ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 6th May, 2026

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 6 May 2026 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Maya Bundy**
Telephone: **03000 416072**

Membership (13)

Reform UK (8):	Mr A Kibble, Mr R Mayall, Mr S Dixon (Chair), Mr T L Shonk, Mr T Mole (Vice-Chair), Mrs S Roots, Mr M Fraser Moat and Mr L Evans
Liberal Democrat (1):	Mr C Sefton
Restore Britain (1):	Mr R Ford
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 Election of Chair

2 Apologies and Substitutes

3 Declarations of Interest by Members in items on the agenda

4 Minutes of the meeting held on 11 March 2026 (Pages 1 - 12)

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

6 Adult Social Care Performance Dashboard (Pages 13 - 38)

7 Adult Safeguarding Update (Pages 39 - 46)

8 Health and Wellbeing Board (Pages 47 - 56)

9 Neighbourhood Health Plan (Pages 57 - 68)

10 Blue Badge Update (Pages 69 - 74)

11 Update on Adult Social Care Campaigns (Pages 75 - 86)

12 Work Programme (Pages 87 - 88)

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
03000 416814

Monday, 27 April 2026

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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, 11th March, 2026.

PRESENT: Mr M Brown, Mr S Dixon (Chair), Mr S Jeffery, Mr A Kennedy, Mr A Kibble, Mr R Mayall, Mr T Mole (Vice-Chair), Ms C Nolan, Mrs B Porter, Mrs S Roots, Mr C Sefton and Mr T L Shonk

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

IN ATTENDANCE: Miss M Bundy (Democratic Services Officer), Mr J Cole (Lead Performance Analyst), Dr A Ghosh (Director of Public Health), Ms H Gillivan (Interim Director Adults and Integrated Commissioning.), Dr M Gogarty (Strategic Lead Public Health Consultant), Mrs S Hammond (Corporate Director Adult Social Care and Health), Ms S Hill (Director of Operations (Long Term Support)), Ms C Holden (Head of Children's Commissioning), Mr M Scrivener (Head of Risk and Delivery Assurance), Mr M Thomas-Sam (Director of Operations (Short Term Support)) and Mrs V Tovey (Assistant Director of Integrated Commissioning)

UNRESTRICTED ITEMS

57. Apologies and Substitutes
(Item. 2)

No apologies were received.

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

Mr Jeffery declared an interest in Item 9 (Neighbourhood Health) that he was the Leader of Maidstone Borough Council and had expressed views there in relation to Local Government Reorganisation (LGR), which was referenced in the report.

59. Minutes of the meeting held on 21 January 2026
(Item. 4)

1. A Member referred to questions they had asked the Cabinet Member at the previous meeting, which they had subsequently submitted by email for a written response. They stated that they had not yet received a written reply. It was agreed that a response would be provided outside of the Committee.

2. RESOLVED that the minutes of the meeting held on January 21 2026 were a correct record and they be signed by the Chairman.

60. Verbal Updates by Cabinet Member, Corporate Director and Director of Public Health
(Item. 5)

1. Diane Morton, Cabinet Member for Adult Social Care and Public Health, provided a verbal update on the following:

   a) Miss Morton announced that it was National No Smoking Day and cited her own personal experience as encouragement for those that smoked to consider quitting.

   b) The tender for older people's nursing and residential care home contracts had closed. Miss Morton was optimistic about the quality of providers and expected a strong framework to go live in mid-summer. She reported that this would be an important step in stabilising the market and addressing costs that remained above the national average.

   c) Demand for Blue Badges continued to rise sharply, with over 48,000 applications received in the past year. A significant proportion of demand related to Special Educational Needs and Disabilities (SEND). Miss Morton stressed the importance of clear and detailed supporting evidence at application and renewal stages to enable quicker and more accurate decisions. Support was also available through Kent Connector Support Hubs hosted by District and Borough councils.

   d) Members were also informed of proposed national changes to Blue Badge renewals, including extending the standard renewal period to five years and potential changes to the £10 fee, although implementation dates and details were not yet confirmed.

   e) Miss Morton summarised a recent letter from Baroness Casey to the Secretary of State which raised serious concerns about repeated failures in adult safeguarding and called for a national safeguarding board, a review of safeguarding legislation, and strengthened national oversight. The letter also highlighted shortcomings in the national response to dementia, calling for dementia to be treated as a clinical priority, and raised issues around motor neurone disease, including a recommendation for a fast-track passport to speed access to support.

   f) Miss Morton reported that colleagues from the Local Government Association (LGA) and peers from other authorities had visited to support work on safeguarding and on refreshing the model for the Health and Wellbeing Board, ensuring alignment with the NHS Ten Year Plan, Kent's priorities, the Joint Strategic Needs Assessment and the Integrated Care Strategy. A full update would be brought to the Committee once the model was finalised.

   g) As the financial year end approached, the forecast for Adult Social Care (ASC) showed stability with a continuing downward trend in the overspend. Miss Morton reminded Members that the overspend had peaked over the previous summer and had since been brought under greater control through spending controls and strategic measures. Risks remained, but progress was documented in quarterly reports to Cabinet.

   h) Miss Morton reported that the Adult Social Care and Public Health Performance Indicator Suite had undergone a refresh. The full ASC suite

was not yet ready for publication but would be shared once finalised. Work was ongoing to present indicators in a more resident-friendly way, possibly online, by early summer.

i) Miss Morton highlighted the imminent launch of the coastal Marmot Programme in Dover, with Sir Michael Marmot attending. She commended the Public Health team for establishing the first coastal regional Marmot Programme in the country.

2. Dr Anjan Ghosh, Director of Public Health gave a verbal update on the following:

a) Dr Ghosh reported that Public Health had been experiencing a busy and productive period both strategically and operationally. Work was underway to redevelop and re-energise the Health and Wellbeing Board in light of national changes, including the abolition of Integrated Care Partnerships referenced in the NHS Ten Year Plan. A further update would be brought once more detail was available.

b) Dr Ghosh reiterated the importance of the upcoming Marmot launch and highlighted the focus on wider determinants of health and work, including a recent Kent and Medway summit on employment, skills and health, and participation in an LGA and Association of Directors of Public Health conference on the built environment.

c) Members were advised that Kent was a training site for public health consultants, general practitioners (GPs) and other registrars. Work was underway with universities and deans to develop a centre of excellence for Public Health in Kent, and further details would be brought back when available.

d) Dr Ghosh explained that the childhood immunisation schedule had changed from January 2026 with the introduction of an additional chickenpox (varicella) vaccine. The measles, mumps and rubella (MMR) vaccine had become MMRV with doses at one year and 18 months, followed by a booster at three to four years.

e) The Kent Public Health Observatory had produced an alcohol licensing tool to support public health and licensing authorities in making representations on applications. A set of mental health indicators had also been developed to inform a strategic approach to mental health due to be discussed by the Integrated Care Partnership Board.

f) Work on age-friendly communities continued, with Ashford and Faversham being accepted into the UK Age-Friendly Communities Network, supporting people to age well and live fulfilling later lives.

g) A stroke prevention pilot with partners including the Integrated Care Board (ICB) and a local GP federation was underway in Dartford, Gravesham and Swanley, focused on identifying undiagnosed atrial fibrillation and supporting healthier lifestyle choices.

h) Dr Ghosh announced the launch of the “Forever Active” programme, an evolution of the Postural Stability and Falls Prevention Service delivered through Active Kent and Medway. Grants had been awarded to 28 Kent charities, social enterprises and clubs.

i) Work with Gypsy, Roma and Traveller communities had included training around 600 people in culturally competent practice, developing stay and play sessions, closer working with family hubs, and health bus checks for residents who had not previously accessed a GP.

j) Dr Ghosh highlighted that Canterbury Health Alliance had won a Healthwatch award for excellence in integrated working, particularly in relation to a neighbourhood team which had positively impacted health inequalities.

k) Further work was underway within the ASC framework on social prescribing, unpaid carers’ health and wellbeing needs, and data analysis on people living alone. A new sexual health clinic was also due to open at the Discovery Centre in Dover later in March.

3. Sarah Hammond, Interim Corporate Director of Adult Social Care and Health, provided a verbal update on the following:

a) Ms Hammond reported that the Adults’ budget deficit, while still significant at around £45m, had reduced from a projected position close to £60m based on the trajectory in September 2025.

b) The total number of individuals receiving a package of care from ASC had decreased, which Ms Hammond attributed to the growing preventative agenda and earlier community-based support. However, individual costs continued to rise above inflation, which was acknowledged as a concern.

c) Engagement with providers had increased, with evidence of providers wishing to work more closely with the Council on quality and affordability. Ms Hammond held regular discussions with the Chair of the National Association of Care Home Providers and acknowledged that more work was needed to ensure a wider range of provider voices were heard.

d) Work with the ICB and NHS Trusts was underway to address the high number of people admitted to hospital without a treatable or acute medical need, particularly in East Kent. Ms Hammond highlighted concerns that some people were spending their final days in Accident and Emergency (A&E) or leaving hospital with greater levels of need than when admitted. It was agreed with NHS partners that the issue extended beyond discharge pressures, with too many people being admitted to A&E to begin with.

e) Ms Hammond referenced a recent Partners in Care and Health visit funded by Central Government, involving experts from the Association of Directors of Adult Social Services (ADAS) and the LGA. Initial feedback was that progress had been made in some areas but that further improvement was needed, particularly in throughput of work. A written report with recommendations was awaited.

f) Ms Hammond outlined six high-level business priorities for 2026-27 for Adult Social Care:

   i. Delivering major recommissioning programmes and strengthening market stability, quality and value for money
   ii. Developing the workforce and digital infrastructure to support safe, efficient and modern practice
   iii. Strengthening practice, safeguarding decision-making and quality assurance including delivering the improvement plan
   iv. Managing demand and affordability through better pathways, decision-making and commissioning rather than in-year savings
   v. Shifting investment upstream into prevention, enablement, community support and technology-enabled lives
   vi. Improving discharge, intermediate care and joint working with health partners to reduce delays and system pressures

g) Ms Hammond informed the Committee that she and Dr Ghosh had submitted statements on behalf of Adults' and Children's Social Care to the Manston Inquiry, which was examining overcrowding and poor health outcomes, including a death, at the Manston facility between June and November 2022. The public hearings were expected in November 2026.

4. In response to questions and comments from Members, discussion covered the following:

a) Ms Hammond confirmed that Kent County Council (KCC) and NHS colleagues were in agreement concerning people being admitted to A&E without a treatable medical condition. She explained that anxiety among care home and community providers about supporting people at the end of life was potentially leading to ambulance calls and hospital admissions. Work was underway with the NHS to provide reassurance and support to care providers, including clarifying appropriate responses and avoiding unnecessary admissions where there was no acute medical solution.

b) It was advised that more people were leaving ASC services than starting, which was not unusual in winter but was slightly more pronounced than in previous years. There had also been a slight decrease in requests for care assessments, suggesting that some needs were being met differently or earlier. Miss Morton highlighted that local GP provision had reduced in some areas, increasing barriers to timely healthcare and contributing to avoidable admissions.

c) Ms Hammond confirmed that right to reside patient figures could be provided in a written response outside of the Committee and stated that many of those admitted without a treatable need were already known to ASC, either in residential care or with existing packages.

d) Ms Hammond explained that the data on ambulance conveyances from care homes were being analysed in new ways and historic comparisons were limited. Nevertheless, it was clear that too many residents without acute needs were being admitted to hospital. She explained this was an opportunity for joint work with providers and the Care Quality Commission

(CQC), including reviewing training and support, and addressing concerns that inspection expectations may be contributing to defensive referrals.

e) Dr Ghosh explained that Kent commissioned the Institute of Health Equity in October 2025, with the Marmot launch in Dover delayed from its original date. The ten-year Marmot Programme would begin with a focus on work and health and on coastal inequalities, before expanding to all eight Marmot principles across the county. The Dover launch event was designed to build momentum and issue a call to action, featuring contributions from Sir Michael Marmot, the Leader of the Council, Miss Morton and the Chief Executive.

5. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the verbal updates.

61. Adult Social Care Performance Dashboard
(Item. 6)

1. The report was introduced by Joe Cole, Lead Performance Analyst, which set out the Key Performance Indicators (KPIs) covering Quarter 3 2025-26. Mr Cole provided a brief overview of performance whereby 3 of the 7 KPIs were RAG rated green, 3 were amber and 1 was red. The KPI that had been rated red (ASH7) was partly due to recent inspections and a number of homes awaiting outcomes.

2. Mr Cole outlined that activity levels remained high and contacts received were higher than in the same quarter of previous years. Safeguarding concerns remained at a high level, and applications for Deprivation of Liberty Safeguards continued to exceed completions, reflecting a long-standing pattern. The quarter recorded the highest number of care and support plan reviews completed in the last two years.

3. In response to questions and comments from Members, discussion covered the following:

a) Helen Gillivan, Director of Adults and Integrated Care, reported that she had met with the new Deputy Director of the CQC to discuss inspection timeliness and partnership working. She confirmed that the Council's internal measurement of ASH7 would be reviewed, and further discussions would take place with the CQC regarding inspections. The current rating, however, remained an accurate reflection of the Council's internal quality monitoring approach. Miss Morton also highlighted potential concerns surrounding inspector capacity within the CQC, indicating it could take some time before all necessary roles were filled.

b) Mr Cole explained that some indicators, such as those linked to the Better Care Fund and people aged 65 and over in long-term support, were nationally comparable, while others were local measures reflecting Kent's operational structures.

c) It was recognised that there was a reduction in ASH13 (average cost of new support packages) and suggested that an additional indicator reflecting the

average cost of all support packages to support broader budget monitoring be considered.

d) Ms Gillivan explained that officers visit care homes to monitor contractual and quality standards and work with providers on improvement plans where needed. Sydney Hill, Director of Operations (Long Term Support), added that, when concerns arise, the Council worked jointly with the CQC and NHS colleagues to review residents' needs, support improvements, and, where necessary, move residents or, in rare cases, support home closures.

e) It was asserted that Kent had approximately 370 residential and nursing care homes, meaning visit activity must remain proportionate and risk-based. It confirmed a more detailed figure could be provided outside of the Committee, if necessary.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the performance of Adult Social Care services in Quarter 3 2025/2026.

62. Public Health Performance Dashboard for Quarter 3
(Item. 7)

1. The item was introduced by Victoria Tovey, Assistant Director of Commissioning, who set out the Key Performance Indicators (KPIs) covering Quarter 3 2025-26. Ms Tovey provided a brief overview of performance whereby all 14 available KPIs were broadly rated green or amber and none were red. 4 indicators, mostly related to substance misuse and smoking services, were unavailable at the time of the report, but trends were generally positive. She also provided an outline of the KPIs that had been refined as part of the service transformation programme to improve outcome focus and align with national targets.

2. In response to questions and comments from Members, discussion covered the following:

a) In response to a question on vaccination- related indicators, Dr Ghosh explained that the dashboard was a subset focussed on commissioned services over which the Council had direct control. Vaccination performance was monitored within a broader internal dashboard and through joint work with the NHS, which was responsible for delivery, but was not currently included as a KPI for the Cabinet Committee.

b) Ms Tovey explained that indicator PH06 (number of adults accessing structured treatment for substance misuse) had been refined to align with national priorities of the Office of Health Improvement and Disparities (OHID), supported by recent additional funding. This measured formed part of a wider set of KPIs, which remained important for monitoring outcomes at both service and corporate levels. Therefore, the change reflected a national focus rather than a removal of existing performance detail.

c) Dr Ghosh outlined that Kent had historically had an issue with low numbers entering treatment relative to need, and that increasing access was a positive step because people in need often faced stigma, chaotic lifestyles and overlaps with mental health and the criminal justice system, which

hindered engagement. Increasing numbers in treatment therefore aligned with unmet need.

3. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the performance of Public Health commissioned services in Quarter 3 (Q3) 2025/26 and the proposed Key Performance Indicator target changes for 2026/27.

63. Risk Management
(Item. 8)

1. The item was introduced by Mark Scrivener, Head of Risk and Delivery Assurance, who presented the strategic risks related to both the ASC and Public Health Directorate, in addition to the risks featuring on the Corporate Risk Register. The report also covered the management process for review of key risks.

2. In response to questions and comments from Members on the Adult Social Care and Health Directorate, discussion covered the following:

   a) Ms Gillivan advised that uplift decisions had been applied during the year where appropriate and emphasised that the Council's responsibility under the Care Act was to maintain the overall sustainability of the social care market rather than individual providers. She explained that the Council commissioned approximately one third of the market, with the majority funded by self-funders. The commissioning team continued to work closely with providers and representative bodies, including the Kent Integrated Care Alliance (KICA) and the National Care Association. Regular provider forums had also been established, and work was ongoing to support workforce development and market capacity across the county. Ms Gillivan also highlighted that alternative models of care were being considered to enable patients to be able to live in their own homes.

   b) Mrs Hammond emphasised that over four years, the Council had increased residential care prices by around 87%, significantly above inflation, and that research showed Kent paying higher fees per head than statistical neighbours and some other counties for similar providers. She outlined that while some providers offered good quality at affordable prices, for others the Council was paying substantially more than comparable authorities. She stated that the Council did not believe the market was close to collapse, though risk remained high, and reported examples of providers recently reducing their charges to retain Council business.

   c) Mr Scrivener explained that the report had been finalised ahead of the listed review date as part of the approval process, which meant it fell between internal review cycles.

   d) Mr Scrivener explained that risk ratings were set by risk owners and were under ongoing review. Recent discussions at the Directorate Management Team included whether ratings should be adjusted in light of new information, including the outcome of current recommissioning.

e) Miss Morton stated that allowing care homes to set charges without constraint would not be affordable for the Council.

3. In response to questions and comments from Members on the Public Health Directorate, discussion covered the following:

   a) Dr Ghosh agreed that the Marmot Programme and wider Public Health work had the potential to implement positive change but emphasised that improvements took time and depended on contributing from the NHS, District and Borough Councils, voluntary sector and residents.

   b) Dr Ghosh acknowledged the importance of wider determinants such as food security, climate change, biodiversity loss and related health impacts. He agreed to consider how these areas might be reflected within the Public Health risk register, stating that responsibilities were shared with partner organisations, including the Environment Agency. Mr Scrivener advised that he would raise the point with the Growth, Environment and Transport (GET) Directorate to consider how such risks were captured.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee considered the risks presented for both the Adult Social Care and Health and Public Health directorates.

64. Neighbourhood Health
(Item. 9)

1. The item was introduced by Dr Ghosh who explained that Neighbourhood Health was a key element of the NHS Ten Year Plan and that the report set out emerging national and local models. He highlighted tensions due to differing definitions of “neighbourhood” used by the NHS, local authorities and residents, and between the NHS’s immediate focus on reducing hospital admissions and the longer-term preventative aims of local government. He also reported that an internal KCC group was being developed to consider the Council’s role across various directorates. National guidance that had yet to be published would also shape detailed plans.

2. The report was introduced by Dr Mike Gogarty, Strategic Lead and Public Health Consultant, who gave a short PowerPoint presentation, the slides of which can be found HERE.

3. In response to questions and comments from Members, discussion covered the following:

   a) Dr Gogarty explained that a range of models were in use nationally and that the Johns Hopkins model, selected by NHS colleagues, was a reasonable option among several available approaches. He stated that the current Neighbourhood Health programme, as defined by the NHS, was primarily focused on short- term hospital admission avoidance rather than the broader spectrum of public health determinants. He confirmed that the Council continued to address wider determinants of health, such as environmental and housing factors, through other programmes and areas of work.

b) Dr Ghosh stated that Neighbourhood Health was not the only mechanism for addressing wider determinants, and that the Council and other agencies, were working on issues such as air quality and housing through other channels. He reported that the Neighbourhood Health Board for Kent and Medway was chaired by the ICB's Chief Operating Officer but would move to joint chairing by the Directors of Public Health for Kent and Medway, which would provide an opportunity to bring a broader perspective into the programme. Dr Ghosh also disclosed that Neighbourhood Health plans would be held under the Health and Wellbeing Board.

c) Dr Gogarty advised that a significant shift of resources from hospital to community settings was unlikely in the short term due to current national priorities. However, he highlighted opportunities to redesign existing services, strengthen prevention work within hospitals, and undertake small-scale pilots to test new approaches ahead of any wider implementation.

d) Dr Ghosh reported that the local ICB Chief Executive had begun to shift some funds from acute services into community health trusts via strategic commissioning, which was a positive step though it was too early to assess long-term impact.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the report.

65. 26/00013 - All Age Home Care Services - Key Decision
(Item. 10)

1. The item was introduced by Miss Morton who explained that the decision concerned the Council's second largest framework and covered commissioning a new "all-age" home care service covering both adults and children.

2. Ms Gillivan provided an overview of the current service delivery arrangements for Homecare, Care and Support in Prisons and Community Support Services for disabled children and outlined information about the commissioning activity to establish a new Open Framework contract for an All Age Homecare Service (for adults and children). She also detailed recommendations for the future of these services to ensure continued high- quality support, good outcomes for people and value for money. Ms Gillivan reported that the Prisons Service aspect may be required to go live at a later date, due to additional requirements for that contract, with minimal financial cost to KCC.

3. In response to questions and comments from Members, discussion covered the following:

a) Concerns were expressed about the £807m framework value and the perceived lack of sufficient financial and service-model detail for a contract of this scale. The use of an 8% annual growth assumption was questioned and clarity was sought on how this related to demand increases versus inflation, considering recent demand trends could imply reductions in unit prices and potential sustainability risks. It was also argued report did not clearly set out how the service model for adults and children would change.

b) In response to these concerns, Ms Gillivan stated that detailed profiling and financial modelling had been undertaken but that it was not possible to include the full detail in the public report. She undertook to reflect on the Member's comments in relation to the 8% assumption and to provide further information as appropriate outside the meeting. She emphasised that, for adults and prisons, there would not be a radical change in the nature of service delivery: it would remain regulated home care aimed at supporting people to remain independent at home, with some specification changes informed by detailed market engagement.

c) Christy Holden, Assistant Director for CYPE Commissioning, explained that for children the new arrangements would allow needs to be categorised more flexibly so that families could be moved between categories in line with changing needs, with costs better aligned to complexity. The underlying nature of care would not change significantly, but the specification and way the service was managed would better reflect children's needs and help keep them out of care where possible.

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

a) APPROVE the commissioning of an Open Framework All Age Home Care Service for adults and children to include Homecare, Care and Support in Prisons and Community Support Services for disabled children with the new arrangements to start on 1 April 2027

b) DELEGATE authority to the Corporate Director, Adult Social Care and Health in consultation with the Cabinet Member for Adult Social Care and Public Health, to take relevant actions including but not limited to, finalising the terms of and entering into required legal agreements, as necessary to award the contract; and

c) DELEGATE authority the Corporate Director, Adult Social Care and Health to open the Framework at regular intervals to allow new providers to join.

In accordance with paragraph 16.31 of the Constitution, Mr Stuart Jeffery requested for it to be recorded in the minutes that he voted against endorsing the proposed decision.

66. Work Programme
(Item. 11)

RESOLVED to note the Work Programme.

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From:	Diane Morton, Cabinet Member for Adult Social Care Sarah Hammond, Corporate Director Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 6 May 2026
Subject:	**ADULT SOCIAL CARE AND HEALTH PERFORMANCE Q4 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 4 (January to March) for the financial year 2025/2026, and the new suite of indicators for 2026/2027.

Adult social care saw increased demand in Quarter 4 for the Connect Service on contacts, and 2025/2026 saw an increase of nearly 20% compared to the previous year. There were more people with an active Care and Support Plan, and an ongoing increase in the number of Deprivation of Liberty Safeguards applications received.

There were decreases in incoming activity for safeguarding concerns, indicating a reverse in the previous trend of ongoing increases, peaking in Quarter 2 this year. The use of short term beds has also continued to decrease, however the number of people in a short term beds this year was higher than seen in 2024/2025. This was also the trend seen for both community enablement services, with a decrease seen into Quarter 4, but with more people receiving the services this year than in previous years.

Of the seven Key Performance Indicators, three were RAG Rated Green, with ASCH 6 - Long Term support needs of older people met by admission to residential and nursing care homes moving from Amber to Green. Four Key Performance Indicators were RAG Rated Amber. No indicators are RAG rated Red, as ASCH 7 - the percentage of KCC supported people in residential homes rated Good or Outstanding by CQC moved from Red to Amber.

Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of adult social care services in Quarter 4 2025/2026 and **NOTE** the new suite of indicators for 2026/2027.

1. Introduction

1.1 A core function of Cabinet Committees 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). This report also provides the list of the new suite of indicators for 2026/2027.

1.2 The full suite of KPIs for 2025/2026 is attached as Appendix 1, with the new suite for 2026/2027 in Appendix 2.

2. Overview of Performance

2.1 The first point of contact for residents and partners to adult social care are with the Adult Social Care Connect Teams. One of the team's main objectives is to offer information and advice to those contacting them and signposting people to community resources or other partners where appropriate. Through this, the Team aim to resolve a persons' contact efficiently and effectively meaning they should not need to make contact again in the immediate future. In Quarter 4, 3% of contacts were from people who had made contact in the past three months (ASCH 1). This is a 1% increase from the previous quarter, but the figure remined below the target of 5% meaning this measure remains RAG Rated Green.

2.2 Overall, the number of people making contact in this quarter was at its highest level for the past two years. Over 8,500 people have made contact with Adult Social Care Connect in Quarter 4, an 8% increase on the previous quarter. The most common source of referrals were family members (22%), followed by self-referrals (17%). The majority of contacts received were done so using the online form (37%), with the second highest proportion of contacts being made as a result of a telephone call (25%), indicating that the digital and online options are being utilised.

2.3 Where a person's needs cannot be met through a conversation or via signposting after a contact is made, adult social care undertake a Care Needs Assessment (CNA) to assess a person's social care needs and their eligibility for further support. Adult social care has continued to see a reduction in the number of CNAs requested, reducing by 5% between Quarter 3 and Quarter 4. Over 3,700 requests for a CNA were made this quarter (ASCH 9), with just over 2,300 assessments awaiting completion on the last day of the quarter, a reduction of 7% and the lowest figure recorded since this metric has been reported on.

2.4 Adult social care set a target of 28 days to complete a CAN, once it is decided that this is the appropriate course of action, in Quarter 4, 75% of CNAs were completed within 28 days (ASCH 2) which was a 3% reduction compared to the last quarter and the first reduction seen this financial year. This measures was RAG Rated Amber having not met its target. This is largely due to completion activity in January, where the percentage completed within 28 days was 72%

however by the end of March 2026, performance had improved to 78%, equal to the highest levels achieved during the financial year.

2.5 When a carer makes contact with adult social care they might require a Carers' Assessment. Adult social care commissions external carers agencies to carry out these duties on their behalf, with a small percentage completed by adult social care practitioners where appropriate. The external carers agencies also look to offer information, advice and guidance, similar to Adult Social Care Connect. Quarter 4 saw nearly 700 referrals made to carers agencies, a similar figure to last quarter. Over 1,000 carers were supported with in the Quarter (ASCH 10) which was an increase of 20% compared to Quarter 3.

2.6 Once a person is assessed as being eligible for care and support, a care and support plan will be developed alongside the person. Over 17,100 people had an active care and support plan at the end of the quarter (ASCH 11). This figure has consistently remained within range of 17,000 people for the past seven quarters, increasing 2% in financial year 2025/2026. The total number of people who had plan in 2025/2026 was over 28,000.

2.7 Adult social care offer a variety of ways in which a person's needs can be met, both in the community and in a residential or nursing setting. In Quarter 4, over 1,800 new packages of care were arranged (ASCH 12) at an average weekly cost of £883 (ASCH 13). The most common type of care provided in the quarter was Short Term Beds (42%), followed by Homecare (29%) and long-term Residential Care (11%). The average weekly cost of new support packages continued to fall, however both these measures are subject to change as information is updated on the client recording system.

2.8 The support put in place for a person to meet their needs is reviewed by adult social care within eight weeks of it commencing and then annually thereafter. For the first time in the past two years, the number of people requiring either a first or an annual review has risen, with this being the third quarter in a row with an increase in the number of first reviews to be completed. Quarter 4 saw the fewest number of care and support plan reviews completed but at over 5,100 this figure is still 13% higher than the same quarter last year.

2.9 Adult social care community enablement services include Kent Enablement at Home (KEaH) and Kent Enablement Service (KES). People are referred to these services to have individual goals set over a short period of time to help them to remain independent and in their own home with no further support needed. In Quarter 4, the number of people supported by KEaH and KES fell by 6% compared to the previous quarter (ASCH 16), however for both services there were more people receiving these services this year compared to last year.

2.10 If a person cannot remain independent in their home with community services, or are on a hospital discharge pathway it may be assessed that short-term support in a residential or nursing setting may be appropriate to enable them to remain independent in the long term as they recover from what may be a temporary health condition or social circumstance. In Quarter 4, 1,360 people

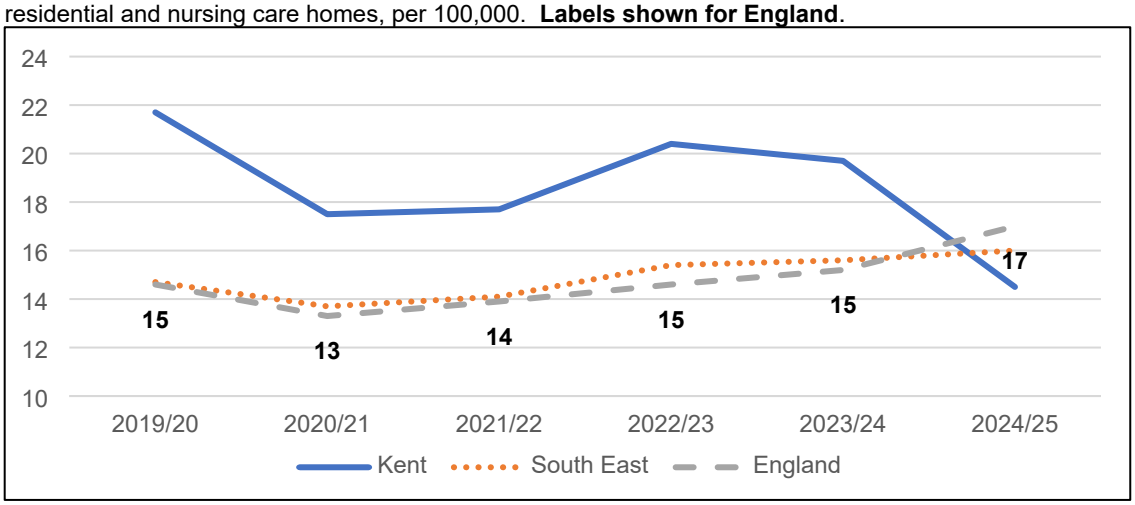
were supported in Short Term Beds, a figure similar but lower to the previous quarter and at its lowest level in the financial year.

2.11 The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into an enablement service was 84% in Quarter 4 (ASCH 4), this is below target and is now RAG Rated Amber (previously Green). Adult social care remains focused on ensuring people receive enablement services and regain their independence to return or remain in their home.

2.12 It may be that a person's care and support needs cannot be met in their own home, with community services, and the most appropriate way for them to be supported is in a residential or nursing setting. Quarter 4 saw 16 per 100,000 population of people aged between 18-64 have their needs met by permanent admission to residential and nursing care homes (ASCH 5). This measure continues to be RAG Rated Green, being below the target. For people aged 65 and over, 584 per 100,000 had their needs met in this way (ASCH 6). This measure is now within target and is RAG Rated Green from Amber following a second successive quarter of rate reduction.

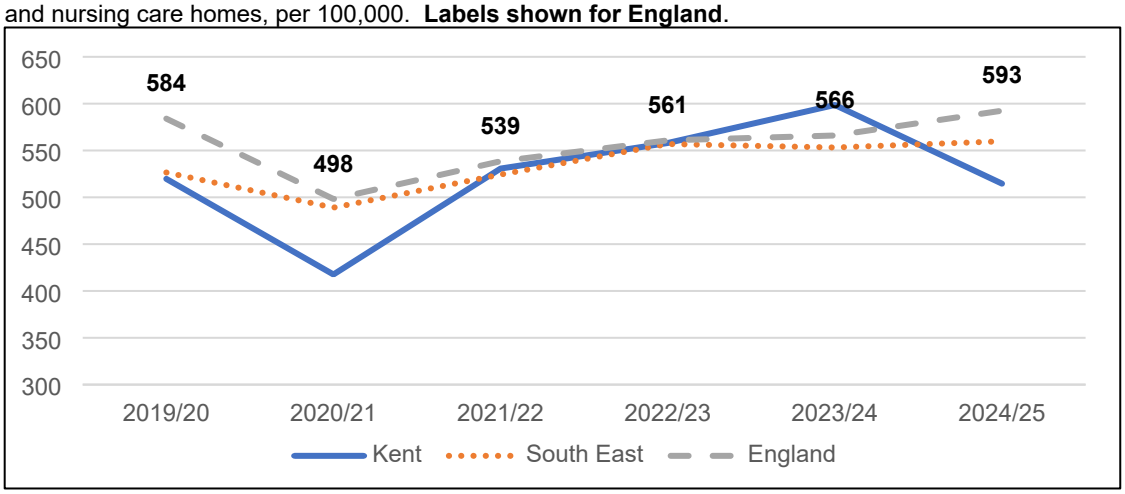
2.13 In the most recently published national Adult Social Care Outcomes Framework for 2024/2025, Kent had 15 per 100,000 population of people aged 18-64 with needs being met by admission to long term residential and nursing care homes, compared to the South East region at 16, and England at 17. Kent had historically been above both the national and regional levels until the most recent financial year when the rate decreased, and is ranked 64th across all local authorities (the lower the rank the better)

Figure 1 – ASCOF 2B: Long Term support needs of adults (18-64 years old) met by admissions to residential and nursing care homes, per 100,000. **Labels shown for England**.



2.14 For those aged 65 and older, Kent also had a lower rate of admissions for 2024/2025 compared to the previous year, at 515 per 100,000 population. Nationally, the rate continued to rise to 593 per 100,000. Kent were ranked 42nd in the country in this metric in 2024/2025, improving their rank from previous years.

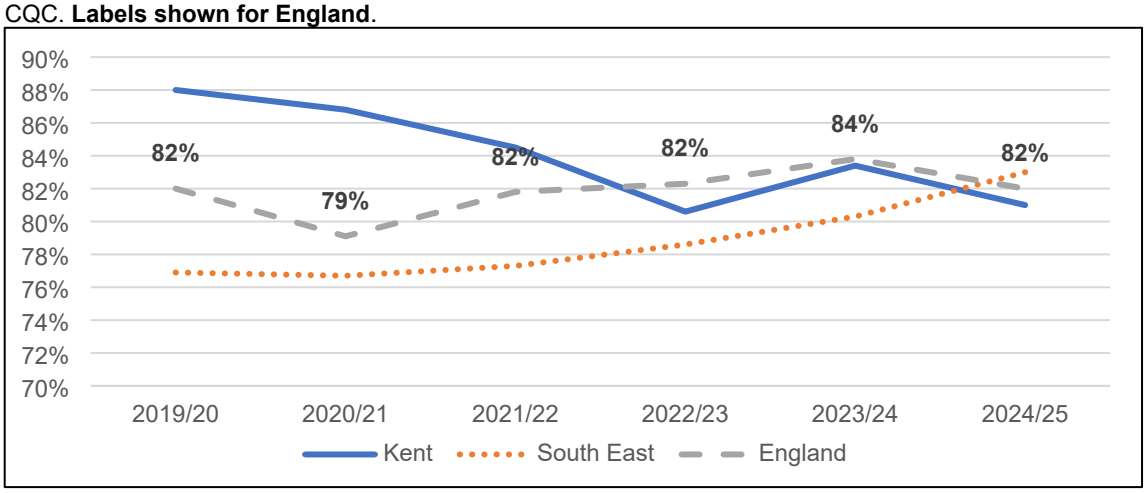
Figure 2 – ASCOF 2C: Long Term support needs of adults (65 and older) met by admissions to residential and nursing care homes, per 100,000. **Labels shown for England**.



2.15 Residential and Nursing homes are inspected on a regular basis by the Care Quality Commission (CQC) who provide an overall rating for the quality of care and support available to the people supported in these settings. In Quarter 4, 75% of KCC supported people in residential or nursing care were in a home that was rated either Good or Outstanding by CQC; an improvement of 2% compared to last quarter (ASCH 7). This improvement means this measure is now RAG Rated Amber from Red being below the 80% target but at the floor threshold of 75%.

2.16 A new national measure was published this year showing the percentage of residential adult social care providers rated good or outstanding by the CQC. this includes all homes in Kent not just those used by KCC. In 2024/2025, 81% of residential adult social care providers in Kent were rated Good or Outstanding, with Kent ranked at 91 nationally (the lower the rank the better) The South East regional value was 83% and for England it was 82%.

Figure 3 – ASCOF 6b Percentage of residential adult social care providers rated good or outstanding by CQC. **Labels shown for England**.

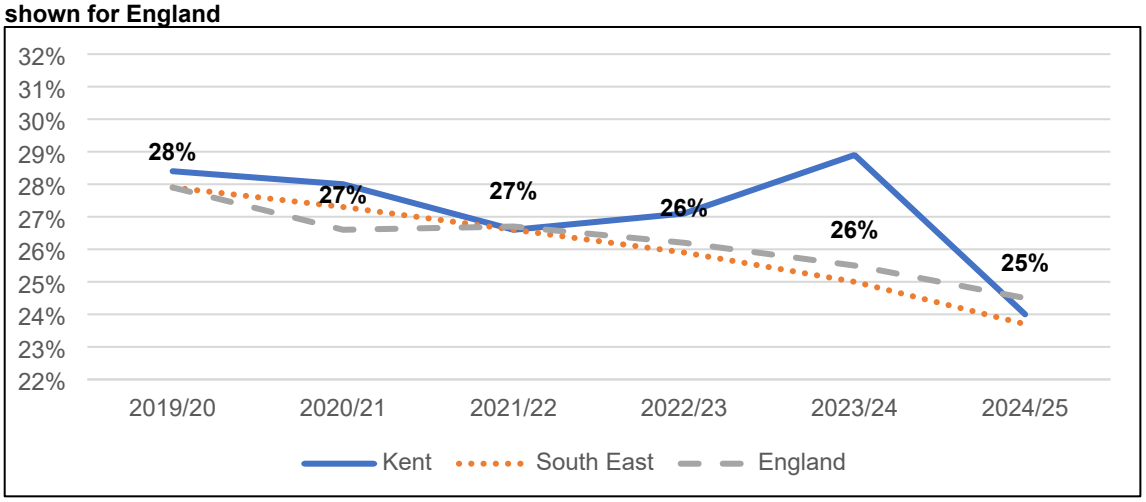


2.17 If a person is supported in the community they may receive a Direct Payment (DP); giving them full control over the way in which their care and support needs are met, including the use of a personal assistant. Quarter 4 saw 26% of people supported by adult social care in the community receiving a DP, the

same figure as last quarter (ASCH 3). This measure remains RAG Rated Amber and has done so consistently for the whole of financial year 2025/26, being above a floor threshold of 24% but below a target of 30%. Despite a rise in homecare provision in Kent, adult social care continue to offer the option of a direct payment to those requiring support, aiding the consistency of the proportion of people who then receive one.

2.18 Despite a 5% decrease in the proportion of people receiving a direct payment, Kent aligned with national and regional trends in 2024/2025, with 24% of people supported choosing to receive a direct payment. This proportion ranks Kent 78th in the country for this measure having previously held a lower rank in previous financial years. (the lower the rank is better)

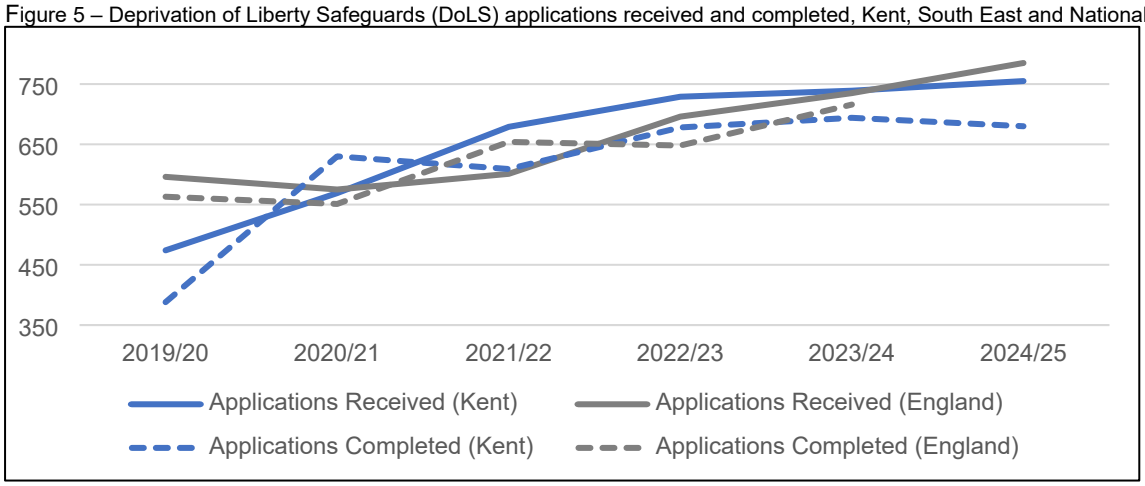
Figure 4 – ASCOF 3D2A – Proportion of people using social care who receive direct payment. **Labels shown for England**



2.19 Deprivation of Liberty Safeguards (DoLS) are a set of legal guidelines put in place to ensure that a person is not unlawfully deprived of their liberty. Applications are made for an assessment to take place. Quarter 4 saw over 2,700 applications received, a 5% increase on last quarter. Even with this increase the number of applications received in 2025/2026 was just over 200 less than received in 2024/2025, however it was still over 10,500 applications for the DoLS Team to manage. Over 2,300 assessments were completed in the quarter, a decrease of 6% compared to the previous quarter (ASCH 20). In total the team completed over 9,200 assessments.

2.20 Activity for both DoLS applications and their subsequent completion have risen over the past six financial years both in Kent and nationally. In 2024/2025, Kent received 755 applications per 100,000 population – a sixth successive financial year increase. This is a picture mirrored nationally, with 785 applications per 100,000 received in 2024/2025.

Figure 5 – Deprivation of Liberty Safeguards (DoLS) applications received and completed, Kent, South East and National



National completion figures for 2024/25 currently under review.

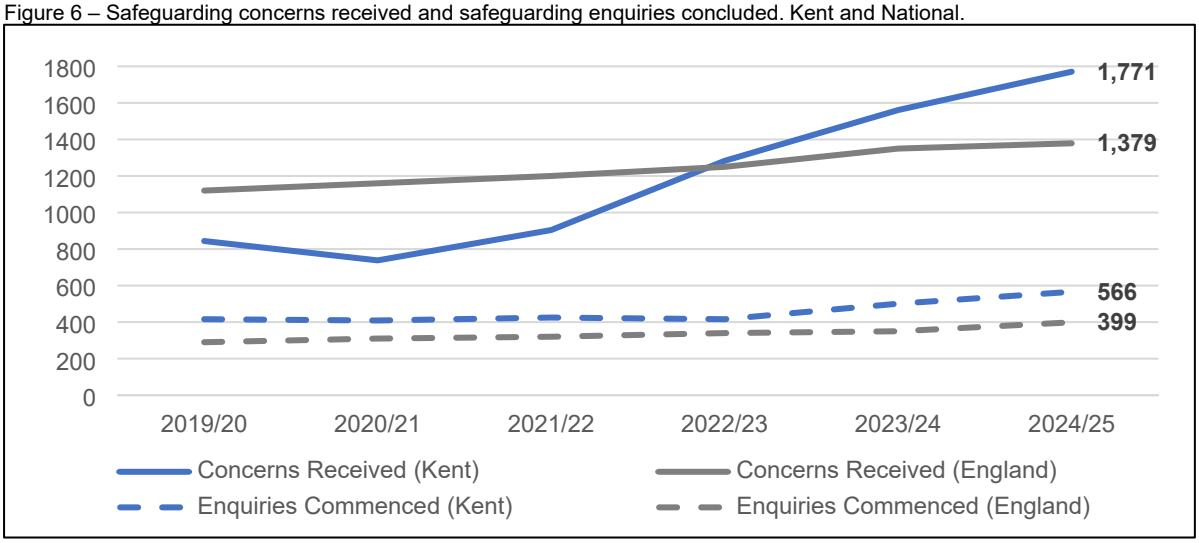
2.21 Demand on the DoLS Team does outstrip capacity therefore the service triages and prioritises applications daily ensuring the most high risk people are seen. The service also works closely with health parters, having a specific pathway for all hospital applications to ensure resources are used correctly.

2.22 The DoLS Team regularly run validation exercises with care homes to ensure that the correct applications are being submitted. This work will be carried out in partnership with the Commissioning Team to ensure a coordinated approach. In addition, targeted resources have been deployed to prioritise visits to people whose assessments have been waiting the longest.

2.23 When someone suspects that an adult is at risk of abuse or neglect they can raise a safeguarding concern, alerting adult social care that action may need to be taken to safeguard the adult in question. In Quarter 4, the volume of safeguarding concerns received by adult social care continued to reduce. Over 5,700 concerns were received which was a 6% decrease on the previous quarter and the lowest quarterly figure since Quarter 2 2024/2025. Overall though the number of safeguarding concerns in financial year 2025/2026 was 9% greater than the previous financial year. The number of safeguarding enquiries open on the last day of the quarter also fell to 1,340 (an 8% reduction) following a rise in the previous quarter (ASCH 21).

2.24 The number of safeguarding enquires commenced in Kent continues to be above national rates per 100,000 population from 2019/2020 onwards, with 566 enquiries commenced per 100,000 compared to 399 nationally in 2024/2025. The rate of safeguarding concerns received per 100,000 population has continued to increase annually and remains higher than the national rate in 2024/2025. 2024/2025 saw 1,771 safeguarding concerns received per 100,000 population in Kent compared to 1,379 nationally.

Figure 6 – Safeguarding concerns received and safeguarding enquiries concluded. Kent and National.



2.25 When adult social care conclude a safeguarding enquiry they will assess the risk to the person they have safeguarded. Quarter 4 saw little movement in the proportion of enquiries in risk either reduced (62%), remained (11%) or was removed (27%) compared to the previous quarter (ASCH 22).

3. Adult Social Care Indicators 2026/2027

3.1 Annually each Directorate review and make amendments where necessary to their locally published measures. Changes are only made where necessary and are reflective of changing business needs or local and national priorities.

3.2 Adult social care has published a suite of KPIs and measures that aim to reflect the variety of responsibilities delivered by the Directorate, and the person's journey, from making contact through to services, and the more specialist areas of DoLS.

3.3 This year we have a new suite of indicators and targets that reflect the priorities for 2026/2027 and the are in line with 'Reforming Kent', this suite also ensure there are close links with the new reporting requirements of the Department of Health and Social Care (DHSC) and the CQC. These can be seen in Appendix 2.

4. Conclusion

4.1 Quarter 4 exhibited stability in adult social care's KPIs, with a measure moving from RED to AMBER and another moving from GREEN to AMBER. A larger proportion of people were supported in residential or nursing homes where CQC rated them either Good or Outstanding and a lower rate per 100,000 population aged 65 or over needs were met by admission to residential or nursing homes. The proportion of people aged 65 or older who were still at home after 91 days following discharge from hospital into reablement services fell by 1% as did the proportion of CNAs completed within 28 days.

4.2 Pressures related to demand on key services with adult social care continued, with contacts made to Adult Social Care Connect increasing and the number of DoLS applications reaching their highest levels in the financial year. The number of people requiring a review to be completed rose and the number of people accessing community enablement services reduced. However when compared to the previous years, the activity delivered in 2025/2026 was higher. The volume of safeguarding concerns received fell for the second quarter in a row and the number of safeguarding enquiries needing to be completed fell, indicated a change in the previous trend on demand and safeguarding colleagues responding to these decreases.

5. Recommendation

5.1 Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of services in Quarter 4 2025/2026 and **NOTE** the new suite of indicators for 2026/2027.

6. Background Documents

None

7. Report Author

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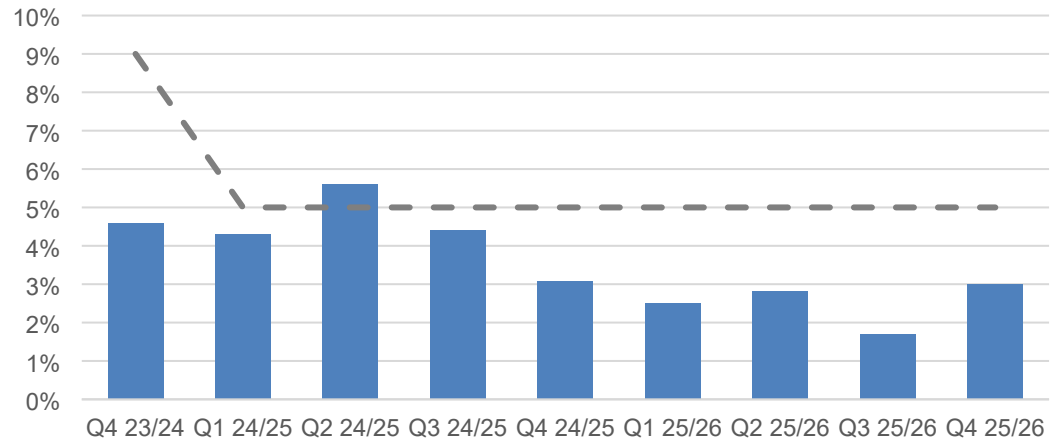
ASCH1: The percentage of people who have their contact resolved by Adult Social Care and Health (ASCH) but then make contact again within 3 months. **GREEN ⇩**



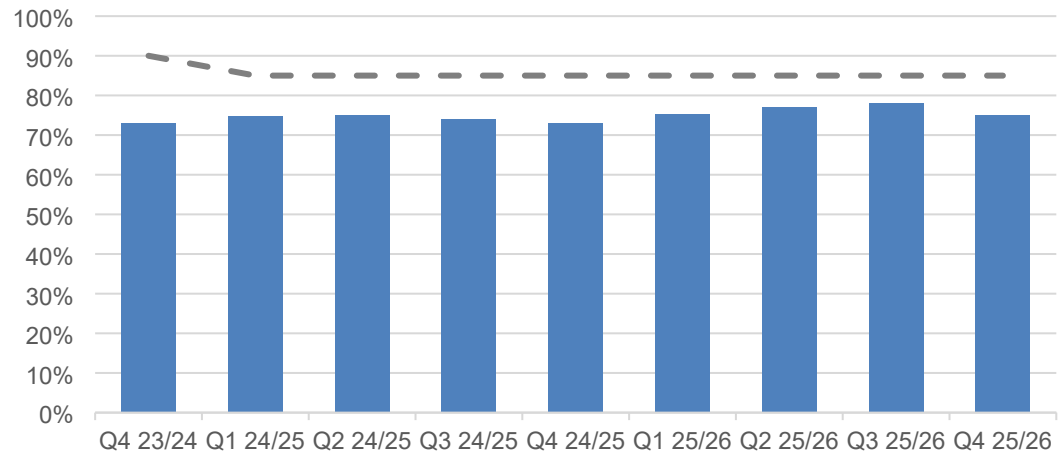
The proportion of people who have their contact resolved within three months has risen to 3% but is still below the 5% target.

Adult Social Care Connect aim to signpost those who make contact with adult social care to useful resources in the community when appropriate.

By successfully informing people of where they can seek further assistance, the likelihood of them making a 'repeat' contact is reduced.

(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 proportion of Care Needs Assessments delivered within 28 days has fallen for the first time since Q4 24/25.

This is largely due to January, where the percentage completed within 28 days for that month was 72%. However the following months improved to 78% in March which was the best performing month of the financial year.

Over 3,900 Care Needs Assessments were completed in Quarter 4, similar to Quarter 3.

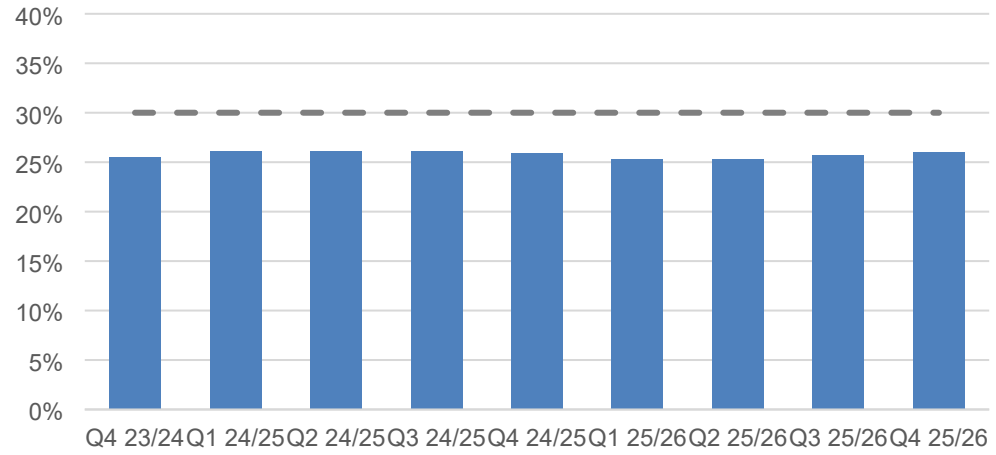
The median wait time in days increased to 27 this quarter as Care Needs Assessments that have been open for longer are completed.

(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 ⇔



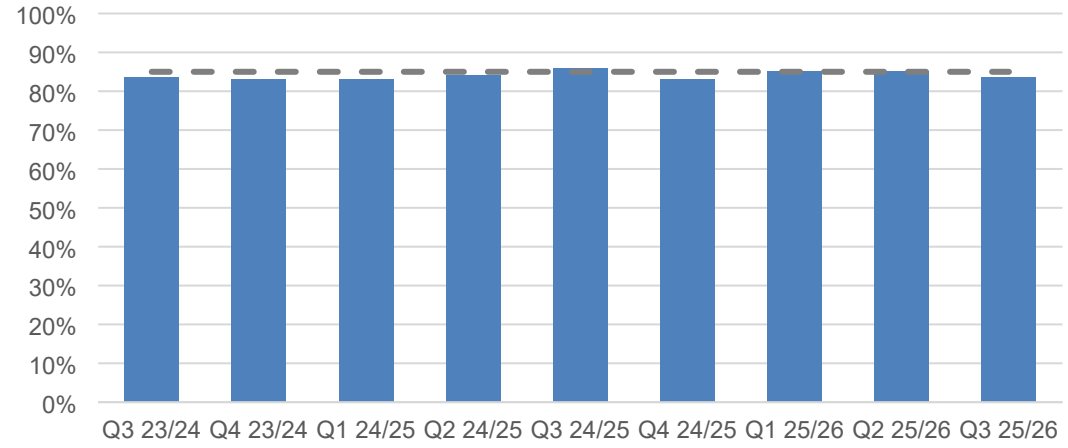
The percentage of people in receipt of a Direct Payment remains at 26%, as it has done for the past two financial years.

Adult social care continue to have new people starting a Direct Payment. The majority of people with a Direct Payment are Carers and people with Learning Disabilities, there has also been a small increase of those with a Mental Health need using direct payments.

(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

AMBER ⇩



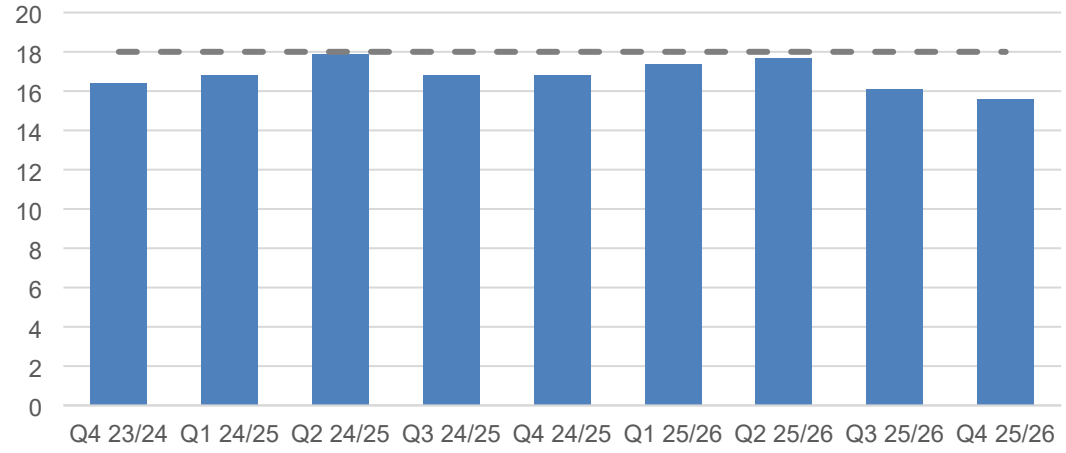
Delivery on this KPI has remained relatively consistent each quarter, either at the target or just below.

Adult social care remain focused on ensuring people in enablement services, especially on a hospital discharge pathway, regain their independence and remain in their home.

(Target 85%, Floor Threshold 80%. 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
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH5: Long Term support needs of adults (18-64 years old) met by admission to residential and nursing care homes, per 100,000 — **GREEN ⇧**



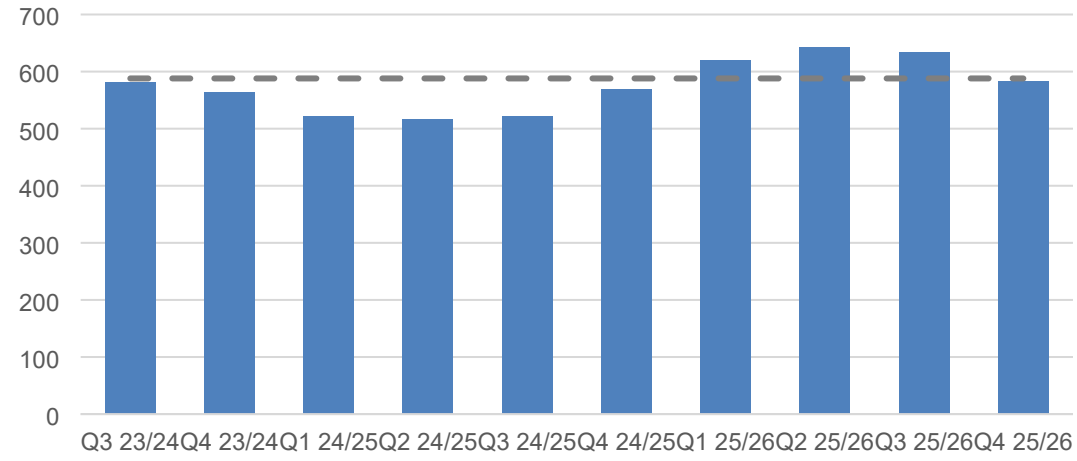
The rate by which a person aged 18-64 has their needs met by admission to residential and nursing care (per 100,000 population) continues to be RAG rated green.

This measure has remained below the target for the past two years as adult social care continue to meet the care and support needs of younger people with support outside of a residential or nursing setting.

Please note that the most recent quarters are subject to updates.

(Target 18, Upper Threshold 22. Rate per 100,000. 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 ⇧**



The rate of people whose needs are met by long term admission to residential and nursing care has fallen in those aged 65 and over.

This is the second quarter in succession where a rate decrease occurred and the measure is now meeting target for the first time this year.

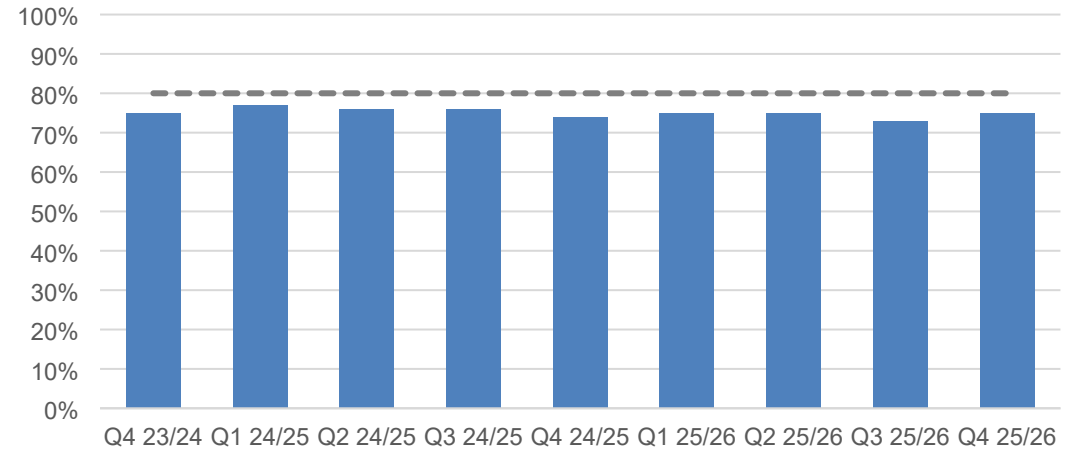
Please note that the most recent quarters are subject to updates.

(Target 588, Upper Threshold 617. Rate per 100,000. Better Care Fund (BCF) Measure National Adult Social Care Client Level Dataset (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 ⇧

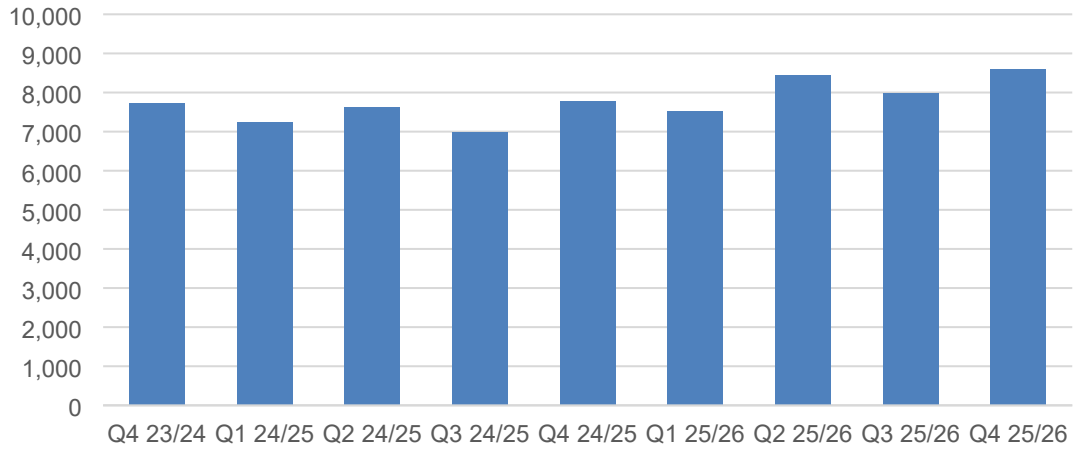


The proportion of KCC people supported in residential or nursing care, where the Care Quality Commission rating is Good or Outstanding, has improved and is now at the 75% which moves them to RAG rated Amber at the floor threshold.

There was a 1% decrease of those in a home rated Inadequate.

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

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



The most recent quarter saw the highest number of contacts received by Adult Social Care Connect for the past two years.

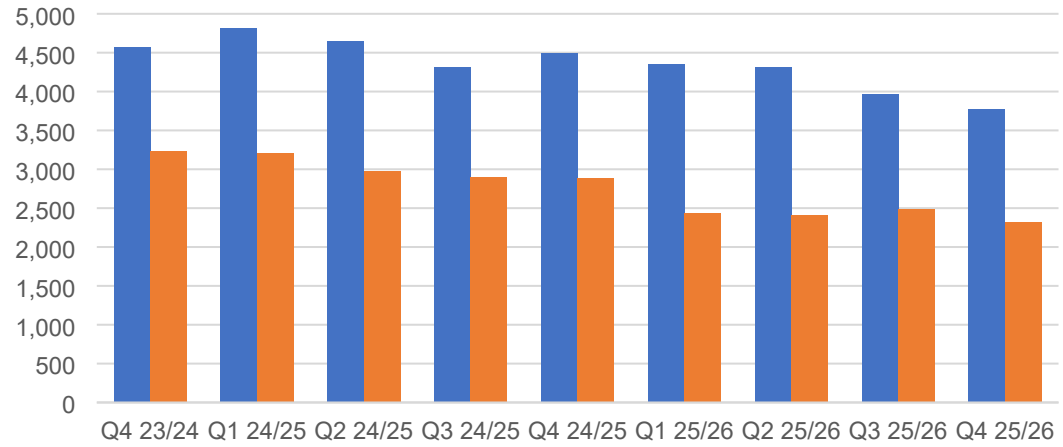
The most common source of referrals in Quarter 4 were family members (22%), followed by self-referrals (17%).

The majority of contacts made were done so using the online web contact form (37%), then a telephone call (25%)

(New measure for 2025/2026 concentrating solely on the work or the Adult Social Care 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
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH9: Care Needs Assessments

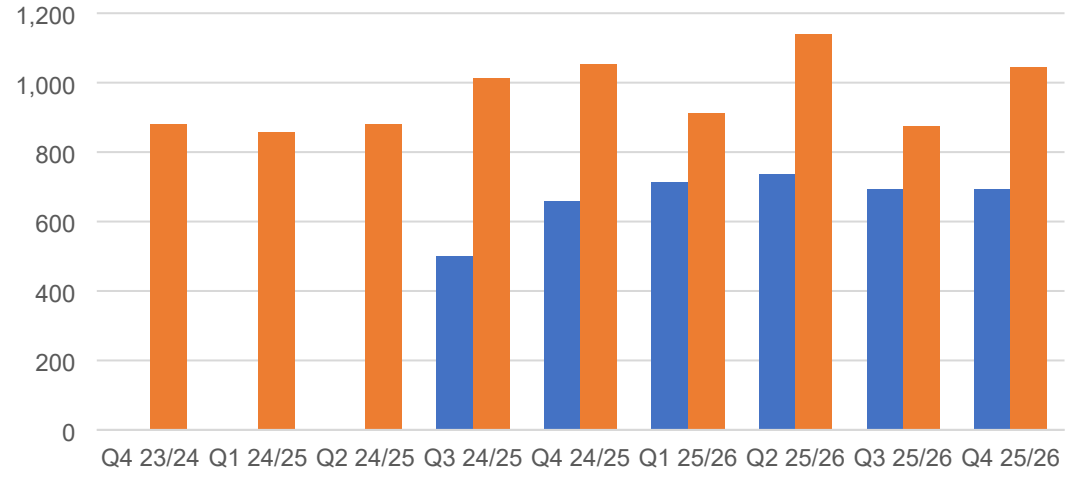


The number of new assessments to be undertaken has fallen quarter on quarter since the start of the financial year.

The number of assessments needing to be completed is now at its lowest level in the past two years.

(Blue – New assessments to be undertaken. Orange – Assessments needing to be completed)

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



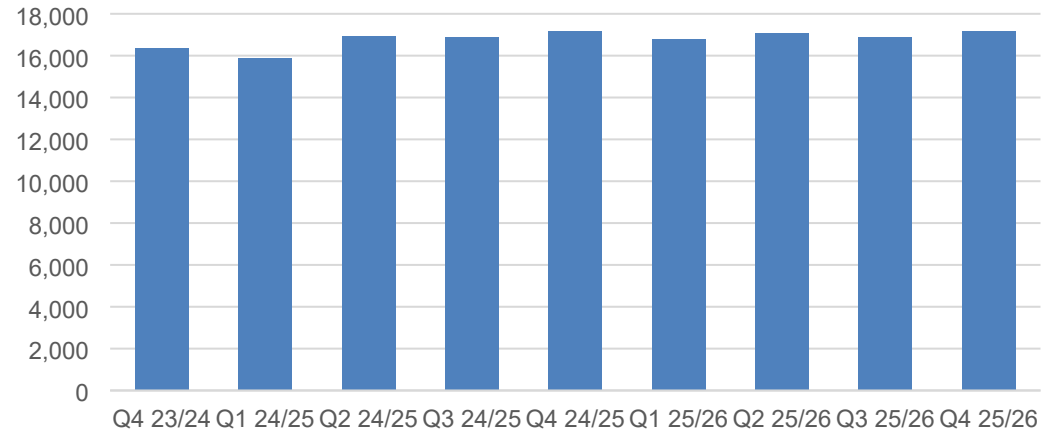
Despite a slight decrease from Quarter 3, the number of carer referrals has remained stable at around 700 per quarter throughout this financial year. In Quarter 4, a total of 743 referrals have been completed; this is the highest level since Quarter 3 of 2024/2025, when this form of reporting started.

Quarter 4 also saw a 20% increase in the number of care assessments or Information and Advice (IAG) provided to carers compared with the previous quarter. Of all carers supported in Quarter 4, 56% received information and advice, while 44% had a full carer's assessment completed.

(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
An appendix of technical notes for each of the measures is provided at the end of the report

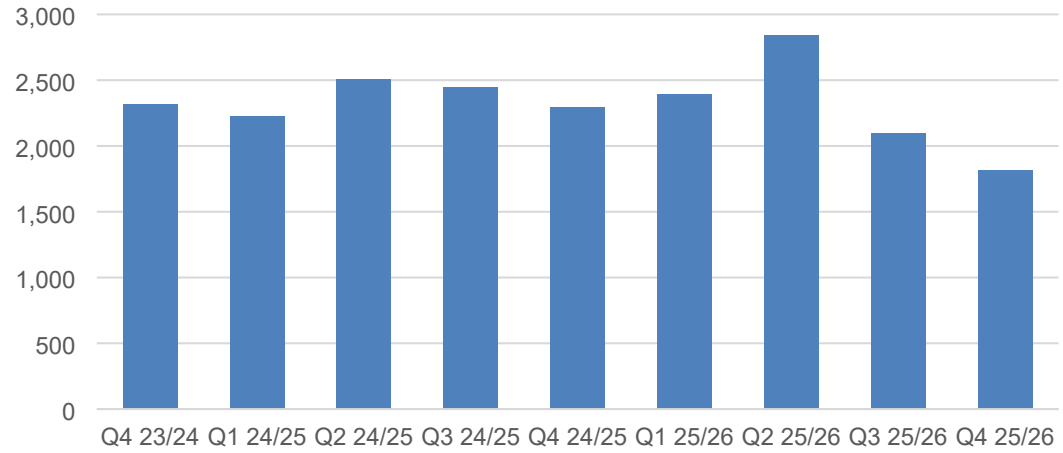
ASCH11: The number of people with an active Care and Support Plan at the end of the Quarter



In 2025/2026, the number of people with an active care and support plan at the end of the quarter rose to 17,177, a 2% increase from Quarter 1 to Quarter 4.

It should be noted that a number of people will have ended throughout the year with new people being supported; so the total number of people supported is a higher figure.

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



A further reduction was seen in Quarter 4 in the number of new support packages being arranged.

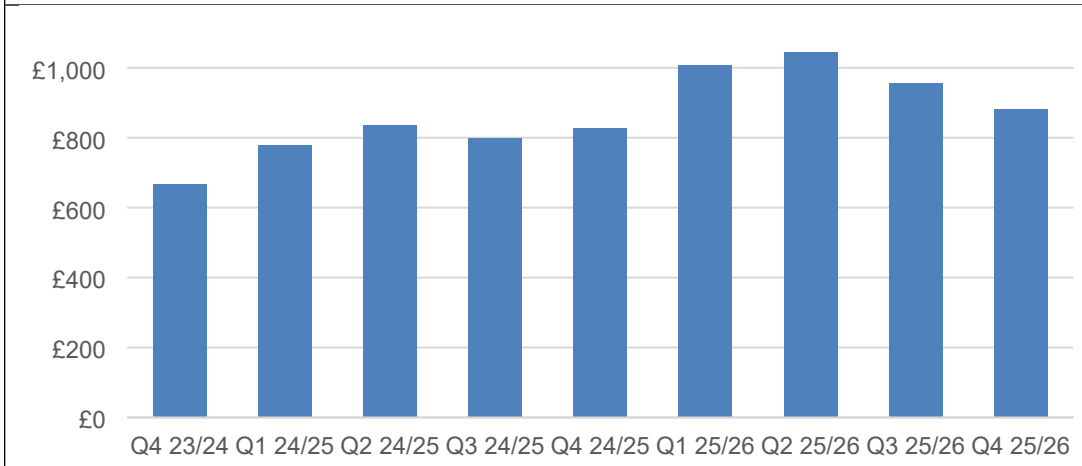
In Quarter 4, the most common type of support package arranged was Short Term Beds (42%), followed by Homecare (29%) and Long Term Residential (11%).

Please note that the most recent quarters are subject to updates.

(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
An appendix of technical notes for each of the measures is provided at the end of the report

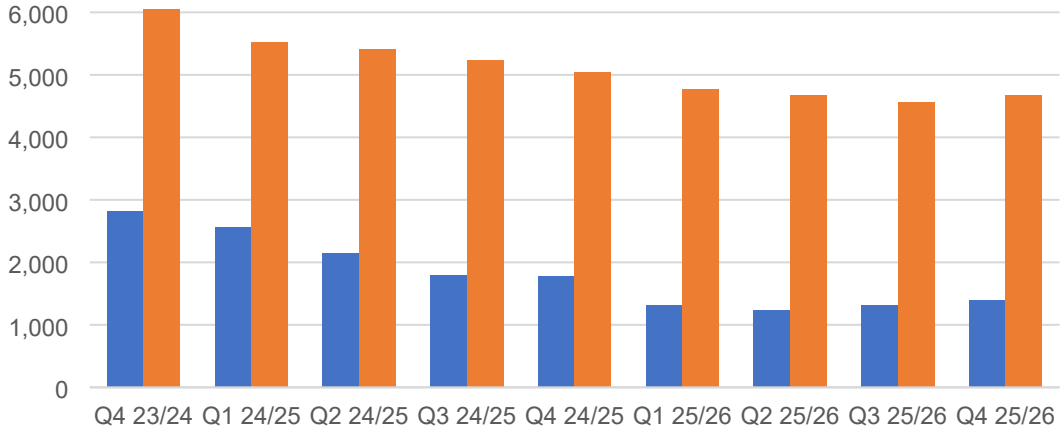
ASCH13: The average cost of new support packages arranged for people in the quarter



The average weekly cost of all new support packages continued to fall in Quarter 4. The average weekly cost now sits at its lowest point this financial year.

Please note that the most recent quarters are subject to updates.

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



The number of people requiring an annual review to be completed has risen slightly for the first time in two years, along with the number of first reviews to be completed increasing for the third consecutive quarter.

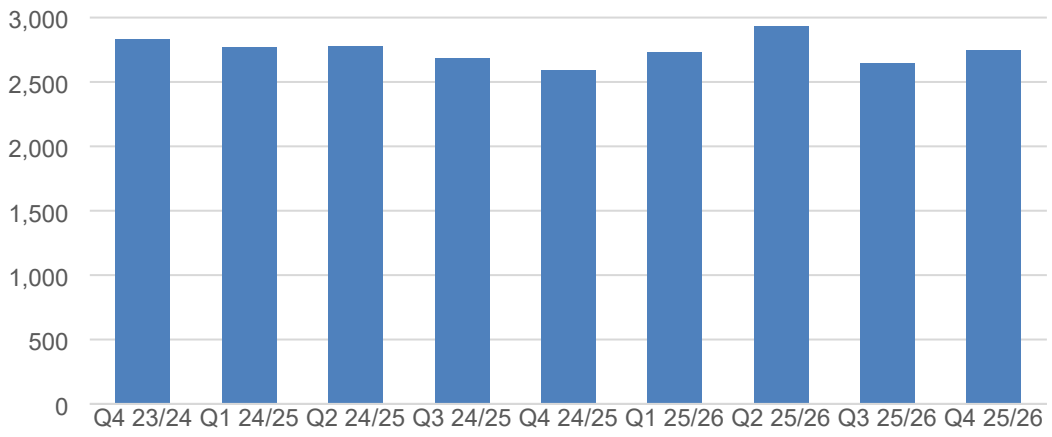
However both sets of figures are much lower than the same time period in 2024/2025.

Quarter 4 saw the fewest number of care and support plans completed (5,146) but this figure is still 13% higher than the same quarter last year.

(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
An appendix of technical notes for each of the measures is provided at the end of the report

ASCH15: The number of Occupational Therapy assessments completed

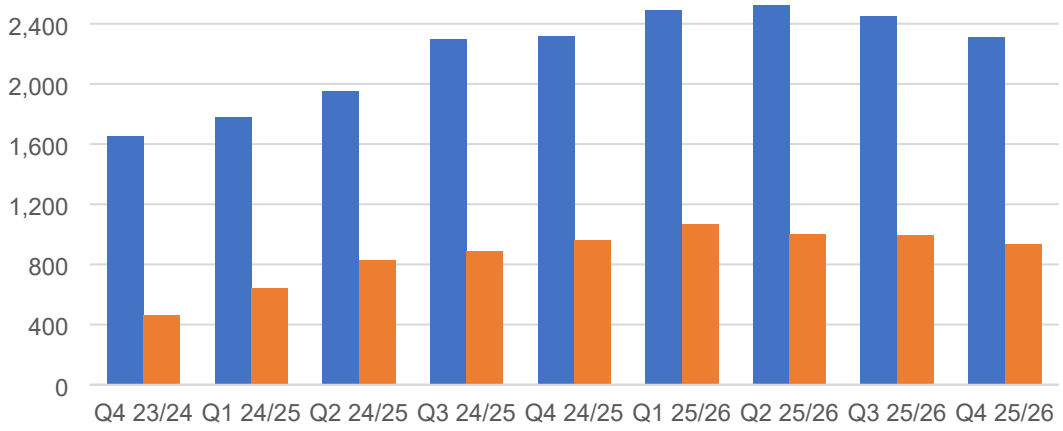


Occupational Therapy Teams continued their high level of activity in Quarter 4, completing the second highest number of assessments in the past year.

The number of Occupational Therapy assessments awaiting completion also fell and ends the financial year 29% lower than at the start.

(New 2025/26 measure)

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



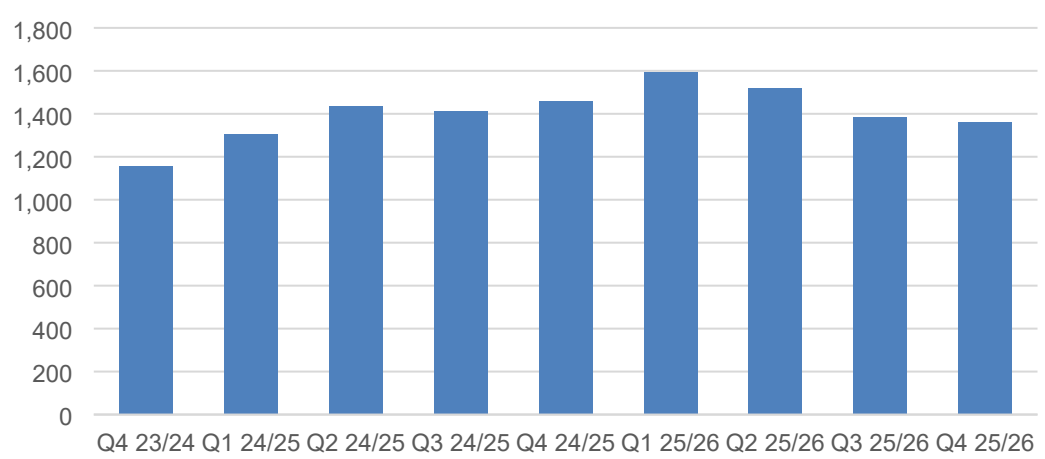
The number of people supported in the community by either Kent Enablement at Home (KEaH) or Kent Enablement Service (KES) has remained at similar levels across the financial year, albeit both have seen reducing numbers, both have delivered to more people this year when compared to previous years.

KEaH received 2,476 referrals in Quarter 4, their highest total of 2025/2026.

(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

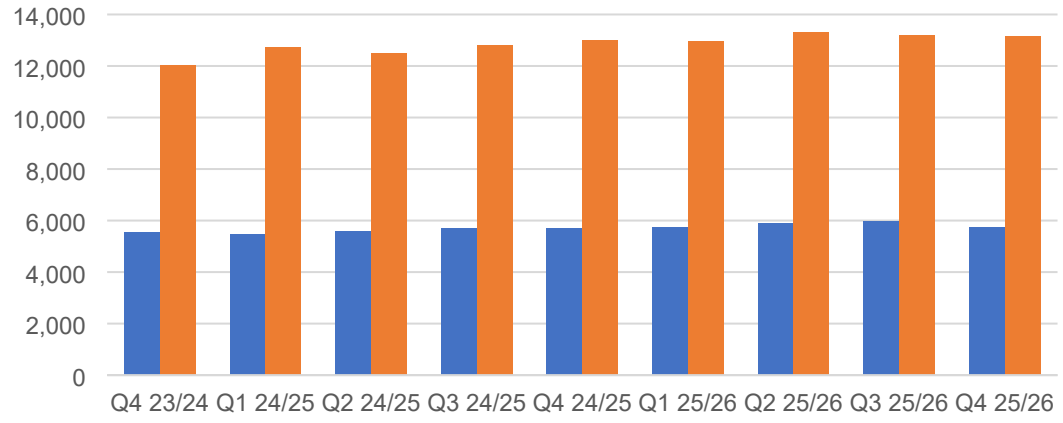


The number of people in Short Term Beds continued to fall in Quarter 4.

Adult social care continue to focus on ensuring people only go into a Short Term Bed if they need to, and helping them to not stay longer in that service than is necessary.

Please note that the most recent quarters are subject to updates

ASCH18: The numbers of people in Long Term Services



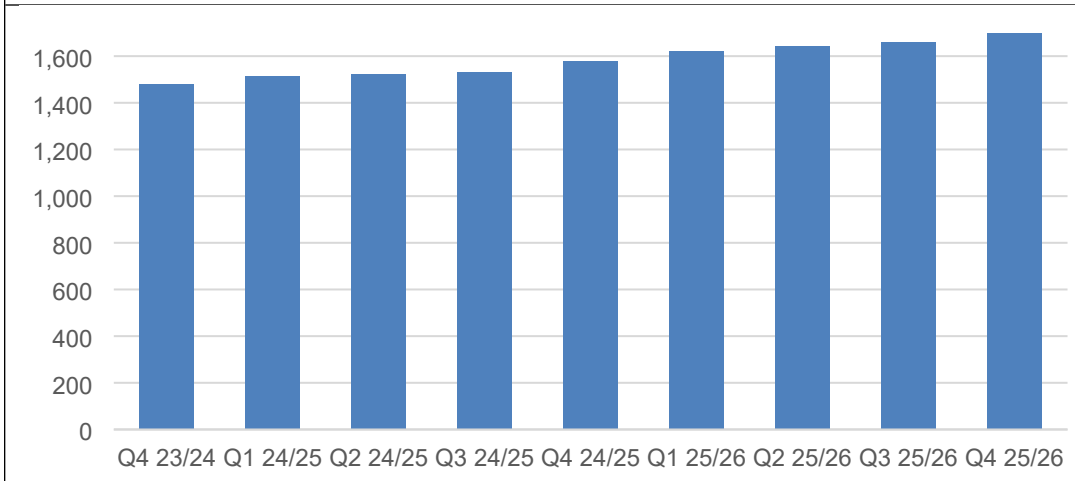
Little change has been seen in the overall number of people in Long Term Services in the previous three quarters.

The number of people in a long term Residential or Nursing has fallen compared to the beginning of the financial year.

(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

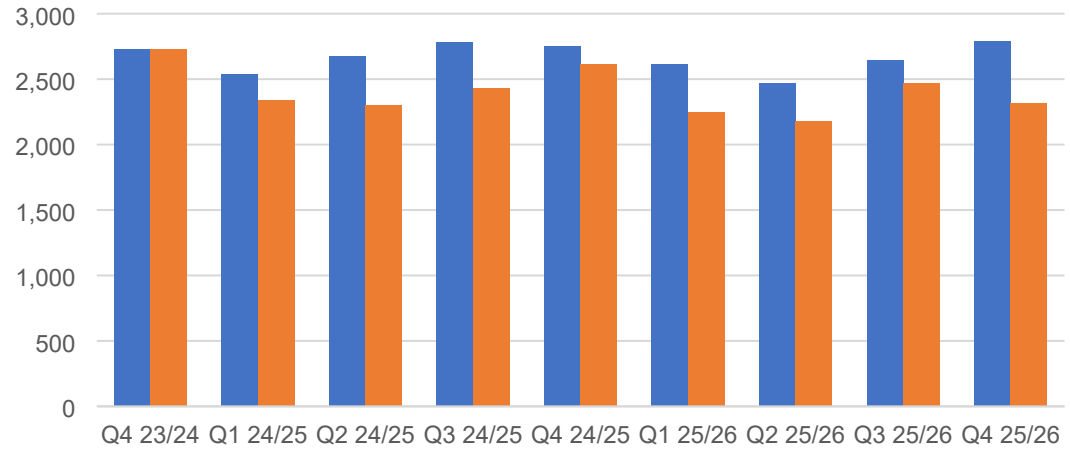
ASCH19: The number of people accessing Adult Social Care and Health Services who have a mental health need



Quarter 4 saw no change in the upward trajectory in the number of people accessing Adult social care services who have a mental health need, however no accelerated increase was seen.

The volume of people with a mental health need who are receiving a service has risen by 5% through 2025/2026.

ASCH20: Number of Deprivation of Liberty Safeguards (DoLS) applications received and completed



Quarter 4 saw the highest number of DoLS applications received in the last two years, increasing by 5% when compared to the previous quarter.

Application completions decreased by 6% in the same period.

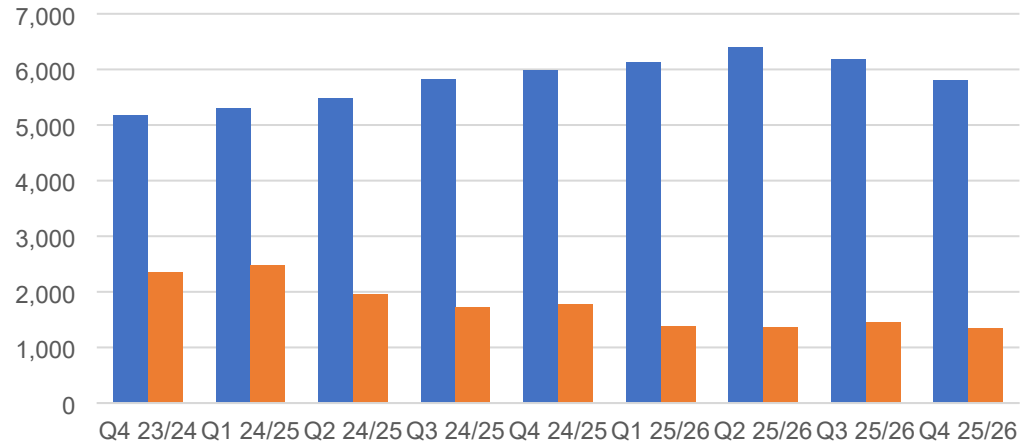
Demand outstrips capacity, therefore the Kent DoLS Service triage and prioritise applications daily to ensure the most high-risk people are seen first and as a priority.

The service works closely with Health Partners and there is a specific pathway for all Hospital applications to ensure resources are used correctly. This is reviewed and monitored daily, with weekly reports to Safeguarding leads in Health.

(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 and safeguarding enquiries open on the last day of the quarter



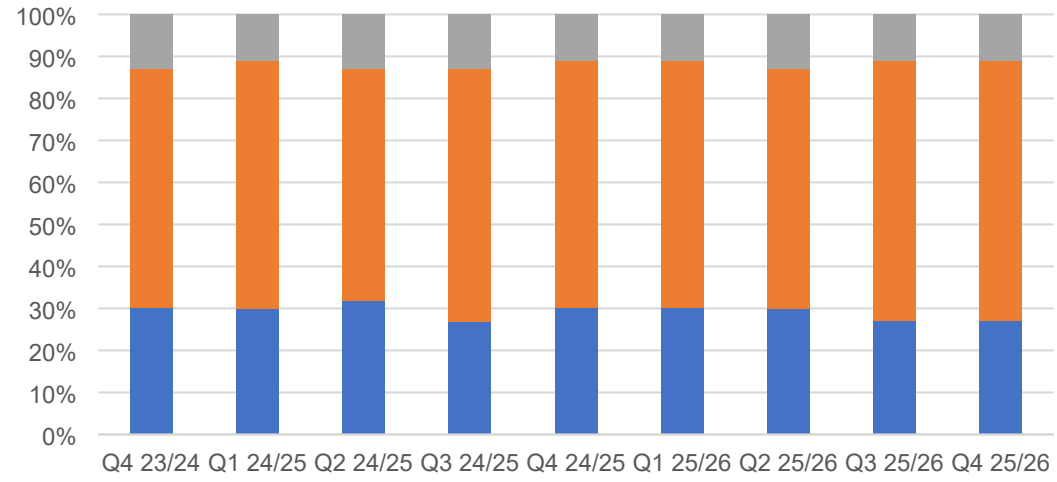
The number of safeguarding concerns received decreased for the second quarter in the row, indicating the start of a trend of a reduction of incoming safeguarding activity for adult social care.

24% of concerns received in the quarter progressed to a safeguarding enquiry, the lowest proportion for any quarter this financial year.

The number of safeguarding enquires, open on the last day of the financial year, was 44 lower than the start despite the year having 9% more concerns received than previously.

(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



Adult social care continue to address risk when safeguarding adults in Kent. Quarter 4 had identical 'risk outcomes' for people who had been safeguarded when compared to the previous quarter - equalling the lowest proportion of enquiries where; risk remained'.

(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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Appendix 2: 2026/2027 Suite of KPIs and Activity Measures

Measure and Reference:	Targets:	Notes:
ASC1: The percentage of people who have their contact resolved by adult social care but then made contact again within three months	Target: 5% Upper Threshold: 9% *The lower the better*	No change
ASC2: The median wait time for Care Needs Assessments	Target: 25 days Upper Threshold: 30 days *The lower the better*	Measure changes from reporting percentage completed within a set time frame to median wait time, reflecting both the direction of 'Reforming Kent' on productivity and the Care Quality Commission (CQC) reporting requirements
ASC3: The percentage of people in receipt of direct payments with adult social care	Target: 30% Floor Threshold: 24% *The higher the better*	No change
ASC4: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Target: 85% Floor Threshold: 80% *The higher the better*	No change
ASC5: Long term support needs of adults (18-64 years old) met by admission to residential and nursing care, per 100,000	Target: 18 per 100,000 Upper Threshold: 22 per 100,000 *The lower the better*	No change
ASC6: Long term support needs of older people (65 and over) met by admission to residential and nursing care, per 100,000	Target: 515 Upper Threshold: 560 *The lower the better*	New lower target and threshold based on previous performance (target) and the South East Association of Director's of Adult Social Services (ADASS) regional delivery (upper threshold)

Measure and Reference:	Targets:	Notes:
ASC7: The percentage of Kent County Council supported people in residential or nursing where the Care Quality Commission rate is Good or Outstanding.	Target: 80% Floor Threshold: 75% *The higher the better*	No change
ASC8: The number of contacts received by adult social care connect about people that might need our support	Activity measure only	Measure title changed for clarity.
ASC9: The number of Care Needs Assessments to be undertaken, and the number completed	Activity measure only	Measure changed to show what we needed to do and what we did. Reflects better the direction of 'Reforming Kent' on productivity
ASC10: The number of carers supported with information, advice or guidance, or an assessment	Activity measure only	Measure title changed for clarity.
ASC11: The number of new support packages being arranged for people in the quarter	Activity measure only	No change
ASC12: The number of people requiring a first reviews (6-8 weeks) or an annual reviews completed in the quarter.	Activity measure only	Measure changed to show the delivery of reviews, reflecting better the direction of 'Reforming Kent' on productivity
ASC13: The number of Occupational Therapy Assessment referrals received and the number completed.	Activity measure only	Measure changed to show what we needed to do and what we did. Reflects better the direction of 'Reforming Kent' on productivity
ASC14: The number of people receiving Kent Enablement at Home, and the average percentage decrease in need.	Activity measure only	Expanded measure splitting the enablement services to show outcomes. This allows for impact of the services to be shown and reflects 'Reforming Kent' for value for money and outcomes, not processes.
ASC15: The number of people receiving Kent Enablement Service, and the average percentage decrease in need.	Activity measure only	Expanded measure splitting the enablement services to show outcomes. This allows for impact of the services to be shown and

Measure and Reference:	Targets:	Notes:
		reflects 'Reforming Kent' for value for money and outcomes, not processes.
ASC16: The number of people in Short Term Beds	Activity measure only	No change
ASC17: The number of people on Long Term services	Activity measure only	No change
ASC18: The number of Deprivation of Liberty Safeguards applications received and completed	Activity measure only	No change
ASC19: The number of safeguarding concerns received and total safeguarding work open on the last day of the quarter.	Activity measure only	Measure amended to now show open safeguarding work as a whole, replacing open enquiries only. This moves the measure to better alignment with the Department of Health and Social Care (DHSC) and CQC reporting.
ASC20: Making Safeguarding Personal: Expressed desired outcomes that were fully or partially achieved.	Activity measure only	Measure changed to be more reflective of people's experiences. Reflects the direction of 'Reforming Kent' on outcomes not processes, and dignity. This can also be related to the DHSC and CQC "I" statements.

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From: Diane Morton Cabinet Member for Adult Social Care

Sarah Hammond, Corporate Director Adult Social Care and Health

To: Adult Social Care and Public Health Cabinet Committee – 6 May 2026

Subject: **Adult Safeguarding Update**

Classification: Unrestricted

Summary: This report is intended to update the Cabinet Committee about Adult Safeguarding and provide an overview of the adult safeguarding processes, the current context, an account of both strategic and operational perspectives, including the partnership arrangements and key challenges. The report also highlights some of the completed and ongoing work in relation to the Care Quality Commission (CQC) Improvement Plan actions and new areas for development. Please note this report does not cover the Deprivation of Liberty Safeguards (DoLS).

Recommendation(s): The Cabinet Committee is asked to **NOTE** and **COMMENT** the content of the report.

1. Introduction

1.1 Safeguarding responsibility is considered to be one of the core statutory functions of a local authority. To put it simply, safeguarding is about making sure people with care and support needs are kept safe from abuse and neglect, such as protecting someone who is experiencing physical abuse from a family member. The Care and support statutory guidance identifies 10 types of abuse and neglect, including physical, domestic violence or abuse, sexual abuse, psychological or emotional abuse, financial or material abuse, modern slavery, discriminating abuse, organisational or institutional abuse, neglect or acts of omission and self-neglect. It is important to note that the safeguarding duties have a legal effect in relation to organisations other than the local authority, on for example, the NHS and the Police.

1.2 Safeguarding risks come several sources, from family or friends, staff, organisations or even the person themselves, with most risks coming from people known to the individual. Incidents can take place in different settings, for example a hospital, care home or the person's own home. Anyone can raise a safeguarding concern – family or friends, staff or carers or a member of the public. Safeguarding is everybody's responsibility and is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect.

2. National context

2.1 Baroness Casey, Chair of the Independent Commission on Adult Social Care raised her concerns about safeguarding in her letter to the Secretary of Health and Social Care in March 2026, with recommendation that an urgent review of existing adult safeguarding statutory duties and powers, to test whether the current framework provides sufficient clarity and leverage in high-risk situations. In his response, the Secretary of State confirmed that his department will create a new national safeguarding board and undertake an urgent review of adult safeguarding statutory duties and powers as you recommend. A new national safeguarding board which is chaired by the Chief Social Worker is to be established reporting to the Minister of State for Care. An urgent review will aim to identify whether this board requires new statutory powers and tests whether the current framework provides sufficient clarity and leverage in high-risk situations.

2.2 One of the challenges reported nationally and also demonstrated locally is the sheer increased in safeguarding activities. The number of safeguarding concerns raised to local authorities has been increasing over time. Between 2016/2017 and 2024/2025, the number of concerns increased by a staggering 76% (from 364,605 to 640,240). This is starkly illustrated by the following tables (1 and 2), taken from the Cause for alarm: what can safeguarding data tell us about the challenges facing health and care services? | Nuffield Trust.

Table 1

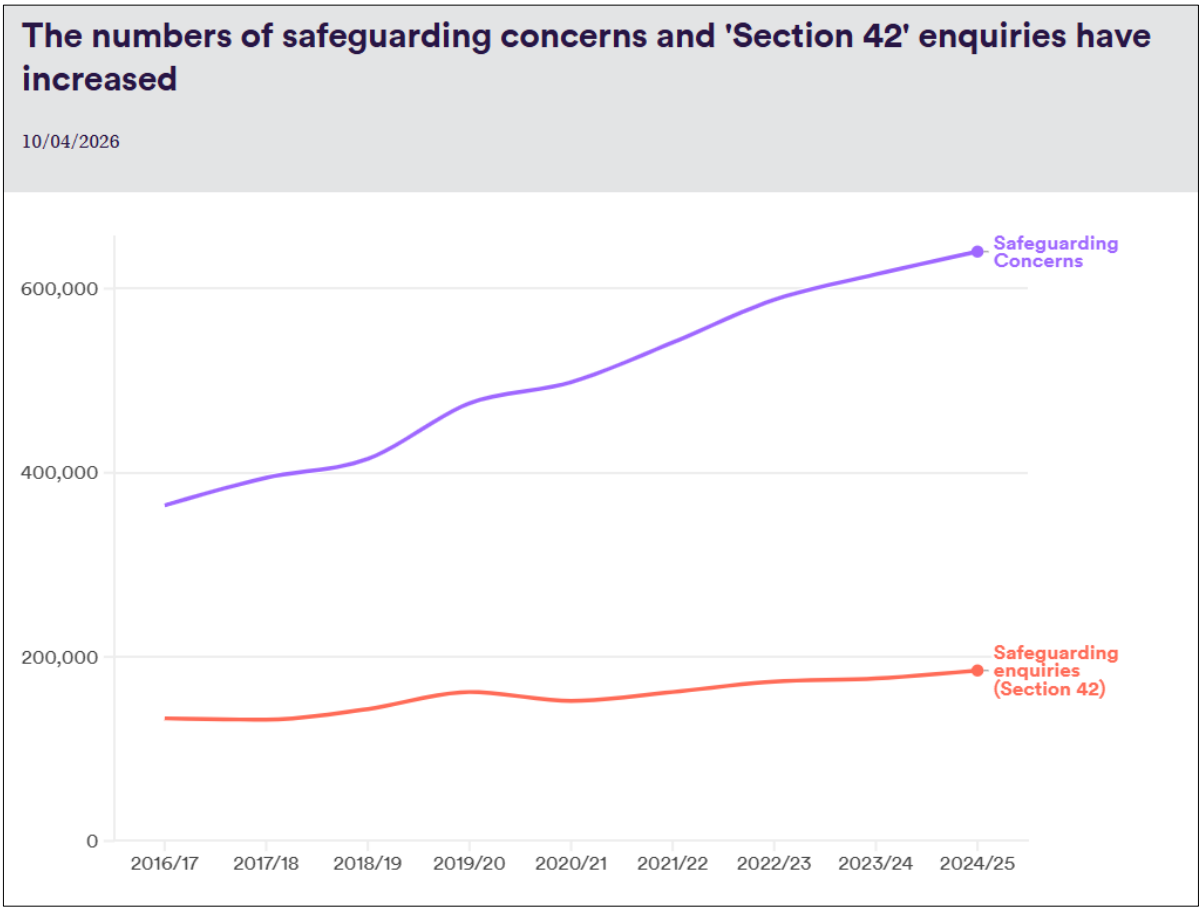
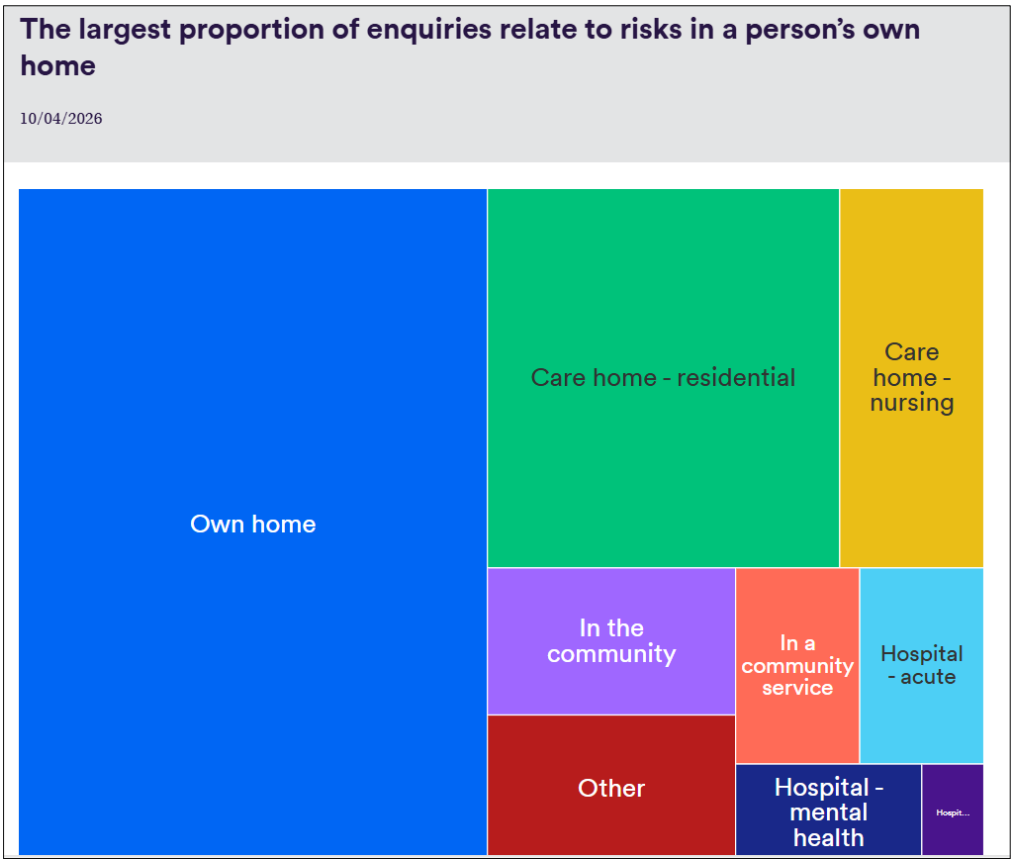


Table 2



2.3 **Raising a Safeguarding Adults Concern**
Kent has an Adult Safeguarding Online Concern form available on the Kent.gov website - **Tell us about an adult safeguarding concern form**

2.3.1 The Concern form has both public and professional online versions and has been recently revised to provide more guidance to the referrer and improve the information being provided in relation to the person and their circumstances, to assist with the application of the statutory criteria. In addition, we have provided key contact details to avoid duplication of referrals for the same person and identified issues. and added resources such as a Kent and Medway Threshold tool to highlight what would and would not constitute the need to raise a safeguarding concern. Due to the high numbers of safeguarding concerns received in relation to self-neglect, additional information is now sought from the referrer, to ascertain if their Concern meets the necessary criteria prior to the form submission.

2.3.2 Kent Strategic Adult Safeguarding and Medway Adult Social Care collaboratively created the Kent and Medway Threshold Tool, to provide a best practice guide for decision making in relation to Safeguarding. This tool has been approved by the Kent and Medway Safeguarding Adults Board (KMSAB) and is hosted on both the KMSAB Website and Kent.gov.

3. Key Safeguarding activities

3.1 Adult Safeguarding

3.1.1 Adult Safeguarding is the protection of an adult's right to live safely, free from abuse and neglect, while promoting their well-being and autonomy. Section 42 of the Care Act 2014 criteria states that statutory safeguarding enquiries should be made by the local authority where a person is 18 years or over and the person has needs for care and support; is experiencing, or at risk of, abuse or neglect; and as a result of their care and support needs, is unable to protect themselves against abuse or neglect, or the risk of it.

3.1.2 The local authority must carry out the safeguarding duties alongside other duties of the Care Act 2014, and work in line with Making Safeguarding Personal (MSP) which is a 'personalised approach that enables safeguarding to be done with, not to, people' and the six principles of safeguarding, Empowerment, Prevention, Proportionality Protection, Partnership and Accountability.

3.2 Managing safeguarding work in Adult Social Care

3.2.1 Operational Safeguarding Teams receive and manage safeguarding concerns and enquiries across four local teams. Safeguarding concerns (a *Safeguarding concern is the initial referral raised by a professional or member of the public, sent to the local authority*) are triaged against the statutory safeguarding criteria and if the criteria is met, the concern would be progressed to an enquiry (*a Safeguarding enquiry is led by the local authority and is undertaken to establish whether any action needs to be taken in relation to the concerns raised, and if so, by whom*.[legislation.gov.uk). All safeguarding work is directly managed by safeguarding teams within the localities to provide an end-to-end safeguarding response to improve consistency, communication, reduce duplication and improve local intelligence around quality of local resources.

3.2.2 Kent also has a Strategic Safeguarding Team, who manage statutory review processes for Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews/Domestic Abuse Related Death Review (DHR/DARDR) and Child Reviews. Currently there are 29 open SARs and 21 DHRs being managed. Following a review, actions will be developed from recommendations within the report completed for each review. The Strategic Safeguarding Team manages the action plans for all statutory reviews undertaken, completing the necessary quality assurance actions required, such as the development of learning briefings, completing dip test audits, or make recommendations to improve practice.

3.2.3 The Strategic Safeguarding Team also work closely with partners in the KMSAB, in relation to the development of multi-agency policies, including the Kent and Medway Safeguarding Adults Board Multi Agency Risk Assessment Meeting (MARM), for people who are not receiving a statutory service but may be at high risk of harm. In addition, the Strategic Safeguarding Team oversee aspects of

quality assurance and the review and development of internal safeguarding processes and procedures including forms, tools and relevant guidance.

3.3 Kent and Medway Safeguarding Adults Board (KMSAB)

3.3.1 The KMSAB is a statutory body created under the Care Act 2014 and is hosted by Kent County Council (KCC). The Board is chaired by an Independent Chair and aims to ensure all member agencies are working together to help keep adults safe from harm and protect their rights. The Board produces annual report which is published on the KMSAB website.

3.3.2 KCC Adult Social Care colleagues work closely with the Board and multi-agency partners in response to statutory responsibilities including the completion of SARs, alongside developing multi- agency policies and guidance, providing assurance in relation to safeguarding processes for each agency, sharing data and developing learning/training for staff.

3.4 Adult Safeguarding Concerns received by Kent Adult Social Care

3.4.1 Concerns received as of 8 April 2026

- April 2024 to March 2025 - 22,595
- April 2025 to March 2026 - 24,565

3.4.2 Increases in the numbers of national safeguarding concerns raised have been noted and in the last published data from the annual Safeguarding Adults Collection (SAC - Microsoft Power BI), the total number of safeguarding concerns reported by local authorities between 1 April 2024 and 31 March 2025 was 640,240, an increase of 4% from the previous year (615,530). The total average number of safeguarding concerns per 100,000 adults was 1379, with Kent at 1771.

3.4.3 The high numbers of safeguarding concerns received in Kent have been noted and further work is required to address this. Joint work with Medway Council has led to the setting of a shared agenda of the Kent and Medway Safeguarding Adults Board Executive Group and at the System Quality Group led by the Integrated Commissioning Board, to raise awareness amongst partners and providers and to identify system wide solutions.

3.5 Data Analysis

3.5.1 Improved data recording in relation to safeguarding concerns has provided greater visibility on which of the partner agencies and provider organisations is raising the most safeguarding concerns to adult social care. Further analysis has been undertaken to cross reference our referral information, alongside the numbers that do not progress to an enquiry. This information is shared with partners via the KMSAB Quality Assurance Working Group. The data has also enabled our internal Locality Safeguarding Teams to identify local partners who make most referrals that do not progress, to build greater knowledge and understanding.

3.5.2 The Strategic Safeguarding Team has worked with internal colleagues, partners and providers and has developed a 'what makes a good referral' presentation, and work continues to develop this offer, including producing an infographic to share with partners.

3.5.3 As highlighted in 2.3, the one of the most common category of abuse received by adult social care is in relation to self-neglect, of which approximately 80% of these concerns did not progress to an enquiry. The Strategic Safeguarding Team has undertaken various strands of work to address this issue which includes changes made to the safeguarding referral form' and the development of the internal self-neglect risk assessment tool for colleagues which assists in establishing if the concern meets statutory criteria for safeguarding or requires a partner agency response such as holding a multi-agency self-neglect meeting.

3.6 Partnership Working

3.6.1 In North Kent there is currently a weekly test and learn meeting for external providers and partners, to discuss safeguarding with a member of the Safeguarding Team with a view to reducing safeguarding concerns that do not meet the statutory Section 42 criteria, improving working relationships and knowledge around safeguarding. In addition, the internal KCC safeguarding performance report has been enhanced to identify if the person has had any previous safeguarding raised or any currently open ('trigger protocol'). This reduces duplication and assists with effective oversight.

3.7 Care Quality Commission (CQC) Improvement

3.7.1 The focus of the CQC Improvement Plan actions concerning safeguarding, centred on improving consistency of practice, performance and relationship with providers. Work undertaken by Strategic Safeguarding includes;

Consistency of Practice and Performance

- Monthly Audits of Safeguarding Enquiries between September – November 2025. Audit criteria centred around CQC identified areas of for improvement.
- Online Safeguarding Concern form changes. The changes were made to ensure that partner agencies had appropriate signposting to other routes of referrals, for example; details to raise a Care Needs Assessment, information on self-neglect criteria, information on pressure ulcers from the Department of Health. In addition, to address issues of duplication in safeguarding concerns raised, contact details of operational teams have been provided within the online safeguarding form, to encourage the referrer to contact the relevant team in the first instance for an update, rather than raising a new referral.
- Identification of agencies raising the highest number of Safeguarding concerns using the adult social care safeguarding data report which contributes towards the KMSAB Data Dashboard. In addition, the data reporting has also been discussed as part of the agenda within the KMSAB Executive Group.

- Safeguarding interface meetings with partners to improve consistency of practice, and to provide feedback on safeguarding concerns raised, where appropriate.
- During Safeguarding Adults Awareness Week 2025, Strategic Safeguarding provided an internal presentation, with a focus on the volume of Safeguarding concerns raised by KCC colleagues.
- As highlighted in 3.2, the recent introduction of safeguarding teams within the localities to provide an end-to-end safeguarding response, is a positive step forward in terms of improving consistency and reducing transfers of support for the person, between teams.

Relationship with Providers;
KCC have worked consistently with providers over the past year in relation to raising awareness of safeguarding criteria. Work undertaken includes:

- Safeguarding Provider Network meeting was held on 18 November 2025 with 57 attendees from a range of providers.
- a 'trigger protocol' was incorporated within Mosaic (Adult Social Care client recording system) to identify previous and duplicate safeguarding concerns for a person.
- Safeguarding awareness sessions held in October 2025.
- MARM awareness sessions held with adult social care staff, and external colleagues which include substance misuse providers.

4. Future developments

4.1 The Strategic Safeguarding team are currently working on a number of different areas of work, such as;

4.2 **Notification pathway for Providers -** working closely with internal colleagues from Commissioning, Performance, Innovation and Partnerships and Adult Short Stay Services, Strategic Safeguarding is scoping an alternative pathway to enable Providers to send low-level 'notifications' to the local authority which would not require a safeguarding response. This follows analysis of safeguarding data, which highlights that social care providers account for the highest proportion of safeguarding concerns received by the local authority, but with only approximately 20% progressing to a safeguarding enquiry.

4.2.1 In Surrey they have a similar alternative pathway for their Providers which has seen a significant decrease in the number of Safeguarding concerns received. Strategic Safeguarding have met with both Surrey Safeguarding leads, and representatives from CQC to ensure that any proposed measures embedded within Kent were appropriate and improved the outcomes for the adults we support.

4.2.2 To further assist Providers, a dedicated Safeguarding Threshold Tool, highlighting what a low- level concern would be, will be developed to provide support with decision making in relation to referrals.

4.3 **Ongoing improvements to Safeguarding Online Concern form**

4.3.1 As part of the changes to the online safeguarding form, to avoid any unnecessary delays in ensuring the person receives that correct support in a timely way; Strategic Safeguarding is currently adding signposting information in relation to Mental Health Services which may be more suitable for the person's needs at that time.

5. Conclusions

5.1 The above information provides an overview of the current position in relation to adult safeguarding in Kent and nationally. As highlighted the ongoing collaborative working with both partners and providers is essential to improve the awareness of safeguarding criteria and ensure that all referrals are appropriate for the route chosen by the referrer, be it safeguarding or for a care needs assessment for example.

5.2. The work undertaken by Strategic Safeguarding and colleagues, will also aid the continuous improvement cycle, ensuring our processes are as effective as they can be, improving both the quality of the information received at the point of referral, and the overall outcome for the person at the centre of the concern. The work with partners and providers is seen as essential in relation to building a safer system around safeguarding for people living in Kent.

6. Recommendations

6.1 Recommendation(s): The Cabinet Committee is asked to **NOTE and COMMENT** the content of the report.

7. Background Documents

Documents referred to within the body of the report as follows;

Kent and Medway Threshold Tool –
https://kmsab.org.uk/assets/1/kent_and_medway_threshold_tool.pdf

8. Report Author

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From:	Jamie Henderson, Cabinet Member for Environment, Coastal Regeneration and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 6 May 2026
Subject:	Development of the Kent Health and Wellbeing Board
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	Kent Health and Wellbeing Board

Summary

The purpose of this paper is to **update, inform, and promote member discussion** around the future role and working of the Kent Health and Wellbeing Board (HWB).

The Health and Wellbeing Board was established in 2013 to lead on partnership endeavours to improve health and wellbeing, and reduce health inequalities across Kent. Its working is informed by the Joint Strategic Need Assessment (JSNA) detailing the health challenges faced by the people of Kent. Delivery is through the Joint Local Health and Wellbeing Strategy (JHWS).

NHS driven system reforms led to the establishment of the Kent and Medway Integrated Care Partnership (ICP) in 2022 and the Integrated Care Strategy. Pragmatically it was agreed that the Integrated Care Strategy should be the Kent Joint Local Health and Wellbeing Strategy with the Integrated Care Partnership becoming the key partnership forum.

However Integrated Care Partnerships are now ending and there is a specific request that the local Health and Wellbeing Board leads on developing a local Neighbourhood Health Plan. In parallel work has been in train with the Local Government Association to rethink the Kent Health and Wellbeing Board to optimise its value.

A workshop of key Kent leaders proposed potential priority areas for Health and Wellbeing Board focus over the coming year. These include the Neighbourhood Health Plan and Better Care Fund (BCF), the Marmot Coastal Region initiative and Action around Mental Health. Additional changes to membership and working were proposed.

Recommendations

The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

1 Introduction

1.1 This paper outlines the important role that the Kent Health and Wellbeing Board (HWB) will play in the next few years. This will include leadership in the development of the required Neighbourhood Health Plan for implementation from April 2027.

1.2 Work has been undertaken to review the membership and purpose of the health and wellbeing board which has played a less central role in recent years while the Integrated Care Partnership (ICP) played a key role in leading local partnerships.

1.3 A range of initial priorities for the Kent Health and Wellbeing Board have been agreed including leadership around mental health challenges, the Marmot Coastal Region initiative, Neighbourhood Health and the Better Care Fund.

2 Background to the Health and Wellbeing Board locally

2.1 Health and Wellbeing Boards (HWBs) were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

2.2 Under the Health and Social Care Act 2012, it was required that Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS) be developed through Health and Wellbeing Board and that these formed the basis of NHS and local authority commissioning plans, across all local health, social care, public health and children's services that would both improve the health and wellbeing of the local community and reduce inequalities.

2.3 Following the implementation of the Health and Care Act 2022 on 1 July 2022, the NHS infrastructure changed with the introduction of Integrated Care Partnerships. Health and Wellbeing Boards continued to be responsible for the development of joint strategic needs assessments and joint local health and wellbeing strategies. However, they then needed to have regard to the Integrated Care Strategy when preparing their joint local health and wellbeing strategies.

2.4 Given the complexity of the local system in Kent and Medway and the need to develop an Integrated Care Strategy, the decision was taken in Kent that the Kent and Medway Integrated Care Strategy be adopted as the Kent Joint Local Health and Wellbeing Strategy.

2.5 This in turn led to a higher profile role for the Integrated Care Partnership relative to the Health and Wellbeing Board. Additionally, some of the Health and Wellbeing Board work has been undertaken by the local Health and Care Partnerships (HCPs), the local Wellbeing and Health Improvement Partnerships (WHIPs) and the local Health Alliances, although the approach varies across Kent.

2.6 The Integrated Care Partnership and local Health and Care Partnership functions are likely to decline while the role of the Health and Wellbeing Board defined within the NHS Neighbourhood Health Framework will become more important. The time is therefore right for a review of the Kent Health and Wellbeing Board to ensure it can optimally lead health improvements in the coming years.

3 Review of the Kent Health and Wellbeing Board

3.1 A review of the Kent Health and Wellbeing Board has taken place led by the Local Government Association (LGA). This included interviews with key stakeholders as well as a workshop.

3.2 There were a range of challenges captured through interviews. These can be summarised:

- Health inequalities across Kent are stark, with significant disparities.
- Coastal communities experience disproportionate ill health and inequality.
- The Board is not functional and needs to change. It is not an effective strategic partnership, being a passive meeting.
- It is a missed opportunity, is too transactional, and needs the right people having impactful conversations to effect change.
- The purpose of the Board is unclear, with no consensus on what good looks like.
- The Integrated Care Partnership has taken the lead in areas the Health and Wellbeing Board should be leading.
- Many elected members are new with little experience of the Health and Wellbeing Board role.
- Meetings are too formal with long reports and need to be more focussed.
- There are too many meetings, the partnership landscape is complex with duplication.
- The potential impact of Local Government Reform and NHS changes in Kent.
- Unresolved, longstanding disagreements between the NHS and councils around funding often impede partnership working.

3.3 A raft of opportunities were also identified:

- The dissolution of the Integrated Care Partnership is an opportunity to reimagine and redesign the Health and Wellbeing Board.
- Recreate the Health and Wellbeing Board as the strategic partnership to lead around inequalities and wider health determinants.

- The Marmot Coastal Region initiative and the Folkestone and Hythe Neighbourhood Health Pilot are recognised as opportunities to prioritise and galvanise action.
- Tangible focus on the coast aided by Marmot, could be a powerful way to gain traction around neighbourhood planning.
- We can develop a compelling narrative and shared sense of purpose with a clear plan and priorities to bring partners along.
- The Health and Wellbeing Board can make the economic argument for addressing wider determinants and inequalities that reflects the current political reality.
- Good feedback about the health alliances in relation to place and system leadership and the opportunity to build on them.
- The DPH and Public Health are respected across the system and appear to have the authority to lead and support change.
- Make meetings less formal, with fewer papers and create the space for discussion using a workshop format with expert input.

3.4 The workshop then went on to consider next steps for the Health and Wellbeing Board. This included discussion around what is needed to ensure partnership working is addressing the priorities agreed for health and wellbeing. The workshop further considered the values, behaviours and ways of working that will foster collaboration to impact our shared priorities. A brief report is appended at Appendix A.

4 The Neighbourhood Health Plan

4.1 The Department for Health and Social Care (DHSC) have produced a Neighbourhood Health Framework detailing actions required to deliver neighbourhood health from now until 2029. This is the subject of a separate paper to this cabinet committee. A key issue is the role of the Health and Wellbeing Board in leading the development of a Neighbourhood Health Plan (NHP). This is to be implemented from April 2027 so will need to be developed over the coming year.

4.2 The Plan will need to:

- Provide an overview of how NHS objectives will be delivered through the three NHS Reform Agendas (improved routine services, proactive care and alternatives to hospital).
- Describe how Neighbourhood Health (NH) will support local goals around inequalities and health outcomes.
- Link local objectives to the Joint Strategic Needs Assessment (JSNA).
- Confirm geographies for Neighbourhood Health.
- Confirm organisational responsibilities.
- Define governance and operational partnerships to deliver the Plan.
- Describe how other local initiatives align with Neighbourhood Health e.g. Family hubs, housing, Voluntary Community Social Enterprise (VCSE), employment support.

4.3 The agreed Neighbourhood Health Plan will be part of the Integrated Care Board's five year commissioning plan. Systems can go further if they wish, for example around Neighbourhood Health and prevention.

4.4 The Health and Wellbeing Board will additionally have a key role in the development of the Better Care Fund (BCF) plans. These will need to strongly link with the Neighbourhood Health Plan. Pooled funding under the BCF will need to be used in line with BCF 2026/27 guidance with funding decisions consistent with the national conditions for the BCF, including required increases in the Integrated Care Board's minimum contributions to adult social care over the next three years.

4.5 There is an expectation that the Health and Wellbeing Board will agree local targets in the Neighbourhood Health Plan to begin delivery in 2027/8 with local outcome measures covering the whole life course including both health and social needs.

4.6 It is suggested by the DHSC, that the Health and Wellbeing Board might use the Local Outcomes Framework in defining local objectives and metrics. It is proposed that the Health and Wellbeing Board look at how neighbourhood health can help deliver objectives around numbers of people in care homes by age, and user and carer satisfaction, as well as objectives around Best Start in Life and Family Hubs.

4.7 There is further an expressed desire from the centre to link the Neighbourhood Health Plan to wider local public service reform including around access to work, to housing and to community initiatives.

4.8 Although it is likely that system change will not be in place for some time, it may make sense for officers to work closely with Medway Unitary colleagues in terms of a unified system wide approach to best secure future action.

5 Membership and Working of the Health and Wellbeing Board

5.1 Current Health and Wellbeing Board membership includes a balance of elected members and senior officers. It includes the County Council Leader and key portfolio holders for Adult Social Care and Health (ASCH), Public Health and Children, Young People and Education (CYPE) as well as the Corporate Directors for ASCH, CYPE as well as the Director of Public Health. It additionally includes elected members from three districts and two Integrated Care Board officers, a GP and a Healthwatch representative.

5.2 To optimally deliver, the workshop suggested there may be a need to reconsider membership. This might include wider NHS membership to include provider trusts e.g. an acute trust Chief Executive Officer (CEO), the mental health trust CEO, the community trust CEO. NHS Chair or Non-Executive Director membership was also proposed. The Board might wish to consider a more geographical spread of district council representatives and to include senior officers from some districts as well as local Health Alliance representation. Consideration might be given to including Growth Environment

and Transport (GET) leadership from KCC as well as VCSE representation. The workshop suggested a need for a resident voice which might extend to a citizen assembly.

5.3 There is also a need to consider officer attendees to aid action required between meetings or an officer led operational delivery subgroup. This will be needed to optimally deliver the Neighbourhood Health Plan. It could include KCC public health, ASCH and CYPE officers as well as NHS, District Council and VCSE officers. There would need to be strong supportive data analytics.

5.4 Additionally, the workshop proposed that the Health and Wellbeing Board needs consider how to get feedback from frontline staff. Ownership of a manageable number of priorities was key with clear actions and outcome measures. The key priority areas proposed were mental health, the Marmot Coastal Region initiative, Neighbourhood Health and the Better Care Fund.

5.5 It was felt effectiveness would be enhanced with some private discussion to allow more challenging conversations. It was proposed that meetings might be quarterly and at rotating venues closer to residents. Governance with links to existing working groups was also discussed.

6 Conclusions and Outputs

6.1 It is timely that the role of the Kent Health and Wellbeing Board be revisited. NHS plans to disband the Integrated Care Partnership means that the Health and Wellbeing Board will again become the key strategic system partnership board considering health and wellbeing.

6.2 Additionally, the DHSC drive to develop neighbourhood health has a key local leadership role for the Health and Wellbeing Board in developing a local Neighbourhood Health Plan (NHP).

6.3 System leaders have been inputting to a Local Government Authority led review of the Health and Wellbeing Board that will help it to effectively discharge its functions including development and subsequent delivery of the Neighbourhood Health Plan. It is likely that this will require some revision of membership. It will also be essential that system officer capacity is focussed on servicing the Health and Wellbeing Board to ensure delivery of the agreed priorities.

7. Recommendation

7.1 The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

8. Background documents

Kent and Medway Integrated Care Strategy

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Appendix A

Health and Wellbeing Board Development Session -Workshop Outcomes 04 March 2026 Considerations for next steps

What is needed to ensure partnership working is addressing the priorities agreed for health and wellbeing?

- Know who your partners are
- What the local authorities are already doing
- Correct membership = Chief Exec, LA Chief Exec, Health Alliance rep, NHS Trusts, VCSE and Non-Exec Directors/ Chair
- Feedback loop from front-line
- Resident voice
- Clear priorities and actionable consequences
- Shared ownership including financial
- Compelling narrative / strapline
- Not spend time on vision but identify a few priorities and work on them, e.g. Mental Health, Better Care Fund, Neighbourhood Health, Marmot
- Co-ownership of priorities – needs to start with co-design and joint agreement (early stages)
- Stop trying to “boil the ocean”
- Start with priorities that small and specific – a shared interest and able to influence
- How to reduce priorities that attract strategic partners (measurable success outcomes).
- Shared agenda setting

Appendix A

Health and Wellbeing Board Development Session -Workshop Outcomes 04 March 2026

- Needs more “gritty” conversations – are non-public meetings needed, i.e. a closed session
- Need to review Membership

What are the values, behaviours and ways of working that will foster collaboration to impact our shared priorities?

- How to do meetings, e.g. quarterly, in workstreams (use existing ones)
- Life course approach
- Vary the meeting venues, closer to residents, and the place of visit/ an understanding
- Consider a resident assembly / citizen assembly
- Governance with system leaders, GP and ICP Sub-committee, KCC Chief Executive, Leader, Corporate Director, ICB Chief Executive and Chief Operating Officer

From:	Jamie Henderson, Cabinet Member for Environment, Coastal Regeneration and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 6 May 2026
Subject:	The Neighbourhood Health Framework and the Neighbourhood Health Plan
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None

Summary
The purpose of this paper is to **update, inform, and promote member discussion** around the NHS drive towards Neighbourhood Health subsequent to the publication of the national Neighbourhood Health Framework and building on the paper on neighbourhood health shared at the last meeting.

The Framework details national objectives and priorities for Neighbourhood Health with a key purpose of reducing emergency admissions. This includes a focus on people who are frail and action through both prevention and better care in the home. There are also objectives around better access to primary care and shorter outpatient waits.

Changes to NHS structures including the development of single integrated neighbourhood teams, multi-neighbourhood teams and integrated health organisations are outlined as well as plans to develop Neighbourhood Health Centres and plans to encourage a shift of resources to community health from hospitals. The structural changes are largely through redeployment of existing staff.

In addition to the centrally dictated priorities above, there is a role for local systems led by the local Health and Wellbeing Board in developing a Neighbourhood Health Plan (NHP). This plan will both ensure wider system action in support of the NHS objectives and enable the addition of further local action to deliver on locally defined health priorities.

It is expected that implementation of the Neighbourhood Health Plan will begin in April 2027 meaning that plan development must take place in the coming year. This will require ensuring that the Health and Wellbeing Board is well placed to lead this agenda and this is the subject of a separate paper.

It is proposed that the existing Integrated Care Strategy, which is also the Kent Joint Health and Wellbeing Strategy, remains broadly the right strategic background to the

development of the Neighbourhood Health Plan further informed by the Kent Prevention Framework, the Marmot Coastal Region initiative and the developed local Health Alliances.

It is important that Adult Social Care and Public Health optimise the opportunity offered by Neighbourhood Health, including around prevention in line with the Prevention Framework, and work with NHS colleagues to deliver sustainable high quality care and support, including around hospital discharge.

Recommendations
The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

1 Introduction

1.1 This paper outlines the content of the national policy paper, the "Neighbourhood Health Framework" published in March 2026 (link below). While it has a key focus on the aspirations for change, improvement and new ways of working in the NHS, there is a key stated role for Local Authorities and wider local systems.

1.2 Specifically, there is a need to develop a Local Neighbourhood Health plan to commence in April 2027, that will address both key local health issues and the national NHS asks and challenges. This plan will be developed by the local Health and Wellbeing Board.

1.3 The paper summarises next steps as stated within the policy paper and proposes an approach to development in Kent building on historic partnership action.

1.4 The development and role of the Kent Health and Wellbeing Board is subject to a separate paper.

2 Stated Aims of Neighbourhood Health in the Framework

2.1 To improve people's health and care outcomes, reduce health inequalities and help them stay well at home. Achieved by prevention and proactive care, strengthened primary and community services and wider partner working (including public health (PH) and adult social care (ASC)).

https://www.gov.uk/government/publications/neighbourhood-health-framework

2.2 To organise services around the person with more convenient, personalised and joined-up care by improving access (including over phone and online) to services, providing outpatients in neighbourhoods, with continuity of care and better coordinated services

2.3 Reduce pressure on hospitals and care homes by decreasing hospital and care home admissions and hospital length of stay and deconditioning

2.4 Cut waste and duplication and help the NHS deliver against its core targets.

2.5 The Framework recognises there is little new here and that services should complement and build upon local plans to transform the wider scope of public services, and support investment in local places and community regeneration.

3. How Success in Neighbourhood Health will be measured locally

3.1 A mix of National and local objectives are proposed with locally agreed targets detailed in a new local Neighbourhood Health Plan (NHP) to begin delivery in 2027/8. The Plan will require the Health and Wellbeing Board (HWB) to take a central role in developing local outcome measures covering "the whole life course including both health and social needs".

3.2 It is suggested that the Health and Wellbeing Board might use the Local Outcomes Framework in defining local objectives and metrics. It is proposed that the Board look at how neighbourhood health can help deliver objectives around numbers of people in care homes by age, and user and carer satisfaction, as well as objectives around Best Start in Life and Family Hubs.

3.3 There is further an expressed desire to link the Neighbourhood Health Plan to wider local public service reform including around access to work, to housing, to the VCSE and to community initiatives.

3.4 In Kent and Medway Integrated Care Board (ICB), leadership of the Neighbourhood Health agenda is through the Neighbourhood Health Programme Board, including senior officers from ASC and PH and is supported by steering groups including a clinical group and the East Kent NNHIP (National Neighbourhood Health Implementation Programme) sub group. The Board will provide local governance alongside the Kent Health and Wellbeing Board.

4 National Goals, Objectives and Metrics in Neighbourhood Health

4.1 Goal 1: improve health outcomes

Focus will be on centrally defined high-priority cohorts including people who are frail, care home residents, housebound people, those at the end of their life, people with heart disease, diabetes and respiratory disease, dementia and mental health conditions, children, and any additional identified local cohorts.

4.1.1 There are a number of objectives and measures outlined:

- Help people with frailty, in a care home or housebound, to stay independent, with a reduction in non- elective admissions by 10% by March 2029

- Improve end of life care with an increase of 10% of people recognised to be approaching the end of their life by March 2029 and reduced non-elective admissions in people at the end of their lives by 10%

- Better treatment of people with the conditions listed above with a 10% improvement in evidence based clinical outcomes

- Improved access to care for children with a 10% reduction in outpatients and “substantial progress to reducing community waits”

4.2 **Goal 2: Improve access to general practice: objectives and metrics**

- 90% of urgent patients will be seen on the same day by March 2027.

- There will be faster access to routine GP care starting with collecting baseline data. The Integrated Care Board (ICB) may set local goals.

- Improve patient satisfaction with GP access starting with collecting baseline data.

4.3 **Goal 3: Improve patient experience of planned care: objectives and metrics**

- Use a single point of access (SPoA) to provide an alternative to outpatient attendance for 25% of referrals in 10 specialties by March 2027 supporting the delivery of an 18 week referral to treatment target (RTT) of 70% by March 27 and 92% by March 2029

- More follow up in local neighbourhoods with a 10% reduction in secondary care follow up by March 27

4.4 **Goal 4: Better Urgent and emergency care performance: objectives and metrics**

- More reactive community care in “high priority” groups (frailty, end of life, care home and housebound). By March 2029 growth in admissions in these groups will be flat with work towards actual reductions. The 85% 4 hour Emergency Department (ED) wait target will be achieved (82% by March 2027) with reduced ED attendances in the priority cohorts.

- Reduced Category 3 and Category 4 ambulance transfers (these are the calls for less urgent or non-urgent issues that have a national two or three hour current target time for response) through diversion to other services. There are no metrices stated.

- Better discharges for people with less delay, there are no firm agreed metrices.

4.5 **Goal 5 Patient and Staff satisfaction; objectives and metrics**

- Patient will feel more in control, measures are being developed

- Neighbourhood teams are motivated, measures being developed

5. Delivering Neighbourhood Health

5.1 The framework talks of three Reform Agendas where a minimum level of action is required. However further actions can be agreed where appropriate by the Health and Wellbeing Board.

5.2 **Reform agenda 1: Improve services for people who need routine healthcare, so neighbourhood health benefits everyone.** This will include:

- Improved access to GPs, tackling outliers and including digital options.
- Better GP care with incentives around improved population health and frailty
- Better GP access to diagnostics, starting with a review of capacity
- Reduce GP bureaucracy including linked electronic records, direct prescriptions to pharmacy, 28 day outpatient prescribing.
- Increase technology in GPs including online consultation, push mechanisms and AI.
- Reform of Out of Hours services as part of an upcoming emergency care strategy
- Strengthen the pharmacist's role as a first point of contact for minor illness and prevention with an ability to prescribe.

5.3 **Reform Agenda 2: improve proactive care for people**

- Integrated Neighbourhood Teams (INTs) will help people to stay healthy with 95% of people with complex needs to have a care plan by 2027. Integrated Neighbourhood Health Teams will have a role in the follow up of people with mental illnesses.
- The initial focus will be on people who are frail and at the end of their life and on people with multiple long term conditions (LTCs) to slow the onset of frailty. It is also proposed initial focus be on Children and young people (CYP) with Children and Young People's Integrated Neighbourhood Teams optimising community as an alternative to hospital provision, and on cancer patients
- ICBs can also establish Integrated Neighbourhood Teams "for other conditions"
- There is specific mention of developing Women's health hubs
- Core Community Services will see an increase in their capacity to manage waiting times so that 78% of people are seen in 18 weeks in 2026/27 and 80% in 2028/29

- A new model for planned care is proposed with better links between GPs and consultants with a SPoA for advice and more community based follow up.

- Improved Data Sharing between the NHS and social care

5.4 **Reform Agenda 3: Deliver better alternatives to hospital care**

- Community response services will be expanded

- Virtual wards will be expanded

- There will be appropriate use of intermediate care including step up and step down services, community beds and home care

- There will be consideration of neighbourhood mental health centres, accessible 24/7 and distinct from general Integrated Neighbourhood Teams. Further guidance will follow the evaluation of this model elsewhere.

6. The Providers of Neighbourhood Health

6.1 There may be changes to commissioning with more health and social care integration. Health and Wellbeing Boards are charged with defining the geography of neighbourhoods through the Neighbourhood Health Plan and will wish to consider local authority boundaries although in reality, it is likely that the multi-partner NHS led Neighbourhood Health Programme Board will determine structure then seek agreement from the Health and Wellbeing Board. Single and multi-neighbourhood provider contracts may be developed but hospital standard and General Medical Service (GMS) contracts (GP contracts) must remain.

6.2 Single Neighbourhood Providers (SNPs) will deliver services through Integrated Neighbourhood Teams in a defined area with a population of around 50 thousand people. Primary care will be able to provide some of these new services in addition to their current contracts, alongside the local Single Neighbourhood Providers contract holder.

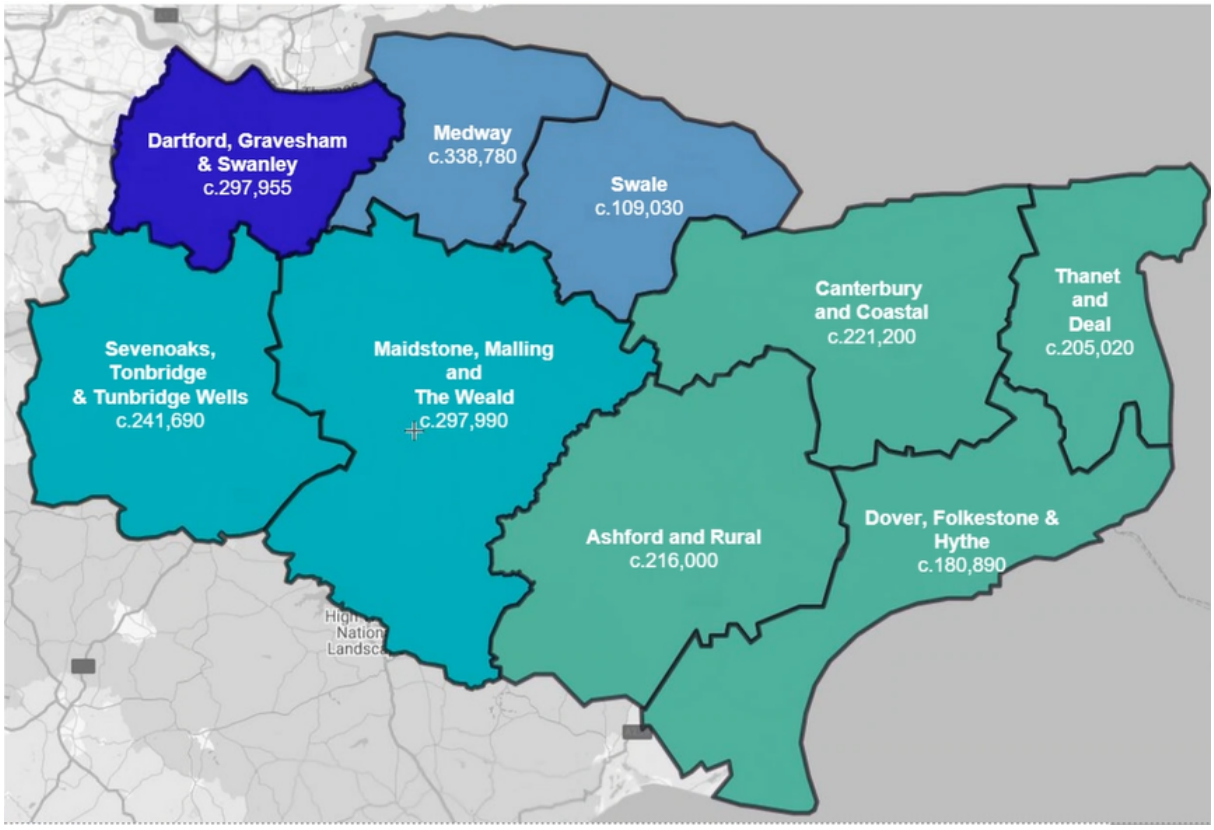
6.3 Additionally there will be Multi-Neighbourhood Providers (MNPs) with a clear relation to the Single Neighbourhood Providers providing services to a population of around 250 thousand people where it makes more sense for the services to be delivered at that scale. It is further important that these align with current and future local authorities

6.4 There are also plans to introduce Integrated Health Organisations (IHOs). These will be selected local providers with a whole population health budget for a given geography, covering one or more Multi-Neighbourhood Providers. The Integrated Health Organisation will allocate resources and plan services, and may hold contracts with other local providers. They will develop the infrastructure to shift resources from acute to community. NHS trusts will be designated by the Department of Health and Social Care (DHSC) and NHS

England to hold Integrated Health Organisation contracts. These designated trusts can then be commissioned by Integrated Care Boards using a newly developed Integrated Health Organisation contract. While only NHS organisations can be Integrated Health Organisations, neighbourhood providers can develop alliances with local NHS providers to be a part of Integrated Health Organisations. Additionally Integrated Health Organisations may commission primary care but must use the nationally agreed contracts

6.5 Kent and Medway ICB have been considering potential footprints for Multi-Neighbourhood Providers locally. There is a clear understanding that the footprints will need to evolve over time and that the “boundaries” of these footprints should not be so fixed that they become a barrier to care and support inequity of service by being too fixed.

6.6 Nine multi-neighbourhood footprints have been proposed in Kent and Medway each ranging from 109,030 to 338,4780 residents. These are designed to be large enough to enable collaboration, yet local enough to maintain a strong sense of place and identity, providing the right balance for effective joint planning and delivery. Each footprint brings together several single neighbourhoods to strengthen integration across health, care, and community services, support shared workforce planning, and align resources around local population needs. There are a total of 45 local Single Neighbourhood Providers based around existing primary care networks (PCNs)



7. Estate, Workforce and Finances

7.1 The NHS 10 year plan requires services to be local, digital, in the home, or if needed in a Neighbourhood Health Centre (NHC) or a hospital. Neighbourhood Health Centres are seen as a crucial part of Neighbourhood Health. It is proposed that they will link with Family Hubs, community centres, foodbanks, and with housing and employment services. GP services will be based in the Neighbourhood Health Centres. They will also seek to align with Mental Health Centres and Community Diagnostic Centres. The national plan is for 250 Neighbourhood Health Centres by 2035, with 120 in place by 2030. They will be a mix of repurposed existing estate and new builds, with 20% of the new builds funded through public capital and 80% through public-private partnerships. Wave 1 will be developed in deprived areas using existing estate.

7.2 Workforce considerations will be informed by the 10 Year Workforce Plan. The Neighbourhood Health workforce will mainly be existing staff working differently, for example consultants providing outreach, with staff working seamlessly across boundaries. It will however include some new services.

7.3 Neighbourhood Health Finances will be challenging, requiring a shift of resources from hospitals to community. ICBs will be required to prioritise funding to Neighbourhood Health, supported by an amended financial framework with some scope for new payment approaches that prove credible, as well as changes to the national Medium Term Plan allocations. Additionally, the Health and Wellbeing Board is asked to consider how shifts to local authority services might support NHS priorities.

8. Next Steps Outlined in the Framework

8.1 Further publications from the centre will help inform the ongoing development of Neighbourhood Health. These will include more detail around Neighbourhood Health Centres, new GP access targets, new payment approaches supporting shift of resources to the community and a raft of Modern Service Frameworks detailing best clinical practice in key diseases.

8.2 There are two required stages to deliver plans which can take place in parallel:

8.2.1 **Stage 1: Immediate changes in 2026/7**
Deliver the minimum requirements and lay future groundwork with wider partners through the Health and Wellbeing Board. The minimum requirements are largely (not exclusively) the responsibility of the NHS:

- A plan to reduce non elective admissions through increased capacity in urgent, rehabilitation and reablement services based on a population risk analysis
- A plan to reduce variation in access to GPs

- Agreed neighbourhood footprints
- Plans to establish Integrated Neighbourhood Teams focussed on high priority cohorts
- A plan on the approach to elective pathways
- Confirmed plans to meet the proposed 18 week community wait and to eliminate 52 week community waits
- Confirm the use of the Better Care Fund (BCF)
- Improve the primary/secondary interface with the “Red Tape “challenge
- Confirm data sharing plans

8.2.2 **Stage 2: Longer term (April 2027-March 2029)**

In parallel the Health and Wellbeing Board will develop a locally owned Neighbourhood Health Plan (NHP) to implement 2027/8. Much of the leadership here will sit with Local Authorities, and ICBs should work with Health and Wellbeing Boards and their partners to develop a locally owned Neighbourhood Health Plan. The Plan will:

- Provide an overview of how NHS objectives will be delivered through the three Reform Agendas
- Describe how Neighbourhood Health will support local goals around inequalities and health outcomes
- Link local objectives to the JSNA (Joint Strategic Needs Assessment)
- Confirm geographies
- Confirm organisational responsibilities
- Define governance and operational partnerships to deliver the Plan
- Describe how other local initiatives align with Neighbourhood Health e.g. Family hubs, housing, employment support

8.3 The agreed Neighbourhood Health Plan will be part of the ICB fiver year commissioning plan. Systems can go further if they wish, for example around Neighbourhood Health and prevention. Health and Wellbeing Board planning around Neighbourhood Health will also need to link to the use of the Better Care Fund (BCF).

9. Implications, challenges, and opportunities for Kent

9.1 The previous paper to this Cabinet Committee on Neighbourhood Health outlined specific opportunities for the authority’s directorates to work with NHS colleagues to deliver prevention in Kent. These opportunities remain important.

9.2 Work is underway to ensure that the Kent Health and Wellbeing Board can optimally impact on local health and wellbeing, and progress in that area is subject to a separate paper to this Cabinet Committee

9.3 Members will note that the stated timescale for implementation of the Neighbourhood Health Plan is from April 2027.This means that work to develop the plan needs to take place under the leadership of the Health and Wellbeing Board in the coming year.

9.4 The Kent Health and Wellbeing Board adopted the Kent and Medway Integrated Care Strategy (ICS) as its Joint Local Health and Wellbeing Strategy for 2024 to 2029. The Strategy was inclusive in its development and supported by a delivery plan for 2024-2026. Given that the key challenges to health and wellbeing have not changed, and the degree of ownership of the Integrated Care Strategy secured at the time, it is proposed that the Neighbourhood Health Plan be developed using the Integrated Care Strategy as the strategic context.

9.5 The Neighbourhood Health Plan will need to be informed by any key shifts defined in the JSNA, however it is unlikely that there will have been significant and material shifts in need since the development of the Integrated Care Strategy.

9.6 The Neighbourhood Health Plan will further be informed by key developments since that time including the Kent Prevention Framework, the Marmot Coastal Region initiative and the development of local Health Alliances.

9.7 It is important that Kent County Council best seize the opportunities presented by the Neighbourhood Health agenda to deliver both improved care and sustainability. A workshop took place internally at the end of April to surface opportunities for ASC and PH to influence the developing Neighbourhood Health agenda to best deliver the Kent ASC Prevention Framework.

10. Recommendation:

10.1 The Adult Social Care and Public Health Cabinet Committee is asked to NOTE the report and COMMENT on the outlined approach.

11. Background documents

Neighbourhood health report

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From:	Diane Morton Cabinet Member for Adult Social Care Sarah Hammond, Corporate Director Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee - 6 May 2026
Subject:	**BLUE BADGE UPDATE**
Classification:	Unrestricted

Summary: This report provides an overview of the Blue Badge Service together with information on application demands, key achievements and challenges and ongoing priorities for the Blue Badge Service.

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

1. Introduction

1.1 The Blue Badge scheme is a statutory scheme, established under Section 21 of the Chronically Sick & Disabled Persons Act 1970. It is governed by law, with local authorities responsible for its administration and enforcement. It provides statutory parking concessions for people with severe mobility issues. It is important to note that it assesses Mobility, not Disability.

1.2 The Blue Badge scheme is administered by Local Authorities in line with National Guidance and Legislation produced by the Department for Transport (DFT), who govern the fee and badge duration. These two areas are outside of Kent County Council's (KCC) control and limits local mitigations despite sustained demand pressure.

1.3 There is a statutory requirement for Local Authorities to provide this service, but the authority has local control on how the scheme is administered and how applications are assessed.

1.4 KCC is the largest Blue Badge Authority in England with 48,116 Applications received in 2025. Around 36% of applicants automatically qualified for a badge in 2025, with the rest, 64% requiring some form of assessment.

1.5 KCC operates a tiered proportionate assessment model to assess mobility, which is used as an example model by other local authorities due to the efficiencies this delivers. This includes Desktop, Telephone and Face to Face assessments. Face to Face is only used in the most complex cases, with around 350 Face to Face assessments offered in 2025.

1.6 KCC also chair the Blue Badge LA Peer group for England, promoting best practice and information sharing and working alongside the DFT and other stakeholders to deliver continuous service improvements and shape national changes to the scheme.

1.7 Misuse and Fraud investigations are limited due to capacity within the Counter Fraud Team due to other financially impactful priorities within KCC.

2. Background

2.1 Applications are made online, either by the individual or by using assisted digital services at Gateways, or by post (10%). Eligibility decisions are functional and impact based, not diagnosis led.

2.3 Demand growth continues to outpace sustainable capacity with the ongoing increase in demand reflecting national trends, as all local authorities are seeing year on year increases in applications

2.4 Complaint and Ombudsman volumes are low relative to application volume, with less than 1% of all applicants contacting Customer Care or the Ombudsman. This provides assurance that decision making is robust and proportionate despite increased demand.

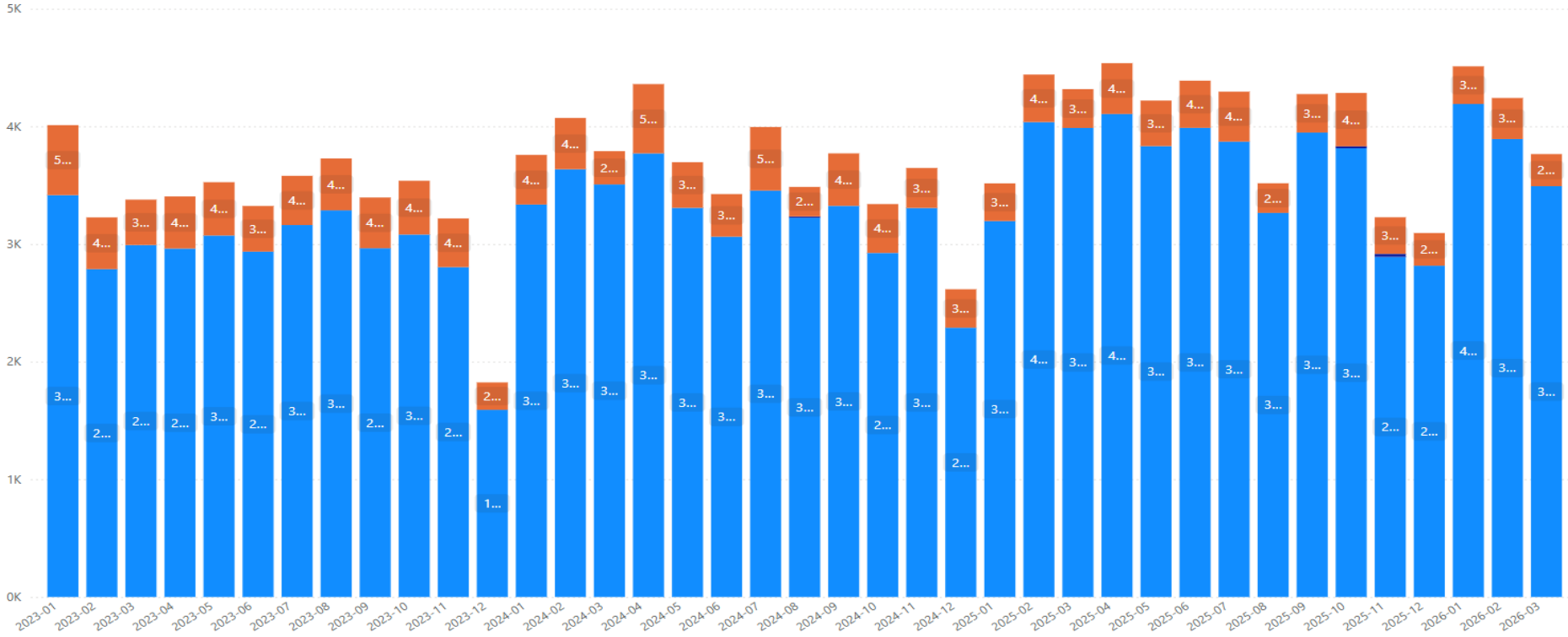
2.5 KCC use a contracted Case Management Provider, IEG4 to deliver efficiencies across all service areas. KCC was a development partner with IEG4 for this product, which allowed maximum efficiencies to be delivered as part of this contract. Badges are issued for three years, or the length of their automatic entitlement, whichever is shorter.

2.6 The service operates with a lean structure, with combined operational, clinical, governance and performance responsibilities.

3. Key Statistics

- 65% of applicants are above the age of 60. 7% of applicants are under 18 years of age.
- 64% of badges issued are “subject to further assessment” (Not Automatically Qualifying)
- Ongoing increase in demand: 3,800 increase from 2023-2024, 4,116 increase from 2024-2025.
- At the start of 2025 there were 4,500 applications awaiting assessment. Currently there are 1,400 applications awaiting assessment.
- The current published wait time for applications is four months.
- Demand is increasing year on year – a 9% increase from the previous year, illustrated in the table below.

Increasing Application Demand 2023-2026



2023	40,155 applications
2024	43,956 applications
2025	48,116 applications
Q1 2026	12,922 applications
2026 (estimated based on Q1 activity)	51,688 applications

4. Key Achievements

4.1 Changes to the recording of assessment outcomes have delivered efficiencies, particularly about unsuccessful applications. This has positively impacted morale of staff.

4.2 Ombudsman challenges have not found any areas of development for the service, reinforcing that the approach being taken by KCC is appropriate and proportionate.

4.3 The Business Support Team continue to support the Prevention and Adult Social Care Connect assessment staff and have successfully taken on the Agilisys staff under TUPE, who are working within the Business Support Team at capacity.

4.4 A standardised appeals approach has been implemented with the support of Digital Services, which also include a review and expansion of the information document provided with unsuccessful applications to assist customers in understanding why decisions have been made.

4.5 KCC continues to lead in national discussions, both with the Department for Transport and our local authority colleagues to share best practice, encourage positive change and support residents in getting the most appropriate service delivery.

4.6 Working with partner agencies to support assisted applications and vulnerable applicants

5. Key Challenges

5.5 Areas outside of KCC control (Badge Fee and Badge Length) could alleviate pressure within the service and lead to increased funding from badge production fees but requires the DFT to make a legislative change. KCC has initiated this discussion alongside our local authority colleagues with the DFT, but it requires ministerial support to propose a legislative change in these areas.

5.5 Application numbers continue to rise significantly year on year.

5.6 As Borough and District councils do not publish the number of disabled bays within their carparks it is not possible to cost out how much revenue is not received by local authorities due to the above concession. There is also the revenue not received as Blue Badge holders can also use on street parking where there are double yellow lines and residential parking restrictions apply.

5.7 However, If you were to take an estimated usage of between 1% and 5% of BB holders using their Blue Badge a day which would attract free parking, that might give you sense of how much is not received, between 780 and 3,900 Blue Badge uses a day x £5 (The average cost of a 3hr stay across Kent) equalling between £1.4m and £7.1m in lost parking revenue in a year period.

6. Ongoing Service Priorities

6.1 Demand management: clearer applicant information and evidence requirements.

6.2 Assessment efficiency: maximise lowest level decision making.

6.3 Workforce resilience: stabilise assessor capacity and review whether current staffing levels are appropriate given ongoing increasing demand.

6.4 Data and insight: improve visibility of throughput and blockages.

6.5 Focus on staff, including supporting personal development.

7. Recommendations

7.1 Recommendation: The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the content of the report.

8. Background Documents

None

9. Report Author

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Adult Social Care Campaigns Update

Adult Social Care and Public Health Cabinet Committee

6 May 2026

Working carers: someone's listening campaign summary

Lisa Clinton
Strategic Involvement and Information Lead

The 'Working carers - someone's listening' campaign was made possible through national DHSC funding

Responding to carers in Kent: someone's listening

kent.gov.uk/workingfamilycarers

Making a difference every day

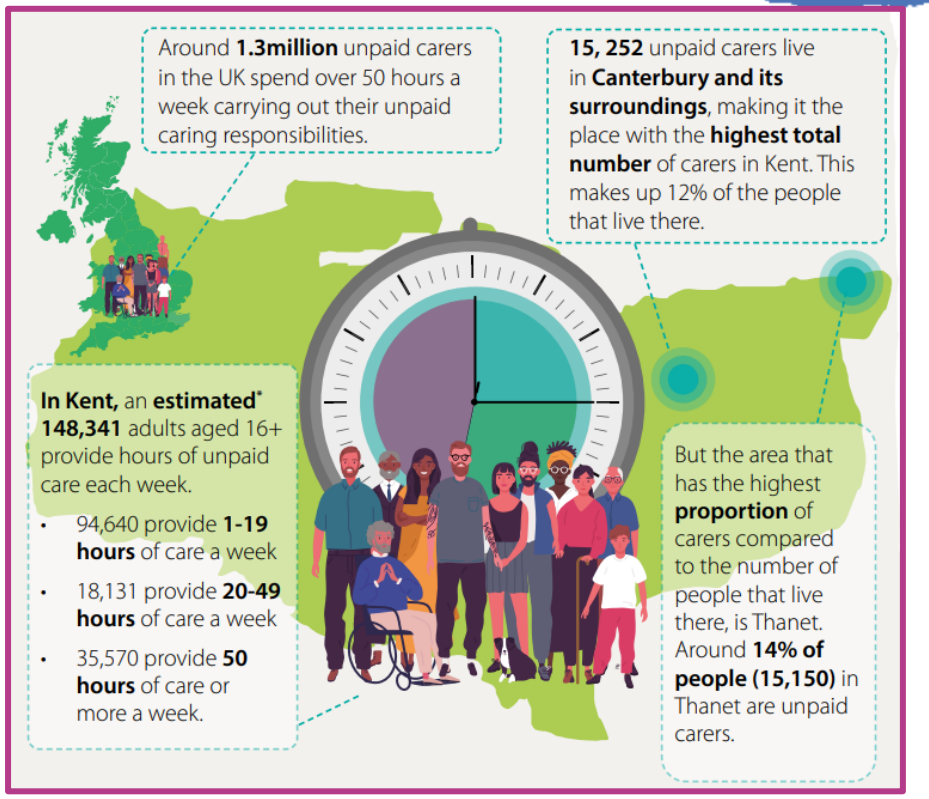
We have responded to carer feedback:

This campaign was initiated by the lived experience co-chair of the Kent Carers' Strategy Group and developed drawing upon carers' lived experiences and population data collated through the Kent Adult Carers' Strategy engagement, co-production and consultation activity.

People in Kent asked for:

- Support for carers to maintain their own identity and live a full life – **including support to work or study**
- **collaborative working** with carers at every stage
- **joined-up working between partner organisations** to offer high quality support that is tailored to the carer's own needs
- **respect for carers** and for their views to be listened to
- **clear and consistent** communication with carers
- more **information** to be made available along with **trusted points of contact**.
- carers to be better supported at **key moments** in their carer journey.

The "someone's listening" concept was created to reassure those struggling with pressures of balancing their caring responsibilities whilst working in paid employment that there is information and support available to them and that they are not alone. It also helps businesses understand legal rights of family carers in their workforce.



Overview of caring in Kent

In Kent, an estimated 182,000 adults aged 16+ provide many hours of unpaid care each week. Becoming a family carer can happen suddenly, leaving people unprepared for the role that they take on. Employers play an important role in supporting working family carers to juggle paid work and their caring responsibilities.

Kent County Council kent.gov.uk

Carers' strategy: priorities for Kent carers

kent.gov.uk/workingfamilycarers

"I hope my employer will be understanding – but I'm going to need financial support and advice to keep up my caring role."

"As I have a young family and work full time, it's been a real struggle at times to give dad the attention he needs."

"A carer's role can make paid work, study, maintaining social connections and getting involved in leisure activities difficult and sometimes almost impossible. Carers are more likely to suffer with physical, emotional and mental health problems."

Key moments for all carers

- First conversation with social care
- Life events (carer and loved one)
- After a hospital stay
- When someone moves away
- New diagnosis
- At the end of life
- After your caring role ends

Priorities - working carers

- Being listened to
- Having supportive employers who understand the responsibilities
- Being able to continue in their paid employment roles
- Awareness of the support available.

2025 campaign summary: someone's listening

kent.gov.uk/workingfamilycarers

Making a difference every day

Launch of initial phase 2025:

- Co-design of **carers information leaflet** (printed and digital versions)
- Co-design of **carers checklist**
- **Employer leaflet for businesses** to support carers in their workforce (printed and digital versions)
- **Media releases highlighting** Carers Rights and Carers Week
- **Web content** developed and hosted on Kent.gov.uk: Support for carers - Kent County Council

Awareness-raising at **KCC carer and workforce in-person events**

In-person social care involvement groups across the county

- Promotion on KCC **internal communication channels** (Kmail and Knet)
- **Partners and provider** engagement and support of the campaign, some including the information and links in their own communications materials.
- **Businesses operating locally** that have promoted to their workforces and have shown support for the campaign so far (Town and Country Housing, local Kent branches: of Hotel Chocolat, Tesco, B&Q, Barclays, Lush, Sussex Beds, Asda, Waitrose, HSBC and M&S.)

2025-26 media and engagement coverage / reach:

- **BBC Kent Facebook:** news post, 230,000 followers
- **BBC News website:** most visited news site in the UK with **75.68% monthly population reach**
- **KM/Kent Online website -** monthly unique visitors per area based on Publisher's statement based on Google Analytics (Jul - Sep 2025). Reaching approximately **49% of all adults in Kent**
- **Kent Connect to Support website**

  Jan 2025 - 2026 homepage with carers campaign feature: 13,576
- **Kent County Council social media posts:** 34,000 followers had the opportunity to see the organic posts on the KCC Facebook profile
- **Crossroads Care:** LinkedIn channel with 1600+ followers
- **Town and Country Housing:** overseeing 13,000+ homes/residents, posted on corporate website
- **TW Life:** News site readership 5000+ in west Kent area

Support the campaign in 2026 to help more people identify as family carers, prevent carer breakdown and encourage businesses and communities to be carer-friendly.

Working Carers
Someone's Listening

2026 campaign summary: someone's listening

kent.gov.uk/workingfamilycarers

Next stage of campaign 2026:

June - August 2026:

- Live with the public in Carers Week with press release and links to useful resources and materials
- Carers Voice Forum to be relaunched increasing membership to invite more family carers. Listening and responding to feedback from carers
- Carers' library engagement sessions with Technology Enhanced Lives Service and Involvement and Information Team

Autumn

- Webinars for local employers/businesses - to increase commercial support and continue momentum throughout the year.

Ongoing activity:

- Continued attendance at community-based carers events
- Link even more closely with Carer Support organisations commissioned by KCC and system partners to ensure joined-up communication, sharing insights and ongoing improvements together,

"With an estimated 5million carers in the UK balancing work and unpaid care, we have to make sure we are getting out to employers to make them aware of the issues carers face in the workplace – and the resources available to help.

The support that carers need is just as important as the support for the people they look after."

Chris Jeffery - Carers' rights campaigner and Chair of Mending the Gap charity

Kent County Council kent.gov.uk

Know how to start

Awareness and prevention campaign summary

Gina Walton
Assistant Director, Commissioning and Partnerships

Responding to people in Kent: Know how to start

kent.gov.uk/howtostart

Making a difference every day

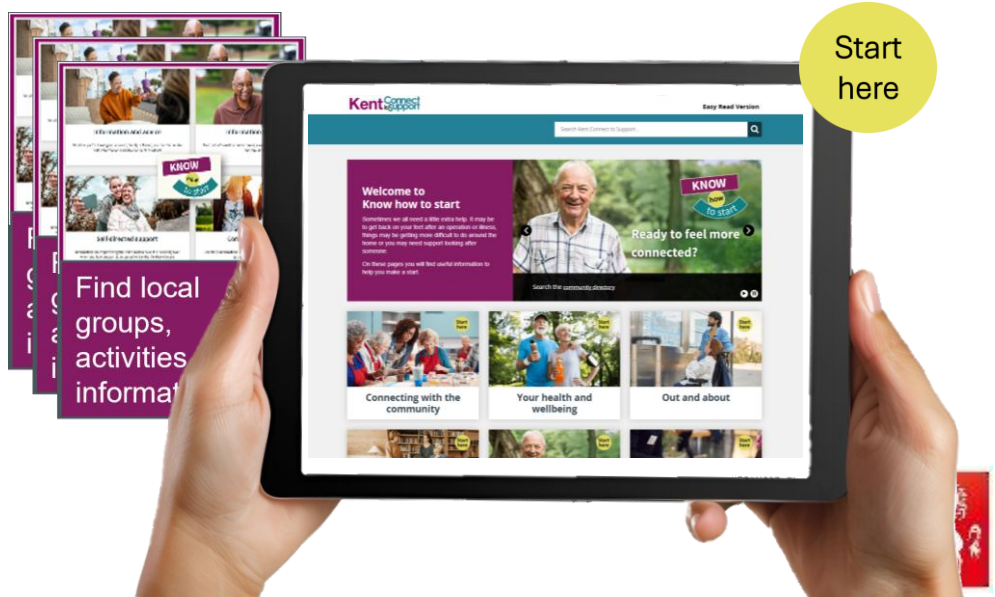
We have responded to public feedback shared with us via:

- engagement and co-production activities in the community
- face-to-face social care involvement groups
- engagement with providers/partners
- our Making a difference every day, Kent Adult Carers' Strategy and Adult Social Care Prevention Framework consultation feedback.

People in Kent have asked for:

- an easy place to start to find streamlined information
- clear signposting for support
- easy to access information
- details of how to empower themselves to stay healthy, socially connected and independent
- information for family carers
- information about how technology can help independence

This campaign draws on ideas from people with lived experience alongside population data collated through the prevention work to shape the approach and identify the key target groups that would benefit most from understanding what is available.



Campaign aims: Know how to start

kent.gov.uk/howtostart

Making a difference every day

The primary aim of the campaign is to:

ENCOURAGE people in Kent who would likely engage with adult social care services

TO engage with preventative services earlier

BY making them aware of what is available and the means to engage with the local groups, activities and services they need.

The secondary aims are to raise awareness more generally about the support available to the wider population and families, carers and friends, amongst our own workforce and with our community and sector partners.

The campaign is funded by national Accelerated Reform Funding for social care and promotes wellbeing services.

Target groups

- Older adults who may be socially isolated owing to loss or lack of confidence
- Family carers who may be at risk of loneliness
- Working age adults with vulnerabilities who may benefit from connecting with their local community.

Kent County Council kent.gov.uk

Campaign resources: Know how to start

kent.gov.uk/howtostart

Making a difference every day

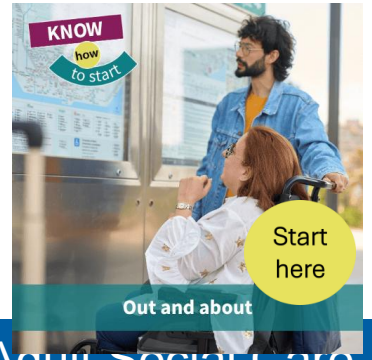
Printed and digital resources cover six clear areas of information:

Connecting with the community:
Groups, activities and organisations that support wellbeing, reduce isolation and help build meaningful social connections.

Looking after others:
Information to support those caring for other adults including carers' groups, a carers checklist, carers needs assessment and more.

Your health and wellbeing:
Mental health and wellbeing advice, local community groups, physical activity programmes, social prescribing services and guidance on healthy lifestyles

Staying independent:
Getting advice on daily tasks and local organisations that can help with technology options, smart home devices and small home adaptations to help you stay empowered at home.



Out and about:
Information on accessible travel options to enable people to go shopping, visit friends and attend appointments.

Advice and guidance:
Specific guidance including Lasting Power of Attorney, Mental Capacity and Deprivation of Liberty Safeguards as well as information on keeping safe and reporting concerns.

Kent County Council kent.gov.uk

Campaign delivery: Know how to start

kent.gov.uk/howtostart

Making a difference every day

Activity up to April 2026

- December 2025 –February: co-design and community involvement
- February: funding agreed, campaign plans, stakeholder engagement
- March: new webpages built, updated community directory launched, advertising secured
- April: paid advertising, marketing materials developed, stakeholder communications and engagement activity.

Upcoming

May: media release and further promotion

May-October: tracking impact and feedback and adapting/re-targeting approach as needed

End October: evaluation

Start here

Adult Social Care – Being the best we can be

By sharing the campaign across your networks, you'll help more people in Kent stay **independent, healthy, and connected**

Kent County Council kent.gov.uk

Recommendations

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

Adult Social Care and Public Health Cabinet Committee Work Programme

Meeting date	Item	Work Type
08 July 2026	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item
08 July 2026	Public Health Performance Dashboard	Report
08 July 2026	Update on Public Health Campaigns/ Communications	Update report
08 July 2026	Work Programme	Standing Item

Date of printing: 27/04/26

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