ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 11th September, 2015

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
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AGENDA

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 11 September 2015 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone: **03000 416172**

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 R E Brookbank, Mrs P T Cole, Mrs V J Dagger, Mr P J Homewood and Mrs C J Waters
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

Webcasting Notice

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By entering into this room you are consenting to being filmed. If you do not wish to have your image captured please let the Clerk know immediately

UNRESTRICTED ITEMS

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

A3 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

A4 Minutes of the meeting held on 10 July 2015 (Pages 7 - 18)

To consider and approve the minutes as a correct record

A5 Meetings dates for 2016/17

To note that the following dates have been reserved for the committee's meetings in 2016/17:-

Thursday 14 January 2016
Thursday 10 March 2016
Tuesday 10 May 2016
Tuesday 12 July 2016
Tuesday 11 October 2016
Tuesday 6 December 2016

Thursday 26 January 2017
Tuesday 14 March 2017

All meetings will commence at 10.00 am at County Hall.

A6 Verbal updates (Pages 19 - 20)

To receive a verbal update from the Cabinet Member for Adult Social Care and Public Health, the Corporate Director of Social Care, Health and Wellbeing and the Director of Public Health.

B - Key or Significant Cabinet/Cabinet Member Decision(s) for Recommendation or Endorsement

B1 Care Act - Power to Delegate Adult Care and Support Functions (Pages 21 - 26)

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 comment on and either endorse or make a recommendation to the Cabinet Member on the proposal that the adult social care and support functions specified in the report be delegated.

B2 Older People's Residential and Nursing contract (Pages 27 - 34)

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 on the progress to date to establish new contracts for nursing and residential care homes from 1 April 2016, in line with the end of the current contracts, and to seek comments or recommendations relating to the Cabinet Member decisions that will be required in due course.

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

C1 Update on Live it Well - The Kent and Medway Mental Health Strategy, 2014 - 2015 (Pages 35 - 46)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on progress against the Live it Well Strategy, and to comment on and endorse a suggested approach to developing

future strategy.

C2 Future Direction for "Mind the Gap: Reducing Health Inequalities in Kent" (Pages 47 - 54)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on proposals to develop a new health inequalities plan for Kent, on which the committee is invited to comment.

C3 Kent Sheds Update (Pages 55 - 62)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on the Kent Sheds project, to which Members are asked to give their support within their local communities.

C4 Care Act Phase 2 - Delay of Introduction of Funding Reform until April 2020: Presentation (Pages 63 - 72)

To receive a presentation setting out progress on the implementation of phase 1 of the Care Act and an update on plans for phase 2, including a delay to the planned funding reforms from 2016 to 2020.

C5 An Active Travel Strategy for Kent (Pages 73 - 78)

To receive a joint report from the Cabinet Members for Environment and Transport and Adult Social Care and Public Health, and the Director of Public Health, and comment on a draft strategy to increase physical activity and improve health as well as improve air quality and reduce traffic congestion. This issue will also be considered by the Education and Young People's Services and Environment and Transport Cabinet Committees.

D - Monitoring

D1 Kent County Council's Local Account for Adult Social Care 2014 - 2015 (Pages 79 - 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 on the Local Account, and agree that a cross-party group of committee Members be convened to review and finalise the local account document and recommend its publication by the Cabinet Member.

D2 Kent and Medway Safeguarding Adults Annual Report, April 2014 - March 2015 (Pages 83 - 128)

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, detailing the work of the multi-agency partnership in the last year, on which the committee is invited to comment.

D3 Annual Equality and Diversity Report 2014 - 2015 (Pages 129 - 136)

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 on equality and diversity work and progress against the County Council's equality objectives for 2014/15, on which the committee is invited to comment.

D4 Work Programme (Pages 137 - 144)

To receive a report from the Head of Democratic Services on the committee's work programme.

E - FOR INFORMATION ONLY - Key or significant Cabinet Member Decisions taken outside the Committee meeting cycle

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

That, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraphs 3 and 4 of Part 1 of Schedule 12A of the Act.

EXEMPT ITEM

F1 Accommodation Strategy Review - next steps (Pages 145 - 156)

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 on the next steps following the accommodation strategy review.

Peter Sass
Head of Democratic Services
03000 416647

Thursday, 3 September 2015

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, 10 July 2015.

PRESENT: Mr C P Smith (Chairman), Mr G Lymer (Vice-Chairman), Mrs A D Allen, MBE, Mrs P Brivio, Mr R E Brookbank, Mrs P T Cole, Mrs V J Dagger, Mrs M Elenor (Substitute for Mr H Birkby), Mr S J G Koowaree, Mr T A Maddison and Mrs C J Waters

ALSO PRESENT: Mr M J Angell, Mr G Cowan, Mr G K Gibbens, Mr M E Whybrow and Mrs Z Wiltshire

IN ATTENDANCE: Mr A Ireland (Corporate Director Social Care, Health & Wellbeing), Mr A Scott-Clark (Director of Public Health), Mr M Lobban (Director of 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

13. Membership
(Item A2)

1. It was noted that Mr P J Homewood and Mrs C J Waters had joined the committee to fill the two vacancies.

2. The Chairman welcomed Mrs Waters to the committee.

14. Apologies and Substitutes
(Item A3)

Apologies for absence had been received from Mr P Homewood and Mr H Birkby.

Mrs M Elenor was present as a substitute for Mr Birkby.

15. Declarations of Interest by Members in items on the Agenda
(Item A4)

1. Mrs A D Allen declared an interest in item B4 as a Trustee of North West Kent Age Concern, and in Item B5 as Co-Chairman of the Dartford and Gravesham Learning Disability Partnership.

2. Mr T Maddison declared an interest in item B5 as a Trustee of Invicta Advocacy.

16. Minutes of the meeting held on 1 May 2015
(Item A5)

1. RESOLVED that the minutes of the meeting held on 1 May are correctly recorded and they be signed by the Chairman.

2. Referring to minute 12, Mr T Maddison asked that the committee be sent a copy of the letter sent to the Minister in response to the publication of the ADASS report 'Distinctive, Valued, Personal – Why Social Care Matters: The Next Five Years'.

17. Verbal updates
(Item A6)

Adult Social Care

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

20 May - Attended Shared Lives Family Visit at Dungeness Lifeboat Station – meeting people with learning disabilities and their families at this event had been very enlightening.
2 July - Visit to Brockhill Performing Arts College – children and adults aged between 6 and 76 had performed together.
Dementia friends – on 6 July, all Cabinet Members had become Dementia Friends. This involved committing to training and actions to help and support people coping with dementia.
Backdating of charges for adult social care and support – Mr Gibbens read a statement clarifying that the Department of Health had very recently confirmed that local authorities were permitted to backdate charges on certain conditions from 1 April 2015, when the Care Act came into force. This information had not been available when he had taken a key decision in February 2015 to establish the new charging arrangements which would apply from 1 April 2015, under section 14 of the Care Act 2014. He therefore intended to take a decision allowing backdating for domiciliary and other non-residential care and support. This would only apply to new clients, from the date on which the decision would come into effect. Backdating for residential care was already in place.

a) in response to a question about the scale of charges involved, Ms Grosskopf clarified that the difference in costs to the County Council of not being able to backdate charges would be approximately £250,000 per year; and

b) Mr Gibbens offered to send more information on the Shared Lives Initiative to one speaker.

2. Mr Ireland then gave a verbal update on the following issues:

Care Act 2014 Phase 2 – there had been no mention of this in the Chancellor's budget speech, so the expectation was that the planned implementation of phase 2 would be unaffected. Regulations relating to the changes in April 2016 were expected to be published in October 2016. ***Deprivation of Liberty Safeguards*** – the scope of these had been widened and a Law Commission consultation issued, to which the County Council would be making a full response. Primary legislation would be required to address the changes.

a) in response to a question about the impact upon the social care budget of the latest Care Act changes, he explained that the full costs and impact had yet to be identified.

Adult Public Health

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

10 June - Spoke at the Kent Sheds Celebration Event at Riverside Centre, Gravesend – the Sheds project was supported by a cross-section of organisations and had given many people a positive outcome, and the inclusion of men and women was welcomed. Mr Gibbens thanked the Public Health and Adult Social Care officers and staff of KMPT for their work in supporting the project.
30 June - Spoke at Public Health Champions Celebration Event, Detling Showground – this was part of a campaign to spread the message about the importance of Public Health and health campaigns, eg workplace health and obesity.

4. Mr A Scott-Clark then gave a verbal update on the following issues:

Public Health Champions - partner organisations such as JobCentre Plus and district councils had now formally become public health champions, and those most recently completing a training course had now 'graduated'. Maintaining connections with public health Champions in partner organisations would be vital. He commended the work of the public health workforce development team.
Workplace Health - a scheme of Kent Healthy Business Awards had been launched, with partners in the Chambers of Commerce, district councils, etc, to raise the profile of workplace health, including a target to reduce the level of sickness absence in the workplace. This had physical and mental health elements.
Campaigns - current campaign activity included guidance about health precautions in a heatwave and support for the Public Health England '10 minute shake-up' campaign, aimed at primary school children, to encourage them to keep active in the school holidays. The mobile health check unit would also be attending the County Show on 10 – 12 July.

a) in response to a question about public health involvement in services for drivers caught up in operation stack, Mr Scott-Clark explained that public health had co-ordinated a multi-agency partner response to distribute food and water to drivers stranded through the heatwave. The County Council's emergency planning team had also been involved, with health partners, in ensuring that drivers were able to renew supplies of essential medication while they were stranded.

5. The verbal updates were noted, with thanks.

18. The 2015 - 2020 Kent and Medway Suicide Prevention Strategy and Action Plan *(Item B1)*

Mr M J Angell, Mr G Cowan, Mr M Whybrow and Mrs Z Wiltshire were present for this item.

Ms J Mookherjee, Public Health Consultant, and Mr T Woodhouse, Public Health Programme Manager, were in attendance for this item.

1. Ms Mookherjee introduced the report and strategy, which the committee had seen through its stages of development. Ms Mookherjee, Mr Woodhouse and Mr Scott-Clark responded to comments and questions from Members, as follows:-

a) a statistic quoted for the number of suicides in any area represented those who were resident in that area, not those who had gone there to commit suicide;

b) cases quoted in which support services had been withdrawn from an individual were those in which the individual had been assessed as no longer requiring those services. The importance of a case being properly reviewed before any service was withdrawn was emphasised;

c) it was important to consider the impact of suicide upon a family, and, in particular, upon children, and have suitable support services available for them;

d) figures for those committing suicide listed in the report should be shown as a rate per 100,000, not per 1,000.

e) those industries with higher rates – eg construction, agriculture and road transport – tended to employ larger numbers of men, who often spent long periods of time away from their families and home support networks. The high rate among construction workers had only recently been identified, and work would be undertaken to find the best ways of engaging with this group to address issues, eg via leisure facilities and the trade bodies to which they belonged;

f) once the strategy had been launched, the Public Health team would work with partners to identify and engage with those most at risk of suicide, and progress reports on the implementation of the strategy would be made to this committee. It was known that only 20% of those who take their own life had contact with secondary mental health care providers in the tewlve months prior to their death, highlighting the need for multi-agency partnerships and population-wide approaches;

g) Kent was proud to have more mental health networking projects than any other county, known as ‘Shed’ projects, and these were a large and important part of the strategy. They had previously been targeted at men but most now included women. Although public health funding had not yet been confirmed for 2016 onwards, Shed projects were not expensive to run, and some were not financed by the County Council. It was suggested that, if an area did not have a Shed project, local County Councillors could perhaps support the establishment of one by using their community grant money;

h) the report contained both actual numbers of deaths by area and rates per 100,000. To compare suicide levels across clinical commissioning group areas, it would be necessary to examine the rates of deaths, as

comparisons using actual numbers would be compromised by the different population sizes within clinical commissioning groups; and

i) social isolation and loneliness both had an impact on the suicide rate. The Shed projects could help in tackling isolation.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and a constructive debate. He undertook to take on board the comments made and take them forward with officers. Recent media coverage of suicide had emphasised the importance of good cross-working with partners such as The Samaritans and Shed projects. He encourages Members to visit their local Shed project and requested that a report on Sheds be added to the committee's next agenda.

3. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to approve the adoption of the 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan, taking account of comments made by the committee, be endorsed.

19. The Public Health Strategic Delivery Plan and Commissioning Strategy
(Item B2)

Ms K Sharp, Head of Public Health Commissioning, was in attendance for this item.

1. Ms Sharp introduced a series of slides about public health transformation, which had been included in the published meeting papers. She explained that the Cabinet Member was being asked to agree to extend current contracts to ensure that they all ended together, to accommodate easier and neater re-commissioning of services grouped together under the 'Living Well' and 'Ageing Well' headings. Ms Sharp and Mr Scott-Clark responded to comments and questions from Members, as follows:-

a) Members could look into how they could support public health initiatives in their local areas. Although public health campaigns encouraged people to live and eat healthily, and provided information about the health benefits of doing so, it was not possible to force them to make the necessary lifestyle changes. Mr Scott-Clark summarised the public health role as being to organise the efforts of society and Ms Sharp added that Members would be kept up to date with progress on campaigns and would be able to see what issues were current in their area of the county;

b) the work undertaken on the strategy and in driving it forward was welcomed and the proposed contract extensions welcomed; and

c) Public Health's work with other directorates and partners was setting an excellent example of joint working, and allowed services to be more responsive to needs, especially in the field of early intervention. Kent could look at and learn from other local authorities which were shaping their services in the same way. Mr Scott-Clark added that the main focus of the strategy was on where most change could be made, eg life expectancy, and on making the strategy holistic and as simple as possible.

2. The Cabinet Member, Mr Gibbens, advised the Committee that a similar report would be made to the Children's Social Care and Health Cabinet Committee on 22 July, concerned with the 'Starting Well' agenda of children's health issues.

3. RESOLVED that:-

a) the planned public health interventions be noted; and

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to extend the current contracts for Smoking Cessation, Health Checks, Health Trainers and Healthy Weight services to run until 30th September 2016, be endorsed.

20. Local Welfare Assistance future options update
(Item B3)

Ms M Anthony, Commissioning and Development Manager, was in attendance for this item.

1. Ms Anthony introduced the report and responded to comments and questions from Members, as follows:-

a) Kent's assessment process was faster than that of many other local authorities and was seen by many as an example of best practice. Similarly, Kent had a clearer picture of local spend patterns through its regular monitoring activity.

2. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Health, to

a) extend the current arrangements for local welfare assistance in the context of the options explored, as set out in paragraph 3(8) (b) of the report; and

b) endorse the co-ordination and integration of the future design, commissioning and provision of any revised model for local welfare provision with that of the larger-scale transformation projects,

be endorsed.

21. Kent Community Hot Meals tender
(Item B4)

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 at the end of the meeting. It is recorded below, in Minute 31.

22. Commissioning of Advocacy Services for Vulnerable Adults
(Item B5)

Mrs A D Allen declared an interest in this item as Co-Chairman of the Dartford and Gravesham Learning Disability Partnership, and Mr T Maddison declared an interest as a Trustee of Invicta Advocacy.

Ms E Hanson, Head of Commissioning, Community Services, was in attendance for this item.

1. Ms Hanson introduced the report and, with Mr Ireland, responded to comments and questions from Members, as follows:-

a) as advocacy work was a specialised field, and suitably-qualified staff hard to find, the County Council would be working with existing and new providers to seek to grow the workforce. This would be included in the design of the service specification;

b) the holistic approach being taken to the service was welcomed. It was important that the service was cross-cutting as advocacy needs cut across several service areas. Mr Ireland added that the current review of service commissioning had been prompted, and was supported, by the changes in the Care Act 2014, which had brought an opportunity to review the model as a whole; and

c) in response to a question about the County Council's ability to accommodate the capacity and provide the specialist knowledge required to run the service, Ms Hanson explained that advocacy was centrally placed in supporting other services, and the knowledge and expertise of advocacy staff could be applied to and could benefit other services.

2. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Health, to re-commission advocacy services for vulnerable adults, and delegate authority to the Corporate Director of Social Care, Health and Wellbeing to authorise the letting of the contract, be endorsed.

23. Care Act - update on phase 1 and plans for phase 2
(Item C1)

Ms C Grosskopf, Strategic Policy Adviser, was in attendance for this item.

1. Ms Grosskopf introduced the regular six-monthly update report on the implementation of the Care Act. Phase 1 had been successfully implemented and had been the subject of a 'deep dive' review by the Local Government Association and the Association of Directors of Social Services. Final confirmation of exactly which elements of Phase 2 would be implemented was expected by the end of July 2015. In response to a question about the new appeals process, Ms Grosskopf explained that the proposed new appeals system was expected to have three stages: internal resolution, if possible, then independent review (by someone who must not have been employed by the County Council for 2-3 years) then a fresh decision by the Council, based on the recommendations of the independent review. Further detail of the appeals process was awaited.

2. RESOLVED that the information provided on Phase 1 of the programme, and the plans being implemented for Phase 2, be noted.

24. Adult Social Care Transformation and Efficiency Partner update
(Item C2)

1. Mr Lobban introduced the six-monthly update report and highlighted the key areas of past and future work and potential savings. He responded to comments and questions from Members, as follows:-

a) the success of the planned pathways to independence would depend on there being suitable accommodation available in the desired area. The County Council was working with district councils and housing providers to develop capacity and there was confidence that this need could be met. All district councils and NHS partners had signed up to a multi-agency accommodation strategy, covering all areas of provision, eg for the elderly, those with learning disabilities, etc; and

b) the County Council's efficiency partner, Newton Europe, had spoken at the recent LGA conference and had used their work with Kent County Council as a best practice example. However, despite the progress made, there was still some 'bed blocking' in hospitals due to a lack of alternative care placements available. Previously, a patient's discharge care package would be planned as soon as they entered hospital, but this practice seemed to be less common now. Mr Lobban agreed that the right menu of services and suitable links between them would make a big difference to services for vulnerable people.

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

25. Kent Drug and Alcohol services - Commissioning Plans
(Item C3)

Ms K Sharp, Head of Public Health Commissioning, and Ms J Mookherjee, Consultant in Public Health, were in attendance for this item.

1. Ms Mookherjee and Ms Sharp introduced the report and emphasised that services needed to be re-commissioned to respond to changes in patterns of substance use and to ensure that services were sustainable, moving to a public health model which allowed a more flexible approach with strategic partners. The committee was being asked to comment on the proposed new approach. Members made the following comments:-

a) the move to prosecute offenders caught driving under the influence of drugs, on their first offence, was welcomed. A roadside test for drug use, similar to that available for drink-driving, was now available;

b) County Council funding could be used to support local issues and prevention campaigns;

c) work on drug and alcohol services was closely link to work on the Suicide Prevention Strategy; and

d) an apparent new pattern of substance use was the use of small metal canisters of 'laughing gas' which were sold at parties and could be seen littering the streets. These were apparently a low-level form of recreational drug use among young people, but it was important that the risks were made clear, eg to those with asthma. Ms Sharp explained that a discussion item on 'legal highs' was on the agenda for a meeting of the Kent Drug And Alcohol Partnership (KDAP) on 13 July, at which the police and prison services would report on recent deaths from the use of legal substances. She undertook to report back to this committee on any issues arising from the KDAP meeting.

2. RESOLVED that the level of efficiency savings which needed to be achieved through the re-commissioning of adult community drug and alcohol services in Kent be noted, and the proposed commissioning approach (option 2 in paragraph 6.1 of the report) and procurement plan designed to achieve savings and required outcomes be welcomed/supported.

26. Integrated Commissioning for Learning Disability in Kent
(Item C4)

1. Ms Southern introduced the report and explained that the County Council would lead on integrated commissioning, and would direct the governance aspects of it, while funding would be provided by clinical commissioning groups (CCGs).

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

27. Adult Social Care Performance Dashboard
(Item D1)

Ms S Smith, Head of Performance, was in attendance for this item.

1. Ms Smith introduced the report and responded to comments and questions from Members, as follows:-

a) when setting targets for work areas such as promoting independence reviews, it was important that targets be challenging but attainable; and

b) the reduction in admissions to permanent residential or nursing care showed that the County Council was responding successfully to changes in life patterns and supporting more people to live independently at home.

2. RESOLVED that information set out in the Adult Social Care performance dashboard be noted.

28. Public Health Performance - Adults
(Item D2)

RESOLVED that the current performance set out in the dashboard, and actions taken by Public Health, be noted.

29. Adult Social Care Annual Complaints Report, 2014 - 2015
(Item D3)

Mr A Mort, Customer Care and Operations Manager, was in attendance for this item.

1. Mr Mort introduced the report and emphasised that, although the number of complaints received had increased, it represented a small percentage of the number of contacts made and was fewer than the number of compliments received. Many of the complaints received arose from communication issues and disputed decisions, such as assessments for care packages and, in particular, charges for services. Feedback given would always be considered carefully and lessons drawn from it, from which improvements could be made. He read out two compliments which had been received recently; one from a relative of a client praising the professionalism of a care manager and one thanking the enablement service for support given, which had helped a client to avoid the need to have a care package. Mr Mort responded to comments and questions from Members, as follows:-

a) asked if some complaints might stem from misunderstandings, eg of the assessment process or the level of care expected, he explained that, if a simple misunderstanding were identified, this would be rectified quickly and would not necessarily be logged as a complaint, but otherwise all complaints were logged.

b) asked if the number of complaints had increased, or were expected to increase, as a result of changes arising from the Care Act, he explained that, as the report was concerned with the year from April 2014 to March 2015, it would not record any complaints arising from the Care Act. Next year's report, however, was expected to include more, as service users were now experiencing and challenging the changes to carers' assessments and the charging structure;

c) as good practice, the County Council tended to record most of the complaints received, whether or not they related to statutory services. The definition of a statutory complaint for adult social care was very broad, so most were logged. However, a few received as complaints might be dealt with in other procedures, for example complaints about human resources issues or safeguarding issues; and

d) asked if the home care provider changes tended to lead to increased complaints, he explained that this had been the case in the past and so, whenever a service provider were changed, an increase in complaints might be expected. However, the recent changes following the home care re-tender had generated fewer complaints than expected.

2. The Cabinet Member, Mr Gibbens, thanked officer teams for their work to minimize complaints as far as possible. He said that he welcomed feedback and complaints as a sign that people felt able to contact the Council to express their views. He also emphasised the importance of identifying and addressing issues and learning lessons from them.

3. RESOLVED that the information set out in the report be noted.

30. Work Programme
(Item D4)

1. Arising from discussion of the dashboard report, which had identified the number of adults with mental health issues and learning disabilities being supported into employment, a request was made that the committee have the opportunity to discuss this issue at a future meeting.

2. RESOLVED that, with the addition of the above, the committee's work programme for 2015/2016 be agreed.

Motion to Exclude the Press and Public for Exempt Business

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.

EXEMPT ITEM (Open Access to Minutes)

31. Kent Community Hot Meals tender (exempt appendix to item B4)
(Item E1)

Mrs A D Allen declared an interest in this item as a Trustee of North West Kent Age Concern.

Ms E Hanson, Head of Commissioning, Community Services, was in attendance for this item.

1. Ms Hanson introduced the report and explained that the provider to whom it was proposed to award the contract had been the only bidder and was currently negotiating with the County Council about unit price and volume. It was hoped that these negotiations would soon be successfully concluded. It was important to fix a fair price for the customer and secure terms which were favourable to the County Council. Ms Hanson clarified the type of meals which would be provided by the contract; frozen meals which would be reheated in a van on the way to the customer's home. This was an essential service for those customers for whom no other options were available, eg those who could not use a microwave. Ms Hanson responded to comments and questions from Members, as follows:-

a) the length of contract was part of the current negotiations. The provider favoured a longer contract of three or five years but a decision on length would be made once calculations around unit price had been completed;

b) although the County Council had not had the opportunity to make a comparison and choice between several bidders, it was emphasised that the range of catering options and products available in the market meant that customers would not miss out on having some choice of product, supplier and price;

c) one Member said he had visited the bidder's factory and been impressed with the production process;

d) in some areas of Kent there was already much competition among providers, including local supermarkets, to deliver to residents, eg those in sheltered housing developments, and the need for another meals contract in those areas was questioned. Ms Hanson confirmed that micro-provision was more advanced in East Kent than in West and reminded Members that the contract currently under discussion aimed to help those customers for whom other options were not suitable. Mr Lobban added that some customers needed to have hot meals delivered for a limited period of time, eg after returning home from hospital, and the service able to be offered to this group of customers was a small but important part of a hot meals service. The unit price being negotiated was more cost-effective than paying a carer to visit a customer to prepare a hot meal; and

e) it was suggested that day centres currently offering a hot meals service could extend their service further afield, but another speaker added that some such concerns would be unable to compete on volume and price as they operated as charities.

2. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to:

a) award the Kent community hot meals delivery contract, to commence on 1 October 2015, to the preferred bidder identified in the exempt appendix, once the negotiations described are successfully concluded; and

b) agree that the Corporate Director of Social Care, Health and Wellbeing, or other suitable delegated officer, undertake the necessary actions to implement this decision,

be endorsed.

By:	Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health
	Mr A Ireland, Corporate Director of Social Care, Health and Wellbeing
	Mr A Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee – 11 September 2015
Subject:	**Verbal updates by the Cabinet Member and Corporate Directors**
Classification:	Unrestricted

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

Adult Social Care

Cabinet Member for Adult Social Care and Public Health – Mr G K Gibbens

1. 14 July – Visited Swaleside Prison

Corporate Director of Social Care, Health and Wellbeing – Mr A Ireland

1. Future Arrangements for Supporting Vulnerable Adults Board
2. Winter pressures

Adult Public Health

Cabinet Member for Adult Social Care and Public Health – Mr G K Gibbens

1. 23 July - Attended and spoke at the Kent Healthy Business Awards at Oakwood House, Maidstone
2. 11 September – Health Visitors welcome event at Sessions House, Maidstone

Director of Public Health – Mr A Scott-Clark

1. Update on Kent Drug and Alcohol Services
2. Update on Department of Health in-year savings from the Public Health allocation 2015/16

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 September 2015

Subject: **CARE ACT – POWER TO DELEGATE ADULT CARE AND SUPPORT FUNCTIONS**

Classification: Unrestricted

Past Pathway: Adult Social Care and Health Cabinet Committee – 15 January 2015

Future Pathway: Not applicable

Electoral Division: All

Summary: Section 79 of the Care Act 2014 gives local authorities the power to delegate most of their adult care and support functions. This issue was discussed at the 22 October 2014 Adults Transformation Board meeting and the 15 January 2015 Adult Social Care and Health Cabinet Committee and it was recommended that this power be exercised for the time being in certain limited areas. This included some aspects related to Phase 2 of the reforms which were due to be implemented in April 2016. However the Government's recent announcement, that these Phase 2 reforms will be delayed until 2020, means that the issue needs to be revisited.

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

a) **NOTE** the issues raised in the report

b) **ENDORSE** or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposal that, under Section 79 of The Care Act, the following adult social care and support functions can be delegated:

1) Assessment and care provision for prisoners
2) Carers' assessments and support for carers.
3) Specialist assessments and support for blind people.
4) Specialist assessments and support for deaf people

c) Detailed decisions of how these delegations will work in practice will be taken by the Corporate Director for Social Care, Health and Wellbeing after full discussion in each case with the Cabinet Member and the Adult Transformation Board.

1. Introduction

1.1 Section 79 of the Care Act gives local authorities the power to delegate most of the care and support functions it has under Part 1 of the Act or under section 117 of the Mental Health Act 1983 (after-care services). The only exceptions relate to

promoting integration with health services, cooperating with partners, safeguarding and decisions about which services to charge for.

1.2 Delegation of functions does not absolve the local authority of responsibility for these functions and it still remains legally accountable for the way in which the functions are carried out or failed to be carried out. The local authority can, therefore, impose strict conditions on how a third party organisation undertakes the function that has been delegated to it.

1.3 If the local authority chooses to exercise its power under Section 79, it is able to determine the extent to which it delegates the function in any particular case, i.e. it can delegate all or part of a function. For example the carrying out of an assessment could be delegated with the final decision kept in-house or also delegated.

1.4 Delegation under Section 79 of the Care Act is strictly speaking distinct from commissioning, arranging or outsourcing procedural activities related to a function. However, in most cases it is anticipated that delegation will take place via the Commissioning process and Legal advice will be sought as appropriate.

2. Specific functions recommended for delegation

2.1 It is the view of the directorate that the local authority will want to exercise this power in order to effectively implement the requirements of the Act in the following areas:

- Assessment and care provision for prisoners (new duty from April 2015 under section 79 of the Act)
- Carers' assessments and support for carers
- Specialist assessments and support for blind people
- Specialist assessments and support for deaf people

In the future it may be deemed necessary to consider other areas for delegation as implementation plans precede. This will be significantly influenced by how the Government decides to implement Phase 2 of the Care Act, which has currently been deferred to 2020. If this proves necessary or desirable, further papers will be brought to future Cabinet Committees.

2.2 This issue was previously discussed at the Adult Social Care and Health Cabinet Committee on 15 January 2015 and the proposal to delegate these functions was endorsed. Committee members are reminded that this proposal was for the Cabinet Member for Adult Social Care and Public Health to take a decision to allow the principle of delegation of these functions. As part of this, the practical details of the delegations were to be agreed by the Corporate Director for Social Care, Health and Wellbeing, in discussion with the Cabinet Member for Adult Social Care and Public Health and the Adult Transformation Board.

2.3 The earlier decision however also explicitly included the delegation of:

- Assessment of self-funders (existing and on-going) for the purposes of the cap on care costs.

As mentioned above, since the earlier discussion by the Adult Social Care and Health Cabinet Committee, the Government has now deferred the

implementation of Phase 2 of the Care Act and the cap on care costs. Consequently the council cannot currently delegate the assessments for this and so, for the purpose of clarity on what the council can and has subsequently chosen to delegate, this needs to be revisited. The Government has indicated that the cap on care costs, and hence the need to assess self-funders, will be introduced from April 2020 but it is too early at this stage to take a Key Decision on this aspect.

2.4 It is recommended that the Cabinet Member for Adult Social Care and Public Health takes a Key Decision (attached as appendix 1) that, in principle, the functions outlined in paragraph 2.1 can be delegated, with the practical details being approved by the Corporate Director for Social Care, Health and Wellbeing.

3. Recommendations

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

a) **NOTE** the issues raised in the report

b) **ENDORSE** or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposal that, under Section 79 of The Care Act, the following adult social care and support can be delegated:

1) Assessment and care provision for prisoners
2) Carers' assessments and support for carers.
3) Specialist assessments and support for blind people.
4) Specialist assessments and support for deaf people

c) Detailed decisions of how these delegations will work in practice will be taken by the Corporate Director for Social Care, Health and Wellbeing after full discussion in each case with the Cabinet Member and the Adult Transformation Board.

4. Background documents:

Care Act 2014
Statutory Regulations 2014 – released October 2014
Statutory Guidance 2014 – released October 2014

5. Report authors:

Christine Grosskopf,
Policy Advisor, Strategy, Policy & Assurance, Strategic and Corporate Services.
Phone: 03000 416181, Email: chris.grosskopf@kent.gov.uk

Relevant Director:
Andrew Ireland, Corporate Director Social Care, Health and Wellbeing
Phone: 03000 416297 Email: andrew.ireland@kent.gov.uk

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KENT COUNTY COUNCIL - RECORD OF DECISION

DECISION TAKEN BY	DECISION NO.
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	14/00137

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: : Delegation of Specific Adult Care and Support Functions

Decision:

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

A) Under Section 79 of the Care Act 2014 the following adult social care and support functions can be delegated:

1) Assessment and care provision for prisoners
2) Carers' assessments and support for carers
3) Specialist assessments and support for blind people
4) Specialist assessments and support for deaf people

B) Detailed decisions of how these delegations will work in practice will be taken by the Corporate Director for Social Care, Health and Wellbeing or other suitable nominated officer.

Any Interest Declared when the Decision was Taken None

Reason(s) for decision, including alternatives considered and any additional information

Section 79 of the Care Act gives local authorities the power to delegate most of the care and support functions it has under Part 1 of the Act or under section 117 of the Mental Health Act 1983 (after-care services). The only exceptions relate to promoting integration with health services, cooperating with partners, safeguarding and decisions about which services to charge for.

Delegation of functions does not absolve the local authority of responsibility for these functions and it still remains legally accountable for the way in which the functions are carried out or failed to be carried out. The local authority can, therefore, impose strict conditions on how a third party organisation undertakes the function that has been delegated to it. If the local authority chooses to exercise its power under Section 79, it is able to determine the extent to which it delegates the function in any particular case, i.e. it can delegate all or part of a function. For example the carrying out of an assessment could be delegated with the final decision kept in-house or also delegated.

The local authority wishes to exercise this power in order to effectively implement the requirements of the Act in a timely and cost effective manner. Initially it is believed this would be in the following areas:

- Assessment and care provision for prisoners (new duty from April 2015 under s76 of the Act).
- Carers' assessments and support for carers
- Specialist assessments and support for deaf people
- Specialist assessments and support for blind people

It is recommended that the Cabinet Member for Adult Social Care and Public Health take a decision that delegation of the above functions can take place in principle, but that the detailed decisions of how this will work in practice can be taken by the Corporate Director for Social Care, Health and

Wellbeing after full discussion in each case with the Cabinet Member for Adult Social Care and Public Health and the Adult Transformation Board.

Background Documents:
Recommendation report from Corporate Director for Social Care, Health and Wellbeing to Cabinet Member for Adult Social Care and Public Health

Cabinet Committee recommendations and other consultation:
The delegation of functions under the Care Act was considered by the Adult Social Care and Health Cabinet Committee on 15 January 2015. Due to a change in Government policy and the deferment of Phase 2 of the Care Act, these delegations will be discussed again at the Adult Social Care and Health Cabinet Committee on 11 September 2015.

Any alternatives considered:

The alternative to exercising the delegation power under the Care Act is to develop policies and procedures for carrying out the new and existing duties by internal staff. This decision is to allow delegation in principle. For each of the functions business cases have been developed. These include the alternative options in detail.

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

From: Graham Gibbens, Cabinet Member 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 September 2015

Decision No: N/A

Subject: **OLDER PERSONS RESIDENTIAL AND NURSING CONTRACT**

Classification: Unrestricted

Past Pathway of Paper: OPPD Divisional Management Team - 7 May 2015, Social Care Health and Wellbeing Directorate Management Team - 10 June 2015

Future Pathway of Paper: N/A

Electoral Division: All

Summary: To inform the Adult Social Care and Health Cabinet Committee of the progress to date to establish new contracts for nursing and residential care homes from 1 April 2016 in line with the end of the current contracts and to seek comments or recommendations relating to the Cabinet Member decisions that will be required in due course.

Recommendation(s):
Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **CONSIDER** and **COMMENT OR MAKE RECOMMENDATIONS** to the Cabinet Member on the progress to date and pricing schedule decision.

1. Introduction

1.1 Through 2014, the 12 year old residential and nursing care home contracts were re-let using a two stage procurement mechanism which first reviewed care home costs through a cost model. This re-set the guide prices for residential, residential high and nursing care. The contracts commenced in October 2014 and expire on 31 March 2016. The reason for the short contract was to ensure there was sufficient understanding of the market and to prepare for the impact of the changes brought in by the Care Act 2014.

1.2 This contract covers approximately £100m of spend on older persons care home provision. The resource required to establish a contract with a suitable contractual term is substantial and will include representation from all areas of the business, led by Strategic Commissioning in Social Care Health and Wellbeing.

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1.3 The implications relating to price impacted by the Care Act 2014 phase 2 were due to be known officially in October 2015. However on 17 July 2015 The Minister for Care and Support announced that this part of the Act will be deferred until 2020. This has changed the nature of the level of work planned for the contract; however there is still significant work to do to shape a contract that will have a longer term, possibly five years with an option to extend for a further three, and provide a position after a period of levelling through the existing contract.

1.4 Other areas of work that need to take place through preparing to let the contracts include:

- the need to account for individuals who are able to use direct payments to purchase residential care, if it is confirmed this will come into effect
- agreeing how care home placements are purchased including the long term and short term arrangements
- developing a pricing strategy
- developing the procurement strategy and plan for approval at Procurement Board
- reviewing the Key Performance Indicators and Quality measures
- reviewing the ranking system

2. Key Issues

2.1 The options presented in 2014 for contracting involved either a Framework (which was discounted due to the limitations of new entrants joining the contract through the length of the contract) or a Dynamic Purchasing System (which was favoured due to the nature of transparency of decision points through the process and how it met the commissioning strategy developed to maximise choice, quality and have a clear process for cost. Additionally providers can join a Dynamic Purchasing System throughout the contract term and change ranking based on key performance indicators.) Procurement colleagues are exploring all options to be analysed to determine the route to market for the new contract for 2016, which will be agreed by Social Care, Health and Wellbeing Directorate Management Team (DMT) prior to approval from Procurement Board.

2.2 The establishment of the guide prices in July 2014 has received considerable of negative feedback from a high number of residential and nursing care providers. A key part of the establishment of the contract will need to balance the impact of transformation against the guide prices for services.

3. Commissioning Strategy

3.1 The Commissioning Strategy requires development however the key principles are:

- **Offer real choice and give control to the users:** Residents and their families will be given choice and good quality information about the types of care homes available to them within the area where they choose to live. This will include transparent and accurate information regarding the cost of the placement and any 'third party top ups' or additional contributions that may be expected of them as well as an indication of the quality of the care home as assessed by KCC and the Care Quality Commission. This principle will be implemented through the KCC Online Care Directory which will be a comprehensive source of information, advice and guidance on all available services, not just those contracted to KCC and will be available in other formats for those who cannot obtain information online.
- **Reduction in bureaucracy:** A joint approach to commissioning and contracting for outcomes will lead to a reduction in duplication of effort across health and social care statutory and public agencies. This will mean that these agencies should agree to collect one set of Key Performance Indicators (KPIs) from care home providers and share them across health and social care agencies.
- **Promote dignity and quality:** Providers should have a clearly laid out set of quality expectations in the revised contract that promote the dignity and well-being of all residents.
- **Develop and use an evidence base:** KCC Commissioning will provide accurate and up-to-date data on the purchasing patterns for long and short term care placements across the older persons residential and nursing sector to enable commissioners and providers to easily establish what is being purchased in terms of the level of need of residents being referred for residential/nursing care placements, at what price and in which areas of Kent. This management

information will be an invaluable tool to inform providers business strategy and planning and for KCC to fulfil its market shaping duty under the Care Act.

- **Coproduce, listen and act:** KCC will listen to the views of those that are using the services i.e. residents of care homes and their families in developing a set of outcomes for residential and nursing care in Kent. These will be an integral part of the new service specification and contract from 1 April 2016.
- **Innovate, be bold and think differently:** Commissioning for outcomes will need to take into account that the model of care and types of provision will need to change during the lifetime of any contract. Therefore, in the contract from April 2016, flexibility will be required to allow providers to deliver new models of care that cross the traditional boundaries between residential/nursing and homecare. It will not be desirable to set prescriptive and restrictive service specifications or contract terms and conditions that could stifle service innovation.
- **Ensure diversity, sustainability and quality of the market:** The commissioning strategy will need to support KCC in its market shaping duty under the Care Act 2014.
- **Incentivise and pay for results:** KCC will explore with providers a system whereby they can be rewarded for evidence of improved quality and/or performance.
- **Ensure VFM and that 'Every Penny Counts':** The centralised purchasing model will ensure that price is clearly linked to the needs of the individual; families and residents are given clear information about any financial contribution that is expected of them; and that there is a clear auditable process to agree and collect any contributions due to KCC.

3.2 The strategy links directly to the KCC Strategic Vision published in March 2015 and one of the key strategic outcomes of "Older and vulnerable residents are safe and supported with choices to live independently". Key outcomes that this strategy will support include the following:

- Families and carers of vulnerable and older people have access to the advice, information and support they need
- Older and vulnerable residents feel socially included
- Residents have greater choice and control over the health and social care they receive

3.3 The commissioning strategy will be aligned to the principles of the KCC Commissioning Framework and support the KCC Accommodation Strategy priorities and design principles for care homes.

4. Transformation and Strategic Intent

4.1 Kent's Accommodation Strategy launched in July 2014 sets the direction of travel in relation to future commissioning along with the Homecare Strategy, the vision for enablement, prevention and the Adult Transformation Programme focusing on acute demand. The CCG's are also investing in community services which will have an impact on the future level of demand for care home placements. This does mean that those requiring care in future will have greater level of need and care homes

are required to respond to these needs as well as demand. KCC has to align all transformational activity with a distinct recognition on the price of purchasing care. The activity that is required in this area includes:

- Focused work on the model of care and commissioning activity for extra care homes including an operational focus to redirect people that previously would have ended up in a care home and developing a marketing strategy
- Forecasting work on the demand making sure that any reduction in need is balanced with the increase in population and requirement of particular types of care
- Workforce strategy to make sure the recruitment and retention of care staff and nursing staff is reflected in the services that need to be commissioned
- Price profiling against need and market drivers – the 2014-2016 contract was designed to set the guide price and see how the market prices against the needs of individuals, this provides greater transparency on the future establishment of guide prices and how the assumptions will be used for third party top ups where people choose more expensive services and also the direct payment/personal budget/individual personal budget requirements from 2016
- How care homes can be incentivised to promote an individual's independence and to support people to move home with greater independence if in a short term placement
- Reviewing how quality assurance is incorporated into both contract monitoring and the wider role of safeguarding all of Kent's vulnerable adults

5. Procurement and Purchasing Strategy

5.1 Procurement colleagues are responsible for developing the Procurement and Purchasing Strategies for approval by Social Care Health and Wellbeing. The Commissioning Strategy will inform the Procurement Strategy. This identifies and recommends the route to market and will be developed for approval by Procurement Board and the market will be involved in the shaping of this.

5.2 The Purchasing Strategy will include several options for procurement and will provide a recommendation for Social Care, Health and Wellbeing Directorate Management Team to approve, which best suits the Commissioning Strategy. This will include a review of the current purchasing routes.

5.3 The new contract will include long and short term residential and nursing placements.

6. Policy Implications

6.1 With the implementation of phase 1 of the Care Act 2014 in 2015, there needs to be focused work in relation to Policy and how that impacts on the contractual requirements for residential and nursing care. There will need to be projects to look at how the implications impact on current practice and training on the processes.
There needs to be dual work undertaken to make sure that the following are considered, implemented and where appropriate included in the contract:

- Fundamental changes associated with the new legal framework
- Transparency of cost of care

- Personal budget/independent personal budget
- Brokerage/information and advice.

7. Financial Implications

7.1 Work is currently underway in line with budget build on the price which the Council purchases care for individuals from April 2016. This will include the impact of the National Living Wage to be introduced from April 2016.

8. Legal Implications

8.1 Commissioning and Procurement will enlist the support of Legal Services through the development of the contract specification and terms and conditions. There will need to be resource allocated at the end point of the tender process for contracts to be signed and sealed and there has to be a separate work-stream to look at how contracts can be awarded, including spot contracts, making sure the most efficient process is undertaken in signing and sealing the contracts.

8.2 Following the work described above, a Cabinet Member decision will be taken in November to agree the guide prices. All members will have a chance to comment on the proposed pricing schedules (guide prices) before the decision is taken when the proposed decision is published. The Adult Social Care and Health Cabinet Committee will meet again in January 2016 where further progress will be reported and the Committee will be asked to comment the further decision to award contracts that will be due in February 2016.

8.3 The procurement plan has been developed to enable contract award by 1 April 2016. However it should be noted that as the budget for 2016/17 will not be agreed by County Council until February 2016 any key decision on price taken before the budget is agreed is taken pending confirmation of the budget. This may impact on contract being awarded by 1 April 2016.

9. Personnel and Training Implications

9.1 The project resource for letting the contract will be led by Strategic Commissioning.

9.2 Operational teams support will be required from Case Management and the Operational Support Unit (Short Term Beds Team) in ensuring that the contracts can meet their requirements and contributions will be sought to input into the project work stream activity.

9.3 Finance will be part of the core project to make sure that the role of Payments, Assessment and Income are factored in. This forms significant input every April and there may be additional resource required short term to complete the changes suggested through the project term.

9.4 ICT will be part of the core project as it is likely that significant systems changes will be required to care items. The ideal would be to include a work-stream to move to a regular payments system however this has been discounted previously by the Adult Services Systems Group as it has not been seen as a priority in light of the changes needed for the Care Act.

9.5 Policy staff will need to ensure that there is consistency with the proposals for the new contract, the legal requirements of the Care Act and translate that back into Policy and roll out to affected staff.

9.6 Training will be a key part of the new contract so that an end to end e-learning module can be developed for existing and new case management staff. There will be additional costs to develop this package of training.

9.7 Procurement staff are required to support the procurement activity required to establish the new contracts from 2016.

10. Equality Impact Assessment

10.1 The Equality Impact Assessment will be updated as part of the project plan when the changes are proposed and can be fully considered.

11. Recommendation(s):

11.1 Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **CONSIDER** and **COMMENT OR MAKE RECOMMENDATIONS** to the Cabinet Member on the progress to date and pricing schedule decision.

12. Background Documents

None

13. Contact

Lead Officer
Christy Holden
Head of Commissioning (Accommodation Solutions)
Christy.holden@kent.gov.uk
03000 415356

Lead Director
Mark Lobban
Director of Commissioning
Mark.lobban@kent.gov.uk
03000 415393

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 11 September 2015

Subject: Update on Live it Well - The Kent and Medway Mental Health Strategy – 2010 – 2015

Classification: Unrestricted

Past Pathway: This is the first committee to consider this report

Future Pathway: N/A

Electoral Divisions: All

Summary

To provide an update on progress for Members against the Live it Well Strategy 2010 – 2015:

To agree for the approach to the development of the next phase of a "Live it Well Strategy" for the next five years, given the changes to the NHS commissioning structures for mental health. The proposal in this paper is to develop a set of key principles which will link to local CCG strategies for Mental Health and enable coordination between NHS and KCC as well as other partners

This paper also proposes that the governance of this whole system mental health strategy is transferred to the Kent Health and Wellbeing Board.

Recommendations:

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

i) Comment on the approach to develop a new and updated set of guiding principles for mental health commissioning, based on the previous Live it Well Strategy Commitments.

ii) Comment on the timescales for the development of the principles across the Kent health economy.

iii) Comment on and endorse the governance for Mental Health 'whole system' commissioning and the move to the Health and Wellbeing Board as per the timescales set out in the report.

iv) Agree that commenting on, or the direction of specific KCC Public Health and Social Care mental health decisions remain the business of this committee.

1. Introduction

1.1 This paper presents the update on the Live It Well strategy for mental health and wellbeing for Kent. The Strategy was live from 2010 to 2015 and there has been an agreement to extend the life of the strategy to 2016 while the Kent health and well-being economy decide its next strategic direction. The strategy has 10 principles, described in this paper, and they broadly follow national guidance on responsible commissioning in mental health. However, since the strategy's development, there have been many commissioning changes and therefore Kent County Council and the seven CCGs are reviewing the outcomes in the current strategy with the aim of creating a framework that is more fit for purpose for 2016-2020.

1.2 The “Live it Well” strategy was presented to Members at the Adult Social Services Policy Overview and Scrutiny Committee on 30 March 2010. It set out a strategy for delivering Kent’s mental health services for the next five years. The aim of the strategy is to promote good mental health and wellbeing in the community, reduce the number of people who have common mental health problems, and lessen the stigma and discrimination associated with mental ill-health.

1.3 “Live it Well” targets prevention at those at higher risk but also wants to make sure the right services are there when people need them. Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships. Wherever possible, services will be community-based, targeted towards primary care and close to where people live.

1.4 These attributes were decided following consultation with service users and carers. They said they wanted services that were local, personalised, timely and non-stigmatising. The “Live it Well” strategy fits well with the national policy “No Health without Mental Health”

1.5 The Kent Joint Health and Wellbeing Strategy sets five strategic outcomes to improve the health and wellbeing for Kent residents. Outcome four of that Strategy aims to support people with mental ill-health issues to ‘live well’. These link closely but not exactly to the Live it Well strategy.

1.6 The Health and Social Care Act 2012 has provided a new structure for commissioning mental health services across Kent, with some services such as offender mental health services being commissioned by NHS England, with the majority of services transferring from Primary Care Trusts to the Clinical Commissioning Groups (CCGs). Since the development of the strategy the landscape has changed dramatically, along with new policies such as the Crisis Concordat.

1.7 *NHS Five Year Forward View*: published in 2014, the Forward View sets out a vision for the future of NHS. It contains ambitions to invest much more heavily in prevention, as well as closing the gap between physical and mental health services *(*parity of esteem*)*.

1.8 The 2014 Care Act introduced major new duties for local authorities in relation to how they conduct assessments, the way they plan care and how they support carers.

1.9 Kent Public Health publish a Mental Health Needs Assessment which gives the 'whole system' overview and commissioning recommendations which feed into the Kent Joint Strategic Needs Assessment. The headlines for the last JSNA highlighted self-harm, adult personality disorder, eating disorders, access to psychological therapies and better data quality for severe mental illness.

2. Live it Well Strategy for Kent 2010- 2015

2.1 The strategy is based on 10 commitments, to be delivered during the lifetime of the five year strategy. These 10 commitments are:

- Public services, the voluntary sector, and the independent sector will work together to improve mental health and wellbeing.
- We will lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services.
- We will reduce the occurrence and severity of common mental health problems by improving wellbeing for more people at higher risk.
- We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities.
- We will reduce the number of suicides.
- We will ensure that all people with a significant mental health concern, or their carers, can access a local crisis response service at any time and an urgent response within 24 hours.
- We will ensure that all people using services are offered a service personal to them, giving them more choice and control.
- We will deliver better recovery outcomes for more people using services with care at home as the norm.
- We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service.
- We will deliver more effective mental health services for offenders and those anywhere in the criminal justice system.

3. Outcomes Achieved 2015

Commitment	Review of Actions
• Public services, the voluntary sector, and the independent sector will work together to improve mental health and wellbeing	• The Live It Well website and social media accounts have been developed which work together to promote over 450 mental health and wellbeing services • Organisations such as Kent Police are asking their front line officers to promote the website • A community mental health and

	wellbeing service is being currently tendered across Kent in conjunction with CCG's
• We will lessen the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services	• KCC PH are rolling out both the *Six Ways to Wellbeing* campaign and *Mental Health First Aid* training to the community • Kent County Council (as an employer) has also signed up to the Time To Change campaign designed to raise awareness of mental health in the workplace • Kent CCG's have instructed all providers for NHS contracts 2015/16 to be working towards Mindful Employer status and to ensure all staff are MH awareness trained
• We will reduce the occurrence and severity of common mental health problems by improving wellbeing for more people at higher risk	• A series of psychological talking therapies (often referred to as IAPT services) are being delivered across the county
• We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities	• Mental health liaison services are now available in A&E departments. Hospitals are receiving support from mental health nurses and consultants in acute settings. CCG's are tasked with commissioning and providing high quality health care for people with long term conditions including mental health via health checks and pro-active care.
• We will reduce the number of suicides	• Despite the implementation of the 2010-15 Kent and Medway Suicide Prevention Strategy, the number of suicides per year has increased (particularly amongst men) and the Kent rate is now higher than the national rate • A number of initiatives to targeting men's mental health (for example the Kent Sheds Project and mental health first aid) have been implemented and will form part of the 2015-20 Suicide Prevention Strategy
• We will ensure that all people with a significant mental health concern, or their carers, can access a local crisis	• The Kent and Medway Mental Health Crisis Concordat have been signed by over thirty organisations within Kent.

response service at any time and an urgent response within 24 hours	An associated Action Plan sets out a wide variety of measures which will improve how individuals suffering a MH crisis will be cared for and treated
• We will ensure that all people using services are offered a service personal to them, giving them more choice and control	• The development of the Community Mental Health and Wellbeing Service – offering non stigmatising, wraparound, social support and signposting will be commissioned in 2016 • There are 99 accredited Brokers who have worked with 171 people to develop their individualised support plan during 2014-2015
• We will deliver better recovery outcomes for more people using services with care at home as the norm	• Primary Care Community Link workers and specialist mental health workers are in place across the county to better support people in recovery
• We will ensure that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service	• A Dual Diagnosis Protocol has been agreed between KMPT, KCC and substance misuse providers and is currently being embedded into practice and commissioning strategies
• We will deliver more effective mental health services for offenders and those anywhere in the criminal justice system	• A community offender's health needs assessment has been undertaken and highlighted the need for offenders to be given appropriate MH and substance misuse services. NHS England are the lead partners. Since the strategy was developed the commissioning arrangements for prisons and probation have changed considerably • There is also considerable emphasis more recently on drug and alcohol services and Domestic Violence

4. Progress to Date

4.1 There has been considerable progress with a number of these commitments. KCC, through Adult Social Care and Public Health, has made a contribution, either in a leading role or in supporting CCG colleagues, in many initiatives designed to deliver on these commitments.

4.2 There is a 'one stop' on-line resource – called **Live it Well Website.** This has had increased investment and significant improvements made over five years, e.g. A revised search facility was launched in August 2013 so that information can be accessed by CCG area on the "Live it Well" website.

The new database of over 420 resources enables people to search under common mental health issues such as anxiety or depression. This website is a collaboration between KCC, CCGs and West Kent MIND and is the public focus of the "Live it Well" strategy. It provides easy access to extensive information about local mental health and wellbeing services, reducing the stigma that can be attached to mental health and connecting people to resources that can reduce the occurrence and severity of common mental health problems. It also hosts the Public Health Six Ways to Wellbeing campaign. The website was used by 76,802 people during 2013-2014 with 153,769 page views. Compared with 2014, 2015 saw 81,382 people using the website, with 215,381 page views, a 5.6% increase in people using the site and 40.07% increase in engagement in page views. The website is found at www.liveitwell.org.uk

4.3 Support from the Mental Health Matters helpline is now available 24 hours a day, 365 days a year. People feeling distressed, anxious or down, are able to call the Mental Health Matters helpline on 0800 107 0160. Support workers at the helpline use counselling skills to provide confidential emotional support and guidance, free of charge. They also have details of a range of self-help resources and local services. Between April 2014 and April 2015, there were a total of 15,939 calls countywide, compared to 2,078 calls for the same period in 2010. This represents a 667% increase in calls over a 5 year period.

4.4 The Live it Library is where service users, carers and professionals can tell their recovery stories. This is a collaborative project between KCC, Kent and Medway NHS and Social Care Partnership Trust. The library now contains over 60 'books' of personal stories. The project aims to challenge stigma, promote understanding, offer hope and enable people to talk about their experiences of living with mental health issues. The library has now successfully moved to the KMPT website http://www.kmpt.nhs.uk/live-it-library/live-it-library.htm.

4.5 The Live it Well strategy promotes personalisation, giving more choice and control to service users, There are now 99 brokers accredited by Signpost UK: an independent organisation that provides assurance that brokers will always act with probity and in service users' interests. These brokers have assisted KCC in having over 800 people receiving self-directed support. This service principle has been incorporated into the community mental health and wellbeing service.

4.6 KCC has contributed to the development of a protocol for services for those people with both mental health needs and substance misuse, to ensure services work together and people receive effective services. These have been backed up with promotion and training activities across all involved organisations in the statutory and independent sectors. An increased number of people accessed alcohol treatment in 2013-2014 whilst the number of people accessing drug treatment declined during the same period. A key area of concern is the higher than average proportion of people entering prison with substance misuse dependency that were not previously known to community treatment teams.

4.7 There has been a significant improvement in the access to psychological talking therapies with improved choice of providers. Investment has risen from £1.8 million in 2009/2010 to £6 million in 2013/2014. These services can be accessed through a GP referral or self-referral. During 2013/14 there were around 31,855 referrals to primary care talking therapies across Kent. Overall this is a success in Kent with South Kent Coast CCG being the 5th best access to therapy in England and having the 15th best recovery rates in the UK. West Kent CCG was the worst CCG 18 months ago but recent indicators show that they have now hit the national target.

4.8 CCGs have developed primary care mental health specialist roles in order to support people who have long term mental health conditions being discharged from secondary services back to primary care. The practitioners' role is to support the GP with improving their physical health such as smoking cessation, weight management, tackling malnutrition and substance misuse as well as ensuring they are managing their mental health and are linked into community resources.

4.9 In partnership with Public Health, Adult Social Care and the CCGs there has been a further investment of £500k into primary care with the establishment of the primary care community link worker service to all Clinical Commissioning Group (CCG) areas in the county of Kent, commencing 1st October 2013. This contract has been extended for a further 6 month period and will be incorporated into the new Community Mental Health and Wellbeing service from the 1st April 2016. The aim of the service is to provide individually tailored, one to one and time limited support to individuals with mental health needs to access community resources and to promote social inclusion. During 2014 - 2015 this resulted in:

- 1581 people in contact with service this year
- 1417 (89%) exits (successfully completed programme)
- 49% presented with housing and/or benefits as an issue that impacted their mental health & wellbeing
- 28% of referrals are self-referrals
- 87% report higher confidence, self esteem
- 70% state that they feel less isolated
- 83% feel better able to manage mental distress

4.10 The vision for the community mental health and wellbeing, service which is currently being tendered, is to keep people well and provide a holistic offer of support for individuals living with mental health and wellbeing needs in Kent and to deliver support in line with national and local guidance and protocols. Everyone who experiences mental health needs has the right to individually tailored one-to-one support to engage in mainstream social leisure, educational, and cultural activities, in ordinary settings, alongside other members of the community who are not using services. The new approach will put a greater focus on outcomes and engage people in innovative ways to achieve these outcomes. Key aims of the service are to; aid recovery and prevent relapse, improve health and social care outcomes for individuals with poor mental health and wellbeing, prevent suicide and reduce the stigma associated with mental illness (parity of esteem), prevent

entry into formal social care and health systems, and prevent negative health outcomes associated with poor mental health.

4.11 The ways in which people are supported can be flexible, person-centred and can help people to make the best use of their community. Providers will help connect and empower communities as there is extensive evidence that connected communities are healthier communities. The service will ensure compliance with statutory responsibilities consistent and equitable across Kent (excluding Medway) providing the right advice, information and assistance to support people across the spectrum of severity. (The service will include the transition challenges faced by young people into adulthood). The model will be based on social inclusion using a community emotional wellbeing, mental health and recovery model and will deliver social interventions through the community to anyone needing mental health and wellbeing support in Primary Care.

4.12 Liaison psychiatry services based in Kent's general hospitals improve the quality of care for people attending or admitted with a mental health condition, prevent unnecessary admissions and reduce their lengths of stay. There was a 20% reduction in the number of people known to secondary care mental health services who attended Kent's emergency departments. There has been new investment from the CCGs to develop new models of services to support individuals and prevent a crisis through crisis cafes.

4.13 Access to a specialist mental health assessment has improved considerably over the last 3 years and there is now a single point of access for all referrals to secondary mental health services. Nationally there has been a significant rise in demand for acute mental health inpatient beds which has resulted in patients from Kent being admitted out of area when a bed is not available locally. The plan to reconfigure acute services has seen an increase in local beds and strengthening of crisis resolution home treatment services.

4.14 The Approved Mental Health Professional (AMHP) service was reviewed in 2012/2013. This saw the development of a new model of service in June 2014. This service is centrally managed with all referrals for Mental Health Act assessments being received, triaged and assessed. There has been a 13% increase in referrals to the Kent AMHP service from 2013-2014 to 2014-2015. Nationally the increase was 5%. Section 136 assessments account for over a third of Mental Health Act assessments in the last financial year.

4.15 More effective mental health services have been provided for offenders through a registered mental health nurse being in every police station 7 days per week 7.00am – 9pm across Kent and Medway. No victim of a sexual assault aged 13+ has to wait no more than 1 hour for examination and assessment. Every prisoner across Kent and Medway has access to improving access to psychological therapies (IAPT) across Kent and Medway's prison estate, including Medway secure training centre and Cookham Wood young offender institute.

4.16 There were 182 suicides in Kent and Medway in 2013, an increase from 145 in 2012. In 2013, there were 36 suicides where an individual had had contact with KMPT in the last 12 months. Occupations such as construction, road transport drivers and agriculture have high rates over suicide in Kent over the last decade. The 2015-2020 suicide prevention strategy will: reduce the risk of suicide in key high risk groups; tailor approaches to improve mental health and wellbeing in Kent and Medway; reduce access to the means of suicide; produce better information and support to those bereaved or effected by suicide; support the media in delivering sensitive approaches to suicide and suicidal behaviour: support research, data collection and monitoring. A full report on the Suicide Prevention Strategy was presented to this Cabinet Committee in July 2015.

5. Development of Kent Wide Guiding Principles for Mental Health 2015-2020

5.1 The review of the Live it Well Strategy has been considered by each CCG and NHS England and Partners to assess the direction of travel for Mental Health Commissioning in Kent for the next 5 years.

5.2 Currently the commissioning responsibilities fall to a number of agencies: KCC is responsible for Social care and support, suicide prevention, mental health promotion and substance misuse and rehabilitation as well as duties under the Care Act. NHS England is responsible for Specialist Mental Health and Prison & Offenders. CCGs are responsible for Acute, Community and placements.

5.3 The 7 Kent CCGs have arranged their mental health commissioning to be organised via 3 co-ordinating Centres (The East Kent CCGs co-ordinated by South Kent Coast) and have by far the largest share of the Commissioning budget.

5.4 Due to the fact that all commissioning partners (NHS England, NHS CCGs) have their own priorities and strategies, they have agreed to work together with KCC to develop a set of shared 'principles' rather than share one over-arching strategy. It has been agreed that the branding of "Live it Well" should continue for these principles.

5.5 There is little appetite to refresh one sole Mental Health strategy for all Kent commissioners. A better way forward, suggested by the NHS partners, is to use the Health & Wellbeing Board and its shared Health and Well Being strategy as the joint strategic approach. Outcome 4 of the Health and Well Being Strategy is for Mental Health and the strengthening of this outcome may be sufficient.

5.6 The review of the current Live it Well Strategy (by the NHS CCGs) has showed the current 10 strategic 'Commitments' were more similar to 'guiding principles' rather than clear, measurable, strategy objectives, and has also suggested that they be strengthened and updated to reflect current concerns e.g. Self Harm, Parity of Esteem.

5.7 The proposal is that a task and finish group be set up to agree a refreshed set of 'Principles' that all partners can sign up to, broadly similar to the 10 Live it Well Commitments described in this paper. However the principles will be

updated to reflect current Kent concerns and widely engage stakeholders, including KCC members.

5.8 Under a set of new 'Principles', each Commissioning agency e.g KCC, NHS England and NHS CCGs will publish their commissioning plans linked to Outcome 4 of the Health and Well Being Strategy for Kent. As the Live it Well branding is well known across Kent and fits with the Health and Well Being Strategy, it is proposed that this title is kept. CCG and NHS leads have agreed this approach.

5.9 KCC already has a Suicide Prevention Strategy, an Alcohol Strategy, and a commissioning plan for Community and Primary Care Well Being. A Drug Strategy is being developed and all fit under the objectives of Outcome 4 of the Health and Well Being Strategy for Kent.

6. Governance

6.1 The current governance arrangements are that a report is presented to the Adult Social Care and Health Cabinet Committee on a yearly basis on the progress of the Live it Well strategy.

6.2 As this is a multi-agency approach to delivering mental health services, it is proposed to transfer the reporting of this and its updated 'principles' to the Kent Health and Wellbeing Board so that it becomes more strategically aligned to the Health and Wellbeing Strategy (Outcome 4).

6.3 Strategies that are specifically led by KCC and decisions required on elements of the Live it Well strategy (both Public Health and Social Care) will remain the business of the Adult Social Care and Health Cabinet Committee.

7. Timescales

7.1 A set of new and updated Principles for Mental Health Commissioning to be developed and agreed by all partners (based on the 10 Commitments of the current Live it Well Strategy).

7.2 Any replacement key principles must be agreed across the whole mental health economy, with the following timescales.

- Autumn 2015 - public and stakeholder engagement and development of key principles – Public Health lead.
- Winter 2015 - preparation of a draft strategic framework for mental health commissioning – Public Health lead.
- Spring 2016 - public consultation.
- April 2016 - formal adoption.

8. Recommendations:

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

i) Comment on the approach to develop a new and updated set of guiding principles for mental health commissioning based on the previous Live it Well Strategy Commitments.

ii) Comment on the timescales for the development of the Principles across the Kent health economy.

iii) Comment and endorse the governance for Mental Health 'whole system' commissioning to the move to the Health and Wellbeing Board as per the timescales above.

iv) Agree that specific County Council Public Health and Social Care mental health decisions remain the business of this committee.

9. Background Documents

Live it Well: the strategy for improving the mental health and wellbeing of people in Kent and Medway 2010 – 2015.

10. Contact Details

- **Lead Officers:**

- Jessica Mookherjee, Consultant in Public Health
  03000 416493
  Jessica.mookherjee@kent.gov.uk

- Sue Scamell, Commissioning Manager Mental Health
  03000 415482
  Sue.scamell@kent.gov.uk

Relevant Director

Andrew Scott-Clark
Director of Public Health
0300 333 5176
Andrew.scott-clark@kent.gov.uk

Penny Southern
Director of Disabled Children, Adults Learning Disability and Mental Health
03000 415505
Penny.Southern@kent.gov.uk

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By:	Graham Gibbens, Cabinet Member, Adult Social Care and Public Health Andrew Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee
Date:	11th September 2015
Subject:	Future Direction for "Mind The Gap: Reducing health inequalities in Kent"
Classification:	Unrestricted
Pathways:	This is the first committee to consider this report
Electoral Division:	All

Summary

Health Inequalities remains an issue for the population of Kent and particularly the populations living in the most deprived decile where life expectancy step changes down for both men and women.

Whilst the gap in life expectancy has narrowed for men, it is widening for women and this appears to be driven by rising rates of COPD and lung cancer mortality.

The current Mind the Gap focused upon the Marmot objectives and although these continue to be relevant for reducing health inequalities, any new Kent plan must focus upon the places and communities the most deprived population with the lowest life expectancies of Kent live.

Measurement of deprivation is being updated in late September and analysis and stock take will be based upon the areas identified using IMD 2015.

This means a full new plan based upon the impending publication and local review take will not be ready until early in the new year

Recommendation:

Members of the committee are asked to comment on the proposed direction of travel and time scales for developing a new health inequalities plan for Kent.

1. Introduction

1.1 Health Inequalities are differences in health outcomes between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

1.2 The national vision is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest which is measured through two key targets in the Public Health Outcomes Framework:

Outcome 1: Increased healthy life expectancy

This takes into account the quality of health as well as the length of life measure and uses a self-reported health assessment, applied to life expectancy.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities.

1.3 In 2012 Kent County Council adopted the Kent Health Inequalities Action Plan titled "Mind the Gap Building Bridges to better health for all".

Mind the gap was built upon the six key policy objectives derived from the work of Sir Michael Marmot entitled "Fair Society, Equal Lives" published in 2010.

The policy objectives are as follows:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

1.4 Those policy objectives are still as relevant today as they were when published in 2010. However just using these policy objectives without providing a greater geographical focus on the communities suffering the worst health and lowest life expectancy, and planning over an unrealistic time period will not in themselves reduce health inequalities significantly.

1.5 Since the approval and publication of Mind the Gap, some significant structural changes have been made in the health and social care sector, not least being the move in April 2013 of the responsibility for Public Health to upper tier local authorities as a result of implementation of the Health and Social Care Act

1.6 This report provides a summary update on the progress made in reducing health inequalities and proposes some principles for the future direction and focus of our reducing inequalities work.

2. Progress

2.1 The standard way of measuring health inequalities is to measure differences in life expectancy. The population is divided into ten equal groups (deciles) based on the Index of Multiple Deprivation (IMD 2010) and then looking at average life expectancy for each decile. This is achieved by building up populations from Lower Layer Super Output Areas, ranking them on the basis of IMD score and finding the average life expectancy for each of the ten groups. Life expectancy is then plotted against the most deprived to least deprived decile and the steepness of the slope represents the inequality of life expectancy that is related to deprivation in the population being studied. The actual gap in life expectancy is taken as the difference between the least and most deprived on the line of best fit.

2.2 It is obvious over the last two years that Public Health analysis has been at both decile level and quintile level, both of which are valid but give very different answers in terms of the difference in years of life expectancy. All future analysis of health inequalities based on life expectancy will be done at the decile level, not quintile.

2.3 Analysis of the current Kent picture of health inequalities using the methodology described in paragraph 2.1 above shows:

- 7.1 life expectancy gap for men
- 5.1 life expectancy gap for women.

This is based on pooled data for 2011-2013 as can be seen in the Charts in Figure 1 Life Expectancy gap in Kent 2011-2013.on the following page.

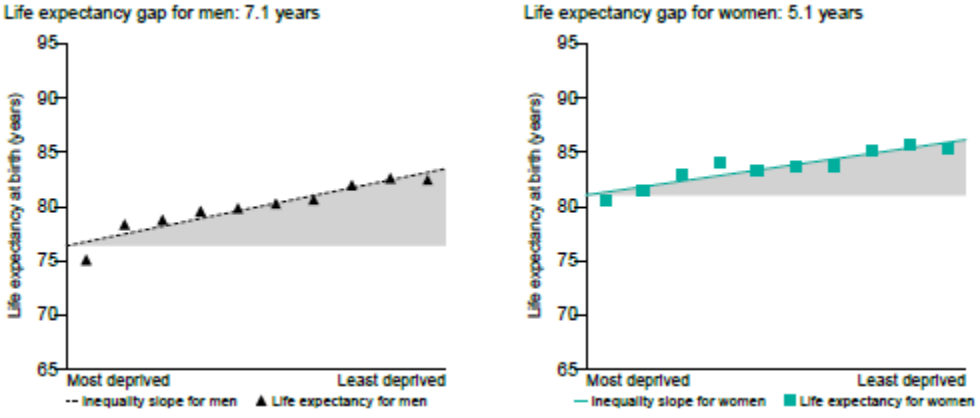


Figure 1 Life Expectancy gap in Kent 2011-2013.

2.4 It is quite clear that people living in the most deprived decile are experiencing the poorest health outcomes and the shortest lives in Kent, in fact so poor and so short the indicator is not included in the line of best fit for the other nine deciles of life expectancy, particularly for men, but this is also true for women. There is also a clear step down between the 9th decile and the lowest decile.

2.5 This decile therefore must be the focus of Kent's future inequalities work and requires a joined up disproportionate response to reduce the disparity.

2.6 Since 2011 in Kent, the trend for health inequalities in men has generally been decreasing over the last five years.

For women in Kent over the same time period the trend has changed from reducing to more recently increasing and overall the gap in life expectancy has increased between the least and most deprived female population in the last five years

Data Years	Life Expectancy Gap – Males years	Life Expectancy Gap – Females years
2007-2009	8.1	5
2008-2010	8.2	4.5
2009-2011	8.2	4.5
2010-2012	7.1	4.8
2011-2013	7.1	5.1

2.7 An analysis of what is driving the increasing trend for the recent widening of the gap for women suggests an increasing upward trend in mortality rates in women from chronic obstructive pulmonary disease (COPD) and a recent rise in mortality rates in women aged under 75 due to lung cancer.

2.8 Smoking rates are strongly associated with both lung cancer and COPD and we also know the smoking rates also account for about half of the inequality gap.

3. Future Direction

3.1 Currently all analysis of deprivation is based on the Index of Multiple Deprivation (IMD) 2010. This is a full five years out of date and also is based

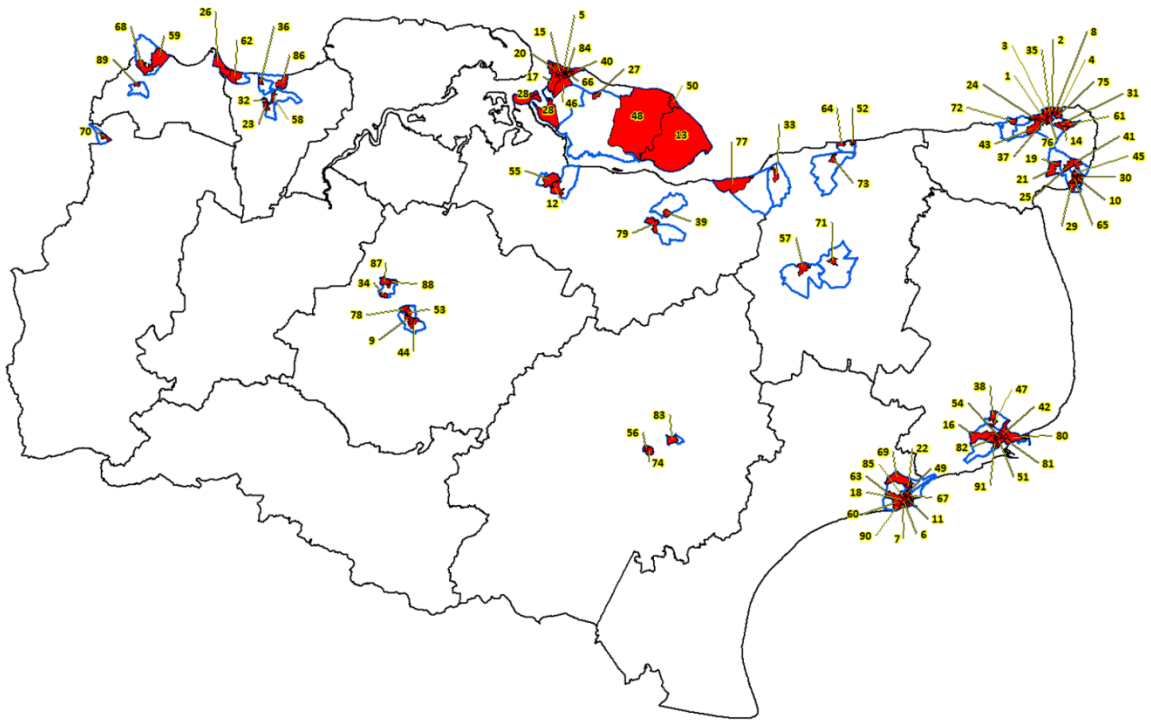
on census population information collected in 2001.

3.2 The Department for Communities and Local Government (DCLG) is currently updating the indices of deprivation, including the Index of Multiple Deprivation (IMD). The indices of multiple deprivation 2015 are likely to be published in late September 2015. Whilst we don't expect an updated IMD to radically change the geographical areas we classify in the lowest decile, any plan should use the most contemporary information and data available.

3.3 As described previously, the population associated with the most deprived decile are suffering the poorest health outcomes and have the lowest average life expectancy. Our focus must be on identifying exactly who and where these populations are and focusing a much greater and coordinated response with these communities; a disproportionate response.

3.3 Analysis using the IMD 2010 shows the populations to be in the areas identified in the map below

Map showing the 91 LSOAs which form the most deprived decile in Kent based on the 2010 Indices of Multiple Deprivation



3.4 Preliminary analysis using IMD 2010 also shows that life expectancy within the 91 lowest deciles varies between each LLSOA and development of the new plan will prioritise which areas in Kent to focus on.

3.5 Moving to a more place based approach will also require local areas to be more joined up and focused on gaining local health improvements and outcomes that will influence life expectancy over the short, medium and long term

3.6 This new placed based approach should have three main components and plans to improve life expectancy and should be joined up and co-ordinated

across the various local public sector organisations The three components include:

1. The Health Service response.
2. The partnership response.
3. Working with local communities in the target areas

3.7 The Health Service response reflects the current variation in delivery of health services to populations in the lowest decile of multiple deprivation. For each area we will need to analyse what are the key causes of premature mortality for people in the lowest decile, how many people that relates to, how many people and what are the key, evidence based interventions required to reduce premature mortality.

3.8 The partnership response will need to look more broadly at the wider determinants of health, for example local economic regeneration, employment, quality of housing, educational attainment and focus on enhancing delivery through working together.

3.9 The third component is about the local communities themselves and how we collectively work with these communities to enhance social capital and cohesion build on local community assets to enhance local outcomes.

3.10 There will therefore be the expectation that local areas will develop local agreed plans in order to focus effort into local places and communities.

3.11 Paragraph 3.4 described the variation in life expectancy for those people living with the 91 lowest deciles. Joined up and coordinated action is already taking place in some areas and it is not the intention of this placed based approach to stop supporting those areas, rather it is to provide focus upon the areas which continue to do less well.

4.0 Timescales

4.1 The new IMD 2015 will not be published until late September and we therefore envisage a draft plan to come back early in the new year

4.2 Timescales are envisaged as follows:

June, July, August 2015	Planning our approach
September 2015	Cabinet Committee paper on approach
September to December 2015	Review and analysis based on IMD 2015.
Draft new plan to this Committee prior to key decision to adopt approach	January 2016.

5.0 Conclusion

5.1 Health Inequalities remains an issue for the population of Kent and particularly the populations living in the most deprived decile where life expectancy step changes down for both men and women.

5.2 Whilst the gap in life expectancy has narrowed for men, it is widening for women and this appears to be driven by rising rates of COPD and lung cancer mortality.

5.3 The current Mind the Gap focused upon the Marmot objectives and although these continue to be relevant for reducing health inequalities, any new Kent plan must focus upon the places and communities the most deprived population of Kent live.

5.4 Measurement of deprivation is being updated in late September and analysis and a detailed analysis and review will be based upon the areas identified using IMD 2015.

5.5 This means a full new plan based upon the impending review and analysis will not be ready until early in the new year

6.0 Recommendation

Members of the committee are asked to comment on the proposed direction of travel and time scales for developing a new health inequalities plan for Kent.

Background documents

"Mind the Gap Building Bridges to Better Health for All"
http://www.kent.gov.uk/__data/assets/pdf_file/0008/14777/Mind-the-Gap-Building-bridges-to-better-health-for-all.pdf

Report Prepared by

Andrew Scott-Clark
Director of Public Health
03000416659
andrew.scott-clark@kent.gov.uk

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 11th September 2015

Subject: Kent Sheds Update

Classification: Unrestricted

Electoral Division: All

Summary:

Kent Sheds is a pioneering and ambitious approach to improving the mental wellbeing of the population (principally aimed at men) by delivering community activities. Sheds were pioneered in Australia and New Zealand in the 2000's due to the lack of men accessing help for emotional wellbeing. Kent has higher suicide rates for men and in 2013 a partnership between public health and KCC Policy developed the SHED programme for Kent, then attracting LIBOR funding for veteran and ex-military men.

Since 2013 the programme has become popular with local people. There are currently 20 Sheds across Kent, including a mobile Shed, that are targeted at men aged 40 to 60, but are inclusive to all adults. There are over 200 members attending Sheds on a regular basis and around 3,000 attendances to date. Kent has the highest density of 'SHEDS' in the UK.
Kent Sheds are given some start-up funding to help them develop and members are encouraged to support Sheds in their local area so to help them become sustainable and attract new members (Shedders).

Recommendations:

Members are asked to comment on the paper, and to support the Sheds programme within their communities.

1. Background

1.1. KCC Public Health has been supporting local, individuals, community groups and organisations to establish a number of Shed projects across the county as part of the Kent Mental Wellbeing Investment Programme. The project improves both physical health and mental wellbeing of participants; benefits local communities and supports men in developing skills for employment.

1.2. The Sheds movement originated in Australia, where there are currently 690 Sheds and over 90,000 Shed members – frequently referred to as 'Shedders' (AMSA, 2015). The Sheds movement has spread to other parts of the world, and there are now over 80 Sheds up and running in the UK.

1.3. According to the Australian Men's Sheds Association (2015) a Shed can be defined as: "a community-based, non-profit, non-commercial organisation that is accessible to all men and whose primary activity is the provision of a safe and friendly environment where men are able to work on meaningful projects at their own pace, in their own time, in the company of other men. A major objective is to advance the wellbeing and health of their male members" (AMSA, 2015).

1.4. The Kent Shed concept and brand was developed with the help of Activmobs (a community insights organisation), Groundwork South, KCC representatives from both Policy and Public Health and most importantly local men in 2013. It had two main objectives, to support ex-military men to reintegrate (externally funded) and to provide accessible opportunities to combat social isolation for men of all ages in Kent.

2. How Kent Sheds operate

2.1 A Kent Shed is a place where men (and women, if they are interested) can go to socialise, share skills and spend time with other men while working on practical projects of value to the community.

2.2 The Kent Sheds programme has been commissioned out to a lead voluntary sector organisation called Groundwork South. The Kent Shed Officer employed by Groundwork helps interested men develop their Shed idea and where needed put in a grant application to the Kent Sheds fund. The programme is also part funded by the Libor Fund which looks to support veterans and ex-service personnel. As such, we support groups who want to establish Sheds that welcome ex-service men and women

2.3 Funding is awarded to enable the setup of the Shed, rather than an ongoing commitment of funding. The activities or Sheds are commonly low cost and Shedders give their own time and resources to make the Sheds a success and build a sustainable project. Sheds are also encouraged and supported to source additional funding so to maximise the KCC investment.

2.4 Kent Sheds have taken a different approach to the traditional Men's Shed; we encourage men of all ages to get involved. Whereas elsewhere, Sheds have tended to be focussed on older men, we have younger men who may be at risk of isolation through unemployment or caring roles, participating as well as some women who attend. Intergenerational skills sharing and mentoring were seen as important factors in moving to 'all ages welcome' Sheds.

3. Evidence for Sheds

3.1 The rationale behind the Sheds movement is that men especially those who are aged 40 to 60 years may be less likely to access conventional approaches to improving mental wellbeing e.g. counselling and talking therapy. Instead, research indicates men prefer to be engaged in the company of their peers, and practical activities. The Sheds approach sees men working 'shoulder to shoulder' to support each other.

3.2 A wealth of research supports shows that the Sheds model leads to improved mental health and wellbeing outcomes for men (Ballinger, Talbot & Verrinder, 2009; Brown, Golding & Foley, 2008; Cordier & Wilson, 2013; Morgan, Hayes, Williamson & Ford, 2007; Ormsby, Stanley & Jaworski, 2010). The key outcomes include feeling a sense of purpose, being part of something and having a sense of belonging, learning new skills in a supportive environment and feeling like they can give back to the community (Ballinger, 2007, Ballinger; Talbot and Verrinder, 2009). This does not mean that men cannot benefit from psychological therapy – but due to their poor access in seeking help– they are more vulnerable to extreme expressions of distress and commit suicide at higher rates than women.

4. Progress to date

4.1 There has been an overwhelming response to the programme and twenty Sheds have been funded to date. Sixteen are currently open, with four which are still in the planning stage. Further information can be found in appendix 1 on individual sheds or via the website www.kentsheds.org.uk.

4.2 There is a huge diversity of the sheds funded and many are themed around sustainable activities such as gardening, woodwork, boats or arts, whilst others are focused on supporting the local community. One of the sheds is a mobile shed which is currently touring the county across the summer months to generate further interest for new sheds.

5. Key outcomes

5.1. With 20 Sheds funded to date this currently represents around 20% of Sheds in the UK. 5.2. In 2014/15 252 individuals attended Sheds including 111 veterans. There have been 3,281 attendances at Sheds to date and an average of 218 attendances per month.

5.2. Based on initial analyses of their Warwick Edinburgh Mental Wellbeing Score (in March); 87% improved their wellbeing score using the Warwick Edinburgh wellbeing scale. A number of Shedders have also gone on to gain paid employment as a result of their work in Sheds.

5.3. A number of other Sheds that have naturally developed have also affiliated with the Kent Sheds brand including those in Medway and a network of champions has been set up facilitated by Groundwork to help Sheds to share best practice and build sustainability.

5.4 Kent Sheds has attracted national attention. It has been featured in a men's forum research report on promoting health and wellbeing in men conducted by the Leeds Beckett University (*What Works?*). It has also been featured in part of a film on Sheds broadcast on a community Chanel (*Better Shed than Dead*) and in a book on Sheds written by the Australian Barry Golding (*Australia Men's Sheds Pioneer*).Over the next year the Kent Sheds team will continue to encourage groups across Kent to set up their own Shed project and help those who have opened to be sustainable.

6. Future for Sheds

6.1 Over the next year the Kent Sheds team will continue to encourage groups across Kent to set up their own Shed project and help those who have opened to be sustainable.

7 Recommendation

Members are asked to comment on the paper, and to support the Sheds programme within their communities.

8 Background information

Please visit: www.kentSheds.org.uk
Email: Julie.cowdry@groundwork.org.uk
Telephone: 01322 384 848.

9. Contact details:

Report Authors:	Relevant Director:
Vicky Tovey Commissioning Manager 03000 416493 Vicktoria.tovey@kent.gov.uk Jess Mookherjee Consultant in Public Health 03000 416779 Jessica.mookherjee@kent.gov.uk	Andrew Scott-Clark Director of Public Health 03000 416659 andrew-scott.clark@kent.gov.uk

Appendix 1: Location of Sheds and mobile Shed programme

Sheds to date:

SHED DETAILS	LEAD CONTACT	CONTACT DETAILS	MAIN ACTIVITY	
Dartford Men's Shed	Darren Riley	07871 972934 dartfordShed@outlook.com DA10 0JR	Community	Open
Kenward Trust Shed - Yalding	Michael Bourne	01622 814187 michael.bourne@kenwardtrust.org.uk ME18 6AH	Creative woodwork shop	Open
Boat Buoys - Gravesend	Ian Stevenson	01474 535022 i.stevenson@sky.com Gravesend Promenade DA12 2BS	Boat restoration	Open
Aylesford Shedders	Maria Gallego	07500 602031 maria.gallego@rbli.co.uk ME20 7NL	Gardening & allotment	Open
Buckland Shed - Cliffe	Scott Tovell	Bucklandfisherys@gmail.com ME3 7RT	Social/environment and skill sharing	Open
The Ashford Shed	Marc Pearson	01233 331919 marc@ashfordvineyard.org	Community/woodwork	Open
Abbey Physic Garden - Faversham	Stewart Morris	stewartmorris59@gmail.com ME13 7BG	Creative, sharing skills, gardens , support	Open
Maidstone Mind Men's World	Julie Blackmore	Maidstone Mind 23 College Road Maidstone ME15 6YH 01622 692383 julieblackmore@maidstonemind.org	Woodworking	Open
Bodger's Hut - Whitstable	Becky Richards	07759 772109 Stream Walk Community Garden Millstream Close Whitstable CT5 1RH	Woodworking	Open
Folkestone Shed	Mark Connorton	01303 259007 markconnorton@volunteershepway.co.uk 3 Mill Bay Folkestone CT201JS	Various community & creative	Open
Dover Community Shed	Vivienne Adam Secretary	07717863010 01304 211070	Community and creative	Open
The Shed - Northfleet	Gary May & Peter Scollard	07895876170 gary@nowallsgardens.org DA11 9SW	Gardening, creative, woodwork & community	Open

Dover Boat Shed	Terry Dickson	info@terancedickson.co.uk Dover Boat Shed Royal Cinque Ports Yacht Club CT16 1LA	Social, learning boat skills, sharing	Open
Mobile Shed - County wide	Linda Jones	07732 491914 lindajones10060@yahoo.com	Mobile Shed / community projects	Open
Park Wood Men's Shed - Maidstone	Nat Moody	Fusion HLC Park Wood Parade Maidstone ME159HL 01622 691177 natmoody@aol.com	Social weekly meet	Open
Riverside Active Lives Gravesend	Vince Durrant	Riverside Community Centre Dickens Road Gravesend DA12 2JY Riverside.activelives@aol.com	Creative/gardening	Open
Eaton Lands Shed Folkestone	Mark Connorton	01303 259007 markconnorton@volunteershepway.co.uk	Not yet operational	Planning
Elephant House Shed Maidstone	Derek Whitehead	Derek.Whitehead@kent.gov.uk Forstal Road Aylesford ME20 7AG 03000 414 842	Conservation / woodworking	Planning
Take Off Shed	Mark Kilbey	01227 788211 34 Military Road Canterbury CT1 1LT	Music/photography/ woodworking/craft/ healthy eating focus	Open
Mongeham Over 50's	Chris Burwash	07580350152 Christian Burwash chrisburwash@hotmail.co.uk	Gardening in the community Deal CT1	Open

Mobile Shed Programme of Visits

MONTH: August 2015

Date of planned visit	Location address where Shed will be parked	Planned Activity
30/07/15	Faversham	Promotion of Sheds project
4/08/15	Margate / Ramsgate	Promotion of Sheds
6/08/15	Maidstone	Promotion of Sheds
12/08/15	Cliftonville	Wood working
13/08/15	Canterbury	Promotion
18/08/15	Dover / Folkestone	Promotion
19/08/15	Ashford	Promotion
21/08/15	Sittingbourne	Wood working
24/08/15	Dartford	Gardening Community Allotment
26/08/15	Tonbridge / Tonbridge Wells	Promotion
27/08/15	Isle of Sheppey	promotion

More sessions are being planned for September

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Care Act Phase 2:

Delay of Introduction of Funding Reform Until April 2020

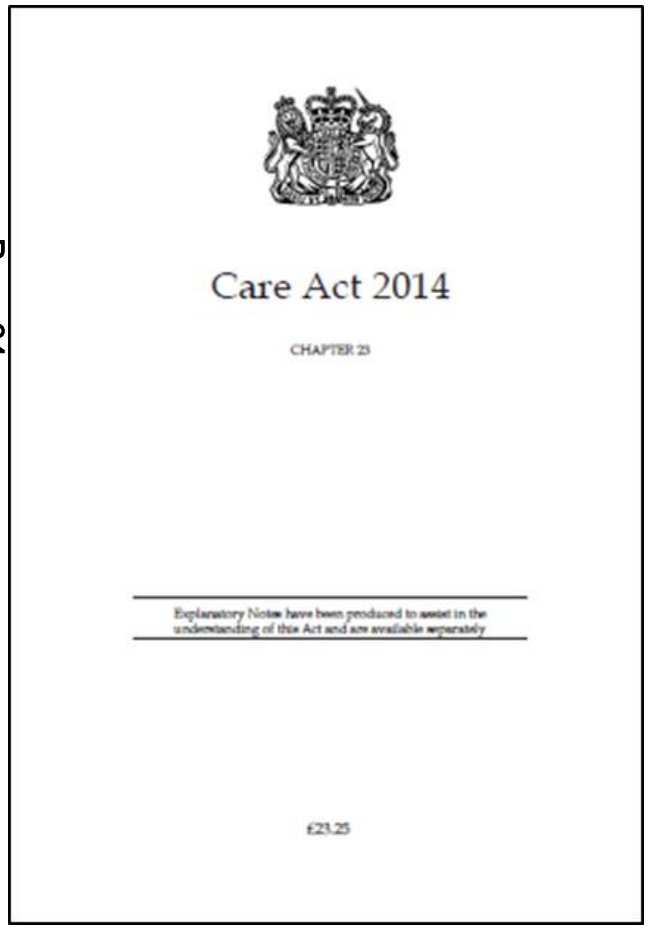
Presentation to the Adult Social Care and Health Cabinet Committee

11 September 2015

Michael Thomas-Sam, Strategic Business Adviser Social Care, Health and Wellbeing

Care Act – Phased Implementation

April 2015: the majority of key changes came into force



Care Act 2014

CHAPTER 23

Explanatory Notes have been produced to assist in the understanding of this Act and are available separately

£23.25

- New in law and practice
- New in law but not new in practice
- Consolidating or modernising existing law

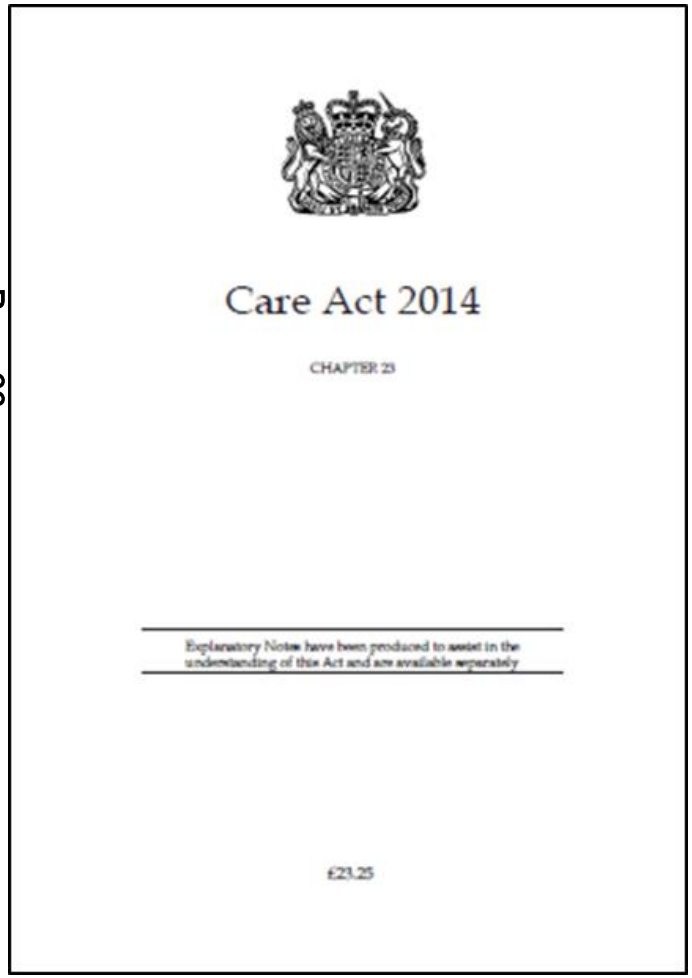
Updated information for the public & staff

The main changes introduced by Phase 1

Duties and other responsibilities	In place	And/or In progress	Embedding in practice
Prevention	✓	✓	✓
National eligibility criteria	✓		✓
Assessment of adult	✓		✓
Meeting care and support needs	✓		✓
Charging	✓		
IT systems	✓		✓
Carers support	✓		✓
Deferred payments	✓		
Information and advice	✓	✓	✓
Independent advocacy	✓		✓
Market oversight	✓	✓	✓
Safeguarding	✓		
Continuity of care	✓		✓
Transition	✓		✓
Provider failure	✓	✓	✓
Prisoners care and support	✓		✓

Care Act – planned phase 2 changes

There had been three planned key changes from April 2016



Care Act 2014

CHAPTER 23

Explanatory Notes have been produced to assist in the understanding of this Act and are available separately

£23.25

- Cap on care costs
- Changes to the capital limits
- Appeals system

17 July announcement to delay the above

Changes expected from April 2016 and now delayed until April 2020

Cap on Care Costs

- £72,000 if eligible needs confirmed at or after age 25
- Free lifetime care if confirmed before age 25

Changes to capital limits

- Non-residential: £27,000
- Residential: £118,000 unless former home disregarded, in which case £27,000
- The capital limit will now remain at £23,250 for the time being

Duty to "meet the needs" of self-funders in residential care if requested (section 18(3) of the Care Act)

- Extensive lobbying to delay this section which already applies to non-residential care and support

Other changes expected from April 2016 and also delayed

Direct Payments

- Direct Payments in residential care (announcement expected only after summer 2016)

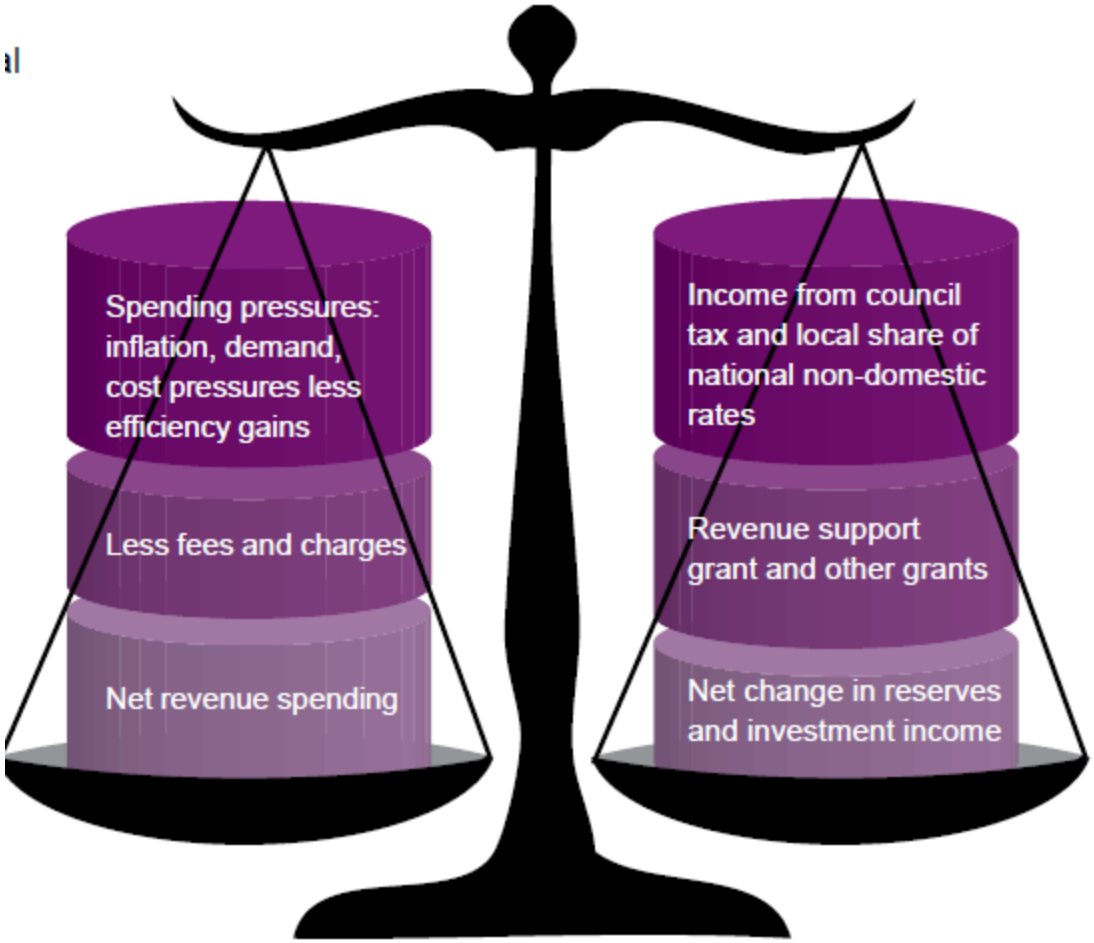
First party top-ups

- Extension of first party top-ups in residential care (delayed until further notice)

Appeals

- New Appeals System (a further announcement will be made about this towards the end of the year)

Balancing spending pressures and income



Key implications

Funding gap

- Estimated to be £700m a year and set to rise to £4.3bn by 2020
- Latent demand feeding through over time
- The extent to which new pension flexibilities may help

Budget announcement (national living wage)

- The LGA estimates that this will add an additional £340m funding pressure in 2016
- Wider workforce implications may add to other existing challenges

Local market conditions

- Provider response may vary leading to:
- Sustainability and quality of provision issues

Thank you

Michael Thomas-Sam, Strategic Business Adviser Social Care, Health and Wellbeing

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From: Matthew Balfour, Cabinet Member for Environment & Transport

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

To: Adult Social Care and Health Cabinet Committee – 11th September 2015

Decision No: 15/00079

Subject: An Active Travel Strategy for Kent

Classification: Unrestricted

Past Pathway of Paper: Verbal report to Environment & Transport Cabinet Committee

Future Pathway of Paper: The draft Strategy will be considered by Members in spring 2016, prior to a Cabinet Member Decision

Electoral Division: All

Summary:

Active travel (specifically choosing journeys by bicycle and on foot instead of by car wherever possible) is recommended by NICE as a means of improving levels of physical activity across the life-course. Active Travel can reduce traffic congestion, improve the environment, improve air quality, and reduce noise pollution.

In Kent, almost half of adults fail to meet recommended levels of physical activity required for good health, and one third of Kent's children are overweight or obese by the time they leave primary school. One in three adults in Kent is at high risk of developing a disease condition through a lack of physical activity. Evidence suggests that objectives and measures to increase active travel will help deliver positive outcomes and that these will be across all KCC directorates.

It is proposed that an Active Travel Strategy be developed and adopted as County Council policy. The strategy will be cost-neutral and provide strategic guidance in order to maximise existing investment in projects.

The development of the Strategy was reported verbally to the Environment & Transport Cabinet Committee on 21st July 2015, and will come back to a future meeting of that committee. A report to the Education & Young People's Cabinet Committee is to be considered on 18th September 2015

Recommendation:

The Adult Social Care and Health Cabinet Committee is asked to comment on the proposal to develop an Active Travel Strategy for Kent

1. Introduction

1.1. By 2050, the NHS cost attributable to obesity and overweight will be £9.7 billion and the total costs will be £49.9 billion. The direct costs of illness as an outcome of physical inactivity to the NHS are quoted to be as much as £1.0 billion per annum, while costs to the whole economy are estimated at £20 billion per annum.

1.2. Over 26% of adults in Kent are classed as physically inactive and at high risk of developing disease conditions as a result of their sedentary lifestyle. Over 43% fail to meet recommended levels of activity required to maintain good health. 21% of children in Kent are above a healthy weight when starting primary school, increasing to 33% by the time they leave.

1.3. Robust evidence has highlighted how active travel, specifically journeys made by cycle and on foot, can contribute to a wide range of outcomes. Active travel gives people an opportunity to be physically active as part of their daily routine, which will contribute to improved health as well as preventing or managing a range of chronic diseases. It can also contribute to improved air quality, reduced congestion and reduced carbon emissions through reducing the number of cars on the road. Kent currently has no strategic policy to meet these objectives through increasing active travel.

1.4. Kent County Council currently does not have a corporate strategy for increasing active travel for every day journeys such as to school, to work or for shopping. Evidence suggests a co-ordinated set of policies and measures will have a positive benefit to reduce traffic congestion, improve the environment and improve public health. Further, if developed, an Active Travel Strategy will provide a commissioning framework for all directorates and partner organisations, it will inform local transport and health policies, it will provide a context for bids for external funding and deliver an increase in walking and cycling to contribute to keeping Kent moving and healthy.

1.5. This strategy will support National Institute for Health & Care Excellence (NICE) commissioning guidance that recommends that schools foster a culture that supports physically active travel for journeys to school and during the school day, through encouraging children to walk or cycle.

2. Financial Implications

2.1 The Strategy will be developed as a cost-neutral document and require no additional investment from Kent County Council budgets. The strategy will act as a commissioning framework to provide strategic guidance on where existing programmes of work can deliver higher returns and maximise existing investment in projects

2.2 Furthermore, the Strategy will be used to support bids for external income, including anticipated Government funding through the Infrastructure Act (2015) which specifically provides for investment in walking and cycling.

3 Supporting KCC Strategic Priorities

3.1 Improving transport is identified in the KCC Strategic Statement 2015-2020 under outcome 2: Kent Communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life. It also relates to priorities 1, 2, 4, 6 and 7 within the Growth Environment and Transport Business Plan 2015 – 2016:

- Contribute to the delivery of the Growth & Infrastructure outcomes,
- Create successful bids to secure funding,
- Facilitate partnerships between transport providers,
- Delivery the Kent Environment Strategy, reducing the impact of traffic,
- Contribute to Public Health by facilitating and promoting active travel.

3.2 The strategy will contribute to outcomes in the Kent County Council Strategic Outcomes Framework by improving the health, environment and sustainability opportunities for Kent. This strategy will deliver key public health outcomes as identified in the Public Health Outcomes Framework, specifically indicators 2.13i (proportion of adults achieving at least 150 minutes of physical activity per week) and 2.13ii (proportion of adults classified as inactive). The actions in this strategy will be informed by NICE Commissioning Guidance PH8 (improving the physical environment to encourage physical activity) and PH41 (local measures to promote walking and cycling as forms of travel or recreation), and deliver objectives in the Public Health England physical activity strategy Everybody Active, Every Day.

3.3 This strategy will also support Growth without Gridlock and act as a complement to the Local Transport Plan for Kent (2011-16) and contribute to outcomes in the Road Casualty Reduction Strategy for Kent (2014-2020).

4 Timescales for consultation and adoption

4.1 The Strategy will be developed by a cross-directorate working group. Partner engagement is planned to take place between September and October 2015. Workshops are proposed in October in the east and west of the county, with further engagement planned for schools and young people. A draft Strategy will be developed between October and December, with full consultation

beginning in January 2016. A final Strategy, taking into account consultation responses, will be presented for consideration to the three Cabinet Committees reviewing this paper during Spring 2016. It is proposed to recommend to the respective Cabinet Members that the Strategy be adopted as Kent County Council policy, subject to the views of these Cabinet Committees at that time.

5. Conclusion

5.1 Increasing the number of journeys made by active modes of travel will have benefits for the residents and visitors to Kent. In order to maximise those benefits, a strategy is required to give direction to all parts of the system.

5.2 Approval is therefore sought to scope, develop and produce an Active Travel Strategy as outlined above.

6. Recommendation(s):

The Adult Social Care and Health Cabinet Committee is asked to comment on the proposal to develop an Active Travel Strategy for Kent

7. Background Documents

The evidence base for policies to promote active travel includes the following:

- National Institute for Health & Care Excellence (2012) - Walking and Cycling: Local Measures to Promote Walking and Cycling as forms of Travel or Recreation.
- Public Health England (2014) - Everybody Active, Every Day. A Physical Activity Strategy.
- Public Health England (2014) - Public Health Outcomes Framework.
- Kent & Medway Public Health Observatory Library (2014) - Active Travel Literature Review (unpublished).
- Department of Health (2011) - Start Active Stay Active: A Report on Physical Activity from the 4 Home Countries.
- National Institute for Health & Care Excellence (2008) - Physical Activity and the Environment.

Contact Details

Report Authors

Andy Fairhurst,
Physical Activity Programme Manager
Telephone 03000 416077
Email: andy.fairhurst@kent.gov.uk

Simon Allum,
Mobility & Safety Team Leader
Telephone 03000 411617
Email: simon.allum@kent.gov.uk

David Adams,
Area Education Officer (South Kent)
Telephone 03000 414989
Email: david.adams@kent.gov.uk

Relevant Director:

Andrew Scott-Clark
Director of Public Health
0300 333 5176

Andrew.scott-clark@kent.gov.uk

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By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director of Health, Social Care and Wellbeing
To:	Adult Social Care and Health Cabinet Committee – 11 September 2015
Subject:	**KENT COUNTY COUNCIL'S LOCAL ACCOUNT FOR ADULT SOCIAL CARE FOR 2014-15**
Classification:	Unrestricted
Previous Pathway:	N/A
Future Pathway:	
Electoral Division:	All

Summary: This report is provided to update the Cabinet Committee on progress with the development of this year's Local Account.

With the withdrawal of the Care Quality Commission (CQC) from assessing and rating Councils with Adult Social Care responsibility, there is now greater emphasis on Councils to work collaboratively to improve performance and outcomes for people. Sector Led Improvement is the national programme designed to do this, and one of the underpinning principles of the sector-led improvement programme in adult social care is a stronger accountability by using increased transparency to promote improvement in services.

The publication of an annual Local Account is one means of achieving this.

Recommendation: Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **AGREE** that a cross party group of Cabinet Committee members will be held during October to review the final version of the local account

b) **AGREE** that the cross party group will make a recommendation to the Cabinet Member for Adult Social Care and Public Health to publish the Local Account

1. Introduction

1.1 The Government's approach to the assessment of adult social care performance has changed in recent years. There is now more emphasis on requirement for councils to manage their own performance, work collaboratively with the sector to improve performance and outcomes and explain how they have performed to local

residents. The Local Account has emerged as standard feature of the new local accountability framework.

2. Policy Context

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

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

2.3 More recently, the commitment to the Care Act reinforces these visions, placing emphasis on maintaining independence, choice and control, quality, dignity and respect and clear information advice and guidance.

2.4 The Council's priorities set out in "Increasing Opportunities, Improving outcomes" also emphasises the importance of customer engagement.

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

3. The 2014-15 Local Account

3.1 This is the fourth year that Kent has produced this document, and will again, include significant input and interest from Service users, carers, partner organisations and Members.

3.2 Each year provides us with an opportunity to improve on both the content and the format with users, carers and the voluntary sector. The approach to this year's account will be slightly different, based on this learning and also learning from other local authorities.

3.3 One of the biggest areas of learning has related to the use and the purpose of the Local Account. Service users and carers do not feel fully engaged in Adult Social care by being consulted with on an annual basis, on what is a summary document. It would be much preferable to have an ongoing and regular communication with them, including them in areas of business of their choosing. The Local account will then simply be a summary of this activity and actions arising out of this activity.

3.4 As a result, there has been significant work undertaken to establish a more robust framework within which we can communicate with our service users, carers and partner organisations, as business as usual. In addition, we have been working to engage with our staff and to ensure that themes within the Local Account are communicated by them as well. This has resulted in booklets, advice and information being developed for them on key areas such charging, customer journeys and other key areas. This new ongoing communications

3.5 In addition to this, we have been working closely with the external communications team and the community engagement team to link into local user and customer forums.

3.6 The intention is to have a regular means of regularly communicating with our service users on their preferred areas of interest by March 2016 and ensuring that the result of this will be the Local Account of next year, which will be a true reflection of their ongoing engagement.

3.7 The Local Account for this year will be influenced by the development of this, the format and content will be scrutinised by our partner organisation and our service users and carers.

3.8 A cross party group of Cabinet Committee members have been invited to contribute to and agree the draft, as was requested last year by the Adult Social Care and Health Cabinet Committee and this will take place during October 2015.

3.9 Following this meeting a recommendation to publish the Local Account will be made to the Cabinet Member for Adult Social Care and Public Health.

4. Publication and feedback

4.1 The final document will be ready for publication in November and will be accompanied by an easy read version and a short video depicting the key messages from the account.

4.2 There are already feedback mechanisms in place, including through the Kent County Council website, twitter, email, post and phone. This will be further emphasised as well as engagement with our Health watch colleagues to help promote the document and gather feedback.

4.3 Lastly, service users and carers will be encouraged to continue to play a part in the evaluation of the document, and monthly Local Account bulletins will continue to be produced to ensure that all information is as up to date as possible.

5. Recommendations

5.1 Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **AGREE** that a cross party group of Cabinet Committee members will be held during October to review the final version of the local account

b) **AGREE** that the cross party group will make a recommendation to the Cabinet Member for Adult Social

6. Background Documents

Transparency in outcomes for Social Care' 2010
Vision for Social Care; Capable Communities and Active Citizens' 2010
Think Local, Act Personal 2011
Care Ac 2014
Increasing Opportunities, Improving outcomes
KCC Annual Report (Local Account) 2011-12
Local Account "Here for You, How did we do?" 2012-13
Local Account "Here for You, How did we do?" 2013-14

7. Contact details

Steph Smith
Head of Performance and Information Management
Social Care, Health and Wellbeing
03000 415501
Steph.smith@kent.gov.uk

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

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

To: Adult Social Care and Health Cabinet Committee – 11 September 2015

Subject: **KENT AND MEDWAY SAFEGUARDING ADULTS ANNUAL REPORT APRIL 2014 – MARCH 2015**

Classification: Unrestricted

Past Pathway: Social Care, Health and Wellbeing DMT

Future Pathway: None

Electoral Division: All

Summary: This report introduces the Kent and Medway Safeguarding Adults Annual Report April 2014 – March 2015 (attached as Appendix 1) which details the work of the multi-agency partnership and how it managed safeguarding adults issues in 2014-2015. The report provides safeguarding activity information and also contains key statements from partner organisations regarding how they dealt with safeguarding issues in their respective agencies.

Recommendations: Members of the Adult Social Care and Health Cabinet Committee are asked to:
a) **NOTE** and
b) **COMMENT** on the attached report

---

1. Introduction

1.1 Safeguarding Adults continues to be the major priority of the Social Care, Health and Wellbeing Directorate. In meeting this responsibility, it is essential that the Directorate plays a key role in the workings of the Kent and Medway Safeguarding Adults Board.

1.2 The Kent and Medway Safeguarding Adults Board works to make sure that all agencies are working together to help keep Kent and Medway's adults safe from harm and to protect the rights of citizens under the Mental Capacity Act.

1.3 The enactment and implementation of the Care Act 2014 placed Safeguarding Adults Boards on a statutory basis from April 2015. The

Care Act (14.116) states that the following organisations **must** be represented on the Safeguarding Adults Board:

- Local Authority
- Clinical Commissioning Groups in the Local Authority's area
- Police

1.4 The Care Act (14.10) also requires that each Local Authority **must**:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom
- set up a Safeguarding Adults Board
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them
- co-operate with each of its relevant partners (as set out in Section 6 of the Care Act) in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority

1.5 In line with the Care Act 2014, the Kent and Medway Safeguarding Adults Board (SAB) is required to publish an Annual Plan each financial year.

1.6 During 2014-2015, the Kent and Medway Safeguarding Adults Board comprised Senior Officers from the key agencies in Kent and Medway involved in safeguarding, including the Police, Health Service, Medway Council and Kent County Council. The current chair of the Board is the Corporate Director of Social Care, Health and Wellbeing, Kent County Council.

2. Financial Implications

2.1 There are no direct financial implications arising from the report.

3. Increasing Opportunities, Improving Outcomes

3.1 The work of the Kent and Medway Safeguarding Adults Board, which is detailed within the Annual Report, plays a key role in supporting KCC's Strategic Statement 'Increasing Opportunities, Improving Outcomes':

"Older and vulnerable residents are safe and supported with choices to live independently".

4. The Report

4.1 The report contains a wealth of information from each of the key agencies engaged in the Kent and Medway Safeguarding Adults Board. The following paragraphs give a brief overview of key sections of the report.

4.2 **Section 2** provides a summary of a number of key documents published in 2014-2015 which have influenced the safeguarding agenda.

4.3 **Section 3** summarises the local context for adult safeguarding in Kent and Medway.

4.4 **Section 4** outlines the multi-agency safeguarding training programme supported by the Kent and Medway Safeguarding Adults Board. This section highlights activity and attendance at training courses.

4.5 **Section 5** provides details of the funding arrangements for the Kent and Medway Safeguarding Adults Board.

4.6 **Section 6** summarises the work of each member agency of the Kent and Medway Safeguarding Adults Board.

4.7 **Section 7** outlines the activity data for adult safeguarding in Kent and Medway. This includes referral data, the background data in regard to victims and the current trends in relation to adult safeguarding in Kent and Medway.

4.8 **Section 8** identifies the key priorities for the Kent and Medway Safeguarding Adults Board for 2015-2016.

5. Conclusion

5.1 The Annual Report provides a retrospective view of the work of the Kent and Medway Safeguarding Adults Board and details key safeguarding activity between April 2014 – March 2015.

6. Recommendations

6.1 Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **NOTE** and
b) **COMMENT** on the attached report

7. Background Documents

None

8. Contact Details

Katherine Stephens
Kent and Medway Safeguarding Adults Board Manager (Interim)
03000 415509
Katherine.stephens@kent.gov.uk

Kent and Medway Safeguarding Adults Board



Annual Report
April 2014 – March 2015

Contents

Section 7:

Safeguarding Activity Report

Appendices

As Chair of the Kent and Medway Safeguarding Adults Board I am pleased to introduce our Annual Report for 2014-2015.

The report is published on behalf of the multi-agency Board and provides partners with an opportunity to celebrate their achievements in 2014-15 and plan for the year ahead. The report contains contributions from a range of organisations who are involved in safeguarding adults experiencing, or at risk of abuse or neglect in Kent and Medway.

The Care Act 2014 placed adult safeguarding on a statutory footing and stated that each Local Authority must establish a Safeguarding Adults Board.

With the implementation of the Care Act, the Board has undergone a governance review with partners in 2015 and developed a three year Strategic Plan.

Our partnership working continues to strengthen our ability to safeguard adults and is underpinned by the principles and values outlined in Appendix 1.

I would like to take this opportunity to thank everyone for their contribution to the work of the Board and associated working groups and their commitment to safeguarding adults in Kent and Medway.

Andrew Ireland

Corporate Director – Social Care, Health and Wellbeing, Kent County Council
Chair of the Kent and Medway Safeguarding Adults Board

Section 1: Introduction

What is safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." Care Act (2014)

The Care Act states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from
- either the risk of, or the experience of abuse and neglect.

Abuse or neglect can take many forms.
The Care Act lists the following types of abuse and neglect:

- Physical abuse
- Domestic Violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

These are reflected in the Kent and Medway Safeguarding Adult's Multi Agency Policy, Protocols and Guidance.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when an adult at risk is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person. The main forms of abuse are outlined in Appendix 2.

Abuse can happen anywhere and take place in any context, for example, in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations. Adults at risk may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

The Care Act 2014 consolidates provisions from over a dozen different Acts into a single, framework for care and support. It is a fundamental reform of the way the law works. It places the wellbeing, needs and goals of people at the centre of the legislation to create care and support which fits around the individual and works for them.

The Act also provides a new framework for adult safeguarding. It sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area.

Section 2: National context

A number of key documents published in 2014-2015 have influenced the safeguarding agenda. They include:

Safeguarding Adults – a joint statement on 2014
Annual Joint Statement on Safeguarding issued by the national member organisations of the core statutory bodies tasked with the implementation of new legislation that will put safeguarding adults on a statutory footing. It outlines key priorities for adult safeguarding in the light of the Care Bill. This includes the Local Government Association, Associations of Directors of Adult Social Services, Association of Chief Police Officers, the NHS Confederation and NHS Clinical Commissioners.

http://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/safeguarding_adults/key_documents/Safeguarding%20Adults%20joint%20statement%20-%20270114.pdf

Care Act 2014 Safeguarding Provisions
Clauses 42-48 of the Care Act provide the statutory framework for protecting adults from abuse and neglect. The safeguarding provisions include:

- New duty for local authorities to carry out enquiries (or cause others to) where it suspects an adult is at risk of abuse or neglect.
- Local Safeguarding Adults Boards to carry out safeguarding adults reviews into cases where someone who experienced abuse or neglect died or was seriously harmed and there are concerns about how authorities acted, to ensure lessons are learned.
- New ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews or other functions.
- Abolition of the existing power (under section 47 of the National Assistance Act 1948) for local authorities to remove people from their homes.
- Requirement for all areas to establish a Safeguarding Adults Board to bring together the local authority, NHS and police to coordinate activity to protect adults from abuse and neglect.

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Care Act Statutory Guidance 2014
The Care Act 2014 statutory guidance was published on 24th October 2014. In addition to providing a fundamental reform of the adult social care and support system, the Care Act also creates a legal framework for key organisations and individuals with responsibilities for adult safeguarding to agree how they must work together and what roles they must play to keep adults at risk safe. Chapter 14 specifically relates to safeguarding (page 229).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

Adult Safeguarding Improvement Tool – March 2015

The Improvement Tool, based on the Adult Safeguarding Standards, was refreshed in March 2015. Developed by the sector, the document sets out key areas of focus which have been used in numerous peer reviews and challenges and as a means of self-assessment. The characteristics of a well-performing and ambitious partnership are described, particularly in relation to the three key partners in safeguarding adults; the council, NHS and Police.

http://www.local.gov.uk/documents/10180/6869714/Adult+safeguarding+improvement+tool.pdf/dd2f25ff-8532-41c1-85ed-b0bcbb2c9cfa

Section 3: Local context

The Kent and Medway Safeguarding Adults Board membership includes representatives from KCC, Medway Council, Kent Police, Acute Trusts, Clinical Commissioning Groups, Community Health Trusts, Kent and Medway NHS and Social Care Partnership Trust, Kent Probation, Kent Fire and Rescue Service, Prison Service, both Kent and Medway Community Safety Partnerships, District Councils, Members from both KCC and Medway Council and representatives from independent provider organisations.

In September 2014, the Board commissioned a Safeguarding Adults Review (SAR) chaired by Paul Pearce. The overview report and recommendations were presented to the Board in June 2015.

The Policy, Protocols and Guidance Working Group met in May, August and November 2014 and February 2014 to review the Kent and Medway multi-agency adult protection policy, protocols and guidance document in light of the Care Act 2014. The updated document can be found at: http://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/multi-agency-safeguarding-adults-policies-protocols-and-guidance-kent-and-medway.pdf

A **Self-Neglect Policy and Procedure** was developed by the Policy, Protocols and Guidance Working Group and the document can found at: http://www.kent.gov.uk/__data/assets/pdf_file/0012/16140/Self-neglect-policy-and-procedures.pdf

Implementation of Making Safeguarding Personal
Making Safeguarding Personal in Kent has gathered momentum. Multi-agency launch events were held in November 2014 with further workshops planned in 2015. These have all been well received. Information is available online for adults with care and support needs. MSP Leaflets.

Section 4: Kent and Medway Multi-agency training

During 2014-2015 the multi-agency training programme has been supported by the Kent and Medway Safeguarding Adults Board.

This has been provided through the funding of the following posts – one external Training Consultant and one full time multi-agency Training Administrator.

The Kent and Medway multi-agency training structure comprises of 6 levels. The training structure continues to be based on common tasks reflected in the Kent and Medway multi-agency policy, protocols and guidance. It aims to ensure that staffs build on their existing knowledge and skills by adopting a sequential learning approach.
It is designed to reflect core and complimentary knowledge and skills within the multi-agency context of safeguarding work. Details of the course aims and objectives are available on the website: http://www.kent.gov.uk/social-care-and-health/information-for-professionals/training-and-development

All agencies take responsibility for the delivery of Level1 and Level 2 training to their staff. Suggested training standards for Level 2 are available for any agency that prefers to commission or deliver its own version of the current Level 2 course. Levels 1 and 2 training for staff in the private and voluntary sector has been available through KCC Learning and Development Team. Levels 3, 4, 5 and 6 of the multi-agency training programme have been provided by the multi-agency funded external Training Consultant. However, the Level 4 course has been provided in collaboration with specialist trainers within a partner agency. The Level 4 and 6 courses have not been run in 2014-2015.

Table.1
Below outlines the level of multi-agency course provision and attendance during April 2014-March 2015.

Course	No of Places offered	Total no of persons attending	Police	KCC	Medway Council	Health	Fire & Rescue
Level 3	306	249	0	122	16	110	1
Level 4	0	0	0	0	0	0	0
Level 5	90	64	0	37	5	21	1
Level 6	0	0	0	0	0	0	0

Ongoing Developments

A full review of multi-agency training is underway.

Section 5: Funding arrangements

The Kent and Medway Safeguarding Adults Board is funded by 5 partner agencies including KCC Social Care, Health and Wellbeing, Medway Council, Kent Police, local Health Comissioners and Kent Fire Service.
Each of these agencies made the following percentage contributions in 14/15:

- KCC, FSC – 36.3%
- Medway Council – 7.5%
- Kent Police – 13%
- NHS Kent and Medway – 32.6%
- Kent Fire Service – 1.6%

The multi-agency budget covers the salaries and expenses for the Safeguarding Adults Board Manager, and Administration Officer posts. It also covers the administration costs for the various multi-agency group meetings, Safeguarding Adult Reviews and the provision of multi-agency training.

The table below sets out the budget contributions for the past three years

	2012-2013 Actual contribution (£000's)	2013-2014 Actual contribution (£000's)	2014-2015 Actual contribution (£000's)
KCC	59.0	50.5	61
Medway Council	14.7	12.6	12.6
Local Health Commissioners	64.0	54.8	54.8
Kent Police	25.6	21.9	21.9
Kent Fire Service	3.0	2.6	2.6
Shortfall	11.4	9.8	15.2
Total	177.7	152.2	168.1

A decision was made by the Board to use reserves in order to reduce the contributions of partners, given the savings agencies needed to make in the financial year.

Section 6: Partner highlights

Kent County Council, Social Care, Health and Wellbeing

Overview of 2014 – 2015

Adult Safeguarding is managed in the divisions of Older People and Physical Disability (OPPD), and Disabled Children, Adults Learning Disability and Mental Health. These are integrated teams with Section 75 partnerships which support Adult Safeguarding. The strategic role of the Adult Safeguarding Unit is fully embedded with a focus on and Quality Assurance and policy development. The Deprivation of Liberty Safeguards (DOLS) function sits within this Unit.

Key Achievements

'Making Safeguarding Personal' has been successfully integrated into adult safeguarding, ensuring vulnerable adults are at the centre of our practice. The launch events took place in November 2014 and are now available to view online on the Kent.gov website. A multi-agency package of workshops for safeguarding leads across Kent has been developed and will be delivered in the Summer 2015.

'The Care Act 2014' guidance was published in October 2014 by the Department of Health and it will come into effect from 1st April 2015. Extensive work has been undertaken by KCC and multi-agency partners, many of them being led by the Safeguarding Adults Board (SAB), to ensure that we are Care Act compliant, for example:

- The Policy, Protocols and Guidance document has been revised in line with the Care Act
- Integration of Making Safeguarding Personal, which was implemented in January 2015
- Ongoing work to revise processes and forms used
- Making information accessible to all
- Fully implementing the innovative Quality in Care partnerships currently being piloted
- Transforming Care – This is the second phase of the Winterbourne Programme and we continue to integrate between Health and Social Care to prevent inappropriate hospital admissions for people with learning disabilities experiencing mental health issues or episodes of challenging behaviour that could be managed in the community

A Safeguarding Adults and Mental Capacity Act Development Framework is being developed to support practitioners at all levels. This will help increase knowledge, skills and understanding of their roles and responsibilities within Adult Safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards.

Key Challenges

- Implementation of the Safeguarding section of the Care Act supported by guidance.
- DOLS applications continue to rise significantly – They have increased 10 fold compared to 2013/14.
- Safeguarding referrals are increasing overall due to increased awareness of the service.

Future Plans 2015-2016

- Continue to focus on the quality of safeguarding work across KCC.
- Consider new models of safeguarding in response to the Care Act 2014.
- Undertake detailed analysis in order to understand the issues related to human trafficking, modern slavery and sexual exploitation nationally and in Kent.

Medway Council

Overview of 2014 – 2015

Medway Council has mainly focused this year on preparing for the new statutory duties of the Care Act (2014), including sign up to the Bronze level of the Local Government Association/Association of Directors of Adult Social Services *Making Safeguarding Personal* Programme.

Key Achievements

- The Jigsaw project (hosted by MCCH) has delivered information sessions to Medway Magistrates Court, Medway Open Road, Victim Support and police staff. A Jigsaw information booklet has been developed, which includes information regarding learning disabilities / autism and inclusion tips, contact details for local and national learning disability / autism organisations, which can provide support and advice and background information about the Living in Fear Project. These booklets are provided to everyone who attends an information session, and includes court-specific information tailored for personnel attending the court-based sessions. The project has also produced Health Check Guidance which is being piloted in a GP surgery in Rochester.
- As a pilot site for Health and Social Care Information Centre (HSCIC) Adult Social Care Safeguarding Survey we were able to collect views from people following adult safeguarding case closures. Of the adults at risk who were interviewed 80% told us that they 'felt listened to' and were 'happy with the end result of what people did to help them keep safe'. Of the adults at risk or their representatives interviewed, 80% and 100% respectively, felt 'a lot' or 'quite a bit safer' because of the help they had received.
- Following our training and development programme for adult safeguarding minute takers, our audit revealed that 90% of our teams had achieved adoption of the standard agenda templates and 60% correct use of the 'essential' agenda items. In 2013 our minutes were taking on average five weeks to be signed off and distributed after the meeting, this has now improved to three weeks showing an overall improvement of 60%.

Key Challenges

- Reviewing the 'Adult Safeguarding Workflow' within our recording system to meet the requirements of the Care Act in order to embed the six principles of adult safeguarding: protection, prevention, accountability, proportionality, empowerment and partnership.
- Managing the increasing demand of adult safeguarding enquiries following an a 40% increase in the number of alerts to the Council.

Future Plans 2015-2016

- The Jigsaw Project has worked with Medway Youth Trust to produce a DVD that will be shown in schools to raise awareness of anti-social behaviour and Hate Crime.
- Our Making Safeguarding Personal (MSP) work programme hopes to continue to engage with key social workers and multiagency partners who are acting as MSP champions; develop supportive, reflective supervision and learning opportunities for staff; review how and in what circumstances advocacy is made available; develop materials to support practitioners and the people they are working with; develop an appropriate range of recording mechanisms; link MSP into wider personalisation, engagement and prevention initiatives and strategies and gain commitment from partner organisations to making the cultural and organisational changes that are required. The publication of our 'Safeguarding and You' customer leaflet and the roll out of our customer satisfaction survey will take place in 2015.

NHS Clinical Commissioning Groups across Kent and Medway

Overview of 2014 – 2015

Clinical Commissioning Groups were formed in April 2013 following the abolishment of Strategic Health Authorities and Primary Care Trusts.
There are eight CCGs across Kent and Medway:
NHS Ashford CCG
NHS Dartford, Gravesham and Swanley CCG
NHS Canterbury and Coastal CCG
NHS Swale CCG
NHS South Kent Coast CCG
NHS Medway CCG
NHS Thanet CCG
NHS West Kent CCG
Until the end of December 2015 the Safeguarding Adults team was hosted by NHS Medway, since then the hosted team has been disaggregated and each CCG's Chief Nurse has the accountability for safeguarding on behalf of their Governing Bodies. The four Designated Nurses for Safeguarding Adults are employed by the CCG's and report directly to the Chief Nurses.

Key Achievements

- All eight CCGs are authorised as statutory organisations. Each CCG has clear lines of accountability for safeguarding reflected in CCG governance arrangements, and arrangements in place to co-operate with the local authority in the operation of the Safeguarding Adults Board. The Designated Nurses from each of the 8 neighbouring CCG's have established effective roles and responsibilities across the commissioning functions during the transitional period following the disaggregation.

- GP awareness of adult safeguarding has been an area of priority for the Designated Nurse although the responsibility for GP training remains with NHS England (Kent and Medway Area Team). The Designated Nurses have delivered level 2 training at GP Protected Learning Time events and in order to support this learning each nurse continues to provide advice and support to their own area.

- In order to provide assurance to their governing bodies that health providers remain compliant with current statutory requirements and respond effectively to changes in legislation and best practice, Safeguarding metrics have been developed covering training, staffing, governance systems, multi-agency working, reporting and investigation of adult protection alerts, Prevent, Domestic abuse, MCA, DoLS and consent.

Key Challenges

- Ensuring that CCGs were sighted on emerging adult safeguarding risks, including compliance with the Mental Capacity Act, and the implications of the Supreme Court judgement on the Deprivation of Liberty.

- Further partnership working with social care partners in order to encourage and improve quality and safety in the care home sector has involved the development of multi-agency Care Home Forums in each CCG.

- Embedding legislation and recommendations from the Care Act 2014 and Counter Terrorism and Security Bill 2015. Sections 42-46 of the Care Act 2014 place on a statutory footing some of the safeguarding obligations that were located in the No Secret's guidance. In discharging the statutory duties there are expressed reciprocal duties for other partners to co-operate. These include NHS England, all CCG's and Health Care Trusts in the Local Authorities' area. The NHS England Safeguarding Adults Accountability and Assurance Framework sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS.

Future Plans 2015-2016

- Implementing safeguarding and MCA provider metrics to capture meaningful safeguarding data and measurable outcomes from provider organisation.
- Continuing to ensure that the CCG's are fully compliant with the NHS England Safeguarding Adults Accountability and Assurance Framework with key areas of work being; Aligning Designated Nurse duties with the Designated Adult Safeguarding Manager roles.
- Amending Awareness, Levels 1 and 2 Safeguarding Adults training to comply with the revised Multi-Agency Policy and procedures, all other relevant legislation and the proposed intercollegiate document for Safeguarding Adults.
- Aligning all CCG Safeguarding policies and strategic objectives with relevant legislation.
- Ensuring both CCGs and Provider organisations are focussed to meet the Making Safeguarding Personal agenda.
- Discharge of the duties of the House of Lords Mental Capacity Act Implementation Programme.

Kent and Medway NHS and Social Care Partnership Trust

Overview of 2014-2015

Kent and Medway NHS and Social Care Partnership Trust (KMPT) has seen a steady increase in the numbers of applications for Deprivation of Liberty as well as requests for S12 doctors to complete assessments. The increased workload for doctors completing assessments has been well managed. Mental Capacity Act compliance and understanding has been monitored closely with quarterly audits throughout the year. This has allowed for targeting of resources and training where needed Domestic Abuse cases have been highlighted in adult protection alerts which demonstrate increased awareness by staff. KMPT continues to contribute to all Multi-agency Risk Assessment Conferences across the county.

Key achievements

- Some success in closing down adult protection cases over 6 months old.
- Improved system for tracking the Deprivation of Liberty applications and outcomes of same, across the organisation. All databases are electronic.
- Positive Increased uptake of Level 3 adult protection training – 'the investigators role' by teams outside of the usual adult community mental health teams.

Key challenges

- With the Health and Social Care Act and the Making Safeguarding Personal agenda there is a need to embed this 'person centred practice' into safeguarding work in a robust but sensitive manner.
- There needs to be structured support to staff to implement the policy on Self-Neglect. Early signs are positive around its introduction.

Future plans 2015-2016

- In line with Health and Social Care Act and revised Multiagency Policies and Protocols, KMPT's internal policies on safeguarding adults will be reviewed.
- Auditing and monitoring of compliance with the Mental Capacity Act particularly the interface with Deprivation of Liberty and the Mental Health Act will continue as a priority.
- Monitor the effectiveness of the Self-Neglect Policy where it is used.

Dartford and Gravesham NHS Trust

Overview of 2014 – 2015

All staff continue to be trained in safeguarding through core induction and mandatory training. The annual safeguarding update for Consultants and new junior medical staff continued throughout the period. Kent County Council (KCC) training dates for additional safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DOLS) have been circulated to all relevant Trust staff groups. KCC have also provided additional onsite training by offering MCA and DOLs as separate whole days of training. These dates are booked up until March 2016.
Capsticks are providing three hours sessions on DOLS Supreme Court ruling, these have been booked up to March 2016 and are well evaluated.

Maintenance of the Safeguarding Vulnerable Adults Dashboard for the Clinical Commissioning Group (CCG) up to March 31st 2013, maintenance of Trust AP1 spreadsheet and the quarterly audit of the numbers and outcomes of safeguarding referrals continue. The Trust Safeguarding Lead or the Safe Guarding & Learning Disability Nurse continue to attend case conferences. The Director of Nursing & Quality (joined in June 2014) is the Executive Lead and attends all relevant board meetings, with the Chairman of the trust as the non-executive lead. The trust also recently appointed a Deputy Director of Nursing who is also supporting the safeguarding agenda. The Safeguarding lead remains the Prevent Lead for Dartford and Gravesham NHS Trust (DGS).

Key Achievements

- The Safeguarding & Learning Disability Nurse took up her post in October 2014 which co-in sided with the 2nd Learning Disability Conference.
- There are now nearly 100 Hospital passports currently placed on the Trust Patient Administration System with Hospital contact numbers on the key fobs. With a huge increase in the numbers of people flagged on the patient system as having a learning disability to over 300. There are however still data protection problems with the sharing of information with the Trust with regards to the flagging of these patients.
- Through the three hour Capsticks training sessions there has been an increase in all professional staff accessing DOLS training.

Key Challenges

- Joint investigations into community acquired grade 3 and 4 pressure ulcers. These are currently being jointly investigated by the Safeguarding & Learning Disability Nurse along with named professionals from KCC.
- Continuing to ensure that medical staff understand their role under the Mental Capacity Act (MCA).
- Ensuring key staff attend relevant training.
- Ensure Best Interest meetings occur appropriately and are documented robustly.

Future Plans 2015-2016

- To continue identifying exactly which patients require DOLS.
- Continue to provide training and education for staff, especially in key areas and those working with adults at risk.
- Working with the CCG to reduce the risk of non-hospital acquired pressure ulcers.
- Increase the profile and awareness of the Learning Disabilities service.
- Investigate option of implementing work experience for young people with Learning Disabilities.

East Kent Hospitals University NHS Foundation Trust

Overview of 2014-2015

The Adult Safeguarding team have renamed, in order to reflect their preventative work, changes because of the introduction of the Care Act 2014 and the inclusion of the Learning Disabilities service. Now known as the "People At Risk Team"(PART), they continue to support doctors, therapists and nurses across each of our three main hospital sites and two community hospitals, in all matters relating to safeguarding and the protection of people's human rights.
They work closely with the specialist Dementia, Nutrition and Tissue Viability teams, to improve the quality of care for patients and ensure that it is person centred.
There have been 37 formal allegations of abuse against the Trust within the last year. The Trust has raised formal concerns on behalf of patients, relating to events in the community on 54 occasions.

Key achievements

- The Harm Prevention group has been established, with the clinical specialist members, to identify and target key clinical issues highlighted in investigations complaints and local intelligence that affect safeguarding.
- The team have engaged with Multi agency initiatives, "Making Safeguarding Personal", "Self-Neglect Policy" and a People Trafficking research project.
- Adult Safeguarding training is now being delivered to the Trust's sub-contractors to improve consistency and partnership working.
- Creation of the SMART + tool for the identification of "adults at risk".
- Audits created to monitor the application of the Mental Capacity Act in clinical practice, the surgical Consent Audit and Do Not Attempt CPR (DNACPR) orders audit.
- An increased focus on training medical staff.

Key challenges

- The Supreme Court judgement about the application of the Deprivation of Liberty Safeguards (DOLS) has had a significant impact on caring for people who lack mental capacity and who are unable to understand their own care and treatment requirements.
- This has required a much larger number of patients to fall in to the DOLS category than before and has created a significant pressure on all staff involved, to adapt to the increased demand.

Future plans 2015-2016

- Create an electronic solution for application and monitoring DOLS applications.
- Continue to increase our understanding of adults at risk within the acute setting including domestic abuse.
- Continue to imbed SMART + Tool.

Medway Community Healthcare

Overview of 2014-2015

Another busy year at Medway Community Healthcare (MCH) from our Safeguarding Adults perspective. The Safeguarding Adults Team collect data about enquiries, alerts raised and DOLS applications made throughout the year: in 2013/14 the team logged 373 such contacts, in 2014/15 that number rose to 625. This increasing awareness shows our staff are identifying concerns and helping keep people safe.

The Deprivation of Liberty Safeguards revised test has resulted in greater numbers of applications from all three of our inpatient units, Darland House, St Bartholomew's Hospital and Wisdom Hospice; an increase from 2 applications in 2013/14 to 103 in 2014/15. Our staff have a clear understanding of capacity assessment and ensuring where possible care is planned in advance with the person we are providing care for.

In addition the Safeguarding Adults Team completed an audit of capacity assessments undertaken by our staff. In October 2014, 780 capacity assessments were available to be audited on our electronic patient record system. The audit evidenced good overall awareness, understanding and implementation of the Mental Capacity Act across services.

The Kent and Medway Self Neglect Policy has also played a significant role within MCH since its launch in October 2014. In addition to the workshop facilitated by the Kent and Medway Safeguarding Adults Board, our Team has facilitated 6 workshops internally which have been well received and have resulted in multi-agency meetings being called under the policy for individuals assessed as being at significant risk of harm.

Key Achievements

- Implementation of revised test under DOLS - *Outcome* – inpatients and carers assured that care provided is in best interests and subject to external scrutiny.
- Engagement and practice of consent and MCA - *Outcome* – Patients treated lawfully
- Implementation of Self Neglect Policy - *Outcome* – Greater scrutiny of risk and utilisation of legislation to provide care to adults at risk of significant harm through self-neglect.

Key Challenges

- Continued application of revised test at end of life.
- Increasing demands for performance data within a small resource.
- Policy and training revision in light of legislation changes.

Future plans 2015-2016

- Implementation of robust Prevent WRAP and Safe Enquiry training at Corporate Induction.
- Increasing awareness of DOLS for staff who visit patients in the community.

Kent Community Health NHS Foundation Trust (KCHFT)

Overview of 2014-2015

During 2014/15, Kent Community Health NHS Foundation Trust (KCHFT) Safeguarding and MCA specialist practitioners worked with frontline staff, to implement the changes resulting from the in-year Supreme Court ruling and ensure that the Trust upheld the law, when caring for patients who may be unable to consent to or during their admission onto one of the Trust's Community Hospitals.

Thirty five safeguarding adult allegations implicating KCHFT were investigated by KCC during the year. The categories of abuse that were of particular note related to neglect associated with tissue viability (pressure ulcers) and failure to act. Following investigation, 5 of the cases were substantiated and 1 was partially substantiated. A further 46 cases implicating KCHFT remained open at the end of 2014/15.

Two hundred and thirty seven allegations implicating other organisations were raised by KCHFT staff, with the highest category of abuse by a significant margin relating to neglect.

Key Achievements

- Our MCA Co-ordinator, who was recruited in-year, provided practical support and advice on complex mental capacity related cases, including collaborating across specialist services such as End of Life and Dementia.
- Our frontline staff are aware of and raise safeguarding alerts, consult regularly with our Safeguarding specialist practitioners on cases of particular concern and access structured Safeguarding supervision that is embedded in the ongoing work between our Safeguarding and operational services.
- We participated in the Kent and Medway Safeguarding Adults Board Self-Assessment Framework review audit, which demonstrated that the Trust met its entire obligation in safeguarding adults accessing its services.

Key Challenges

- Reducing the number of substantiated cases of neglect relating to tissue viability and failure to act.
- Improving MCA training compliance proved challenging and was heavily dependent on timely support from Operational Managers.
- On-going challenges implementing changes to the DOLS legislation.

Future Plans 2015-2016

- Full implementation of the Care Act 2014 and *Care and Support Statutory Guidance 2014* across the Trust.
- Maintain MCA training compliance, in particular the advanced level of training relating to DOLS.
- Continue the work of extending the role of the MCA link/Safeguarding champion across identified operational services.
- Incorporate *Prevent* basic awareness and WRAP3 training into our safeguarding training, at induction and 3 yearly updates.

Kent Police

Overview of 2014-2015

Austerity measures continue to impact on policing in Kent. Further re-structure has established the amalgamation of the police response teams with the neighbourhood teams and the custody functions. Vulnerability is seen as a force priority and it is hoped that further reductions will not impact too heavily on the Public Protection Units. (PPU)

Kent Police have been involved in the role out of the Making Safeguarding Personal programme by assisting in facilitating multi-agency cascade training throughout 2014. The police training school has reviewed and developed the joint training level four course and are looking to roll this out shortly.

The Missing Persons Liaison Officers (MPLO) and County Co-ordinator are now established within the structure of the PPU. This has enabled us to focus more clearly on institutions in respect of clients who go missing and helps us to understand more closely the homes we have in Kent and Medway.

Canterbury area has embarked on a county project to examine our response to dementia patients that wander. A multi-agency working group has been established and are looking at effective strategies to anticipate wanderer's actions, provide preventative measures and explore the deployment of electronic devices to assist in their protection.

The Central Referral Unit both at Kroner House and at Compass House have Police Designated Adult Safeguarding Managers identified to provide a consistent and dedicated response for partners to liaise with in matters of safeguarding concern.

The 2013 Protocol and Good Practice Model for police and local authority disclosures in parallel proceedings has updated the disclosure process for children but not adults. Police were heavily involved in the responses to the protocol for children and will now embark on assisting to update the adult process.

Kent Police have now developed a dedicated Sexual Offences Investigation Team to improve the police response to allegations of sexual crime. This centralised team of dedicated officers will improve our response to sexual crime and be active in uncovering safeguarding issues with victims.

Key Achievements

- The development of training for the new Care Act 2014.
- PPU taking over the strategic lead of Missing Persons.
- The effective roll out of Making Safeguarding Personal Training.

Key Challenges

- The effective use of the legislation encompassed in the Care Act 2014.
- Reaffirm safeguarding principles within a further restructure of Kent Police.
- Piloting preventative measures for Dementia sufferers.

Future Plans 2015-2016

- Continued adult safeguarding training for the workforce.
- Further develop the multi-agency response to Dementia sufferers who wander.
- Full engagement with the Kent and Medway Safeguarding Adults Board to implement the Care Act 2014.
- Engagement with the Kent and Medway Safeguarding Adults Board to update the disclosure process.

Adult Abuse Data Financial Year 2014/15

	Total recorded crimes	Total Secondary Incidents	Total
Ashford	29	59	**88**
Canterbury	130	94	**224**
Dartford	36	53	**89**
Dover	82	65	**147**
Gravesham	24	78	**102**
Maidstone	49	68	**117**
Medway	67	223	**290**
Sevenoaks	26	30	**56**
Shepway	42	50	**92**
Swale	49	144	**193**
Thanet	81	108	**189**
Ton/Malling	38	43	**81**
T/Wells	23	43	**66**
Force	**676**	**1058**	**1734**
2013-14	674	1405	2079

Crime Type Breakdown

	Violence	Sexual	Theft	Robbery	Other
Ashford	21	5	1	1	1
Canterbury	104	11	9	0	6
Dartford	29	3	2	0	2
Dover	57	7	7	0	11
Gravesham	16	2	4	1	1
Maidstone	38	2	1	0	8
Medway	43	8	14	0	2
Sevenoaks	26	0	0	0	0
Shepway	39	1	2	0	0
Swale	38	8	3	0	0
Thanet	52	12	13	0	4
Ton/Malling	33	1	4	0	0
T/Wells	15	4	3	0	1
Total	**511**	**64**	**63**	**2**	**36**
2013-14	470	58	97	2	44

Crime types mostly relate to recorded crimes with secondary incidents mostly remaining unclassified.

Violent crime reports have increased with the biggest increases being Canterbury up from 85 to 104 and Tonbridge and Malling up from 17 to 33. Theft has decreased across the board but with the biggest reduction in Shepway down from12 to 2.

Secondary incidents (Non crime) investigations have reduced by 345 over the year; again these are across the board with the largest reduction in Thanet down from 287 to 189.
The reasons for this are unclear but could be due to better working practices around the interface of safeguarding and mental health. This also may be a reflection of earlier, more personal interventions with the role out of Making Safeguarding Personal.

Medway NHS Foundation Trust

Overview of 2014-2015

All staff continues to be trained in safeguarding through core induction and mandatory training. Medway Foundation Trust (MFT) training dates for additional safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DOLS) have been circulated to all relevant Trust staff groups. These dates are booked up until December 2015. The Trust Safeguarding Lead continues to attend case conferences. The Safeguarding Lead remains the Prevent Lead for Medway Foundation Trust (MFT).

Key Achievements

- There has been a huge increase in safeguarding training attendance.
- Best Interest meetings occur appropriately and are documented robustly.
- We have incorporated Prevent basic awareness into our safeguarding training.

Key Challenges

- With the Health and Social Care Act and the making safeguarding personal agenda there is a need to embed this 'person centred practice' into safeguarding work in a robust but sensitive manner.
- Joint investigations into hospital acquired grade 3 and 4 pressure ulcers. These are currently being jointly investigated by the Safeguarding and Tissue Viability Nurse along with named professionals.
- The Supreme Court judgement about the application of the Deprivation of Liberty Safeguards (DOLS) has had a significant impact on caring for people who lack mental capacity and who are unable to understand their own care and treatment requirements, this has required a much larger number of patients to fall in to the DOL's category than before and has created a significant pressure on all staff involved, to adapt to the increased demand.

Future Plans 2015-2016

- Create an electronic solution for application and monitor DOLS applications.
- Continue to increase our understanding of vulnerable adults within the acute setting including domestic abuse.
- Full implementation of the Care Act 2015 and Care and Support Statutory Guidance 2014 across the trust.
- To continue identifying exactly which patients require DOLS
- Continue to provide training and education for staff, especially in key areas and those with especially vulnerable patients.
- Working with the CCG to reduce the risk of non-hospital acquired pressure ulcers.
- Increase the profile and awareness of the LD service.
- Monitor the effectiveness of the Self-Neglect Policy where it is used.

Maidstone and Tunbridge Wells NHS Trust

Overview of 2014-2015

The outcome of the 2014 Care Quality Commission report in relation to the Trust identified that Trust staff were able to describe how they would get support and advice, who from, and they were able to demonstrate how they would raise their concerns and make Safeguarding Adults referrals appropriately.

The Trust has in place a Safeguarding Adults Committee with both multi-professional and multi-agency representation. The Committee is chaired by the Deputy Chief Nurse. The Safeguarding Adults Committee continues to report to the Quality and Safety Committee and the Trust Board gain periodic assurance throughout the year via this route.

The Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure has been reviewed and updated as a result of the changes in case law with regards to Deprivation of Liberty Safeguards. As a result of the impact of the Supreme Court Judgement the Trust has provided a number of training sessions, ward based and have seen the numbers of DOLS applications rise exponentially in line with national trends.

The Trust Domestic Abuse Policy and Procedure was published last year and covers Domestic Abuse responses for both patients and staff members. Matron for Safeguarding Adults has assisted with a number of staff related referrals with regards to Domestic Abuse.

The Trust's Missing Adult Patient Policy and Procedure was published in March 2015. Kent Police are considering using M&TW's policy as the basis for a Procedure across Kent.

The Trust's suite of training has been updated to reflect the Care Act Guidance.

The impact upon patients is that they can be assured that if they raise concerns these will be responded to appropriately.

Key Achievements

- Continue to raise awareness of the use of the MCA and DOLS processes.
- Staff continue to feel confident about raising safeguarding alerts.
- Training delivery reviewed, revised and updated in line with the Care Act 2014.

Key Challenges

- To continue to follow the DOLS processes even though it is widely acknowledged that they are not fit for purpose.
- To administrate and report effectively on the various areas attached to the Safeguarding Adults agenda, i.e. *Prevent*, Learning Disability admissions, Best Interest meetings.
- To ensure that the Learning Disability Agenda is given the time warranted to progress such issues as easy read leaflets, Hospital passports and capturing required data.

Future Plans 2015-2016

- To continue focussing on Mental Capacity Act and Deprivation of Liberty Safeguards training in 2015.
- To consider options available to ensure that Learning Disability issues are prioritised.
- To continue working with our security contractor to ensure that security staff are trained in how to effectively manage patients who are potentially at risk of harm.

South East Ambulance NHS Foundation Trust

Overview of 2014-2015

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties. During 2014/15 the Trust has undertaken a review of its safeguarding arrangements and the safeguarding team has seen an increase in capacity during this period. Referral rates have continued to rise with an overall increase of 18% from 2013/14 across the whole Trust area. Unfortunately it is not possible to break down the reporting figures by local authority area due to data entry challenges, however, it is anticipated this will be addressed during 2015/16.

Key Achievements

- Appointment of a full-time Safeguarding Support Officer adding resilience and capacity to the safeguarding team.
- Re-introduction of a Domestic Abuse (DA) pilot in Sussex with increased DA awareness training across the whole Trust.
- Successful pilot for an on-line reporting process across the whole Trust.

Key Challenges

- A significant backlog of data entry for vulnerable person (VP referrals) due to legacy departmental capacity issues made reporting and analysing referrals for the year challenging. This has since been rectified at the end of Q4 and into Q1 2015/16.
- Lack of capacity within the team during the first half of the year meant it wasn't possible to properly engage with local safeguarding boards across the region. This has improved following the appointment of additional staff in the team.
- Understanding how the 111 service differed from the 999 service provided across the Trust and the unique challenges faced by staff who do not see the patient with regards to making referrals was a core requirement.

Future Plans 2015-2016

- The safeguarding team will continue to roll out the electronic reporting across all Trust sites (including both 111 sites) leading to improved monitoring and analysis of the information being gathered.
- The DA pilot will continue as per the commissioned plan, including project review and evaluation to assist the development of business case proposals for its sustained continuity beyond December 2015.
- The team will continue to work with 111 to improve the understanding of safeguarding referral requirements and referral data analysis.
- A significant volume of safeguarding and DA reporting metrics have been agreed with lead commissioners for reporting where possible during 2015/16.
- In partnership with learning and development colleagues, the team will progress the delivery of MCA training to all clinical staff in accordance with the Trusts key skills plan (including application of capacity assessments, obtaining consent to treatment and use of control and restraint techniques) supported, if appropriate, by a tier of Mental Health expertise available to operational staff.

Kent Fire and Rescue Service

Overview of 2014-2015

During the last year, the Service has invested in increasing the number of officers it has specifically trained to carry out home safety visits for vulnerable people.

This has included merging two teams; the Home Safety Visit team and the Vulnerable Persons team. A comprehensive training programme was put in place which included training sessions and a period of shadowing.

A group of volunteers have been recruited to assist the Service in identifying vulnerable people and referring them for home safety visits.

The volunteers have been attending various venues, groups and meetings across Kent and Medway, including Domestic Abuse one-stop shops, Sure Start children centres and retirement associations. The volunteers have also been piloting a GP referral system in rural surgeries.

Over the last few years, there has been a gradual increase of operational fire-fighters identifying signs of vulnerability whilst responding to emergency incidents and referring people to the Vulnerable Persons team for action.

Key Achievements

- 5210 home safety visits were carried out in households scoring high in terms of risk from fire or ability to escape from fire. Through the Home Safety Visit Scheme, officers have reduced the risk of fire for 5210 vulnerable households by installing risk reduction measures such as; specialist smoke alarms, flame retardant bedding, timed cooker switches and giving fire safety advice.
- 10 dementia champions have been trained and 400 people in the Service received the Dementia Friends training. Through better knowledge of dementia within the Service, officers are now better equipped to communicate and work more effectively with suffers and their families.
- The Service has increased the number of officers trained to identify and support vulnerable people.
- Establishment of a 24 hour out of hours safeguarding duty system. The safeguarding duty system has provided 24 hour safeguarding advice for Kent Fire and Rescue staff which has resulted in earlier safeguarding responses being actioned.

Key Challenges

- Raising the Service's profile as a safeguarding partner to prevent barriers in information sharing.
- Trying to identify individuals that would benefit from our home safety services that are not already known to other agencies.
- Continuing to raise awareness of our services with other agencies that have a high staff turnover such as care agencies.

Future Plans 2015-2016

The Service is looking at closer joint working between key agencies, including co-location of staff to assist in the effective identification and response to members of the community at high risk from fire who also need support from other agencies.

Section 7: Safeguarding Activity

1. BACKGROUND TO DATA

The data for this report was extracted from the Kent County Council social care system (SWIFT) and the Medway Council safeguarding database. In most cases, the data included in this report is consistent with the Department of Health (DH) statutory returns: Abuse of Vulnerable Adults (AVA) for 2012-13 and the Safeguarding Adults Return (SAR) for 2013-14 & 2014-15.

** 2014-15 data is not yet validated and so maybe subject to change*

The first part of the report looks at new safeguarding adults referrals. A referral is made when a concern has been raised leading to an adult safeguarding investigation. The second part of the report summarises the outcomes of safeguarding referrals in Kent and Medway.

2. NEW SAFEGUARDING ADULTS REFERRALS

2.1 Number of referrals and rate of change

There were a total of 3517 new safeguarding adult referrals in the period 2014-2015, which sees a 0.7% decrease on the previous year. Kent saw a decrease of 3.1% in their referrals from 2013-14 to 2014-15. Medway's rate of referrals has decreased by 22.5%.

During 2014/15, Medway had 604 adult safeguarding alerts, which progressed to 244 number of safeguarding enquiries (referrals).

In 2013/14, when a safeguarding alert met the criteria for a safeguarding investigation these were recorded and counted as a 'safeguarding referral'. However, Medway Council had no recording mechanism for the numbers of alerts that did not meet the criteria for a referral. The ASCOF's Safeguarding Adult Return did not mandate us to record alerts and subsequently those cases then went onto to further investigation (referrals) were only submitted.

With the introduction of Frameworki in April, every safeguarding concern notified to us is raised on the system as a safeguarding alert, hence why the number of alerts appears to be high this year but the number of safeguarding referrals, those that have progressed to a safeguarding enquiry, has decreased as a result. Therefore, due to the method and criteria for recording these are not comparative figures as with last year.

Area	12-13	13-14	14-15	% change between 13-14 & 14-15	% of total in 14-15
Kent	2863	3176	3273	-3.1%	93.1%
Medway	313	315	244	-22.5%	6.9%
Total	3176	3491	3517	0.7%	100.0%

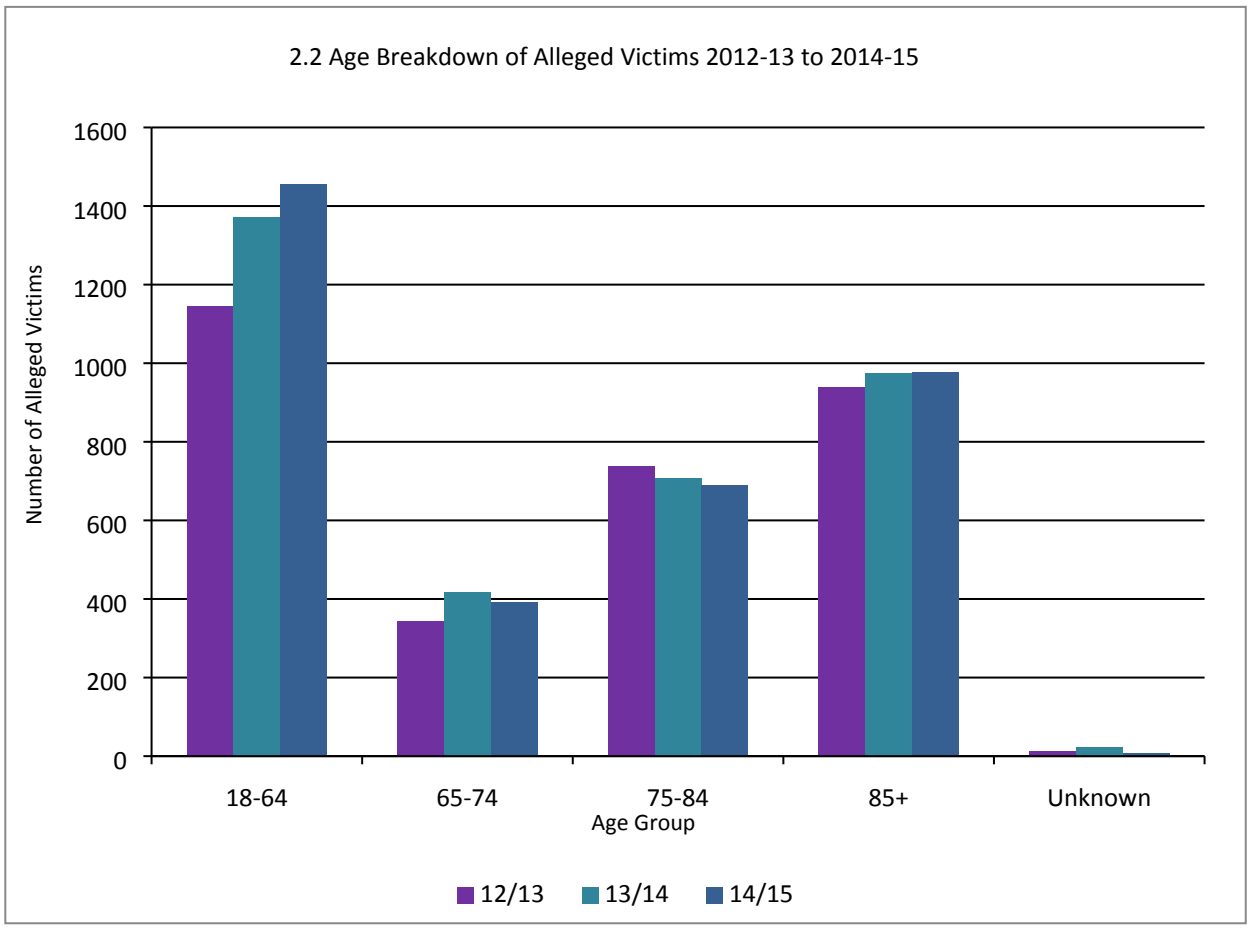
Table 2.1: Number of referrals year on year and rate of change 12-13 to 14-15

2.2 Age of alleged victims

In the period 2014 to 2015, the majority of all referrals, 38.8%, were from the 18-64 age group, with the second most prevalent group being the 85+ age category, 29.4%. There has been no significant change in the proportions of referrals across the age groups over the past three years.

Age group	12-13		13-14		14-15	
	Number	%	Number	%	Number	%
18-64	1145	36.1%	1372	39.3%	1454	41.3%
65-74	344	10.8%	416	11.9%	391	11.1%
75-84	737	23.2%	707	20.3%	690	19.6%
85+	939	29.6%	974	27.9%	976	27.8%
Unknown	11	0.3%	22	0.6%	6	0.2%
Total	3176	100.0%	3491	100.0%	3517	100.0%

Table 2.2: Age breakdown of alleged victims for the periods 2012-13 to 2014-15

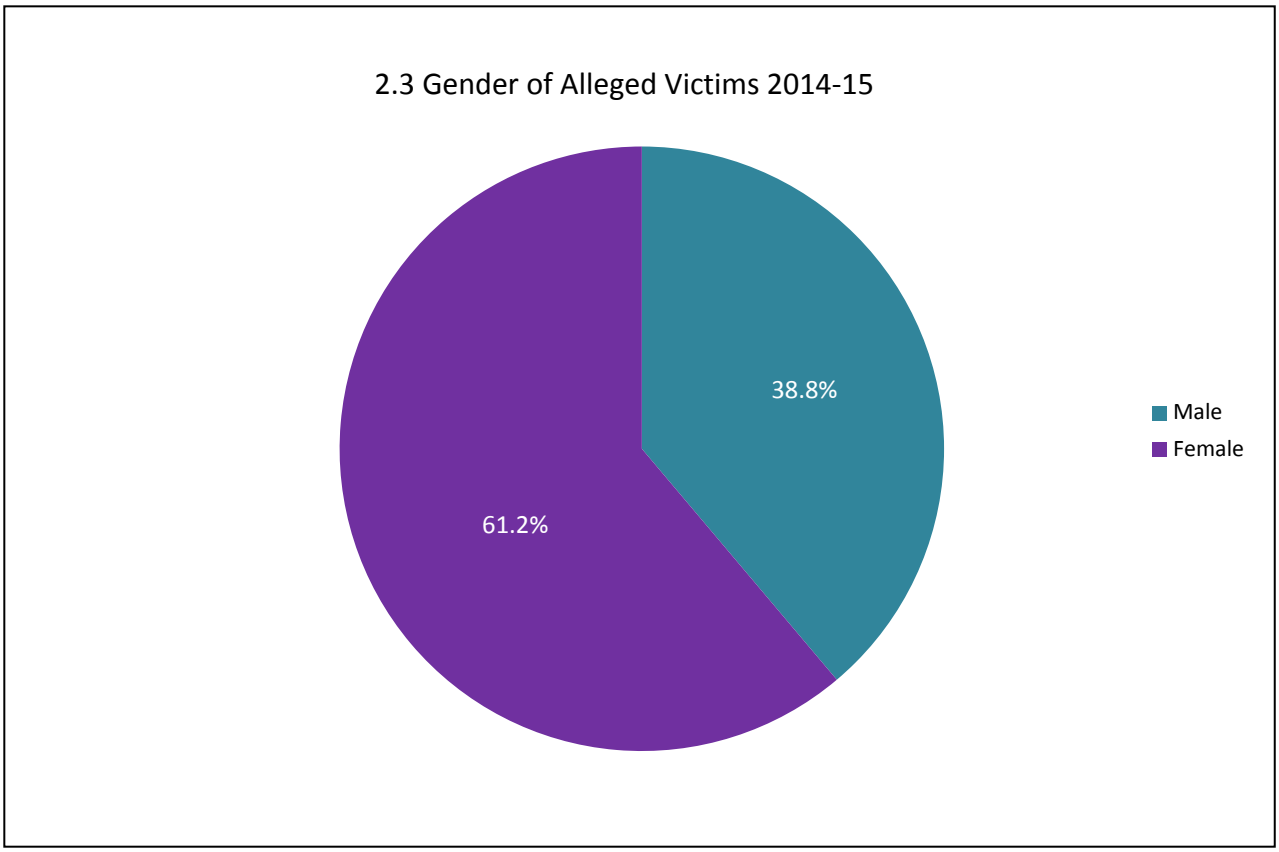


2.3 Gender of alleged victims

In 2014-2015, the highest proportions of alleged victims were female at 61.2%. This is consistent with the previous two years of reporting.

Gender	12-13		13-14		14-15	
	Number	%	Number	%	Number	%
Male	1193	37.6%	1375	39.4%	1366	38.8%
Female	1983	62.4%	2116	60.6%	2151	61.2%
Total	3176	100.0%	3491	100.0%	3517	100.0%

Table 2.3: Gender of alleged victims over the periods 2012-13 to 2014-15



2.4 Ethnicity of alleged victims

In 2014-2015, the percentage of victims from a black or ethnic minority background increased from 3.0% to 3.4%. The percentage of alleged victims from a white background has decreased slightly from 88.1% to 86.5%. There has been an increase of 1.3 percentage points in the number of individuals were the ethnicity was not stated/not obtained between 2013-14 and 2014-15.

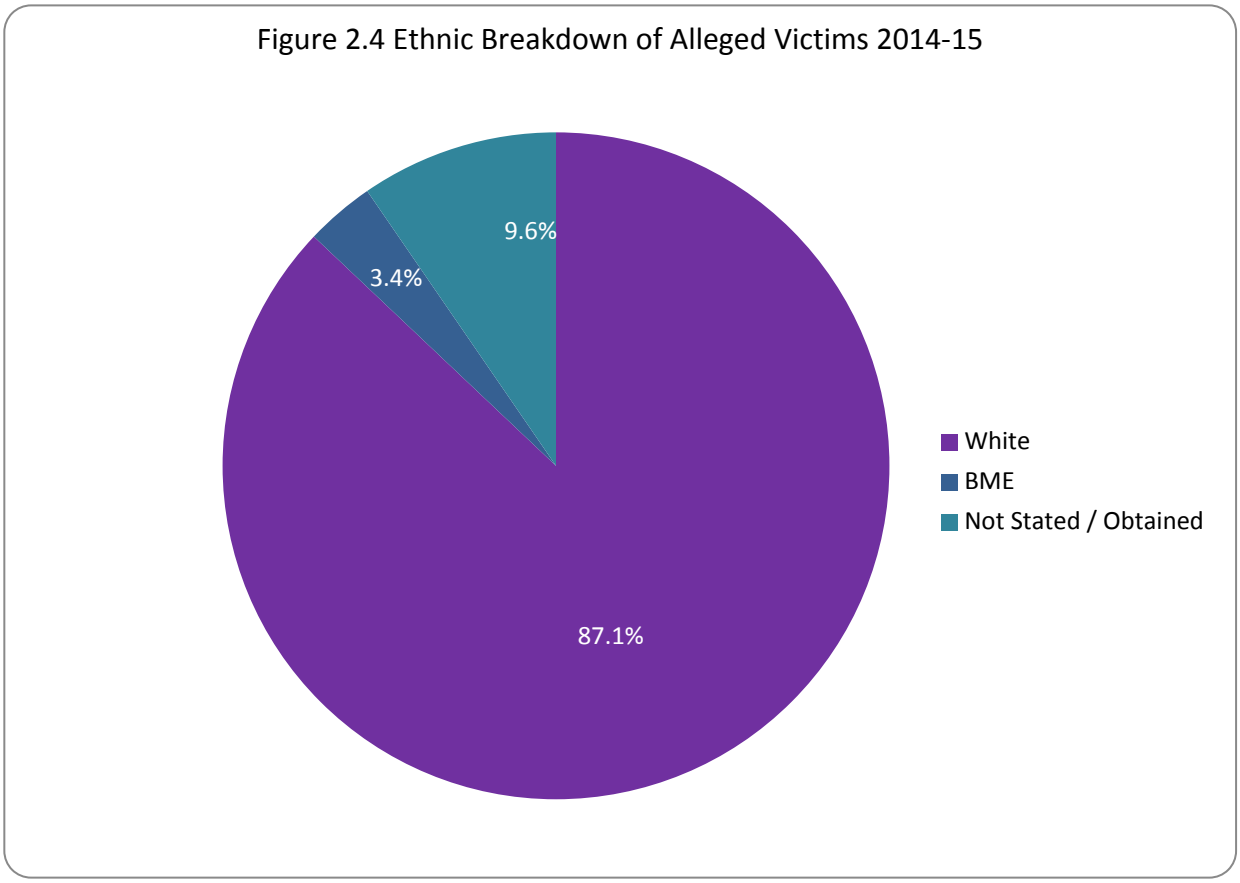
Ethnicity	12-13		13-14		14-15	
	Number	%	Number	%	Number	%
White*	2713	85.5%	3077	88.1%	3062	87.1%
BME **	113	3.6%	106	3.0%	118	3.4%
Not stated/ obtained	348	11.0%	308	8.8%	337	9.6%
Total	3174	100.0%	3491	100.0%	3517	100.0%

Table 2.4: Breakdown of Ethnic Group for the periods 2012-13 to 2014-15

* *'White' contains the DH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background.*

** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups

Figure 2.4 Ethnic Breakdown of Alleged Victims 2014-15



2.5 Primary Support Reason of alleged victim

The Health and Social Care Information Centre (HSCIC) introduced a new way of categorising clients as part of the zero based reviews of Adults Social Care statutory returns. This saw a move away from using the primary client category towards recording a Primary Support Reason (PSR). Primary Support Reasons represent the reason why an individual is receiving support from the local authority rather than categorising them simply by the health condition that may result in an individual having support needs.[1] 2014-15 is the first year that the new Primary Support Reasons were reported.

The table below shows the number and proportions of individuals according to the Primary Support Reason. In both Kent and Medway the most prevalent support reason was Physical Support with Learning Disability Support as the second most prevalent. There were 14.7% and 23.0% of individuals with no support reason in Kent and Medway respectively. This is to be expected as individuals subject to a safeguarding referral will not always be receiving support from the local authority.

[1] Equalities and Classifications Guidance (EQ-CL), HSCIC 2014-15

Primary Support Reason	Kent		Medway	
	No.	%	No.	%
Physical Support	1267	38.7%	86	35.2%
Sensory Support	61	1.9%	2	0.8%
Support with Memory and Cognition	398	12.2%	23	9.4%
Learning Disability Support	654	20.0%	39	16.0%
Mental Health Support	419	12.8%	33	13.5%
Social Support	8	0.2%	5	2.0%
No Support Reason	466	14.2%	56	23.0%
Total	3273	100.0%	244	100.0%

Table 2.5: Breakdown of Primary Support Reason (PSR) for the periods 2012-13 to 2014-15

2.6 Location of alleged abuse

In 2014 to 2015 the main location for incidences of alleged abuse was within a residential care home, with 38.6% of referrals occurring here. This is consistent with the reported figures for the previous two years. 34.4% of incidences were reported to be in the alleged victims own home, this represents a 0.4 percentage point decrease from 2013-14. Incidences of abuse where the location is unknown have decreased by 0.5 percentage points. There were 112 referrals where the location of the alleged abuse was a Mental Health Inpatient Setting, this accounts for 3.2% of all new referrals. Historically, this data has not been consistently collected so there is no three year comparison however, comparable data will be available for future years reporting.

Location	12-13		13-14		14-15		% point change 2013/14-2014/15
	Number	%	Number	%	Number	%	
Own Home	1161	36.6%	1215	34.8%	1209	34.4%	-0.4
Community Service	131	4.1%	109	3.1%	116	3.3%	0.2
Care Home	1270	40.0%	1415	40.5%	1359	38.6%	-1.9
Hospital	125	3.9%	191	5.5%	150	4.3%	-1.2
Mental Health Inpatient Setting	~	~	~	~	112	3.2%	~
Public Place	89	2.8%	71	2.0%	70	2.0%	0.0
Other	143	4.5%	130	3.7%	156	4.4%	0.7
Not Known	257	8.1%	360	10.3%	345	9.8%	-0.5
Total	3176	100.0%	3491	100.0%	3517	100.0%	~

Table 2.6: Location of alleged abuse for the periods 2012-13 to 2014-15

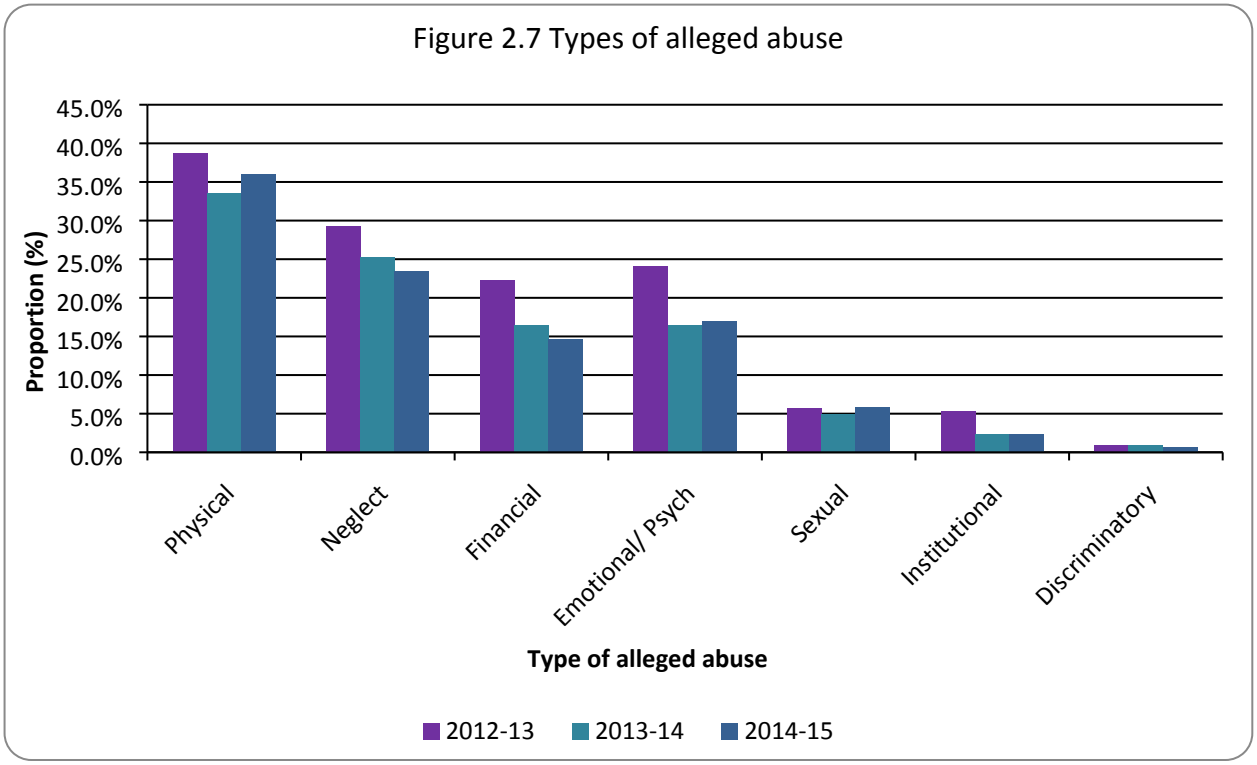
** All care home settings, including nursing care, permanent and temporary*
*** Acute, community hospitals and other health settings*

2.7 Types of abuse

Physical abuse has remained the category most prevalent over the past three years. The proportion of incidences where emotional/psychological abuse was a factor has decreased over the past three years by 7.1 percentage points between 2012-13 and 2014-15. Incidences where financial abuse was apparent have also decreased over the past three years, falling from 22.3% in 2012-13 to 19.0% in 2014-15. This may be due to recording issues, whereby staff only record the main type of abuse when there is more than one type of abuse. There has also been a recent change in systems and the recording process in Kent and Medway.

Categories of alleged abuse	2012-13		2013-14		2014-15	
	Number	%	Number	%	Number	%
Physical	1231	38.8%	1407	33.6%	1100	36.0%
Neglect	931	29.3%	1054	25.2%	750	23.5%
Financial	707	22.3%	688	16.4%	572	14.7%
Emotional/ Psychological	765	24.1%	691	16.5%	366	17.0%
Sexual	183	5.8%	206	4.9%	146	5.8%
Institutional	167	5.3%	98	2.3%	65	2.4%
Discriminatory	28	0.9%	39	0.9%	9	0.6%

Table 2.7: Type of alleged abuse by area (a referral may have multiple types of abuse recorded – the percentage figures relate to the proportion of all referrals where each type of abuse was apparent)



2.8 Source of safeguarding referral

The table below shows the comparison of safeguarding referrals over the past three years. The majority of referrals continue to come from social care staff however; there has been a 2.8 percentage point decrease from 2013-14 to 2014-15. Referrals from health care staff have seen an increase of 2.9 percentage points to 23.5%.

The proportions across the other sources of referrals have remained consistent over the past few years with no statistically significant increase or decrease between 2013-14 and 2014-15.

The 'Other' category includes Carers, Voluntary Agencies/Independent sector, Anonymous, Legal, Other LA, Benefits Agency, Probation Service and Strangers. The relatively high percentages for this category may be due to recording issues. Both Kent and Medway have safeguarding websites and leaflets accessible by members of the public. Safeguarding Awareness Week is key to increasing safeguarding awareness amongst members of the public.

Source of Referral	12-13		13-14		14-15		Percentage point change 13-14 & 14-15
	Number	%	Number	%	Number	%	
Social Care staff	1325	41.7%	1689	48.4%	1602	45.6%	-2.8
Health Staff	754	23.7%	718	20.6%	827	23.5%	2.9
Self Referral	97	3.1%	129	3.7%	122	3.5%	-0.2
Family member	273	8.6%	271	7.8%	202	5.7%	-2.0
Friend/Neighbour	37	1.2%	49	1.4%	25	0.7%	-0.7
Other service user	3	0.1%	8	0.2%	7	0.2%	0.0
Care Quality Commission	63	2.0%	115	3.3%	132	3.8%	0.5
Housing	64	2.0%	45	1.3%	60	1.7%	0.4
Education/Training Workplace	18	0.6%	10	0.3%	22	0.6%	0.3
Police	163	5.1%	152	4.4%	132	3.8%	-0.6
Other	379	11.9%	298	8.5%	386	11.0%	2.4
Unknown	0	0.0%	7	0.2%	0	0.0%	-0.2
Overall Total	3176	100.0%	3491	100.0%	3517	100.0%	~

Table 2.8: Source of safeguarding for the periods 2012-13 to 2014-15

3 CLOSED REFERRALS

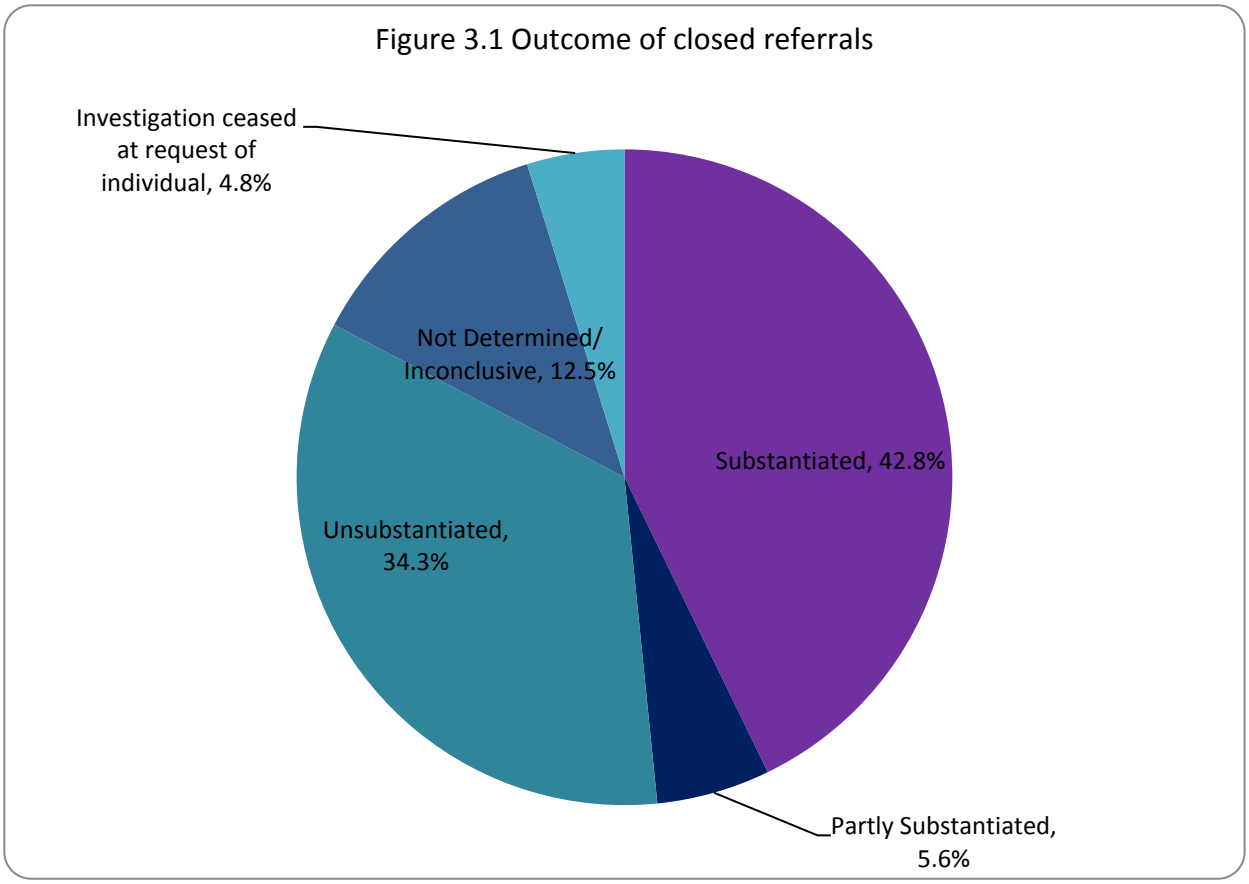
3.1 Outcome of closed referrals

In Kent, the highest proportion of cases were substantiated (43.5%) whereas in Medway the highest proportion of cases were unsubstantiated (39.5%). Medway had a higher proportion of cases that were partially substantiated than Kent, but a lower number of cases that were not determined/ inconclusive. Across both Kent and Medway, the highest proportion of cases were substantiated and the lowest proportion resulted in the investigation ceasing at the individuals request.

Area	Substantiated		Partly substantiated		Un-substantiated		Not determined/ inconclusive		Investigation ceased at request of individual	
	No.	%	No.	%	No.	%	No.	%	No.	%
Kent	1357	43.5%	167	5.4%	1060	34.0%	392	12.6%	144	4.6%
Medway	72	32.7%	20	9.1%	87	39.5%	25	11.4%	16	7.3%
Total	1429	42.8%	187	5.6%	1147	34.3%	417	12.5%	160	4.8%

Table 3.1a Outcome of closed referrals in Kent and Medway 2014-15

Figure 3.1 Outcome of closed referrals



3.2 Action resulting from closed referrals

The recording of the result of actions taken for closed safeguarding referrals was introduced as a part of the changes to the statutory returns in 2013-14. In 2014-15, across Kent and Medway, the highest proportion of cases resulted in no action taken and the lowest number of cases resulted in action being taken but the risk still remaining in both 2013-14 and 2014-15. However, in Medway the highest proportion of cases in 2014-15 resulted in the risk being removed at 59.5% and no cases had a result where no action was taken. In Kent the proportions have remained consistent across both years for the result of action taken for closed referrals.

It is not representative that no action was taken on cases in the first section of the table below. For those cases recorded as 'no action taken', the cases may have been inappropriate and therefore passed on to the appropriate teams. Cases may have been closed due to the case being open to Areas and no specific safeguarding action being required. In other cases, some work would have taken place in relation to safeguarding and these cases would have been closed at Stage 2.

Area	No Action Taken		Risk Remains		Risk Reduced		Risk Removed	
	13-14	14-15	13-14	14-15	13-14	14-15	13-14	14-15
East Kent Total	59.7%	54.8%	6.0%	6.2%	20.2%	27.4%	14.1%	11.7%
West Kent Total	76.9%	55.4%	3.1%	6.4%	14.6%	27.1%	5.5%	11.1%
Central Duty Team	66.7%	53.6%	5.8%	7.2%	21.5%	28.0%	6.1%	11.1%
Medway	18.8%	0.0%	5.5%	16.8%	49.0%	23.6%	26.6%	59.5%

Table 3.2 Actions resulting from closed safeguarding referrals 2013-14 & 2014-15

Section 8: Priorities for 2015-2016

A number of priorities have been identified for 2015 - 2016

- Reviewing the multi-agency training programme
- Publishing a strategic plan for the Kent and Medway Safeguarding Adults Board
- Reviewing the multi-agency policy, protocols and guidance document
- Responding to the recommendations from Safeguarding Adults Reviews
- Updating the Kent and Medway Safeguarding Adults Board website in light of the Care Act 2014
- Responding to national safeguarding developments, including commissioning detailed analysis in order to understand the issues related to human trafficking, modern slavery and sexual exploitation nationally and in Kent and Medway
- Assess progress with local implementation of the Mental Health Crisis Concordat

Appendices

Appendix 1

Kent and Medway Safeguarding Adults Board Principles and values

The Kent and Medway Safeguarding Adults Board is underpinned by the following principles and values:

- It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity
- All agencies and services should ensure that their own policies and procedures make it clear that they have a zero tolerance of abuse
- Priority will be given to the prevention of abuse by raising the awareness of adult protection issues and by fostering a culture of good practice through support and care provision, commissioning and contracting
- Adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services.
- These principles are applicable to all adults whether living in a domestic setting, care home, social services or health setting or any community setting
- Protection of adults experiencing, or at risk of, abuse or neglect, is a multi-agency responsibility and all agencies and services should actively work together to address the abuse of adults
- Interventions should be based on the concept of empowerment and participation of the individual at risk
- These principles should constitute an integral part of the philosophy and working practices of all agencies involved with adults experiencing, or at risk of, abuse or neglect, and should not be seen in isolation
- It is the responsibility of all agencies to take steps to ensure that adults experiencing, or at risk of, abuse or neglect ,are discharged from their care to a safe and appropriate setting
- The need to provide support for the carers must be taken into account when planning services for adults experiencing, or at risk of, abuse or neglect, and a carer's assessment should be offered
- These principles are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation.

Appendix 2

The main forms of abuse are:

- Physical abuse including assault, hitting, slapping, pushing, misuse of medication, restraint, or inappropriate physical sanctions

- Domestic Violence including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence

- Sexual abuse including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or acts to which the adult has not consented, or was pressured into consenting

- Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks

- Financial or material abuse, including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits

- Modern slavery encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

- Discriminatory abuse, including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion

- Organisational abuse including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation

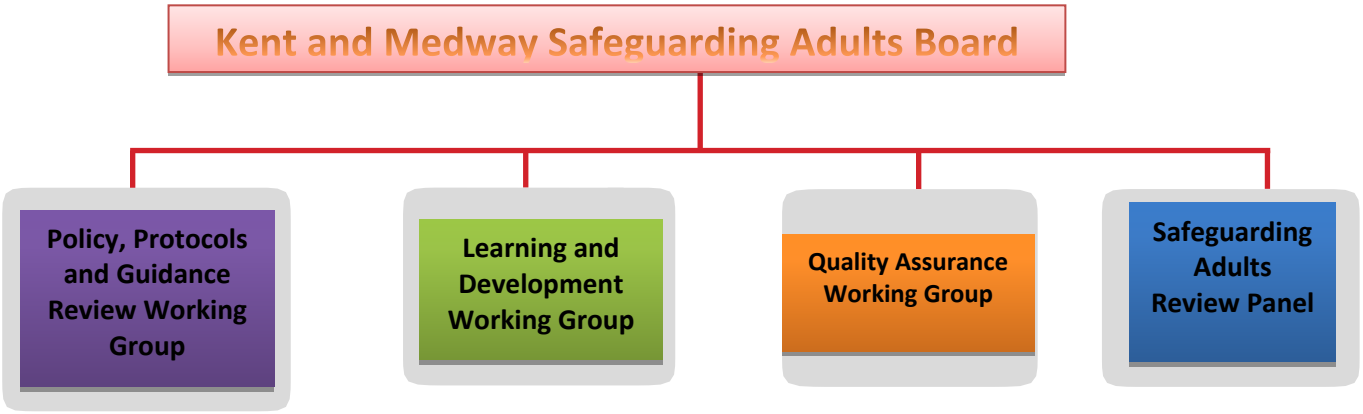
- Neglect and acts of omission, including ignoring medical, emotional or physical care needs, failure

to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

- Self-neglect covers a wide range of behavior neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding

Appendix 3

Kent and Medway Safeguarding Adults Board Governance Structure



Kent and Medway Safeguarding Adults Board



ANNUAL REPORT 2014 – 2015

Please visit our website: www.kent.gov.uk

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 September 2015

Subject: **ANNUAL EQUALITY AND DIVERSITY REPORT 2014-2015**

Classification: Unrestricted

Previous Pathway: Social Care, Health and Wellbeing Directorate Management Team

Future Pathway: Governance and Audit Committee

Electoral Division: All divisions

Summary: This report sets out a position statement for services within Social Care, Health and Wellbeing regarding equality and diversity work and progress on KCC Equality objectives for 2014/15.

Recommendation(s): Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **COMMENT** on key achievements (Section 5)
b) **AGREE** the proposed changes to equality Objectives and to receive revised objectives in 2016 (Section 8)
c) **AGREE** to receive the report annually in order to comply with Public Sector Equality Duty (PSED) and ensure progress against County Council objectives

1. Introduction

1.1 Publication of equality information is compulsory in England for all public authorities. Proactive publication of equality information ensures not only compliance with the legal requirements, but also greater understanding by the public of the difficult decisions an authority faces, and why it takes those decisions. Gathering equality information and using it to inform decision-making can also enable authorities to achieve greater value for money in the services they deliver through better targeting of services.

2. Financial Implications

2.1 There are no financial implications in producing an annual report.

3. Policy Framework

3.1 Advancing equality and reducing socio-economic inequalities in Kent contributes towards the Council's Medium Term Plan, 'Increasing Opportunities, Improving Outcomes'. As such the objectives correspond with existing council priorities and the objectives support the aims of, helping the Kent economy to grow, putting the citizen in control and tackling disadvantage.

3.2 The council has published its equality and diversity objectives for 2012-2016. Each service was asked to provide equality information and to demonstrate how they complied with equality legislation between 1 April 2014 – 31 March 2015, and what performance measures they have in place to achieve the Kent County Council (KCC) Equality Objectives.

4. Adult Social Care

4.1 Despite a continuing, difficult financial climate there is a commitment to achieving fairness and equality for all Kent's residents, and shaping services accordingly. The Social Care, Health and Wellbeing Directorate (SCHW) has a leading role in discharging the Council's statutory responsibilities for public health and social care. Above all, the Directorate aims are about building on peoples' strengths and capabilities and promoting their independence to improve their health and wellbeing, assisting people to achieve outcomes that matter to them and working with statutory and non-statutory partners to protect the most vulnerable children and adults.

4.2 The principal responsibilities of the Directorate include undertaking individual and population needs assessment, commissioning and arranging services to meet the eligible needs of people and safeguarding vulnerable children and adults. Adult Social Care demonstrates its commitment by embedding equality throughout the organisation to ensure that the needs of all communities are considered in the commissioning and delivery of services.

4.3 The Health and Social Care sector continues to operate in an era of unprecedented change. Every aspect of social care provision, including how services are commissioned is being transformed. This is being brought about by a number of significant legislative and regulatory changes and integration of services. The Social Care, Health and Wellbeing Directorate is contributing to the delivery of KCC's whole council transformation as described in the Transformation Plan – 'Facing the Challenge: Whole Council Transformation'. This is the way in which the council will transform services to meet the financial challenges it faces, while meeting the increasingly complex needs of the people it supports. The council leads by example to influence its partners, contractors, local businesses and residents, and by embedding equality as an integral part of its policies and programmes.

4.4 In addition, the following principles are important:

- Focus on outcomes rather than process
- Focus on prevention and addressing underlying causes rather than symptoms
- Focus on evidence based policy and practice

4.5 It is not surprising then, that at time when faced with significant reductions in resources and with increased demands on services, that the focus is on supporting the most vulnerable groups living in Kent: older people, people with learning disabilities or physical disabilities, people with mental health needs and other vulnerable adults. Since implementation of the Care Act there are additional vulnerable groups that need to be taken in to consideration e.g. prisoners and carers.

4.6 The changing population, combined with the limits on finances, means that there is a need to be increasingly creative about responding to the needs of residents including promoting preventative strategies, greater independence and resilience for local people. The people supported have increasingly diverse and complex needs. The population is living longer with complex needs putting further demand on social care, and people want better quality and choice in the services they use.

4.7 A key challenge in Adult Social Care has been to develop a better understanding of the diversity of service users. Whilst the service works on a personal basis with many clients and has an understanding of an individual's care needs, it is recognised that there is an ongoing need to better understand change in population and the broader patterns of experience to help plan resources for the future. This information will be used to reflect more fully the local communities worked with in future editions of our Local Account Annual Report.

5. Key Achievements

5.1 Achievements in adult social care are published in the Local Account Annual Report 2014-15. Achievements illustrate how the Directorate has worked hard to:

- Keep vulnerable adults safe
- Monitor and improve the quality of services
- Tailor services to meet the needs of specific groups within the population
- Introduce and develop services to meet newly identified needs
- Enable people to regain their independence and remain at home
- Reduce the number of permanent admissions to residential care
- Support more people through a person-centred process and receive a personal budget
- Use surveys and other feedback to look at what is being done well and what needs further work
- Deliver joint services with health and work towards further integration of services.

5.2 Some examples of these achievements are highlighted below to show how adult social care work covers the nine protected characteristics of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, marriage and civil partnership and sexual orientation, where relevant to the service provided.

5.3 As part of the newly transformed service, Older People and Physical Disability has increased its service access hours to 8am to 8pm, seven days

a week, including Bank Holidays, providing access to support for vulnerable people whenever they need it.

5.4 Older People and Physical Disability Care Pathways have been re-designed to better address the needs of our service users. The outcomes achieved in 2014-15 mean service users receive the most appropriate support, with a focus on enabling independence and reducing dependency. As a result more older and disabled people have benefited from enablement, and are now living independently in their own homes with less or no homecare support.

5.5 The Autistic Spectrum Conditions service has developed through establishing the Autism Collaborative. A draft Kent Strategy on Autism has been produced and covers access to services, workforce planning and links with the criminal justice system.

5.6 When children with learning disabilities become adults and transition to adult support services, they can experience disruption in the support they receive, which can have a negative impact on their wellbeing and outcomes. During this year, services for children with disabilities has joined the Learning Disability and Mental Health division, in order to ensure that children with disabilities receive a joined-up service through their life, including in the transition from childhood to adulthood.

5.7 During 2014/15, work has continued in partnership with Kent and Medway Commissioning Support, the Clinical Commissioning Groups, Public Health England and NHS England to improve the uptake of health screenings and health promotion by people with learning disabilities. The following health areas continue to be targeted: obesity, diabetes, cardio vascular disease and epilepsy.

5.8 Information is shared between organisations in order to ensure that people with a learning disability are identified by GP practices. Training has been provided for GPs to ensure that they understand the barriers for people with learning disabilities to use health checks and that the GP is provided with tools to overcome this, and developing an audit of screening practice in GP surgeries for people with learning disabilities with colleagues from Public Health England.

5.9 About 28,000 adults in Kent have a learning disability and more than 4,000 are supported by the council. The publication Adult Learning Disabilities in Kent - review 2013 captures the work we and our partners, including Kent Community Health Trust and Kent and Medway Partnership Trust, do for people. The service also works to make learning disability part of everyone's planning with services that are inclusive and personalised.

5.10 The council continues to invest in Easy Read publications to make important and relevant information more understandable and familiar. Easy Read is one of the ways the council is helping people who may need information presented in a way which is easier to understand.

5.11 The Kent Advanced Mental Health Professional (AMHP) service continues to be delivered as a 24 hour dedicated service supported by a mixed team of

mental health social workers and community psychiatric nurses, on a rota for a week at a time, based in the Community Mental Health Teams.

5.12 The Live It Well website provides information and signposting to support people to improve their wellbeing and mental health. The website contains a database of free or low cost resources in the community to improve wellbeing and mental health which people can search for. Use of this search function has increased by 181% over the last year.

5.13 To effectively manage the increase in demand for Deprivation of Liberty Safeguards (DOLS) applications, we have taken a number of actions. These have included introduction of a triage system to prioritise the highest risk cases and providing staff training to ensure we have the right specialist skills in our workforce to carry out the assessments of need and best interest. The key change is that it is no longer necessary for someone to be actively trying to leave before DOLS is applied. The impact of this judgement means that considerably more people will now be subject to DOLS authorisations. It is more likely that people with some disabilities (mental health conditions) and older people (with age-related mental disorders such as dementia) are more likely than the general population to need to be subject to DOLS authorisations. Therefore it is important that the increase in DOLS activity is managed effectively, ensuring that the needs and best interests of these vulnerable people are protected.

5.14 In light of the Care Act a Self-Neglect Policy and set of procedures has been developed working with our partners. This was commissioned by the Safeguarding Adults Board to ensure that there is equity in terms of a formal multi-agency response to support people who place themselves and others at significant risk of harm because they are unwilling or unable to provide adequate care for themselves.

5.15 Making Safeguarding Personal (MSP) was launched in November 2014. Multiagency workshops have been carried out to introduce the principles of MSP to practitioners, and have been very successful. This approach engages people who are victims of abuse or neglect in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

5.16 In response to the Care Act a Carers commissioning strategy has been developed to improve Carers support services through assessment and short breaks contracts, including joint commissioning with clinical commissioning groups. This creates equity in terms of access to services for carers with those who are cared for.

5.17 The Public Health service have developed the Suicide Prevention Strategy. The equality impact assessment showed that age, gender and disability were identified as characteristics that could impact on suicide rates. Subsequently the strategy will focus on action in these areas. The impact assessment showed that there is a lack of local information about suicide in relation to race and religion. National research is being used to ensure any needs

related to these characteristics are met. The strategy was finalised in July 2015.

5.18 The role we play in improving health and wellbeing continues to grow in prominence. Through the Health and Wellbeing Board organisations are brought together to coordinate and oversee the development of integrated approaches to the commissioning of services. The council has a lead responsibility for a range of local public health improvement and prevention work. Addressing health inequalities and ensuring access to public health information is continues to be a priority. Healthwatch continues to be the consumer voice for health and social care. Through these arrangements, the voices of people at risk of discrimination and inequalities continue to be heard.

5.19 Equality and Diversity information relating to staff is reported to Divisional Management Team meetings as part of routine HR reporting. Any specific issues are picked up through this route for management action. The council's Personnel Committee receives an annual report on staffing figures.

6. Key Challenges

6.1 Demographic changes and resource pressures covered in Section 4 continue to provide the biggest challenge in a generation. The Directorate has coped well with the introduction of the Care Act and providing access to services for additional groups within the population. Although the estimated 8,000 additional assessments of individuals was not realised, the Care Act has had a significant impact on the service.

6.2 Plans to ensure a proportionate response to manage the additional workload continue to be developed, within resource constraints. Equality considerations are embedded within core processes to ensure they are not overlooked despite the pace of change.

7. Due regard

7.1 The council continues to use Equality Impact Assessments (EqIA) to capture and evidence analysis on the impact of its decisions and policies on the People of Kent. The Equality Act abolished the need for EqIAs but is clear on the need to undertake equality analysis in order to demonstrate that due regard has been paid to our Equality duties. The council evidences this by way of an EqIA. Decisions taken without full equality analysis leaves the authority open to potential Judicial Review.

8 Future reporting

8.1 Equality Objectives are now being reviewed as existing Objectives are due to expire in 2016. Successive annual reports demonstrate that the council has and continues to make good progress against them. As such last year's report proposed that the authority further embeds its equality objectives in the council's Strategic Statement, Increasing Opportunities Improving Outcomes and its Commissioning Framework. This will allow the organisation to develop

equality objectives that are further embedded in the core work of SCHW and KCC.

8.2 Duplication has been reduced through streamlining the council's equality duty by including public information within other published reports such as the 'Here for you, how did we do?' Local Account for Kent Adult Social Care and the 'Adult Learning Disability in Kent Review'.

9 Legal Implications and Risk Management.

9.1 The Public Sector Equality Duty (Section 149 of the Equality Act 2010) requires the Council to publish its Equality Annual Report each year.

10 Equality Impact Assessment

10.1 There is no requirement to undertake an Equality Impact Assessment because this paper reports performance monitoring on the previous year's work and internal governance arrangements.

11. Conclusion

The annual report has been able to identify progress on the relevant equality objectives. The Directorate can demonstrate that it provides accessible and usable services but it needs to continue to improve its governance arrangements and review how it communicates and provides information with service users.

12. Recommendation(s): Members of the Adult Social Care and Health Cabinet Committee are asked to:

a) **COMMENT** current performance (Section 5)
b) **AGREE** the proposed changes to equality Objectives and to receive revised objectives in 2016 (Section 8)
c) **AGREE** to receive the report annually in order to comply with Public Sector Equality Duty (PSED) and ensure progress against County Council objectives

13. Background Documents

Kent County Council Equality Objectives http://www.kent.gov.uk/about-the-council/strategies-and-policies/corporate-policies/equality-and-diversity/equality-and-diversity-objectives

2014-15 Local Account – Here for you, how did we do?

14. Contact details

Relevant Director:
Anne Tidmarsh, Director for Older People and Physical Disability
anne.tidmarsh@kent.gov.uk
03000 415521

Report Author:
Mags Harrison, Transformation and Pioneer Integration Programme Manager
Older People and Physical Disability
Mags.harrison@kent.gov.uk
03000 415347

From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 11 September 2015

Subject: **Work Programme 2015/16**

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 Adult Social Care and Health Cabinet Committee.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 2015/16.

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decisions List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six 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 report 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 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
Local Area Single Assessment and Referral (LASAR)
Kent Drugs and Alcohol Action Team (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 services
Dementia
Autism
Lead on Health integration
Integrated Equipment Services and Disability Facilities Grant
Occupational Therapy for Older People

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

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, paragraphs 21 to 23, and these should also inform the suggestions made by Members for appropriate matters for consideration.

3. Work Programme 2015/16

3.1 An agenda setting meeting was held on 10 July 2015, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion to the agenda of future meetings.

3.2 The schedule of commissioning activity 2015-16 to 2017-18 which falls within the remit of this Cabinet Committee will be included in the Work Programme and considered at future agenda setting meetings. This will support more effective forward agenda planning and allow Members to have oversight of significant service delivery decisions in advance.

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 of 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 2015/16.

6. Background Documents

None.

7. Contact details

Report Author:
Theresa Grayell
Democratic Services Officer
03000 416172
theresa.grayell@kent.gov.uk

Lead Officer:
Peter Sass
Head of Democratic Services
03000 416647
peter.sass@kent.gov.uk

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Last updated on: 1 September 2015

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE – WORK PROGRAMME 2015/16

Agenda Section	Items
3 DECEMBER 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **'Mind the Gap' strategy refresh** – key decision • **Active Travel Strategy** - Lead in to/consultation on (joint Strategy Public Health and Growth, Environment and Transport (will be a Cabinet decision in April 2016) • **Learning disability commissioning project** - key decision will be in January 2016 • **Update on Public Health Transformation programme** – after decisions about streamlining contract end dates • **Community Mental health and Wellbeing service** – social care/CCG funding. New contract from April 2016 • **KCC/KMPT Partnership** (arose at Health and Wellbeing Board agenda setting on 4/6/15) • **Community Support Strategy**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly* • **? Helping Vulnerable Adults into Employment** - joint report with Economic Development? Education? •
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard** now to alternate meetings • **Work Programme** • **discussion of how to monitor commissioning** – seek a regular role for Members
E – for Information, and Decisions taken between meetings	
14 JANUARY 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **Active Travel Strategy** - Lead in to/consultation on (joint Strategy Public Health and Growth, Environment and Transport (will be a Cabinet decision in April 2016) • **Outcome of consultation on in-house residential care homes**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Budget Consultation and Draft Revenue and Capital Budgets** • **Update on Care Act implementation** – 6 monthly
D – Monitoring	• **Work Programme**
E – for Information, and Decisions taken between meetings	
10 MARCH 2016	

B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	•
C – Items for Comment/Rec to Leader/Cabinet Member	• **Tobacco Control** – 'one year on' update
D – Monitoring	• **Directorate Business Plan and Strategic Risk report** • **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** now to alternate meetings • **Work Programme**
E – for Information, and Decisions taken between meetings	
10 MAY 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly (report of latest procurement stage)*
D – Monitoring	• **Work Programme**
E – for Information, and Decisions taken between meetings	
12 JULY 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	•
C – Items for Comment/Rec to Leader/Cabinet Member	• **Update on Care Act implementation** – 6 monthly
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard** now to alternate meetings • **Complaints and Compliments annual report** • **Work Programme**

E – for Information, and Decisions taken between meetings	
11 OCTOBER 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Live it Well Strategy refresh** • **'Mind the Gap' strategy refresh** – advance discussion in September, decision in December • **Lead in to/consultation on Active Transport Strategy** (joint Strategy Public Health and Growth, Envt and Transport (will be a Cabinet decision in April 2016) – possibly an information item?
D – Monitoring	• **Local Account Annual report** • **Safeguarding Vulnerable Adults annual report** • **Equality and Diversity Annual report** • **Work Programme**
E – for Information, and Decisions taken between meetings	
6 DECEMBER 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly* • **? Helping Vulnerable Adults into Employment** - joint report with Economic Development? Education? •
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard** now to alternate meetings • **Work Programme** • **discussion of how to monitor commissioning** – seek a regular role for Members
E – for Information, and Decisions taken between meetings	

NEXT MEETINGS:

26 JANUARY 2017
14 MARCH 2017

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By virtue of paragraph(s) 3, 4 of Part 1 of Schedule 12A
of the Local Government Act 1972.

Document is Restricted

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