ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Tuesday, 10th May, 2016

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

Tuesday, 10 May 2016 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, Mr S C Manion, Mrs C J Waters and Mr G K Gibbens
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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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 March 2016 (Pages 7 - 22)

To consider and approve the minutes as a correct record.

A5 Verbal updates by the Cabinet Member and Directors (Pages 23 - 24)

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

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

C1 Adult Social Care Transformation and Efficiency Partner update (Pages 25 - 32)

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 progress on the implementation phase of the Adult Social Care Transformation Portfolio, including the work with the Efficiency Partner, Newton Europe, on which the Committee is asked to comment.

C2 Public Health Quality report (Pages 33 - 60)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on the quality of current public health programmes, and measures being put in place to improve it, on which the Committee is asked to comment.

D - Monitoring

D1 Public Health Risk Management (Pages 61 - 76)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on the risk management arrangements in place, on which the Committee is asked to comment.

D2 Work Programme 2016/17 (Pages 77 - 82)

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

E1 Financial arrangement to place a legal charge on a property of a service user accessing Domiciliary Care (decision number 16/00039) (Pages 83 - 90)

To receive a report from the Cabinet Member for Adult Social Care and Public Health the Corporate Director of Social Care, Health and Wellbeing on a non-key decision taken since the last meeting of the Cabinet Committee.

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
03000 416647

Friday, 29 April 2016

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.

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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 Thursday, 10 March 2016.

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

ALSO PRESENT: Mr B E Clark, Mr A D Crowther, Mr T Gates and Mr G K Gibbens

IN ATTENDANCE: Mr A Scott-Clark (Director of Public Health), Dr F Khan (Deputy 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

80. Introduction and Chairman's announcement
(Item A1)

The Chairman advised the committee that, due to the amount of business expected, meetings for the rest of the year were likely to be longer, and he asked that Members bear this in mind when setting diaries and be prepared to attend into the afternoon.

81. Apologies and Substitutes
(Item A2)

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

Mr A Terry was present as a substitute for Mr Birkby and Mr Caller was present as a substitute for Mrs Brivio.

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

There were no declarations of interest.

83. Minutes of the meeting held on 14 January 2016
(Item A4)

RESOLVED that the minutes of the meeting held on 14 January 2016 are correctly recorded and they be signed by the Chairman.

84. Verbal updates
(Item A5)

1. Mr G K Gibbens gave a verbal update on the following adult social care issues:

10 February – Spoke at Skillnet Social Value Workshop at Maidstone Salvation Army centre. This had shown what encouraging work was going on to help people back into employment.
25 February – Chaired annual meeting with Kent Age UK Chairs. This body aimed to help voluntary sector partners to fulfil their vital role in social care provision.
3 March – Attended South Kent Coast Health and Wellbeing Board Development Day in Dover. This board was helping to improve the links between health and social care.

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

Care Quality Commission Consultation on Shaping the Future. This important consultation had closed on 4 March and a Member briefing on the outcomes would be prepared shortly. The consultation was for officers at this stage, and aimed to identify and shape the questions which would be included in the later stage, at which time Members would be engaged and be able to have input.
Visit to Queens House. Here he had met staff in the adult social care and specialist children's services teams.
Attended Association of Directors of Adult Social Services (ADASS) Policy Event. Further details of the issues covered at this event would be available for this committee's 10 May meeting.
Winter Pressures. As reported to the January meeting, pressures over the Christmas period had been light but had increased as the weather had grown colder in the new year. Adult Social Care staff had been in attendance at hospitals to do all they could to facilitate timely discharges. While there had been some increase in the overall number of delayed transfers from hospital, the number of delays attributable to social care causes had decreased.

3. Mr G K Gibbens gave a verbal update on the following adult public health issues:

3 February – Attended Local Government Association Annual Public Health Conference in London. There had been good input into an item about preventing suicide and Kent's approach had been cited as a good example.
23 February – Spoke at the Arts in Recovery Festival Launch at Sessions House. It had been encouraging to see the role that arts could play in helping those with substance misuse issues to recover.
Supporting Public Health work. Member grant money left over at the end of the financial year could be used to support various Public Health initiatives. Members who had spare funds and wished to use them for this purpose were encouraged to contact the Public Health team.

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

Chaired workshop on Illicit Tobacco, at which Public Health and Trading Standards colleagues had discussed how joint working would address the issue of illicit tobacco coming into, and circulating within, the county.

Attended Local Government Association/Association of Directors of Public Health (ADPH) conference, this had included an excellent workshop on mental health, for which he expressed his appreciation to the team involved.
Attended Chief Medical Officer/Directors of Public Health development day. This had discussed current key Public Health issues, including antibiotics, childhood obesity and smoking.
Attended round-table meeting on Tobacco Control with the Minister of Public Health. It was hope that a tobacco control strategy would soon be ready to publish.
Appointed representative of the Association of Directors of Public Health for the South East. Mr Scott-Clark received congratulations from Members on this appointment.

5. RESOLVED that the verbal updates be noted.

85. Proposal on the Closure of the Dorothy Lucy Centre, Maidstone - Additional Information (decision number 16/00007)
(Item B1)

Mr B E Clark, County Council Member for Maidstone South, was present for this item, and Ms C Holden, Head of Commissioning for Accommodation Solutions, was in attendance for this and the following item.

Mrs Marian Reader and Ms Anna Ralph were present at the invitation of the Cabinet Member, as they had been the lead petitioners in opposing the proposed closure.

1. The Chairman welcomed Mrs Reader and Ms Ralph to the meeting and explained that the role of the Cabinet Committee was to comment on and/or endorse the decision proposed to be taken by the Cabinet Member, which was set out in detail in the recommendation report.

2. The Chairman then asked Members if, in debating agenda items B1 and B2, they wished to refer to the information set out in the exempt appendices to these items, F1 to F3. Members confirmed that they did not wish to refer to this information and discussion of these items therefore took place in open session.

3. Ms Holden introduced the report and summarised the consultation process and the further work undertaken since then to identify need and alternative provision. It had not been possible to make a recommendation to the January meeting of the committee but a detailed proposal was now being presented for the committee's comment, prior to a formal decision being taken by the Cabinet Member. The proposal was that use of the Dorothy Lucy Centre for short-term respite care would end in August 2016 and for day services in March 2017.

4. Mrs Reader addressed the committee to represent the views of local people about the proposed closure and made the following points: alternative provision to be made should be local so that friends and family could visit easily; money could be raised to extend and upgrade the centre to provide more accommodation, particularly as the elderly population was increasing; it was short-sighted to close a popular facility at which many local people had received excellent care from dedicated staff; the centre's respite care was particularly helpful and popular; staff there lived locally and their families' livelihoods would be affected by the closure and subsequent loss

of jobs; the day services were a lifeline for elderly people locally; the centre was irreplaceable for local people.

5. Ms Ralph then addressed the committee, supported many of the points made by Mrs Reader and added the following: the respite care given at the centre was a vital support to those caring for a relative 24 hours a day; the centre had been assessed by the Care Quality Commission in 2013 as being 'good', so the proposal to close it was questioned; people living with dementia did not cope well with change and it would be difficult for them to travel to access services provided elsewhere, hence day services provided elsewhere would not work for those currently using the Dorothy Lucy Centre; there were many families which would suffer through the proposed closure and some people did not have a family to support and fight for services for them; the Dorothy Lucy Centre could be given to someone other than the County Council to run.

6. Mr Clark referred to the points he had raised at the January meeting and added the following: the Dorothy Lucy Centre was very well regarded within the community; there was concern that there would be sufficient alternative provision for all current users to be able to transfer, especially those needing services for dementia, as there were not yet like-for-like services for all clients; day care services were proposed to remain open for one more year, until March 2017, so the whole centre could perhaps stay open for another year; to fragment the services now would make closure an inevitable choice in a year's time, if alternative provision of the remaining service was found not to be viable; the fact that the centre would stay open for a while longer was welcomed, to allow the establishment of like-for-like services.

7. Members then made the following comments and asked questions, to which Ms Holden responded:

a) concern had been expressed at the January meeting of the committee that the County Council was withdrawing from residential and day care provision at the Centre, and this concern was repeated. Moving all service provision to the private sector could compromise its long-term sustainability and the quality of care provided. Such a move was a retrograde step. Kent should instead retain a mixed economy of elderly care provision, with the County Council continuing to provide some services, alongside the private and voluntary sectors. Ms Holden explained that the County Council was currently to retain four of its centres as integrated care centres;

b) a view was expressed that, to continue to keep open premises which had been assessed as 'substandard', was not what the County Council wanted to be seen to be doing. Instead, it should look to develop a long-term strategy for services for the elderly and those with dementia, to set out how those services could be provided by different means. The challenge of providing services for these client groups was the same across the county, and making changes to service provision was never popular with those who used them. However, the proposed changes seemed to present a sensible way forward;

c) the Dorothy Lucy Centre had been spared closure some years ago when other premises had been closed, but it seemed that there was still no

solution in place. The report referred to things which 'could be' provided, but the certainty that these things would be provided and would be of suitable quality was questioned. A view was expressed that there was not currently sufficient capacity in the private sector in Kent to cover the needs of those with dementia, who found such uncertainty difficult and distressing;

d) no good, sound reason had been given for closing the centre. Media coverage had highlighted cases of substandard elderly care provision around the country, yet a centre delivering good-quality care was to be closed; and

e) provision of care to the elderly was inevitably an emotive subject, and the views of those campaigning to keep the centre open were understood. However, the County Council had a duty to look at care provision for the whole of Kent within the budget which was available, and to apply a strategic view to what was viable and what was not.

8. The Cabinet Member, Mr Gibbens, gave a commitment that, if the proposed decision to close the centre was indeed taken, no closure would happen until alternative care provision was established and operating to his satisfaction. This same commitment to continued provision had been established in the past when making changes in service provision, for example, of day services for people with learning disabilities, and was applied strictly in each case. Mr Gibbens emphasised that cost was not the main issue in the proposal. He acknowledged and said he appreciated Members' concerns about the closure of a service against a background of an ageing population and increasing levels of dementia. It was vital to plan now for services which would be needed in 20 years' time, and how those services could best be delivered, and put in place provision which supported this. For this purpose, the County Council had developed its Accommodation Strategy. Work on this strategy had highlighted a shortage both of extra care sheltered housing and nursing care beds and had shown that people had greater needs at the time that they entered such facilities. He assured the committee and the public that he would not allow the Dorothy Lucy Centre to close until he was satisfied that suitable alternative provision was in place. He thanked Mrs Reader, Ms Ralph and Mr Clark for attending to address the committee and said he understood the views they had presented. He assured them that he would not be taking a decision until later in March, and that he had not yet decided what decision this would be.

9. RESOLVED that:-

a) the content of the report and the work undertaken to date be noted; and

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health:

i) to close the Dorothy Lucy Centre, Maidstone;

ii) to re-provide elderly frail services (currently provided by the Dorothy Lucy Centre) through existing external provision;

iii) to re-provide dementia day services (currently provided by the Dorothy Lucy Centre) through a block contract;

iv) to re-provide the short-term beds (currently provided by the Dorothy Lucy Centre) in the independent sector;

v) that Dorothy Lucy Centre day provision continue to operate as is until at least March 2017, to allow time to complete a procurement exercise for a block contract and implement a transition plan;

vi) that existing services not close until alternative provision is available for the current service users;

vii) to give consideration to leasing the day centre part of the building to an external provider as an interim measure if they are unable to secure a suitable venue within the procurement timetable, with the understanding that they identify an alternate venue within a given timeframe; and

viii) to delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement this decision,

be endorsed.

Carried, 7 votes to 4.

NOTE: Subsequent to the Cabinet Committee meeting, the Cabinet Member had further discussion with some local Members, during which greater clarity was provided about the proposed order of closure of the various elements of the services currently provided at the Dorothy Lucy Centre.

86. Proposal on the Closure of Kiln Court care home, Faversham - Additional Information (decision number 16/00008)
(Item B2)

Mr T Gates, County Council Member for Faversham, was present for this item.

1. Ms Holden introduced the report and outlined the work which had been undertaken since the committee had considered the issue at its January meeting. It had not been possible to make a recommendation at that time, due to the further work needed, but a detailed proposal was now being presented for the committee's comment, prior to a formal decision being taken by the Cabinet Member.

2. Mr Gates addressed the committee and said he hoped that Kiln Court would be allowed to remain open as there was no alternative provision yet in place; the arguments against closing Kiln Court were the same as those against closing the Dorothy Lucy Centre, ie it was valued and used by local people and those who benefitted from its services would find change very difficult to cope with; the home could be kept open for future use, be modernised and have services added to it to make its retention more feasible, perhaps being run by Age UK or a similar organisation; he referred to a letter from Brenda Chester from Faversham Health Matters which had been sent to him and all Member of the committee, setting out a case for keeping the home open and the lack of alternative local facilities for

Faversham people; if it were to be closed, those who currently used the home would have to move a long way away, where their families may have difficulty in visiting them; alternative services needed to be local; the length of time allowed between the report to the committee's January meeting and the taking of the decision in March did not seem sufficient to have completed and considered all the work required to be undertaken; the financial pressures upon the County Council were well understood, but the recent 2% increase in Council Tax could perhaps be spent on social care services; a past agreement about the use of the Kiln Court site was that it should always be used for social care purposes, and the current proposal could be challenged by the parties to that agreement. Ms Holden explained that the County Council was unable to approach any one provider, eg Age UK, to provide services but was required to enter open procurement and a formal tender exercise with the care market as a whole. If Kiln Court were to be declared surplus to requirements, the disposal of the site would require a separate decision to be taken by a Cabinet Member.

3. Members then made the following comments:-

   a) it was important that Kent retain a mixed economy of care provision, with the involvement of the public, private and voluntary sectors. The public trusted the public sector to support them in difficult times, and the County Council needed to demonstrate that it was able to deliver such services. For the public sector to stop providing care facilities could prove, in the future, to be a mistake, despite the current financial restrictions upon local authorities;

   b) a letter sent to Members by Brenda Chester had made some good points, particularly about a 2-tier system of choice based on a service user's ability to pay; the County Council should surely look to offer quality care to all those who needed it;

   c) elderly care, like primary school education, needed to be provided locally. The report recommendation for Kiln Court did not include the same level of detailed assurances about alternative local provision as had been included for the Dorothy Lucy Centre, and the possibilities/scope for alternative provision set out in the report seemed less certain;

   d) people who had contributed much to the county during their lives should be able to rely on receiving good quality care in their later years; and

   e) in response to a query about the presentation of the information awaited at the time of the January report to the committee, Ms Holden, explained that a summary of the discussions with the clinical commissioning group was set out in section 4 of the current report.

4. RESOLVED that:-

   a) the content of the report and the work undertaken to date be noted; and

   b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to

i) close Kiln Court care home, Faversham; and

ii) delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision,

be endorsed.

Carried, 8 votes to 4.

5. The Cabinet Member, Mr Gibbens, emphasised that cost was not the main issue in the current proposal; the chief concern was the quality of care provided to those who needed it. He reiterated his commitment that no closure would happen until alternative care provision was established and operating to his satisfaction. He thanked Members for their comments and Mr Gates for attending to address the committee, and said he understood and respected the views put forward.

87. Proposed Revision of Rates Payable and Charges Levied for Adults' Services in 2016-17 (decision number 16/00016)
(Item B3)

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

1. Miss Goldsmith introduced the report and explained that the review of rates and charges was undertaken annually. On this occasion, most rates and charges had been maintained at the 2015/16 level, the one exception being the charges made to other local authorities for assessments for clients placed within Kent.

2. Miss Goldsmith advised the committee that one area of information – the personal expenses allowance – could not yet be set as the rates had yet to be published by the Department of Health. This rate was not something over which the County Council had any discretion or control, but the rate, when published, would have an impact on the Council's financial assessment process.

3. In response to a question about what constituted a meal, charged at £3.90, Mrs Tidmarsh clarified that this would normally be a hot main meal of two courses. However, this may vary from area to area, depending on the local provider.

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

a) to approve that:

i. the client contributions for residential care for older people remain at £463.07;

ii. the client contributions for residential care for people with learning difficulties remain at £631.26;

iii. the Wellbeing Charge - Better Homes Active Lives scheme for older people remain at £15.00;

iv. the Wellbeing Charge - Better Homes Active Lives scheme for people with learning difficulties remain at £44.92;

v. the notional charges for Day Care remain at:
Learning Disability – Day Centre £37.64
Learning Disability – Day Centre half day £18.82
Older People – Day Centre £29.99
Older People – Day Centre half day £15.00
Physical Disability – Day Centre £35.80
Physical Disability – Day Centre half day £17.90
Older People with Mental Health Needs – Day Centre £35.45;

vi. the client contributions for Meals Charges remain at:
Meal Charge £3.90
Meals and other snacks £4.90
Refreshments flat rate charge £1.00; and

vii. for Local Authority Charges for Adult services: Assessment hourly rate to increase to £68.76 per hour.

b) to note:
i. the recommendation to continue the £10 charge for blue badge
ii. the continuation of the current mileage rate paid to Voluntary Drivers
iii. the rates for consultancy work and key publications; and

c) to delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement the decision,

be endorsed.

88. Contract Award for Older Persons' Residential and Nursing Care Homes - effective April 2016 (decision number 15/00089b)
(Item B4)

Ms C Holden, Head of Commissioning for Accommodation Solutions, was in attendance for this item.

1. The Chairman asked Members if, in debating this item, they wished to refer to the information set out in the exempt appendix, F4. Members confirmed that they did not wish to refer to this information and discussion of this item therefore took place in open session.

2. Ms Holden introduced the report and explained that the procurement process had taken longer than expected as additional work had needed to be undertaken in relation to the National Living Wage, but a guide price and contract award was now being presented for the committee's comment, prior to a formal decision being taken by the Cabinet Member. The outcome of the tender evaluation process and the names of the successful tenderers to whom it was proposed that contracts be awarded were set out in the exempt appendix to the report.

3. Ms Holden and Mr Lobban responded to comments and questions from Members, as follows:-

a) surprise was expressed at the limited affect that the introduction of the national living wage in April 2016 appeared to have had on prices. Mr Lobban confirmed that the national living wage had been subject to a detailed analysis which had shown that it had added an annual pressure of approximately £6m. He reminded the committee, however, that the national living wage would increase further each year, so it was important that the County Council establish a good mechanism by which this ongoing increase could be managed, year on year; and

b) in response to a query about care placement training, Ms Holden confirmed that all placement managers would undergo suitable training on the new process during March and April 2016.

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

a) agree the guide prices for Older Persons' Residential and Nursing Care as follows:

Residential:	£373.51
Residential High:	£455.45
Nursing:	£504.73
Nursing High:	£530.28

b) award contracts to the successful tenderers, identified in the exempt appendix to the report; and

c) delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other suitable nominated officer, to undertake the necessary actions to implement the decision,

be endorsed.

89. Progress Report on Smoking and Tobacco Control
(Item C1)

1. Dr Khan introduced the report and outlined the work underway to address the prevalence of smoking in Kent, which was above the national average. This work included campaigns to promote plain packaging, to encourage young people not to take up smoking and to establish smoke-free parks, for which there was currently a pilot scheme in Shepway. Dr Khan responded to comments and questions from Members, as follows:-

a) no mention was made of the role played by the Fire Service in highlighting the dangers of smoking as a cause of house fires. People would often be more willing to take advice from a uniformed firefighter than from the County Council;

b) tobacco control was part of the health improvement model (HIM) and the data on which this model was based had been generated by a national health survey;

c) work to determine the safety and effectiveness of e.cigarettes as a method of giving up smoking (eg, compared to nicotine patches) had been undertaken by University College London and Public Health England, and the current thinking was that their use was less harmful that smoking tobacco. However, the amount of nicotine contained in e.cigarettes was not yet regulated and hence could vary. There was evidence that their use could cause minor hypertension;

d) the import of illicit tobacco into a county with several points of entry - ports and airports - would always present a challenge. Mr Scott-Clark agreed that strategic partnership working, including Ministerial support and work with Public Health England and NHS partners, would be the most effective way of addressing this and would be key to levering in all possible support to tackle illegal activity. Kent was indeed a key route into London and the rest of the UK;

e) work to address smoking prevalence and illicit tobacco was welcomed, although the news that Kent still lagged behind the rest of the UK in addressing smoking prevalence was disappointing. Gillingham Football Club was currently running a healthy lifestyle project in an effort to teach families about healthy living and encourage them to reassess their lifestyles. What was also of concern, apart from tobacco smoking, was the smoking of cannabis, and it would be useful to have a report to a future meeting on the prevalence of cannabis smoking and what could be done to address it. Mr Scott-Clark added that there was a clear north-south divide in the prevalence of smoking, and confirmed that prevalence was higher around areas where tobacco products entered the country;

f) rates of mortality due to smoking varied between areas of affluence and deprivation. Health survey data had shown that people in deprived areas were more likely to smoke, as well as to have other unhealthy behaviours. It was also known that people from deprived areas tended to present with cancer symptoms later and were therefore less likely to be able to benefit from available treatment; and

g) it was depressing to see young people smoking, and a clear message needed to be sent that smoking was definitely ‘not cool’.

2. RESOLVED that work undertaken to address smoking and tobacco control issues be endorsed.

90. Sexual Health Service update
(Item C2)

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

a) the report was welcomed and Kent's advanced provision of HIV services acknowledged. Dr Khan undertook to look into and provide information on the extent to which Kent's HIV rates were higher than other areas of the UK, but explained that many people were difficult to engage with and test due to their transient lifestyles; and

b) the fact that teenage pregnancy rates in Kent were the lowest ever was welcomed. The report made no mention of teenage pregnancy in relation to sexual health, although the two issues were related. Dr Khan advised that, although the County Council's Teenage Pregnancy Strategy had now ended, work was still going on to address teenage pregnancy rates. Although the provision of sexual health services contributed only in a limited way to addressing teenage pregnancy rates, the target age range of sexual health services had been extended. Work to raise young women's aspirations for their future would make a greater contribution to tackling teenage pregnancy rates.

2. RESOLVED that work undertaken to implement sexual health services across Kent be noted and welcomed.

91. Adult Health Improvement Services - Commissioning Strategy
(Item C3)

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

1. Mr Scott-Clark and Ms Sharp introduced the report and emphasised the need for a balance of intervention and prevention over the short and long-term to achieve sustainable health improvement, and for local authorities to be partners in this work. To support this partnership working, the County Council's procurement process had been aligned with those of its district council and NHS partners. An extension to the contract would be requested, to allow time to further develop this joint working.

2. Mr Scott-Clark and Ms Sharp responded to comments and questions from Members, as follows:-

a) the County Council wanted to implement its new adult health improvement model as soon as possible and wanted to make the procurement process for this as efficient as possible. It would spend the extension time to clarify what could be delivered by current partnership working and what would need to be procured elsewhere or by other means; and

b) the potential role of district council partners and the Kings Fund in identifying and addressing health improvement issues had not previously been drawn on, but the role of district councils in controlling licensing and housing would make a valuable contribution, and district council-run leisure facilities could also offer much to support health improvement projects in an area.

3. RESOLVED that the feedback from stakeholders since January and the opportunities for working jointly with partners on the re-commissioning of adult health improvement services be noted.

The Vice-Chairman took the Chair for the next three items of business

92. Market Shaping and Oversight Protocol and Adult Social Care Community Support Market Position Statement
(Item C4)

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

1. Ms Hanson introduced the report and explained that the two documents presented in the report represented two aspects of the County Council's role in relation to the care market under the new requirements of the Care Act 2014.

2. In response to a concern that the County Council's ability to shape the market would diminish as it reduced its direct involvement in service provision, Ms Hanson confirmed that 90% of the County Council's current provision was commissioned externally. Part of the County Council's commissioning approach was to determine what needed to be purchased and who was best placed to provide it.

3. RESOLVED that the Adult Social Care Market Shaping and Oversight Protocol and the Adult Social Care Community Support Market Position Statement be endorsed, and authority to update the Market Position Statement as necessary be delegated to the Corporate Director of Social Care Health and Wellbeing.

93. Draft 2016/17 Social Care, Health and Wellbeing Directorate Business Plan
(Item D1)

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

1. Mr Thomas-Sam introduced the report and confirmed that, following consideration by the Cabinet Committee, and including any comments made by the committee, the final version of the Directorate Business Plan would be cleared by the Corporate Director and the Cabinet Member and collectively agreed by the Leader and Cabinet before publication on the County Council's website.

2. RESOLVED that the draft 2016/17 Directorate Business Plan for the Social Care, Health and Wellbeing Directorate be noted.

3. Concern was expressed about the volume of information which Members were asked to read and consider in advance of a meeting in order to be able to have a meaningful discussion and offer useful comment to officers. Mr Gibbens said he appreciated this view and said he had tried to minimise the volume of paper as far as possible. Providing information sufficient to allow Members to give an informed opinion, but without overloading them, was sometimes a difficult balance to achieve. He welcomed any suggestion from Members about how the volume of reading material could be reduced.

94. Risk Management: Social Care, Health and Wellbeing (Adult Social Care and Specialist Children's Services divisions)
(Item D2)

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

RESOLVED that the risk management arrangements for Adult Social Care and Specialist Children's Services, outlined in the report, be noted.

The Chairman resumed the Chair for the remainder of the business.

95. Adult Social Care Performance Dashboard
(Item D3)

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

1. Ms Smith introduced the report and emphasised that performance was generally good across all areas of adult social care activity. She responded to comments and questions from Members, as follows:-

a) one area in which performance was rated red was the number of people aged over 65 receiving domiciliary care, which was still rising beyond target. However, this figure should be considered with the number of people in receipt of a direct payment, with which they would purchase their own care services. Although the County Council would encourage service users to take up a direct payment of they felt they wished to and could manage their own funds, people would never be pressured to take this up if they did not wish to; and

b) as mentioned in Mr Lobban's verbal update earlier in the meeting, while there had been some increase in the overall number of delayed transfers from hospital, the number of delays attributable to social care causes had decreased. Continuing work with NHS colleagues would address the number of cases attributable to other causes. However, the process of discharging patients to other suitable care could not always be straightforward, and finding the right solution in some cases would necessarily take more time.

2. RESOLVED that the Adult Social Care performance dashboard be noted.

96. Public Health Performance - Adults
(Item D4)

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

1. Ms Sharp introduced the report and announced that the County Council's suicide prevention strategy had recently been launched and was being publicised to reach as broad an audience as possible, using a range of sites, including pubs, petrol station forecourts and on public transport.

2. RESOLVED that the current performance, and actions taken by Public Health to address areas of concern, be noted.

97. Kent Alcohol Strategy - update
(Item D5)

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

a) the Chief Medical Officer had recently reduced the recommended maximum alcohol consumption per week for an adult male from 21 to 14 units, to match the recommended consumption for an adult female;

b) concern was expressed that common-sense advice on alcohol was hard to find – for example, red wine was previously thought to be beneficial in small doses but was now thought not to be. The public needed to be able to access reliable information and advice on which to base decisions about their lifestyle and habits. One example was information about the relative strengths of different alcoholic drinks; one unit of a stronger drink might be equivalent to several units of a weaker drink; and

c) although alcohol consumption might be reducing, other habits such as the smoking of cannabis were on the increase. It would be useful to have a report to a future meeting on the prevalence of cannabis smoking and what could be done to address it.

2. RESOLVED that the progress to date and planned work for the next period be noted and a more detailed report by the Kent Drug and Alcohol Partnership be made to the May 2016 meeting of the committee.

98. Work Programme 2016/17
(Item D6)

RESOLVED that the committee's work programme for 2016/17 be agreed.

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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 – 10 May 2016

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. Community Health & Wellbeing Service
2. 21 April - Visit to West Kent Mind in Sevenoaks
3. 21 April – Visit to Age UK Sevenoaks
4. 21 April – Visit to Age UK Tunbridge Wells

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

1. Sustainability and Transformation Plans
2. Delayed Transfers of Care Review

Adult Public Health

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

1. Community Pharmacy Consultation
2. 26 April – Visit to Folkestone Men's Sheds

Director of Public Health – Mr A Scott-Clark

1. Suicide Prevention Campaign for men under 45

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From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director of Social Care Health and Wellbeing
To:	Adult Social Care and Health Cabinet Committee 10 May 2016
Subject:	**ADULT SOCIAL CARE TRANSFORMATION AND EFFICIENCY PARTNER UPDATE**
Classification:	Unrestricted
Previous Pathway of Paper:	N/A
Future Pathway of Paper:	N/A
Electoral Division:	All divisions

Summary: This report provides progress on the implementation phase of the Adult Social Care Transformation Portfolio including the work with the Efficiency Partner, Newton Europe.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **COMMENT** on the information provided in the report.

1. Background

1.1 Following the decision to appoint Newton Europe as the Adult Social Care Transformation and Efficiency Partner, a commitment was made to provide the Adult Social Care and Public Health Committee with regular updates. This report provides a further update on Implementation.

2. Phase 2 Implementation Update

2.1 Programmes supported by Newton Europe in Phase 2 are:

- Acute Hospital Optimisation (formally Acute Demand)
- Access to Independence (formally Enablement)
- Your Life Your Home (formally Alternative Models of Care)
- Kent Pathways Service (formally Pathways to Independence)
- Shared Lives

2.2 Progress on these programmes is set out in this report.

2.3 Acute Hospital Optimisation (formally Acute Demand)

The aim of the project is to promote independence of individuals leaving an acute setting who may require services on discharge. This will be achieved by ensuring individuals end up on the best pathway for their needs that promotes wellbeing and independence in a consistent and structured way across Kent.

2.3.1 Current Activities – what has been achieved?

Implementation continues across Kent, with the Adult Social Care teams at Maidstone General Hospital and Tunbridge Wells Hospital running daily team reviews of open cases to support and standardise decision making. The sustainability of the newly embedded processes at William Harvey Hospital, Darent Valley Hospital, Medway Foundation Trust, Kent & Canterbury Hospital and Queen Elizabeth the Queen Mother Hospital is being driven by the Short Term Pathway Team Leads; supported by Newton Consultants.

The current results from implementation demonstrate that performance continues to improve and that, relative to the baseline period (Financial Year 2014-15), we are helping to avoid the use of –

- 7.7 Short Term Beds (STBs) per Week = 399 STBs annually (up from 322)
- 7.4 Long Term Beds (LTBs) per Week = 384 LTBs annually (up from 312)

2.3.2 Next Steps

Implementation commenced in March 2016 in Maidstone General Hospital and Tunbridge Wells Hospital. Learnings from implementing the project within Integrated Discharge Teams in East Kent are being used and the solution is being further developed in West Kent. The project team are working with the local teams as well as management to ensure that the processes, quality and results will be sustained across all Acute Hospitals once the project team finish in June 2016.

2.3.4 Case Study

Mr R was referred to the Adult Social Care team at Medway Hospital as the Ward staff believed he required a Nursing Home placement. However, the caseworker identified that he had enablement potential and referred him to a residential care home with a clear plan to increase his mobility and confidence. Since moving there, Mr R has improved from needing a hoist to now being able to transfer and walk with the assistance of a walking stick.
He is looking forward to returning home with Kent Enablement at Home (KEaH) and being able to re-integrate into his local community.

2.4 Access to Independence – (Formally Enablement)

The Access to Independence project aims to create more time for the KEaH teams so they can provide extra support to additional service users. Focus is on goal/target based enablement with support provided by Occupational Therapists. KEaH have two key priorities:

1) To ensure that anyone with enablement potential gets access to the service.

2) To give everyone the best chance to be independent through structured delivery of enablement.

2.4.1 Current Activities – what has been achieved?

Roll out is complete in East Kent and has now moved into West Kent. In the East, the service now has capacity for more service users every week, using fewer support worker hours on a weekly basis. The improved outcomes in the East mean we will need to purchase nearly 250,000 fewer hours of ongoing support per year.

Significant improvements are now being demonstrated across Kent resulting in service users remaining fully independent of any support. In the last year there has been an increase of service users that have no ongoing care needs, which equates to approximately 800 people per year.

2.4.2 Next Steps

Roll out is underway in West Kent and best practice is being defined from an operational and practice perspective to support the sustainability of the New Ways of Working. The roll out in West Kent is due to be completed by June 2016.

2.4.3 Case Studies

Mr A had a stroke, followed by an extended stay in hospital. Upon coming home he was not able to access the kitchen by himself and a nursing agency carried out this support on his behalf. As a result of the stroke, Mr A needed to prepare thickened drinks, rather than the normal ones - hence his access to the kitchen was vital. One of the supervisors in the Dover team set a goal for the support workers to work with Mr A on mobilising and progressively be comfortable accessing the kitchen. They also worked with him ensure he understood the importance of thickened drinks to support his ongoing wellbeing. He's now happily living at home by himself with no ongoing statutory support.

2.5 Your Life Your Home (YLYH) – (Formally Alternative Models of Care)

There are currently over 1,200 adults with a learning disability in residential care. Approximately 350 of these people can have their needs met in alternative settings that will allow them to lead more independent lives. Alternative accommodation that may be more suitable includes:

- a flat with shared communal areas with other service users
- own or shared housing
- shared living with a family

2.5.1 Current Activities

The following outcomes have been seen to date:

- currently the process is operating in two out of the six localities. (Evaluation of the pilot phase in South West Kent and Ashford and Shepway was signed off at Portfolio Board with agreement to move into Stage 3.)

- seven people have moved from residential care into their new homes so far
- the teams are working with approximately 20 service users at the moment, to find them suitable accommodation and put in place support packages ahead of them moving
- currently rolling out to the remaining four localities, aiming to be up and running across the county by June
- the KCC Coordination Lead and Coordination Support roles have been filled and handover from Newton is in progress.

2.5.2 Next Steps

In April, rollout will move into Dover and Thanet and Maidstone and Malling. The roll out for DGS has been provisionally agreed for May 2016.

To ensure sustainability, Newton Europe will hand over ownership of the processes to the KCC project team. Stage Gate Reviews will be set up for the duration of the project to monitor progress.

2.6 Kent Pathways Service – (Formally Pathways to Independence)

The Kent Pathways Service (KPS) project aims to improve service users' independence and reduce their care requirements. This is achieved through 6-12 weeks of intensive training by helping service users to learn or re-learn skills after a change in their circumstances. The identified demand for such a service is over 1800 referrals.

2.6.1 Current Activity – what has been achieved?

KPS completed roll out across East Kent in November 2015. West Kent KPS commenced in Maidstone and Malling in January 2016 and has travelled across to South West Kent; reaching Dartford, Gravesham and Swanley in March 2016. Figures taken at beginning of March confirmed the following: 138 successful completed programmes in Dover and Thanet, nine in Ashford and Shepway, four in Canterbury and Swale and two in South West Kent. This demonstrates good progress and is reflective of the programme still being in its early stages.

2.6.2 Next Steps

To support the role out further work is taking place with teams to focus on sustainability. This includes developing a matrix to describe aspects of the KPS service and measures the progress made towards a successful and sustainable service based on a bronze, silver and gold standard. Currently, KPS are working towards attaining Bronze in DGS. South West Kent has achieved Bronze and is working towards Silver. Silver has been attained in Dover and Thanet and Ashford and Shepway and Gold has been reached in some key areas.

2.6.3 Case Studies

(1) J was referred to KPS as he was looking for Voluntary Work rather than attending a day at Day Care. J was supported to put together his CV which he then dropped off at various Charity Shops in his locality, with the help of his Support Worker. J was offered a job at the 'Mind' shop and he had a taster day where his Support

Worker checked on him throughout the day. J enjoyed this and is now attending once a week.

(2) N was referred to KPS to support with travel training as N attends college 4 days a week. N was supported to learn the route from home to the train station where he could get the train and then walk to college. N's Support Worker stayed with N until he felt confident to travel independently and also produced photos to help N with visual reminders.

2.7 Shared Lives

Shared Lives offers people over the age of 18 support placements within a family home for long term; transition; short breaks and day support. The service is suitable for people with learning and physical disabilities, mental health issues, people on the autistic spectrum, older people and people living with dementia. Shared Lives is similar to fostering in that people with a learning disability live with a host family for an extended period of time. The experienced Shared Lives team works with the person to match them with a suitable household.

2.7.1 Current activity - what has been achieved?

The following outcomes have been seen to date:

- continued increase in enquiries and applications through design has led to increase in available hosts
- 11 new Hosts approved since December
- 45 applications awaiting approval
- 13 long term hosts available with 16 beds (with some currently matched)
- 5 potential service users currently available to match with available hosts.

2.7.2 Next Steps

The aim is to place at least 32 Service Users from Residential Care into Shared Lives for a Long Term placement. The Shared Lives service is currently recruiting additional Host families. These will be available to take placements from the Your Life Your Home (YLYH) project when referrals are received. YLYH have just completed the trial of their project in two areas and therefore, referrals to the Shared Lives service have been limited so far.

2.7.3 Case Studies

O had been living with his brother, mother and step-father. Due to his mother's health issues, O was referred to Shared Lives along with his brother for respite which they received successfully for several months. At a later date, it was decided that O was referred for a long term placement. After several matching visits with hosts in the Thanet area, O moved in with the family.

Since then O's independence has increased. He now takes a shower twice a day with only occasional prompting. Taking an interest in helping with

household chores and keeping his room tidy, he has learnt to use the washing machine and make a cup of tea for not only himself but for others.

O has enjoyed many days out at theme parks and trips to London. He is currently looking forward to a holiday in the summer months. He has also started swimming lessons with another adult that lives with him.

O's mother contacted Shared Lives to say thank you for finding such a suitable placement for O and the support she had been given from Shared Lives. She commented that she was thrilled to see how he was thriving and developing new skills.

3. Financial Implications

3.1 The table below outlines the current opportunity matrix.

Area	Project	Target programme benefit (end of Design)	Programme benefit - current forecast
OPPD	Acute – STBs	£0.37m	£0.58m
	Acute - LTBs	£1.97m	£3.51m
	Enablement – Efficiency	£1.64m	3.04m
	Enablement – Outcomes	£3.35m	£3.42m
LD	Your Life, Your Home	£3.74m	£3.74m
	Shared Lives	£0.83m	£0.83m
	KPS – Cost reduction	£0.46m	£0.46m
	KPS – Cost avoidance	£0.82m	£0.82m
Total		**£13.18m**	**£16.40m**

4. Legal Implications

4.1 No significant impacts have been identified and any subsequent legal impacts arising from Phase 2 implementation will be managed through the Adult Transformation Portfolio Board within the existing risk management approach.

5. Equality Implications

5.1 Equality Impact Assessments were carried out as part of Phase 2 Design and there were no significant implications identified.

6. Recommendation

6.1	**Recommendation:** The Adult Social Care and Health Cabinet Committee is asked to **COMMENT** on the information provided in the report.

7. Background Documents

Item C1 – Social Care and Health Cabinet Committee, 3 December 2015 – Adult Social Care Transformation and Efficiency Partner Update
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=829&MId=5791&Ver=4

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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: 10 May 2016

Subject: Public Health Quality Report

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary: This report presents an overview of the quality of Public Health programmes.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider the measures being put in place to improve the quality of Public Health programmes and to comment on the direction of travel.

1.INTRODUCTION

The Quality Report is designed to give the Adult Social Care and Health Cabinet Committee assurance of the processes and controls that have been developed around quality. It contains analysis of how the providers of Public Health commissioned services are delivering on quality standards.

2.BACKGROUND

What is Quality in Health Care

Lord Darzi describes a high quality service as one that is based on the following three domains:

- Clinical effectiveness
- Patient safety
- Patient experience

2.1 Clinical effectiveness- is defined as "the application of the best knowledge, derived from research, clinical experience, and patient preferences to achieve optimum processes and outcomes of care for patients. The process involves a framework of informing, changing, and monitoring practice." (Department of Health, 1996). Clinical effectiveness is about improving patients' total experience of healthcare and is an essential part of improving and assuring quality. The aim of clinical effectiveness is to use evidence to improve the effectiveness of clinical practice and service delivery.

2.2 Patient safety- is a broad subject which covers everything from technology and redesigning hospitals to washing hands correctly. Many of the features of patient safety do not rely on financial resources, but rather they require the commitment of individuals to practise safely.

2.3 Patient experience- can be defined as the way a patient feels about their care based on all interactions: before, during, and after delivery of care. This can be affected by many factors and at many stages of the care pathway. For example if patients feel that the care they have received is of a high standard, or alternatively if they feel that the way they have been treated by staff is not acceptable, this can have a huge impact on how satisfied patients are with the health services available to them. A large component of quality and effectiveness is aiming to improve this experience for patients.

For the purpose of this report

1. Clinical effectiveness will cover performance of the programmes reporting by exception.
2. Patient safety will cover serious incidents, incidents and complaints about the service. It will also include staffing levels and training of staff.
3. Patient experience will cover, patient satisfaction and friends and family test results.

3. MEASURES PUT IN PLACE TO IMPROVE THE QUALITY OF PUBLIC HEALTH PROGRAMMES

A number of measures have been put in place to improve the quality of Public Health programmes

3.1 Quality Committee - has been set up that has the overall responsibility for delivery of the clinical governance and quality agenda. The Deputy Director of Public Health (DDPH) chairs this meeting and ensures that clinical governance is delivered throughout the Public Health programmes, that quality remains a priority, and is an integral part of Public Health's policies and procedures.

3.2 Quality dashboard- has been developed outlining quality indicators for each of the Public Health programmes. The indicators are based on National Institute of Clinical Excellence (NICE) guidance and other relevant national guidance.

3.3 Clinical Governance Framework- been developed through which Public Health can seek assurance on clinical performance, quality of service and mechanisms for

continuous improvement. The main components of the clinical governance framework are:

1. Risk Management and Safety
2. Clinical effectiveness and evidence based care
3. Patient and carer experience and involvement
4. Clinical Audit
5. Education Training and Continued Professional Development
6. Staffing and staff management
7. Serious incident management
8. Patient group direction

3.4 Serious incident policy and reporting- Public Health has a serious incident policy in place. Both commissioning and provider organisations are accountable for effective governance and learning following a serious incident. Provider organisations take the lead in responding to a serious incident. Providers of Public Health services commissioned by Kent County Council (KCC) are now contractually required to report any serious incidents to the Public Health team, to carry out a root cause analysis into the incident and produce action plans. There is a dedicated secure e-mail address for reporting of serious incidents phsui@kent.gcsx.gov.uk .

3.5 Education, training and continuous professional development- A system has been put in place as part of performance meetings where providers of Public Health programmes report on staff appraisal and mandatory training compliance. In addition providers may also be asked to submit information about any nationally mandated training like CSE (Child Sexual Exploitation) and PREVENT (Prevent training is part of the Government's counter-terrorism strategy).

3.6 Assurance on Safeguarding- Head of Public Health Commissioning is responsible for ensuring that there are clear safeguarding requirements within Public Health contracts and that these contracts are refreshed annually. Deputy Director of Public Health as the overall lead for quality ensures that providers of Public Health programmes have safeguarding policies in place, that policies are adhered to and that there is a robust programme of staff training.

3.7 Quality assurance appraisal of Public Health programmes- A quality assurance appraisal of the Public Health commissioned programmes was carried out to review governance structures, links to the Safeguarding Board, patient involvement in health care, role of elected members in awarding of contracts and the role of the HWBB in quality. An action plan is being developed to fill identified gaps.

3.8 Digital reporting of quality indicators- work is being done with providers of Public Health programmes to report on quality indicators using a digital reporting system. This will be rolled out in the next few weeks (appendix 2)

3.9 Additional resource- funding has been secured for 6 months for an addition resource to facilitate the process of embedding the quality indicators in Public Health commissioned programmes and to improve their reporting.

3.10 Care Quality Commission (CQC) registration- Providers of our commissioned services meet the essential standards of quality and safety required by their registration. The Cabinet Committee can be assured that the fundamental standards are being met for our service users. As registration is live and subject to change this report provides the Cabinet Committee assurance on the current registration status.

3.11 Links with the Quality Surveillance Group- A network of Quality Surveillance Groups (QSG) has been established across the country to bring together different parts of health and care economies locally to routinely share information and intelligence to safeguard the quality of care patients receive. The QSG provides an open forum for local supervisory, commissioning and regulatory bodies to share intelligence. It gives the opportunity to highlight and discuss early warning signs of the risk of poor quality, as well as opportunities to coordinate actions to ensure improvement. Its purpose is to not only ensure quality, but also to reduce the burden of performance management and regulation on providers of services, by ensuring that work is done in a more coordinated way. Public Health sits on the QSG for Kent and Medway.

3.12 CSE Training- Sexual Health contracts for the integrated service require providers to fulfil all of the following quality requirements and require the other providers to be compliant with the mandatory sexual exploitation and grooming training.

- Training on sexual exploitation and grooming is mandatory for all staff working with children and young people.
- Document and monitor sexual exploitation and grooming activity
- Development of pathways and protocols with partners to ensure exchange of information relating to vulnerable children, young people and adults.
- Training on and working towards Kent Children Safeguarding policy with particular reference to the matrix on early sexual behaviour.
- Training to recognise unreported sexual violence; to be aware of the local services and support arrangements and how to ensure that clients can access services.
- Monitoring of standards, competencies to ensure that the specialist skills of staff are maintained as outlined by the relevant faculties.

4.PROVIDER SUMMARIES

4.1 KENT COMMUNITY HEALTH NHS FOUNDATION TRUST (KCHFT)

Public Health commission the following programmes from KCHFT:

4.1.1 HEALTH TRAINER SERVICE

Introduction to the programme-The Health Trainer Programme is a national programme specifically designed to tackle health inequalities. It is a targeted service focusing on areas of deprivation. Health Trainers work with people at greater risk of

poor health. They work with clients on a one to one basis to assess their health and lifestyle risks and facilitate behaviour change. Part of their role also includes signposting individuals to other services and activities that might be suitable to their needs.

Clinical effectiveness-The Health Trainer service over achieved on their targets last year and the team has increased in size and continues to grow. There has been some good progress made within Job Centre Plus and Probation where the service is seeing a sizable number of clients. The service is experiencing an increase in the number of clients with mental health conditions, and as result is working more closely with Kent and Medway Partnership Trust (KMPT), Porchlight, Change Grow Live (GCL) and Turning Point. Number of clients seen from deprived areas has increased by 56%. All Health Trainers have been trained to deliver Health Checks and have moved to an electronic record system.

Patient safety-There has been one reported complaint and one incident in the service from April 2015 to January 2016.
There has been a high staff turnover rate. This is due to the restructuring of the service by KCHFT. Most vacant positions have now been recruited to. The existing vacancy rate is because health trainers who have been appointed start on a band 2 trainee level. This is not reflected in the band 3 position vacancies. KCHFT are working with its finance team so that this position can be reflected in all reports. There were 2.4 whole time equivalent (WTE) vacancies in month 10.

KCHFT is achieving more than the year to date target for mandatory training for Health Trainer staff. 98.7% of staff have completed their mandatory training and 100% have completed their appraisals.

Patient experience- 99.3% of the patients who used the service said they would recommend the service to friends or family. 99.1% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the Health Trainer service felt that they had been involved in decision making about their health, had been given the right information and had been listened to and talked about life.

4.1.2 HEALTHY WEIGHT SERVICE

Introduction to the programme- KCHFT Health Weight Team is commissioned to deliver services in East Kent. The team deliver seven distinct schemes of work across all three tiers of the healthy weight pathway (Health Walks, Exercise Referral Scheme, Food Champions, Fresh Start, Specialist Weight Management Service, Change for Life and Ready Steady Go).

Clinical Effectiveness- KCHFT provides a number of programmes that support healthy weight. A specialist weight management service is provided in Swale for people who have severe and complex problems. KCC is currently reviewing the obesity pathway including tier 3 services and is in discussions with CCG's around the future of these services to ensure there are sufficient services in place to meet local need.

A Community Weight Management Programme called Fresh Start is subcontracted by KCHFT to 34 pharmacies across Kent. 80% of people who engage in the programme complete it, which is in line with national guidance. The average weight loss is above 3% which is expected for an effective Tier 2 programme. A pilot integrated hub weight management model is being piloted in Dover. The outcomes of this programme will be evaluated and will add to the evidence base.

KCHFT also provide a Family Weight Management programme which is targeted at families where there is one or more child who is overweight or very overweight. These programmes are proving hard to recruit to. The families who do participate show good outcomes with regard to behaviour change. The Healthy Weight Team has provided training for all Kent school nurses on a nationally designed programme. The training aims at increasing the confidence of school nurses in raising the issue of weight and to be able to support families, schools and the wider community. KCHFT has also trained 34 Food Champions who are based in a number of settings, including Children's Centres.

Patient safety-There have been no reported complaints or serious incidents in the service during this period. The vacancy rate in the service is 4.8%. KCHFT is achieving more than the year to date target for mandatory training. 99.3% of the staff completed the mandatory training. The appraisal rate is 100%. 89.5% of the staff working in the healthy weight service completed children safeguarding training.

Patient experience- 98.1% of the patients who attended the service said they would recommend the service to friends or family. 96.2% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the Healthy Weight service felt that they had been involved in decision making about their health, had been given the right information and had been listened to and talked about life.

4.1.3 STOP SMOKING SERVICE

Introduction to the programme- The service is commissioned to provide a universal service to smokers who want to quit. The service has a particular focus towards reducing smoking prevalence in people with mental health problems, pregnant women and people from routine and manual class. The service is also commissioned to provide training, support, and resources for its own in house staff as well as for approximately 400 Advisors who are based within community settings. These vary from GPs, pharmacies, mental health workers, libraries, supermarkets, hospitals, Children Centres, prisons, and workplaces.

Clinical Effectiveness- Last year has seen a decline in the number of smokers accessing the smoking cessation services. This is a national trend and despite fewer people accessing the service, the success rate of those quitting has remained constant at 52%. However the estimated smoking prevalence for Kent has not decreased, implying that smokers are not finding alternative ways to quit.

Restructuring of the service has led to a reduction in the number of advisers working within acute trusts. This has resulted in missed opportunities for a seamless stop smoking service from acute to community services. There is still a lack of public

awareness and understanding among health partners of the process, accessibility and delivery of the stop smoking service.

The service is e-cigarette friendly. Text and online support is still not available. Data quality remains an issue. Baby clear data has been inconsistent and is currently not fit for purpose. Despite these issues and weaknesses the stop smoking service does have considerable strengths. It is a vital service for improving health and reducing inequalities and aims to work flexibly to respond to the needs of commissioners.

Patient safety-There have been no reported complaint or serious incident in the service during this period. There has been a high staff turnover rate because of restructuring. The vacancy rate in the service is 23.3%. In month 10 there were 6.2 WTE vacancies in the service. 99.5% of staff in the stop smoking service have completed their mandatory training and 92.6% of staff have completed the children safeguarding training. The appraisal rate is 100%.

Patient experience- 99.6% of the patients who attended the service would recommend the service to friends or family. 94.8% of the patients accessing the services were satisfied with the service. 94.7% of the patients surveyed in the Stop Smoking service felt that they had been involved in decision making about their health, 96.1% felt they had been given the right information and 94.7 % had been listened to and talked about life.

4.1.4 SEXUAL HEALTH SERVICES

Introduction to the programme- The sexual health service provides a range of services delivered through clinical and non-clinical settings across Kent. The services provided are contraception, genitourinary medicine (GUM), HIV treatment and support, psychosexual therapy service, pharmacy sexual health services and the National Chlamydia Screening Programme. In addition services are being made available on line such as chlamydia screening and HIV home sampling tests

Clinical Effectiveness-There have been major improvements in the delivery of sexual health services after the roll out of the integrated sexual health model. The establishment of a clinical service lead for psychosexual therapy has enabled the provider to make improvements in recording service outcomes and expanding the service across Kent.

Partnering of KCHFT with the local pharmacy partnership has improved the process for the delivery of training to pharmacists to provide a sexual health service. The programme is dispensing an ever increasing number of free emergency hormonal contraception (EHC) to females within the age brackets for this service. This is because of better availability of EHC in this contract. There is coverage across all districts but there is a special focus on areas with the highest teenage pregnancies rates. Alcohol screening is undertaken with all clients and approximately 13% of those screened receive an alcohol brief intervention.

Lower than target diagnosed Chlamydia positivity remains a challenge. The changes to the contract have impacted upon the volume of chlamydia screens undertaken

amongst 15-24 year olds as the activity is more targeted and embedded into all components of sexual health services.

Patient safety-There has been one serious incident, 23 incidents, and 7 near misses in the service. Following the tender of the sexual health service and subsequent restructuring process turnover rates have been high. There are 9.9 WTE vacancies in the sexual health services. The vacancy rate in the service is 10.9%. The staff turnover rate is 22.3%. KCHFT is achieving more than the year to date target for mandatory training. 94.8% of staff have completed their mandatory training and the appraisal rate is 89.3%. 86% of the staff have completed the adult safeguarding training and 90.4% of staff have completed the children safeguarding training. No frontline staff in sexual health services can practice without completion of mandated CSE training. 98.7% of staff working in the sexual health services have completed their CSE training, 1.3% shortfall accounts for vacancies and absent staff.

Patient experience- 96.9% of the patients who attended the service said they would recommend the service to friends or family. 98.3% of the patients accessing the services were satisfied with the service. 98.5% of the patients surveyed in the Sexual Health service felt that they had been involved in decision making about their health, 96.4% felt they had been given the right information and 98.6% had been listened to and talked about life

4.1.5 SCHOOL NURSING SERVICE

Introduction to the programme- The 5-19 element of the Healthy Child Programme is led by the school nursing service. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children who are at risk of poor outcomes. School nurses have a crucial leadership, co-ordination and delivery role within the Healthy Child Programme. Following holistic assessment, interventions are planned in partnership with both the child/young person and other agencies, in order to achieve outcomes.

Clinical Effectiveness- KCHFT undertook an internal review of its operational responses to safeguarding requests in order to agree a robust and accountable position and ensure consistent practice occurs across Kent. KCHFT has also established a joint working group with school nurses and safeguarding nurses to address inconsistent and inequitable practice. There is a move to improve documentation to support robust decision making processes in order to improve outcomes for children and young people subject to safeguarding interventions.

The introduction of a Kent wide questionnaire for reception aged children has been successfully implemented across all schools in Kent .In September 2015 a transition questionnaire for parents of year 6 children and a pupil questionnaire for children moving from primary to secondary school education was also introduced.

An offer of a market place has been put in place for year 9 pupils to promote public health messages. The aim is to increase the uptake of the market places in secondary schools. The school health service continues to improve on its targets for

National Child Measurement Programme (NCMP) with 97% of year R children being height and weighted in 2014/15 and for year 6 this has increased from 93.4% to 97%.

KCHFT is working towards building the school nursing workforce capacity to address the emotional health and wellbeing of children and young people. Work has also been done to identify what information within the year R assessment can be shared with education.

Patient safety-There have been no serious incidents but there were 39 incidents, and 7 near miss in this time period.

The vacancy rate remains above the trust target but has reduced as more band 5 nurses have been recruited. The shortage of qualified school nurses is a national and local issue. This impacts on the delivery of the school health service in terms of clinical leadership for the teams and delivery of public health and safeguarding interventions. Two band 6 nurses have been recruited and currently 6 students are undertaking the Public Health degree. KCHFT is achieving more than the year to date target for mandatory training at 94.8%. The appraisal rate of 80% for this service is lower as compared to rest of KCHFT. 79.9% of the school nurses have completed the adult safeguarding training and 96.1% have completed the children safeguarding training.

Patient experience- 83.9 % of the patients who used the service said they would recommend the service to friends or family. 88.8% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the School Nursing service felt that they had been involved in decision making about their health, 96.3% felt they had been given the right information and 100% had been listened to and talked about life.

4.1.6 HEALTH VISITING SERVICE

Introduction to the programme -The 0-5 element of the Healthy Child Programme is led by Health Visiting services. The Health Visiting service is a workforce of specialist community public health nurses who provide expert advice, support, and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family's future health and wellbeing. The service is central to delivering public health outcomes for children. There are five mandated checks carried out by the Health Visiting service in the programme.

Clinical effectiveness- Figures for the antenatal visit remain low but performance is improving. Work is ongoing to enable antenatal information to be gained in a timely manner from the acute trust. The target for health check at 2-2.5 yr is not being met. Maternal mental health provision has also been identified as an area that requires more work. Health Visiting will continue to contribute to the assessment of maternal mood as part of the 6-8 week mandated assessment. KCHFT is working in partnership with other providers to ensure appropriate follow up post identification of low maternal mood. Health visitors actively advise clients about the Healthy Start Vitamins programme. The Health Visiting service is also developing a more

systematic approach to partnership working with Children's Centres, 100% of Children Centres have partnership agreements in place now.

Patient safety-In this period time period there have been 2 serious incident, 74 incidents, and 15 near misses in the service. 8 complaints were received about the service.

The vacancy rate is high for the Health Visiting service. Currently there are 9.5 WTE vacancies in the service. Staff turnover rate is improving. In future Health visiting resources will be allocated based on need and will be reviewed regularly to ensure equity of provision based on changing demographics and deprivation weightings. Workforce strategy development work is ongoing. Benson Wintere workforce modelling is being used to inform future provision.

KCHFT is achieving more than the year to date target for mandatory training. 91.7% staff completed their mandatory training.

Patient experience- 98.2 % of the patients who used the service said they would recommend the service to friends or family**.** 97.5% of the patients accessing the services were satisfied with the service. 100% of the patients surveyed in the NHS Health Check service felt that they had been involved in decision making about their health, 100% felt they had been given the right information and 100% had been listened to and talked about life.

4.1.7 NHS HEALTH CHECKS

Introduction to the programme-The NHS Health Check is a programme that offers a free midlife MOT. This programme is for adults aged 40-74 without a pre-existing condition, it checks the circulatory and vascular health and assesses the risk of getting a disabling vascular disease.

Clinical effectiveness- KCHFT is meeting its invitation target but the uptake of Health Checks is below the target. Work is being done with low uptake practices with a high eligible population to increase the number of checks completed in the final quarter of the year. Bank staff have been trained to deliver Health Checks to increase the number of clinics offered. The service has appointed to all vacant positions and has an interim Programme Manager in place. KCHFT is working with the Skip to Be Fit, CRI and Wellbeing People pilots and is looking at increasing marketing to support uptake. A concerted effort is also being made to increase work place checks and strengthen links with local businesses, this is being completed in conjunction with the Healthy Business Awards.

Patient safety- No serious incidents or incidents have been reported in the service. 98.9% of the staff have completed their mandatory training and 100% have completed their appraisals.

Patient experience- 97.9 % of the patients who used the service said they would recommend the service to friends or family. 98.0% of the patients accessing the services were satisfied with the service.

5.METRO

Introduction to the programme - Metro delivers the C card condom and sexual health awareness programmes across Kent. This is a free condom programme for under 19's.

Clinical effectiveness- In year one of this contract the provider has evaluated the C Card programme. Through this the provider has been able to identify improvements to support the delivery, promotion and monitoring of this programme. The work done by the provider has led to an increase in usage of the C card programme amongst 17-19 year old. This was achieved through targeted and focused activity in specific geographical populations such as Swale and with other population groups.

Patient safety- No serious incidents or incidents were reported. One informal compliant was made to the C Card programme which was resolved within the service. There have been no reported shortages in staffing levels in the service. All practitioners have completed their mandatory training including safeguarding and are assessed as being competent to deliver the service. Metro has a CSE champion and have completed the KSCB CSE tool kit.

Patient experience- satisfaction rates are reported informally during contract review meetings. These will be formally reported when the digital reporting service goes live.

6. MAIDSTONE AND TUNBRIDGE WELLS HOSPITAL NHS TRUST

Introduction to the programme - MTW provides sexual health services in West and North Kent. The services provided by the trust include specialist HIV care and treatment, integrated sexual health service and sexual health outreach service.

Clinical effectiveness- In year one of the contract the provider has had to meet significant challenges because of having to vacate premises historically used for sexual health clinics. The trust overcame this obstacle by being flexible in its approach to the delivery of services. In order to have a fit for purpose workforce the provider put in place a programme to identify gaps in clinical skills. This work has informed the workforce development strategy to deliver an integrated service. The service offered has been at the minimum level required throughout the implementation of the contract in West Kent. This has not been replicated in North Kent but solutions have been identified.

Patient safety- All staff have completed their safeguarding training. 98.6% of staff working in the sexual health services have completed their CSE training, 1.4% shortfall accounts for vacancies and absent staff. Work is ongoing to improve reporting at the contract review meetings. The service appointed to a substantive second Genito Urinary Medicine (GUM/HIV) health consultant post in March 2016 thus completing the required staffing levels for this speciality. No serious incidents, incidents, or near misses were reported by the service.

Patient experience- The patient satisfaction rate was 96% however these rates are at Trust level. From Quarter 2, 2016/17 the service will report patient satisfaction rates for the sexual health service.

7.TURNING POINT & CHANGE, GROW, LIVE (FORMERLY KNOWN AS CRI)

Introduction to the programme - CRI now known as CGL (Change Grow and Live) deliver substance misuse treatment services in West Kent (covering districts of Maidstone, Tonbridge and Malling, Tunbridge Wells, Sevenoaks, Dartford and Gravesham). Turning Point delivers substance misuse treatment services in East Kent (covering districts of Swale, Ashford, Canterbury, Thanet, Shepway and Dover).

Turning Point provides substance misuse services including access to detox and residential rehabilitation. CGL deliver an integrated drug and alcohol service in West Kent. They help vulnerable adults to understand the risks their drug or alcohol use pose to their health and wellbeing, and support them to reduce or stop their use safely. Once stability or abstinence has been achieved, an aftercare service is provided to help maintain recovery and prevent the possibility of a relapse. CGL offer support for people who use legal highs, illegal drugs, Over the counter (OTC) medication and multiple drug /or alcohol use.

Clinical effectiveness- Numbers into Adult Treatment services are increasing; this is primarily due to an increase in alcohol clients. Opiate numbers have been decreasing however they still account for a significant proportion of those in treatment.

Reflecting the numbers accessing treatment for alcohol related problems, there is increasing successful exits of alcohol clients, whilst opiate successful exits have decreased. The complexity of health, social care, and dependency of the opiate cohort is increasingly making this group hard to engage. Recent drug deaths have been to people who have physical health complexities and who are not engaged with treatment services. Blood Borne Virus (BBV) rates of testing and vaccination have improved; historically this has been a problem which is now showing signs of improvement. Work is also being done to explore in more depth the underlying reasons why some individuals have repeated unsuccessful treatment episodes. e.g. what are the relapse triggers and how can the whole system mitigate these.

Patient safety- CGL has reported 1 serious incident in the service. The provider has a very robust and active safety process within the organisation. All the staff are fully involved in the governance process and lessons learnt are actively embedded into the service improvement. CGL is involved in Operation Willow, have a CSE champions and have completed their Kent Safeguarding Childrens Board (KSCB) CSE toolkit.

Turning Point has reported 1 serious incident in the time period. The learning from root cause analysis is shared with wider partners to ensure there is a continuous programme of service improvement. Turning Point has robust safeguarding and safety policies which they audit and review regularly. Turning Point is also involved in Operation Willow.

Patient satisfaction- CRI and Turning Point have a very active service user involvement programme. The results of patient satisfaction are informally report to Public Health. Going forward CRI and Turning Point will report on quality indicators using the new digital reporting system.

8. ADDACTION

Introduction to the programme - Addaction provide advice on drugs and alcohol for young people aged 10 to 17. Young Addaction, support young people to understand the effects of their substance misuse and the harm it can cause to them and the people around them. As well as one-to-one work Addaction also offer a range of early intervention programmes in schools, youth clubs and other settings, helping young people reach their full potential.

Clinical effectiveness- Service continues to deliver early intervention services across Kent and continues to target vulnerable young people and those at risk. Performance data shows the provider is achieving effective results in engaging young people who are at risk of reoffending, at risk of exclusion and are children of substance misusing parents. The service is less effective in engaging young asylum seekers or refugees and looked after children. Work is continuing to ensure needs are being met for other vulnerable groups particularly Children in Care**.** The provider delivers more structured treatment for those young people who have very complex needs around their substance misuse. Compared to national figures Addaction is engaged with more complex client group, especially those with two or more vulnerabilities, and those with early onset.

Addaction is achieving a higher proportion of planned exits from structured treatment, consistently achieving over 90%. Work is going on with the provider to ensure that information about other Public Health services and GP registration is provided to clients before they exit the service.

Patient safety- Addaction has not reported any serious incidents or complaints in the service in this time period.

Patient satisfaction- Addaction conducts a young people's survey each quarter. A questionnaire is given to all young people engaged in the treatment service and feedback from the survey is used to inform development and reflect on the current offer. In the previous survey 94% of young people stated they would recommend the service to their friends and would be happy using the service in the future.

9. DISCUSSION

A recent departmental governance review of Public Health, conducted by internal audit, identified Quality as a high priority area for development within the Public Health division. The work outlined in section 3 of this report outlines what steps have have been taken to improve the quality of commissioned services in response to the

audit report. In addition to the quality indicators mentioned in appendix 2 of the report, specific quality indicators are being developed for each programme.

10. BACKGROUND DOCUMENTS

none

11 RECOMMENDATIONS

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider the measures being put in place to improve the quality of Public Health programmes and to comment on the direction of travel.

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Appendix 1 Performance Dashboard for Public Health Programmes

Health Checks Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	0.00%		0.00%		0.00%	S	
Short Term Sickness	2.48%		0.88%		0.88%	A	
Maternity Leave	0.0%		0.0%			S	
Turnover Rate			39.3%	10%	39.3%	A	
Vacancy Rate	6.8%	5%	6.8%	5%	6.8%	A	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	0.8					A	
Mandatory Training Compliance			98.9%	85%	98.9%	A	
Appraisal Rate			100.0%	85%	100.0%	S	
Other Absence (excluding Sickness and Maternity)	0.2%		1.6%			A	

Patient satisfaction

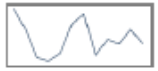
Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Friends and Family (% of patients who would recommend out service)	93.7%		97.9%			A	
Patient Experience % (overall satisfaction)	98.8%	90%	98.0%	90%	98.0%	F	

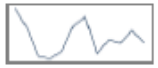
Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Health Trainers Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	3.60%		3.18%		3.18%	F	
Short Term Sickness	4.02%		1.36%		1.36%	A	
Maternity Leave	0.0%		0.0%			S	
Turnover Rate			19.2%	10%	19.2%	F	
Vacancy Rate	6.5%	5%	6.5%	5%	6.5%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	2.4					F	
Mandatory Training Compliance			98.7%	85%	98.7%	A	
Appraisal Rate			100.0%	85%	100.0%	S	
Other Absence (excluding Sickness and Maternity)	3.3%		1.7%			A	

Patient satisfaction

Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Friends and Family (% of patients who would recommend out service)	100.0%		99.3%			S	
Patient Experience % (overall satisfaction)	98.8%	90%	99.1%	90%	99.1%	A	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Health Weight Service Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	0.00%		0.00%		0.00%	S	
Short Term Sickness	1.27%		0.99%		0.99%	F	
Maternity Leave	6.1%		3.6%			F	
Turnover Rate			5.8%	10%	5.8%	F	
Vacancy Rate	4.8%	5%	4.8%	5%	4.8%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	0.9					F	
Mandatory Training Compliance			99.3%	85%	99.3%	F	
Appraisal Rate			100.0%	85%	100.0%	S	
Other Absence (excluding Sickness and Maternity)	0.2%		0.3%			F	

Patient satisfaction

Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Friends and Family (% of patients who would recommend out service)	98.1%		94.5%			F	
Patient Experience % (overall satisfaction)	97.8%	90%	96.2%	90%	96.2%	F	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Stop smoking Service Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	0.00%		0.00%		0.00%	S	
Short Term Sickness	0.00%		1.24%		1.24%	F	
Maternity Leave	1.5%		3.9%			F	
Turnover Rate			28.2%	10%	28.2%	F	
Vacancy Rate	23.3%	5%	23.3%	5%	23.3%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	6.2					F	
Mandatory Training Compliance			99.5%	85%	99.5%	F	
Appraisal Rate			100.0%	85%	100.0%	S	
Other Absence (excluding Sickness and Maternity)	0.9%		0.2%			A	

Patient satisfaction

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Patient Experience % (overall satisfaction)	92.3%	90%	94.8%	90%	94.8%	A	
Friends and Family (% of patients who would recommend out service)	100.0%		99.6%			S	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Sexual Health Service Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	2.99%		3.48%		3.48%	A	
Short Term Sickness	2.30%		2.29%		2.29%	A	
Maternity Leave	4.1%		4.9%			F	
Turnover Rate			22.3%	10%	22.3%	F	
Vacancy Rate	10.9%	5%	10.9%	5%	10.9%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	9.9					F	
Mandatory Training Compliance			94.8%	85%	94.8%	A	
Appraisal Rate			89.3%	85%	89.3%	F	
Other Absence (excluding Sickness and Maternity)	0.1%		0.9%			F	

Patient satisfaction

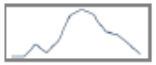
Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Patient Experience % (overall satisfaction)	97.6%	90%	98.3%	90%	98.3%	A	
Friends and Family (% of patients who would recommend out service)	96.4%		96.9%			A	

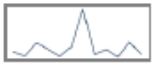
Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

School Nursing Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	1.76%		2.73%		2.73%	F	
Short Term Sickness	3.00%		1.82%		1.82%	A	
Maternity Leave	6.6%		5.4%			F	
Turnover Rate			11.3%	10%	11.3%	F	
Vacancy Rate	12.4%	5%	12.4%	5%	12.4%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	11.9					F	
Mandatory Training Compliance			94.8%	85%	94.8%	F	
Appraisal Rate			80.0%	85%	80.0%	A	
Other Absence (excluding Sickness and Maternity)	4.4%		12.6%			F	

Patient satisfaction

Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Patient Experience % (overall satisfaction)	97.4%	90%	88.8%	90%	88.8%	F	
Friends and Family (% of patients who would recommend out service)	83.9%		78.1%			F	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

C&YP Health and Wellbeing Team (Healthy Schools) Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	0.00%		1.61%		1.61%	S	
Short Term Sickness	11.19%		1.99%		1.99%	A	
Maternity Leave	0.0%		0.0%			S	
Turnover Rate			0.0%	10%	0.0%	S	
Vacancy Rate	0.8%	5%	0.8%	5%	0.8%	S	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	0.1					S	
Mandatory Training Compliance			98.9%	85%	98.9%	S	
Appraisal Rate			100.0%	85%	100.0%	S	
Other Absence (excluding Sickness and Maternity)	8.2%		14.8%			F	

Patient satisfaction

Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Patient Experience % (overall satisfaction)		90%		90%	0.0%	S	
Friends and Family (% of patients who would recommend out service)	0.0%		0.0%			S	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Health Visiting Service Key Indicators 15/16

Staffing

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Long Term Sickness	1.50%		2.30%		2.30%	F	
Short Term Sickness	2.51%		1.89%		1.89%	A	
Maternity Leave	1.7%		1.5%			A	
Turnover Rate			16.1%	10%	16.1%	F	
Vacancy Rate	2.3%	5%	2.3%	5%	2.3%	F	

Indicator	M10	Month Target	YTD	YTD Target	YTD Status		Trend
Vacancies (WTE)	9.5					F	
Mandatory Training Compliance			91.7%	85%	91.7%	A	
Appraisal Rate			90.1%	85%	90.1%	F	
Other Absence (excluding Sickness and Maternity)	1.5%		1.4%			A	

Patient satisfaction

Indicator	M10	M10 Target	YTD	YTD Target	YTD Status		Trend
Patient Experience % (overall satisfaction)	98.2%	90%	97.5%	90%	97.5%	F	
Friends and Family (% of patients who would recommend out service)	96.4%		96.9%			A	

Key

A = Adverse, decline on last month.	Performance against Indicator is on Target.
F = Favourable, inprovment on last month.	Performance against Indicator is off Target.
S = Static, no change from last month.	Performance against Indicator is within acceptable tolerance of target.
#N/A or **DCU** = Not Applicable / Data Currently Unavailable	No target set for this indicator

Appendix 2 Public Health Quality Indicators – Service Provider Response Template

Topic	Question	Answer	Evidence Required	Frequency
Quality Governance	1. Do you have a Quality Governance Framework in place? If so, please submit a copy of your framework and a copy of your Quality Accounts and Service Performance Report	Yes / No	Submit: • Copy of framework • Quality Accounts and service performance report	Annually
	2. If CQC registered, do you comply with all CQC standards	Yes / No / NA	Submit: • Up to date CQC report	Annually
	3. Have you had any external or internal inspections within the latest reporting period	Yes / No If yes: Date of inspection	Submit: • Inspection Report	Quarterly
	4. How many service quality audits (including clinical audits) have you undertaken in the previous reporting period?	Number		Quarterly
	5. Please list quality audits that you have completed in the latest reporting period and provide copies of the audit findings and associated action plans arising from these		Submit: • Audit Reports • Action plans	Quarterly
	6. Do you have up to date policies and procedures relating to: a. Quality Governance b. Safeguarding Children c. Safeguarding Adults d. Human Resources (including safer recruitment and DBS) e. Staff supervision f. Escalation of concerns and whistleblowing g. Mandatory training h. Risk Management, serious incidents, near misses and learning i. Duty of Candour j. Information Governance	 Yes / No – date of last update Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No	Submit: • Copy of relevant policies	Quarterly (pre-fill)

Topic	Question	Answer	Evidence Required	Frequency
	k. Storage of records l. Health and Safety m. Clinical Policies	Yes / No Yes / No Yes / No		
Staffing	7. What is the whole-time equivalent (WTE) staffing establishment for this service?	Number		Quarterly
	8. How many whole-time equivalent (WTE) staff are currently in post?	Number & calculated percentage		Quarterly
	9. How many staff are currently in post (headcount)?	Number		Quarterly
	10. How many staff in the service require professional registration to undertake their role but are not currently registered with the relevant registration body?	Number		Quarterly
	11. How many staff have left the service within the past 12 months	Number & calculated percentage		Quarterly
	12. Of the staff currently in post, how many meet the meet the competency standards that apply to their role?	Number & calculated percentage		Quarterly
	13. How many staff in the service are absent due to long-term sickness?	Number & calculated percentage		Quarterly

Topic	Question	Answer	Evidence Required	Frequency
	14. How many days were lost to sickness absence in the previous reporting period?	Number		Quarterly
	15. Please provide a copy of your leadership structure	-	Submit: • Copy of leadership structure	Annually
	16. Have you undertaken a staff survey in the past 12 months?	Yes / No		Annually
	17. What was the overall staff satisfaction rate?	Percentage		Annually
18. Training	19. How many staff have received the relevant mandatory training?	Number & calculated percentage		Quarterly
	20. Breakdown of mandatory training and number of staff trained within past 12 months	-	Submit: • Copy of mandatory training logs	Quarterly
Patient / Service User feedback	21. How many service users /patients have been surveyed or asked about their level of satisfaction with the service within the latest reporting period?	Number		Quarterly
	22. Of those asked, how many indicated that they were satisfied / very satisfied with the service they have received?	Number & calculated percentage		Quarterly
	23. How many complaints have you received in the latest reporting period?		Submit: • Summary of the complaints and status of the complaint (i.e. on-going, closed)	Quarterly
Serious Incidents	24. How many Safety Alerts (CAS) have been actioned in the latest reporting period	Number	Submit: • Evidence of how the alert has been actioned	Quarterly
	25. How many serious incidents occurred within the latest reporting period?	Number		Quarterly

Topic	Question	Answer	Evidence Required	Frequency
	26. Please submit a completed form showing the status of each incident or serious incident that occurred in the previous period or is still open from a previous period (status listed as under investigation closed and lessons actioned)	Number	Submit: • Summary of the complaints and status of the incident (i.e. under investigation, closed)	Quarterly
Risk	27. Please provide a copy of your risk register relating to this service		Submit: • Risk register	Quarterly

Appendix 3

Definitions

1. **Serious incidents** requiring investigation were defined by the NPSA's 2010 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation as

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- a never event - all never events are defined as serious incidents, although not all never events necessarily result in severe harm or death.
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population.
- allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

2. **Incident –** an event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm to a patient, staff, visitors or members of the public.

3. **A near miss** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage; in other words, a miss that was nonetheless very near.

NHS England -Serious Incident framework supporting learning to prevent recurrence April 2015

National Patient safety agency: Being Open 2010

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From	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee - 10 May 2016
Subject:	Public Health Risk Management
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This report presents the strategic risks relating to the Public Health Division of the Social Care Health and Wellbeing Directorate.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Risk Management arrangements for Public Health outlined in this report.

1. Introduction

1.1 Risk management is a key element of the Council's Internal Control Framework and the requirement to maintain risk registers ensures that potential risks that may prevent the Authority from achieving its objectives are identified and controlled. The process of developing the registers is therefore important in underpinning business planning, performance management and service procedures. Risks outlined in risk registers are taken into account in the development of the Internal Audit programme for the year.

1.2 The Public Health Division maintains its own risk register, with a hierarchical report through the Social Care, Health and Wellbeing Directorate to ensure that risks are escalated when necessary.

1.3 A standard reporting format is used to facilitate the gathering of consistent risk information and a 5x5 matrix is used to rank the scale of risk in terms of likelihood of occurrence and impact.

2. Risks relating to Public Health

2.1 Risk is inherent in any undertaking, and ensuring that the risks are managed effectively is a key part of management. The coming year brings many risks that the division needs to manage effectively, including the challenges of delivering service transformation, alongside a backdrop of reducing funding.

2.2 The risks currently on the Public Health divisional level risk register are

- Chemical, biological, radiological, nuclear and explosives (CBRNE) incidents and communicable disease outbreaks.
- Implementation of new models within reduced financial envelope
- Maintaining performance and quality of services throughout the transformative period, and within resource constraints
- Ensuring health inequalities do not widen
- Information Governance
- Business Disruption
- Managing and working within the market

Further detail on these risks, and the controls in place, is available in Appendix 1.

2.3 Many of these risks are linked to risks on the Authority's Corporate Risk Register, for example the risk of communicable disease outbreak is contained within the Corporate Risk Register, under risk number four, Civil Contingencies.

2.4 During the past year the following risks have been removed from the Public Health Division risk register

- Managing the transition of responsibility for the Healthy Child Programme from NHS to the County Council in October 2015
- Managing in-year budget cut of £4m following government reduction to grant

2.5 The Divisional level risk register is formally reviewed by Public Health Departmental Management Team on a quarterly basis.

2.6 In addition to the internal risk management, there is also a process in place whereby contracted providers are required to maintain risk registers and manage risk within the services they provide. These risk registers are formally reviewed on a quarterly basis in contract management meetings.

3. Recommendation

3.1 Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the Risk Management arrangements for Public Health outlined in this report.

4. Background Documents

4.1 KCC Risk Management Policy on KNet intranet site.
http://knet/ourcouncil/Pages/MG2-managing-risk.aspx

5. Contact details

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Public Health Divisional Risk Register

APRIL 2016

Public Health Risk Register - Summary Risk Profile

Low = 1-6	Medium = 8-15	High =16-25

Risk No.*	Risk Title	Current Risk Rating	Target Risk Rating
PHD 01	Implementation of new models	9	4
PHD 02	Maintaining performance and quality of services throughout the transformative period	6	4
PHD 03	Health inequalities	9	6
PHD 05	Information governance	9	6
PHD 06	Business disruption	6	6
PHD 07	Managing and working within the market	9	6
PHD 08	CBRNE Incidents and communicable diseases	12	12

*Each risk is allocated a unique code, which is retained even if a risk is transferred off the Corporate Register. Therefore there will be some 'gaps' between risk IDs.

NB: Current & Target risk ratings: The 'current' risk rating refers to the current level of risk, taking into account any mitigating controls already in place. The 'target residual' rating represents what is deemed to be a realistic level of risk to be achieved, once any additional actions have been put in place. On some occasions the aim will be to contain risk at current level.

Risk ID	PHD 01	Risk Title	Implementation of new models			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Public Health is working to transform both children's and adults services, to deliver services more aligned with the need of the people of Kent, whilst also facing reducing budgets.	That the reduction in resource available to the new services will hamper the new services in their ability to deliver.	Reduction in outcomes for customers, and the ability of the services to meet key objectives, including the reduction of health inequalities	Andrew Scott-Clark, Director Public Health Karen Sharp, Head of Public Health Commissioning	Possible (3)	Significant (3)
				Target Residual Likelihood	**Target Residual Impact**
				Unlikely (2)	Moderate (2)

Control Title	Control Owner
Public Health commissioning function in place to ensure robust commissioning process is followed	Karen Sharp, Head of Public Health Commissioning
Working to a clear strategy, and to an advanced agenda, allows for good communication with providers and potential providers	Karen Sharp, Head of Public Health Commissioning
Regular meetings with provider and representative organisations (Local Medical Council, Local Pharmaceutical Council). Regular 'meet the market' events to support commissioning processes	Karen Sharp, Head of Public Health Commissioning
Analyse long term financial situation and develop services that will be sustainable	Andrew Scott-Clark, Director Public Health
Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored.	Karen Sharp, Head of Public Health Commissioning

Action Title	Action Owner	Planned Completion Date
Develop a long-term resource allocation plan, taking account of likely financial resources over next four years	Andrew Scott-Clark, Director Public Health	29/07/2016
Work with partners to understand long-term need, and identify areas for joint commissioning	Karen Sharp, Head of Public Health Commissioning	29/07/2016

Risk ID	PHD 02	Risk Title	Maintaining performance and quality of services throughout the transformative period			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**	
Public Health are working to develop better, more integrated services, and have been working towards procuring new services in the coming year.	That the work to redesign services may mean that quality and performance of current services drop	That customers and patients do not receive the highest level of service. That patient safety is compromised.	Karen Sharp, Head of Public Health Commissioning Deputy Director of Public Health	Unlikely (2)	Significant (3)	
				Target Residual Likelihood	**Target Residual Impact**	
				Unlikely (2)	Moderate (2)	

Control Title	Control Owner
Working to a clear strategy, and to an advanced agenda, allows for good communication with providers. Contract extensions planned to give providers long-term notice on decisions about future contracting	Karen Sharp, Head of Public Health Commissioning
Robust contract management meetings are held on a regular basis with providers to review performance and delivery.	Karen Sharp, Head of Public Health Commissioning
Performance on key performance indicators is reported regularly to Cabinet and Cabinet Committees	Karen Sharp, Head of Public Health Commissioning
A robust quality assurance system is in place, and a quality dashboard regularly monitored	Deputy Director of Public Health

Action Title	Action Owner	Planned Completion Date
Ensure procurement timetable is clear, and, where times need to change, that the impact of changes are quickly communicated	Karen Sharp, Head of Public Health Commissioning	01/07/2016
Ensure regular updates reported to committee on performance and commissioning strategy	Karen Sharp, Head of Public Health Commissioning	29/07/2016
Regular quality meetings and robust quality process followed as routine	Deputy Director of Public Health	29/07/2016

Risk ID	PHD 03	Risk Title	Health Inequalities			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Analysis of health inequalities in Kent shows that health outcomes are much worse in the most deprived decile areas in Kent These areas have high rates of premature mortality (deaths occurring under the age of 75 years) due to causes such as cardiovascular disease, respiratory disease and alcohol-related disease and cancer; causes that are strongly linked to unhealthy behaviours such as poor diet, physical inactivity, smoking and excessive alcohol. The average life expectancy in the most deprived decile areas in Kent is 76 years for men and 80 years for women, compared to 83 years and 86 years respectively in the most affluent areas.	The risk is that whilst health is improving in general, the health of these communities would not improve at the same rate as that of less deprived communities	These inequalities will lead to rising health and social care costs for the Council and its partners, amongst those groups least able to support themselves financially	Andrew Scott-Clark, Director Public Health	Possible (3)	Significant (3)
				Target Residual Likelihood	**Target Residual Impact**
				Possible (3)	Moderate (2)

Control Title	Control Owner
Analysis is focussed on the measurement and monitoring of health inequalities with an emphasis on providing partners and commissioners with clear and unambiguous messaging on 'call to action'.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory
Mind the Gap strategy in place, including work with partners, such as District Councils and Clinical Commissioning Groups to coordinate efforts to tackle health inequalities	Andrew Scott-Clark, Director Public Health
Commissioning takes account of health inequalities when developing service-based responses. For example, Health trainers have a target to work with 62% of people from the most deprived wards	Deputy Director of Public Health
Use of Public Health England campaigns and behaviour change tools, targeting areas identified through *Mind*	Karen Sharp, Head of Public Health Commissioning

the Gap Analysis		
Action Title	**Action Owner**	**Planned Completion Date**
Work with commissioned communications agencies to ensure that campaigns are targeted effectively, and that they take account of the behavioural insights produced as part of the consultation exercise on the health improvement model, and the clustering of unhealthy behaviours	Karen Sharp, Head of Public Health Commissioning	29/07/2016
Ensure that transformed services take account of need to address health inequalities	Deputy Director, Public Health	30/08/2016
Use latest release of Indices of Multiple Deprivation data, alongside Kent Public Health Observatory data to identify areas of health inequality	Andrew Scott-Clark, Director Public Health	30/05/2016
Use new analysis to ensure that the *Mind the Gap* action plan is effectively targeted	Andrew Scott-Clark, Director Public Health	30/09/2016

Risk ID	PHD 05	Risk Title	Information Governance			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**	
With New Ways of Working, flexible working and increased information sharing across agencies, there are increased risks in relation to data protection. The Public Health Observatory has access to NHS data to allow it to deliver its statutory responsibilities. The success of health and social care integration, and the effective delivery of services in partnership, is dependent upon organisations being able to share information across agencies	This could lead to breaches of the Data Protection Act if protocols and procedures are not followed.	Health sector would be reluctant to share data in future, or would not be encouraged to deliver joint or integrated services	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory	Possible (3)	Significant (3)	
				Target Residual Likelihood	**Target Residual Impact**	
				Possible (3)	Moderate (2)	

Control Title	Control Owner
Caldicott Guardian in place for Public Health and Caldicott Guardian Guidance and register in place. The Caldicott Guardian officers have regular formal meetings and there is a structured and clear process for reporting serious breach incidents via the Caldicott support network.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory
Information governance requirements are included as part of standard contracts with providers, where relevant. Annual Information Governance Statement completed by all contracted providers.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory Karen Sharp, Head of Public Health Commissioning
Authority-wide group in place to provide strategic leadership on Information Governance.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory

Clause in employment contracts requiring compliance with data protection requirements.	Andrew Scott-Clark, Director Public Health
Information-sharing agreements and protocols for specific projects are in place.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory
E Learning training for staff to raise awareness.	Andrew Scott-Clark, Director Public Health
All projects need to have information protocols and agreements where information is to be shared across agencies.	Gerrard Abi-Aad, Head of Health Intelligence PH Observatory

Action Title	Action Owner	Planned Completion Date
All staff to undertake, and keep up to date with, training on information governance and data protection	Andrew Scott-Clark, Director Public Health	30/05/2016

Risk ID	PHD 06	Risk Title	Business Disruption			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
Possible disruption to services	Impact of emergency or major business disruption on the ability of the Division and its contracted service providers to provide essential services to meet its statutory obligations	Such an event would impact on the customers of our services and possibly the reputation of the service would suffer	Andrew Scott-Clark, Director Public Health	Possible (3)	Moderate (2)
				Target Residual Likelihood	**Target Residual Impact**
				Possible (3)	Moderate (2)

Control Title	Control Owner
Business continuity planning forms part of the contracting arrangements with private and voluntary sector providers	Karen Sharp, Head of Public Health Commissioning
Business Continuity plans reviewed annually or in light of significant changes or events.	Andrew Scott-Clark, Director Public Health
Business Continuity Systems and Procedures are in place	Andrew Scott-Clark, Director Public Health Karen Sharp, Head of Public Health Commissioning

Risk ID	PHD 07	Risk Title	Managing and working within the market			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**	
Managing and working with the market for Public Health services, many of which have not been market tested before.	Public Health contracts out to the market for its service delivery. Danger that there is a limited market for these services	Challenge in obtaining best value or innovation required to improve and develop services	Karen Sharp, Head of Public Health Commissioning	Possible (3)	Significant (3)	
				Target Residual Likelihood	**Target Residual Impact**	
				Possible (3)	Moderate (2)	

Control Title	Control Owner
Public Health commissioning function in place to ensure robust commissioning process is followed	Karen Sharp, Head of Public Health Commissioning
Commissioning strategies have been developed for the two major areas of change, and consulted upon extensively with Cabinet Committees and partners.	Karen Sharp, Head of Public Health Commissioning
Regular meetings with provider and representative organisations (Local Medical Council, Local Pharmaceutical Council). Regular 'meet the market' events to support commissioning processes	Karen Sharp, Head of Public Health Commissioning
Opportunities for Joint Commissioning in partnership with key agencies and cross-directorate (health, social care) being explored.	Karen Sharp, Head of Public Health Commissioning

Action Title	Action Owner	Planned completion date
Work with partners to understand long-term need, and identify areas for joint commissioning	Karen Sharp, Head of Public Health Commissioning	29/07/2016

Risk ID	PHD 08	Risk Title	CBRNE Incidents and communicable diseases			
Source / Cause of risk	**Risk Event**	**Consequence**	**Risk Owner**	**Current Likelihood**	**Current Impact**
The Council, along with other Category 1 Responders in the County, has a legal duty to establish and deliver containment actions and contingency plans to reduce the likelihood, and impact, of high-impact incidents and emergencies. The Director of Public Health has a legal duty to gain assurance from the National Health Service and Public Health England that plans are in place to mitigate risks to the health of the public, including outbreaks of communicable diseases e.g. Pandemic Influenza. Ensuring that the Council works effectively with partners to respond to, and recover from, emergencies and service interruption is becoming increasingly important in light of recent national and international security threats and severe weather incidents.	Failure to deliver suitable planning measures, respond to and manage these events when they occur.	Potential increased harm or loss of life if response is not effective. Increased financial cost in terms of damage control and insurance costs. Adverse effect on local businesses and the Kent economy. Possible public unrest and significant reputational damage. Legal actions and intervention for failure to fulfil the County Council's obligations under the Civil Contingencies Act or other associated legislation.	Andrew Scott-Clark, Director Public Health	Possible (3) **Target Residual Likelihood** Possible (3)	Serious (4) **Target Residual Impact** Serious (4)

Control Title	Control Owner
Kent Resilience Forum has a Health sub-group to ensure co-ordinated health services and Public Health England planning and response is in place	Andrew Scott-Clark, Director Public Health
The County Council, jointly with Medway Council Public Health Department, maintains an on-call rota on behalf of and with Public Health England to ensure preparedness for implementing the Scientific, Technical	Andrew Scott-Clark, Director Public Health

Advisory Cell (STAC) in the event of a major incident with implications for the health of the public.	
KCC and local Kent Resilience Forum partners have tested preparedness for chemical, biological, radiological, nuclear and explosives (CBRNE) incidents and communicable disease outbreaks, in line with national requirements. The Director of Public Health has additionally sought and gained assurance from the local Public Health England office and the NHS on preparedness and maintaining business continuity	Andrew Scott-Clark, Director Public Health
The Director of Public Health works through local resilience forums to ensure effective and tested plans are in place for the wider health sector, to protect the local population from risks to public health.	Andrew Scott-Clark, Director Public Health

From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 10 May 2016

Subject: **Work Programme 2016/17**

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 2016/17.

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)

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
Drugs and Alcohol Action Team (DAAT)

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 2016/17

3.1 An agenda setting meeting was held on 16 March 2016, 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 2016/17.

6. Background Documents
None.

7. Contact details

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Last updated on: 19 April 2016

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE – WORK PROGRAMME 2016/17

Agenda Section	Items
12 JULY 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	• **Recommissioning of Infrastructure Support to the Voluntary Sector** • **'Mind the Gap'** – key decision • **Integrated Domestic Abuse Support Services (now part of the Housing-Related Support Review)**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Update on Care Act implementation** – 6 monthly • **Employment of Vulnerable Adults** – added at 3 Dec agenda setting • **Community Mental Health and Wellbeing Service** (6months after start of contract) • **Update on next stage of CQC consultation** – July or later? • **Update on suicide prevention campaign for men under 45** • **Report on patterns of cannabis smoking in Kent and how to address this**– requested at 10 March • **Alcohol Strategy – outcomes of previous Strategy, start of prep of new Strategy** • **Accommodation Strategy – gaps in funding and provision in parts of the county** (requested by Mrs Brivio, 19 April 2016)
D – Monitoring	• **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard** 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	• **Local Account Annual report** – Final version for Members' comment prior to publication – October or December? • **Decision on the Short Breaks Service**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Report back on operation of Kent Drug and Alcohol Services contract (6m after start)** • **Update on next stage of CQC consultation** – if not in July
D – Monitoring	• **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	• **Local Account Annual report** – Final version for Members' comment prior to publication (if not in October)
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly*
D – Monitoring	• **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard** to alternate meetings • **Work Programme**
E – for Information, and	

Last updated on: 19 April 2016

Decisions taken between meetings	
26 JANUARY 2017	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Budget Consultation and Draft Revenue and Capital Budgets** • **Update on Care Act implementation – 6 monthly** • **Update on Public Health Transformation** • **Cabinet Member's Priorities for the 2017/18 Directorate Business Plan** •
D – Monitoring	• **Work Programme**
E – for Information, and Decisions taken between meetings	
14 MARCH 2017	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Draft Directorate Business Plan** • **Strategic Risk report** • **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** to alternate meetings • **Work Programme**
E – for Information, and Decisions taken between meetings	

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

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

To: Adult Social Care and Health Cabinet Committee – 10 May 2016

Subject: **16/00039** - **FINANCIAL ARRANGEMENT TO PLACE A LEGAL CHARGE ON A PROPERTY OF A SERVICE USER ACCESSING DOMICILIARY CARE -** DECISION TAKEN OUTSIDE THE CABINET COMMITTEE MEETING CYCLE

Classification: Unrestricted

FOR INFORMATION ONLY

Summary: A decision was required to allow Kent County Council to place a legal charge, at the request of the service user's Court of Protection-appointed Deputy, on the property that this individual currently resides in.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **NOTE** that the following non-key decision was taken by the Cabinet Member for Adult Social Care and Public Health, in accordance with the decision-making process set out in Appendix 4 Part 6 of the Constitution, and on advice from Democratic Services.

16/00039 - Financial arrangement to place a legal charge on a property of a service user accessing domiciliary care (Appendix 1)

1. Introduction

1.1 In accordance with Appendix 4 Section 6 of the Constitution, and on advice from Democratic Services, this decision did not meet the County Council's criteria for a key decision and was not appropriate for consideration or comment by a Cabinet Committee as it followed on from a recommendation made by a social care review panel regarding the care arrangements for an individual service user.

1.2 The decision needed only to be published for a period of five clear working days before being taken, and for a further five clear working days for the call-in process. There were no comments and questions raised by Members on the proposed decision, and no requests to call in the decision once taken. The decision therefore became implementable on 20 April 2016.

1.3 The signed record of decision and the supporting report are appended to this report.

2. Decision 16/00039 - Financial arrangement to place a legal charge on a property of a service user accessing domiciliary care.

2.1 A decision was required to allow Kent County Council to place a legal charge, at the request of the service user's Court of Protection-appointed Deputy, on the property that this service user currently resides in. The reason for doing so is that a Best Interests Review meeting had determined that it is in the service user's general best interest for the current preferred provider to continue to provide care and support in the service user's own home rather than in a care home.

2.2 Currently the universal Deferred Payment scheme does not allow discretion to apply the scheme to someone receiving care and support at home, therefore an individual member decision was required.

3. **Recommendation**: The Adult Social Care and Health Cabinet Committee is asked to **NOTE** that the following non-key decision was taken by the Cabinet Member for Adult Social Care and Public Health, in accordance with the decision-making process set out in Appendix 4 Part 6 of the Constitution, and on advice from Democratic Services.

16/00039 - Financial arrangement to place a legal charge on a property of a service user accessing domiciliary care (Appendix 1)

4. Background documents:

None.

5. Report Author

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KENT COUNTY COUNCIL – RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	16/00039

For publication

non- key Cabinet Member decision*

Subject: FINANCIAL ARRANGEMENT TO PLACE A LEGAL CHARGE ON A PROPERTY OF A SERVICE USER ACCESSING DOMICILIARY CARE

Decision:

As Cabinet Member for Adult Social Care and Public Health, I agree to the request to place a legal charge on this service user's property on the basis that this is an individual decision and is in no way regarded as setting any precedent.

Reason(s) for decision:

A decision is required to allow Kent County Council to place a legal charge, at the request of the service user's Court of Protection-appointed Deputy, on the property that this individual currently resides in. The reason for doing so is that a Best Interests Review meeting had determined that it is in the lady's general best interest for her current preferred provider to continue to provide her care and support in her own home rather than in a care home. Currently the universal Deferred Payment scheme does not allow discretion to apply the scheme to someone receiving care and support at home, therefore an individual decision is required.

The assessed needs of this service user can be met in a care home at the Kent County Council guide price of £487.42 per week, although, in practice, the typical cost of a nursing home place in West Kent is about £603 per week. However, the best interest decision makers agreed that it is preferable for the service user to be cared for at home at a cost of £1,000 per week. This is £512.58 per week above the Kent County Council guide price for residential care. The service user does not have the liquid assets to fund the extra £512.58 per week and so her Deputy has asked the County Council in writing to fund this on a temporary basis and place a legal charge on the service user's property, as a security for the loan, to cover the shortfall in the cost of care at home. Kent County Council would be able to recoup the amount owed to the Council when the property is later sold.

Kent County Council Legal Services have confirmed that nothing in the Care Act 2014 expressly prohibits or permits this arrangement. However, alternative types of financial arrangement that are similar to deferred payments for non-residential care are envisaged within section 36 of the Care Act 2014, regarding 'alternative financial arrangements'. Kent County Council also has a general power of competence under section 1 of the Localism Act 2011 and this arrangement could be exercised under that provision. It is confirmed that this arrangement does not expose Kent County Council to any risk under the consumer credit legislation.

Cabinet Committee recommendations and other consultation:

None. This decision does not meet the County Council's criteria for a key decision and is not appropriate for consideration or comment by a Cabinet Committee as it follows on from a recommendation made by a social care review panel regarding the care arrangements for an individual service user. The decision need only be published for period of five clear working days before being taken, and for a further five clear working days for the call-in process.

Any alternatives considered:

It is likely that if the request for the temporary financial arrangement is not approved, the service user may have to go into a care home.

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

signed

12 APRIL 2016

date

Decision No. 16/00039

From: Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing

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

Subject: **FINANCIAL ARRANGEMENT TO PLACE A LEGAL CHARGE ON A PROPERTY OF A SERVICE USER ACCESSING DOMICILIARY CARE**

Classification: Unrestricted

Summary: A decision is required to allow Kent County Council to place a legal charge**,** at the request of the service user's Court of Protection-appointed Deputy, on the property that this individual currently resides in. The reason for doing so is that a Best Interests Review meeting has determined that it is in this individual's best interest for her current preferred provider to continue to provide her care and support, in her own home rather than in a care home. Currently the universal Deferred Payment scheme does not allow discretion to apply the scheme to someone receiving care and support at home, therefore an individual decision is required.

Recommendation: The Cabinet Member for Adult Social Care and Public Health is asked to **AGREE** to the request to place a legal charge on this service user's property on the basis that this is an individual decision and is in no way regarded as setting any precedent.

1. Introduction

1.1 The request is to allow an elderly lady in her 90s who suffers from dementia and lacks mental capacity to be looked after in her own home, even though her assets put her well above the capital threshold for financial support from the public purse. The Court of Protection-appointed Deputy confirmed on 3 July 2014 that the home had recently been valued at £350,000, and that the lady had £4,500 savings, as at the same date. The property is not currently subject to any mortgage or legal charge. The equity in the property could not be released at the moment.

1.2 This lady has been receiving care and support from a provider which is no longer on the Kent County Council's contractor framework, following the implementation of the new domiciliary care contract re-let. It is the view of the best interest decision makers that, for reasons of continuity of care, and in the lady's general best interests, it is preferable for her to remain at home with the current provider and the level of care package.

1.3 The outcome of the recent assessment/review concluded that a care home placement will meet her assessed needs, however, the best interest decision making process considered that her preference, as an expressed choice via the Deputy appointed to look after her affairs, is to continue to live at home.

1.4 The assessed needs of this service user can be met in a care home at the Kent County Council guide price of £487.42 per week, although, in practice, the typical

cost of a nursing home place in West Kent is about £603 per week. However, the best interest decision makers have agreed that it is preferable for the service user to be cared for at home at a cost of £1,000 per week. This is £512.58 per week above the Kent County Council guide price for care homes. The service user does not have the liquid assets to fund the extra £512.58 per week and so her Deputy has asked the Council in writing to fund this on a temporary basis and place a legal charge on the service user's property as a security for the loan, to cover the shortfall in the cost of care at home. As a result, Kent County Council would be able to recoup the amount owed to the Council when the property is later sold. A financial assessment carried out in April 2015 determined her assessed contribution to be £149.44 per week. Thus the amount being loaned will be £512.58 per week, as KCC is liable to pay the remaining £337.98.

2. Policy context

2.1 The Care Act 2014 does not expressly prohibit or permit this arrangement. However, alternative types of financial arrangement that are similar to deferred payments for non-residential care are envisaged within section 36 of the Care Act 2014, regarding 'alternative financial arrangements'. Furthermore, Kent County Council has a general power of competence under section 1 of the Localism Act 2011 and this arrangement could be exercised under that provision.

2.2 The policy position is that the value of a person's home is not taken into account in the financial assessment for non-residential services, in others words it is disregarded. However, the request, if approved, will result in Kent County Council placing a legal charge on the service user's property, as a security for the loan to cover the shortfall in the cost of care at home. Kent County Council would subsequently recoup the amount owed to the Council when the property is later sold.

2.3 Kent County Council's Legal Services have confirmed that, with the agreement of the Court of Protection-appointed Deputy, acting on behalf of this service user, Kent County Council can enter into this agreement by way of a legal charge to be placed on the property of the service user. The Legal Department has also confirmed that this arrangement does not expose Kent County Council to any risk under the consumer credit legislation.

2.4 The property has been valued at £350,000 and we understand that there are no mortgages or other outstanding charges secured on the property. It is understood that, as at 19th May 2014, there was sufficient equity in the property to fund the amount of top-up for just under 13 years. That is subject to any decrease or increase in the value of the property as a result of property market fluctuation or damage to the property, and subject to any other charge being placed on the property prior to this present legal charge being placed. Kent Legal Services will confirm the detailed information before the agreement is signed.

2.5 It is likely that, if the request for the temporary 'financial arrangement' is not approved, the service user may have to go into a care home.

2.6 This decision does not meet the County Council's criteria for a key decision and is not appropriate for consideration or comment by a Cabinet Committee as it follows on from a recommendation made by a social care review panel regarding the care arrangements for an individual service user. The decision need only be published for

period of five clear working days before being taken, and then for a further five clear working days to allow for the call-in process, as set out in the County Council's published decision making procedure rules.

3. Recommendation

3.1 Recommendation: The Cabinet Member for Adult Social Care and Public Health is asked to **AGREE** to the request to place a legal charge on this service user's property on the basis that this is an individual decision and is in no way regarded as setting any precedent.

4. Relevant Officers

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