ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 12th November, 2025

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 12 November 2025 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Ruth Emberley**
Telephone: **03000410690**
ruth.emberley2@kent.gov.uk

Membership (13)

Reform UK (9):	Ms I Kemp (Chair), Mr A Kibble, Mr R Mayall, Mr S Dixon, Mr M Brown, Mrs B Porter and Mr T L Shonk *(plus 2 vacancies)*
Liberal Democrat (1):	Mr C Sefton
Conservative (1):	Mr A Kennedy
Green (1):	Mr S Jeffery
Labour (1):	Ms C Nolan

UNRESTRICTED ITEMS

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

1 Introduction/Webcasting Announcement

2 Election of Vice Chair of the Committee

3 Apologies and Substitutes

4 Declarations of Interest by Members in items on the agenda

5 Minutes of the meeting held on 10 September 2025 (Pages 1 - 10)

6 Verbal Updates by Cabinet Member, Corporate Director and Director of Public Health

7 Adult Social Care and Health Complaints Report 2024/2025 (Pages 11 - 26)

8 Annual Report on Quality in Public Health (including Annual Complaints) (Pages 27 - 32)

9 Adult Social Care Performance Dashboard Quarter 2 2025/2026 (Pages 33 - 50)

10 Adult Social Care Operational Pressures Escalation Plan 2025/2026 (Pages 51 - 86)

11 Accommodation Market Position Statement (Pages 87 - 112)

12 25/00094 Long Acting Reversable Contraception - Key Decision (Pages 113 - 132)

13 Work Programme (Pages 133 - 136)

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)

Benjamin Watts
Deputy Chief Executive (Monitoring Officer) 03000 416814

Tuesday, 4 November 2025

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

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Public Health Cabinet Committee held at Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 10th September, 2025.

PRESENT: Ms I Kemp (Chair), Mr A Kibble, Mr R Mayall, Mr S Dixon, Mr R Ford, Mr M Brown, Mr T Shonk, Mr D Burns, Mr C Sefton, Ms C Nolan and Mr S Jeffery.

ALSO PRESENT: Miss D Morton, Ms G Foster, Mr M Mulvihill

IN ATTENDANCE: Richard Smith (Corporate Director of Adult Social Care), Dr Ellen Schwartz (Deputy Director of Public Health), Helen Gillivan (Interim Director of Integrated Commissioning), Victoria Tovey (Assistant Director of Integrated Commissioning), Mark Albiston (Director for Adult Social Care), Simon Mitchell (Assistant Director for Adults Commissioning), Mark Scrivener (Head of Risk and Delivery Assurance), Helen Groombridge (Adult Social Care & Health Performance Manager,), Sarah Crouch (Public Health Specialist), Abenaa Gyamfuah-Assibey (Public Health Specialist), Chloe Nelson (Senior Commissioner), Georgina Walton (Digital and Innovation Lead) and Ruth Emberley (Democratic Services).

UNRESTRICTED ITEMS

16. Introduction/Webcasting Announcement
(Item. 1)

17. Apologies and Substitutes
(Item. 2)

Apologies were received from Mr Andrew Kennedy and Mr Oliver Bradshaw, with Mr Dean Burns substituting for Mr Bradshaw.

18. Declarations of Interest by Members in items on the agenda
(Item. 3)

There were no Member declarations of interest.

19. Minutes of the meeting held on 8 July 2025
(Item. 4)

RESOLVED that the minutes of the meeting which took place on the 8 July 2025 were a true and accurate record and a paper copy to be signed by the Chair.

20. Cabinet Member, Corporate Director and Director of Public Health Verbal Updates - No papers
(Item. 5)

1. The verbal update was presented by Miss Diane Morton (Cabinet Member for Adult Social Care and Public Health), Mr Richard Smith (Corporate

Director for Adult Social care) and Dr Ellen Schwartz (Deputy Director of Public Health)

2. Miss Morton provided the following update:

   a) Following World Suicide Prevention Day, the Cabinet Member took the opportunity to reflect on the work which had been carried out in Kent. The new Suicide Prevention grants had been awarded to several charities and social enterprises across the county.

   b) Kent was hosting the Baton of Hope on 22 September, which was the biggest anti-stigma campaign that the Kent Suicide Prevention Team had been involved in to date. The campaign involved a tour of the UK, and Kent had been chosen as one of the areas the baton would visit. Medway, Maidstone, Canterbury and Margate would all be involved.

   c) Community equipment supplier NRS ceased to operate at the end of July 2025. MedEquip took over the contract by 1 September 2025 and recruited staff, secured a facility, mobilised 57 vehicles, secured stock, handled 617 calls and completed 308 deliveries. Mr Simon Mitchell, the Commissioning Staff and Occupational Therapy Team were acknowledged and thanks given to their efforts during the transition period.

3. In answer to some Member questions and comments, the following was said:

   a) Several interventions were available for mental health, wellbeing and suicide, the Live Well Kent Service being one, as well as other commissioned specialist services. Other actions included the provision of work force training to identify signs that people may need support. Many of the services were reviewed on an annual basis to establish whether they could refresh delivery and operation.

   b) The Batton of Hope was welcomed as an important event in local schools and universities; several students would be attending the celebration and taking part to raise further awareness.

   c) NRS suffered a major cyberattack in 2024 however approximately 4-6 weeks prior to the organisation's collapse further issues with the company became apparent and a support package was sought. There were no other warning signs prior to this. The support package sought by NRS prior to closure was not granted as Kent County Council felt the assurance provided by the supplier was insufficient.

e) It was confirmed by the Cabinet Member for Adult Social Care and Public Health that she was working with colleagues in other areas across the country to shared ideas regarding the lack of funding available for Adult Social Care.

4. The Corporate Director for Adult Social Care, Mr Smith, provided the following update:

a) The most recent Association Director of Social Services (ADAS) survey returned results which confirmed the state of the market and finances were serious. The Casey Commission was scheduled to produced interim recommendations over the coming years however the directorate was still facing demand which outstripped resources available from central Government. Current demand for older people and younger adults was approximately 10-12%, however the funding formula was approximately 4%.

b) Ms Helen Gillivan was welcomed into the post of Interim Director of Integrated Commissioning. Thanks and best wishes were expressed for Richard Ellis who left Kent County Council.

c) High temperatures of the summer had caused an increase on stress on resources for the Adult Social Care Directorate and thanks was expressed to staff who worked hard to keep the services going.

d) Artificial Intelligence tool Magic Notes had successfully been piloted and would be rolled out over the next few months to wider parts of the team. This product would help with the assessment process and productivity.

5. The Deputy Director of Public Health, Dr Ellen Schwartz provided the following update:

a) An increased focus had been placed on infection prevention control, working in particular with community settings and care homes to increase the standard of infection prevention control.

b) A series of pandemic planning exercises had been conducted in preparation for the next pandemic.

c) Work concerning the Building Blocks of Health had been carried out across the Council to support health and environment work; this included many initiatives such as working with the Kent Housing Group and the Coastal Region Programme.

d) The statutory pharmaceutical needs assessment was due for publication in late September 2025.

e) An expansion and development of a supervised tooth brushing programme for 3–5-year olds in deprived areas was due for

launch in late 2025. A SEND (Special Education Needs) Health Needs Assessment was due for completion for this project.

f) The Kent Public Health Observatory had developed some key data resources to inform Planning and Commissioning directorates of the Joint Strategic Needs Assessment and Specific Health Needs Assessments.

g) The development of a centre of excellent in research and innovation was currently underway, with Kent County Council being viewed as an attractive training location, with 27 trainees in the Public Health department, this calendar year.

h) Improvements arounds the pathways for substance misuse treatment were underway, in addition to work on improving service users' experienced for replacement treatment, by working to identify an alternative to methadone.

i) Gambling was a new area to Public Health and work was going to be conducted with national investment from the end of 2025 to progress this.

j) Significant work had been carried out in conjunction with KMPT (Kent and Medway Partnership Trust) as well as other mental health providers in order to improve services across the board.

k) A needs assessment was conducted last year in relation to sexual health services and work was being conducted to improve the support available. This included the development of a new sexual health clinic in Dover.

l) On integrated commissioning, the Public Health Service Transformation programme continued to improve services. A new therapeutic support service for children and young people aged 4 to 19 year who required mild to medium emotional support had been procured. A new infant feed service had also been procured, as well as the development of the Cyber Sanctuary Initiative to protect survivors of domestic abuse from digital stalking and cybercrime.

6. In answer to Member questions and comments, the following was said:

a) It was confirmed that Public Health worked primarily with the UK Health Security Agency who were responsible for monitoring emerging diseases. Dr Schwartz confirmed that imported diseased were highly unlikely to cause a pandemic; this would more likely arise due to a novel agent meeting a population who was not immune.

b) Kent and Medway were a low Tuberculosis endemicity areas, although nationally there was a recognised increase. Close work continued with partner agencies to ensure pathways were robust and that systems from prevention to treatment worked effectively together. In relation to measles, it was confirmed

that once infection levels were at the expected level of 95%, transmission could not happen and therefore even if people were not vaccinated, they would not become ill. However, vaccination rates were decreasing both globally and locally. It was confirmed that Chickenpox could lead to prolonged illness and therefore a vaccination scheme rollout against Chickenpox was being supported.

7. RESOLVED Members noted the verbal updates.

21. Performance Dashboard - Adult Social Care

(Item. 6)

1. The item was presented by the Adult Social Care & Health Performance Manager, Ms Helen Groombridge.

2. The report was taken as read however some of the key points were highlighted as follows:

    a) Adult Social Care continued to operate under high and increasing levels of demand, although the service had been able to deliver an increased number of Care Needs Assessments and reviewed the Care and Support Plan and people in enablement services.

    b) Adult Social Care received and concluded the highest rate of safeguarding concerns and inquiries in Quarter 1.

    c) With regard to the Key Performance Indicators (KPIs) none were rated red, 4 were rated amber and 3 rated green.

3. In answer to some Member questions and comments, the following was said:

    a) Just under 3% of people made further contact with the service after initial contact. Reasons for this included a change in care needs following initial contact or a change in information.

    b) It was clarified that the Kent Enablement Service (KES) and Kent Enablement at Home (KeaH) were both enablement services run by the Council, however KES focused on providing mental health support, inclusive of autistic spectrum needs and the Kent Enablement at Home service primarily assisted people with physical health needs. It was explained that people return to Adult Social Care for a variety of different reasons and so the model was built around trying to meet service user needs at the first point of contact, without committing to a long term package.

    c) A requirement for Care Needs Assessments increased in 2023 and 2024 onwards. It was evidence from September 2024 (to date) that the impact of previous changes had resulted in less

Care Act Assessments needed by the 24 long term community teams. Although new Care Act referrals had reduced, the team continued to generate the same level of Care Act Assessments as before.

d) Demand for Social Care came from 3 areas: discharge from hospital due to a health condition, access to preventative services in the community and children and young people entering the system. It was confirmed that that the increase for care increased every year.

4. RESOLVED Members noted the performance of services in Quarter 1 2025/2026.

22. Performance Dashboard - Public Health
(Item. 7)

1. The item was presented by the Assistant Director of Integrated Commissioning, Ms Victoria Tovey.

2. Ms Tovey took the report as read and highlighted the following key points:

a) Of the 14 KPIs, 7 were green, 2 were not available as data from the National Drug Treatment Monitory System was yet to be provided and 5 were amber.

b) Two of the amber rated KPIs were in the Health Visiting Service; although rag rated amber, performance was still higher than other neighbouring regions. The One You Kent Service (Lifestyle Service), Sexual Health Services and young person substance misuse service were all currently rated amber.

3. In answer to Member questions and comments, the following was said:

a) Additional Government funding had been provided to smoking cessation services; the Stop to Start grant had been provided and the funds utilised toward increased capacity. A commissioned dedicated outreach service to help more people to stop smoking had been commissioned, as well as the creation of a one-day seminar aimed at reaching people who may not engage in traditional stop smoking services, which had a strong evidence basis.

b) Vaping cessation presented a different set of difficulties in that it was a nicotine replacement product; however, it was recognised as an increasing problem. Work had been carried out with colleagues in trading standards to ensure no illegal products were imported and sold in Kent, in addition to proactive work with young people.

c) Sincere thanks was expressed to the effort involved in cross agency working which focused on the crackdown on illegal

vaping resulting in several successful operations throughout the county.

4. RESOLVED Members noted the performance of Public Health commissioned services in Quarter 1 2025/2026.

23. Risk Management: Adult Social Care
(Item. 8)

1. The item was presented by Head of Risk and Delivery Assurance, Mr Mark Scrivener, who drew Members' attention to the key points of the report.

2. In answer to Member questions and comments the following was said:

a) The Corporate Director for Adult Social Care, Mr Richard Smith, explained to Members that the directorate needed to look at how to reduce the current number of people who required expensive services. There were 4 Adult Social Care and Access Services and residents were signposted as much as possible, in line with the statutory requirement around information, advice and guidance. Investment had been made in enablement services to prevent care packages being put in place at the point of crisis as this has been proven to be unsustainable and costly.

b) If ongoing support and services were required then the directorate reviewed the most person-centred way of delivering this, as this often resulted in the most cost-effective way of meeting need.

c) Mr Smith explained that Community services had been rewired back into communities; integration had a structure based on health and care partnership footprint, joint working around learning disability services had demonstrated positive result and Kent had recently been held as an exemplar in hospital discharge in East Kent due to sustained improvement in performance. Kent was therefore doing all it could to integrate health services with citizens of Kent.

d) The Interim Director of Integrated Commissioning, Ms Helen Gillivan, confirmed that the directorate had co designed a market position statement around accommodation and close work had been carried out between the housing and district partners.

e) Mr Scrivener confirmed that, whilst the report was an annual item, there was an officer and Member dynamic throughout the year where risks were monitored and discussed. Other places such as the Governance and Audit Committee, Cabinet Committee and on occasion, the Scrutiny Committee, were also responsible for monitoring and reporting on risk.

3. RESOLVED Members considered and commented on the risk presented in the report

24. 25/00070 Parent and Infant Mental Health Service - Non Key Decision
(Item. 9)

1. The item was presented by the Senior Commissioner, Ms Chloe Nelson and Public Health Specialist, Abenaa Gyamfuah-Assibey.

2. Ms Assibey presented the key points to the Members regarding the non key decision.

3. There were no Member questions or comments.

4. RESOLVED that Members CONSIDERED and ENDORSED the proposed non significant key decision as set out in the Proposed Record of Decision (appendix A) to:

   A) APPROVE the additional expenditure of £400,000 across the contract period for the Parent Infant Mental Health Service from DFE Family Hub Grant and Public Health Grant to support venue costs.

   B) DELEGATE authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, to exercise relevant contract extensions and enter into relevant contracts or legal agreements; and

   C) DELEGATE authority to the Director of Public Health, to take other necessary actions, including but not limited to allocating resources, expenditure, and entering into contracts and other legal agreements, as required to implement the decision

25. 25/00054 Adult Social Care Prevention Framework - Key Decision
(Item. 10)

1. Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton, introduced the Adult Social Care Prevention Framework as a practical plan for years 2025 to 2035.

2. The item was presented by Public Health Consultant, Ms Sarah Crouch, who highlighted the key points to Members.

3. In answer to Member questions and comments, the following was said:

   a) Statutory services required protection although the Prevention Framework was a positive future step.

   b) Mr Smith explained that the directorate had a statutory duty under the Care Act to provide services which prevented, reduced and delayed the need for ongoing services as well as the need for people to access statutory services, as well as provide advice and guidance. How this would be accomplished

was set out in the Prevention Plan and any issues surrounding funding were a separate matter.

c) There has been an increase in individuals who required more complex support and care and consequently, this was costing more. The Prevention Framework aimed to support resident earlier on so need could be diverted.

d) The amount paid for services in 2021 had increased and would continue to do so, taking into account inflationary factors. Other factors such as increase in hospital discharge resulted in a cost pressure and without a preventative offer, residents would continue to reach out to Adult Social Care at a point of crisis.

e) The entirety of the Social Care budget comprised of central Government grants that had an inflation uplift each year, social care precept, contribution from business rates and other general Council Tax Funds. The issue arose from the fact that the budget did not increase each year and therefore did not meet demand.

f) Efforts to undertake recommissioning activities and to review large contracts were being made in order make sure they were fit for purpose and giving best value for money, in addition to meet the needs and demands of residents. It was confirmed that all recommissioned contracts would contain a preventative element.

4. RESOLVED that Members CONSIDERED and ENDORSED the proposed decision attached as Appendix A, on pages 97 – 99 of the report.

26. 25/00014 Wellbeing Services in the Community - Key Decision
(Item. 11)

1. The item was introduced by the Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton, who thanked officers for their extensive work on the project.

2. The item was presented by the Digital and Innovation Lead, Ms Georgina Walton. Ms Walton presented a slideshow to the Committee.

3. There were no questions or comments from Members.

4. RESOLVED that Members CONSIDERED and ENDORSED the proposed decision set out in the Proposed Record of Decision.

27. 25/00081 Wellbeing Services in the Community for Adults with Sensory Impairments - Contract Extension - Key Decision
(Item. 12)

1. The item was introduced by the Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton and presented by the Assistant Director for Adults Commissioning Mr Simon Mitchell. Mr Mitchell drew the key points to

Members' attention and confirmed that since the submission of the report, one of the subcontractor's names had changed and Mr Mitchell confirmed this would be amended in the paper before finalisation.

2. RESOLVED that Members CONSIDERED and ENDORSED the proposed decision as set out in Appendix A of the report.

28. Decisions Taken out of Committee Cycle
(Item. 13)

1. The item was presented by the Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton. The decision involved the community equipment supplier MedEquip taking over NRS contracts at the end of July 2025. As Members had already discussed this, it was by unanimous agreement to note the recommendation.

2. RESOLVED that Members noted that the following decision has been taken in accordance with process set out in Part 2 paragraph 12.36 of the Constitution:25/00055 - Kent Community Equipment Service - Direct Award of contract under Framework Y24008

29. Work Programme
(Item. 14)

1. The item was presented by Democratic Services Officer, Miss Ruth Emberley.

2. RESOLVED that Members noted the Work Programme.

From: Diane Morton, Cabinet Member for Adult Social Care and Public Health

Sarah Hammond, Corporate Director Adult Social Care and Health

To: Adult Social Care and Public Health Cabinet Committee – 12 November 2025

Subject: **ADULT SOCIAL CARE AND HEALTH ANNUAL COMPLAINTS REPORT 2024/2025**

Classification: Unrestricted

Summary: This report provides Members with information about the operation of the Adult Social Care and Health Complaints and Representations Procedure between 1 April 2024 and 31 March 2025

Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report.

1. Introduction

1.1 This report provides an overview of the operation of the complaints and representation procedure for Adult Social Care and Health during 2024/2025. The report includes summary data on the complaints, enquiries and compliments received during the year. It also provides examples of the actions taken and improvements made from complaints, which are used to inform future service delivery.

2. Policy Context and Procedures

2.1 The “Local Authority Social Services and National Health Service Complaints (England) Regulations 2009” places a duty on Local Authorities to have arrangements in place for dealing with complaints.

2.2 Associated with the Regulations, guidance was issued which outlines the three key principles of the procedure, **Listening** – establishing the facts and the required outcome; **Responding** – investigating and making a reasoned decision based on the facts/information and **Improving** – using complaints data to improve services and inform the business planning and commissioning processes.

2.3 Customer feedback provides an opportunity to improve our understanding of someone's journey into the service they experience. Investigations provide the opportunity to resolve concerns by putting remedies in place if an error has occurred. The procedure is flexible and puts the person at the heart of the investigation.

3. Total Representations received by Adult Social Care and Health (ASCH)

3.1 A total of **1064 complaints** were logged during 2024/2025 about services delivered or commissioned in relation to ASCH.

3.2 The number of **complaints** received during 2024/2025 has increased by 7% from the previous year. Enquiries saw a similar increase of 7% and Compliments also rose by 9%.

3.3 **375 complaints were rejected** following the initial assessment by the Customer Care and Complaints Team, these include where people raised concerns about services which were not for Kent County Council (KCC), where possible, people were signposted to appropriate organisations.

3.4 The percentage of people raising a complaint remains consistent from previous years at 1% in relation to the number of people receiving support from adult social care.

Year	Complaints received	% increase/ decrease on previous year	% of people or their representative raising a complaint
2024/2025	**1064**	**+7%**	**1%**
2023/2024	992	+4%	1%
2022/2023	958	+ 29%	1%

3.5 A total of **503 Enquiries** were received in 2024/2025, which is an increase of 7% on the previous year when we saw a significant increase. The majority of these Enquiries, (66%), were from MPs or Members on behalf of a constituent about an aspect of the service they received:

Year	Enquiries received	% increase / decrease
2024/2025	**503**	**+7%**
2023/2024	471	-11%
2022/2023	530	+ 43%

3.6 In 2024/2025, **604 compliments** were received which represents a 9% increase from the previous year. Compliments are equally useful in helping to identify areas of excellent service or good practice.

Year	Compliments received	% increase / decrease
2024/2025	**604**	**+9%**
2023/2024	553	+ 26%
2022/2023	439	+ 17%

3.7 In 2024/2025**, 175 informal concerns** were received which represents a 39% decrease from the previous year. Informal concerns are locally resolved, within a short period of time, usually within 24 hours, by the Customer Care and Complaints Team, in consultation with the operational service. Someone raising an informal concern is happy for it not to be progressed via the formal complaint route. In all cases we ensure people are aware of the right to escalate it through the formal route should they wish to at a later date.

Year	Informal concerns	% increase / decrease
2024/2025	**175**	**-39%**
2023/2024	286	+ 16%
2022/2023	247	+ 18%

3.8 An example of an informal concern, a neighbour raised concerns with us regarding the care of an elderly neighbour and the level of care they were receiving. Whilst we cannot let the neighbour know the outcome of our investigation, we referred it to the local team to investigate and take appropriate action.

4. Coroner's Inquest Requests

4.1 In 2024/2025 we managed **34** Coroner's requests. This is a decrease of 11% on the requests received in the previous year.

Year	Coroner Enquiries	% increase / decrease
2024/2025	**34**	**-11%**
2023/2024	38	+ 15%
2022/2023	33	- 25%

4.2 The Customer Care and Complaints Team manages the process to ensure effective communication, tracking and sign off between the Coroner's Office, ASCH operational teams and Invicta Law.

5. Compliance with standards

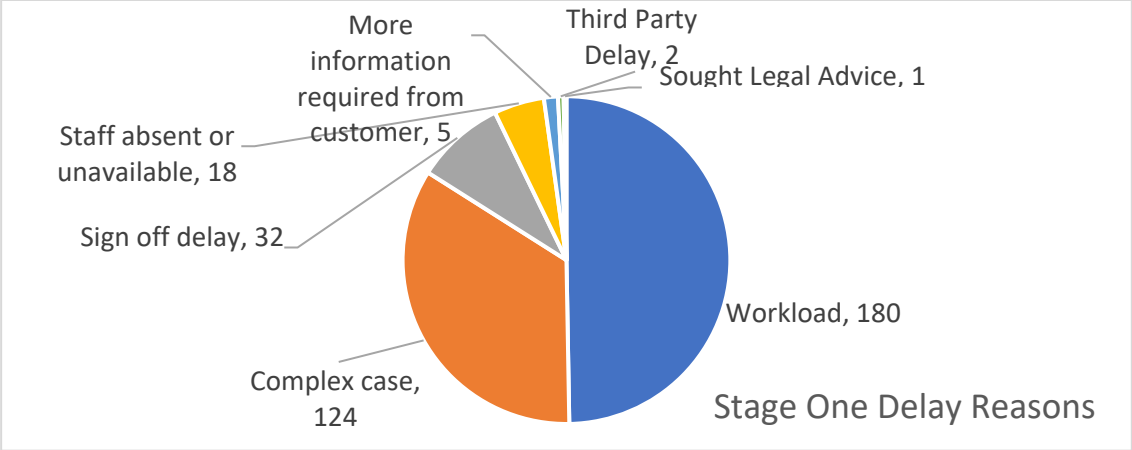
5.1 KCC aims to respond to 85% of complaints within KCC's Key Performance target of 20 working days. Some complaints can be complex due to a variety of reasons, this can include the need to consult with another team or a partner agency. Additional time is sometimes required to either meet with the person making the complaint or liaise with other agencies. When this happens, and with the agreement of the person making the complaint, an extension to the deadline is agreed; 21 complaints had their timescales extended during the year.

5.2 The response time achieved within the 20-day target was **60%** which was a 2% increase from the previous year.

Year	Complaints closed	% responded to within 20 days
2024/2025	**641**	**60%**
2023/2024	942	58%
2022/2023	906	71%

5.4 Delay reasons - The table below shows the overall delay reasons cited for not meeting the 20-day standard.

Stage 1 delay reason	**Total**	**%**
Workload	180	17%
Complex case	124	12%
Sign off delay	32	3%
Staff absent or unavailable	18	2%
More information required from customer	5	0%
Third Party Delay	2	0%
Sought Legal Advice	1	0%
Total	362	



6. Listening to people making complaints and methods of engagement

6.1 Managers investigating complaints within ASCH will routinely ring the person making the complaint to discuss their complaint. This discussion creates the opportunity to understand the impact of the complaint on the person and supports the preparation of the response to ensure all areas are covered. It also provides a contact person for the person making the complaint should further communication be required during the investigation.

6.2 Feedback is accepted in a variety of formats which allows people to complain in the way they feel most comfortable. The most popular way to make a complaint was via email at 50%, followed by self-service at 25%, then telephone at 19%. There has been an increase in take up of using email with small decreases in self-service and telephone.

Method	Total	%
Email	533	50%
Self service	263	25%
Telephone	197	19%
Contact Centre	39	4%
Post	28	3%
Online	2	0%
Social Media	2	0%
Total	1064	

7. Complaint outcomes

7.1 Each complaint is fully investigated, and a response letter sent to the person making the complaint with the findings and outcomes. Where complaints are upheld, the details of what has been done to put things right and an apology is offered. Some complaints lead to lessons being identified, both for the individual practitioner, or the wider service which offers reassurance the issue has been

taken seriously. A summary of the outcome of the complaints is recorded in the table below:-

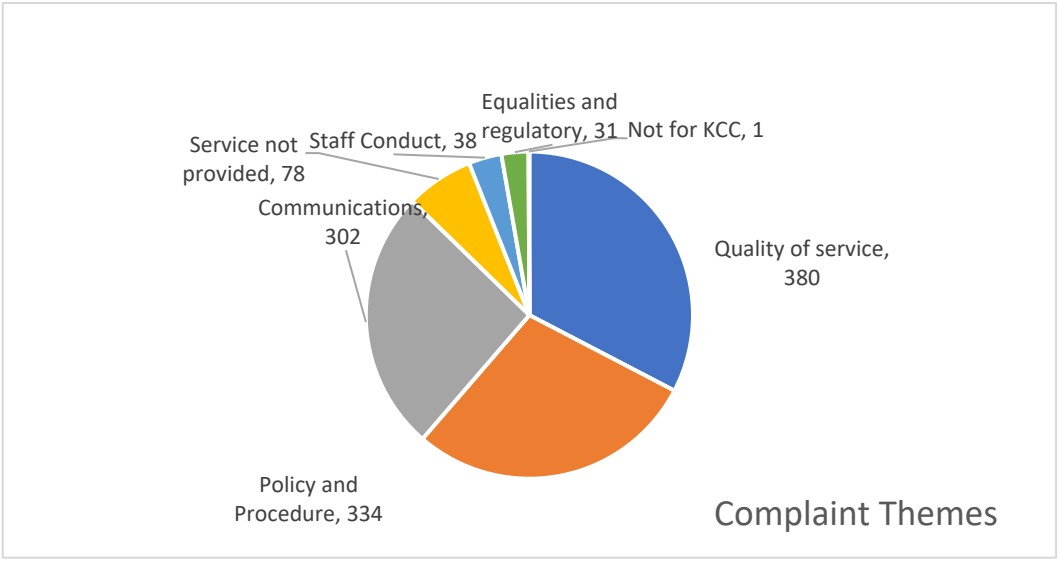
Year	Complaints closed	Upheld + partially Upheld	Not upheld	Resolved upon receipt/ withdrawn/suspended/ another procedure
2024/2025	**1072**	**49% (520)**	**23% (242)**	**29% (310)**
2023/2024	946	51% (481)	28% (264)	21% (201)
2022/2023	906	44%	27%	29%

7.2 Whilst the volume of complaints increased this year, the percentage of complaints upheld or partially upheld is 49% resulting in a decrease of 2% from the previous year.

7.3 There was an increase of complaints or concerns (29%) raised which were "resolved upon receipt" and which demonstrates flexibility is applied by the Customer Care and Complaints Team if a concern raised can easily be resolved without progressing to a full investigation, in agreement with the person making the complaint.

8. Themes identified arising from complaints

8.1 The reasons for complaints are shown below and categorised under the following main Corporate headings:-



Primary cause	Total	%
Quality of service	380	33%
Policy and Procedure	334	29%
Communications	302	26%
Service not provided	78	7%
Staff Conduct	38	3%
Equalities and regulatory	31	3%
Not for KCC	1	0%
Total	1164	

8.2 There were three main areas for complaints last year, these being issues with the quality of service delivered, issues arising from disagreements with policy and/or procedure and communications.

8.3 Complaints re communications cited issues such as unreturned calls, unanswered emails, and lack of updates on cases. People making a complaint explain this has caused frustration for them and their families, particularly in urgent situations.

8.4 In respect of complaints logged as policy and procedure, many complaints revolved around financial assessments, backdated charges, and disputed invoices. Common concerns include unexpected bills, incorrect calculations, and a perceived lack of transparency in financial processes. People and families cite they felt unsupported, and left in uncertainty about care plans, financial matters, and service changes.

8.5 Those complaints identified as matters relating to quality of service, highlighted delays in processing applications, such as Blue Badge renewals, care needs assessments, and financial assessments. Where people have felt the need to complain, they feel these delays often exceed the stated timelines, causing inconvenience to individuals who rely on these services.

8.6 Quality of service complaints also addressed issues with the quality of care provided, such as allegations of inappropriate behaviour by caregivers, and perceived unmet care needs.

9. Putting things right and Improving– creating opportunities

9.1 Feedback from complaint investigations provides a vital source of insight about people's experiences of adult social care and gives us the opportunity to put things right.

9.2 When a complaint is upheld often lessons or corrective actions are identified to remedy the specific complaint. Sometimes these corrective actions relate to issues

which are appropriate to share across all teams and other times they relate to an individual practitioner and the person is supported through supervision and training.

9.3 The lessons are shared with the Strategic Safeguarding, Practice and Quality Assurance Team so Key Messages are cascaded to all staff and Policies are reviewed and updated if appropriate.

9.4 A selection of some of the corrective actions are below:-

You said: That you wanted people's preferred method of communication to be captured and used by the service to contact you.	**We did:** We have asked practitioners to ascertain people's preferred method of communication at all stages of their support and intervention
You said: That you were not contacted regarding support for a relative, that the social worker was away and that you were getting no responses.	**We Did:** We have taken steps to improve case handover to ensure that when people leave the service their cases are transferred to new workers to maintain case progression. We reminded staff to update family members on the progress of cases, changes of worker and when plans change. And to document the reasons for case reallocation.
You said: That you had an assessment but you disagreed with the outcome, you felt that you were not listened to with regards to your reasoning. You were left without care an support for several weeks whilst we identified a suitable provider	**We did:** We continue to review our waiting times and seek to be proactive in ensuring that our residents' are assessed in a timely manner and care and support provided in a timely manner where care and support needs have identified following assessment. We reminded all staff of the importance of keep in regular contact to explain to them any difficulties we are encountering in terms of identifying suitable care providers for them.
You said: That when an emergency placement organised for your son, the social worker did not visit him for several weeks to check on him.	**We did:** We now have put in place guidance for staff that if young people need to move into emergency accommodation that has not been viewed/inspected prior to the move, the social worker or a member of the commissioning team must visit the property before the young person moves in. We have also issued guidance that when moving to new accommodation in an emergency situation, the young person will be visited in person at the property by the allocated social worker within one week of moving.

You said: That you were not informed of your right to request a Disability Related Expenditure Assessment (DREA) which meant that your relative would have received some additional assistance towards his care.	**We did:** Whilst there is no evidence that we miscalculated charges, we acknowledged that we did not provide information relating to DREAs and due to the oversight we waived charges.
You said: You were struggling with our lack of communication whilst you were also responsible for your mother's care	**We did:** We apologised for your experience. We also provided you with some information that may support you, including the option for a carer's assessment.
You said: You said there was a lack of communication and that the support plan had not been reviewed. Furthermore no one attended a multi-agency meeting.	**We did:** We reviewed our processes in relation to our overdue reviews and reflect on how we communicates when there is a delay in being able to respond to a request for a review into a change of needs. A review team was created to focus on overdue reviews. The team also reviewed risk management and prioritisation of cases.
You said: That your mother was entitled to financial support for her care and that due to her particular needs she is entitled to care under Section 117 as per KCC's policy.	**We did:** On reviewing your mother's case we recognised that the policy had not been applied correctly. The complaint highlighted that there was a lack of knowledge in this team's understanding of the S.117 policy**.** A training session will be arranged to address this.

Top 10 remedy actions undertaken:-

Action	Total	%
Formal apology	207	26%
Discuss at team meeting	114	14%
Arrange staff training or guidance	97	12%
Provided service requested	94	12%
Change or review communications	80	10%
Financial remedy	66	8%
Explanation	51	6%
Change or review policy or procedure	32	4%
Review contract or partner arrangements	12	2%
Change or review service	11	1%

10. Financial implications

10.1 In 2024/2025 a total of £239,680.60 was paid to people making a complaint as gesture of goodwill payments, financial settlements or reimbursement. This figure includes £161,337.38 paid as a result of Local Government and Social Care Ombudsman (LGSCO) investigations during this period. This increase is due to an historical case closing with a remedial cost of £114,721.36.

10.2 Gesture of goodwill payments made up £15,452.69 of the total amount which was paid in recognition of the impact of errors or where a delay had occurred which resulted in some injustice to the person we support or their family, time and trouble and distress and uncertainty caused. The majority of the gesture of goodwill payments were under £500 and were in line with the financial remedy guidance set out by the LGSCO as part of complaint resolution.

10.3 The financial reimbursements, waivers and other payments (without the above historical case) made up £55,218.73 and relate to where errors occurred over charges, where someone was charged incorrectly, where families were not informed about the need to pay for a service, a miscommunication about a charge, or where services did not meet the required standard.

10.4 The majority of payments relate to waive fees rather than payments. The payments without the historical case saw an increase of 53% on the previous year. The service has been more proactive in identifying issues early on in the process at stage one. This has included reimbursing people for care not received, waiving charges or where charges should not have been applied.

10.5 Time and trouble payments which are frequently applied by the Ombudsman, are often now applied by the service where appropriate. This helps to resolve issues earlier and avoid unnecessary escalation of issues. Time and trouble payments are

typically in between £100 and £500 and are issued in line with the LGSCO's guidance.

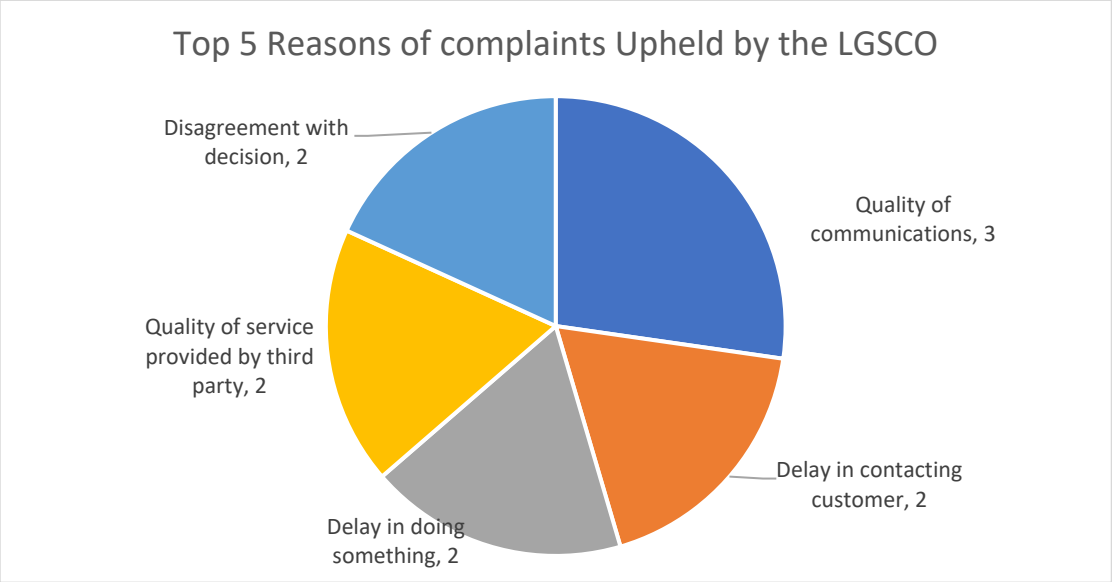
11. Complaints received via the Local Government and Social Care Ombudsman

11.1 The second stage of the complaints process is the Local Government and Social Care Ombudsman (LGSCO). Following an Initial Enquiry and request for documents, the LGSCO then gives the Council four weeks to respond to a Full Investigation request and we have responded to all enquiries within agreed timescales.

11.2 A total of 47 complaints, (4%), of all complaints received, were progressed to the LGSCO. The table below shows 18 cases were fully investigated by the LGSCO and a decision was issued. This is a decrease of 33% on the previous year. Of those investigated, the LGSCO found fault and upheld 13 cases, five were not upheld. 23 were closed because, following initial enquiries and explanation or information provided, the LGSCO felt there would be no wider public benefit to a full investigation and required no further action or they were out of jurisdiction. six were premature to the Ombudsman and were progressed as new complaints by KCC.

Upheld	Not upheld	Closed: out of jurisdiction/no further action or withdrawn	Premature	Total
13	5	23	6	47

11.3 The diagram below demonstrates the top five causes of the upheld LGSCO complaints



Causes of Upheld Complaints	Total	%
Quality of communications	3	23
Delay in contacting customer	2	15
Delay in doing something	2	15
Quality of service provided by third party	2	15
Disagreement with decision	2	15

11.4 The LGSCO issues an Annual Letter to KCC which summarises the activity with them and highlights any issues for the coming year. There has been a change in approach in recent years with the LGSCO selecting cases where it is considered to be more in the public interest to investigate. This has resulted in the overall number of upheld complaints increasing nationally across all services. The upheld rate for KCC adult social care is 72% of complaints, in comparison to 78% nationally for Adult Social Care complaints.

11.5 ASCH has taken forward the agreed remedies set out by the LGSCO which need to be implemented and include sending apology letters to the person we support or their family, offering financial remedies, reviewing policies or procedures in recognition of the error and staff training. All recommendations have been taken forward.

11.6 A summary of each Decision can be found on the LGSCO's website at the following link SearchResult - Local Government and Social Care Ombudsman

12. Improvements to the process

12.1 A training programme has been offered for staff on the complaints process, conducting a complaint investigation and writing a response. We have continued to roll these out over the course of the year, supporting the service in conducting robust investigations.

12.2 The customer feedback team has begun to review processes to identify how we can best support services in responding to feedback in a timely manner. This work has continued into 2025/2026.

13. Compliments

13.1 Compliments have increased by 9% in the last year and cover a wide range of topics. The below table demonstrates the themes compliments are categorised as.

Row Labels	Count of Primary cause
Delivery	423
Customer care	125
Good Staff Attitude	27
Quality	18
Availability of staff	5
Prompt response	2
Accessibility	1
Quality of communication	1
Other	2
Grand Total	604

13.2 Those compliments related to **Delivery,** covered exceptional support and assistance, compassionate and caring staff, teamwork and collaboration, actions which made a difference and professionalism.

13.3 Those categorised as **Customer care**, included expressions of gratitude and appreciation for staff, the support received for relatives and their families, the quality of care received, positive impact on lives and professionalism.

13.4 Compliments relating to **good staff attitude**, covered thanks for compassion and support received, support and assistance in various scenarios, communication with families, positive impact on individuals and welcoming environments created by staff.

14. Recommendations

14.1 Recommendations: Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **COMMENT** on the content of this report.

15. Background Documents

None

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 12 November 2025
Subject:	**Public Health Annual Quality Report For 2024/25**
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None

Summary: This report covers the year 2024 to 2025. It provides an update on the actions Public Health has taken since the recommendations made in the 2022/2023 report to maintain the promotion of high quality, safe effective services which provide a positive experience for people who use our services.

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the content of this report.

1. Introduction

1.1 This Public Health Quality Annual Report 2024–2025 provides an overview of the quality assurance and governance processes currently in place, and those under development, to ensure the delivery of high-quality Public Health services.

1.2 A comprehensive review of quality processes in Public Health was conducted in May 2023, focusing on commissioned services. This resulted in 13 key recommendations for improvement.

1.3 This report outlines the current quality assurance mechanisms and provides updates on progress made in response to the recommendations. Key areas of improvement include recruitment, the development of a Public Health Quality Assurance Framework, and the revision of the Patient Safety Incident Policy.

2. Background

2.1 Integrated Commissioning and the Public Health Team leads the commissioning of Public Health services. Quality is considered at all steps of the commissioning cycle, from needs assessment to service delivery. Commissioners, as well as public health consultants and specialists are involved throughout the commissioning cycle. Existing processes are in place, as described below, to ensure services are safe, effective and provide a positive experience for people who use our services.

2.2 Quality in Commissioned Services

2.2.1 Public Health services are commissioned in response to the findings of the statutory Joint Strategic Needs Assessment (JSNA) and additional needs assessments. The quality of the JSNA is monitored by qualitative feedback from Kent County Council (KCC) partners, in particular NHS services.

2.2.2 Public Health consultants and specialists collaborate with commissioners to develop service specifications. These specifications include essential quality elements such as safeguarding requirements, staff qualifications, regulatory registrations (such as with CQC), adherence to national standards and guidance, audit and data monitoring obligations.

2.2.3 Public Health commissioning has processes in place which facilitate the commissioning of services which are safe, effective and provide a positive experience for people who use our services. All procurements follow the KCC policy 'Spending the Council's Money', which complies with applicable procurement legislation.

2.2.4 Public Health specifications require the below policies to be in place as a minimum:

- Safeguarding Children Policy (to include Child Sexual Exploitation, Criminal Exploitation of Children, Missing Persons, Radicalisation)
- Safeguarding Adults Policy (dependant on commissioned service)
- Equalities and Diversity Policy
- Health and Safety Policy
- Whistleblowing Policy
- Supervision and Performance Management Policy
- Governance/Clinical Governance
- Information Governance/Data Management
- Complaints (and complements) policy
- Incidents and Serious Incident reporting

2.2.5 During mobilisation of a newly commissioned service, Public Health commissioners or the Commercial and Procurement Division (depending on value) check procedures stated in policies are in place and of the required quality. The commissioners would check ongoing compliance through contract monitoring.

2.3 Quality Assurance Mechanisms

2.3.1 Each commissioned service is assigned a named contract manager who works closely with providers to monitor service quality. Formal contract meetings are held regularly to review Key Performance Indicators (KPIs), incidents, workforce levels, complaints demand/waiting lists and user satisfaction/ feedback. Agreed actions documented in meeting minutes and action plans.

2.3.2 Service provider contracts include the requirement to obtain the views and experiences of people who use these services and to show how these are used to improve the provision of services. Feedback from other user groups and

insight work is also shared to support continuous improvement. There is a new requirement for providers to incorporate the NHS Integrated Commissioning LEEF (Lived Experience and Employment Framework) into service delivery.

2.3.3 The contracts also include the requirement to audit specific activities at set intervals. The results of these surveys and audits are shared and discussed at governance or contract meetings as appropriate.

2.3.4 Public Health staff contribute to multi-agency work led by relevant organisations such as the NHS. This includes safeguarding (children and adults), Child Death Overview Panels, Domestic Homicide Reviews, Suicide Prevention Real-Time Surveillance, and the Controlled Drug Local Intelligence Network.

2.4 Quality Improvement and Learning

2.4.1 The Public Health Service Transformation Programme

2.4.2 The Public Health Service Transformation Programme started in the summer of 2023 and included a detailed review of individual services including quality indicators and assurance processes. In 2025, several key decisions were taken to enable recommissioning of multiple services. The programme is expected to complete in March 2026.

2.4.3 Serious Incidents

2.4.4 Serious Incidents provide an opportunity to learn, improve, and develop services. Public Health has a system in place for reporting serious incidents, reviewing them, learning from them, and applying that learning. This process, including the reporting mechanisms, was reviewed and improved in 2020. It is currently undergoing a further review to refine the requirements and incorporate the new Patient Safety Incident Reporting Framework. The process clearly defines the responsibilities of Public Health Consultants, Contract Managers, providers, and Commissioning and Commercial Assistants, along with timelines for each step.

2.4.5 The serious incident process links with the death in service process.

2.4.6 Public Health leads and chairs a serious incident learning panel renamed recently as the Kent Drug and Alcohol Death Partnership to reflect the multiagency membership of the group. Case studies of reported deaths are brought to the group and discussed openly resulting in suggestions of how improvements can be made.

2.4.7 Complaints, Compliments and Comments

2.4.8 Any complaints, compliments and comments about Public Health Services received are dealt with by either the programme lead or commissioner who will liaise directly with the service it relates to. These are discussed at the relevant meetings; lessons are learnt, with any agreed actions implemented to improve services.

2.4.9 All public Health complaints, compliments and comments are included in the Adult Social Care and Health Complaints Report, which is shared with the Cabinet Committee annually.

2.4.10 The table below details the number of complaints, compliments and comments received during 2024/2025 within Public Health.

Case type	Total
Complaints: • One you services – Weight management • Suicide prevention phone line	2
Comments • Distribution of NHS promotional material. • Sexual Health Services phone line	2
Member Enquiries • Sexual Health services in East Kent	1
General Enquiries • Floride in Water • Sewage outage (redirected to Environmental Agency)	2
Compliments • Public Health Champions course feedback	1
Total Cases	8

2.4.11 No complaints required escalation to be resolved.

3. Quality Process recommendations

3.1 The 2023 quality processes review identified several areas for improvement. These include:

- Recruitment of a Quality Lead to lead and oversee quality
- Re-establishing a Public Health Quality Committee
- strengthening assurance processes for the JSNA
- Undertaking targeted audits of services
- Enhancing equity assessments for access, uptake, and outcomes
- Implementing a Professional Development Policy for Public Health
- Reviewing and improving complaints and compliments processes
- Strengthening the serious incident process for timely and holistic analysis

4. Annual Update

4.1 Quality Assurance roles

4.1.1 In line with the 2023 recommendations, the Public Health Quality Lead was recruited in September 2024.

4.1.2 A decision was taken not to re-establish the Quality Committee and to produce the Quality Assurance Framework instead, with the addition of Quality Assurance as a standing item to the Public Health Senior Management Team meeting agenda for senior leadership oversight.

4.2 The Public Health Quality Assurance Framework

4.2.1 To systematically address the 2023 recommendations, development of the Public Health Quality Framework was initiated. The framework aims to set out how Public Health services and the wider function of public health in Kent are quality assured. A draft is in place and will be used to address gaps identified from the 2023 quality process review.

4.2.2 Governance of the framework will be overseen by the Public Health Senior Management Team.

4.2.3 The Public Health Quality Assurance Framework is expected to be completed early 2026.

4.3 Management of Patient safety incidents

4.3.1 Patient safety incidents are currently managed under the Serious Incident Framework 2015. This system was last updated in 2020.

4.3.2 A new national framework, the Patient Safety Incident Response Framework (PSIRF), was introduced in 2022. It shifts focus of patient safety incidents from blame-focused investigations to learning-focused responses.

4.3.3 Work has begun to review and align Kent's incident management system with PSIRF, including updates to the digital reporting system. Revision of the current Serious Incident reporting policy has begun and is expected to be implemented by April 2026.

5. Conclusions

5.1 The 2023 review led to 13 recommendations for quality improvement which are being addressed through recruitment, governance changes, the Transformation Programme and framework development.

5.2 The development of the Public Health Quality Assurance Framework is underway to ensure consistent quality across integrated commissioning and other public health functions. The framework will be used to address the gaps identified and recommendations listed from the 2023 quality process review.

6. Recommendations

6.1 The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** the content of this report.

7. Background Documents

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/809305/Quality_in_public_health_shared_responsibility_2019.pdf

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Sarah Hammond, Corporate Director Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 12 November 2025
Subject:	**ADULT SOCIAL CARE AND HEALTH PERFORMANCE Q2 2025/2026**
Classification:	Unrestricted
Previous Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary:
This paper provides the Adult Social Care and Public Health Cabinet Committee with an update on adult social care activity and performance during Quarter 2 (July to September) for the financial year 2025/2026.

Contacts and safeguarding concerns were at their highest levels for two years in Quarter 2, with the number of people supported with a mental health need continuing to increase.

Adult social care was able to reduce the number of people with an open care needs assessment, care and support plan review or with an open safeguarding enquiry, despite the incoming safeguarding demand. The volume of Deprivation of Liberty Safeguards applications were higher than completions, an ongoing trend.

Of the seven Key Performance Indicators, four were RAG rated Green, with ASCH4, people at home 91 days after discharge having received enablement, moving from Amber to Green. None of the indicators are RAG rated Red, with all remaining continuing to be RAG rated Amber.

Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of adult social care services in Quarter 2 2025/2026.

1. Introduction

1.1 A core function of the Cabinet Committee is to review the performance of services which fall within its remit. This report provides an overview of the Key Performance Indicators (KPIs) for Kent County Council's (KCC) adult social care services. It includes the KPIs presented to Cabinet via the KCC Quarterly Performance Report (QPR).

1.2 The full suite of KPIs is attached as Appendix 1.

2. Overview of Performance

2.1 When a person makes contact with adult social care for the first time, they will be assisted by one of four area-aligned Adult Social Care Connect Teams, who will look to offer advice and guidance to those people making contact, and signposting them to available resources in their local area where appropriate. In Quarter 2, 8,441 people made contact with Adult Social Care Connect, a 12% increase on the previous quarter and the highest volume seen for over 2 years. Contacts saw the highest activity in July, with 3,368 people making contact, 19% more compared to July 2024.

2.2 One of the key aims of the Adult Social Care Connect Team is to avoid the contact being 'repeated' by ensuring that the person's queries are met with the appropriate solution. In Quarter 2, only 3% of contacts were from people who had made contact in the previous 3 months (ASCH 1) the same percentage seen in the previous 2 quarters. The measure continues to be RAG rated Green, below its target of no more than 5%.

2.3 After a contact is received a person may be assessed as needing to have a Care Needs Assessment (CNA), which is carried out to ascertain their eligibility under the Care Act for further support from the local authority. In Quarter 2, 4,320 requests for CNAs were made, continuing an ongoing downward trend. In the same period, 4,326 assessments were completed which led to the number of people with an incomplete assessment falling slightly. The number of people with an incomplete assessment is 500 fewer than the same quarter last year.

2.4 When completing a CNA, adult social care aim to complete the assessment within 28 days. On occasion, completion of an assessment can take a longer period while we work with the person to establish their care needs and for the person to be confident and happy with the outcome. In Quarter 2, 77% of CNAs were delivered within 28 days (ASCH 2) the highest proportion seen in the last two years. Although a 2% increase in comparison to Quarter 1, the measure remains RAG rated Amber as it is below the 85% target.

2.5 There are three externally commissioned carers' organisations across Kent who support carers with carrying out carers' assessments and offering information, advice and guidance (IAG) to those identifying as caring for others. In Quarter 2, 735 referrals were received by carers' organisations and 1,138 carers were supported with an assessment or IAG (includes people from

previous quarters). This quarter saw a 58% increase in completed carers' assessments compared to Quarter 1.

2.6 If a person is assessed as being eligible for care and support as a result of their CNA, they will receive a care and support plan that details how their unmet needs are to be met. This is a written record of what is included in their care and is agreed and signed by the person in receipt of support. At the end of Quarter 2, 17,065 people had an active care and support plan. This figure has remained at around 17,000 for the past five quarters.

2.7 As part of their care and support plan it may be assessed that a person's needs are best met, through the provision of a package of care. This can be arranged in a variety of ways including through a Direct Payment (DP), a homecare service or in a residential or nursing home setting. In Quarter 2, 2,761 new packages of care were arranged at an average weekly cost of £1,012. The annual price uplift given to providers to account for inflation leads to a sharper increase in averages between financial years. Just over a quarter of new packages in Quarter 2 were short term beds (26%), followed by homecare (21%) and direct payments (14%).

2.8 Once a new service has started, this will be reviewed at six-eight weeks and then an annual review is carried out. This is to ensure the care in place is appropriate and the person's assessed needs are being met. The number of people awaiting an initial review fell again in Quarter 2 to 1,238 as did the number of people waiting for their annual review to 4,681. Review completion remained at a high level in Quarter 2 – 17% higher than the same quarter last year.

2.9 Adult social care offers enablement services designed to work closely with the individual on setting personalised goals which will enable them to remain independent at home with no further support. These services are delivered through the Kent Enablement at Home (KEaH) service and the Kent Enablement Service (KES). During Quarter 2, 3,520 people engaged with these services. Demand for KEaH services has continued to increase for the 6th consecutive quarter, with 2,521 people receiving the service in Quarter 2. Meanwhile KES has seen a slight decrease when compared to Quarter 1, with 999 people.

2.10 For people who may not be able to receive enablement at home or may require a further period of assessment for long-term provisions, their needs can be met through short term support (six-eight weeks) in a residential or nursing setting, referred to as a short-term bed. This offer is mostly utilised for people on a hospital pathway to minimise the risk of them being readmitted to hospital. At the time of reporting, there were 1,479 people in a short term bed in Quarter 2.

2.11 A current local and national adult social care measure used to report on the effectiveness of enablement pathways from hospital is ASCH 4. In Quarter 1 adult social care saw a 2% increase in the number of people, over the age of 65, who remained at home 91 days after discharge from hospital into enablement/ rehabilitation services. In the last quarter, this measure has

reached the 85% target and as a result has been RAG rated Green (measure is a quarter in arrears due to the 91 day reporting period).

2.12 However, if it is assessed that a person's needs could no longer be met in their own home, they may require long term support in a residential or nursing service. For adults aged 18 to 64, 18 per 100,000 of the population have met this criteria (ASCH5), which is a slight increase on the previous quarter. Meanwhile, for older people (65 years and older) 558 per 100,000 of the population had their long term support needs met by admission to a residential or nursing care home (ASCH 6). Both of these measures remain RAG rated GREEN in Quarter 2.

2.13 In order to provide services, all residential and nursing homes are required to register with the Care Quality Commission (CQC), which has the responsibility for inspecting and rating all registered homes. In Quarter 2, 75% of people placed by adult social care in those homes had been rated Good or Outstanding by CQC (ASCH 7). This is the second consecutive quarter where the measure has met the floor threshold and has been RAG rated Amber.

2.14 In some cases, to meet a person's individual care and support needs, a DP is the best way for adult social care to support a person in maintaining their independence and giving them full control over the care they receive. In Quarter 2, the percentage of people in receipt of a DP continued at 25% (ASCH 3). This is above the floor threshold and remained RAG rated Amber.

2.15 Deprivation of Liberty Safeguards (DoLS) are legal protections under the Mental Capacity Act 2005 designed to ensure that those lacking mental capacity to consent to their care are not unlawfully deprived of their liberty when in a hospital or a care home setting. In Quarter 2, the DoLS Team received a further 2,469 applications bringing the current financial year total to 5,087 which is 3% less than the same period last year. The team has completed a further 2,179 DoLS applications during the quarter, bringing the overall total for the financial year to 4,427.

2.16 If someone is concerned about themselves or someone else being at risk of abuse or neglect, they are able to share this with adult social care by raising a safeguarding concern. Since the start of the financial year, adult social care has received 12,531 concerns out which 6,400 (51%) have come in during Quarter 2. This figure marks yet another highest total for a single quarter and continues an increasing trend for incoming concerns.

2.17 If it is assessed that the risk outlined in the concern meets the Section 42 criteria, a safeguarding enquiry will be carried out. A total of 1,360 concerns were converted into enquiries by the end of Quarter 2. Despite the increasing number of incoming concerns, this quarter marks the second consecutive decrease in the number of new enquiries, with a reduction of almost 2% when compared to Quarter 1.

2.18 Upon completion of Section 42 enquiry, adult social care is required to assess the identified safeguarding risk status to the person. The proportion of those

whose risk was removed (30%), risk reduced (57%) or risk remained (13%) have remained consistent when compared to previous quarters.

3. Conclusion

3.1 Contacts made to Adult Social Care Connect and safeguarding concerns received reached their highest levels in two years, highlighting continued levels of increased demand in adult social care. Levels of CNAs and care act review completions meant that less people had an outstanding assessment or review at the end of the quarter. Fewer people were awaiting completion of a safeguarding enquiry at the end of the quarter also. The number of people accessing provision with a mental health need grew and the number of DoLS applications were higher than DoLS assessment completions for another quarter.

3.2 The proportion of people who had their contact resolved and returned within three months continued to be RAG rated Green, alongside the proportion of people still at home 91 days after discharge from hospital and the long term needs of adults (both young adults and older people) met by admission to residential care; which moved in a positive direction after being RAG rated Amber last quarter. All other key measures are RAG rated Amber for a consecutive quarter without any substantial change in value.

5. Recommendation

5.1 Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of services in Quarter 2 2025/2026

6. Background Documents

None

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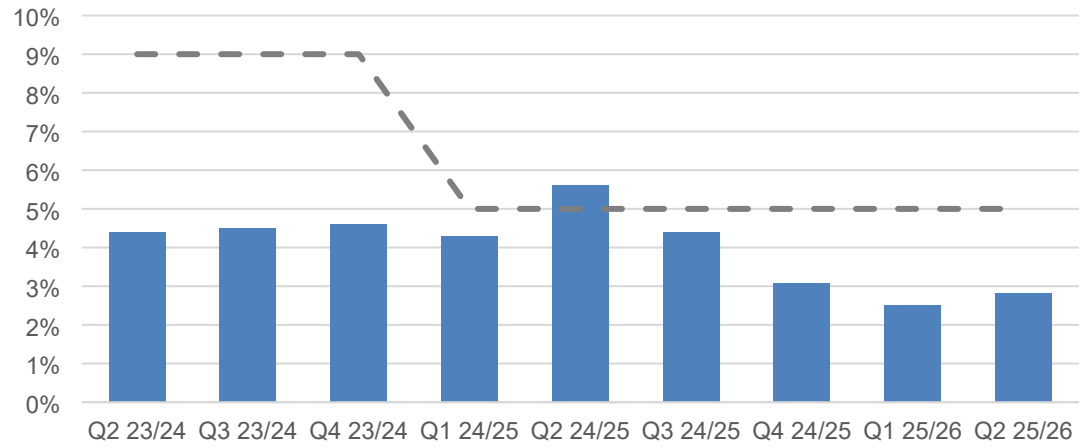
ASCH1: The percentage of people who have their contact resolved by Adult Social Care and Health (ASCH) but then make contact again within 3 months. **GREEN ⇩**



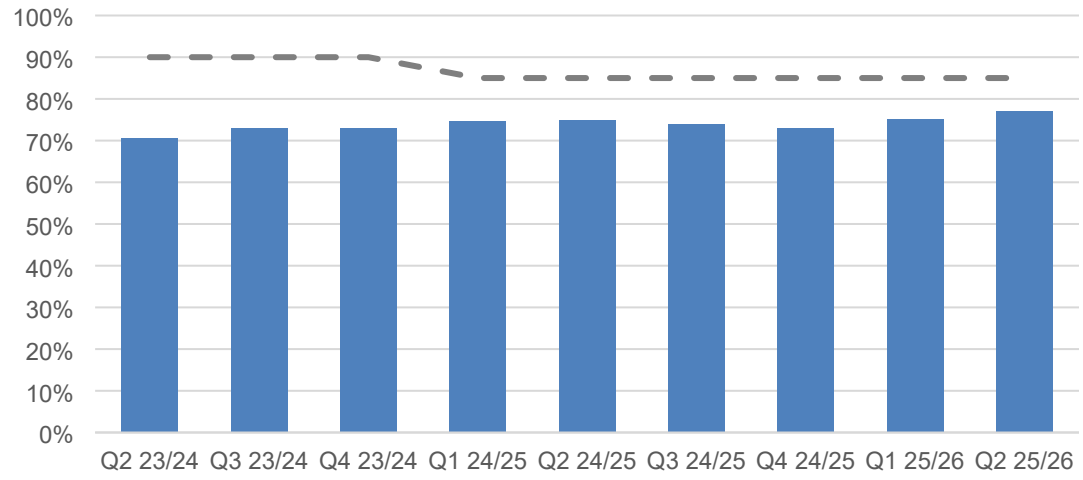
The % of people with their contact resolved who return within three months remains within target at 3%.

Work continues by the teams at the front door to ensure people are signposted and referred to other agencies or forms of support appropriately.

Reasons for making contact again with adult social care include where someone's needs have changed, or they are making contact for a different reason than their original contact.

(Target 5%, Upper Threshold 9%. Axis does not end at 100%)

ASCH2: The proportion of new Care Needs Assessments delivered within 28 days. **AMBER ⇧**



The % of Care Needs Assessments (CNA) completed within 28 days continues to increase, and is now at 77%, the highest % seen in two years.

All teams in adult social care work to ensure people receive timely CNAs so they can progress to the next steps in receiving the support they need.

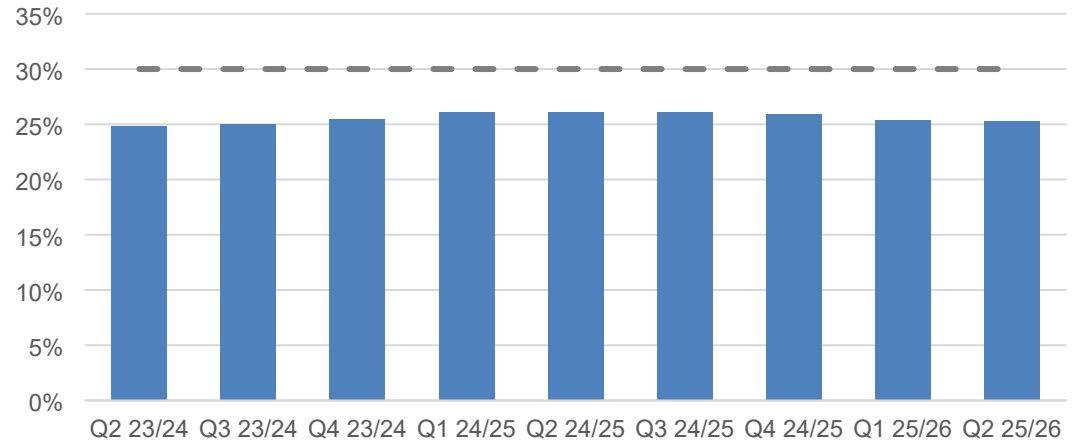
In some cases, CNAs can take longer as adult social care work with people to understand and establish their care needs, and for the person to be confident and happy to sign their assessment

(Target 80%, Floor Threshold 75%)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH3: The percentage of people in receipt of a Direct payment with Adult Social Care and Health

AMBER ⇔



Adult social care continues to see 25% of people with community services having a Direct Payment (DP).

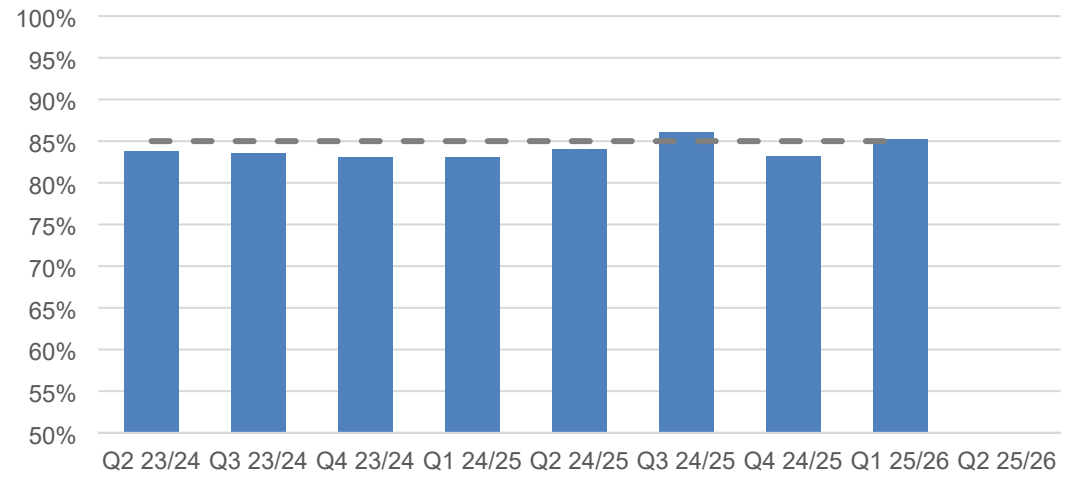
Although the % has remained the same, adult social care did see an increase in the number of people with Learning Disabilities with a DP.

Adult social care has seen increases in people receiving homecare services, as a community service this is counted in the denominator and impacts this KPI.

(Target 30%, Floor Threshold 24%. Axis does not end at 100%)

ASCH4: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

GREEN ⇧



Adult social care has met target on the number of people still at home 91 days after discharge for the second time in the past two years.

For Quarter 1 the best outcomes within this measure were for those accessing the Kent Enablement at Home Service.

(Target 85%, Floor Threshold 24%. Axis does not start at 0%
KPI runs in arrears to account for 91-day time frame)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
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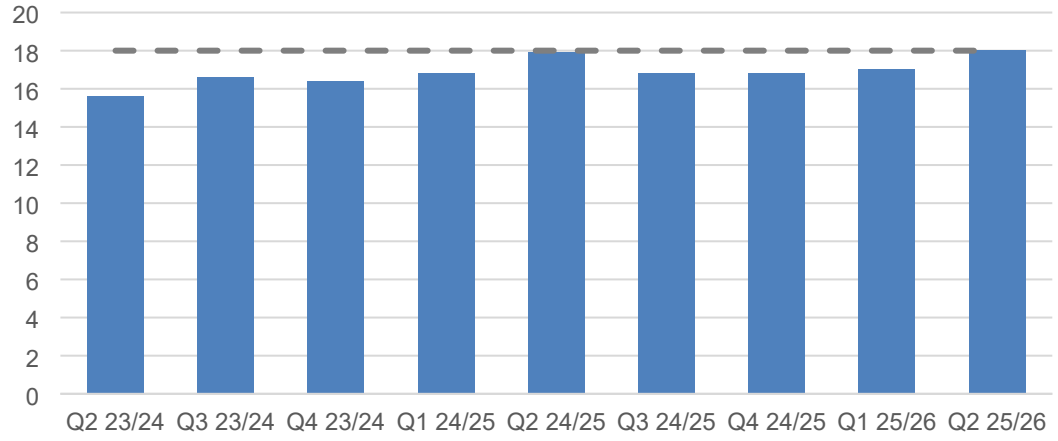
ASCH5: Long Term support needs of adults (18-64 years old) met by admission to residential and nursing care homes, per 100,000

GREEN ⇩



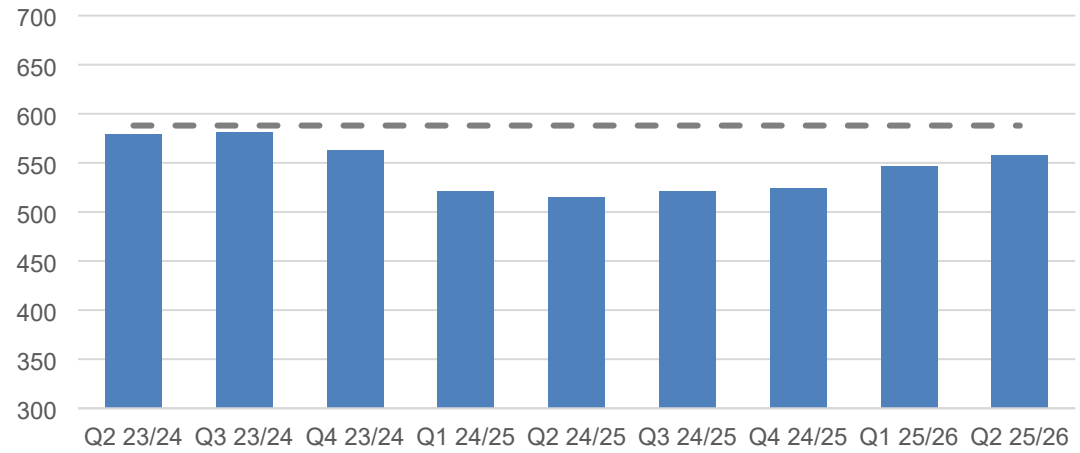
Adult social care continues to ensure only those aged 18-64 years who need to, have long term care in a residential or nursing care home do so. Whilst assessing and reviewing a person care and support needs, all enablement and community services are explored before a care home placement is made.

At 18 per 100,000 of the population, this KPI remains within target even with the increases experienced in Quarter 2.

(Target 18, Upper Threshold 22. Rate per 100,000.
Axis does not end at 100%. National ASC CLD method applied)

ASCH6: Long Term support needs of older people (65 and over) met by admission to residential and nursing care homes

GREEN ⇩



Adult social care has seen increases in those needing long term support in a residential or nursing care home for the last five quarters.

As with younger adults, all enablement ad community services are explored prior to a care home placement

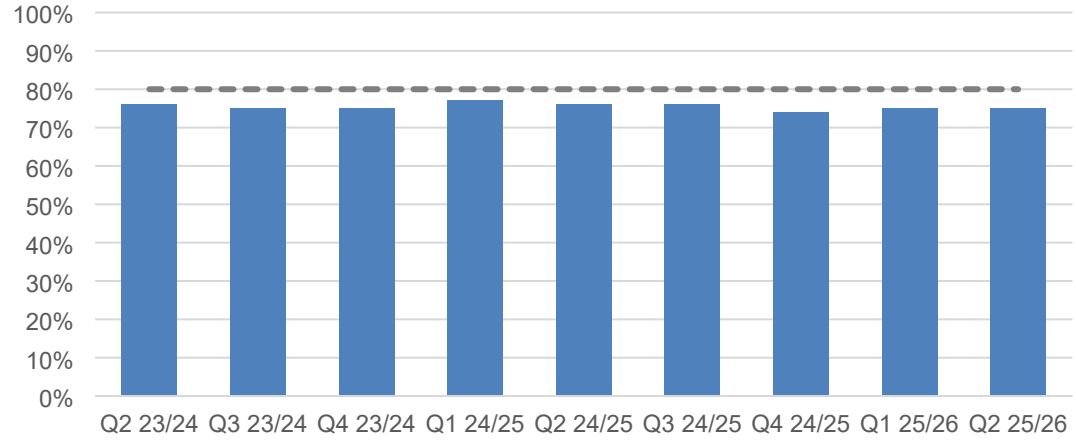
People who were former self-funders, so those who were already in a care home at time of assessment with adult social care due to becoming eligible for Local Authority support are included in the new starts, having not received services with us before.

(Target 588, Upper Threshold 617. Rate per 100,000. BCF Measure
Axis does not start of end at 100%, National ASC CLD method applied)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH7: The % of Kent Count Council (KCC) supported people in residential or nursing care where the Care Quality Commission rating is Good or Outstanding

AMBER ⇔

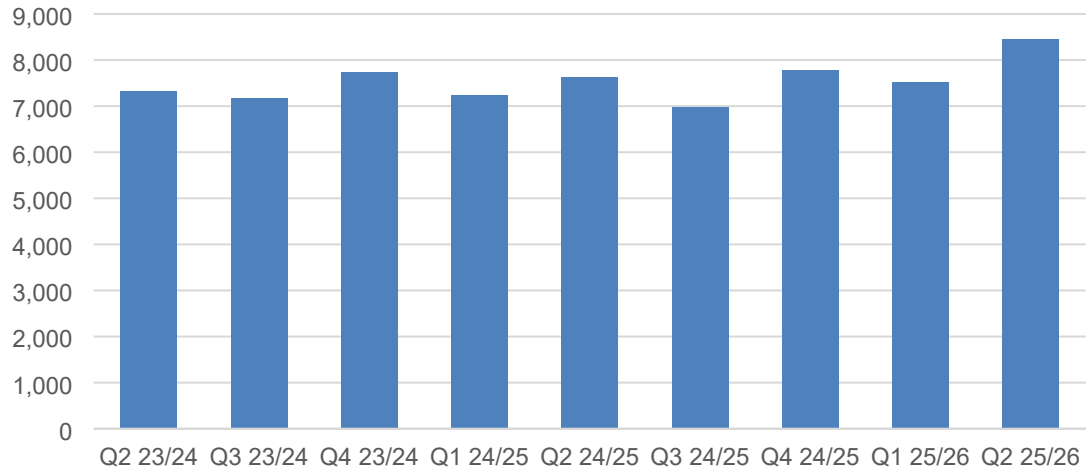


75% of those supported by adult social care in a care home rated Good or Outstanding by the Care Quality Commission.

The percentage of homes rated as inadequate remains at 2% but the overall number of them has fallen by 25

(Target 80%, Floor Threshold 75%. Corporate Risk Register CRR0015)

ASCH8: The number of people making contact with Adult Social Care Connect



The number of people making contact with the Adult Social Care Connect Team was over 8,400 in Quarter 2, this was a 12% increase on those in Quarter 1, and the highest volume seen for over 2 years.

Contact activity was at its busiest in July, with 3,368 people making contact. For comparison, only 2,824 people made contact in the same month last year.

(New measure for 2025/26 concentrating solely on the work or the ASC Connect Teams)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
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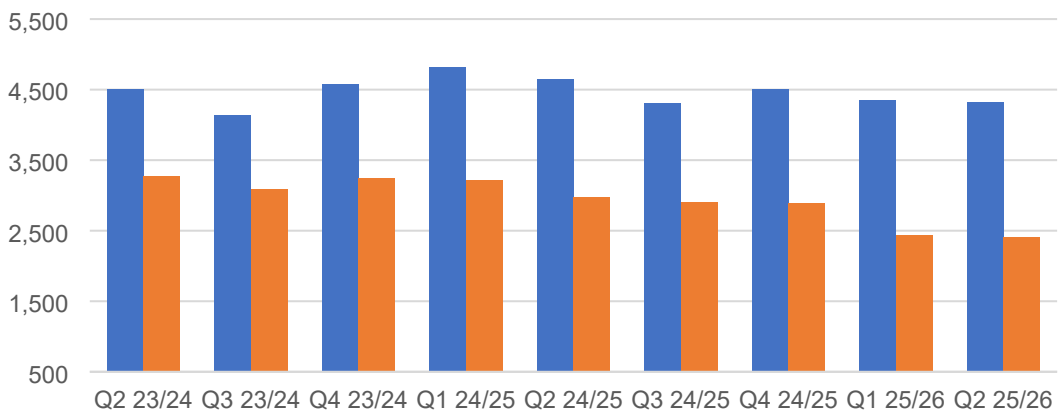
ASCH9: Care Needs Assessments



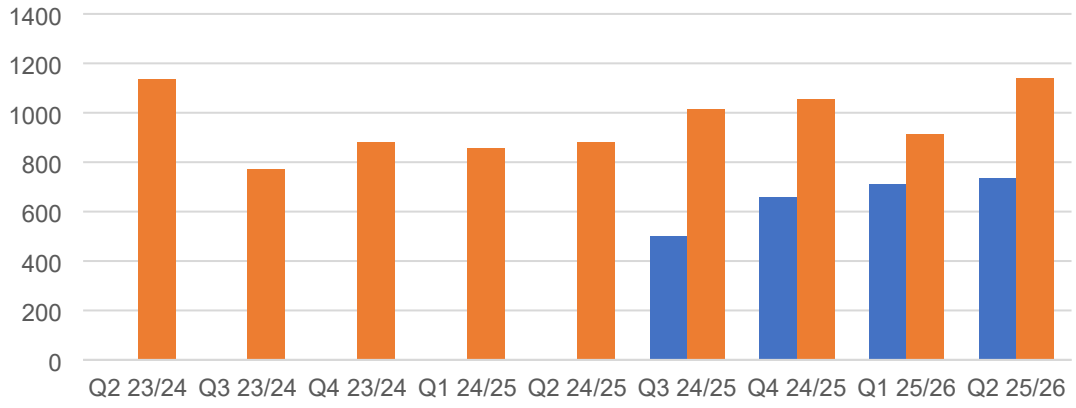
Adult social care had 4,320 CNAs incoming in Quarter 2,continuing an ongoing downward trend.

Adult social care completed 4,326 CNAs in Quarter 2, slightly more than was incoming. July 2025 saw the highest number of completions in 14 months.

The number of people awaiting completion of a CNA remained at same level of 2,400 compared to the previous month, but was 500 less than Quarter 2 last year.

(Blue – New assessments to be undertaken. Orange – Assessments needing to be completed. Axis does not start at 0)

ASCH10: Number of carer referrals to ASCH and those supported with IAG or an assessment



Carer referrals received increased for the 4th consecutive quarter.

531 carers 'assessments were completed in Q2, a 58% increase on the previous quarter, while a similar level of carers received information and advice as an outcome of their referral compared to the previous quarter.

(Blue – Carer referrals made.
Orange – Carer Assessments delivered or IAG provided)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
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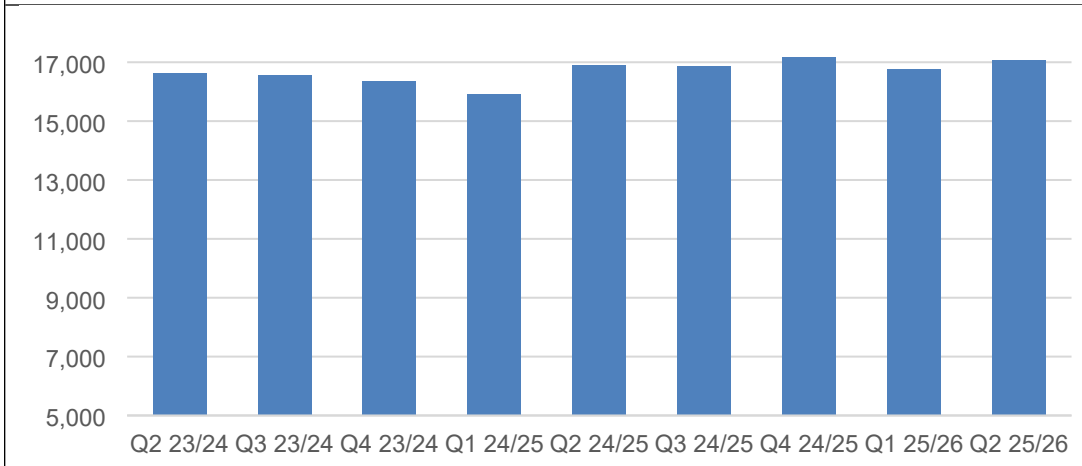
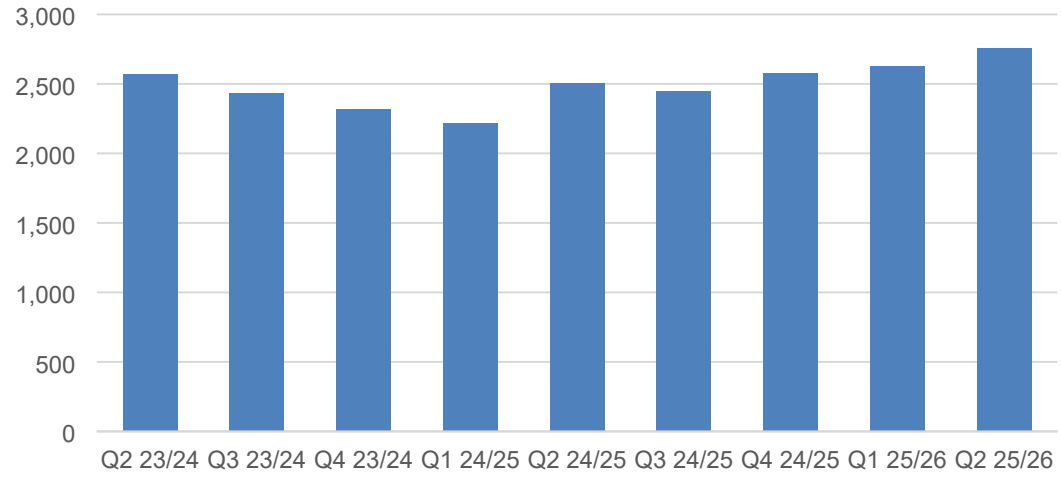
ASCH11: The number of people with an active Care and Support Plan at the end of the Quarter



The numbers of people with an active care and support plan remains relatively stable over the past five quarters, with over 17,000 people in Quarter 2.

(Axis does not start at 0)

ASCH12: The number of new support packages being arranged for people in the quarter



Over 2,700 new packages of care were arranged in Quarter 2, which is an increase on previous quarters, and currently follows a seasonal trend on increased packages in each Quarter 2.

Just over a quarter of new support packages were short term beds (26%), followed by Homecare (21%). Direct Payments were the third most common (14%) with day care and supporting independence services both around 8%.

(Corporate Risk Register CRR0015)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
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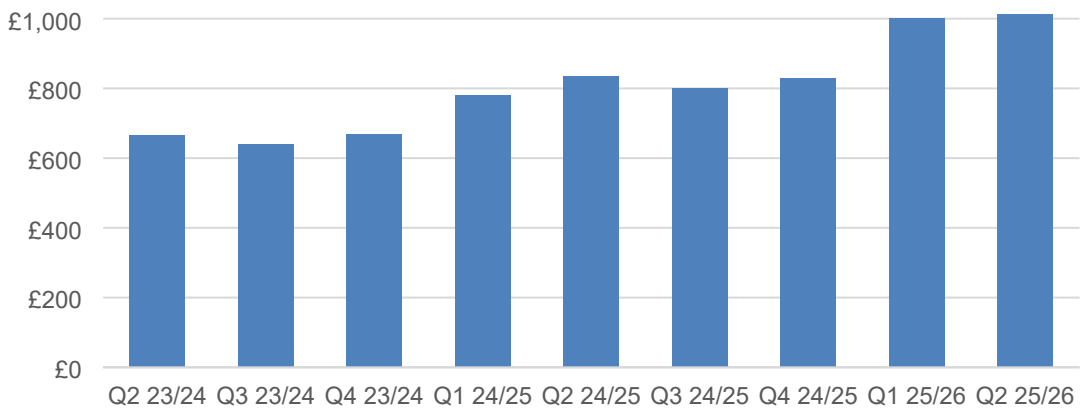
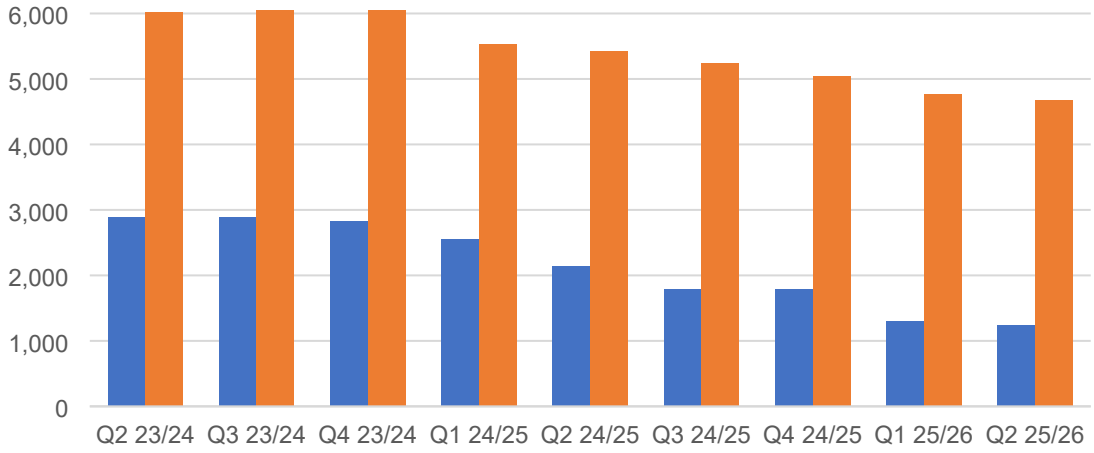
ASCH13: The average cost of new support packages arranged for people in the quarter



The cost of new support packages has increased in 2025/26. The more prominent increases seen from Quarter 4 to Quarter 1 includes the annual price uplift given to providers.

ASCH14: The number of people requiring a first review (6-8 weeks) or an annual review to be completed on the last day of the quarter



Work by all adult social care teams to ensure people are receiving the review of their care and support plan, continues to lead to decreased numbers of those with one to be completed.

Adult social care has the lowest number of people with a review to be completed for over two years.

2,309 first reviews were completed in Quarter 2, 6% more than the previous Quarter 2.

3,061 annual reviews were completed as well, 28% more than the previous Quarter 2

(Blue – first reviews to be completed
Orange – annual reviews to be completed)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
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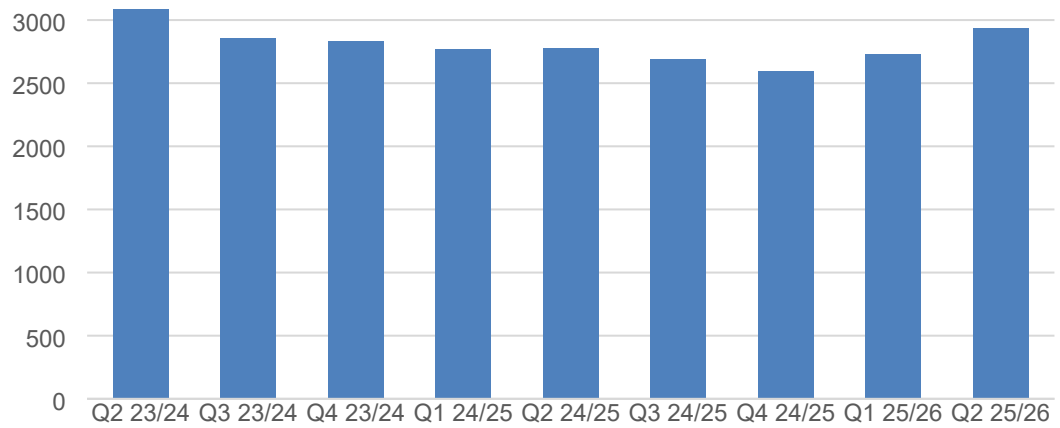
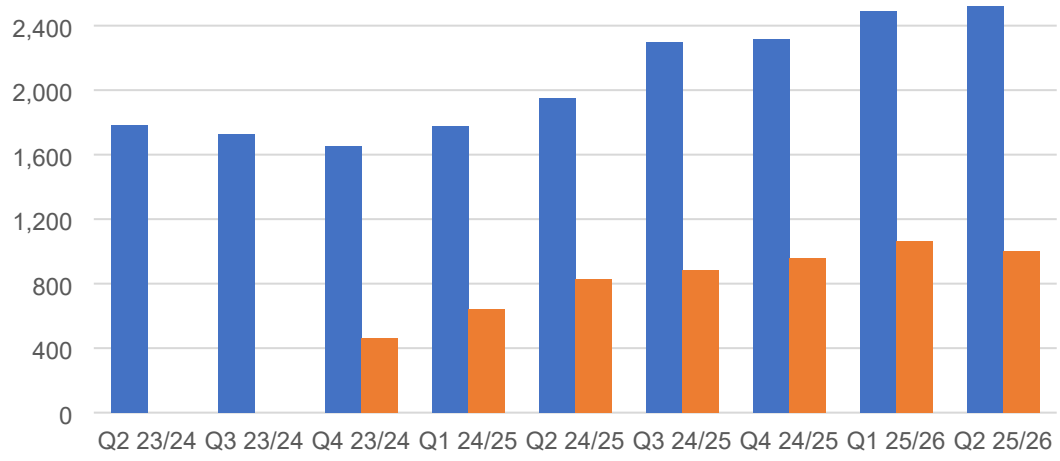
ASCH15: The number of Occupational Therapy assessments completed



The Occupational Therapy (OT) Teams continue to increase the number of OT assessments completed, with 2,932 completed in Quarter 2, 200 more than the previous quarter.

(New 2025/26 measure)

ASCH16: The number of people in a KCC community enablement service



Kent Enablement at Home (KEaH) continues to increase the number of people receiving enablement with their service.

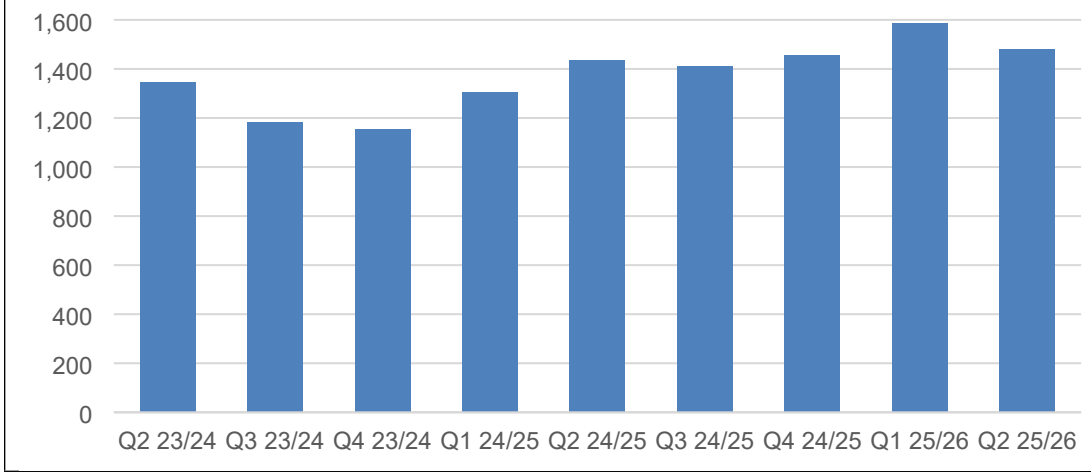
Quarter 2 saw the highest number of people with the service recorded.

Kent Enablement Service (KES) saw a slight decrease in those with their service, however this does remain high at just under a 1,000 people.

(Blue – Kent Enablement at Home (KEaH)
Orange – Kent Enablement Service (KES)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

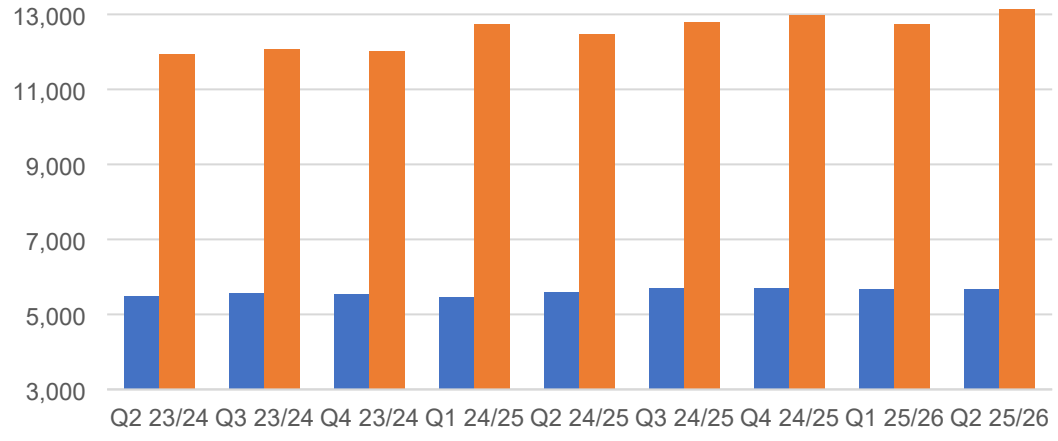
ASCH17: The number of people in Short Term Beds



Quarter 2 continued to see Community and Short Term Pathway Teams working to make sure people who no longer needed to be in the short term bed either return home with other or no services, or are made a long term placement if that is the most appropriate for that person care.

Due to this, and at time of reporting seeing a lower number of short term bed starts in the quarter (subject to change) there is a decrease in the number in a short term bed.

ASCH18: The numbers of people in Long Term Services

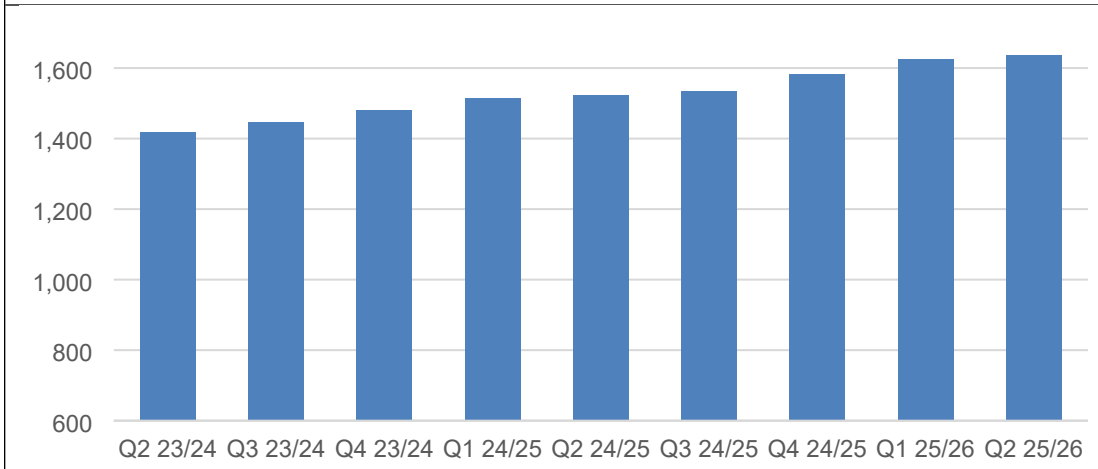


The number of people in a Long Term Service (residential or nursing) in quarter 2 is currently at a similar level to the previous quarter (subject to change), however there is an increase in the number of people in a community service, part of which is due to an increase in the number of people receiving homecare.

(Blue – Residential or Nursing services
Orange – Community Services)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

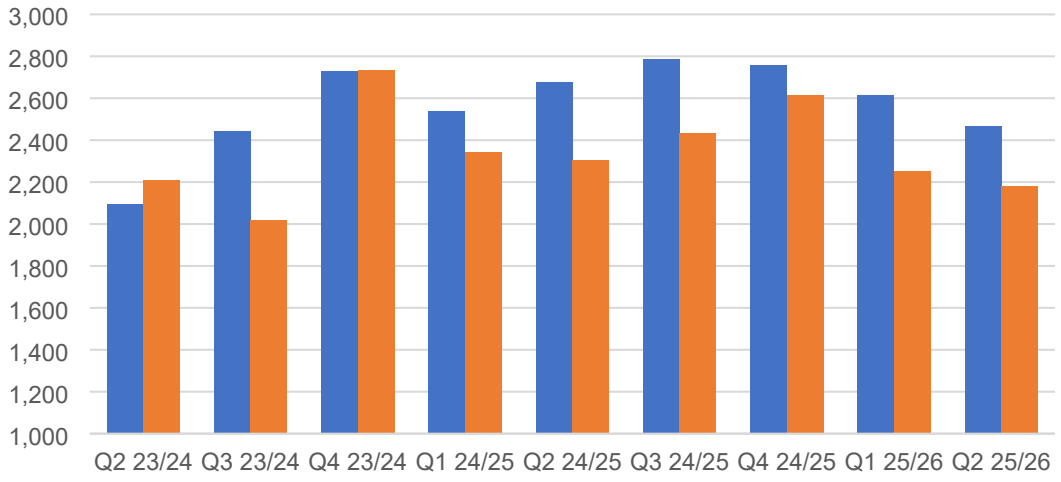
ASCH19: The number of people accessing Adult Social Care and Health Services who have a mental health need



People accessing adult social care with a mental health need continues its upward trajectory. Currently, the majority of people presenting with a mental health need are supported through a Supporting Independence Service (SIS).

An increasing number are supported in their own home with a Homecare provision – with 101 people in receipt of their care in this way at the end of Q2 compared to 70 in Q2 24/25.

ASCH20: Number of Deprivation of Liberty Safeguards applications received and completed



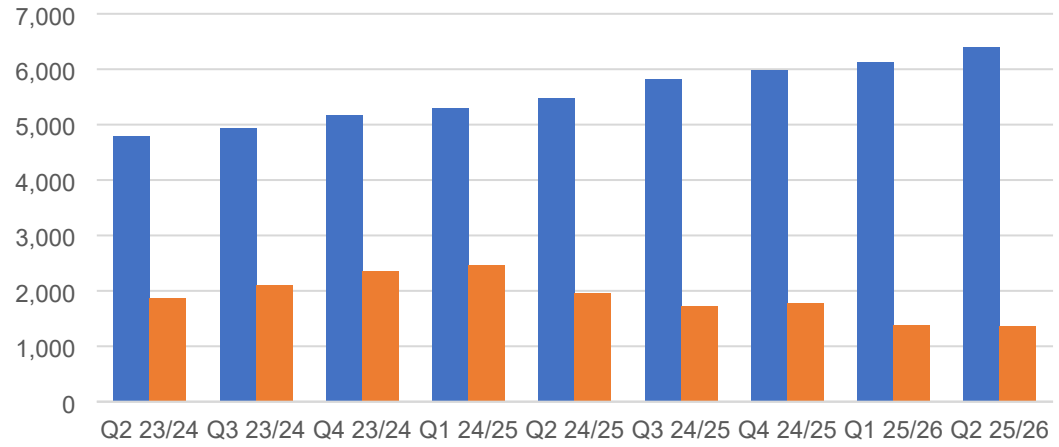
Deprivation of Liberty Safeguards (DoLS) applications continue to be at a high level, with 2,400+ received in each quarter since Q3 2023/2024.

Adult social care completed more than 2,000 applications again in Q2 but incoming demand outstripped completed work for the 6th consecutive quarter.

(Blue – applications received
Orange – applications completed)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH21: The number of concerns received safeguarding enquiries open on the last day of the quarter



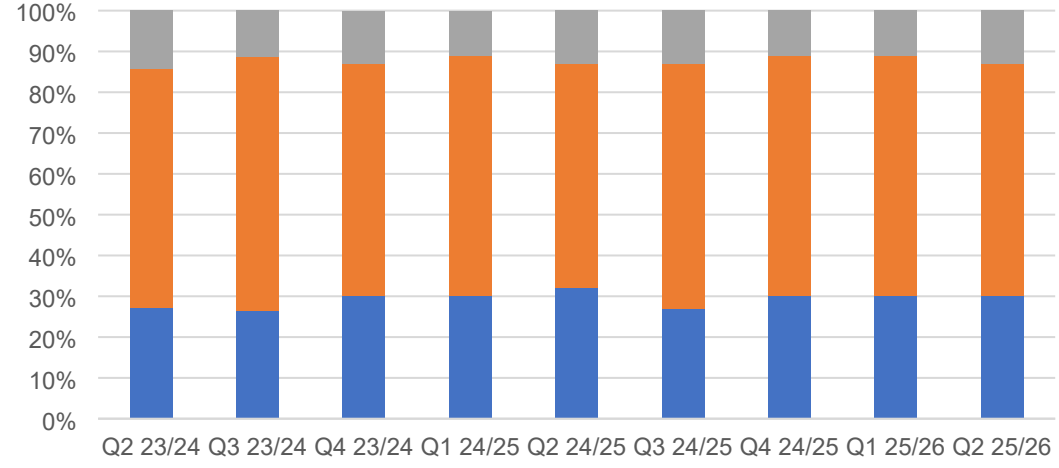
Adult social care one again saw an increase in the number of concerns which have been received in the quarter, continuing an ongoing trend of increasing demand.

Operational teams and managers are utilising data around referrers to organise workshops discussing trends in referral reason to ensure safeguarding concerns are being raised appropriately.

Open safeguarding enquiries continue to fall, with targeted action carried out in each of the teams to manage increased demand whilst concluding open work.

(Blue – concerns received
Orange – enquiries open on the last day of the quarter)

ASCH22: Outcome of concluded Section 42 Safeguarding Enquiries where a risk was identified



There continues to be a high number of safeguarding work concluded, with 1,487 Section 42 enquiries completed in Q2.

The average duration of concluded work is at its lowest point since Q3 2023/24 at 38 days.

There continues to be a focus in the teams in bringing those enquiries which have been open for the longest to a close.

(Blue – risk removed, Orange – risk reduced, Grey – risk remained)

For measures that include the provision of a service or service activity over time, the values for last four quarters have been updated with backdated information
An appendix of technical notes for each of the measures is provided at the end of the report

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From:	Diane Morton Cabinet Member for Adult Social Care and Public Health Sarah Hammond, Corporate Director Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 12 November 2025
Subject:	**Adult Social Care and Health Operational Pressures Escalation Plan 2025/2026**
Classification:	Unrestricted

Summary: This report provides an overview of the Adult Social Care and Health Operational Pressures Escalation Plan 2025/2026. The Plan describes how the council operates within the NHS Integrated Operational Pressures Escalation Levels (OPEL) framework 2024 to 2026, building on local plans and practice which are well established and embedded through operational experience.

Recommendation(s): The Cabinet Committee is asked to **NOTE** the content of the report and the Adult Social Care and Health Operational Pressures Escalation Plan 2025/26.

1. Introduction

1.1 This report provides an overview of the Adult Social Care and Health (ASCH) Operational Escalation Plan 2025/2026 (Attached as Appendix 1)

1.2 The ASCH Operational Pressures Escalation Plan exists to ensure Kent County Council (KCC) responds appropriately to surges in demand across the Kent and Medway Health and Social Care System.

1.3 The Plan describes how KCC operates within the NHS Integrated Operational Pressures Escalation Levels (OPEL) framework 2024 to 2026, building on local plans and practice which are well established and embedded through operational experience.

2. Background

2.1 In December 2024, NHS England published the Integrated Operational Pressures Escalation Levels (OPEL) framework 2024 to 2026. The framework exists to support the management of operational pressures across NHS England's providers, including acute trusts, community health, mental health, and NHS 111 services.

2.2 The NHS framework aims to:

- enhanced oversight of patient safety and, patient-centred decision-making across the urgent and emergency care (UEC) pathway through clear and consistent identification of risk to access to care for patients
- increased efficiency across the UEC pathway through optimising use of resources, and enabling clinical and operational teams to monitor operational pressure and, identify patterns and interdependencies between operational parameters
- improved communication by providing a common structure for measuring operational pressures and standardised escalation processes, enhancing the speed of response
- a consistent response to changes in operational pressure by giving parity of esteem across those NHS providers covered by this framework
- improved transparency across all levels of the NHS to promote engagement of and collaboration between all stakeholders in managing operational pressures effectively

2.3 Adult social care has historically faced system pressure during the winter period due to its interdependencies with the NHS, the need to support hospital discharges and increased demand for care and support during winter. Adult social care continues to manage and navigate extreme pressures whilst continuing to operate in the context of high demand for services, budget pressures, market pressures and workforce issues both within our own social care workforce but also the wider care workforce across Kent.

2.4 The ASCH Operational Pressures Escalation Plan exists to ensure KCC responds appropriately to surges in demand across the Kent and Medway Health and Social Care System. The objectives of the Plan are;

- To provide information about the national operating frameworks and service requirements
- To describe the monitoring and reporting arrangements in place to provide early warning of surge pressure
- To inform staff about the national, regional, and local processes and procedures to be used to manage a surge in demand
- To identify roles and responsibilities for services, teams, and individuals
- To describe the actions required in response to surge in demand

2.5 Minor updates to this year's Operational Pressures Escalation Plan, were approved by ASCH Directorate Resilience Group on 2 October 2025, in anticipation of major updates in 2026 reflecting significant operational changes.

3. Supporting Hospital Discharge

3.1 Adult social care works closely with NHS partners in developing Hospital Discharge pathways and integrated community support services which provide better outcomes for people and are more sustainable for the health and social care system. There are a range of initiatives in place which highlight adult social

care's commitment to partnership working, innovation and continuous improvement, including:

- Kent Enablement at Home (KEAH) work closely with acute and community hospitals in West and North Kent to support timely discharge planning delivering a short-term assessment and enablement service through a person's recovery following acute health need.
- Home First Service in East Kent is delivered in partnership with Kent Community Health NHS Foundation Trust (KCHFT) supporting people discharged from hospital regain independence and transition smoothly back home from hospital.
- 'Transfer of Care Hubs' bringing together health and social care workforce to work together to ensure people return home from hospital safely and efficiently, with the right community support.

3.3 Adult social care is working closely with the Kent and Medway Integrated Care Board (ICB) to implement a fully integrated brokerage service responsible for arranging services to facilitate hospital discharges on behalf of both health and social care. A joint brokerage team will be created to arrange support required to facilitate timely and smooth hospital discharges. The changes made will improve the person's experience, reduce costs, improve market management and better align with our strategic visions and national legislation around integration.

4. Conclusions

4.1 The ASCH Operational Pressures Escalation Plan exists to ensure KCC responds appropriately to surges in demand across the Kent and Medway Health and Social Care System.

4.2 The Plan outlines how KCC functions within the NHS OPEL framework (2024-2026), building on established local plans and operational experience.

4.3 The Plan is expected to undergo major revisions in 2026, incorporating both operational changes and reflect any changes nationally in health and social care.

5. Recommendations

5.1 Recommendation(s): The Cabinet Committee is asked to **NOTE** the content of the report and the Adult Social Care and Health Operational Pressures Escalation Plan 2025/2026.

9. Background Documents

None

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Operational Pressures Escalation Plan

Adult Social Care and Health

Adult Social Care

Kent County Council kent.gov.uk

1. Introduction

In December 2024, NHS England published the Integrated Operational Pressures Escalation Levels (OPEL) framework 2024 to 2026. The framework exists to support the management of operational pressures across NHS England's providers, including acute trusts, community health, mental health, and NHS 111 services. The 2024 publication supersedes all previous version of the national framework which has been in operation since 2016.

On 19th March 2020, NHS England published COVID-19 Hospital Discharge Service Requirement with the aim of maintaining enough capacity to support people who have acute healthcare needs due to coronavirus (COVID-19) in hospitals. These requirements were subsequently revised by the Hospital Discharge Service: Policy and Operating Model (21st August 2020) and Hospital Discharge and Community Support: Policy and Operating Model (5th July 2021). KCC ASCH Directorate responded to COVID-19 Hospital Discharge Service Requirement and subsequent revision in August 2020 and July 2021 by transforming the way Local Authority teams operate to support the safe and rapid discharge of those people who no longer need to be in a hospital bed. Whilst these sets of guidance no longer apply the changes made to the way local teams operate remain.

On the 31st March 2022, the Department for Health and Social Care published Hospital Discharge and Community Support Guidance which superseded the previous policy and operating model. The expectation is that local teams should adopt discharge processes that best meet the needs of the local population. This includes the 'discharge to assess, home first' approach, which is well established in Kent. It is expected that systems work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate. This is a current area of development across Kent and Medway. Multi-agency partners are working together to develop the model within existing resources, and agree any investment to reshape provision towards more home-based, strengths-based care and support, and with less reliance and expenditure on bed-based provision.

Transfer of Care Hubs, are now established countywide as the local health and social care system-level coordinating centres linking all relevant services across sectors to aid discharge, recovery and admission avoidance.

This Plan describes how KCC continues to operate within the 2024 OPEL Framework, building on local plans and practice which are well established and embedded through operational experience since the implementation of NHS England (South) Surge Management Framework which predates OPEL. This Plan operates against the backdrop of the Hospital Discharge and Community Support Guidance (31st March 2022), and will continue to be updated as health, care and other public services move towards more integrated, multi-disciplinary working, and to reflect future funding arrangements.

2. Aim and Objectives

2.1 Aim

The aim of this Plan is to ensure KCC Adult Social Care and Health Directorate responds appropriately to surges in demand across the Kent and Medway Health and Social Care System.

2.2 Objectives

The objectives of this Plan are;

- To provide information about the national operating frameworks and services requirements
- To describe the monitoring and reporting arrangements in place to provide early warning of surge pressure
- To inform staff about the national, regional, and local processes and procedures to be used to manage a surge in demand
- To identify roles and responsibilities for services, teams, and individuals
- To describe the actions required in response to surge in demand

3. National Operating Framework

3.1 Operational Pressures Escalation Levels (OPEL) Framework

The OPEL Framework 2024 replaces all previous versions of the NHS OPEL Framework. The current framework aims to:

- enhanced oversight of patient safety and, patient-centred decision-making across the urgent and emergency care (UEC) pathway through clear and consistent identification of risk to access to care for patients
- increased efficiency across the UEC pathway through optimising use of resources, and enabling clinical and operational teams to monitor operational pressure and, identify patterns and interdependencies between operational parameters
- improved communication by providing a common structure for measuring operational pressures and standardised escalation processes, enhancing the speed of response
- a consistent response to changes in operational pressure by giving parity of esteem across those NHS providers covered by this framework
- improved transparency across all levels of the NHS to promote engagement of and collaboration between all stakeholders in managing operational pressures effectively

The OPEL Framework 2024 is for the management of operational pressures across NHS acute trusts, community health service (CHS) providers, mental health (MH) service providers, NHS 111 providers, integrated care systems (ICSs), and NHS England regional and national teams. The framework provides the core parameters that each of these types of provider must use to determine their OPEL (Appendix 1: OPEL parameter definitions).

As a minimum, an OPEL assessment must be completed by each provider once per 24-hour period or more frequently in response to changes in assessments. The first assessment must be completed no later than 10:00, 7 days per week. Subsequent frequency of OPEL assessments is directed by OPEL score and corresponding escalation level (Table 1: OPEL score and corresponding level).

Table 1: OPEL score and corresponding level

(Normalised) OPEL Score	**Corresponding escalation level**	**Clinical Risk**
0-15	OPEL 1	Low
>15-40	OPEL 2	Medium
>40-70	OPEL 3	High
>70-100	OPEL 4	Very High

The OPEL framework supports organisations' responses to stabilise and recover by providing actions for each OPEL and identifying the responsibilities for NHS acute trusts, MH service providers, CHS providers, NHS 111 providers ICSs and NHS England regions (Appendix 2: Actions to stabilise and recover).

3.2 Hospital Discharge and Community Support Guidance

Hospital Discharge and Community Support Guidance applies to;

- all NHS trusts,
- community interest companies and private care providers of acute, community beds and community health services,
- social care staff in England.

It is expected that NHS bodies and local authorities should agree the discharge models that best meet local needs and are effective and affordable within the budgets available to NHS commissioners and local authorities.

Where somebody is admitted to hospital for elective treatment their likely short-term care needs upon discharge should be considered and discussed with them prior to their admission. Where somebody has been admitted to hospital as an emergency admission, their likely short-term care needs on discharge should be considered as soon as possible after their admission.

Where a patient is likely to need an interim package of care on leaving hospital, pending any assessment of their longer-term care needs, the Transfer of Care Hub assesses the appropriate discharge pathway and any immediate support the person will need on being discharged, including any issues relating to safeguarding and housing.

Care Act assessments to determine the long-term health and social care needs should take place after someone has left hospital and after an initial period of recovery.

It is the responsibility of acute and community hospitals to refer patients to the Transfer of Care Hub as soon as it is clinically safe to do so.

It is expected that no one has to transfer permanently into a care home for the first time directly following an acute hospital admission - everyone should be offered the opportunity to recover and rehabilitate at home or in a bedded setting before their long-term needs and options are assessed and agreed.

Acute hospitals are responsible for leading on the discharge of all patients on pathway 0. Providers of community health services lead on pathways 1-3. The model operates at least 8 am – 8 pm 7 days a week.

For 95% of patients leaving hospital this means that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home.

The Transfer of Care Hub assesses the suitable level of care support, visit patients at home on the day of discharge or the day after to arrange what support is needed in the home environment and rapidly arrange for that to be put in place. If care support is needed on the day of discharge from hospital, this is arranged prior to the patient leaving the hospital site, by a care coordinator.

Social Care Services are expected to be an active participant in Transfer of Care Hubs.

Mental Capacity
Duties under the Mental Capacity Act 2005 continue to apply. If a person is suspected to lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then there must be a best interest decision made for their ongoing care in line with the usual processes. If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes arrangements and orders from the Court of Protection for community arrangements still apply but should not delay discharge.

4. Activation and Escalation

The OPEL score for each provider is determined by the parameters (Appendix 1: OPEL parameter definitions). Health and Social Care organisation across Kent and Medway are expected to maintain robust, up-to-date local escalation plans signed off at Board level which dovetail into up-to-date overarching system-wide plans.

All local escalation plans should have clearly defined escalation triggers. Kent County Council has agreed the following indicative descriptions of pressure on Social Care services for each escalation level.

Table 2: KCC Escalation Levels

Operational Pressures Escalation Levels for Kent County Council	
OPEL One	• The number of referrals received by KCC from Community Health providers after a discharge from an acute or community hospital is within normal expected level • KCC Short-term Pathway staffing levels are sufficient to meet current referral rate • KCC Short-term Pathway Service appropriately represented at Transfer of Care Hub

	were emerging issues can be discussed and actions agreed • There is capacity in the residential and nursing home market to accommodate the current demand for placements • There is capacity in the home care market to accommodate the current demand for care packages • There is capacity within the Kent Enablement at Home service for all eligible people after discharge from acute or community hospital settings • Care reviews are taking place at the end of Kent Enablement at Home service • There is capacity within the existing Assessment Bed service for all eligible people at discharge from Community Health provision • The number of cases in the Area Referral Service triage workflow is within business-as-usual capacity • All Continuing Health Care Decision Support Tool Assessments are taking place within agreed policy timeframe • The number of referrals from rapid response / ICT is within normal expected level • All Care Act assessments following discharge from an acute or community health setting are completed within 3 to 6-weeks of discharge date • All reviews following KCC community Assessment Bed placement or short-term care package are taking place with 6-weeks of start date • All cases that cannot be resolved at first contact are being review within an acceptable timeframe • Scheduled case reviews are completed as planned • There are no cases waiting for Practice Assurance Panel decision
OPEL Two	• In some areas number of referrals received by KCC from Community Health providers after a discharge from an acute or community hospital is above the normal expected level • In some areas, KCC Short-term Pathway staffing levels are not sufficient to meet current referral rate • KCC Short-term Pathway Service is not appropriately represented at Transfer of Care Hub were emerging issues can be discussed and actions agreed • In some areas there is insufficient capacity in the residential and nursing home market to accommodate the current demand for placements • In some areas there is insufficient capacity in the home care market to accommodate the current demand for care packages • In some areas there is insufficient capacity within the Kent Enablement at Home service for all eligible people after discharge from acute or community hospital settings • In some areas, care reviews are not taking place at the end of Kent Enablement at Home service • In some areas there is insufficient capacity within the existing Assessment Bed service for all eligible people at discharge from Community Health provision • In some areas the number of cases in the Area Referral Service triage workflow is above the normal expected level • In some areas, Continuing Healthcare Decision Support Tool Assessments are taking place outside agreed policy timeframe • In some areas, the number of referrals from rapid response / ICT is above the normal expected level • In some areas, Care Act assessments following discharge from an acute or community health setting are not being completed within 3 to 6-weeks of discharge

	date • In some areas, reviews following KCC community Assessment Bed placement or short-term care package are not taking place with 6-weeks of start date • In some areas, not all cases that cannot be resolved at first contact are being review within an acceptable timeframe • In some areas, scheduled case reviews have been de-prioritized • In some areas, a small number of cases are waiting for Practice Assurance Panel decision
OPEL Three	• County-wide number of referrals received by KCC from Community Health providers after a discharge from an acute or community hospital is above the normal expected level • County-wide, KCC Short-term Pathway staffing levels are not sufficient to meet current referral rate • KCC Short-term Pathway Service is not appropriately represented at Transfer of Care Hub were emerging issues can be discussed and actions agreed • County-wide there is insufficient capacity in the residential and nursing home market to accommodate the current demand for placements • County-wide there is insufficient capacity in the home care market to accommodate the current demand for care packages • County-wide there is insufficient capacity within the Kent Enablement at Home service for all eligible people after discharge from acute or community hospital settings • County-wide, care reviews are not taking place at the end of Kent Enablement at Home service • County-wide there is insufficient capacity within the existing Assessment Bed service for all eligible people at discharge from Community Health provision • County-wide the number of cases in the Area Referral Service triage workflow is above the normal expected level • County-wide, Continuing Healthcare Decision Support Tool Assessments are taking place outside agreed policy timeframe • County-wide, the number of referrals from rapid response / ICT is above the normal expected level • County-wide, Care Act assessments following discharge from an acute or community health setting are not being completed within 3 to 6-weeks of discharge date • County-wide, reviews following KCC community Assessment Bed placement or short-term care package are not taking place with 6-weeks of start date • County-wide, not all cases that cannot be resolved at first contact are being review within an acceptable timeframe • County-wide, scheduled case reviews have been de-prioritized • County-wide, a significant number of cases are waiting for Practice Assurance Panel decision
OPEL Four	• The number of referrals received by KCC from Community Health providers after a discharge from an acute or community hospital is beyond business as usual capability County-wide • KCC Short-term Pathway is experiencing a critical staff shortage and is unable to meet current referral rate • Available capacity in the residential and nursing home market across Kent and Medway is exhausted • Available capacity in the home care market in Kent and Medway in exhausted

	• The Kent Enablement at Home service is unable to take on any new people County-wide • There are currently no Assessment Beds available and the situation is unlikely to improve • The number of cases in the Area Referral Service triage workflow is beyond business-as-usual capability County-wide • Continuing Health Care Decision Support Tool Assessments have been suspended • The number of referrals from rapid response / ICT is beyond business as usual capability County-wide • All actions to ensure Care Act assessments following discharge from an acute or community health setting are completed within 3 to 6-weeks of discharge date have been exhausted • Reviews following KCC community Assessment Bed placement or short-term care package have been suspended • Care reviews at the end of Kent Enablement at Home service have been suspended • Cases that cannot be resolved at first contact are not being review within an acceptable timeframe; risks to people's safety remain unresolved. • Scheduled case reviews have been suspended • Practice Assurance Panel has been suspended

4.1 Status and Monitoring System

The Single Health Resilience Early Warning Database (SHREWD) is used across Kent and Medway to provide online reporting to support decision-making and the operational management of the whole health and social care system.

The system allows immediate identification of pressures and delays in the system which means that conference calls are more focused and corrective actions are agreed from a position of knowledge, enabling decision makers to be proactive rather than reactive. It facilitates a collaborative whole health economy approach to working to reduce system pressures.

SHREWD is the default mechanism used by Kent County Council for sharing Operational Pressures Escalation with Health partners. All teams with access to the system update their indicators on a daily basis to ensure that the most up-to-date and accurate information is available to decision makers.

Within Adult Social Care and Health, the information system Mosaic is used to monitor operational pressure. Team Leaders and Service Managers use Mosaic to identify pressure points in their workflows, to inform the prioritisation of local resources and escalation, as appropriate, using this Plan as a guide.

4.2 Indicators

The KCC indicators currently reported using SHREWD are:

- Staffing of Short-term Pathway Team (%)
- Integrated Care Centre / In House Provision Assessment Bed availability (including dementia bad availability)

- KCC case load (per Area) – total case load currently managed by each Short-term Pathway Team
- Referrals (per Area) – total cases currently in Health provision pending assessment outcome
- Kent Enablement at Home (KEaH) daily capacity
- Discharge to Assess Pathway One: Total availability remaining against week capacity

4.3 Triggers

Trigger levels are set for each indicator and reviewed regularly to ensure status levels are appropriate.

A colour coding system applies to each indicator aligned to the OPEL Framework; Green for OPEL 1, Amber for OPEL 2, Red for OPEL 3 and Black for OPEL 4.

Staffing of Short-term Pathway Team

When Teams are staffed at 70% and above allowing for sickness, annual leave and training the status is Green. When staffing falls below 70% and above 50% status is Amber. Red status is triggered when staffing falls below 50% and above 30%. The status of teams staffed below 30% is reported as Black.

OPEL	KCC Staffing (%)
1	70-100
2	50-69
3	30-49
4	29-0

Integrated Care Centre / In House Provision Assessment Bed Availability

Assessment Bed availability is a product of the total number of beds at each location minus the current number of beds occupied.

This indicator has been included to provide at a glance availability information County-wide. Trigger levels have been set in line with Assessment Bed Occupancy.

The number of dementia beds available is also reported daily.

Case Load

Trigger levels for the Case Load are set as follows:

KCC Health Caseload				
OPEL	DGS	East Kent	Swale	West Kent
1	0-39	0-39	0-39	0-39
2	40-59	40-59	40-49	40-59
3	60-99	60-99	50-69	60-99

4	100-200	100-200	70-80	100-200

KCC Social Caseload				
OPEL	DGS	East Kent	Swale	West Kent
1	0-39	0-39	0-39	0-39
2	40-59	40-59	40-59	40-59
3	60-99	60-99	60-99	60-99
4	100-500	100-500	100-500	100-500

Referrals
Trigger levels for the Referrals are as follows:

KCC Referrals to KCC				
OPEL	DGS	East Kent	Swale	West Kent
1	0-9	0-9	N/A	0-9
2	10-14	10-14	N/A	10-14
3	15-19	15-19	N/A	15-19
4	20-29	20-100	N/A	20-100

Kent Enablement at Home (KEaH) daily capacity
Triggers levels are set for Kent Enablement at Home to identify current capacity within the service to support people discharged by acute/community hospitals.

OPEL	KEAH Pressure Status
1	5-6
2	3-4
3	1-2
4	0

Discharge to Assess Pathway One: Total availability remaining against week capacity
The following trigger levels are indicative and apply to West Kent only.

When the total availability remaining against weekly capacity is between 42 and 35 the status is Green. When the total availability remaining against weekly capacity is between 34 and 15 the status is Amber. Red status is triggered when the total

availability remaining against weekly capacity is between 14 and 6. If the total availability remaining against weekly capacity is between 5 and 0 status is reported as Black.

5. Command and Control

A range of multi-agency and single agency groups exist to maintain oversight of OPEL and ensure timely actions are taken to de-escalate the health and social care system when needed.

5.1 Multi-Agency Groups

Whole System Escalation Teleconference Calls

Multi-agency System Resilience / Whole System Escalation Teleconference Calls are established to anticipate and mitigate risk caused by operational pressures across each Health economy particularly those relating to capacity and transfers of care.

Teleconference calls are held and increased and decreased in frequency according to the operational pressures being faced by each site. The aim of the teleconferences is to:

- anticipating and mitigating risk caused by pressures across the Health Economy particularly those relating to capacity and transfers of care
- agreeing local actions to be taken, including communication with partners and the public on the current status of services
- provide updates to relevant stakeholders.

Whole System Escalation Teleconference Calls are attended by the Prevention and Adult Social Care Connect Operations Manager and / or Short-Term Pathway Team managers during office hours, Monday to Friday.

Urgent Care Delivery Boards

Urgent Care Delivery Boards has been established to provide whole system oversight and leadership to drive improvement in A&E performance and ensure high quality Urgent Care Pathways for patients.

Each Board includes representatives from Acute NHS Trusts, South East Coast Ambulance Service (SECAMB), Kent Community Health NHS Foundation Trust (KCHFT) or Medway Community Health, or HCRG Care Group, Kent and Medway NHS and Social Care Partnership Trust (KMPT), Integrated Care 24 (IC24), NHS 111, G4S (patient transport) and Kent and Medway Integrated Care Board. KCC is represented at each Delivery Board by the Prevention and Adult Social Care Connect Operations Manager.

Urgent Care Delivery Board areas operate OPEL 1 when operating within normal parameters. At OPEL 1 and 2 operations and escalation is delegated to the relevant named individuals in each organisation across the Delivery Board. At OPEL 3 and 4 senior involvement across the Delivery Board is expected.

Operational Pressures meeting the criteria for OPEL 2, 3 and 4 are escalated to the respective Urgent Care Delivery Board:

- East Kent – including William Harvey Hospital, Queen Elizabeth the Queen Mother Hospital and Kent and Canterbury Hospital
- West Kent – including Tunbridge Wells Hospital and Maidstone Hospital
- North Kent – including Darent Valley Hospital
- Medway and Swale – Medway Maritime Hospital

Local Health Economy (LHE) Teleconference Calls
Local Health Economy (LHE) Teleconference Calls (previously referred to as D2A) are business-as-usual for health and social care services. The frequency of these teleconferences are agreed locally according to the operational pressures being faced by each site. The aim of the teleconferences is to maximise throughput and prevent bridging.

During office hours, Monday to Friday LHE Teleconference Calls are attended by Kent Enablement at Home, Purchasing, and Social Care Discharge Co-ordinator.

5.2 KCC Operational Pressures Escalation Group

On occasions when despite the application of local actions the pressure on capacity and the need to mitigate against the possibility of compromising patient care, requires additional support from other service providers, including those which cross locality boundaries, the KCC Operational Pressures Escalation Group may be initiated.

The Group will be chaired by a Director of Adult Social Care and will include Assistant Director(s), Short-Term Pathway Service Manager(s), Head of Kent Enablement at Home, Access to Resources Manager and Commissioning Manager(s). The Group will consider current position, actions required to alleviate pressure and support required from other agencies.

The KCC OPEL status on SHREWD may be escalated based the Group's assessment of current pressures.

If necessary, the NHS 111 Directory of Service (DoS) Capacity Management Protocol will be activated based the Group's assessment of current pressures.

6. Capacity and Demand Management Measures

The Local Authority has established a range of measures which contribute to reducing demand, increasing capacity and maintaining through-put within health and social care services.

6.1 Reducing Demand

Cold Weather and Heatwave Actions
KCC Adult Social Care and Health has well-established action plans designed to reduce the avoidable impact on health from periods of extreme weather (Adverse Weather Plan). These Plans cover:

- Seasonal preparedness

- Alerting and activation
- Response to severe weather

Cold weather and heatwave action plans are inclusive of contracted providers and include public messaging.

Covid-19 / Flu Vaccination
Considering the risk of flu and COVID-19 co-circulating in winter, the national flu immunisation programme is essential to protecting vulnerable people and supporting the resilience of the health and care system.

All frontline health and social care workers should receive a vaccination. This should be provided by their employer, to meet their responsibility to protect their staff and service users and ensure the overall safe running of services. Employers should commission a service which makes access easy to the vaccine for all frontline staff, encourage staff to get vaccinated, and monitor the delivery of their programmes.

It is the ambition of the Department of Health and Social Care (DHSC) that 100% of frontline health and social care staff are offered the vaccine.

The Authority has arrangements in place to encourage all frontline social care staff regardless of their risk status to be vaccinated against seasonal flu. Seasonal flu vaccination arrangements are publicised to staff through the Authority's intranet and staff communication channels.

Risk reduction awareness, information and education are key elements of the Authority's communication strategy through print media, online and directly with contracted providers, the community and voluntary sector.

NHS 111 Directory of Service (DoS) Capacity Management Protocol
The NHS 111 Directory of Service (DoS) Capacity Management Protocol allows Health and Social Care providers to notify NHS 111 of service pressures and seek to reduce referrals by providing members of the public with other suitable options depending on need.

When services provided by KCC are experiencing pressure, new referrals from NHS 111 can be reduced by providing members of the public with other suitable options depending on need.

Social Care services provided by KCC have been categorised as Band B / C meaning that implementation of the protocol will have a medium / low impact the Health and Social Care System. As such, the protocol can be implemented without ratification by ICB Director on Call.

When indicated by the OPEL status level the Prevention and Adult Social Care Connect Operations Manager may take the following steps to activate the Protocol:

a) Call NHS 111 on 01233 363020 to change the service capacity status
b) Inform the ICB commissioning lead in hours or NHS Director on Call out of hours
c) Review escalation status after 4 hours and if pressure remains repeat step A and B.

Admission avoidance
KCC Adult Social Care and Health continues to support admission avoidance schemes designed to reduce the pressure on the health and social care system, promote independence and wellbeing, including:

- Crisis intervention
- Emergency / unplanned respite and support to carer breakdown
- Support to Rapid Response with personal care
- OT equipment
- Technology Enabled Lives
- Enablement Services

6.2 Increasing Capacity

Resource Planning
Locally agreed resource plans account for known periods of operational pressure such as holiday periods to ensure staff are in place ready to support when required.

Each service will prioritise workload and where there are excess resources, considering interdependencies, offer mutual aid to other service(s), to ensure continuity across the county in line with existing Business Continuity arrangements.

Staff Redeployment Process
At times of pressure, the Prevention and Adult Social Care Connect Operations Manager will notify the Assistant Director of additional resource requirements.

The Assistant Director will assess available resources within existing staff group and redeploy staff to alleviate pressure where appropriate.

Where existing resources cannot be redeployed, the Assistant Director will contact the Director of Adult Social Care. Where necessary the Director may make time limited arrangements.

Extended Access
The KCC Out of Hours Service continues to provide a central point of contact during evenings, weekends and public and Bank Holidays.

Kent Enablement at Home (KEaH) through Careline and our commissioned service across health and social care, facilitate and support social care discharges on Pathway 1 (Home). Assessment bed provision, in-house for Pathway 2 and our external provision is used for Discharge to Assess Pathway 3. This support efficient, quick, and safe discharges outside office hours.

Contracts outside framework
Where necessary, KCC continues to negotiate individual contracts with providers, outside the framework, where this is required to meet the needs of the individual or where framework providers are unable to meet current demand such that maintaining through-put within health and social care services is compromised.

Supporting the Market
The Authority continues to provide support to the market by:

- Circulating and promoting guidance to all social care providers, the voluntary and community sector
- Working with partners to encourage those who are eligible to access free flu vaccine
- Monitoring market position through the capacity tracker and CQC survey

The Authority maintains close working relationships with contracted and non-contracted providers. Partnership working between care providers to cover packages of care is well established.

6.3 Maintaining through-put

Practice Assurance Panel
The frequency of Practice Assurance Panels may be increased at the discretion of the Prevention and Adult Social Care Connect Operations Manager to maintain through-put if diarised panels are not deemed sufficient. Decision to hold extra-ordinary Practice Assurance Panel will be informed by current OPEL Status.

Assessment Beds
Placement Co-ordinators provide daily reports on progress of each assessment bed placement. The aim of the report is to reduce drift and increase throughput. Assessment bed placement exceeding 3-week period are escalated for immediate action.

On the eighth week of a twelve-week disregard period, providers are notified to allow sufficient time for arrangements to be made for discharge or funding to be agreed at the end of the disregard period.

Contracted Residential and Nursing Provision
Where system pressure has been exacerbated by lack of capacity in contracted provision of planned and emergency respite, assessment bed and long term residential and nursing care, this is escalated to commissioners for immediate action.

7. Roles and Responsibilities

The roles and responsibilities of key staff are described below. Staff with specific roles and responsibilities should know where to go and what to do when this plan is implemented.

All Social Care staff have a potential role in managing and responding to operational pressures.

This document is made available in a place to which all staff members have access. All staff should be aware of the plan and where the plan can be located.

Actions described to deescalate operational pressures will be triggered by the OPEL status of Kent County Council, the Area or region.

7.1 Director of Adult Social Care (Short Term Support)

The leads for Operational Pressures Escalation is the Directors of Adult Social Care – Short Term Support.

The Director of Adult Social Care – Short Term Support will:

- be informed of current OPEL status, capacity and demand through SHREWD
- receive updates provided by Assistant Directors, Prevention and Adult Social Care Connect Operations Manager, and Short Term Pathway Team Managers
- seek assurance that actions required are implemented in accordance with agreed procedures
- where required, consider use of additional resources, or redeployment of existing resources in line with agreed Business Continuity arrangements
- initiate the KCC Operational Pressures Escalation Group, as and when required
- initiate discussions with health partners on use of available beds at community hospitals or funding options to support spot purchase of short-term placements.

7.2 Prevention and Adult Social Care Connect Operations Manager

The Prevention and Adult Social Care Connect Operations Manager will:

- be informed of current OPEL status, capacity and demand through SHREWD
- receive regular updates from the Short-Term Pathway Team Managers
- attend Urgent Care Delivery Board teleconferences, providing a position statement on behalf of the Local Authority to multi agency partners
- maintain oversight of the redeployment of staff resources, to alleviate pressure for a time limited period
- escalate resourcing pressures to the Assistant Director who will consider use of additional resources or redeployment of existing resources, in line with agreed Business Continuity arrangements across service area boundaries.
- initiate the KCC Operational Pressures Escalation Group, as and when required

7.3 Short Term Pathway Team Manager

Short Term Pathway Team Managers will ensure that all indicators are updated on SHREWD on a daily basis.

Short Term Pathway Team Managers will:

- be informed of current OPEL status, capacity and demand through SHREWD
- receive regular updates from the Social Care Discharge Co-ordinator
- update the KCC OPEL status on SHREWD based on the current indicators for KCC
- look to see whether people in Community Hospitals or cared for by Community Health can be supported in their own home by Kent Enablement at Home on occasion when doing so will reduce pressure in the system and prevent escalation
- seek agreement to use contracted care in the home providers to facilitate discharge, bridging the gap until Kent Enablement at Home carers are available

- When KEaH has very limited or no capacity and notification to decline is received within 2 hours, progress to Purchasing and request commencement of enablement package within 2-week timeframe
- explore alternative capacity to bridge the gap when a care in the home package start date has been agreed but there are insufficient resources within Kent Enablement at Home
- consider the use of residential or nursing home placements from non-contracted providers and those in other areas were capacity is available
- consider redeployment of staff resources, to alleviate pressure for a time limited period
- attend Operational Teleconference Groups
- initiate the KCC Operational Pressures Escalation Group, as and when required

On occasions when discharges are delayed due to assessment bed availability, the Short Term Pathway Team Manager may alert Integrated Care Centres and in house provision to current pressures, to agree flexibility (in advance where possible) for accepting patients later in the day and prioritise referrals from Short-term Pathway.

7.4 Senior Practitioner / Social Care Discharge Co-ordinator

Senior Practitioner / Social Care Discharge Co-ordinators will ensure that all indicators are updated on SHREWD on a daily basis.

Senior Practitioner / Social Care Discharge Co-ordinators will:

- ensure that actions are implemented in accordance with the current OPEL status
- attend LHE Teleconference Calls as required
- escalate resourcing pressures to the Short-Term Pathway Team Manager
- escalate any delays in acquiring a Kent Enablement at Home care package to the Short-Term Pathway Team Manager
- explore alternative capacity to bridge the gap when a care in the home package start date has been agreed but there are insufficient resources within Kent Enablement at Home
- consider the use of residential or nursing home placements from non-contracted providers and those in other areas were capacity is available
- alert In-house Provision to developing pressure to ensure actions are implemented to increase capacity and throughput.

7.5 Arrangement Support Team

The Arranging Support Hospital Team collate current availability of Integrated Care Centre / In House Provision assessment beds and update Assessment Bed Occupancy indicator on SHREWD daily. In addition, the Hospital Discharge Team maintain up-to-date details of vacant beds in older person's residential and nursing homes County-wide. This includes planned and emergency respite, assessment beds and long-term placements in residential / nursing care.

Arranging Support Teams may negotiate individual contracts with providers, outside the framework (see Contracts outside framework). Rigorous processes are in place

to ensure contracts outside the framework are only used when absolutely necessary; this may result in a delay to care package start date.

Arranging Support Teams may operate a skeleton service during bank holidays on request.

7.6 In-house Provision

In-house residential and domiciliary provision will:

- expand capacity wherever possible when this action is triggered by the OPEL status
- consider use of agency staff to increase staffing capacity where necessary whilst limiting all staff movement between settings unless absolutely necessary to help reduce the spread of infection
- support the safe, but immediate discharge of patients

Kent Enablement at Home (including KEaH Plus) will:

- receive information from Registered Practitioners and Case Officers about potential care package requirements for people at triage
- pre-plan resource requirements and identify any issues by exception the Short-Term Pathway Team Manager to be included in status reports
- For all referrals where a start date cannot be found in the next 24 hours inform the referrer with 2 hours of receipt
- Ensure that all eligible people referred who cannot be accepted for a start date within 24 hours are followed up in the community

Registered Managers of In-house establishments will:

- ensure the vacant beds indicator is updated manually on a daily basis and increase this frequency to twice daily where indicated by the OPEL status
- prioritise referrals for people on the hospital discharge pathway
- co-ordinate additional board rounds daily

7.7 Team Managers – Community / Locality Teams

Team Managers will use Mosaic and Power BI reports to identify pressure points in their workflows on a regular basis:

- Cases in the triages workflows coming through Adult Social Care Connect, KEaH and other referral sources
- Continuing Health Care Decision Support Tool Assessments within agreed policy timeframe
- Referrals from rapid response / ICT
- Reviews following Assessment Bed placement or short-term care package within 6-weeks of start date transferred from Short-term Pathways
- Care reviews at the end of Kent Enablement at Home service
- Scheduled case reviews

In response to operational pressure Team Managers will liaise with Senior Practitioners to:

- Re-allocate work / cases across the ASCH workforce
- Risk assess and prioritise contacts / reviews
- Where Continuing Health Care Decision Support Tool Assessments are taking place outside agreed policy timeframe, escalate issue to senior management
- Request prioritisation though Purchasing for Rapid Response referrals
- Increase the frequency of panels where the speed of decision making is contributing to operational pressure
- When KEaH has very limited or no capacity and notification to decline is received within 4 hours, progress to Purchasing and request commencement of enablement package within 2-week timeframe dependent on capacity
- Encourage light-touch / virtual MCA assessment for less complex cases
- Prioritize face-to-face MCA assessment for most complex / unfriended cases
- Deprioritize care reviews at the end of KEaH package
- Deprioritize scheduled reviews
- Ensure that the Risk Register is updated and escalate concerns to Senior Managers

8. De-escalation

The defined roles and responsibilities will be implemented according to the OPEL status of Kent County Council, the Urgent Care Delivery Board Area or region with the aim of de-escalating operational pressures.

The OPEL status Kent County Council is informed by the indicators and triggers described above. The overall organisation OPEL status is updated on SHREWD by the Short-Term Pathway Service Manager on a daily basis according to available trend data for each indicator.

For ease of reference for external organisations, Kent County Council actions in support of the wider Health and Social Care economy are summarised at Appendix 3: Kent County Council Operational Pressures De-escalation Actions

The Authority must ensure that scarce resources are used at an appropriate time and to best effect in support of the Health and Social Care economy. On occasion, the Authority may not respond to status level of wider Health and Social Care Economy where doing so would have no positive impact on it.

Each indicator will be maintained at a lower level, dependent on the current number of referrals, before the step down of appropriate actions. This will ensure that when the actions end the risk of returning to the higher status level is reduced.

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Role / Response	OPEL One	OPEL Two	OPEL Three	OPEL Four
Registered Managers / Team Leaders In-house Provision	Business as usual	Business as usual	• Consider the use of agency staff at in house residential units to increase capacity if necessary • Short Term Pathway residential provision to increase admission rate on a daily basis where it is safe to do so and escalate any issues for resolution. • Update vacant beds indicator twice daily. • Co-ordinate additional board rounds daily	• Continue with Level Three Actions.
Kent Enablement at Home Locality Organisers	Business as usual	• For all referral where a start date cannot be found in the next 24 hours inform the referrer with 2 hours of receipt. • Ensure that all eligible people referred who cannot be accepted for a start date within 24 hours are followed up in the community	• Continue with Level Two Actions	• Continue with Level Three Actions
Short Term Pathways Senior Practitioner / Social Care Discharge Co-ordinator	Business as usual	• Work with families to identify suitable options to facilitate through-put. • When a care in the home package start date has been agreed but there are insufficient resources within Kent Enablement at Home explore alternative capacity to bridge the gap. • Where KEaH are unable to commit to a start date in next 24 hours, assess and refer to Purchasing for a care package. • Represent KCC at Length of Stay (LOS) meetings.	• Continue with Level Two Actions. • Alert In-house Provision to developing pressure to ensure actions are implemented to increase capacity and throughput. • Consider use of residential or nursing home placements from non-contracted providers and those outside Kent and Medway. • Ensure Shrewd is updated twice daily by 10.30 am and again between 14:00 and 15:30 • If authorised, Consider use of residential or nursing home placements from non-contracted providers and those in other areas were capacity is available.	• Continue with Level Two and Three Actions. • Represent KCC at Multi-Agency Conference calls
Short Term Pathway Team Manager	Business as usual	• Represent KCC at Multi-Agency conference calls. • Represent KCC at Medically Fit / Length of Stay (LOS) meetings. • Consider temporary redeployment of staff across Area	• Prioritise work to facilitate hospital discharge where it is safe to do so. • If authorised, consider use of residential or nursing home placements from non-contracted providers and those outside Kent and	• Continue with Level Two and Three Actions. • Represent KCC at Multi-Agency Conference calls.

Role / Response	OPEL One	OPEL Two	OPEL Three	OPEL Four
			Medway.	
Prevention and Adult Social Care Connect Operations Manager	Business as usual	• Maintain oversight of temporary redeployment of staff across Area • Represent KCC at Multi-Agency conference calls. • Represent KCC at Medically Fit / Length of Stay (LOS) meetings • When KEaH has very limited or no capacity and notification to decline is received within 2 hours, authorise progress to Purchasing	• Seelk approval for purchasing from off-framework providers • Continue with Level Two Actions.	• Continue with Level Two and Three Actions. • Implement Service Business Continuity Plans as appropriate.
Team Managers – Community / Locality Teams	Business as usual	• Re-allocate work / cases across ASCH workforce • Risk assess and prioritise contacts / reviews	• Increase the frequency of panels where the speed of decision making is contributing to operational pressure • Deprioritize care reviews at the end of KEaH package • Deprioritize scheduled reviews	• Continue with Level Two and Three Actions. • Implement Service Business Continuity Plans as appropriate.
Assistant Director	Business as usual	• Consider temporary redeployment of staff from Adult Community Team to Short-Term Pathway to manage increased referrals or fill temporary gaps in staffing resource	• Consider the temporary redeployment of staff from across Area boundaries to manage increased referrals or fill temporary gaps in staffing resource • Represent KCC at Multi-Agency conference calls	• Continue with Level Two and Three Actions. • Represent KCC at Multi-Agency Conference calls.
Director of Adult Social Care	Business as usual	Business as usual	• Discuss with health partners use of available beds at community hospitals or funding options to support spot purchase of short-term placements • Discuss with health partners joint funding opportunities to alleviate short-term pressures	

Appendix 1: OPEL parameter definitions

The following documents define each parameter in the Integrated OPEL Framework 2024 to 2026, to ensure they can be consistently applied across all relevant processes and activities.

Acute Parameters

Community Health Service Parameters

Mental Health Parameters

NHS 111 Parameters

Appendix 2: Actions to stabilise and recover

The OPEL Framework supports organisations' responses to stabilise and recover by providing actions for each OPEL and identifying the responsibilities for NHS acute trusts, MH service providers, CHS providers, NHS 111 providers ICSs and NHS England regions. OPEL actions should be implemented in conjunction with local surge and escalation policies and procedures.

Appendix 3: Kent County Council Operational Pressures De-escalation Actions

Action	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Business as usual	✓			
Review people using assessment beds with a view to 'Step Down' creating capacity.		✓		
Work with families to identify suitable options to facilitate through-put		✓		
Ensure Shrewd is updated daily before 10.30		✓		
Work with families to identify suitable options to facilitate safe discharge whilst waiting for a care package start date.		✓		
When a care in the home package start date has been agreed but there are insufficient resources within Kent Enablement at Home explore alternative capacity to bridge the gap.		✓		
Represent KCC at Medically Fit / Length of Stay (LOS) meetings.		✓		
Consider temporary redeployment of staff to Short-Term Pathway to manage increased referrals or fill temporary gaps in staffing resource		✓		
For all KEaH referral where a start date cannot be found in the next 24 hours inform the referrer with 2 hours of receipt.		✓		
Where KEaH are unable to commit to a start date in next 24 hours, assess and refer to Purchasing for a care package		✓		
Where Continuing Health Care Decision Support Tool Assessments are taking place outside agreed policy timeframe, escalate issue to senior management		✓		
Consider the use of agency staff at in house residential units to increase capacity if necessary			✓	
Short Term Pathway residential provision to increase admission rate on a daily basis where it is safe to do so and escalate any issues for resolution.			✓	
Update vacant beds indicator twice daily.			✓	
Co-ordinate additional board rounds daily			✓	
Consider use of contracted or non-contracted care providers to bridge			✓	

Action	OPEL 1	OPEL 2	OPEL 3	OPEL 4
the gap if Kent Enablement at Home has insufficient capacity.				
Consider use of residential or nursing home placements from non-contracted providers and those in other areas were capacity is available			✓	
Alert In-house Provision to developing pressure to ensure actions are implemented to increase capacity and throughput.			✓	
Ensure Shrewd is updated twice daily by 10.30 am and again between 14:00 and 15:30			✓	
Prioritise work to facilitate hospital discharge where it is safe to do so.			✓	
Increase the frequency of Practice Assurance Panels where the speed of decision making is contributing to operational pressure			✓	
Deprioritize reviews at the end of KEaH package			✓	
Deprioritize scheduled reviews			✓	
Consider the temporary redeployment of staff from across Area boundaries to manage increased referrals or fill temporary gaps in staffing resource.			✓	
Discuss with health partners use of available beds at community hospitals or funding options to support spot purchase of short-term placements.			✓	
Use non-contracted home care and care home providers if necessary.				✓
Implement Service Business Continuity Plans as appropriate.				✓

Appendix 4: Dynamic risk assessment in response to changes in OPEL

OPEL provides a consistent framework for the Dynamic Risk Assessment that should be undertaken when making decisions in response to operational pressure, regardless of organisation. In the same way that OPEL augments and is used in conjunction with local surge and escalation policies and procedures, OPEL must be used as a consistent measure alongside the National Quality Board DRA framework, to augment local information when undertaking DRA and enacting actions. As an overview:

- **organisations should undertake continuous DRA:** when responding to changes in OPEL, and use the parameters within each pillar of the OPEL framework to consistently monitor changes in OPEL and the impact of any actions taken
- **dynamic risk perception:** risk can be viewed differently by different stakeholders, and it is important to gain a comprehensive understanding about the risks and potential actions by listening to different staff groups, professions and patients.
- **actions are grounded by providers' OPEL assessments and DRA:** we expect ICSs and NHS England regions to implement all OPEL 3 or 4 actions if any provider within their region is assessed as OPEL 3 or 4, regardless of the aggregated OPEL score for that ICS or region
- **decision-making in extremis:** the actions in the OPEL framework are not routine actions and the focus of decisions made in extreme situations – for example, in response to overcrowding and delays – may be the mitigation of more substantial patient risks elsewhere in the pathway. To enable this, risk sharing across system partners – for example, across multiple providers – may be necessary and should be supported by integrated care boards (ICBs)
- **documentation of actions:** all decisions should be recorded, including those to mitigate anticipated risks, as well information on how a risk has been identified and measured to determine its potential for harm. This documentation will be a useful resource for learning and evaluation
- **consideration of external factors:** all decisions must consider the wider external factors that could affect the desired outcomes: for example, decisions made by other providers or neighbouring systems, regional functions or any external issue impacting on the UEC pathway

Appendix 5: Version Control and History of Plan Tests

Version Control

Version Number	Revision Date	Status	Summary of Changes	Reviewed / Approved By
0.1	21/09/2020	Draft	• Draft Plan published for consultation	Head of Directorate Business and Planning
0.2	25/09/2020	Draft	• Draft Plan updated for presentation to ASCH Senior Management Team	ASCH Senior Management Team
0.3	01/10/2020	Draft	• Updated to reflect feedback from ASCH Senior Management Team	
0.4	12/10/2020	Draft	• Updated to reflect feedback from Kent & Medway Winter stress test	
1.0	28/10/2020	Approved	• Draft prepared for presentation to ASCH Directorate Management Team	ASCH Directorate Management Team
1.1	18/06/2021	Approved	• Update to section 3 reflecting financial support and funding flows (April 2021 to 30 September 2021) • Minor revision to section 6.2 accounting for potential staffing pressure in summer 2021	ASCH Directorate Resilience Group
1.2	05/08/2021	Approved	• Update to section 1, 3 and 6 reflecting publication of Hospital discharge and community support: policy and operating model in July 2021	ASCH Directorate Resilience Group
1.3	26/09/2022	Approved	• Updated section 1, 3 and 6 reflecting publication of Hospital Discharge and Community Support Guidance in March 2022 • Updated throughout to reflect changes in NHS structure through the Health and Care Act 2022 • Plan approval by Directorate Resilience Group	ASCH Directorate Resilience Group
1.4	11/07/2023	Draft	• Updated throughout to reflect implementation of locality model across operational teams with effect from April 2023	
1.5	30/08/2023	Approved	• Updated to reflect publication of revised Operational Pressures Escalation Levels (OPEL) Framework 2023/24	ASCH Directorate Resilience Group

Version Number	Revision Date	Status	Summary of Changes	Reviewed / Approved By
1.6	05/01/2024	Approved	• Amended roles and responsibilities to reflect outcome of extended working review.	John Callaghan
1.7	01/08/2024	Approved	• Amended to reflect changes to section 82 of the NHS Act 2006 and section 74(1) of the 2014 Care Act made by the Health and Care Act 2022 • Organisational details including reference to Adult Social Care Connect, Arranging Support Teams and role of Short-Term Pathway Operational Manager updated • History of Plan Tests updated	John Callaghan / ASCH Directorate Resilience Group
1.8	02/10/2025	Approved	• Amendments to reflect publication of Integrated operational pressures escalation levels (OPEL) framework 2024 to 2026 • Minor update approved by ASCH Directorate Resilience Group in anticipation of major update in 2026 reflecting significant operational changes anticipated through Short Term Pathway and joint brokerage projects.	John Callaghan / ASCH Directorate Resilience Group

History of Plan Tests

Date	**Exercise / Actual invocation**	**Description of Scenario** (What happened, how long did the situation last)	**Lessons identified** (What went well, what didn't go so well, what could be done better next time?)
24/07/2024	Actual invocation	Maidstone and Tunbridge Wells NHS Trust declared OPE Level 4 status. KCC stepped up to support by reviewing patient flow through the system. Fifteen potential discharges were identified and put through an Extra-ordinary Practice Assurance Panel outside the diarised Panel process to expedite decision making thereby improve through-put.	Extra-ordinary Practice Assurance Panel outside the diarised Panel process now included in this plan as a potential option to maintain / improve through-put.
08/09/2025	Exercise	Exercise Aegis, NHS England's strategic winter preparedness exercise involving regional representatives from across the south east for a test event at Heathrow airport. Scenarios designed to prompt strategic reflection and collective action across systems, with a focus on: • Clinical and operational safety • Urgent and emergency care performance • Emergency department oversight • Strategic response to pressure • Governance and decision-making • Workforce resilience	Adult social care advised to expect increase pressure winter 2025/26 due to season flu.

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Kent County Council Adult Social Care and Health

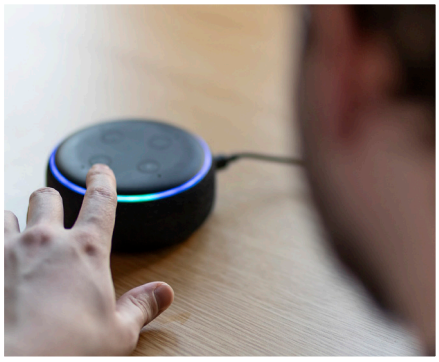
Making a difference every day



Adult Social Care Accommodation Market Position Statement

2025 to 2035






Kent Housing Group
The Voice of Housing in Kent

Kent County Council
kent.gov.uk

Contents

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Foreword

As Cabinet Member for Adult Social Care and Public Health, I am proud to introduce Kent County Council's Adult Social Care Accommodation Market Position Statement for 2025–2035.

This document sets out our shared vision for the future of housing and care in Kent - one where every adult who draws on social care has access to safe, inclusive and empowering accommodation that supports independence, dignity and wellbeing. It reflects our commitment to prevention-first approaches, person-centred care and strong partnerships across housing, health and the voluntary sector.

We know that the right accommodation can transform lives. Whether it's supporting people to remain in their own homes, expanding supported living or developing modern extra care housing, our goal is to ensure that Kent's care and housing markets are ready to meet the needs of our growing and diverse population.

This statement is not just a strategic document - it is a call to action. We invite providers, developers and partners to work with us to innovate, invest and co-produce solutions that will shape the future of adult social care in Kent.

Together, we can build a county where everyone has the opportunity to live well, in the place they call home.

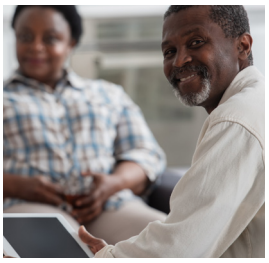
Diane Morton

Cabinet Member for Adult Social Care and Public Health
Kent County Council

Purpose







We all want to live in the place we call home, with the people and things we love, in communities where we look out for one another, doing the things that matter to us.

This Market Position Statement sets out how Kent County Council and our partners will work with the housing and care accommodation market to make that vision a reality.

This Market Position Statement (MPS) sets out Kent County Council's (KCC) strategic direction for the future of housing and care for adults who draw on social care, whilst also recognising the needs of young people transitioning to adulthood and care leavers. It brings together the shared ambitions of Kent's district and borough councils, Kent County Council and wider partners, to ensure that accommodation supports people to live the lives they want in safe, inclusive communities.

The MPS focuses on accommodation-based care and support provided by KCC, but also recognises our wider system leadership role. We have a responsibility, alongside district and borough councils, the NHS, housing providers and the voluntary sector, to influence the development of housing and care markets so that people who fund their own care, as well as those supported by the council, have access to the right options at the right time.

Our priority is prevention: ensuring people can remain independent at home for as long as possible, supported by good quality housing, adaptations, technology and timely care. Where higher levels of support are required, KCC aims to ensure a diverse mix of supported living, extra care, residential and nursing provision, with services that are modern, inclusive and designed around people's needs and aspirations.

This document highlights the current state of housing and care provision across Kent, identifies gaps, sets out projected needs and provides clarity on where investment and innovation are required. It is designed to give the market confidence to plan, invest, and partner with us. In doing so, it will support district and borough councils, developers and providers to demonstrate how they will meet the diverse accommodation and support needs of Kent's population – not just for today, but for the future.

The overarching objectives of this market position statement are to:

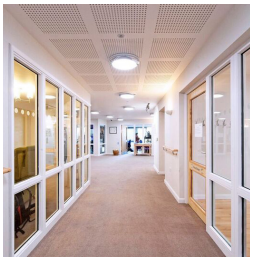
- Build a shared understanding of current and future accommodation needs across Kent, based on robust data and population projections.
- Signal commissioning priorities and investment opportunities so providers, developers, and partners can plan with confidence.
- Shape a diverse, sustainable market that offers high-quality, inclusive accommodation options across all adults that draw on care and support.
- Promote independence and prevention, ensuring accommodation supports people to live in the place they call home for as long as possible.
- Foster innovation and partnerships, working with providers, housing partners, health, and communities to develop new models of care and support.
- Strengthen workforce and financial sustainability, so Kent's care and accommodation market remains resilient and fit for the future.

We also need to consider the changes that the future will present, particularly in terms of local government review and the transition towards devolution. This document can be used to align our aims and support a smooth transition, ensuring that our shared objectives continue to be met as the local government landscape evolves.

We would like to thank all of our partners for their support in devising this statement, and we look forward to working with them to co-produce a delivery plan that will be essential in ensuring successful delivery.

Strategic context




There are a number of strategies and frameworks that this market position statement will have links with:

The Care Act 2014 requires Kent County Council to produce a 'market position statement' to give direction to providers and developers on future commissioning. Local authorities have a duty to write a market position statement to let providers know that what they commission could change and what their commissioning intentions are. It is a key element of the commissioning cycle, as it will inform the subsequent planning and delivery of services for future years.

Reforming Kent 2025-2028 sets out the vision for Kent and how we will work with partners and providers to deliver a sustainable, prevention-first adult social care system. It reflects national priorities for adult social care reform and provides reassurance that, whatever future governance arrangements emerge from the local government review, our direction remains clear: independence, prevention and partnership at the heart of commissioning.

Making a difference every day; our strategy for adult social care, 2022 to 2027 is how the council aims to underpin all the services that are available to Kent residents. The three core principles are:

- **Putting the person first** - always starting our conversation with the voice of the person, focusing on what the person can do and keeping them at the heart of everything we do; developing working relationships people can trust and helping them to achieve outcomes that are important to them.

- **Improving all the time** - finding innovative ways to help people and make sure any support offer is tailored to the individual, learning from feedback from the people we support and building continuous improvements together.

- **Measuring what matters** - understanding how we are making a difference to the life of the person we support by working with them, our staff and partners.

Adult Social Care and Health Directorate Commissioning Intentions 2022 to 2027: sets out how the directorate plans to create person-centred and flexible care and support in Kent to address the challenges and opportunities in adult social care.

Adult Social Care Prevention Framework 2025 – 2035: sets out the Kent Adult Social Care ambition to help more people in Kent to live fulfilled, healthy and independent lives now and in the future.

Kent and Medway Housing Strategy 2025-2035: sets out the Kent and Medway-wide objectives to deliver more homes, with infrastructure alongside, to improve the availability of affordable housing, the quality of the housing stock, and to achieve knock-on benefits to the health and wellbeing of residents.

By linking Making a difference every day, the Prevention Framework, Commissioning Intentions and the Kent and Medway Housing Strategy, this market position statement ensures that services are person-centred, proactive and sustainable. It provides the clarity and guidance needed for partners to plan and deliver housing and care that meets the diverse needs of Kent's population, both now and in the years ahead.

This approach aligns with the NHS Long Term Plan, supporting integrated, community-based care that promotes independence and prevents unnecessary hospital admissions. The market position statement also emphasises neighbourhood health, ensuring people have access to local services, social opportunities, and support networks that maintain wellbeing.

Strategic Direction for Commissioning Adults Accommodation in Kent

"We all want to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing things that matter to us"*

* (Time to act: A roadmap for reforming care and support in England, ADASS, Association of Directors Adult Social Services. Anna Dixon and Kate Jopling 2023).

Accommodation position: present and future

"I want to live independently in my own home with dignity"

A home is a place of belonging, comfort, and security. Home is often thought of as a place where individuals feel accepted, loved, and at ease, surrounded by familiar people, objects, and memories. For many, home is not just where they live, but where they feel most connected and at peace.

Supporting people in their own home

Our aim: Kent County Council is committed to ensuring that home is where people live best.

We will support all adults to remain as safely and independently in their own homes and communities for as long as possible, providing the right care and support to maintain wellbeing, choice and connection to their communities.

How we will achieve this:

- Providing information, advice and support
- Adaptations funded by Disabled Facilities Grants
- Carer support
- Smart homes and assistive technology – using connected devices, sensors and remote monitoring to help people live safely and independently while providing reassurance to carers and families
- The use of care within the right accommodation for the person
- The council will work with their district and borough council partners around the provision of housing across the county and we are clear that new properties need to meet the accessibility standards set out in part M4(2) of the Building Regulations wherever possible, with an appropriate proportion of new homes provided to M4(3) wheelchair accessible standard.

Supporting evidence: care and support provided in the home is the primary means of support provided by the council for most older people and adults with physical disabilities. The number of people supported in their own homes has increased over the last ten years. Significant population growth in the older age groups and moderate growth in the working age population will mean that more people need to be supported in their own homes over the next ten years. The projected figures are likely to be higher still if the council is successful in diverting people who would otherwise have been placed in residential care.

People receiving care and support in their own home					
	Older people	Working age adults with physical disabilities	People with mental health conditions	People with learning disabilities	People with sensory needs
Current demand	3,480	760	100	80	60
Projected demand in 2035 (based on population growth)	+710	+60	+10	+10	<0

Source: Kent County Council caseload data; ONS sub-national population projections (2022 based). Figures rounded to nearest ten.

The council, working with partners and providers, will need to address the challenge of increasing the scale of the care workforce, focussing on the quality of care and the skills and retention of care workers. These challenges will not be able to be addressed by the council and its partners alone and support from central government will be sought where required.

Our shared aims:

- **Home is best:** We are committed to supporting people to live safely, independently and well in their own homes and communities for as long as possible.
- **Flexible, person-centred support:** Providers must deliver care that adapts to a person's routines, preferences, and goals, rather than imposing rigid schedules. Care should empower people to maintain independence, participate in their communities and make choices about when, how and by whom their care is delivered.
- **Expand and strengthen care at home:** We will work with providers to expand high-quality care and support delivered in people's homes, ensuring services are person-centred, flexible and built around individual needs, outcomes, and aspirations. Providers must be equipped to deliver care that adapts to changing needs and promotes independence.
- **Sustainability and diversity in provision:** We seek a balanced market that includes a mix of small, medium, and larger providers, ensuring resilience to change and which promotes stability across Kent. Services must be financially sustainable, adaptable, and able to respond effectively to population needs.
- **Digital and assistive technologies:** We will commission innovative digital solutions and assistive technologies that promote safety, independence and connection. This includes the use of remote monitoring and virtual visits where appropriate, helping people to stay well at home while ensuring timely support when their needs change. We will work with providers who can integrate technology into personalised care, improving outcomes for individuals and supporting carers and professionals to deliver responsive, high-quality services.
- **New build standards:** All new build homes are to be built to M4(2) accessible and adaptable homes standards with an appropriate proportion provided as M4(3) wheelchair accessible as evidenced by district and borough needs assessments.
- **Disabled Facility Grants:** Work with district and borough council partners to ensure people are able to access Disabled Facilities Grants for adaptations as efficiently as possible.
- **New homes delivery programmes:** Engage and support the Maintaining Independence Through Housing (MITH) project to deliver more homes for older people that help maintain independence for longer.
- **In-house and partnership options:** Where market capacity is limited, we will explore in-house or partnership delivery options to ensure the continuity of care and equity of access across Kent.

Supported living

"I want to live in a place that feels like home and suits me"

Supported living refers to schemes that provide personal care and or support to people as part of the support that they need to live in their own home. The personal care/support is provided under a separate contractual arrangement to those for the person's housing.

Accommodation can be for one person or shared with others and may be provided by private or social landlords. Support can range from a few hours a week to 25 hours care, delivered on a one-to-one basis. Support levels are flexible and can increase or decrease as a person's needs change, helping people to build skills, confidence and independence over time.

Our aim: To have a flexible range of supported living options available to people in the area that they want to live in. We want to transform supported living across Kent so that people can live independently in homes of their choice, with flexible, person-centred support that adapts as their needs change. Our ambition is to ensure everyone can access high-quality, sustainable options that promote independence, wellbeing, and connection to their community.

How we will achieve this:

- Collaborate with district and borough partners to shape inclusive housing strategies that increase access to suitable social housing and enable people to remain in their chosen communities.
- Co-design new supported living models with providers, people with lived experience and families – expanding provision for those with complex needs and ensuring options reflect diverse aspirations.
- Recommission supported living contracts to embed flexibility, person-centred outcomes and innovation – including blended support models, technology-enabled care, and sustainable pricing.
- Encourage investment and partnerships that stimulate growth in under-served areas and promote quality, stability, and long-term sustainability across the market.

Supporting evidence: Supported living is the primary accommodation or service for people with learning disabilities and mental health needs in Kent. The number of people accommodated in supported living has increased over the last ten years. Modest growth in the need for supported living placements for working age people is expected over the next ten years due to population growth. However, the aim to reduce reliance on residential care over time will increase demand for supported living further as people are placed in more independent settings. There is some uncertainty over the projected demand from people with mental health conditions in particular, with recent pressures suggesting that future need may be higher than population projections would suggest. In children's services, the focus is to maximise children's independence so that when they turn 18, where eligible, they will be suitable for supported living – this will also increase demand on services.

We do not currently have access to data specifically around the needs of neurodivergent people. We are working closely with district and borough councils to support understanding of the specific accommodation need of neurodivergent people who draw on care and support.

Current supply

897 supported living schemes
Accommodation for **2785** people
For all people who draw on care and support but the largest number available for those with learning disabilities.

Current supply - location of supported living schemes

Cluster	Number of schemes
Ashford	46
Borough Green and Wrotham	17
Canterbury and Coastal	69
Canterbury and Rural	25
Cranbrook	1
Dartford, Gravesham and Swanley East	61
Dartford, Gravesham And Swanley West	22
Edenbridge	2
Elham	8
Maidstone West	97
Maidstone West (Medway)	121
Paddock Wood	14
Sevenoaks	4
Sheppey	17
Shepway	105
South Kent Coast	107
Swale and Canterbury	19

Thanet and Coastal	109
Tonbridge	19
Tunbridge Wells and Langton Green	34
Total	**897**

People in a supported living service (excludes Shared Lives placements)

	Older People	Working Age Adults with Physical Disabilities	People with Mental Health Conditions	People with Learning Disabilities	People with Sensory Needs
Current demand 2025	190	510	920	1,660	60
Projected demand 2035 (based on population growth)	+40	+40	+70	+120	<0

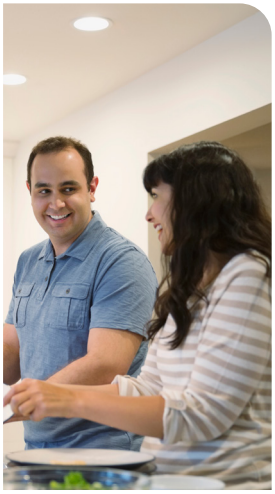
Source: Kent County Council caseload data: ONS Sub-national population projections (2022 based) figures rounded to the nearest 10.

Our shared aims:

- **Expand supported living across Kent:** We are committed to ensuring that as many people as possible can live in their own homes within the communities of their choice.
- **Flexible, person-centred support:** We want to commission support packages that enable individuals to build skills, grow in independence, and live as independently as possible.
- **Tailored housing solutions:** Working with district and borough partners, we will support people to live where appropriate in general needs housing with tailored support that meets their assessed needs and aspirations. We want supported living to be affordable and within communities rather than campus style provision.
- **Innovative support for complex needs:** We want to collaborate with providers to create services for people with complex needs, including drug and alcohol dependencies and people with a forensic history. These providers will use trauma-informed, recovery-focused, and outcome-driven approaches.
- **Short-term support for hospital discharges:** We are creating short-term supported living for people leaving hospital under mental health sections. These services will give intensive, tailored support to help people regain independence and move confidently into their own homes, working closely with local partners to make sure housing options are available.
- **Technology-enhanced support:** Providers will work with the Council to utilise technology to enhance the support offered within supported living.
- **Support for young people and care leavers:** We will ensure supported living is available for young people and care leavers, co-designed with children's services to offer safe, stable environments that help build independence and readiness for adulthood.

Extra care housing

"I feel safe, I can live the life I want and I am supported to manage any risks"



Extra care housing provides people with the opportunity to live in their own purpose built self-contained home while accessing care, meals and community spaces or site. This can enable people to live independently for longer. Emergency response is available 24-hours-a-day with individual care and support delivered as required.

Our aim: To make extra care housing a preferred, mainstream option across Kent, enabling people to live independently with the support they need. We want extra care to be flexible, innovative and outcome-focused preventing crisis, enhancing quality of life and providing a sustainable alternative to residential care.

How we will achieve this:

- Actively promote extra care to residents, families, and professionals, highlighting it as a first-choice alternative to residential care.
- Enable early moves into extra care, with wrap-around services that maintain independence and prevent unnecessary hospital or residential placements.
- Identify and address barriers to take up of extra care housing e.g. moving costs/arrangements.
- Work with providers to co-design inter-generational, tech-enabled, and flexible extra care models that meet diverse needs and lifestyles.
- Identify underused land, outdated care homes, or other assets with public sector partners to deliver high-quality, sustainable extra care housing.
- Engage in planning processes to ensure the need for extra care (for rent and sale) is reflected in policy where appropriate.
- Encourage providers to integrate technology and data-driven approaches to improve independence, safety, well-being and service sustainability.

Supporting evidence: Various research studies have confirmed the benefits of extra care in terms of wellbeing for residents and potentially cost savings in care[1].

Extra care is now an established form of independent living accommodation within Kent. Kent has 834 homes for older people commissioned directly by the council. There are a further four schemes comprising a total of 250 homes which are not commissioned directly by the council. There are a further 433 homes in private extra care schemes, primarily for leasehold owners and a further 313 expected to be completed 2026.

[1] Extra Care Housing: The Current State of Research and Prospects for the Future - Blogs - Housing LIN

There is large scale potential demand for this accommodation with projections suggesting a need for almost 500 additional social/affordable rented extra care homes by 2035, not including any current shortfall in provision. Current schemes are designed for older people and typically are restricted to those aged 55 and over although the model is likely to benefit some younger people with care needs.

There is a particular need on the Isle of Sheppey, Canterbury and Thanet where there is either no provision or schemes are full with long waiting lists.

Current Supply

- **18** Extra Care Schemes focused on affordable rented provision
- **834** Flats in the **18** contracted schemes (just over half are one bedroom with the remainder being two bedroom)
- **90%** are social rented homes, with **10%** for shared ownership

There is a wider market of extra care schemes for older people includes 11 further schemes totalling 683 units (250 for social/ affordable rent) with the remainder 433 primarily for leasehold sale.

Current demand and potential growth in demand 2025-2035

	People living in Extra Care 2025	HLIN 'ideal'** rate of provision 2025	Shortfall based on HLIN 'ideal' rate of provision 2025	Growth in demand 2025-2035 (excl shortfall)
Older people in extra care (The council's placements)	830	2,640	1,560	+490
Older people in other extra care (social rented but not funded by the council)	250			
Older people in other extra care (private, primarily leasehold)	430*	5,290	4,850	+970

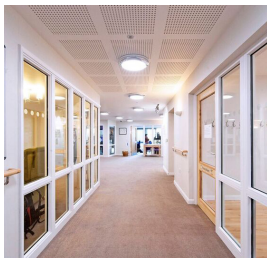
**Approximate figures as exact tenure mix and occupancy rate in private schemes not published.*
*** HLIN tool sets ideal rate of provision at 15 units per 1,000 people aged 75+ for rent; 30 units per 1,000 people aged 75 and over for sale. In practice, this is not achieved in any authority area in England but is an aspirational prevalence rate included in the model. If this rate was achieved it would involve greater number of moves from other accommodation types including mainstream housing and diversion of those who may otherwise be placed in residential care. Figures rounded to nearest ten.*

Our shared aims:

- **Expand extra care housing across Kent:** We are committed to ensuring that as many people as possible can live in their own homes within the communities of their choice.
- **Alternative to residential care:** Extra care is to be positioned as a modern, flexible, and sustainable alternative to traditional residential care, addressing gaps in provision and supporting independence.
- **Innovative, needs-led approach:** New extra care schemes will be designed around individual needs rather than age, supporting intergenerational living and flexible care packages.
- **Connected to communities:** Extra care should be fully integrated into local communities, promoting and encouraging social inclusion, access to local services, and opportunities for residents to actively participate and contribute.
- **Modern, sustainable homes:** Providers will deliver fit-for-purpose, cost-effective schemes with viable business models. Technology will be used to enhance independence, safety, and overall outcomes for residents.
- **Expanding care-ready schemes:** We will collaborate with district and borough councils to increase the provision of "care-ready" schemes that can transition into full extra care when the need arises – for example, Farrow Court in Ashford.

Residential and Nursing Care Homes

"I feel safe and supported in my residential home, and I am treated with dignity and respect by staff who understand my needs"



Residential care homes provide accommodation, personal care and support for people who need extra support in their daily lives, which cannot be delivered in their own homes.

Nursing care homes offer a higher level of personal care and will have a qualified nurse on duty at all times. The council commissions nursing care placements for people who require nursing care in instances where their social care needs are greater than their health care need.

Our aim: To enable those individuals that require a residential or nursing home to have access to good quality provision that holds residents central to decisions with a caring, compassionate and competent workforce. Residential and Nursing Care will only be considered when community-based support is not possible.

We are committed to delivering good quality, person-centred care in a sustainable and cost-effective way, supported by a skilled, compassionate and competent workforce.

How we will achieve this:

- Communicate clearly with the market around gaps in provision.
- The council will recommission its older persons residential and nursing care services to address a range of strategic, financial and operational challenges.
- We will work with district and borough planning teams and explore in-house options to ensure that all new or expanded care home provision meets the needs of residents and aligns with the council's strategic priorities.
- We will engage with providers to ensure services are delivered by a competent, compassionate and sustainable workforce.

Supporting evidence: there are 4,386 people placed by the council in residential care homes and 1,213 people placed in nursing care homes. Most of those placed are older people with limited provision for other people who draw on care and support with other needs, particularly for nursing care. The number of older people placed in residential care has stabilised over recent years as more people are being supported in their own homes or extra care housing. The projected need for residential care, driven by population growth, could be diverted to these independent settings in the future. Reduced reliance on residential care for working age people is also expected, with the projected growth in demand due to population growth instead being met by supported living placements. Growth in demand for nursing care is expected over the next ten years because of the complex needs associated with an ageing population. Whilst strong growth in demand is not expected from working age groups, there are some current shortfalls in provision making it hard to find placements.

Current supply residential care home total number of beds in Kent

Authority	Learning disabilities	Mental health	Mental health and older people	Older people	People with physical disabilities	Not known	All
Ashford	159	15		196			370
Dartford	203	103		1,074	68		1,448
Dover							
Folkestone and Hythe Canterbury	250	29		600	52		931
Gravesham	53	14	247				314
Maidstone	83	16		534	21		654
Sevenoaks	41			444	24		509
Swale	155			486	64	5	710
Thanet	122	8	100	848			1078

Tonbridge and Malling	21			206	38		255
Tunbridge Wells	77	17		252	30		376
Kent total	1431	234	100	5754	297		7822
Medway							15
Unknown						1	1
Total	1446	234	100	5754	297	6	7837

Source: Kent County Council Adult Social Care and Health directorate

Residential care home total number of beds in Kent

Nursing care home accommodation (beds) in Kent					
Authority	Learning disability	Mental health	Older people	Physical disability	All
Ashford	0	0	619	32	651
Canterbury	9	0	542	55	606
Dartford	0	0	561	0	561
Dover	40	0	357	0	397
Folkestone and Hythe	0	0	547	39	586
Faversham	0	0	289	0	289
Maidstone	0	23	762	0	785
Sevenoaks	0	0	533	0	533
Swale	0	0	243	0	243
Thanet	0	0	510	0	510
Tonbridge and Malling	0	0	722	0	722
Tunbridge Wells	0	0	830	0	830
Unknown	0	0	36	0	36
Kent total	49	23	6551	126	6749

Current demand for residential care (long term and short term placements and small % placed outside county) funded by Kent County Council					
	Older people	Working age adults with physical disabilities	People with mental health conditions	People with learning disabilities	People with sensory needs
Current demand 2025	2,890	300	370	820	40
Projected demand 2035	+580	+20	+30	+60	<10

Source: Kent County Council caseload data; ONS Sub-National Population Projections (2022 based). Figures rounded to the nearest 10.

Key note*
The number of older people and working age adults placed in residential care has stabilised over recent years as more people are being supported in their own home, supported living or extra care housing.

Kent County Council's strategies mean that not all projected demand will be met by residential homes. People who draw on care and support with more complex needs will continue to require residential placements, but alternative models are expected to reduce the projected demand for residential placements.

This approach supports independence, aligns with people's preferences and ensures residential care is focused on those with the highest and most complex needs.

Current Demand Nursing Care funded by Kent County Council					
	Older People	Working age adults with physical disabilities	People with mental health conditions	People with learning disabilities	People with sensory needs
Current demand 2025	1,110	60	20	<10	20
Projected demand 2035	+230	Current placement pressures but limited growth long term	Current placement pressures but limited growth long term	Current placement pressures but limited growth long term	Stable

Source: Kent County Council caseload data; ONS Sub-National Population Projections (2022 based). Figures rounded to the nearest ten.

Our shared aims:

- **Independence first:** We are reducing reliance on residential care wherever possible, supporting people to live independently in the community.
- **Stable and targeted demand:** Overall demand for older people's residential care has stabilised. Where possible, alternative support options are offered before residential placement.
- **Specialist and inclusive services:** Increasing need for nursing and residential services that support bariatric needs, physical disabilities, mental health and dual diagnoses, including drug and alcohol dependency.
- **Fit-for-purpose and sustainable homes:** We want modern, safe, and accessible homes that support independence and well-being. Providers must demonstrate viable business models to ensure long-term sustainability - small, substandard, or unviable homes will not meet the council's requirements.
- **Digital and innovative approaches:** We are looking for providers who use digital technologies to enhance independence, monitor outcomes, improve safety, and increase efficiency, while keeping care personal and responsive.
- **Supporting hospital discharge:** We need residential and nursing providers who can support people leaving hospital, including short-term and step-down placements, to ensure safe, timely transitions back to the community or to longer-term care.
- **Intensive support for independence:** Step-down services should provide intensive, tailored support that enables people to regain independence, reduce readmissions, and move confidently to more independent accommodation where possible.
- **Sustainable and affordable:** All provision must be cost-effective and financially sustainable. Providers should understand local authority care rates and ensure services remain viable as private funding changes
- **Connected to communities:** Residential provision is embedded within communities as opposed to being a campus provision (a group of homes clustered together on the same site sharing staff and facilities).

Eligible children and young people transitioning to adult social care

"I am supported to be as independent as I can, doing things I like in my local community and I have a choice about my future."

Not all children in care or those known to children social services will require adult social care accommodation services. Children's services start talking to children at the age of 14 about what their ambitions are for adulthood, where they might need services from adult social care and their future accommodation options. Over time, the intelligence and forecasting will become better and feed into the transition plans and future accommodation needs.

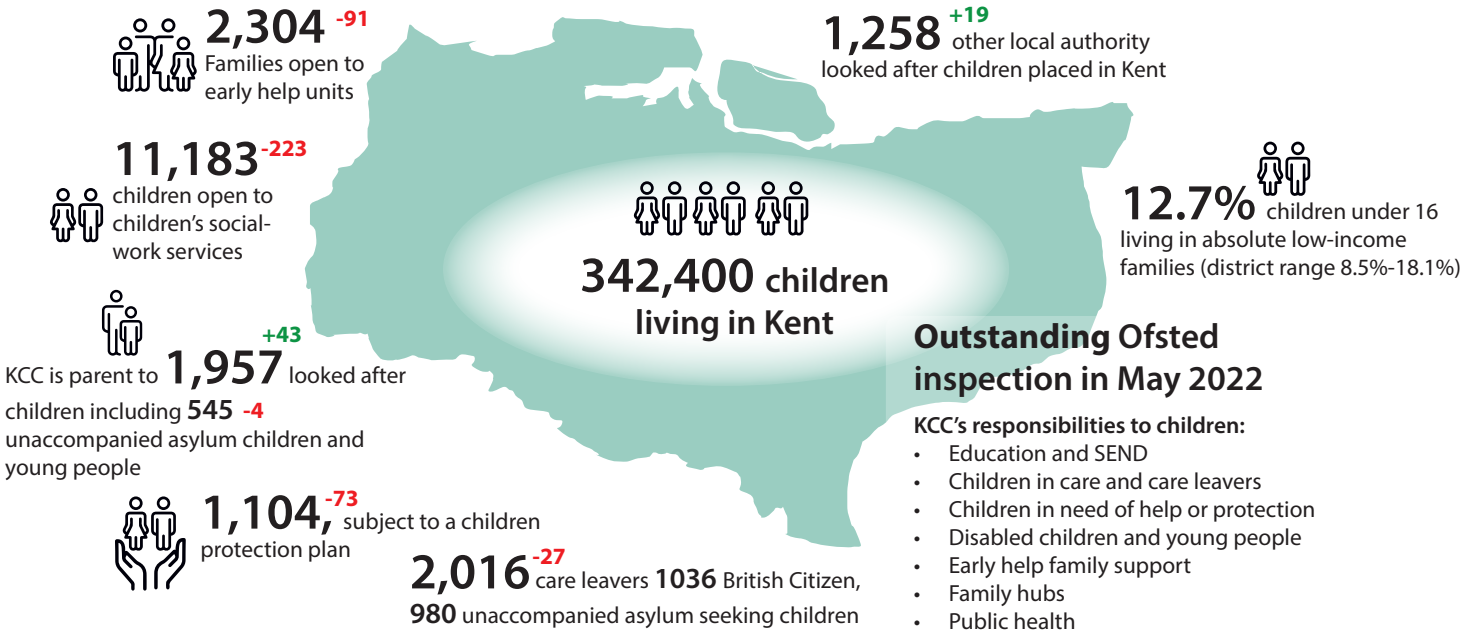
Our aim: is for young people to achieve their ambitions and fulfil their aspirations as they prepare for adulthood. We want to make sure, where eligible, their transition to adult social care is seamless, they are living in high-quality accommodation that they can call home and once they have gained independent living skills, they feel confident and ready to move on to their own independent accommodation.

How we will achieve this:

- As a children's service, we will be flexible in making sure that our young people continue to be accommodated with good support provided from the age of 16, to develop their independence skills.
- Focus on early intervention, early help and prevention. We recognise the importance of earlier, preventative action to support children and families so that fewer children become looked after by targeting services to those who are on the edge of care and are embracing the aims of the Families First Programme.
- To fulfil our duty to support the most vulnerable children and families in our county, ensuring joined up safeguarding and effective corporate parenting arrangements, the Children, Young People and Education Directorate fully acknowledge that this means planning, with the Adult Social Care and Health Directorate, to make sure that those children who will become eligible for adult social care, have their needs assessed, the voices heard and have a say in where and how they want to live as adults.
- To ensure that both the Children, Young People and the Education Directorate, Adult Social Care and Health Directorate work collectively to make sure that transition between the two statutory responsibilities is a seamless experience with least disruption.

Accommodation pathway	
Age	**Accommodation**
0-18	• Foster Care (in a family home - DFG applications may be required for those accommodating disabled children) • Children's residential homes (usually accommodating four children in an adapted large family home) - The council buys this service in from the provider market and is developing its own in-house provision. District councils welcomed the early discussions and are supporting the council in this new direction.
16/17	• Kent supported homes - host provision, in a family home • Supported accommodation – shared accommodation with access to at least five hours' support per week - must be registered with Ofsted • Supported accommodation - larger homes or purpose-built shared accommodation with access to up-to ten hours' support per week' must be registered with Ofsted.
18 plus care leavers	• Shared accommodation up to the age of 19 • Some legacy accommodation up to the age of 21 (intention to cease this by March 2026).

Introducing Kent's children and young adults



Red figures show the change since last year (31 Dec 2024 vs 31 Dec 2023)

Our shared aims

- **Innovative, flexible services for young people:** We are developing flexible services to accommodate young people from age 16 who require tailored support. These services are designed for those who previously would have needed significant mental health support or detention through Youth Justice services.
- **Partnership working with housing partners:** The council continues to work closely with district and borough housing partners to review joint protocols. This focuses on supporting homeless 16 and 17 year olds, as well as providing transitional support for care leavers moving into independent or supported living accommodation.

Summary of current position and future direction

	Current position	Future direction
Older people including dementia	• Increase in the number of older people being supported in their own homes • Over-provision of standard residential care • Under-provision of dementia nursing care • Under-provision of extra care • Inefficient rehabilitation and enablement model for intermediate care	• Increase provision of extra care housing • Increase mainstream housing supply that enables people to live in their own home for as long as possible • Aim for all new build housing to be built to M4 (2) accessible and adaptable standards and % of M4 (3) wheelchair accessible housing • Any increase in provision should be for nursing and dementia care homes that cater for complex needs • Increase fit-for-purpose modern care homes and as a result reduce older housing stock • Greater use of tele-technologies across all provision
Learning disability	• Varying availability of supported accommodation • Lack of supported living that encourages people to live as independently as possible. People become 'trapped' in support linked to accommodation for financial viability purposes • Lack of social housing opportunities for people with an learning disability to live with support in their communities • Lack of provision for people with an learning disability and complex needs - more placements are made outside of Kent because of this. • Lack of provision for people with an learning disability and forensic history	• Residential provision to be reserved for people with complex needs • Increase in supported living provision within Kent for people with an learning disability and complex needs • Greater use of tele-technologies across all provision • Extra care housing to be needs led rather than age-led to open the option of extra care housing for people with an learning disability to access where appropriate

Physical disability	• Lack of suitable mainstream housing and supported living to enable people with a physical disability to live independently • People with a physical disability end up in unsuitable placements due to lack of adapted housing • Varying waiting lists for disabled facility grants across the county	• Increase mainstream housing supply that enables people to live in their own home for as long as possible • Aim for all new builds to meet M4 (2) accessible and adaptable standards and for % of new builds to meet M4 (3) wheelchair accessible standards • Extra care housing to be needs led rather than age-led to open the option of extra care housing for people with a physical disability where appropriate • Promote use of tele-technologies across all provision
Mental health	• Lack of suitable provision for people with mental health needs across the county • People leaving hospital need a more intensive support that can then reduce and there is a lack of this type of provision • Lack of suitable supported living placements that allow flexibility in support packages to allow increase or reduction in support as people's mental health improves or declines • The market needs clarity around the type of support available and how this can work with different types of accommodation options	• Develop more supported accommodation specifically to meet the needs of people who draw on care and support with mental health needs • Develop a model that allows flexibility of support for people that increases or decreases as their mental health improves or declines • Replicate models across the county for "step down" accommodation for individuals occupying acute psychiatric beds who are clinically ready for discharge • Ensure health, housing and social care partners have a coordinated response to the need for more accommodation options for people with mental health conditions • Provide some services specifically for women only with mental health needs
Children and young people supported in their own home supported living/extra care	• Other local authorities placing in Kent feed the provider market to expand with KCC buying only 21% of the Children's Home placements in Kent • Due to affordable access to these placements, KCC is buying 50% of placements for Kent children outside of Kent	• Be clear where young people are able to hold tenancies, or have others sign for them • Improve the experience of those eligible young people transitioning to adult social care

Autistic people without a learning disability	• Limited availability of specialist providers and accommodation • Lack of specialist provision that can support with co-occurring conditions e.g.: diabetes management, British Sign Language trained staff (this is an issue in learning disability too) • Limited availability of sensory-friendly environments • Inconsistent inclusion of autistic voices in commissioning • Limited flexibility in support models, such as the application of Positive Behaviour Support (PBS), which may not fully accommodate the diverse needs and preferences of autistic adults • Limited commissioning of autism specific assistive technology	• Increase provision of autism-specific supported living and residential services, including sensory-friendly environments • Develop flexible support models that accommodate fluctuating needs and communication preferences and needs • Embed co-production with autistic adults in commissioning and service design • Expand local provision for autistic people with complex needs to reduce out-of-county and inappropriate placements • Promote and expand the commissioning of assistive technology tailored to autistic individuals (e.g. communication aids, sensory regulation tools) • Joint commissioning with health and • Explore crisis accommodation to prevent admission and "step down" provision to support discharge • Autism training for all social care and housing providers

Technology and accommodation

Technology Enhanced Lives (TELS) is Kent County Council's dedicated assistive technology service for adult social care. This service was co-produced and harnesses innovative digital solutions tailored to each individual, empowering people to live with greater independence, dignity, and safety in the place they call home through an outcomes-based approach.

Assistive technology plays a vital role in enhancing the efficiency of care and support and helps with the growing requests for support. TELS offers a forward-thinking, technology-first approach. The service includes multiple pathways:

- **TELS Long-term support** for individuals with Care Act eligible needs
- **TELS Short-term support** for hospital discharge, enablement, and respite
- **TELS Private pay options** for self-funders and sign-posting
- **TELS Digital skills support** to build confidence in using technology

The success of TELS is built on collaborative partnerships between Kent County Council and the wider care industry. By adopting a technology-first mindset, TELS is helping to deliver personalised, sustainable care and support solutions that also alleviate capacity pressures across the sector.

Between November 2023 and August 2025, TELS has supported over **3,000 Kent residents** with technology to manage their care and support needs. Solutions have included monitored equipment and sensors linked to a 24/7 monitoring centre, pager-connected devices, fall sensors, standalone devices, GPS-enabled devices, and AI-driven systems that help understand daily living patterns.

TELS is delivered in partnership with the **PA Consulting - led Argenti consortium**, with technology assessments and installations provided by **Red Alert**, and a 24/7 response service for monitored equipment delivered by **Appello**.

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DECISION REPORT TO CABINET COMMITTEE

From: Diane Morton, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Adult Social Care and Public Health Cabinet Committee – 12/11/2025

Subject: Long-Acting Reversible Contraception Recommission

Decision no: 25/00094

Key Decision: Yes – It involves expenditure or savings of more than £1m

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? *Yes*

Summary:

Kent County Council has a statutory duty to provide certain sexual health services, including contraception, as per Section 6 of The Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013.The services are funded solely from the Public Health Grant.

This paper sets out the commissioning strategy for Long-Acting Reversible Contraception (LARC) Services in Primary Care which aims to maintain and strengthen the service, ensuring continuity of care and delivery of the Council's statutory obligations.

The contracts for the current service cease on 30th November 2026. It is proposed that Long-Acting Reversible Contraception (LARC) Services in Primary Care are recommissioned, with the aim entering new contracts from 1st December 2026 to ensure there is no gap in service for Kent residents. The process will adhere to 'Spending the Council's Money' and relevant procurement legislation.

These are open access, demand led services, delivered across multiple providers. As a result, expenditure will be impacted by levels of uptake, number of suppliers, cost fluctuations of devices, negotiated tariffs and other external factors. The total spend for the services in scope of this decision will be £13m over 6 years 4 months.

Recommendation(s):

The Adult Social Care and Public Health Cabinet Committee is asked to CONSIDER and ENDORSE, or MAKE RECOMMENDATIONS to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A)

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1. Introduction

1.1 This report seeks the committee's endorsement for the proposed commissioning strategy for Long-Acting Reversible Contraception (LARC) services in primary care, due to be implemented from 1st December 2026 up to no later than 31st March 2033.

1.2 This paper provides an overview of the current service and presents recommendations in the context of the current and planned future commissioning of the LARC service.

1.3 Kent County Council (KCC) has a statutory duty to provide certain sexual health services as per Section 6 of The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. These include the three broad responsibilities of:

I. Testing and treatment for sexually transmitted infections (STIs).

II. Advice on, and reasonable access to a broad range of contraceptive substances and appliances.

III. General advice and promotion of key messages to enable positive sexual health outcomes and to prevent ill sexual health.

1.4 Commissioning LARC in primary care ensures KCC meets its statutory duty to provide reasonable access to a broad range of contraceptive substances and appliances. LARC methods are most commonly known as coils and implants and offer a longer term, more effective alternative to the NHS-funded routine contraception in general practice, for example the oral contraceptive pill (‘the pill’).

1.5 Sexual Health is a key part of ensuring the overall health and wellbeing of the Kent population. Good sexual health and wellbeing can improve fundamental aspects of people's lives including protection from long term consequences of disease and risks to physical and psychological health. It can also contribute to people’s access to education, economic participation and increase opportunities in the social and community spheres. Unplanned pregnancies can contribute to poor health outcomes, and provision of these statutory services plays an important role in reducing the negative consequences and overall costs of ill sexual health.

1.6 Long-Acting Reversible Contraception (LARC) services are guided by national best practice and have a strong return on investment evidence base. LARC in

primary care is highly cost-effective, with an estimated ROI across the system of £48 for every £1 invested (see 15.2).

1.7 'Primary Care' in this document refers to General Practice (GP) delivery. It is a healthcare service that serves as the first point of contact for patients seeking medical attention. In its widest context, primary care services include GPs, dentists, pharmacists, and opticians. LARC services in primary care, are undertaken in GP practices.

1.8 Recommissioning of the LARC in primary care services will ensure that Kent residents do not experience a gap in service provision and receive continuity of care from trusted providers after the current contracts expire on the 30th November 2026. This ensures access to the right service, in the right place, for people in Kent who need it, and contributes towards positive sexual health outcomes.

2. Strategic context

2.1 Provision of LARC services aligns with national strategies such as the Women's Health Strategy for England (2022) by the Department of Health and Social Care (DHSC). The service supports the council to deliver against the NHS Long Term Plan, by reducing unplanned pregnancies, improving population health outcomes, and addressing health inequalities through accessible, preventative care delivered in community settings.

2.2 The service will continue to support the Public Health Outcomes Framework (PHOF) published by the Department of Health and Social Care. PHOF provides a national structure for improving and measuring public health outcomes. This includes sexual health indicators that guide service delivery and enable benchmarking, such as the number of LARCs fitted in Kent compared with other local authorities. This alignment ensures that the service remains outcome-focused, evidence-based, and accountable for delivering value to the population.

2.3 Locally, the provision of the services supports the Kent and Medway Integrated Care Strategy and delivers against recommendations within the most recently published Kent Sexual Health Needs Assessment 2024. These include expanding and ensuring local convenient access to contraception, and targeting priority groups, such as young people and those experiencing health inequalities. This is with the aim of ensuring provision is equitable, responsive to local needs, and embedded within wider health and care pathways.

2.4 Commissioning of LARC contributes to the objectives of the Council's strategic statement by supporting a preventative approach to improving population health and empowering people to make their own contraceptive choices. By ensuring access to contraception the service helps prevent unplanned pregnancies, which are significant contributors to poor health outcomes, and address health inequalities across Kent.

2.5 The service is also aligned to the Council's strategic statement by delivering measurable financial benefits. Preventing unplanned pregnancies reduces demand on health and social care services, avoiding associated costs and improving long-term outcomes for individuals and families.

3. Background

3.1 Contraceptive LARC provided in primary care has been commissioned by KCC since 2013 and the Council has a strong history of widespread GP participation and coverage. Prior to this LARC was commissioned via a primary care Local Enhanced Service within the NHS.

3.2 Contraceptive LARC services in Kent are provided through two main routes: within primary care settings by GP practices and in the specialist Integrated Sexual Health (ISH) clinics.

3.3 ISH Services are offered by Maidstone and Tunbridge Wells NHS Trust (MTW) in West and North Kent, and by Kent Community Health NHS Foundation Trust (KCHFT) in East and South Kent. The ISH specialist services primarily cater to people for their contraceptive needs who have more complex cases.

3.4 Currently, Kent has 102 contracts with GP practices for this service, which in some instances involve one contract covering multiple sites. Therefore, the overall number of GP surgeries are higher. The number of GP surgeries signed up to the LARC services contract can vary over time. Importantly, GP practices are embedded within local communities, offering widespread and easily accessible services across the entire geography of Kent.

3.5 The GPs and their practices play a crucial role in maximising patient choice and increasing the availability of LARC appointments. In Kent, approximately 11,000 procedures are performed annually by trained and certified practitioners. During April 2024 to March 2025, primary care providers performed 53% of all LARC procedures.

3.6 The service provides three types of LARC, with their approved lifespan being three to eight years, demonstrating the financial benefit and personal benefit to the Kent resident. These are:

- Intra-uterine device (IUD) - This is the copper coil, a non-hormonal option.
- Intra-uterine system (IUS) - This is the coil and uses hormones.
- Sub-dermal Implant (SDI) - This is a hormonal implant that sits under the skin.

3.7 In addition to Council commissioned service providing a variety of LARC devices for contraceptive reasons only, Integrated Care Board (ICB) commissions Intrauterine System (IUS) for other health care purposes, including gynaecological reasons.

3.8 NICE Clinical Guideline 30 recommends that all healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods. Under KCC's current contract LARC can only be fitted and removed by practitioners (nurses or doctors) who are trained and accredited with Letters of Competence (LoC) from the College of Sexual and Reproductive Health (CoSRH), which provides assurance of a minimum recognised standard of training and competency.

3.9 LARC is an extremely effective method of contraception. LARC offers the patient over 99% effectiveness in preventing pregnancy, is long lasting (typically

over three years from insertion/implantation) and is not user dependant unlike other methods such as oral contraceptive (medication which the patient must remember to take as prescribed) (see 15.9).

3.10 Without LARC being offered in primary care, patients would need to access this provision from the integrated sexual health services (ISHS) or out of area provision (using GPs or sexual health clinics that are outside of Kent, e.g. London). Access via the ISHS clinics would place pressure on an already busy service and would cause delays in care. The use of out of area services would increase costs to the council and there would be less control over spend and costs. It would also result in some Kent residents being unable to access the contraception they need in a timely way.

3.11 The LARC commissioning work has been completed in alignment with the comprehensive transformation programme Kent County Council Public Health has been undertaking since July 2023. The Public health service transformation programme (PHSTP) was designed to improve service delivery to communities, particularly targeting underserved communities, aiming to ensure that services are efficient, evidence-based, deliver outcomes and achieve best value.

3.12 KCC Integrated Commissioning team has been collaborating with Kent and Medway ICB (KMICB), Kent Women's Health Hubs, and Medway Council commissioners to keep abreast with the evolving primary care landscape and to explore opportunities to harmonise and streamline the local LARC system working towards more sustainable and joined up care system.

3.13 The number of LARC procedures in GP practices has declined over time in the Kent population. 15,530 procedures were performed in 2018-19, compared with 10,074 in 2024-25. This is due to several reasons including behaviour change in the population, static tariff payments, and limited growth in the number of trained LARC fitters. This key decision will support with a longer-term holistic approach to increasing LARC uptake back to pre-pandemic levels.

3.14 The outcomes that this service will aim to achieve are:

3.15 Increase in the number of eligible people in the population choosing LARC as their contraception method.

3.16 Sustain and increase the number of GP practices participating in this contract.

3.17 The use of LARC increases to contribute to a decrease in the number of unplanned pregnancies and terminations of pregnancy.

3.18 Greater awareness in the professional and resident populations of the benefits of LARC.

4. Commissioning Options

4.1 The recommendation is to maintain and strengthen LARC services in primary care through the re-procurement of these services, ensuring the council meets its statutory obligation.

4.2 Options that were considered for commissioning LARC are the following:

- **Option 1 - Cease commissioning through primary care** - discarded due to risks associated with reduced accessibility to contraception and increased pressure on specialist integrated sexual health services.

- **Option 2 - Commission via a single provider model** - discarded due to risks associated with lack of flexibility in provision and poorer geographic coverage.

- **Option 3 - Proposed decision, continue with commissioning of LARC and strengthen model** - retain the service model and continue commissioning LARC directly from multiple primary care providers via a Provider Selection Regime (PSR) compliant procurement process (as per The Health Care Services (Provider Selection Regime) Regulations 2023).

4.3 Benefits of the proposed approach include:

- Good geographical coverage across the county ensuring equitable service, as the same service is available regardless of geographical area in the county.

- The current service model minimises the need for the patient to travel and ensures a reasonably equitable service access across the county.

- Continuity of service in local settings fostering accessibility and patient choice.

- The commissioning authority remains close to the communities, able to respond to local needs.

- Direct assurance of each provider's competence which supports good quality and safety of the service.

- Maintaining control and access to service data and ability to audit performance.

- Flexibility for GP practices to contract on behalf of other practices to improve access.

- Value for money benefits demonstrated by the public health outcomes and the resulting return on investment to the wider system.

4.4 KCC intends to continue to manage the contracts directly rather than via a third party.

5. Commercial Implications

5.1 The contract for the current service is due to expire 30th November 2026.

5.2 The proposed timeline is to run a PSR procurement process to enable new contracts to be awarded in October 2026 and commence by 1st December 2026.

5.3 The council intends to offer contracts up to no later than 31st March 2033. This period will align LARC service with other KCC Public Health services also

delivered by primary care (such as Smoking and NHS Health Checks).

6. Financial Implications

6.1 These contracts will be funded entirely from the ringfenced Public Health Grant. Providing and securing the provision of open access Sexual Health Services is a condition of the grant. The aim is to ensure that Kent residents are not turned away if they present with an eligible need, albeit this needs to be affordable.

6.2 Levels of uptake have reduced since the COVID-19 pandemic and part of the commissioning strategy is to increase uptake to meet identified need in the population. This increase in activity will result in an increase in costs each year and this has been budgeted for in the financial calculations.

6.3 Background work to inform the recommendations in this paper includes review of current provider tariffs and benchmarking. KCC intends to amend tariffs as part of the recommissioning process.

6.4 The anticipated contract term is from 1st December 2026 until 31st March 2033. The initial term up to four years and four months, with two one-year extension options. The funding allocation is £13m for a six year and four months contract. The spend in the first year is circa £1.7m.

6.5 The actual costs will be dependent on presenting demand, price of devices, agreed tariffs and procurement outcomes. Affordability and funding levels received via the annual PH grant will also be key.

6.6 The table below outlines the levels of expenditure anticipated over the maximum contract term.

01/12/2026-31/03/2033 (6 years 4 months)	Cost to KCC Public Health
Primary care delivery of LARC	£9,800,000
Device prescription costs	£4,200,000
Total	£13,000,000

6.7 The outlined cost estimate represents an increase to the existing annual budget for the service over the medium term, if the activity trend increases as predicted. This will be built into budget planning. In the unlikely event that the Public Health Grant in future years is insufficient to cover the activity levels and demand for contraception, the prices set for devices, or external factors, the contract requirements will be renegotiated to fit the available budget.

7. Legal implications

7.1 Under the Health and Social Care Act 2012, Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect and enhance the population's health.

7.2 KCC commissions LARC as part of its statutory responsibilities and as a condition of its Public Health Grant. These responsibilities are outlined in Section 6 of The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

7.3 The recommissioning of these services will fall under the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022. Appropriate legal advice is sought and will be utilised throughout the process to ensure compliance with the relevant legislation.

8. Equalities implications

8.1 An Equality Impact Assessment (EqIA) has been completed for the service. Current evidence suggests that there no negative impacts to people in Kent because the service model is not reducing or changing in nature. This recommendation is an appropriate measure to advance equality and create stability for vulnerable people. The EqIA is included as Appendix B.

8.2 The EqIA will continue to be reviewed throughout the length of the contractual period.

9. Data Protection Implications

9.1 A Data Protection Impact Assessment (DPIA) has been completed. The DPIA will be continuously updated following contract award to ensure it continues to have the most up-to date information included and reflects any changes to data processing. The scope of data collection and processing in the proposed future commissioning approach will remain similar to the current service.

9.2 The DPIA will be updated following contract award, kept under continuous review and updated to reflect any changes to data processing that may be implemented during the life of the contract.

12. Other corporate implications

12.1 The management and implementation of the recommission will be delivered by KCC Public Health and Integrated Commissioning teams with input from other teams such as HR, Legal and Commercial & Procurement. Progress will be monitored through internal governance arrangements.

13. Driving continuous improvement through the commissioning strategy

13.1 Alongside the contracting changes set out in this paper, the commissioning strategy will aim to strengthen the LARC services in primary care and drive best value. A series of improvements will be explored and taken forward during the contract term if deemed beneficial. This includes:

13.2 Exploring opportunities to streamline contract management functions from a cross service and cross directorate perspective. For example, working more closely with the ICB to ensure a consistent, equitable, and a quality enhanced approach. Likewise, across the Public Health directorate with other primary care services as previously mentioned, health checks and smoking services.

13.3 Work to increase rates of LARC usage in Kent. Listening to GPs and residents about their experiences and ensuring where possible that the approach improving rates of LARC use in the population.

13.4 More emphasis on quality assurance to be increasingly satisfied that Kent residents are getting a consistent and quality service, working alongside primary care contracts.

13.5 Improved data insights so that we can better understand who is and who is not using the LARC service to ensure that we are reaching those people in Kent who would most benefit and inform proactive action.

14. Conclusions

14.1 Provision of LARC in primary care is an essential public health intervention that enables Kent County Council to meet its statutory duties and to deliver measurable health and economic benefits.

14.2 LARC is an extremely effective form of contraception and supports the prevention of unplanned pregnancies. Optimising the use of effective contraception reduces pressure on health and social care systems and contributes to improved outcomes for individuals and communities across Kent. This service aligns with national and local strategies for addressing health inequalities and promoting long-term wellbeing of Kent residents.

14.3 LARC use is declining, which is resulting in poorer health outcomes in the Kent population, this key decision will support with the aim of increasing LARC use.

14.4 The current contracts with GP practices delivering LARC will end on 30 November 2026. The recommendation is to maintain the current commissioning model and reprocure the service directly with the primary care providers by 1st December 2026. This route will ensure that Kent residents are still able to access this service in the same way.

Recommendation(s):

The Adult Social Care and Public Health Cabinet Committee is asked to CONSIDER and ENDORSE, or MAKE RECOMMENDATIONS to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A)

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15. Background Documents

15.1 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013

15.2 Public Health England (2021) Extending Public Health England's contraception return on investment tool. Maternity and primary care settings. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001464/ROI_LARC_maternity.pdf

15.3 Women's Health Strategy for England (2022)

15.4 NHS Long Term Plan

15.5 Public Health Outcomes Framework

15.6 Kent and Medway Integrated Care Strategy

15.7 Kent Sexual Health Needs Assessment (2024) https://www.kpho.org.uk/__data/assets/word_doc/0006/174813/Sexual-Health-Needs-Assessment-2024-External.docx

15.8 NICE Clinical Guideline CG30 Long-acting reversible contraception https://www.nice.org.uk/guidance/cg30/chapter/Recommendations

15.9 NHS (2024) How well contraception works at preventing pregnancy https://www.nhs.uk/contraception/choosing-contraception/how-well-it-works-at-preventing-pregnancy/

15.10 The Health Care Services (Provider Selection Regime) Regulations 2023

15.11 Health and Social Care Act 2012

15.12 Health and Care Act 2022

16. Appendices

A. Proposed Record of Decision document (PROD)
B. Equality Impact Assessment (EqIA) 2025-10-06 LARC in primary care.docx

17. Contact details

Lead officers:	**Lead Director:**
Professor Durka Dougall Public Health Consultant 07961851576 Durka.dougall@kent.gov.uk Vicky Tovey Assistant Director of Integrated Commissioning 03000 416779 Victoria.Tovey@kent.gov.uk Hannah Brisley Senior Commissioner 03000 410 278 Hannah.Brisley@kent.gov.uk Terhi Suikkanen Commissioner 03000 417536 Terhi.suikkanen@kent.gov.uk	Dr Anjan Ghosh Director of Public Health 03000 412633 Anjan.Ghosh@kent.gov.uk

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care and Public Health	25/00094

For publication *[Do not include information which is exempt from publication under schedule 12a of the Local Government Act 1972]*

Key decision: YES

Subject Matter / Title of Decision:
Long-Acting Reversible Contraception (LARC) Services Recommission

Decision:

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

1. **APPROVE** the re-commissioning arrangements and continued contracting with primary care via a procurement compliant process for the delivery of Long-Acting Reversible Contraception. The new contract will commence on 1 December 2026for an initial period of four years and four months, with the option to extend for up to two additional one-year periods, ending no later than 31 March 2033.

2. **DELEGATE** authority to the Director of Public Health to undertake all necessary actions, including, but not limited to awarding contracts, finalising terms, entering into legal agreements, and making any necessary refinements to the commissioning strategy over the life of the contract as described to implement the decision, providing they do not require additional governance.

3. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health and the Corporate Director Finance to utilise the relevant contract extensions.

Reason(s) for decision:

Kent County Council (KCC) has a statutory duty to provide reasonable access to a broad range of contraceptive substances and appliances as per Section 6 of The Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013.

Provision of Long-Acting Reversible Contraception (LARC) in primary care is an essential public health intervention which enables Kent County Council to meet its statutory duties and to deliver measurable health and economic benefits. Continuing to commission LARC through primary care offers advantages in terms of accessibility, convenience, patient choice, comprehensive care, and cost-effectiveness.

The current Long-Acting Reversible Contraception (LARC) Service in Primary Care contract is due to end on 30tNovember 2026. To ensure continuity of service, new contracts are required for the delivery of LARC within primary care.

Background

LARC is an extremely effective form of contraception and supports the prevention of unplanned pregnancies. Unplanned pregnancies are significant contributors to poor health outcomes, and provision of the LARC service plays an important role in reducing the negative consequences and costs of it. Effective contraception reduces pressure on health and social care systems and contributes to improved outcomes for individuals and communities across Kent.

Long-Acting Reversible Contraception (LARC) services are guided by national best practice and have a strong return on investment evidence base. LARC is a clinically effective and cost-efficient contraception method, currently delivered via integrated sexual health services and primary care providers. All practitioners providing the commissioned service have achieved a relevant Letter of Competence issued by College of Sexual and Reproductive Health (CoSRH).

The service provides LARC fitting and removal procedures to women who opt to use these methods to prevent pregnancy. KCC currently commissions LARC in primary care via 102 GP practices across Kent. Trained practitioners in the participating GP practices undertake approximately 11,000 procedures each year. The current service model minimises the need for the patient to travel and ensures a reasonably equitable service access across the county. Use of LARC has not returned to pre-pandemic levels, approximately 5,000 less procedures per year are currently being undertaken.

The outcomes this service will aim to achieve are:

a. Increase in the number of eligible people in the population choosing LARC as their contraception method.

b. Sustain and increase the number of GP practices participating in this contract.

c. The use of LARC increases to contribute to a decrease in the number of unplanned pregnancies and terminations of pregnancy.

d. A greater awareness in the professional and resident populations of the benefits of LARC.

Proposed decision

The proposal is to continue commissioning LARC directly from multiple primary care providers via a Provider Selection Regime (PSR) compliant procurement process (as per Procurement Act 2023). The recommendation is to maintain and strengthen these services, ensuring the council meets its statutory obligation.

Benefits of this approach include:

- Good geographical coverage across the county ensuring equitable service, as the same service is available regardless of geographical area in the county.
- Continuity of service in local settings fostering accessibility and patient choice.
- The commissioning authority remains close to the communities, able to respond to local needs.
- Direct assurance of each provider's competence which supports good quality and safety of the service.
- Maintaining control and access to service data and ability to audit performance.
- Flexibility for GP practices to contract on behalf of other practices to improve access.
- Value for money benefits demonstrated by the public health outcomes and the resulting return on investment to the wider system.

The commissioning strategy will aim to strengthen the LARC services in primary care and drive best value. LARC recommissioning plans will be developed where possible in alignment with the commissioning model adopted for NHS Health Checks and smoking cessation services which are also delivered by primary care.

How the proposed decision supports the Council's strategic statement

Commissioning of LARC contributes to the objectives of the Council's strategic statement by supporting a preventative approach to improving population health and empowering people to make their own contraceptive choices. By ensuring access to contraception the service helps prevent unplanned pregnancies, which are significant contributors to poor health outcomes, and address health inequalities across Kent.

The service is also aligned to the Council's strategic statement by delivering measurable financial benefits. Preventing unwanted pregnancies reduces demand on health and social care services, avoiding associated costs and improving long-term outcomes for individuals and families.

Locally, the provision of the services supports the Kent and Medway Integrated Care Strategy and delivers against recommendations within the most recently published Kent Sexual Health Needs Assessment 2024. These include expanding and ensuring local convenient access to contraception, and targeting priority groups, such as young people and those experiencing health inequalities. This is with the aim of ensuring provision is equitable, responsive to local needs, and embedded within wider health and care pathways.

Financial Implications

The funding for these contracts is solely from the Public Health Grant. The funding allocation is £13m for a six year and four months contract. The spend in the first year will be circa £1.7m.

As this is an activity-based contract and an open access service, the costs will be dependent on presenting demand and agreed costs. This has been budgeted for in the financial calculations. The aim is to ensure Kent residents are not turned away if they present with an eligible need, albeit this needs to be affordable. Factors such as the funding levels received via the annual PH grant to KCC, procurement outcomes or changes to unit costs in health and social care may influence the actual value of the contract. Final costs will be subject to activity levels, device prescription price fluctuations and negotiations on tariffs.

In the unlikely event the grant in future years is insufficient to cover the contract value, prices, scope or activity levels will be renegotiated to fit the available budget.

Legal Implications

Under the Health and Social Care Act 2012, Directors of Public Health (DPH) in upper tier and unitary Local Authorities have a specific duty to protect and enhance the population's health. KCC commissions the services set out in this paper as part of its statutory responsibilities and as a condition of its Public Health Grant. These responsibilities are outlined in Section 6 of The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

The recommissioning of these services will be compliant with the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022.

Appropriate legal advice is sought and will be utilised throughout the process to ensure compliance with the relevant legislation.

Equalities implications

An Equality Impact Assessment (EqIA) has been completed for the service. Current evidence suggests there no negative impacts to people because the service model is not reducing or

changing in nature. This recommendation is an appropriate measure to advance equality and create stability for vulnerable people. The EqIA will continue to be reviewed throughout the length of the contractual period.

Data Protection implications

A Data Protection Impact Assessment (DPIA) has been completed. The DPIA will be continuously updated following contract award to ensure it continues to have the most up-to date information included and reflects any changes to data processing.

Cabinet Committee recommendations and other consultation:

Any alternatives considered and rejected:

1. **Cease commissioning through primary care** - discarded due to risks associated with reduced accessibility to contraception and increased pressure on specialist integrated sexual health services.

2. **Commission via a single provider model** - discarded due to risks associated with lack of flexibility in provision and poorer geographic coverage.

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

....

signed date

EQIA Submission – ID Number

Section A

EQIA Title
LARC in priamry care

Responsible Officer
Nathalie Reeves - AH Public Health

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Durka Dougall - AH PH

Type of Activity

Service Change
No

Service Redesign
No

Project/Programme
No

Commissioning/Procurement
Commissioning/Procurement

Strategy/Policy
No

Details of other Service Activity
No

Accountability and Responsibility

Directorate
Adult Social Care and Health

Responsible Service
Strategic commissioning Public Health

Responsible Head of Service
Durka Dougall - AH PH

Responsible Director
Anjan Ghosh - AH Public Health

Aims and Objectives

The aim of this activity is to procure the existing Long Acting Reversible Contraception (LARC) in Primary Care service, for 6 years (72 months), in an identical model to the current service.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?
Yes

It is possible to get the data in a timely and cost effective way?
Yes

Is there national evidence/data that you can use?
Yes

Have you consulted with stakeholders?
Yes

Who have you involved, consulted and engaged with?
Chris Beale
Vicky Tovey
Durka Dougall
Matt Wellard

Has there been a previous Equality Analysis (EQIA) in the last 3 years?

Yes

Do you have evidence that can help you understand the potential impact of your activity?

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients

Service users/clients

Staff

Staff/Volunteers

Residents/Communities/Citizens

Residents/communities/citizens

Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing?

Yes

Details of Positive Impacts

The LARC in Primary Care service is commissioned by Kent County Council to provide positive benefits to the Kent population. It enables women to receive a reliable, long-term, and highly effective means of contraception to put them in control of their reproductive health. Furthermore, provision of LARC is associated with positive outcomes for service users due to reducing unintended pregnancies which is tied to poorer outcomes.

Age:

The service is aimed at individuals of reproductive age, typically females aged 15–45 years, who can benefit from contraception. However, the contract does not impose a strict age limit. Clinical discretion allows for provision outside this range where appropriate. For those under 16, Fraser guidelines and Gillick competence assessments are applied. Therefore, there are no negative impacts associated with age, as access is based on clinical need and capacity to benefit, not age alone.

Disability:

The Service provides access for all Kent residents with support provided for those with a disability that may otherwise limit their access. General Practices adhere to strict accessibility regulations in their practice and ensure that disabled service users can access the service.

Sex:

The service is aimed at those who were designated as female at birth and capable of becoming pregnant as it aims to provide a contraceptive benefit via provision of LARC devices (which are designed solely for this service user group). Therefore, there are no negative impacts associated with sex because the service is only aimed at individuals who were female at birth, who are the only group which can benefit from the service.

Gender Identity / Transgender:

The service does not discriminate based on gender identity or transgender service users. The service adheres to the Faculty of Sexual and Reproductive Healthcare (FSRH) guidance on contraceptive choices ensuring transgender service users are given the most appropriate advice and contraceptive care.

Race:

The service does not discriminate based on race.

Religion / Belief:

The service does not discriminate based on religion or belief and will provide equality of access to service users across Kent regardless of religion or belief.

Sexual Orientation
The service does not discriminate based on sexual orientation.

Marriage / Civil Partnerships:
The service does not discriminate based on sexual orientation.

Carers Responsibilities:
The service does not discriminate based on those with carer responsibilities, and General Practices have working practices to accommodate patient availability when booking appointments.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

No. Note: If Question 19a is "No", Questions 19b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Age

Not Completed

Mitigating Actions for Age

Not Completed

Responsible Officer for Mitigating Actions – Age

Not Completed

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

No. Note: If Question 20a is "No", Questions 20b,c,d will state "Not Applicable" when submission goes for approval

Details of Negative Impacts for Disability

Not Completed

Mitigating actions for Disability

Not Completed

Responsible Officer for Disability

Not Completed

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

No. Note: If Question 21a is "No", Questions 21b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Sex

Not Completed

Mitigating actions for Sex

Not Completed

Responsible Officer for Sex

Not Completed

22. Negative Impacts and Mitigating actions for Gender identity/transgender

Are there negative impacts for Gender identity/transgender

No. Note: If Question 22a is "No", Questions 22b,c,d will state "Not Applicable" when submission goes for approval

Negative impacts for Gender identity/transgender

Not Completed

Mitigating actions for Gender identity/transgender

Not Completed

Responsible Officer for mitigating actions for Gender identity/transgender

Not Completed

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race
No. Note: If Question 23a is "No", Questions 23b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Race
Not Completed
Mitigating actions for Race
Not Completed
Responsible Officer for mitigating actions for Race
Not Completed
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No. Note: If Question 24a is "No", Questions 24b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Religion and belief
Not Completed
Mitigating actions for Religion and belief
Not Completed
Responsible Officer for mitigating actions for Religion and Belief
Not Completed
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No. Note: If Question 25a is "No", Questions 25b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Sexual Orientation
Not Completed
Mitigating actions for Sexual Orientation
Not Completed
Responsible Officer for mitigating actions for Sexual Orientation
Not Completed
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No. Note: If Question 26a is "No", Questions 26b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Pregnancy and Maternity
Not Completed
Mitigating actions for Pregnancy and Maternity
Not Completed
Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Completed
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No. Note: If Question 27a is "No", Questions 27b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Marriage and Civil Partnerships
Not Completed
Mitigating actions for Marriage and Civil Partnerships
Not Completed
Responsible Officer for Marriage and Civil Partnerships
Not Completed
28. Negative impacts and Mitigating actions for Carer's responsibilities

Are there negative impacts for Carer's responsibilities
No. Note: If Question 28a is "No", Questions 28b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Carer's responsibilities
Not Completed
Mitigating actions for Carer's responsibilities
Not Completed
Responsible Officer for Carer's responsibilities
Not Completed

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ADULT SOCIAL CARE & PUBLIC HEALTH CABINET COMMITTEE
WORK PROGRAMME 2024/25

	12 November 2025 at 2pm		
1	Intro/ Web announcement	Standing Item	
2	**Election of Vice Chair**	**Procedural**	
3	Apologies and Subs	Standing Item	
4	Declaration of Interest	Standing Item	
5	Minutes	Standing Item	
6	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item	
7	Adult Social Care Operational Pressures Escalation Plan 2025/2026	Annual Item	
8	Adult Social Care Performance Dashboard Quarter 2 2025/2026	Bi-annual Item	
9	Adult Social Care and Health Complaints Report 2024/2025	Annual Item	
10	Annual Report on Quality in Public Health, including Annual Complaints Report	Annual Item	
11	**Long Active Reversable Contraception – Key Decision**	**Key Decision**	
12	Accommodation Market Position Statement		
13	Work Programme	Standing Item	

	21 January 2026 at 2pm		
1	Intro/ Web announcement	Standing Item	
2	Apologies and Subs	Standing Item	
3	Declaration of Interest	Standing Item	
4	Minutes	Standing Item	
5	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item	
6	Draft Revenue and Capital Budget and MTFP	Bi-Annual item	*Budget item only to be taken in January*
7	Performance Dashboard	Bi-Annual item	
8	Update on Public Health Campaigns/Communications	Annual Item	
9	**Carers' Support Service Contract Award - Key Decision**	**Key Decision**	
10	Further Review of the CQC Improvement Plan		
11	Exercise Pegasus and Kent Pandemic Plan		
12	Work Programme	Standing Item	

	11 March 2026 at 2pm		
1	Intro/ Web announcement	Standing Item	
2	Apologies and Subs	Standing Item	
3	Declaration of Interest	Standing Item	
4	Minutes	Standing Item	
5	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item	
6	Performance Dashboard ASC & PH	Quarterly Item	
7	Risk Management	Annual	
8			
9			

10			
11	Work Programme	Standing Item	

ASC Item	**Cabinet Committee to receive item**
Work Programme 2025	Standing Item
Key Decision Items	
Adult Social Care & Health Pressures	Annual Item
Performance Dashboard	September, November, March and May
Draft Revenue and Capital Budget and MTFP	November and January
Risk Management: Adult Social Care	March
Annual Complaints Report	November
PH Item	**Cabinet Committee to receive item**
Work Programme 2025	Standing Item
Key Decision Items	
Performance Dashboard	January, March, July, September
Update on Public Health Campaigns/Communications	Bi-Annually (January and July)
Draft Revenue and Capital Budget and MTFP	Bi-Annually (November and January)
Annual Report on Quality in Public Health, including Annual Complaints Report	Annually (November)
Risk Management report (with RAG ratings)	Annually (March)