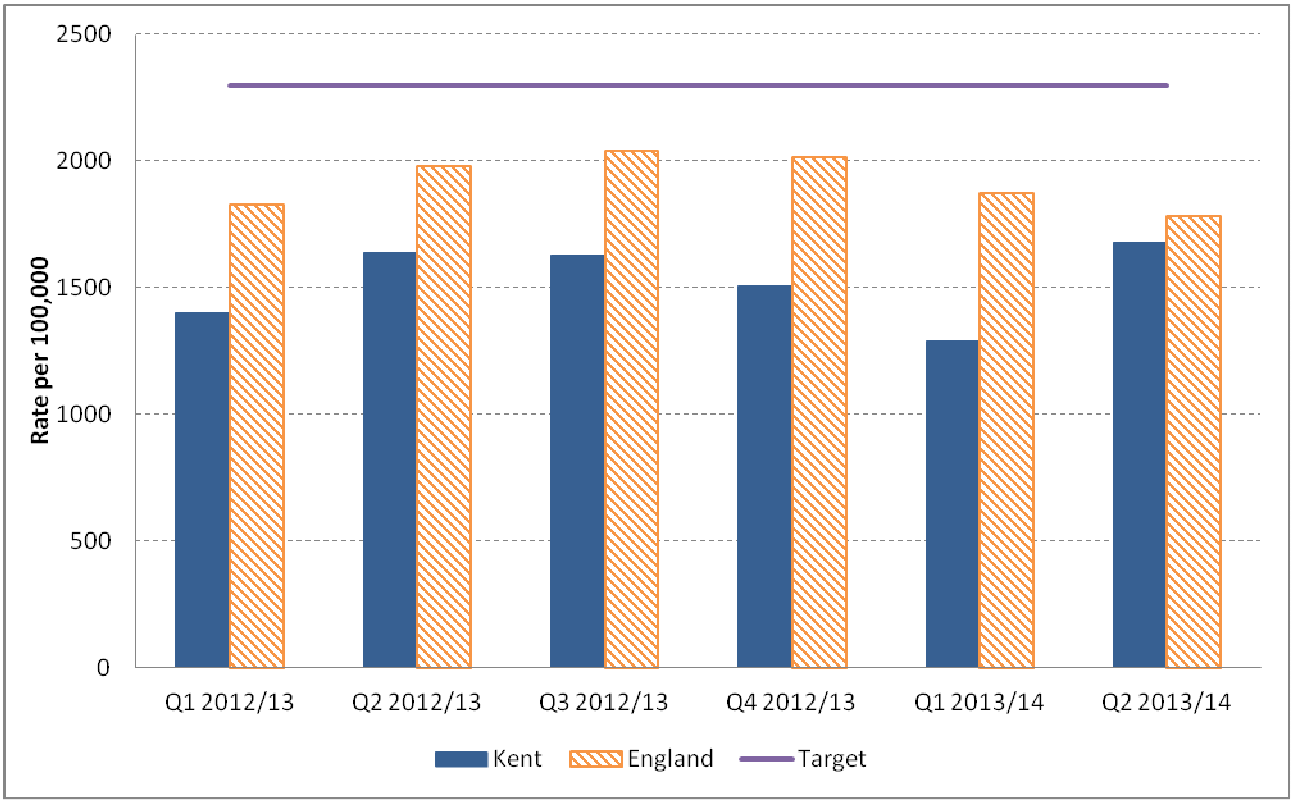
Community Sexual Health Services : Proportion of clients accessing GUM offered an appointment seen within 48 hours	GREEN ⇧



Trend Data –by Quarter	Target	2012/13		2013/14			
		Q3 (Oct-Dec)	Q4 (Jan-Mar)	Q1 (Apr -Jun)	Q2 (Jul-Sep)	Q3 (Oct-Dec)	Q4 (Jan-Mar)
% offered an appointment seen within 48 hours	95%	98.5%	98.5%	97.8%	96.6%	97.4%	99.9%
RAG Rating	-	Green	Green	Green	Green	Green	Green

Commentary
GUM (Genitourinary Medicine) clinics in Kent consistently offer the majority of clients an appointment within 48 hours, performing above the high target of 95%. Performance of this service is being monitored in quarterly performance monitoring meetings with the commissioned providers GUM figures are not reported Nationally; therefore we are unable to make comparisons.
Data Notes: Higher values are better. Data source: Provider. Indicator Reference: PH/SH/01

Community Sexual Health Services : Chlamydia screening and Positivity rate	RED ⇧



Trend Data –by Quarter	Target	2012/13				2013/14			
		Q3		Q4		Q1		Q2	
Screening Uptake	-	10,269		9,268		8,240		10,061	
Positive tests reported	7%	750	7.3%	693	7.5%	594	7.2%	772	7.7%
rate per 100,000	2,300	1,631		1,507		1,292		1,679	
RAG of Positivity Rate	-	Red		Red		Red		Red	
England rate per 100,000	2,300	2,040		2,016		1,872		1,785	

Commentary

Concerns have been identified regarding performance of this service. The provider implemented an action plan to tackle the shortfall of positivity; this included public health campaign activity, radio messaging, promotional materials and the establishment of improved and focused internal performance measures and targeting of at risk groups/communities.

The target population in Kent of people aged 15 – 24 years old is 183,899. To meet the National target of the positive rate of 2,300 per 100,000, Kent would need 4230 positive diagnoses; using the NCSP calculator tool there would need to be population coverage of 32.9% equalling 60,424 tests.

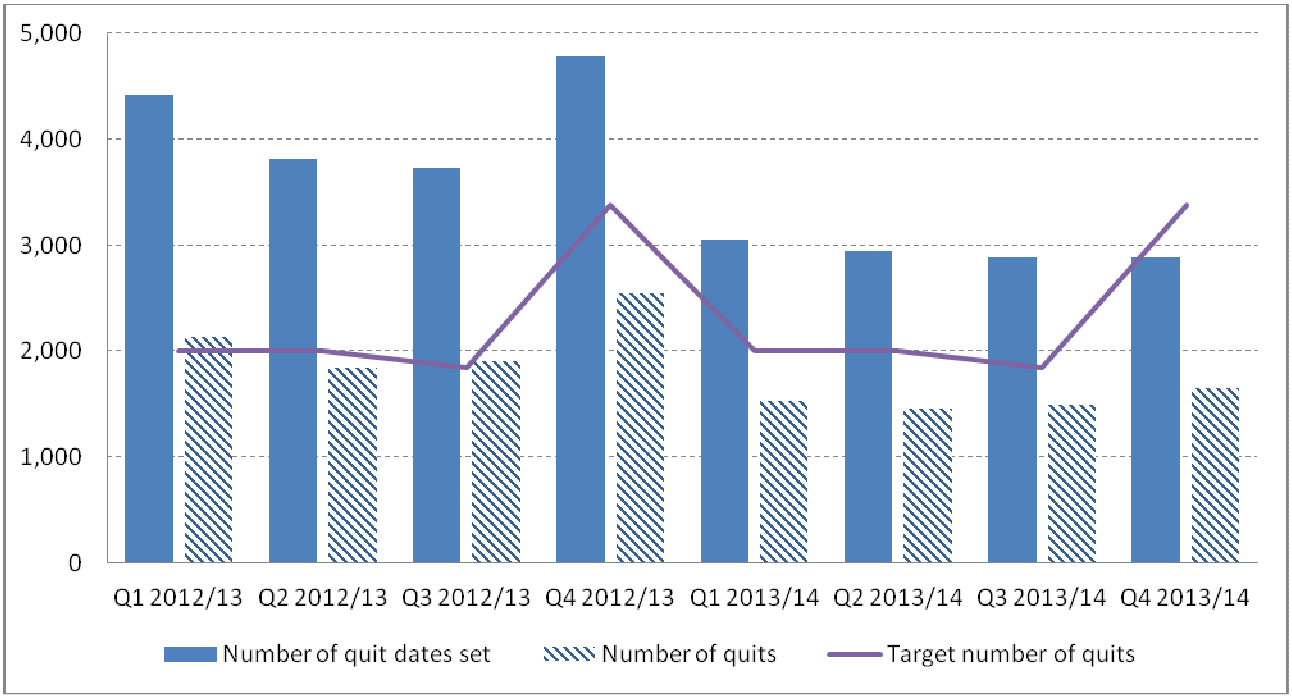
Community sexual health services are currently out for tender and new services will be place for January 2015.

Please note Quarter 1 has been amended from the previous report. Q3 figures will not be published Nationally until June alongside Q4.

Chlamydia Diagnoses is Public Health Outcome Framework Indicator 3.02

Data Notes: Higher values are better. Data Source: NCSP CTAD. Indicator Reference: PH/SH/02

Stop Smoking Services	RED ⇧



Trend Data – quarter end	Full 2012/13	2013/14				
		Q1	Q2	Q3	Q4	Full 2013/14
Number of quit dates set	**16,758**	3,055	2,947	2,882	2,885	**11,769**
Target number of quits	**9,249**	2,007	2,007	1,849	3,386	**9,249**
Number of quits	**8,412**	1,536	1,454	1,488	1,653	**6,131**
Proportion of target quitting	**90.9%**	76.5%	72.4%	80.5%	48.8%	**66.3%**
RAG Rating	**Amber**	**Red**	**Red**	**Red**	**Red**	**Red**

Commentary

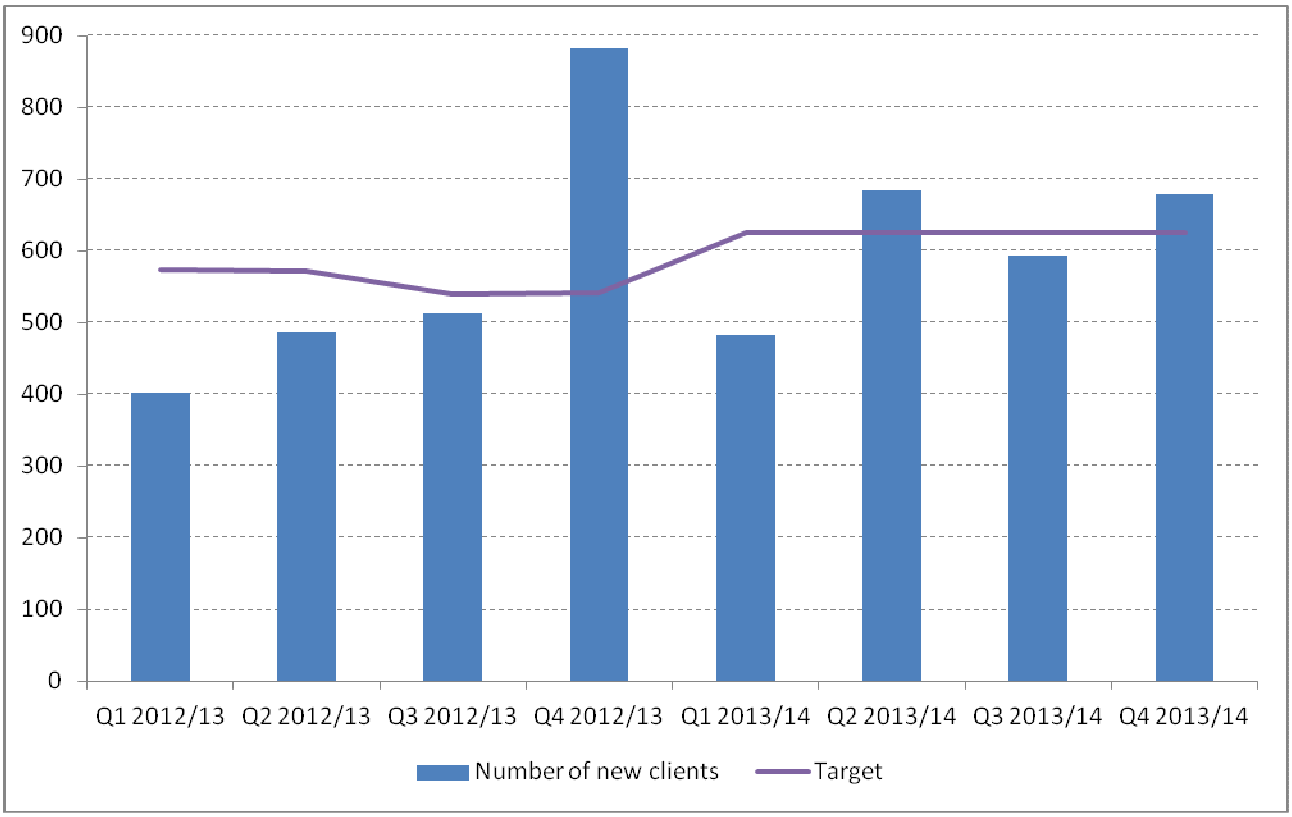
Kent Public Health has continued to monitor the poor performance of smoking cessation services in relation to the target number of quits; the provider is attending performance meetings where an action plan and proposed trajectory is monitored.

Kent Public Health is currently modelling smoking cessation service targets for 2014/15, with an emphasis at CCG level.

Please note the figure for Q1, Q2 and Q3 2013/14 have been amended following an updated Department of Health submission.

Data Notes: Data Source: Department of Health Data return by KCHT. Indicator reference: PH/AH/02

Health Trainers – proportion of new clients	GREEN ⇧



Trend Data – quarter end	2012/13				2013/14			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of new Clients	402	486	513	883	482	684	593	679
Target number of new clients	574	572	540	541	625	625	625	625
% of target	70%	85%	95%	163%	77%	109%	95%	109%
RAG Rating	Red	Amber	Amber	Green	Red	Green	Amber	Green

Commentary
The health trainer service is continuing to develop reporting mechanisms with Kent Public Health in order to become more output and outcome focussed. New performance indicators are currently being developed for 2014/15.
Data Notes: Source KCHT. Indicator Reference PH/AH/04

From: Graham Gibbens, Cabinet Member for Adult Social Care & Public Health
Andrew Ireland, Corporate Director for Social Care, Health & Wellbeing

To: **Adult Social Care & Health Cabinet Committee**

Date: **11 July 2014**

Subject: Adult Social Care Performance Dashboard for February 2014

Classification: Unrestricted

Summary: The performance dashboard provides members with progress against targets set for key performance and activity indicators for May 2014 for Adult Social Care.

Recommendation: Members are asked to REVIEW the 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. The main element of the Performance Report can be found at Appendix A, which is the Adults Social Care dashboard which includes latest available results for the key performance and activity indicators

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

5. 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

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

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

8. 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.

Recommendations

9. Members are asked to:
REVIEW performance dashboards

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Appendix A: Adult Social Care Dashboard, May 2014

Background documents: None

Adult Social Care Dashboard

May 2014

APPENDIX A

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
↓	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Adult Social Care Indicators

The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet. 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 May 2014 where possible, with a few indicators still requiring some update, with new targets and indicators being chosen.

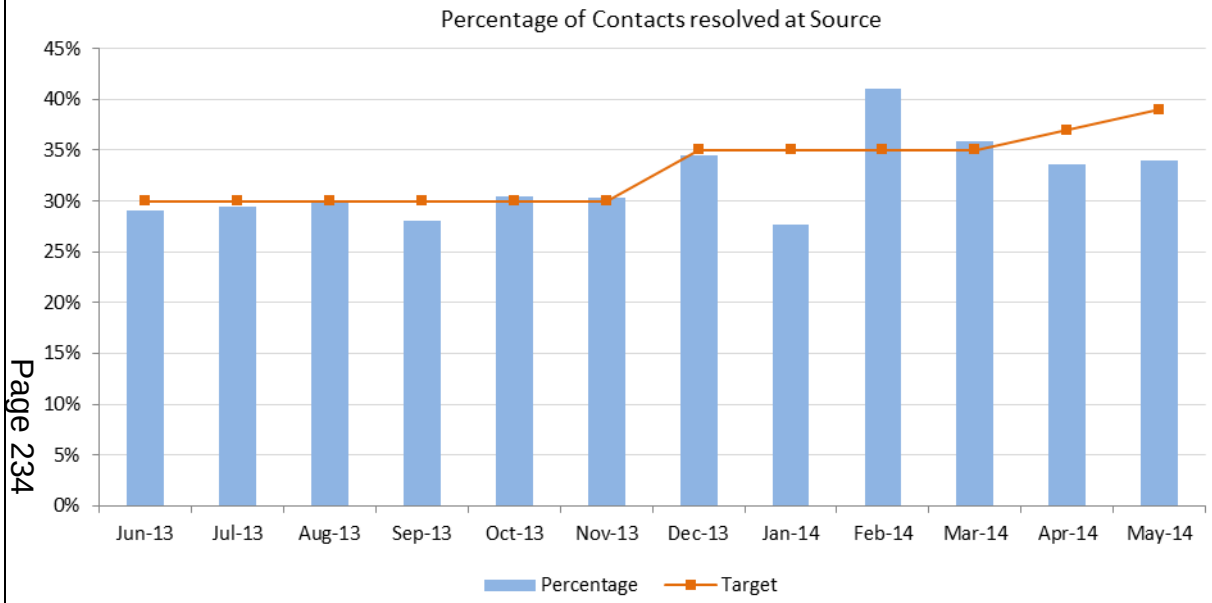
Following months will provide all information.

APPENDIX A

Indicator Description	SCHW SPS	QPR	2013-14 Outturn	Current 14-15 Target	Current Position	Data Period	RAG	Direction
1. Percentage of contacts resolved at source (ASC01)	Y	Y	35.9%	39%	**37.0%**	Month	AMBER	↑
2. Number of completed Promoting Independence Reviews		Y	350	638	**349**	Month	RED	↑
3. Number of adult social care clients receiving a Telecare service (ASC02)	Y	Y	3238	TBC	**3531**	Cumulative	GREEN	↑
4. Referrals to enablement (ASC03)	Y	Y	74%	75%	**77%**	Month	GREEN	↓
5. Delayed transfers of care			5.73	5.40	**5.63**	12M	GREEN	↓
6. Admissions to permanent residential or nursing care for people aged 65+			149	130	**98**	12M	GREEN	↑
7. Number of people aged 65+ in permanent residential care (AS01)	Y	Y	2845	2793	**2765**	Snapshot	GREEN	↑
8. Number of people aged 65+ in permanent nursing care (AS02)	Y	Y	1429	1428	**1398**	Snapshot	GREEN	↑
9. Number of people aged 65+ receiving domiciliary care (AS03)	Y	Y	5161	4977	**5133**	Snapshot	AMBER	↓
10. Number of people with a learning disability in residential care (AS04)	Y	Y	1243	1258	**1226**	Snapshot	GREEN	↑
11. Number of people with a learning disability receiving a community service			1343	1197	**1342**	Snapshot	AMBER	↓
12. Percentage of adults in contact with secondary mental health in settled accommodation			87.40%	75%	**86.90%**	Quarterly	GREEN	↑

APPENDIX A

1. Percentage of contacts resolved at source (ASC01)			AMBER ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



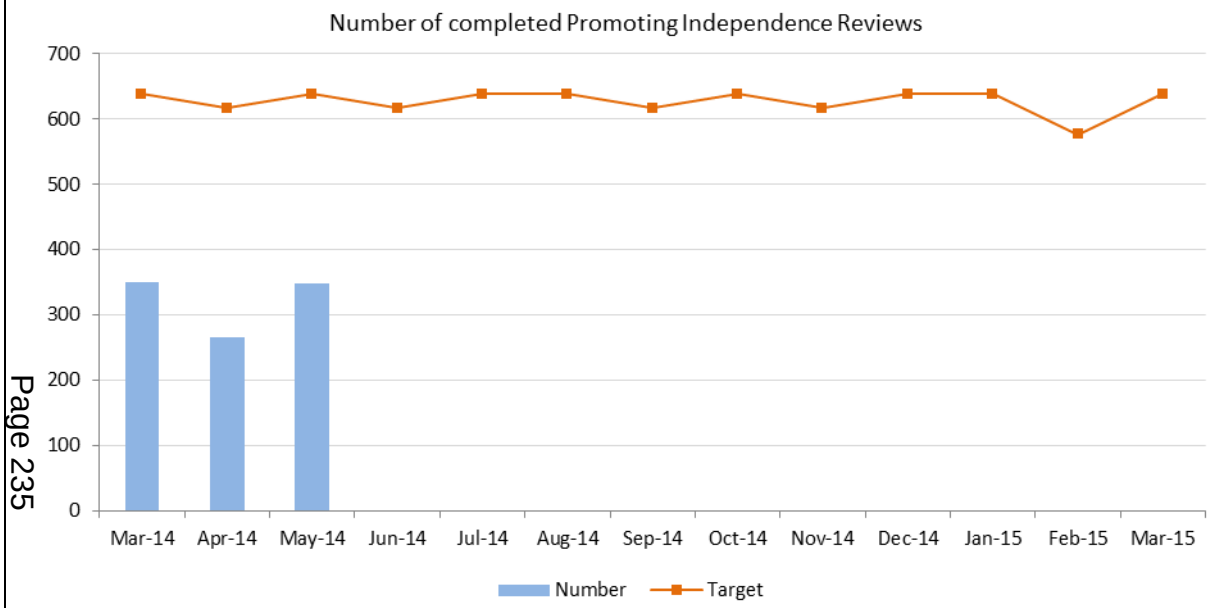
Data Notes.
Data Source: SWIFT report but this will be monitored using the Locality Referral Management Service information.

Quarterly Performance Report Indicator

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Target	**25%**	**25%**	**26%**	**28%**	**30%**	**30%**	**31%**	**33%**	**34%**	**35%**	**37%**	**39%**
Percentage	29.11%	29.50%	29.90%	28.07%	30.43%	30.28%	34.50%	27.71%	41.00%	35.90%	33.61%	34.00%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	RED	GREEN	GREEN	AMBER	AMBER

Commentary

2. Number of completed Promoting Independence Reviews			RED ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
The information collected shows the number of review completed as at Monday of every week and is presented weekly within DivMT dashboards. Due to the target for this indicator being weekly, when it is presented in a monthly format the target will vary because of the number of days in the month. If a particular week falls across two months, the number of reviews is proportionate.

Data Source: Newton Europe PIR Tracker

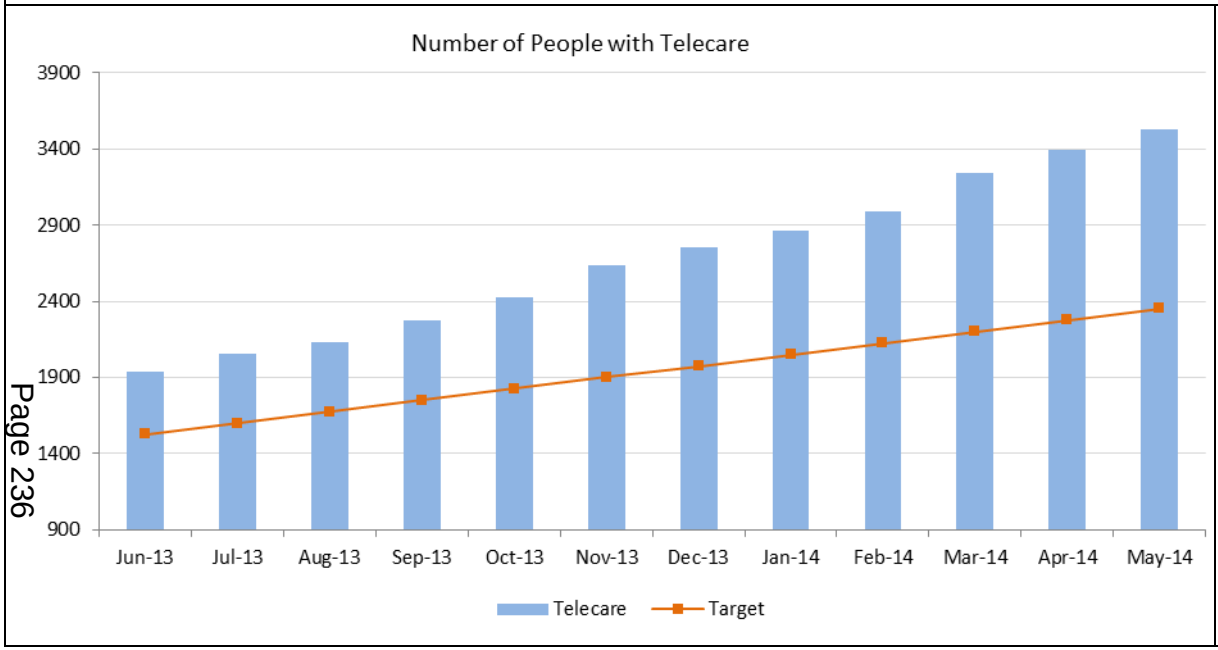
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Target	**638**	**617**	**638**									
Number	350	265	349									
RAG Rating	**RED**	**RED**	**RED**									

Commentary

This indictor is linked to the Adult Social Care Transformation Programme and to the Optimisation and Care Pathways Programme's managed by Newton Europe. The Kent target for Promoting Independence Reviews is 144 per week.

APPENDIX A

3. Number of adult social care clients receiving a Telecare service (ASC02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability/ Learning Disability and Mental Health



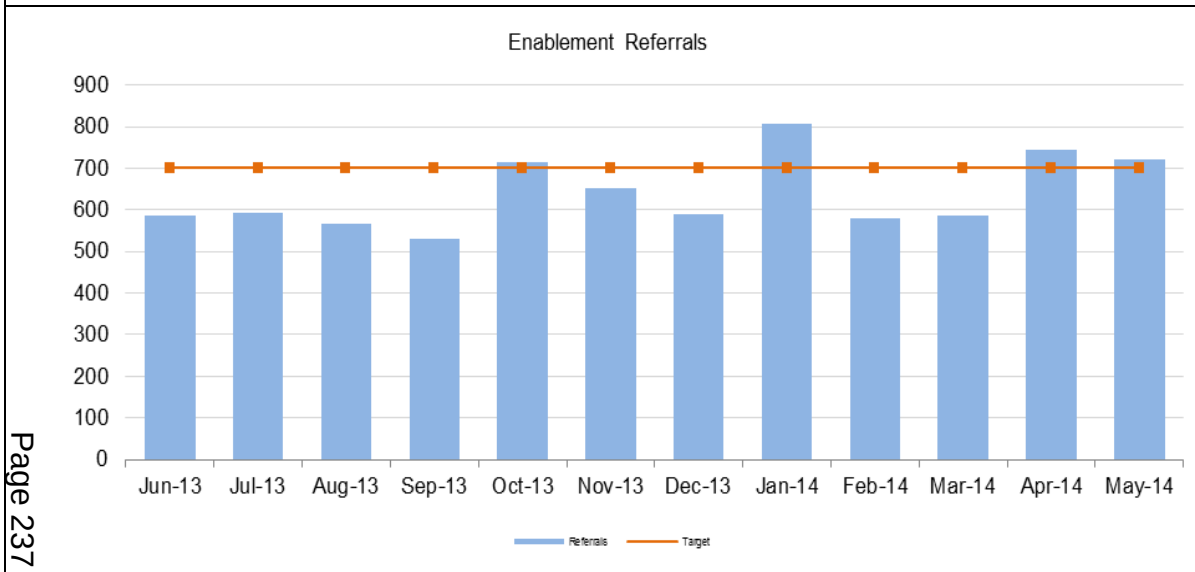
Data Notes.
Units of Measure: Snapshot of people with Telecare as at the end of each month
Data Source: Adult Social Care Swift client System

Quarterly Performance Report Indicator

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Target	**1525**	**1600**	**1675**	**1750**	**1825**	**1900**	**1975**	**2050**	**2125**	**2200**	**2275**	**2350**
Telecare	1937	2051	2130	2276	2426	2634	2754	2859	2992	3238	3392	3531
RAG rating	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**

Commentary

4. Referrals to Enablement (ASC03)			GREEN ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**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

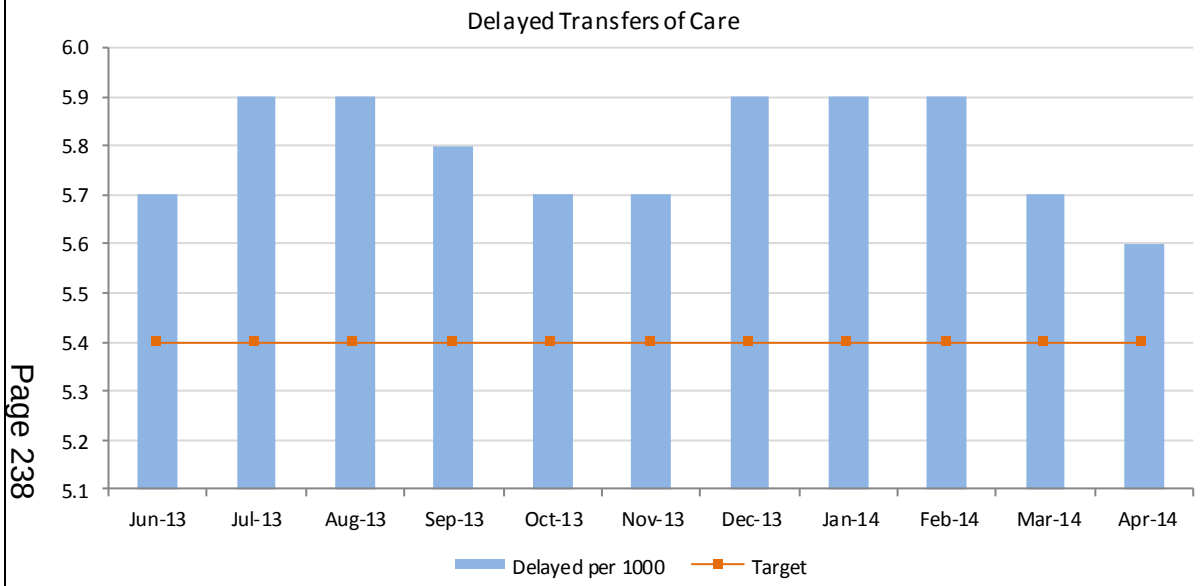
Quarterly Performance Report indicator

Trend Data	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Enablement Referrals	585	592	568	531	716	652	589	805	578	585	745	722
Target	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**
RAG Rating	RED	RED	RED	RED	GREEN	AMBER	RED	GREEN	RED	RED	GREEN	GREEN

Commentary

- **This is now being linked into the Newton Europe analysis.**
- Referrals are not has high this month as last month. A monthly KEAH report is produced that reports the details of referrals at a locality level. Part of the reporting looks at inappropriate referrals. These seem to have been stable over the last few months.

5. Delayed transfers of care			GREEN ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**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.

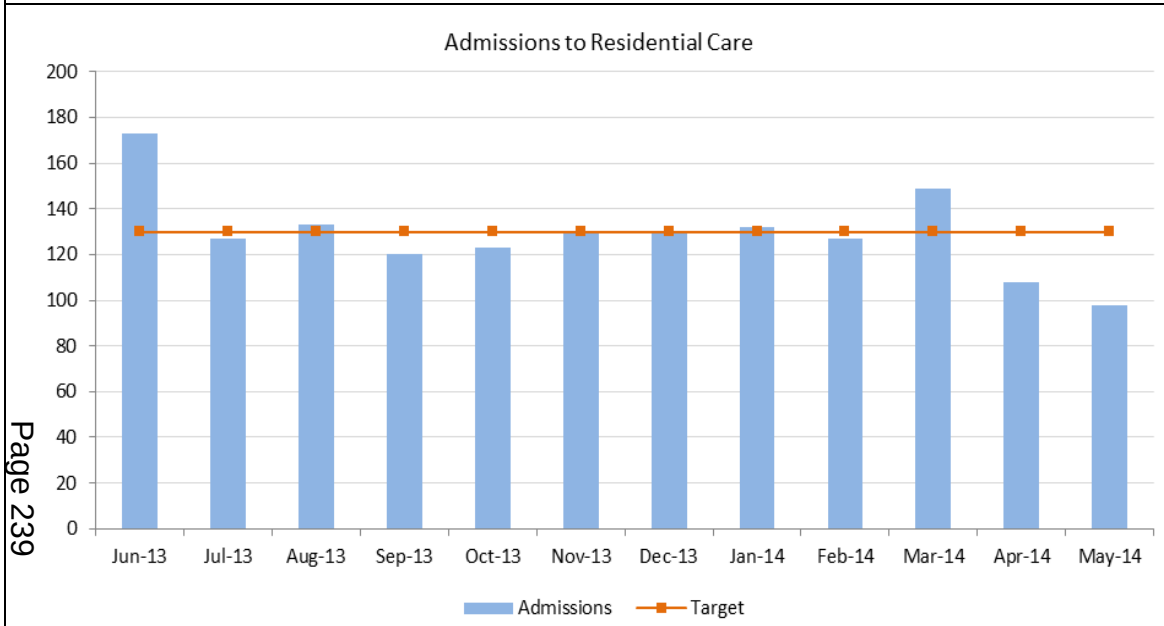
	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Target	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**
Delayed per 1000	5.7	5.9	5.9	5.8	5.7	5.7	5.9	5.9	5.9	5.7	5.6
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently about 25% delays are attributable to Adult Social Care. The top three reasons for delays includes: Waiting NHS non-acute care, patient choice and then Social care assessment.

APPENDIX A

6. Admissions to permanent residential or nursing care for people aged 65+			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: Older People placed into Permanent Residential Care per month.

Data Source: Adult Social Care Swift client System – Residential Monitoring Report

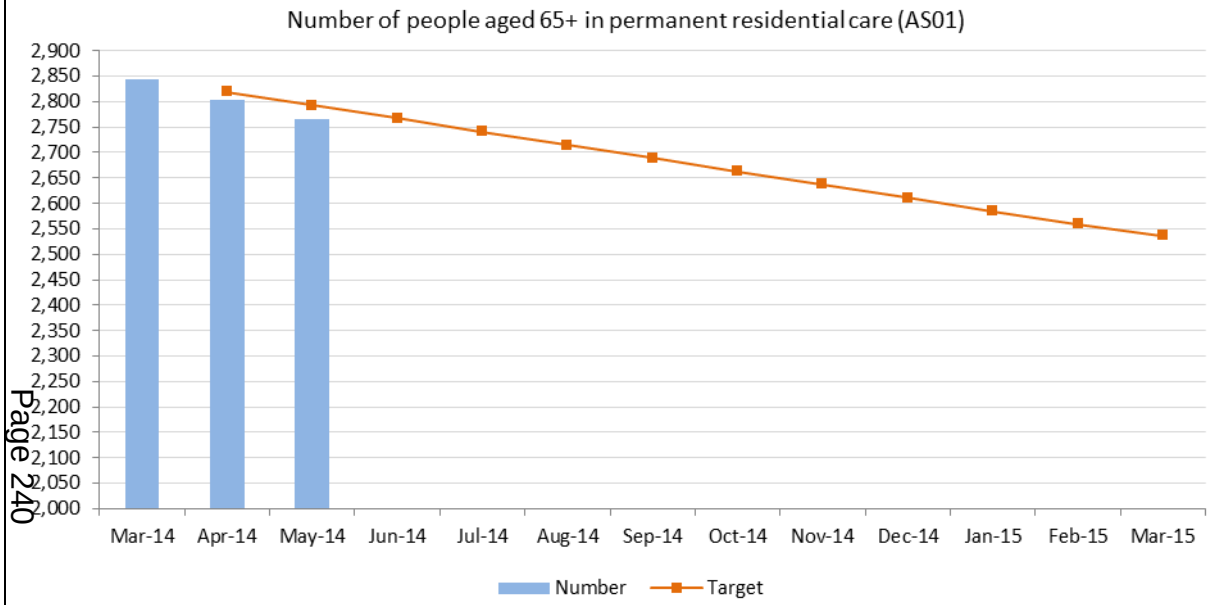
	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Target	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**	**130**
Admissions	173	127	133	120	123	129	130	132	127	149	108	98
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	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.

APPENDIX A

7. Number of people aged 65+ in permanent residential care (AS01)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

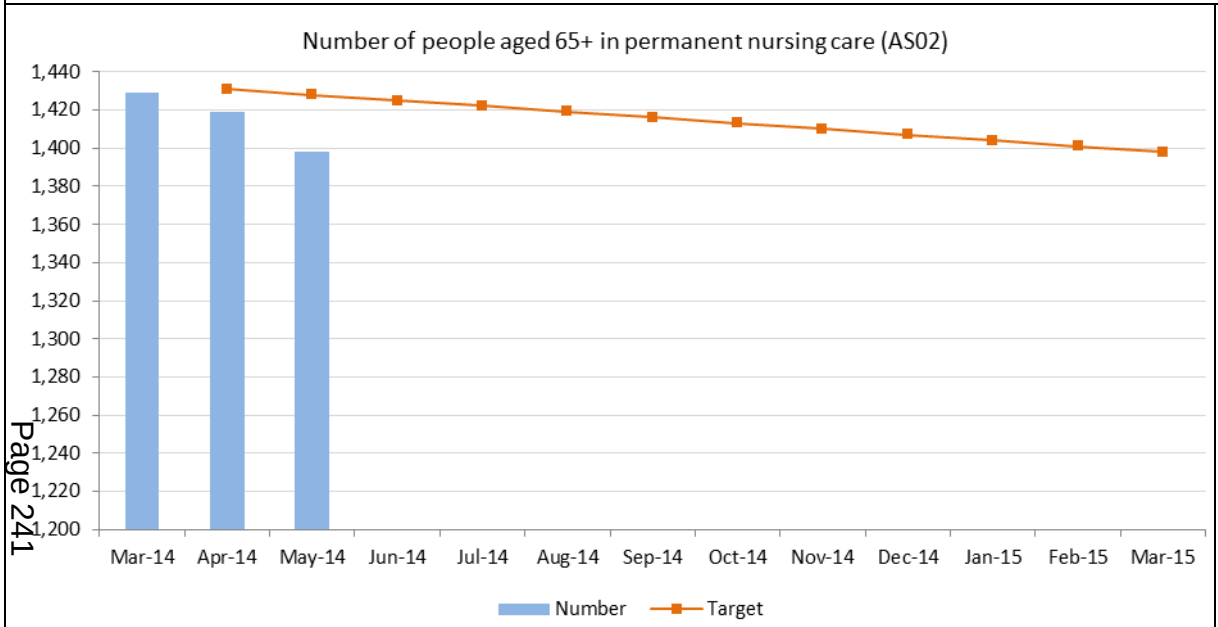
Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target		**2819**	**2793**	**2767**	**2741**	**2715**	**2689**	**2663**	**2637**	**2611**	**2585**	**2559**	**2536**
Number	2845	2803	2765										
RAG Rating		GREEN	GREEN										

Commentary

8. Number of people aged 65+ in permanent nursing care (AS02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

Data Source: MCR summary report – SWIFT

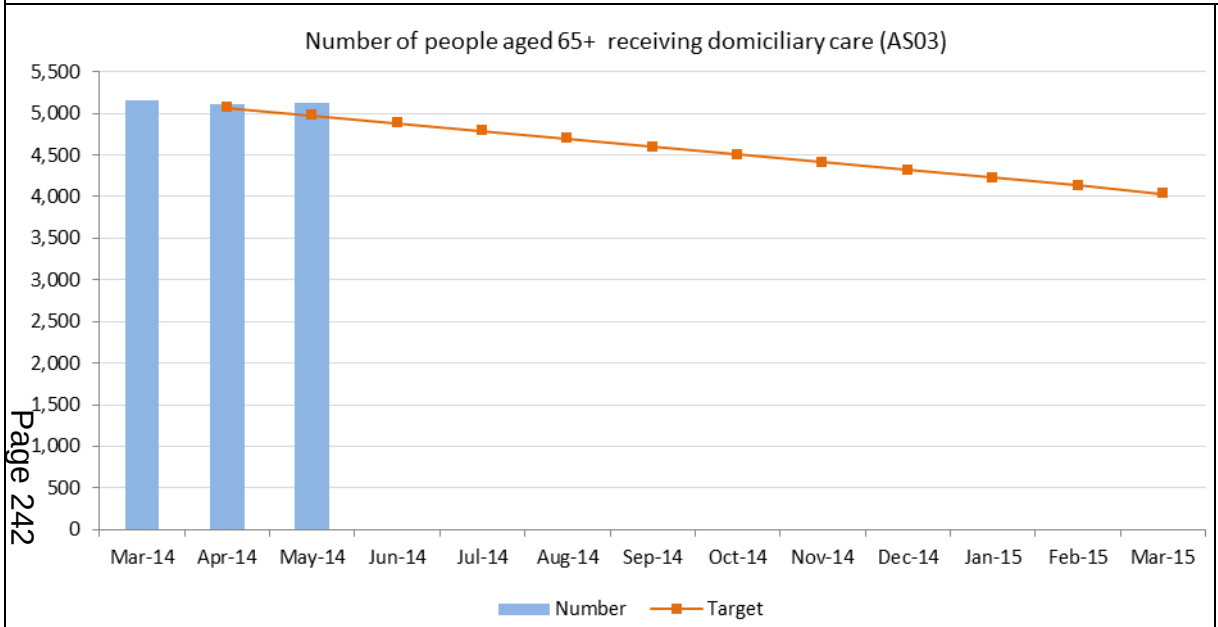
Quarterly Performance Report indicator

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target		**1431**	**1428**	**1425**	**1422**	**1419**	**1416**	**1413**	**1410**	**1407**	**1404**	**1401**	**1398**
Number	1429	1419	1398										
RAG Rating		GREEN	GREEN										

Commentary

APPENDIX A

9. Number of people aged 65+ receiving domiciliary care (AS03)			AMBER ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ receiving domiciliary care

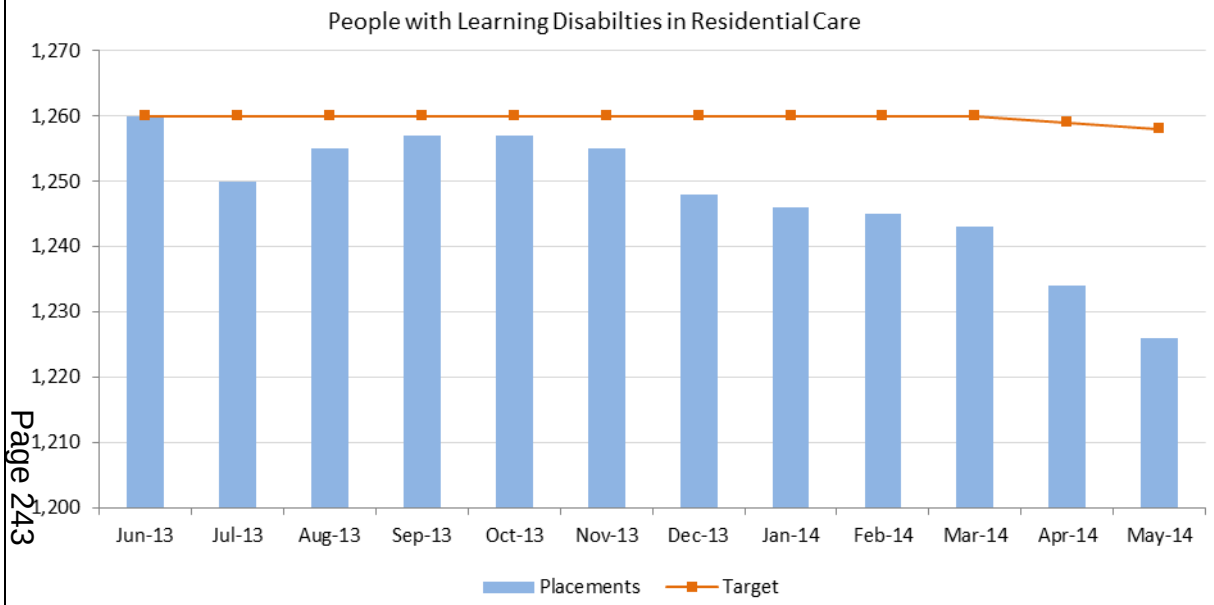
Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

Trend Data	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target		**5071**	**4977**	**4883**	**4789**	**4695**	**4601**	**4507**	**4413**	**4319**	**4225**	**4131**	**4037**
Number	5161	5112	5133										
RAG Rating		AMBER	AMBER										

Commentary

10. Number of people with a learning disability in residential care (AS04)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**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: MCR summary

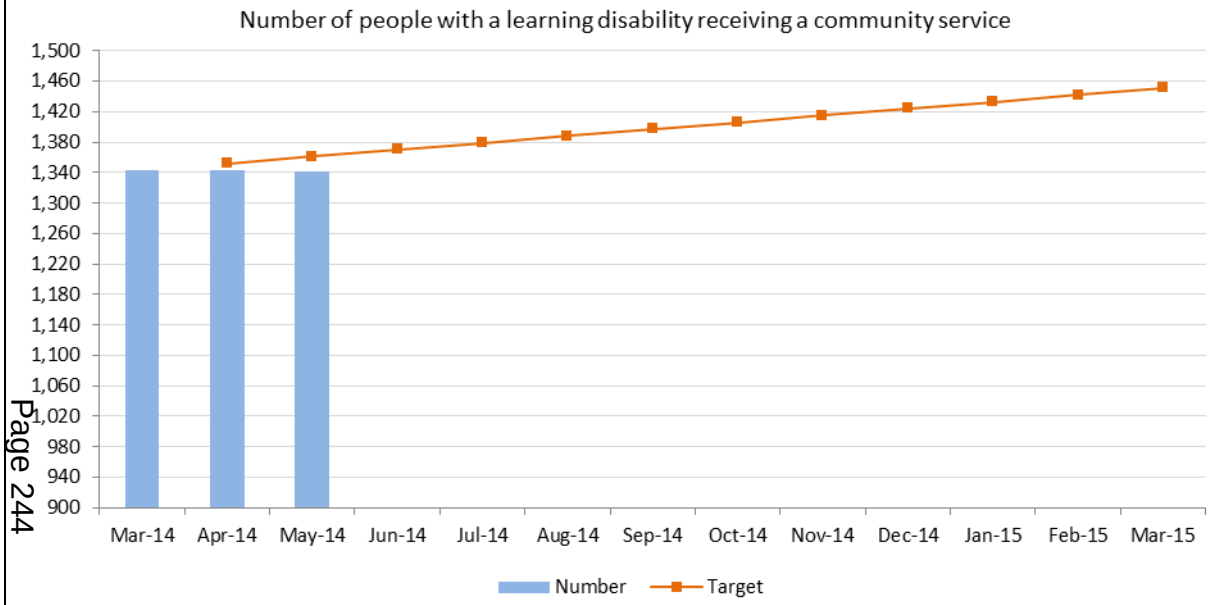
Quarterly Performance Report indicator

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Target	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1259**	**1258**
Number	1260	1250	1255	1257	1257	1255	1248	1246	1245	1243	1234	1226
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

It is a clear objective of the Directorate to ensure that as many people with a learning disability live as independently as possible. All residential placements have now been examined to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. In addition, the teams continue to work closely with the Children's team as young people coming into Adult Social Care through transition from the majority of the new residential placements.

11. Number of people with a learning disability receiving a community service			AMBER ⇩
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Learning Disability



Data Notes.

Units of Measure: Number of people with a learning disability receiving supported living, supporting independence or shared lives service as at month end.

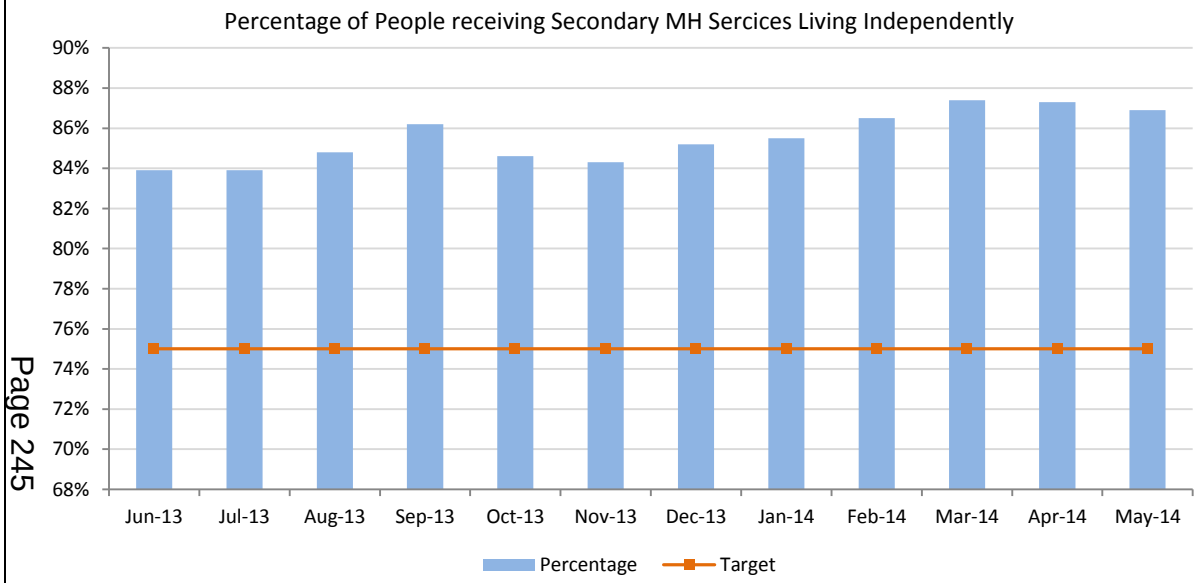
Data Source: MCR summary

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target		**1352**	**1361**	**1370**	**1379**	**1388**	**1397**	**1406**	**1415**	**1424**	**1433**	**1442**	**1451**
Number	1343	1343	1342										
RAG Rating		AMBER	AMBER										

Commentary

People receiving a direct payment are not included in this number and could be receiving a community service. As at May 2014 the number of people receiving a direct payment 1151

12. Percentage of adults in contact with secondary mental health services living independently, with or without support			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	People with Mental Health needs



Data Notes.
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Percentage	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
Target	83.90%	83.90%	84.80%	86.20%	84.60%	84.30%	85.20%	85.50%	86.50%	87.40%	87.30%	86.90%
RAG Rating	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**

Commentary

Settled accommodation "Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence." It provides an indication of the proportion of people with mental health needs who are in a stable environment, on a permanent basis.

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

Andrew Ireland, Corporate Director for Social Care, Health & Wellbeing

To: **Adult Social Care & Health Cabinet Committee**

11 July 2014

Subject: **Risk Management - Strategic Risk Register**

Classification: **Unrestricted**

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary: This paper presents the strategic risks of relevance to the Adult Social Care & Health Cabinet Committee, in addition to the risks featuring on the corporate risk register for which the Corporate Director is the designated 'risk owner'. The paper also explains the management process for review of key risks.

Recommendation(s):

The Cabinet Committee is asked to consider and comment on the risks presented.

1. Introduction

1.1 Directorate business plans (known as Strategic Priorities Statements) were reported to Cabinet Committees in March / April as part of the new business planning process introduced for 2014/15. The Strategic Priorities Statement included a high-level section relating to key directorate risks. These risks are set out in more detail in this paper.

1.2 Risk management is a key element of the Council's Internal Control Framework and the requirement to maintain risk registers ensures that potential risks that may prevent the Authority from achieving its objectives are identified and controlled. The process of developing the registers is therefore important in underpinning business planning, performance management and service procedures. Risks outlined in risk registers are taken into account in the development of the Internal Audit programme for the year.

1.3 Corporate Directors lead or coordinate mitigating actions in conjunction with other Directors across the organisation to manage risks featuring on the Corporate Risk Register. The Corporate Director for Social Care, Health and Wellbeing Directorate is the designated 'Risk Owners' for several corporate risks, which are presented to the Committee for comment in appendix 1.

1.4 Directorate risk registers are reported to Cabinet Committees annually, and contain strategic or cross-cutting risks that potentially affect several functions across the Social Care, Health and Wellbeing Directorate, and often have wider potential interdependencies with other services across the Council and external parties.

1.5 The risk levels take into account any controls already in place to mitigate the risk. If the current level of risk is deemed unacceptable, a 'target' risk level is set and further mitigating actions introduced with the aim of reducing the risk to a tolerable and realistic level. A matrix is used to rank the scale of risk in terms of likelihood of occurrence and impact

1.6 The numeric score in itself is less significant than its importance in enabling categorisation of risks and prioritisation of any management action. Further information on KCC risk management methodologies can be found in the risk management guide on the KNet intranet site.

2. Financial Implications

2.1 Many of the strategic risks have financial consequences, which highlight the importance of effective identification, assessment, evaluation and management of risk to ensure optimum value for money.

3. Strategic Priorities and Policy Framework

3.1 Risks highlighted in the risk registers relate to strategic priorities of the *Facing the Challenge* KCC transformation agenda, as well as the delivery of statutory responsibilities.

3.2 The presentation of risk registers to Cabinet Committees is a requirement of the County Council's Risk Management Policy.

4. Risks relating to the Social Care, Health & Wellbeing Directorate

4.1 There are currently 15 strategic risks featured on the Social Care, Health & Wellbeing risk register (appendix 2). The risks reflect the current challenges and the transformation and level of change taking place. All risks have mitigations and planned actions in place to manage them. Many of the risks highlighted on the register are discussed implicitly as part of regular items to Cabinet Committees.

4.2 It is likely that the risk profile will continue to evolve during the coming months as KCC's transformation agenda progresses.

4.3 Inclusion of risks on this register does not necessarily mean there is a problem. On the contrary, it can give reassurance that they have been properly identified and are being managed proactively.

4.4 The risk registers should be regarded as 'living' documents to reflect the dynamic nature of risk management. The Social Care, Health and Wellbeing Directorate Management Team formally reviews their risks, including progress against mitigating actions, on a quarterly basis, although individual risks can be identified and added to the register at any time. In addition to the Directorate wide risk register, risks are also monitored and reviewed at

Divisional Management Meetings and as part of significant Directorate programmes and projects.

5. Recommendation

Recommendation:

The Adult Social Care & Health Cabinet Committee is asked to consider and comment on the strategic and corporate risks outlined in appendices 1 and 2.

Appendices

Appendix 1 – Corporate Risk Register – SCHW Related Risks, June 2014
Appendix 2 – SCHW Risk Register, June 2014

6. Background Documents

6.1 KCC Risk Management Policy on KNet intranet site.

7. Contact details

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Relevant Director:

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Appendix 1

KCC Corporate Risk Register

SOCIAL CARE HEALTH & WELLBEING DIRECTORATE RELATED RISKS

SOCIAL CARE HEALTH & WELLBEING Corporate Risks
Summary Risk Profile

Low = 1-6	Medium = 8-15	High =16-25

Risk No.*	Risk Title	Current Risk Rating	Target Risk Rating
CRR 2	Safeguarding	15	10
CRR 9	Better Care Fund (Health & Social Care)	12	8
CRR 10(a)	Management of Adult Social Care Demand	20	12
CRR 10(b)	Management of Demand – Specialist Children's Services	20	12
CRR 12	Welfare Reform changes	12	9
CRR 19	Implications of the Care Act 2014	15	6

*Each risk is allocated a unique code, which is retained even if a risk is transferred off the Corporate Register. Therefore there will be some 'gaps' between risk IDs.

NB: Current & Target risk ratings: The 'current' risk rating refers to the current level of risk taking into account any mitigating controls already in place. The 'target residual' rating represents what is deemed to be a realistic level of risk to be achieved once any additional actions have been put in place. On some occasions the aim will be to contain risk at current level.

Likelihood & Impact Scales					
Likelihood	Very Unlikely (1)	Unlikely (2)	Possible (3)	Likely (4)	Very Likely (5)
Impact	Minor (1)	Moderate (2)	Significant (3)	Serious (4)	Major (5)

Risk ID	CRR2	Risk Title	Safeguarding			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
The Council must fulfil its statutory obligations to effectively safeguard vulnerable adults and children.	Insufficiently robust management grip, performance management or quality assurance. Its ability to fulfil this obligation could be affected by the adequacy of its controls, management and operational practices or if demand for its services exceeded its capacity and capability. Insufficient rigor in maintaining threshold application/inconsistency. Increase in referrals and service demand resulting in unmanageable caseloads/ workloads for social workers. Decline in performance and effective service delivery leading to critical inspection findings and reputational damage	Serious impact on vulnerable people. Serious impact on ability to recruit the quality of staff critical to service delivery. Serious operational and financial consequences. Attract possible intervention from a national regulator for failure to discharge corporate and executive responsibilities. Incident of serious harm or death of a vulnerable adult or child.	Corporate Director SCHWB **Responsible Cabinet Member(s):** Specialist Children's Services Adult Social Care & Public Health	Possible (3) **Target Residual Likelihood** Unlikely (2)	Major (5) **Target Residual Impact** Major (5)

Control Title	**Control Owner**
Consistent scrutiny and performance monitoring through Divisional Management Team, District 'Deep Dives' and audit activity	Corporate Director SCHWB
Independent scrutiny by Kent Safeguarding Children Board	
Manageable caseloads per social worker and robust caseload monitoring	Director Specialist Children's Services
Significant ongoing work to increase rigour and managerial grip in Duty and Initial Assessment Teams	Director Specialist Children's Services

Central Duty Service & Central Referral Unit now in place to ensure increase in consistency and threshold application.	Corporate Director SCHWB
SCHWB management team monitors social work vacancies and agrees strategies for urgent situations.	Corporate Director SCHWB
Active strategy in place to attract and recruit social workers through a variety of routes with particular emphasis on experienced social workers. Detailed programme of training.	Director Specialist Children's Services / Corporate Director Human Resources
CMT, SCHWB Directorate Management Team and the Cabinet Member for Adult Social Care & Public Health and Specialist Children's Services receive quarterly safeguarding performance reports.	Corporate Director SCHWB
Programme of internal and external audits for adult safeguarding case files with regards to SCHWB and Kent & Medway Partnership Trust (KMPT) in place. Peer reviews of safeguarding arrangements conducted by Essex County Council.	Corporate Director SCHWB
Performance management of safeguarding is part of the Improvement Plan in place between KCC (SCHWB directorate) and KMPT.	Director Learning Disability & Mental Health
SCHWB Strategic Adults Safeguarding Board provides a strategic countywide overview of adult safeguarding within SCHWB and monitors progress towards the SCHWB Strategic Adult Safeguarding action plan.	Corporate Director SCHWB
Safeguarding Vulnerable Adults (SGVA) coordinators work closely with Contracting colleagues where there are safeguarding concerns in the independent sector using 'Quality in care' framework.	Corporate Director SCHWB
Regular monitoring of SCHWB safeguarding action plan by the SCHWB Strategic Adults Safeguarding Board. Ongoing monitoring of KMPT safeguarding action plan.	Director Commissioning
SGVA Co-ordinator meetings take place on a monthly basis. These meetings are an opportunity to share best practice and raise ongoing issues. The work plan for the group continues to be monitored.	Director Commissioning
Exercise to map levels of safeguarding training completed by staff in the independent sector conducted. Providers signposted to where they can access information about safeguarding training.	Director Commissioning
Practice Development Programme in place to strengthen practice across Children and Families Team.	Director Specialist Children's Services
Long-term vision for Children's Services in KCC established.	Corporate Director SCHWB
Children's Quality Assurance Framework in place.	Director Specialist Children's Services
Ofsted action plans monitored at bi-monthly Kent Corporate Parenting Group (KCPG)/Corporate Parenting Panel (CPP) meetings	Director Specialist Children's Services

Action Title	**Action Owner**	**Planned Completion Date**
Continued work to strengthen delivery of early help, intervention and	Director Commissioning	April 2014 (review)

prevention services. Services being commissioned to phased timetable according to Commissioning and Procurement Plan Supplier Framework.		
Ongoing development of further strategies and campaigns to support recruitment so that we attract and retain high calibre social workers and managers. Use of competent agency social workers and managers on temporary basis to fill vacancies.	Corporate Director SCHWB / Corporate Director Human Resources	April 2014 (review)
A structured mechanism for feeding back lessons learnt from assessment, regulation and inspection needs to be implemented.	Director Specialist Children's Services	April 2014 (review)
Feed any outstanding work actions from the Ofsted Action Plans/ Children's (social care) Transformation programme (which combines continued improvement with efficiency) into business as usual.	Director Specialist Children's Services	September 2014
Implementation of transformation programme for children's services, including Social Work Contract Programme.	Director Specialist Children's Services	September 2014 (review)

Risk ID CRR9	Risk Title	Better Care Fund (Health & Social Care Integration)				
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**	
The Health & Social Care Act came into effect in April 2013 giving KCC, as an upper tier Authority, a new duty to take appropriate steps to improve and protect the health of the local population. The Government's spending review in June 2013 announced an Integration Transformation Fund (now relabeled Better Care Fund), which provides an opportunity to create a shared plan for health & social care activity and expenditure. The plan for 2015/16 needs to start in 2014 and form part of a five-year strategy for health & social care. A fully integrated service calls for a step change in current arrangements to share information, staff, money and risk. There are a number of national conditions attached to the Fund.	Service delivery requirements suffer during the major integration programme. Failure to maximise opportunities presented for health & social care integration, and ensure changes achieve maximum impact. Governance arrangements for pooled budgets unclear.	Ineffective health and social care provision for citizens of Kent. Business Continuity issues due to delay in the development and management of essential new complex partnerships between KCC and the NHS.	Corporate Director SCHWB **Responsible Cabinet Member(s):** Education & Health Reform Adult Social Care & Public Health	Possible (3) **Target Residual Likelihood** Unlikely (2)	Serious (4) **Target Residual Impact** Serious (4)	

Control Title	Control Owner
KCC has designated Cabinet Portfolio Holders for Public Health and Health Reform, who have assumed central roles at strategic level	Leader of the Council
Quality and Safety Assurance Framework drafted for Public Health	Director Public Health
Health & Wellbeing Board and CCG-level Health & Wellbeing Board sub-committees established	Cabinet Member for Education & Health Reform
Health Protection Committee established with Directors of Public Health in Kent & Medway as Chairs	Director Public Health

Joint Commissioning Board Strategy & Commissioning plans established with Clinical Commissioning Groups	Director Commissioning
Public Health Steering Group established	Director Public Health
Agreement for Communications support in the event of a public health emergency	Head of External Communications
Kent chosen as one of 14 pioneers of health & social care integration in the UK	Corporate Director SCHWB (KCC lead)
Integration Pioneer Steering Group established as an informal group of the Health & Wellbeing Board to provide strategic direction and oversee successful delivery of health & social care in Kent	Director Older People & Physical Disability (KCC lead)
Shared Clinical Commissioning Group and KC integrated health and social care commissioning plan approved	Corporate Director SCHWB

Action Title	**Action Owner**	**Planned Completion Date**
Alignment of the Adult Social Care Transformation Programme with Commissioning plans of Clinical Commissioning Groups (CCGs)	Corporate Director SCHWB Director Older People & Physical Disability	July 2014 (review)
Engage and work with the Kent CCGs on both adult and children's health services	Corporate Director SCHWB	July 2014 (review)
Clarify governance arrangements for pooled budgets with Clinical Commissioning Groups via the Health & Wellbeing Board	Corporate Director SCHWB (KCC lead)	August 2014
KCC/CCG stakeholder event to be held	Corporate Director SCHWB (KCC lead)	July 2014
Further integrated plan update to be submitted to the September Health and Wellbeing Board	Corporate Director SCHWB	September 2014

Risk ID CRR10(a)	Risk Title	Management of Adult Social Care Demand			
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Adult social care services across the country are facing growing pressures. Overall demand for adult social care services in Kent continues to increase due to factors such as increasing numbers of young adults with long-term complex care needs and Ordinary Residence issues. This is all to be managed against a backdrop of reductions in Government funding, implications arising from the implementation of the Care Bill, a recent Supreme Court ruling that may lead to increases in Deprivation of Liberty Assessments and longer term demographic pressures.	Council is unable to manage and resource to future demand and its services consequently do not meet future statutory obligations and/or customer expectations.	Customer dissatisfaction with service provision. Increased and unplanned pressure on resources. Decline in performance. Legal challenge resulting in adverse reputational damage to the Council. Financial pressures on other council services.	Corporate Director SCHWB **Responsible Cabinet Member(s):** Adult Social Care & Public Health	Likely (4) **Target Residual Likelihood** Possible (3)	Major (5) **Target Residual Impact** Serious (4)

Control Title	Control Owner
Analysis and refreshing of forecasts to maintain the level of understanding which feeds into the relevant areas of the MTFP and the business planning process	Corporate Director SCHWB / Director Commissioning
Implementation of Adults Transformation partnership programme underway including: Care Pathways, Commissioning & Procurement and Optimisation	Director Commissioning/Director Older People & Physical Disability/Director Learning Disability & Mental Health
Monitoring, vigilance and challenge regarding the placement of Adults into Kent by other local authorities.	Director Commissioning
Lobby the Treasury to investigate Ordinary Residence matters in more detail as a national funding issue.	Corporate Director Finance & Procurement
Legal Services are engaged where required to support KCC when challenging other Authorities to accept Ordinary Residence re: responsibilities	Director Learning Disability & Mental Health
Benefits of enablement support to existing and potential service users, their families and key partners being marketed. Work is linked into the Adult Transformation Programme and ensure there is sufficient capacity in the market to provide	Director Commissioning

Enablement Services	
Joint commissioning of services with health, in particular for people with dementia, long term conditions and for carers (links to Better Care Fund – see Risk CRR9).	Director Commissioning Director Older People & Physical Disability
Utilise opportunities to make contracting and procurement controls drive value for money further	Director Commissioning
Develop better understanding of demand profile and respond as early as possible to have the greatest impact on demand management	Director Commissioning
Continued drive to maximise the use of Telecare as part of the mainstream community care services	Director Older People & Physical Disability and Director Learning Disability and Mental Health
Maintain the use of appropriate tools to obtain value for money in relation to the commissioning of expensive specialist residential accommodation	Director Commissioning
Health & Social Care Integration Programme in place with a strategic objective of proactively tackling demand for health & social care services	Director Older People & Physical Disability
Risk stratification tools devised. Now being used by GP's	Director Older People & Physical Disability
Briefings being provided in relation to key elements of the Care Bill and their potential implications for KCC	Strategic Business Advisor, SCHWB
Care Bill Preparation Programme established as part of the Adults Transformation Change Portfolio to ensure implementation of Care Bill	Strategic Business Advisor, SCHWB
Twice-yearly Adults Transformation progress updates reported to Cabinet Committee	Director Commissioning
Continued support for investment in preventative services through voluntary sector partners	Director Commissioning
Briefings on implications of Supreme Court ruling relating to Deprivation of Liberty Assessments issued	Corporate Director SCHWB

Action Title	**Action Owner**	**Planned Completion Date**
Public Health & Social Care to ensure effective provision of information, advice and guidance to all potential and existing service users, and to promote self management to reduce dependency	Director Public Health / Director Older People and Physical Disability Services	July 2014 (review)
Tracking and monitoring impact of delivery of Adult Social Care Transformation Programme	Corporate Director SCHWB	September 2014 (review)
Detailed Care Bill Programme plan to be completed for approval by the Adults Transformation Board	Strategic Business Advisor, SCHWB	June 2014

Initial analysis being conducted to identify likely extent of demand for Deprivation of Liberty Assessments	Director	Commissioning	June 2014

Risk ID CRR10(b)	Risk Title	Management of Demand – Specialist Children's Services			
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Local Authorities continue to face increasing demand for specialist children's services due to a variety of factors, including consequences of highly publicised child protection incidents and serious case reviews, and policy/legislative changes. At a local level KCC is faced with additional demand challenges such as those associated with significant numbers of Unaccompanied Asylum Seeking Children (UASC) There are also particular 'pressure points' in several districts. These challenges need to be met as specialist children's services face increasingly difficult financial circumstances and operational challenges such as recruitment and retention of permanent qualified social workers.	High volumes of work flow into specialist children's services leading to unsustainable pressure being exerted on the service.	Additional financial pressures placed on other parts of the Authority at a time of severely diminishing resources. Children's services performance declines as demands become unmanageable. Failure to deliver statutory obligations and duties or achieve social value. Ultimately an impact on outcomes for children, young people and their families.	Corporate Director SCHWB Corporate Director EYPS **Responsible Cabinet Member(s):** Specialist Children's Services	Likely (4) **Target Residual Likelihood** Possible (3)	Major (5) **Target Residual Impact** Serious (4)

Control Title	Control Owner
Analysis and refreshing of forecasts to maintain the level of understanding which feeds into the relevant areas of the MTFP and the business planning process	Corporate Director SCHWB / Director Commissioning
Kent Integrated Adolescent Support Service (KIASS) aims to reduce demands by enabling swift access to specific additional and early help, particularly for the most disadvantaged and vulnerable young people, to meet their needs quickly and flexibly.	Corporate Director Education and Young People Services
Plans developed to appropriately manage the number of children in care	Director Specialist Children's Services
Intensive focus on ensuring early help to reduce the need for specialist children's support services.	Corporate Director EYPS / Corporate Director SCHWB
Utilise opportunities to make contracting and procurement controls drive value for money further	Director Commissioning
Continued support for investment in preventative services through voluntary sector partners	Director Commissioning

Maintain the use of appropriate tools to obtain value for money in relation to the commissioning of expensive specialist residential and independent fostering accommodation	Director Commissioning	
Action Title	**Action Owner**	**Planned Completion Date**
Ensure the appropriate number of looked after children in care (subject to continual monitoring) including ensuring appropriate thresholds for intervention	Director Specialist Children's Services	September 2014 (review)
Ensure that children in care receive appropriate levels of support and services through effective multi-agency intervention that is responsive to their needs.	Director Specialist Children's Services	July 2014 (review)
Implement a programme of work to deliver integrated, early help and prevention service for the 0-19s and their families that is streamlined, responsive and effective in terms of reducing demand for acute services and managing need at the appropriate level/tier of support.	Corporate Directors SCHWB and EYPS	September 2014 (review)
Diagnostic work for children's services being conducted with aid of efficiency partner	Director Specialist Children's Services	August 2014 (review)

Risk ID CRR 12	Risk Title	Welfare Reform changes			
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
The Welfare Reform Act 2012 put into law many of the proposals set out in the 2010 white paper *Universal Credit: Welfare that Works*. It aims to bring about a major overhaul of the benefits system and the transference of significant centralised responsibilities to local authorities. KCC needs to be prepared to manage the uncertain affects and outcomes that the changes may have on the people of Kent.	The impact of the reforms in regions outside of Kent could trigger the influx of significant numbers of 'Welfare' dependent peoples to Kent. Failure to plan appropriately to deal with potential consequences. The financial models and budgets and funding sources underpinning the new schemes prove to be inadequate and allocation of payments and grants has to become prioritised against more challenging criteria.	Failure to meet statutory obligations. Ineffective delivery of schemes and operations to customers compounds demand on KCC and partner services. An increase in households falling below poverty thresholds with vulnerable people becoming exposed to greater risk. New schemes and operations are undermined by a negative impact on Kent's demographic profile. Insufficient employment to meet additional demand and to fill the publics' 'funding gap' places additional challenges for adult and child safeguarding and demand for social support. Increasing deprivation leads to increase in social unrest and criminal activity.	Corporate Director SCHWB **Responsible Cabinet Member(s):** Adult Social Care & Public Health	Possible (3) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Significant (3)

Control Title	Control Owner
Welfare Reform sub-group of Kent Chief Execs Group in place	
Regular reporting to Corporate Board and Policy & Resources Cabinet Committee	Head of Policy & Strategic Relationships
Key work streams and outputs to prepare for changes identified and detailed in a Welfare Reform Implementation,	Head of Policy & Strategic

Response and Monitoring Plan	Relationships / Head of Business Intelligence
Ongoing analysis of impacts conducted by Policy & Strategic Relationships and Business Intelligence teams plus external partners to give an indication of scale of implications of reforms. Mechanism developed to track benefit migration into Kent.	Head of Business Intelligence / Head of Policy & Strategic Relationships
Six-monthly in-depth research updates produced to aid monitoring of potential impacts	Head of Policy & Strategic Relationships & Head of Business Intelligence
Briefings given to Managers and staff in SCHWB directorate to raise awareness of potential implications of changes	Policy Manager, Strategic & Corporate Services & Benefits Manager, Finance
Council Tax Benefit Localisation scheme in place	Head of Financial Strategy
Kent Support and Assistance Service pilot scheme operating	Cabinet Member Adult Social Care & Public Health
Contacts established with other Local Authorities and interested partners to share intelligence	Research & Evaluation Manager

Action Title	**Action Owner**	**Planned Completion Date**
Universal Credit – Local Support Service Framework (LSSF) Continue work with DWP to establish local delivery aspects in terms of face-to-face support	Head of Customer Contact	September 2014 (review)
Close monitoring of demand and performance of Kent Support and Assistance Service (localised social fund) to inform planning of future programme	Director Commissioning SCHWB	May 2014(review)

Risk ID CRR 19	Risk Title	Implications of the Care Act 2014				
Source / Cause of risk		**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
The Care Act 2014 establishes a new legal framework for care and support services. The new law marks the biggest change to care and support law in England since 1948. The changes will have significant implications for Kent residents and Kent County Council, in terms of both opportunities and risks.		Costs of implementation may not be fully funded. The effect of the changes in law on the existing cost differential between the Local Authority and a self-funder may erode. Significant increase in people coming forward for care and financial assessments. The public may not understand the reforms. Appropriate systems enhancement may not be completed within 2016 timescales	Additional financial pressure Increase in demand for services in addition to existing demand pressures (see CRR 10a risk) Confusion and dissatisfaction of residents and potential service users	Corporate Director Social Care Health & Wellbeing **Responsible Cabinet Member(s):** Adult Social Care and Public Health	Possible (3) **Target Residual Likelihood** Unlikely (2)	Major (5) **Target Residual Impact** Significant (3)
Control Title					**Control Owner**	
Care Act Programme established to ensure KCC is well placed to deliver its new responsibilities and that Kent residents who need social care, their carers and local providers are able to take advantage of the developments coming. Programme Board contains representatives from across KCC and efficiency partner.					Corporate Director Social Care Health & Wellbeing (SCHWB)	
Adults Transformation Board to oversee the Care Act Programme, setting direction, approving decisions and ensuring successful implementation					Corporate Director SCHWB	
Care Act Programme is part of the wider Adults Transformation Change Portfolio to ensure appropriate linkages with other programmes in the portfolio, ensuring that they are "Care Act proof".					Corporate Director SCHWB	
Regular briefings for elected Members and other stakeholders being held					Care Act Policy Lead Manager	
Action Title			**Action Owner**		**Planned Completion Date**	
Outline Programme Plan in place including a number of projects:						
Costs modelling – to ensure that KCC has a full understanding of the total costs involved in implementing the Care Act			Finance Business Partner / Principal Accountant (Projects)		September 2014	

Communications – to provide clear and accurate communication to inform the public, service staff and providers about forthcoming changes	Communications Account Manager, Social Care	October 2014 (review)
Workforce capacity, planning and training – ensuring the necessary capacity and that all relevant staff receive appropriate training prior to implementation	Professional Development Advisor, Social Care	January 2015
Commissioning – ensuring that duties regarding preventative services, information & advice, independent advocacy, the facilitation of independent financial advice and oversight of care markets are implemented	Head of Commissioning (Community Support) / Head of Commissioning (Accommodation solutions)	January 2015
Financial assessment and charging – to address the changes in assessment, including the residential means-test threshold, and changes to charging, including the extension of powers to charge	Assessment & Income Client Services Manager	November 2014
Safeguarding – to address safeguarding aspects of the Care Act, including making arrangements for the Adult Safeguarding Board	Head of Adult Safeguarding	November 2014
IT and information systems – to provide effective and timely changes to IT and finance systems	ICT Applications Team Manager	July 2014 (review)
Detailed programme plan to be submitted to Adults Transformation Board	Care Act Programme Manager	July 2014

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APPENDIX 2

Social Care Health & Wellbeing Directorate Risk Register

JUNE 2014

Social Care Health & Wellbeing Directorate
Summary Risk Profile

Low = 1-6	Medium = 8-15	High =16-25

Risk No.*	Risk Title	Current Risk Rating	Target Risk Rating
SCHWB 01	Transformation of adult social care services	16	9
SCHWB 02	Transformation of children's services	9	6
SCHWB 03	Safeguarding – Protecting vulnerable children and adults	16	9
SCHWB 04	Austerity and pressures on public sector funding	25	16
SCHWB 05	Health and social care integration Pioneer and BCF	12	6
SCHWB 06	Health and Social Care Act 2012	12	9
SCHWB 07	Increasing demand for social care services	20	16
SCHWB 08	Managing and working within the social care market	12	9
SCHWB 09	Information technology	16	6
SCHWB 10	Information governance	9	6
SCHWB 11	Business disruption	9	9
SCHWB 12	KCC KMPT partnership agreement	9	6
SCHWB 13	Preparation for legislative change	15	6
SCHWB 14	Organisational change	12	12
SCHWB 15	MCA and Deprivation of Liberty assessments	16	8

*Each risk is allocated a unique code, which is retained even if a risk is transferred off the Corporate Register. Therefore there will be some 'gaps' between risk IDs.

NB: Current & Target risk ratings: The 'current' risk rating refers to the current level of risk taking into account any mitigating controls already in place. The 'target residual' rating represents what is deemed to be a realistic level of risk to be achieved once any additional actions have been put in place. On some occasions the aim will be to contain risk at current level.

Likelihood & Impact Scales					
Likelihood	Very Unlikely (1)	Unlikely (2)	Possible (3)	Likely (4)	Very Likely (5)

Impact	Minor (1)	Moderate (2)	Significant (3)	Serious (4)	Major (5)

Risk ID: SCHW 01	**Risk Title:**	**Transformation of adult social care services**			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Transformation of adult social care services.	The transformation programme is being implemented in adult social care. Adopting new ways of working and implementing a programme of significant change is not without risk. Significant savings need to be made and carrying out the transformation is a demand on resources. If the transformation programme does not meet targets then this will lead to further pressures on the service and on budgets.	If the transformation programme does not meet targets this will lead to significant pressures on the service and on the directorate and local authority budgets. How the phases of the Transformation Programme are managed and implemented is crucial as it will have a major impact on the service.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning	Likely (4) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Significant (3)

Control Title	**Control Owner**
A Transformation Board is established with agreed Governance arrangements including links with DMT/Div MTs and the Corporate Facing the Challenge/Transformation Programme.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Oversight and monitoring by Programme Board, Budget Board and Cabinet.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Separate risk register and issues log	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Support of Efficiency partner with diagnostics and implementation.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/

	Mark Lobban, Director Commissioning
Transformation Programme in place with links and interdependencies with the KCC Transformation /Facing the Challenge Programme.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning

Action Title	**Action Owner**	**Planned Completion Date**
Ensure effective two way communication re the Transformation Programme. Need to ensure staff are informed and there is "ownership" of the message. A 6 weekly communication bulletin is produced and disseminated.	Mark Lobban, Director Commissioning	01/10/2014
Communicate the revised Transformation blueprint	Mark Lobban, Director Commissioning	01/07/2014
On-going work with an Efficiency Partner	Mark Lobban, Director Commissioning	01/10/2014
Implementation and roll-out phase of Transformation: Optimisation, Care Pathways, Commissioning. Roll out of "Sandbox" methodology.	Anne Tidmarsh, Director Older People and Disability	01/10/2014
Manage the interdependencies and relationship between transformation and other Corporate/Directorate programmes e.g. new ways of working and boundaries re-alignment	Mark Lobban, Director Commissioning	01/10/2014
Working with Newton Europe on the design of Phase 2	Mark Lobban, Director Commissioning	31/03/2015

Risk ID: SCHW 02	Risk Title:	Transformation of children's services			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Transformation of children's services	SCS transformation to make continuous improvements to services for vulnerable children and young people in Kent	Failing to transform and continuously improve services adversely impact on vulnerable children and young people	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mairead MacNeil, Director Specialist Children's Services	Possible (3) **Target Residual Likelihood** Unlikely (2)	Significant (3) **Target Residual Impact** Significant (3)

Control Title	**Control Owner**
Performance framework, operational framework, quality assurance framework.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services
Practice Development Programme rolled out including masterclasses/training. Programme being evaluated.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services
Robust performance monitoring	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services
Children's Transformation is part of the over-arching cross-directorate 0-25 Portfolio. Children's Transformation is underpinned by the Social Work Contract, and all activity is robustly monitored via SCS Div Mt and the Children's Transformation Board. The Social Work contract is being implemented via a "workforce optimisation" workstream of children's transformation.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services

Action Title	**Action Owner**	**Planned Completion Date**
Rolling programme of audits of services	Mairead MacNeil, Director Specialist Children's Services	01/10/2014
Recruitment to permanent Social work and Management vacancies. New website produced, recruitment events.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014

Needs to be clear links between Transformation and Prevention. Support of Newton-Europe as an Efficiency Partner.	Mairead MacNeil, Director Specialist Children's Services	01/10/2014

Risk ID: SCHW 03	Risk Title: Safeguarding – Protecting vulnerable children and adults				
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Safeguarding – Protecting vulnerable children and adults	The council must fulfil its statutory obligations to effectively safeguard vulnerable children and adults.	Its ability to fulfil this obligation could be affected by the adequacy of its controls, management and operational practices or if demand for its services exceeds its capacity and capability.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning Mairead MacNeil, Director Specialist Children's Services Anne Tidmarsh, Director Older People and Disability Penny Southern, Director Learning Disability and Mental Health	Likely (4) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Significant (3)

Control Title	**Control Owner**
Deep dives for constructive challenge by Senior Managers of front line services. More Deep dives planned.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing
Extensive Staff Training. In SCS a Capability Framework to be launched with a Safeguarding element.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist

	Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Multi-agency public protection arrangements	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
OPPD Safeguarding Improvement Plans in place	Anne Tidmarsh, Director Older People and Disability
Quarterly reporting to Directors and Cabinet Members and Annual Report for Members	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Safeguarding Boards in place for children's and for adult social care services, providing a strategic countywide overview across agencies.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Consistent scrutiny and performance monitoring through Divisional Management Teams, Deep Dives and audit activity	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban,

	Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Children's Transformation Plan in SCS part of the wider 0 to 25 Portfolio.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services
In Kent a joint Kent Winterbourne Steering Group has been established to learn the lessons from Winterbourne. The Steering group has established its own risk register and action plan.	Penny Southern, Director Learning Disability and Mental Health

Action Title	**Action Owner**	**Planned Completion Date**
Audit feedback sessions	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Cross-County file audits	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Implement the outcomes of the internal audit report (adult services). Has been through the assurance processes and actions to be included in the Safeguarding Action Plans.	Mark Lobban, Director Commissioning	01/09/2014
Practice development programme to strengthen practice across children and families. Delivery of Phase 4 Improvement Plan Actions.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Active recruitment programme in place to attract and retain high calibre social workers and managers	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Ongoing provision of safeguarding training for the relevant staff.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Transformation in SCS to get the business processes right to assist practitioners.	Mairead MacNeil, Director Specialist Children's Services	01/10/2014

Risk ID: SCHW 04	Risk Title: Austerity and pressures on public sector funding				
Source / Cause of Risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Austerity and pressures on public sector funding impacting on capital and revenue budgets.	Public sector finance pressures and the need to achieve significant efficiencies for foreseeable future impacting on capital and revenue budgets. Partner organisations and private sector providers also experiencing funding challenges potentially putting joint working at risk. Increased stress on some families due to financial pressures.	Major funding pressures impact on the delivery of social care services. The capital strategy putting specific projects at risk.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Michele Goldsmith, Finance Business Partner	Very Likely (5) **Target Residual Likelihood** Likely (4)	Major (5) **Target Residual Impact** Serious (4)

Control Title	Control Owner
More efficient use of assistive technology	Mark Lobban, Director Commissioning/Penny Southern, Director Learning Disability and Mental Health/Anne Tidmarsh, Director Older People and Disability
Robust debt monitoring	Michele Goldsmith, Finance Business Partner/Andrew Ireland, Corporate Director, Social Care Health & Wellbeing
Robust financial and activity monitoring regularly reported to DMT and budget reporting within the DIv MTs	Michele Goldsmith, Finance Business Partner/Andrew Ireland, Corporate Director, Social Care Health & Wellbeing
Children's Transformation Board has been given a wider scope /TOR to include improvement of Business as usual functions. To manage budget reductions including care cost reduction and placement reconfiguration and improve business processes.	Mairead MacNeil, Director Specialist Children's Services
Strategic Priority Plans in place for 2014/15 and divisional plans to be produced.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing

Transformation programme to ensure efficiencies and the best use of available resources.	Michele Goldsmith, Finance Business Partner/Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/Penny Southern, Director Learning Disability and Mental Health/Anne Tidmarsh, Director Older People and Disability

Action Title	Action Owner	Planned Completion Date
Building community capacity. In LD services the GDP programme moving from segregated facilities to inclusive settings with partners.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Business Plans for specific LD capital projects to demonstrate the efficiencies and value.	Penny Southern, Director Learning Disability and Mental Health	01/09/2014
Continue to work innovatively with partners, including health services, to identify any efficiencies.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Continued drive to deliver efficient and effective services through transformation and modernisation agenda.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Developing robust commissioning arrangements. Manage /shape the social care market.	Mark Lobban, Director Commissioning	01/10/2014
Development of appropriate incentives within the commissioning framework	Mark Lobban, Director Commissioning	01/10/2014
Focus on prevention, enablement and independence for vulnerable adults.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	01/10/2014
Continue to review and ensure value for money from residential and IFA placements.	Mark Lobban, Director Commissioning	01/10/2014
SCS Transformation Board to continue to manage budget reductions including care cost reduction and placement reconfiguration. Improve business processes	Mairead MacNeil, Director Specialist Children's Services	01/10/2014

Risk ID: SCHW 05	Risk Title: Health and Social Care integration Pioneer and BCF				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Health and social care integration	Strategic developments and changing processes to develop integrated services will have a significant impact on ways of working	This is a major strategic development that will impact on ways of working and the delivery of services	Anne Tidmarsh, Director Older People and Disability	Likely (4)	Significant (3)
				Target Residual Likelihood	**Target Residual Impact**
				Possible (3)	Moderate (2)

Control Title	Control Owner
The Better Care Fund will help the integration programme and the development of joined up working and commissioning.	Anne Tidmarsh, Director Older People and Disability
Kent is one of the 14 Integrated Health Pioneers. This is giving renewed impetus to the integration programme in Kent. An Integration Pioneer Steering Group is in place.	Anne Tidmarsh, Director Older People and Disability
Local Better Care Fund delivery groups in place covering the CCG areas. Locality action plans in place.	Anne Tidmarsh, Director Older People and Disability
Project management arrangements in place with a Programme Plan and local action plans based on the the Programme Plan.	Anne Tidmarsh, Director Older People and Disability
Reporting and inputting to Transformation Board but also to Health and Well Being Boards, and CCG based programme boards for BCF delivery programmes.	Anne Tidmarsh, Director Older People and Disability

Action Title	Action Owner	Planned Completion Date
Developing integrated performance measures and monitoring	Anne Tidmarsh, Director Older People and Disability	01/10/2014
Local BCF delivery groups working on local action plans.	Anne Tidmarsh, Director Older People and Disability	01/10/2014
The Better Care Fund plan has been produced and agreed by the Health and Wellbeing Board and submitted to NHS England. A further update required by the Health and Wellbeing Board for September 2014.	Jo Frazer, Programme Manager	30/09/2014
Working towards greater Connectivity of information systems via a shared Care plan.	Anne Tidmarsh, Director Older People and Disability	01/10/2014
Work closely with the CCGs to focus on long term conditions to improve people's ability to self care.	Anne Tidmarsh, Director Older People and Disability	01/10/2014
Kent has Pioneer Status for Health and Social Care Integration. This will widen the	Anne Tidmarsh, Director Older	01/10/2014

integration programme to include commissioning and provision. Further work to be done to develop and take forward the integration programme and wider Pioneer work.	People and Disability

Risk ID: SCHW 06	Risk Title: Health and Social Care Act 2012				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Health and Social Care Act 2012	New working arrangements and health architecture following the Health and Social Care Act.	Significant implications for the future delivery and provision of social care and health. Emergence of Clinical Commissioning Groups and the transfer of public health functions to Local authorities requires building new relationships and working arrangements. Could be increased diversity of practices to reflect the CCG areas. Possible implications for Section 75 agreements. Risks of potential cost shunting.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning Mairead MacNeil, Director Specialist Children's Services Anne Tidmarsh, Director Older People and Disability Penny Southern, Director Learning Disability and Mental Health	Likely (4) **Target Residual Likelihood** Possible (3)	Significant (3) **Target Residual Impact** Significant (3)

Control Title	**Control Owner**
Existing partnership working with Health which is leading to shared improvements.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability

Effective joint initiatives in place with Health.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
JSNA to support health and social care commissioning	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Close working at leadership level seeking to build a shared transformation plan. Health and Well Being Board in place. FSC Directors meet with the CCG Accountable Officers.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Maintain close links with commissioners to ensure application of continuing health care and Section 117 arrangements.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability

Ensure adherence to CHC framework. Monitor joint working arrangements.		Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Restructure of OPPD boundaries and restructure of teams in progress.		Anne Tidmarsh, Director Older People and Disability
Ensure Section 75 agreements are monitored in new arrangements.		Mark Lobban, Director Commissioning/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Action Title	**Action Owner**	**Planned Completion Date**
Alignment of the commissioning plans for SC and Clinical Commissioning Groups. Use of the Health and Well Being Strategy.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Continued joint working with Health through the changes to the health architecture. Working with the CCGs and other health providers.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
OPPD boundary realignment work taking place on phased basis to align boundaries with CCGs.	Anne Tidmarsh, Director Older People and Disability	1.10.2014
Work in progress to complete a new Section 75 agreement with the CCGs for a Section 75 Agreement to include Personal Health Budgets.	Anne Tidmarsh, Director Older People and Disability	1.10.2014
Strategic approach to the development of Kent Health Watch.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014

Risk ID: SCHW 07	Risk Title: Increasing demand for social care services				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Risk that demand will outstrip available resources.	Risk that demand will outstrip available resources. Fulfilling statutory obligations and duties becomes increasingly difficult against rising expectations. Increased demand due to: - demographic changes in population i.e. more people living longer, more people with dementia and an increase in clients with complex needs. Austerity potentially leads to more stress, family breakdown and need for support from specialist children's services. More reliance on informal carers leads to strain on families and individuals.	Austerity potentially leads to more stress, family breakdown and need for support from specialist children's services. More reliance on informal carers leads to strain on families and individuals	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning Anne Tidmarsh, Director Older People and Disability Penny Southern, Director Learning Disability and Mental Health	V Likely (5) **Target Residual Likelihood** Likely (4)	Serious (4) **Target Residual Impact** Serious (4)

Control Title	Control Owner
Continue to explore roles and functions	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Contracting and Procurement controls	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People

	and Disability
Core monitoring in place for Members	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Early intervention and Preventative services aimed at reducing demand. Promoting independence through for example: enablement, fast track minor equipment, short term care with step down and step up support.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ / Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability. Patrick Leeson Corporate Director EYS.
Joint planning and commissioning with partners	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Modernisation of older peoples and learning disability services	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability

Continued representation to central government and other agencies regarding the disproportionate number of people in need across the age ranges (children and adults) being placed by other local authorities into Kent.		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mairead MacNeil, Director Specialist Children's Services/ Penny Southern, Director Learning Disability and Mental Health
Robust reporting and analysis to DMT and Business Planning		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Implementation of Adults Transformation Programme underway including: Care Pathways, Commissioning and Procurement and Optimisation.		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning/ Penny Southern, Director Learning Disability and Mental Health/ Anne Tidmarsh, Director Older People and Disability
Action Title	**Action Owner**	**Planned Completion Date**
Managing Prices: Re-tendering for Home Care and Residential Care.	Mark Lobban, Director Commissioning	1.10.2014
Review of care ensuring good outcomes linked to effective arrangements for support. monitoring of trusted assessor arrangements e.g. carers assessments.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Adult social care Transformation Programme - tracking and monitoring the impact of delivery -on going.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Continue to invest in preventative services through voluntary sector partners.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Continued use and development of Assistive Technology (Telecare). Extend scope	Andrew Ireland, Corporate Director, Social Care Health &	1.10.2014

of Telecare.	Wellbeing	
Continued modernisation of Older People Services and of Learning Disability Day Services through the Good Day Programme.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10. 2014
To monitor demand for services including new referrals and people requiring services for longer -often with complex needs.	Penny Southern, Director Learning Disability and Mental Health	1.10.2014
Checking cases to ensure that where SCHW is approached to take cases on then the individual case does "qualify" under the Ordinary Residence guidance - on going.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Continued working to ensure children in care are supported with a permanency plan. Early help for families. Promoting adoption and permanency where it is right for the child.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014

Risk ID: SCHW 08	Risk Title: Managing and working within the Social Care Market				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Managing and working within the Social Care Market.	SCHW adult services commissions about 90% of services from outside the Directorate. Many of them from the Private and Voluntary sector. Although this offers efficiencies and value for money it does mean the directorate needs the market to be buoyant to achieve best value and to give service users real choice and control. Develop and promote the Children's social care market to ensure the sufficient supply to meet the needs of children in need and children in care.	Lack of capacity impacts on choice to support the personalisation agenda. Impact on P&V sector if we are contracting a range of different services in the community through personal budgets/direct payments creates a level of uncertainty for the P&V sector.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning	Possible (3) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Significant (3)

Control Title	Control Owner
A risk based approach to monitoring providers	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
A strong Strategic Commissioning and Access to Resources function across FSC to ensure KCC gets value for money - whilst maintaining productive relationships with providers.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Commissioning framework for children's services	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Commissioning in partnership with key agencies (health)	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director

		Commissioning
Develop commissioning plans for specific service areas to determine if a tendering process is required and then implement.		Mark Lobban, Director Commissioning
Separate Project Risk register held. Working with legal services and corporate procurement. Regular briefings to staff and communication with service users.		
Every provider has signed the National Fostering Framework agreement and KCC service specification.		
Developing Market Position Statements for each commissioning area.		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Procurement and contract controls		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Regular market mapping and price increase pressure tracking		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Regular meetings with provider and trade organisations		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Reviewing relationships with voluntary organisations		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Mark Lobban, Director Commissioning
Action Title	**Action Owner**	**Planned Completion Date**
Continue to review high cost placements in IFA and residential. Developing a commissioning framework for children's residential care.	Mark Lobban, Director Commissioning	1.10.2014
Continued on-going review of high cost placements in Learning Disability Services to ensure value for money. Efficiency Partners involved in the review.	Mark Lobban, Director Commissioning	1.10 2014
Ensuring market is able to offer choice in the new market conditions opened up by personalisation	Mark Lobban, Director Commissioning	1.10.2014
Home Care Re Tender taking place. Tendering process being managed to ensure	Mark Lobban,	1.10.2014

providers meet quality and financial standards. Communicating with staff to keep them informed. Close monitoring of data will be required to ensure there are arrangements in place for each client. Mobilisation phase commenced.	Director Commissioning	
Project to improve quality of care in independent sector. Framework to be produced.	Mark Lobban, Director Commissioning	1.10.2014
Preparations taking place for a tender for residential and nursing home care.	Mark Lobban, Director Commissioning	1.10.2014

Risk ID: SCHW 09	Risk Title: Information Technology				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Need to ensure that information systems are fit for purpose and support business requirements.	There is a risk that the ICT systems will fail.	If information systems are not fit for purpose then it can impact on the business and the delivery of services.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mairead MacNeil, Director Specialist Children's Services Penny Southern, Director Learning Disability and Mental Health	Likely (4) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Moderate (2)

Control Title	Control Owner
An ICS board has been established to oversee the procurement and integration of the new system.	Mairead MacNeil, Director Specialist Children's Services
In specialist children's services, phase one of the new Liberi system has been implemented.	Mairead MacNeil, Director Specialist Children's Services
Upgrade to latest version of SWIFT/AIS for compelling technical reasons and the need to unsure the system meets Care Act requirements.	Penny Southern, Director Learning Disability and Mental Health
Systems group is in place with clear governance arrangements to manage demands for changes to the system and to ensure operational resilience.	Penny Southern, Director Learning Disability and Mental Health
It is recognised as a risk that the contract with the current system provider is time limited and the procurement procedures are to be implemented to prepare for a tendering process.	Penny Southern, Director Learning Disability and Mental Health

Action Title	Action Owner	Planned Completion Date
The contract with the current provider is time limited. A number of actions are now required. 1) A specification to be developed that reflects the Care	Penny Southern, Director Learning Disability and Mental	31.12.2014

Act/Transformation/SEND changes 2) A strategic decision making group to consider the direction of travel and the scope of business requirements. 3) Initiate and follow the procurement processes.	Health	
Any issues and risks regarding the new Liberi system are to be dealt with in the Programme board. Phase 2 to be implemented.	Mairead MacNeil, Director Specialist Children's Services	1.10.2014
Project management arrangements in place and working towards an upgrade of SWIFT/AIS. System user involvement to assist with the design and testing of an upgraded version of SWIFT/AIS.	Penny Southern, Director Learning Disability and Mental Health	1.10.2014

Risk ID: SCHW 10	Risk Title: Information Governance				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
With New Ways of Working, flexible working and increased information sharing across agencies there are increased risks in relation to data protection.	The success of health and social care integration is dependent upon organisations being able to share information across agencies boundaries. Such working means that client information may be shared with other organisations which may have an implication on information sharing protocols. Also flexible working could lead to increased risk of loss of data or equipment.	This could lead to breaches of the Data Protection Act if protocols and procedures are not followed.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	Possible (3)	Significant (3)
				Target Residual Likelihood	**Target Residual Impact**
				Possible (3	Moderate (2)

Control Title	Control Owner
Caldicott Guardian in place for SCHWB and Caldicott Guardian Guidance and register in place.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Mark Lobban, Director Commissioning/Anne Tidmarsh, Director Older People and Disability/Penny Southern, Director Learning Disability and Mental Health
Clause in employment contracts requiring compliance with data protection requirements.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Mark Lobban, Director Commissioning/Anne Tidmarsh, Director Older People and Disability/Penny Southern, Director Learning Disability and Mental Health
E Learning training for staff to raise awareness. All staff to complete the e-learning training.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Mark Lobban, Director Commissioning/Anne Tidmarsh,

		Director Older People and Disability/Penny Southern, Director Learning Disability and Mental Health
Information sharing agreements and protocols for some specific projects are in place.		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Mark Lobban, Director Commissioning/Anne Tidmarsh, Director Older People and Disability/Penny Southern, Director Learning Disability and Mental Health
Organisational policies on IT security and the principles of Data Protection in place.		Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Mark Lobban, Director Commissioning/Anne Tidmarsh, Director Older People and Disability/Penny Southern, Director Learning Disability and Mental Health
Action Title	**Action Owner**	**Planned Completion Date**
In SCS regular communication with staff to remind them of data protection requirements and the need to use secure e-mails etc. Also topic discussed at SCS Div MT.	Mairead MacNeil, Director Specialist Children's Services	1.10.2014
Information Governance reports to DMT with updates.	David Oxlade, Head of Operational Support	1.10.2014
All projects need to have information protocols and agreements where information is to be shared across agencies.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
On-going work with health partners regarding information sharing through the Pioneer Programme.	Anne Tidmarsh, Director Older People and Disability	1.10.2014
Standard operating procedures being produced with organisations that are to be data processors with access to adult social care client database information.	Anne Tidmarsh, Director Older People and Disability	1.10.2014
Need to continue to raise awareness across staff groups	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014

Risk ID: SCHW 11	Risk Title: Business Disruption				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Possible disruption to services	Impact of emergency or major business disruption on the ability of the Directorate to provide essential services to meet its statutory obligations.	Such an event would impact on the customers of our services and possibility the reputation of the service would suffer	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Penny Southern, Director Learning Disability and Mental Health	Possible (3) **Target Residual Likelihood** Possible (3)	Significant (3) **Target Residual Impact** Significant (3)

Control Title	Control Owner
Business continuity planning forms part of the contracting arrangements with private and voluntary sector providers	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Penny Southern, Director Learning Disability and Mental Health
Business Continuity Plans in place	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Penny Southern, Director Learning Disability and Mental Health
Business Impact Analysis is reviewed at least every 12 months or when substantive changes in processes and priorities are identified.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Penny Southern, Director Learning Disability and Mental Health
Good partnership working at all levels for emergency planning.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/ Penny Southern, Director Learning Disability and Mental Health
Crisis/emergency planning training available for staff.	

Action Title	Action Owner	Planned Completion Date
Learn lessons from the response to the adverse weather events that occurred in	David Oxlade, Head of Operational Support	1.8.2014

winter/spring.		
Workplace management team to work with strategic commissioning to ensure contracted services have business continuity arrangements in place.	David Oxlade, Head of Operational Support	1.10.2014
Business Continuity Risk Assessment identifies actions at divisional level	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.11.2014
Regular review and update of continuity plans	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014

Risk ID: SCHW 12	Risk Title: KCC KMPT partnership agreement				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Partnership agreement with KMPT to deliver mental health services.	Risk that a failure to meet mental health statutory requirements would have legal, financial and reputational risks for the Local Authority and would impact on service quality for service users.	Legal, financial and reputational risks for the Local authority and impact on service users.	Penny Southern, Director Learning Disability and Mental Health	Possible (3) **Target Residual Likelihood** Possible (3)	Significant (3) **Target Residual Impact** Moderate (2)

Control Title	Control Owner
Improved governance and performance monitoring arrangements in place.	Penny Southern, Director Learning Disability and Mental Health
Safeguarding posts in place. Safeguarding audits take place and regular performance monitoring.	Penny Southern, Director Learning Disability and Mental Health
Operating Agreement developed and established between KCC and KMPT.	Cheryl Fenton, Head of Mental Health Social Work
Div Mt oversight of the joint operating plan and improved data quality to monitor services.	Cheryl Fenton, Head of Mental Health Social Work

Action Title	Action Owner	Planned Completion Date
Improve the supervision and support for social care staff - Arrangements for professional supervision in place. Induction for restructured posts in place and being implemented. Supervision audits on-going. Various workforce reviews undertaken - to monitor outcomes. Targeted recruitment plan re posts that are hard to recruit to.	Cheryl Fenton, Head of Mental Health Social Work	1.10.2014
Operating Agreement between KCC and KMPT monitored through Div MT on an on-going basis.	Cheryl Fenton, Head of Mental Health Social Work	1.10.2014
Continue to promote the personalisation agenda with social care clients in mental health services. Including increase in social care clients with a personal budget - some increase in the number of DPs. SDR service restructured. Training on personalisation provided, teams producing action plan re promoting personalisation.	Cheryl Fenton, Head of Mental Health Social Work	1.10.2014

Monitor KPIs -focus on red indicators and exception reports. Address IT issues - action plan to do this. On-going monitoring, discussion and action planning re KPIs in place. Learning from audits.	Cheryl Fenton, Head of Mental Health Social Work	1.10.2014
Develop the mental health social care responses in primary care; project management arrangements developed. A steering group is looking at models for the delivery of primary care/social care (clusters 1, 2 and 3)	Penny Southern, Director Learning Disability and Mental Health	1.10.2014

Risk ID: SCHW 13	Risk Title: Preparation for legislative change				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Care Act and Children and Families Act.	Care Act - Significant implications for adult social care services. It establishes a new legal framework for care and support services. An emphasis on early intervention, prevention and increasing choice and control and changes to charging. New duties to be introduced to provide support services to carers. Children and Families Act introduced, implications for - assessments for children with SEN, adoption services and contact and residence plans.	The Care Act when implemented will have a significant impact on services. The Children and Families Act has implications for some SCS services and a significant impact on SEN services.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Michael Thomas-Sam, Strategic Business Advisor	Possible (3) **Target Residual Likelihood** Possible (3)	Significant (5) **Target Residual Impact** Moderate (2)

Control Title	Control Owner
Transactional, activity and financial implications of the Act are reported to DMT. Implications of the Act also reported to CMT to inform the 2015/16 budget. On course to present a Programme Plan to the Transformation Board, Corporate Board and Cabinet Committee in July.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing/Michael Thomas-Sam, Strategic Business Advisor
Reports to Corporate Board and DMTs. Also to Policy and Resources Committee and Kent Joint Chiefs meeting.	Michael Thomas-Sam, Strategic Business Advisor
Children and Families Act implemented. Working with colleagues in SEN services on the changes.	Mairead MacNeil, Director Specialist Children's Services/Penny Southern, Director Learning Disability and Mental Health
A Care Act Programme established to ensure KCC is well placed to deliver the new responsibilities. A programme board in place with representatives from across KCC and the efficiency partner. Regular briefings for elected Members and other stakeholders held.	Michael Thomas-Sam, Strategic Business Advisor

Action Title	Action Owner	Planned Completion Date

To continue to prepare for the Care Act. Project plans in place with work streams for key areas. To determine the implications of the Act and the associated regulations and guidance for KCC. To prepare for implementation when the Act in enacted in 2015. To present the Programme Plan through Governance arrangements in July.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
To keep DMT and Div Mts informed of developments and preparations for the Care Act. To communicate through briefings and updates to staff.	Michael Thomas-Sam, Strategic Business Advisor	1.10.2014
An outline programme plan in place with a number of projects including: costs modelling; communications; workforce capacity; commissioning; financial assessment and charging; safeguarding; IT and information systems	Michael Thomas-Sam, Strategic Business Advisor	1.10.2014
The principles contained in the Care Act to inform the Transformation programme.	Michael Thomas-Sam, Strategic Business Advisor	1.10.2014
Further input to an SEN pathfinder project and development of a "local offer".	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.9.2014
Workshops and training to be arranged on the implications of the Care Act.	Michael Thomas-Sam, Strategic Business Advisor	1.10.2014

Risk ID: SCHW 14	Risk Title: Organisational change				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Significant amount of organisational change.	Several major change programmes underway at the same time.	Possible impact on service delivery and could lead to unclear responsibilities	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing Mark Lobban, Director Commissioning Mairead MacNeil, Director Specialist Children's Services Anne Tidmarsh, Director Older People and Disability Penny Southern, Director Learning Disability and Mental Health	Likely (4) **Target Residual Likelihood** Likely (4)	Significant (3) **Target Residual Impact** Significant (3)

Control Title	Control Owner
Programme Management arrangements in place with implementation groups and careful communication and engagement of stakeholders. Phase 3 of the Boundary Re-alignment project is in progress. Working closely with the Efficiency Partner on the Optimisation Programme and Transformation. Staff briefings have taken place and the formal consultation period is taking place in June 2014.	
New ways of working is leading to changes in KCC accommodation arrangements and where people are based. A New Ways of Working Risk Register exists to log risks. FSC has representation on the New Ways of Working Programme Board.	
Business support arrangements in place. On-going engagement in management team.	
Facing the Challenge: Delivering Better Outcomes. Transformation Plan - version 1 produced and disseminated. Phase	

2 now in progress - report went to the county council on 27 March with a progress report and update		
Action Title	**Action Owner**	**Planned Completion Date**
Phased approach to the project. Links to other programmes including Transformation, Access to Services and the HASCIP Pioneer Programme. Phase 3 of the project is underway. Formal consultation is taking place in June with feedback and final proposal expected to be announced in July 2014.	Anne Tidmarsh, Director Older People and Disability	1.10.2014
To continue to communicate the implications of New Ways of working for the Directorate and workplace management team to develop a NWW risk register. Key risks will then escalate to the SCHW risk register.	Penny Southern, Director Learning Disability and Mental Health	1.10.2014
Continue to maintain close working with support services e.g. finance, ICT, training, communication.	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014
Corporate transformation team set up, further workshops being delivered for staff. New Directorates took effect from 1 April 2014. Phase 2 of Facing the Challenge in progress	Andrew Ireland, Corporate Director, Social Care Health & Wellbeing	1.10.2014

Risk ID: SCHW 15	Risk Title: MCA and Deprivation of Liberty Assessments				
Source / cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
A judgement by the Supreme Court has implications for the number of Deprivation of Liberty Assessments that are required.	The number of Deprivation of Liberty assessments has significantly increased. This could lead to DOLs applications and Best Interests Assessments not being done within the statutory framework.	This could result in some people living in circumstances where they are deprived of their liberty based on the new legal interpretation but without a DoLs assessment. This could be detrimental to the individual and could result in a challenge based on the Supreme Court judgement.	Mark Lobban, Director Commissioning	Likely (4) **Target Residual Likelihood** Likely (4)	Serious (4) **Target Residual Impact** Moderate (2)

Control Title	Control Owner
DMT briefed on the judgment and its implications.	Andrew Ireland
Briefing issued by Corporate Director.	Andrew Ireland
Extension to 14 Days for urgent authorization of MCA assessments	Mark Lobban

Action Title	Action Owner	Planned Completion Date
To include staff currently on BIA training on the rota when they complete their training in June. Explore possibility of commissioning interim/agency staff to complete BIA work and the possibility of secondments providing the posts can be backfilled.	Mark Lobban, Director Commissioning	31.7.2014
Review the MCA/BIA work to identify any efficiencies that can be made in the processes or ways of working.	David Oxlade, Head of Operational Support	31.7.2014
As this risk is the result of a national judgment - most Local Authorities will be facing similar challenges. To keep abreast of any national (DH) or regional developments.	Mark Lobban, Director Commissioning	31.7.2014
An initial analysis to identify the likely extent of demand. The number of referrals has doubled and some providers have requested assessments of all their residents.	Mark Lobban, Director Commissioning	31.7.2014

From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – Tuesday, 8 July 2014

Subject: **Work Programme 2014/15**

Classification: **Unrestricted**

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

Summary: This report gives details of the proposed work programme for the Growth, Economic Development and Communities Cabinet Committee.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 2014/15.

1. Introduction

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decision List; from actions arising from previous meetings, and from topics identified at agenda setting meetings, held 6 weeks before each Cabinet Committee meeting in accordance with the Constitution and attended by the Chairman, Vice Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Member, is responsible for the final selection of items for the agenda, this item gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Terms of Reference

2.1 At its meeting held on 27 March 2014, the County Council agreed the following terms of reference for the Adult and Social Care and Health Cabinet Committee '*To be responsible for those functions that sit within the Social Care, Health and Wellbeing Directorate and which relate to Adults. The functions within the remit of this Cabinet Committee are:*

Strategic Commissioning Adult Social Care
Quality Assurance of Health and Social Care
Integrated Commissioning – Health and Adult Social Care
Contracts and Procurement
Planning and Market Shaping
Commissioned Services including Supporting People
LASAR (Local Area Single Assessment and Referral)
KDAAT

Older People and Physical Disability
Enablement
In-house Provision – residential homes and day centres
Adult Protection
Assessment and Case management

Telehealth and Telecare
Sensory service
Dementia
Autism
Lead on Health integration
Integrated Equipment Services and Disability Facilities Grant
Occupational Therapy

Transition planning

Learning and Disability and Mental Health
Assessment and Case management
Learning Disability and mental health In-house Provision
Adult Protection
Partnership Arrangement with the Kent and Medway Partnership Trust and Kent Community Health NHS Trust for statutory services Operational support unit Community Health NHS Trust for statutory services Operational support unit

Health - when the following relate to Adults (or to all)
Adults' Health Commissioning
Health Improvement
Health Protection
Public Health Intelligence and Research
Public Health Commissioning and Performance

2.2 Further terms of reference can be found in the Constitution at Appendix 2 Part 4 paragraph 21 and these should also inform the suggestions made by members for appropriate matters for consideration.

3. Work Programme 2014/15

3.1 The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in appendix A to this report, and to suggest any additional topics that they wish to considered for inclusion to the agenda of future meetings.

3.3 When selecting future items the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any 'for information' or briefing items will be sent to Members of the Cabinet Committee separately to the agenda or separate member briefings will be arranged where appropriate.

4. Conclusion

4.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme to help the Cabinet Member to deliver informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions for future items to be considered. This does not preclude Members making requests to the Chairman or the Democratic Services Officer between meetings for consideration.

5. Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 2014/15.

6. Background Documents

None.

7. Contact details

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WORK PROGRAMME – 2014/2015
ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Agenda Section	Items
11 JULY 2014	
B - Adults	• **Outcome of consultation on Home Support Fund policy**
D – Public Health	• **Healthy Living Pharmacies** (discussion of review of current services – prior to going to market) • **Health Checks Programme** (discussion of review of current services – prior to going to market) • **Postural Stability Service** (discussion of review of current services – prior to going to market) • **Suicide Prevention strategy** (intro paper prior to taking key decision to Cttee in September)
E – Performance Monitoring	• **Financial Monitoring Report** • **Adult Social Care Performance Dashboards** • **Public Health Performance Dashboard - Health Improvement Programme Performance report** • **Local Account Annual Report** • **Risk Registers** appearing again for NEW Directorate set-up following transformation
F – for Comment or Recommendation	
G - Briefings	
26 SEPTEMBER 2014	
B - Adults	• **Social Care, Health and Wellbeing Transformation update** Incl Report new Safeguarding monitoring style **–** *regular six-monthly* meeting dates make this not-quite-six-monthly. Place it in September or December?* when will this cease to be needed?
D – Public Health	• **Tendering for postural stability classes** • **Health Check programme update**
E – Performance Monitoring	• **Financial Monitoring Report** • **Adult Social Care Performance Dashboards** (incl Annual Public Involvement and Consultation and Engagements Report) • **Public Health Performance Dashboard - Health Improvement Programme Performance report Annual Complaints and Compliments Report** • **Care Act Update** – financial implications • **Transformation/Efficiency Partner update** (roughly 6-monthly) • **Alcohol Strategy for Kent –** regular updates • **Safeguarding Vulnerable Adults Annual report**
F – for Comment or Recommendation	• **Update on Independent Living Fund (ILF)**
G - Briefings	• **Care Quality Commission Consultation on new inspection regime and changes coming**
4 DECEMBER 2014	
B - Adults	• **Social Care, Health and Wellbeing Transformation update –** *regular six-monthly* see note in September* when will this cease to be needed?
D – Public Health	• **Adult Healthy Weight review** decision report for endorsement or rec (part-exempt) • **Healthy Living Pharmacies** decision report for endorsement or rec (part-exempt) • **Health Checks Programme** decision report for endorsement or rec (part-exempt) • **Postural Stability Service** decision report for endorsement or rec (part-exempt**)**
E – Performance Monitoring	• **Financial Monitoring Report** • **Adult Social Care Performance Dashboards and mid-year business plan**

	Monitoring • **Public Health Performance Dashboard - Health Improvement Programme Performance report** • **Live it Well Strategy Annual Update** • **Care Act Update**
F – for Comment or Recommendation	• **Budget**
G - Briefings	•
JANUARY 2015	
B - Adults	•
D – Public Health	• **Health Inequalities update** *(12 months on from report at Jan 2014 mtg)* • **Suicide Prevention Strategy** decision report for endorsement or rec (part-exempt)
E – Performance Monitoring	• **Financial Monitoring Report** • **Adult Social Care Performance Dashboards** • **Public Health Performance Dashboard - Health Improvement Programme Performance report** • **Local Account Annual report**
F – for Comment or Recommendation	• **Draft Revenue and Capital Budgets 2013/14**
G - Briefings	•
SPRING 2015	
B - Adults	• **Social Care, Health and Wellbeing Transformation update –** *regular six-monthly* when will this cease to be needed?
D – Public Health	• **Suicide Prevention Strategy** decision report for endorsement or rec (part-exempt)
E – Performance Monitoring	• **Strategic Priority Statements** incl **Risk Registers** • **Financial Monitoring Report** • **Adult Social Care Performance Dashboards** • **Public Health Performance Dashboard - Health Improvement Programme Performance report**
F – for Comment or Recommendation	
G - Briefings	

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of the Local Government Act 1972.

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