ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Thursday, 4th December, 2014

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Thursday, 4 December 2014 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

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

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

Membership (13)

Conservative (8): Mr C P Smith (Chairman), Mr G Lymer (Vice-Chairman), Mrs A D Allen, MBE, Mr R E Brookbank, Mrs P T Cole, Mrs V J Dagger and Vacancy

UKIP (2) Mr H Birkby and Mr A D Crowther

Labour (2) Mrs P Brivio and Mr T A Maddison

Liberal Democrat (1): Mr S J G Koowaree

Webcasting Notice

Please note: this meeting may be filmed for the live or subsequent broadcast via the Council's internet site or by any member of the public or press present. The Chairman will confirm if all or part of the meeting is to be filmed by the Council.

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

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

A3 Declarations of Interest by Members in items on the Agenda

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

A4 Minutes of the meeting held on 26 September 2014 (Pages 9 - 24)

To consider and approve the minutes as a correct record

A5 Meeting Dates for 2015

Thursday 15 January
Tuesday 3 March
Friday 1 May
Friday 10 July
Friday 11 September
Thursday 3 December

All meetings are planned to commence at 10.00 am. If an earlier start time is required for any meeting, this will be announced nearer the time.

A6 Verbal updates (Pages 25 - 26)

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

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

B1 Smoking Cessation service - proposals for future delivery (decision number 14/00146) (Pages 27 - 34)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Interim Director of Public Health, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to extend the current contract with Kent Community Health NHS Trust to deliver the smoking cessation service until 31 March 2016.

B2 Adult Healthy Weight commissioning plan (decision number 14/00148) (Pages 35 - 42)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Interim Director of Public Health, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to extend the contract for tier 1 and tier 2 weight management services to 31 January 2016, pending competitive tender of the healthy weight service.

B3 Tendering outcomes for Community Sexual Health Services (decision number 14/00143) (Pages 43 - 48)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Interim Director of Public Health, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to enter into a contract (with the organisations named in the accompanying exempt report) to deliver community sexual health services in Kent.

B4 Extending the current contract for Health Trainers by nine months (from March 2015 to January 2016) (decision number 14/00147) (Pages 49 - 54)

To receive a report from the Cabinet Member for Adult Social Care and Public

Health and the Interim Director of Public Health, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to extend the current contract with Kent Community Health NHS Trust to deliver the Health Trainers service until 31 January 2016, pending competitive tender of the service.

B5 Local Welfare Assistance future options (Pages 55 - 90)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, to consider and discuss the future of local welfare in the context of the options explored and endorse the favoured option, sent out in the report.

B6 Provision of support to socially-excluded groups (Pages 91 - 100)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, to consider the information provided about preventative services for socially-excluded groups and give a view on future support for these groups.

B7 Care Act Implementation - Eligibility Criteria for Adult Care and Support (decision number 14/00134) (Pages 101 - 110)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to adopt the new national minimum eligibility criteria as Kent's offer from April 2015.

B8 Care Act Implementation - Charging and Deferred Payments (decision numbers 14/00135 and 14/00136) (Pages 111 - 120)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decisions on charging policies for adult care and support, deferred payments and temporary financial assistance.

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

C1 Self-Assessment Framework (Pages 121 - 152)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing on the self-assessment framework and to comment on the issues set out in the report.

D - Monitoring

D1 Adult Social Care Performance Dashboard for September 2014 (Pages 153 - 170)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, outlining the performance and activity indicators for Adult Social Care for September 2014.

D2 Public Health Performance - Adults (Pages 171 - 176)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Interim Director of Public Health, outlining the performance of services which relate to children and young people.

D3 Work Programme (Pages 177 - 184)

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

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

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

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

EXEMPT ITEM

F1 Tendering outcomes for Community Sexual Health Services - exempt appendix to item B3 (Pages 185 - 186)

Peter Sass
Head of Democratic Services
03000 416647

Wednesday, 26 November 2014

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

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 26 September 2014.

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

ALSO PRESENT: Mr G K Gibbens

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

UNRESTRICTED ITEMS

1. Apologies and Substitutes
(Item A2)

The Democratic Services Officer reported that she had not been notified of any apologies or substitutes.

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

There were no declarations of interest.

3. Minutes of the meeting held on 11 July 2014
(Item A4)

RESOLVED that the minutes of the meeting held on 11 July are correctly recorded and they be signed by the Chairman. There were no matters arising.

4. Verbal updates
(Item A5)

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

Residential Care Contract – 16 July
Older Persons Nursing tender stage one analysis guide price recommendation
Home Support Fund Policy
15 July - Presented at the Capita 'Delivering Dilnot' Conference in London
16 July - Presented at the Kent Care Workforce Summit in Ashford
30 July - Visited Age UK in Canterbury
02 September - Spoke at the Learning Disability Partnership Awards at Sessions House – other Members added that they had attended similar awards

events in their local areas and had found the experience enlightening. Members were encouraged to become involved in their local learning disability partnerships.
12 September - Attended the Kent 'Forget Me Nots' Dementia Group Meeting – this had been the first such event for Kent and had been well received as a way of exploring how to live well with Dementia. He would like to repeat the event in future years.

He added that he would be happy to receive from any Member suggestions of how to reduce the volume of papers produced for the meeting and any request from a Member for him to visit any Adult Social Care premises in the county.

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

Mobilisation of new home care contract – this was progressing well and was encouraging more people to take up a direct payment.
Care Act Stocktake – this Department of Health initiative had started on 22 September. The Directorate was up to date with all key milestones. Following the stocktake, it would be possible to see a national picture of implementation of the Act.
Private and Voluntary sector home closures – he praised the excellent efforts of the staff of the two homes concerned in moving more than 60 elderly residents at short notice when the homes were forced to close. The impact of the two closures on the number of care places available locally would be monitored.
Safeguarding Vulnerable Adults Board Annual Report.
Deprivation of Liberty Safeguards – this was a national issue, arising from a recent judgement in Cheshire.

Members asked how much information about the home closures could be shared with them and Mr Lobban undertook to respond to the questioners outside the meeting.

3. Mr G K Gibbens then gave a verbal update on the following issues:-

Contract Award for Kent Community Infant Feeding Service
10 July - Attended Mental Health Engagement event for Dartford, Gravesham and Swanley, Swale & West Kent Clinical Commissioning Group (CCG) Areas in Lenham
15 July - Attended the Local Government Association Physical Activity Senior Leadership Forum in London – 'keep active' initiatives were targeted particularly at young women and older people.
17 September - Presented at the Public Health England Conference in Warwick - he congratulated the public health team on the positive feedback that had come from this event and said that some of the public health initiatives being championed in Kent were being copied by other local authorities.
15 October 2014 seminar by Professor Chris Bentley on Health Inequalities – Members were given the details of this event and encouraged to attend.

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

Health Checks success
Sexual Health services non-award, and retender – contracts had not been awarded for two of the seven lots – contraception and sexual health (CASH)/genito-urinary medicine (GUM)/HIV and young people's services – as no bids had met the

specification, so for these parts of the service the market would be re-tried. An update on the issue would be reported to the Committee's December meeting.
Flu campaign
Kent Housing Group Conference
Public Health England Conference

He responded to a question about the target for the number of health checks undertaken and explained that, although he did not want to get too focussed on numerical targets, Kent could aim to raise its uptake rate as high as possible, and could aim to reach beyond the national target of 75%.

5. RESOLVED that the verbal updates be noted.

5. NHS Health Checks - proposals for future delivery
(Item B1)

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

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

a) it was a challenge for the County Council that its performance at delivering health checks was not as it would like, but it was hoped that an improvement could be achieved soon. Ms Sharp responded that analysis of what happened after a health check, eg how a patient planned to address any issues highlighted in their health check, was also important;

b) the recommendation in the report was welcomed but it was suggested that it could be enhanced to aim for a higher target rate of uptake, and should at least start off as 50%;

c) one speaker who had recently attended the contracting Trust's annual general meeting told the Committee that the Trust had recently received a good CQC assessment and that he was content that it was capable of meeting the challenge of improving the uptake of health checks;

d) progress so far had been good but would need to be sustained. Ms Sharp said performance had moved from a red to a green rating within one quarter and reassured Members that the County Council was not complacent in setting or striving to reach its targets; and

e) Ms Sharp explained that the element of risk mentioned in the report referred to any area of expected activity which was not covered within the required timescale and reassured Members that the terms of the contract would stipulate that any such area would not be paid for. Any saving made by this means could be used to fund pilots for other areas of work, eg with Public Health England.

2. Mr T A Maddison proposed and Mr S J G Koowaree seconded that the recommendation in the report be enhanced to specify a target rate for Kent of 50% uptake.

Agreed without a vote.

3. The Cabinet Member, Mr Gibbens, thanked Members for their comments, of which he would take account when taking the decision, and reiterated comments previously made about target setting. Sensible, realistic targets should be set, with a timeframe within which they would expect to be achieved. He reminded Members that updates on this and other public health issues would be available to the committee as part of the regular performance monitoring reports.

4. RESOLVED that:-

a) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to extend the contract with Kent Community Health Trust to 31st January 2016, after taking account of views expressed by the committee, be endorsed; and

b) a series of innovation projects designed to deliver a significant improvement in the uptake of checks, with the aim of achieving a target rate of 50% in Kent, be endorsed.

6. Tendering for Postural Stability classes
(Item B2)

Ms M Varshney, Consultant in Public Health, was in attendance for this item, with Ms Sharp.

1. The Chairman asked Members of the Committee if, in debate, they wished to refer to the list (which had been tabled) of companies which had submitted expressions of interest in bidding for the contract. Members confirmed that they did not wish to do so and the item was therefore considered without going into closed session.

2. Ms Sharp introduced the report, which had been prepared following a report to the Committee's July meeting on the dynamic purchasing system. She explained that all those companies which had submitted expressions of interest would be invited to tender for a two-year contract, with an award of contract taking place in November 2014 and classes starting in January 2015. Ms Varshney added that the programme of postural stability classes would ensure systematic delivery, with referrals being made to community-based classes via a central point.

3. The Chairman clarified that the award of contract would ultimately be made to the bidder/s identified at the end of the process as the highest scoring, and checked that Members of the committee understood and were happy that that would be the process. Members confirmed that they were happy to accept that approach.

4. Ms Varshney and Ms Sharp responded to comments and questions as follows:-

a) it was important that the approach taken to identifying and involving suitable participants for postural stability classes was appropriate and consistent. A suitable population could be identified by various routes, including GPs, district nurses and social workers, all of whom were well placed to identify patients and clients who would benefit most from them; and

b) Members asked for clarification and more detail about the workings of the dynamic purchasing system, *and this would be provided in a future report to the Committee.*

5. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to award contract/s to those bidders receiving the highest scores in the tender evaluation process, be endorsed.

7. Outcome of formal consultation on the closure/variation of service of Swale Learning Disability Day Service
(Item B3)

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

1. Ms Southern introduced the report and reminded Members that this was the latest in a programme of modernisation of day services for people with learning disabilities. Ms Watson set out the arrangements for the 14-week consultation. They responded to comments and questions from Members, as follows:-

a) the vital importance of good public consultation was emphasised, and a suggestion made that information about such service reviews in future could be sent to local households with council tax bills;

b) in response to a question about equality impact assessments, how they worked and an example of their importance, Ms Southern explained that the equality impact assessment process was important but complicated, as clients engaging with a service would have a wide variety of complex needs. The equality impact assessment would be reviewed throughout each stage of the project to ensure all needs were included;

c) a Member who had been involved in the modernisation of services for people with learning disabilities in Ashford, the first such service to be modernised, asked for an update on the progress of those service since modernisation. Ms Southern explained that an annual review on progress was reported to the Project Advisory Group (PAG) and a review of all such services undertaken and reported to the Good Day Board, which would monitor progress and draw out any lessons which could be learnt from previous exercises. That information could be shared with elected Members and made available on the County Council website;

d) the clarity of the easy-read documents appended to the report was praised, as was the thoroughness of the consultation and the reporting of service users' views. Ms Southern agreed that clarity of information was very important for the client groups concerned; and

e) the now well-established custom of keeping existing services open until new services were up and running was praised as it would ensure there was no gap in provision.

2. The Cabinet Member, Mr Gibbens, emphasised that, in all such modernisation programmes, he had always made sure that no facilities would be closed until replacement services were available. He undertook to ensure that an update report on past modernisation programmes was presented to a future meeting of the Committee.

3. RESOLVED that:-

a) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, after taking account of views expressed by the committee, to proceed with the transformation of the Swale Learning Disability Day Service and to continue the service into a more inclusive, accessible, community-based service, operating from community hubs, be endorsed; and

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

8. Personal Health Budgets - Section 75 Agreement
(Item B4)

Ms J Frazer, Programme Manager, Health and Social Care Integration, and Ms M Reynolds, Senior Associate, Kent and Medway Commissioning Service, were in attendance for this item.

1. Ms Frazer and Ms Reynolds introduced the report and explained the workings of a Section 75 agreement. They responded to comments and questions from Members, as follows:-

a) service users currently affected by the new arrangement would be only those in receipt of a Direct Payment who had taken part in a pilot scheme, so numbers were currently small, and it was not yet clear to what extent the numbers would grow in the future. Projections made for the scope of the new arrangements were based on a broader range of service users with long-term conditions;

b) in response to a question about the likely increase in annual cost as the client base grew, Ms Reynolds and Mr Ireland explained that the Section 75 agreement gave the County Council a mechanism for claiming from CCGs sufficient funds to meet demand and had been established with the expectation that funds would increase. *Ms Frazer undertook to circulate to the committee an example case study which was listed as a background document to the report;* and

c) one additional member of staff would be employed to manage the administrative required to operate the Section 75 agreement.

2. RESOLVED that:-

a) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to enter into a Section 75 agreement with the Kent clinical commissioning groups (CCGs) to allow the CCGs to utilise the County Council's financial systems to make personal health budget direct payments, be endorsed; and

b) authority be delegated to the Corporate Director of Social Care, Health and Wellbeing, or other suitable officer, to arrange the sealing of the Section 75 agreement.

9. The wellbeing charge in existing and new extra care schemes
(Item B5)

Ms C Holden, Head of Strategic Commissioning, was in attendance for this and the following item.

1. Ms Holden introduced the report and explained that the purpose of the wellbeing charge was to cover such expenses as background support, non-scheduled calls and emergency responses to residents of extra care housing developments, and was means-tested. Many of the clients to whom the wellbeing charge applied were self-funders. The service charge referred to in the report covered such things as heating, lighting, cleaning and maintenance of communal areas, and any surplus funds generated by chargeable facilities could be directed towards reducing this charge.

2. In debate, Members welcomed the reduction in the charge as a sensible move which should encourage more people to choose to move into extra care housing.

3. RESOLVED that:-

a) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, after taking account of the views expressed by the committee, to reduce the wellbeing charge as follows:-

i) at the existing Extra Care Housing Schemes, it be set at £15 per week from 1 April 2015, with the exception of the particular circumstances at Thomas Place set out at ii) below;

ii) at Thomas Place, it remain at £13.91 per week for existing tenants, unless they are subsequently financially assessed as being able to meet the full cost of their social care (in which circumstances, it rise to £15 per week); and

iii) for new Extra Care Housing Schemes the charge be set at £15 per week with immediate effect,

be endorsed; and

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

10. Contract Award for Older Persons Residential and Older Persons Nursing Care homes
(Item B6)

Ms C Maynard, Procurement Category Manager, was in attendance for this item, with Ms Holden.

1. The Chairman asked Members of the Committee if, in debate, they wished to refer to the content of the exempt appendix which was included in the agenda pack as item E1. Members confirmed that they did not wish to do so and the item was therefore considered without going into closed session.

2. Ms Holden introduced the report and, in response to a question about the breakdown of scores, explained that 50% of the score was for the price tendered, 30% was for quality and capability and the remaining 20% for a provider's performance against the agreed key performance indicators introduced as part of the contract.

3. RESOLVED that:-

a) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to agree that the Kent County Council enter into contracts with the suitable residential care and nursing care homes identified through the tender exercise, be endorsed; and

b) authority be delegated to the Corporate Director of Social Care, Health and Wellbeing, or other suitable officer, to undertake the actions to implement this decision.

11. Adult Social Care Transformation - Phase 1 update and appointment of partner for Phase 2 design
(Item B7)

1. The Chairman sought and received the Committee's agreement to consider this item as urgent business as it had not been published in time to comply with the required notice of five clear working days before the meeting.

2. Mr Lobban introduced the report and presented a series of slides which set out the progress made on phase 1 of the transformation programme, the process to be followed for the appointment of a partner for phase 2 and initial plans for phase 3. He emphasised that the relationship with Newton Europe had been constructive as its work was complimentary to the County Council's work. It was important, therefore, to maintain the pace of change. Mr Lobban and Mr Ireland responded to comments from Members, as follows:-

a) the approach taken was supported and the savings made so far were commended;

b) it was emphasised that the importance of achieving a correct assessment was vital;

c) Members asked to have the opportunity to meet representatives of Newton Europe;

d) one speaker said that, when Newton Europe had first been appointed, he had had concerns that the predicted savings were realistic, but was pleased now to see that these savings had been achieved; and

e) the enablement service currently being run as a result was excellent.

3. Mr Ireland added that the presence of Newton Europe had had a very positive impact on County Council staff and the savings achieved had been the result of close joint working.

4. The Chairman placed on record his congratulations and thanks to County Council staff on the positive way in which they had embraced the process of working with Newton Europe as an efficiency partner. The Cabinet Member, Mr Gibbens, added his thanks to Mr Lobban and his team on the work put into preparing the presentation and update report. He hoped that the Committee had found the presentation helpful and offered Members the opportunity to view a more detailed presentation and meet representatives of Newton Europe.

5. RESOLVED that:-

a) the update on phase 1 of Adult Social Care Transformation and the outcome of the assessment stage of phase 2 be noted;

b) the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to appoint Newton Europe to support the County Council in designing phase 2 of adult social care transformation, be endorsed;

c) authority be delegated to the Corporate Director of Social Care, Health and Wellbeing, in consultation with the Cabinet Member for Adult Social Care and Public Health, to enter into the necessary contracts, following final confirmation of funding details and the satisfactory negotiation of detailed terms and conditions, to a maximum value of £2.5million;

d) the Corporate Director of Social Care, Health & Wellbeing, or other delegated officer, undertake the necessary actions to implement this decision; and

e) the Committee's congratulations and thanks be passed to County Council staff on the positive way in which they had embraced the process of working with Newton Europe as an efficiency partner, and to Mr Lobban and his team on the work put into preparing the presentation and update report.

12. Delivery plan for reducing excess winter deaths in Kent
(Item C1)

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

1. Ms Varshney introduce the report and responded to comment and questions from Members, as follows:-

a) there were many schemes advising people about staying healthy through the winter, eg 'Keep Warm, Keep Well', and this range of advice could be confusing for some residents. It was the role of the Kent and Medway Sustainable Energy Partnership (KMSEP) to co-ordinate advice from healthcare professionals, and a call centre was being developed to provide a single contact number that people could call for advice;

b) meals on wheels services used to ensure that elderly people had at least one hot meal a day but the service had now been reduced in some areas of the county. Mr Lobban advised that the meals on wheels contracts had been cut back due to a decline in demand and increasing competition from other companies, from which clients cold buy meals direct. Mr Scott-Clark agreed that services could be patchy and added that some residents with the greatest challenge to keep themselves and their homes warm in winter were in the more affluent areas of the county, in which some people were living alone in large family houses which they could not afford to heat or insulate adequately. It was often difficult also to get these clients to hospital when needed as they lived in remote rural areas; and

c) National Institute of Clinical Excellence (NICE) guidance on addressing winter excess deaths was currently in draft form but would be included in the delivery plan when finalised.

2. RESOLVED that the plan and its delivery schedule for 2014/15 be welcomed and the plan be promoted within local and strategic forums.

13. Developing a Public Health Strategy
(Item C2)

1. Mr Scott-Clark presented a series of slides which set out the context of and process for establishing a public health strategy and summarised the strategy's key components. The slides had been included in the agenda pack for the meeting. He responded to comments and questions from Members, as follows:-

a) the public health practice part of the strategy currently had three key elements – Health Improvement, Health Protection and Improving Services – but the plan was to add a fourth – the Public Health of the public;

b) an example was given of the way in which the strategy would be applied, eg to help people to stay in work or move from benefits into work. The Public Health Minister had recognised the work which had gone on in some parts of the county between GPs and JobCentre Plus, but to be truly effective this work would need to be county-wide. The importance of being in regular paid work and having a stable income as a support to good health was well established;

c) immunisation programmes were overseen by Public Health England but programmes were formally commissioned by NHS England. The

importance of people taking responsibility for their own health was highlighted and supported;

d) environmental factors such as air quality and pollution surely had some impact on public health issues, and Mr Scott-Clark confirmed that statistics on this would be included in the strategy. Recent work in Europe on the health effects of pollution could also be included.

2. RESOLVED that the information set out in the presentation, and given in response to comments and questions, be noted, and the outline public health strategy be welcomed and commended.

14. Better Care Fund update
(Item C3)

Ms J Frazer, Programme Manager, Health and Social Care Integration, was in attendance for this item.

1. Ms Frazer introduced the report and presented a series of slides, which had been included in the agenda pack, setting out the plan, its context and links to other work such as phase 2 of the adults transformation programme. In response to questions, she explained that the funding for 2015/16 was not yet known and the plan was to achieve inter-operability of several systems rather than trying to achieve one system, which was not feasible.

2. RESOLVED that the information set out in the report, and given in response to comments and questions, be noted.

15. Care Act Implementation Programme Update
(Item C4)

Mr M Thomas-Sam, Strategic Business Advisor, and Ms C Grosskopf, Policy Manager, were in attendance for this item.

1. Mr Thomas-Sam and Ms Grosskopf introduced the report and responded to comments and questions, as follows:-

a) a view was expressed that the Government's blanket allowance of £125,000 per authority was unfair to a large authority such as Kent, and Mr Thomas-Sam assured Members that the County Council would be making this point clearly and firmly to the Government as part of the consultation on the funding formula. Other speakers supported this and said that lobbying should be strong as the allocated funding was clearly inadequate and there were still many unknowns. Mr Ireland added that final funding guidance would be issued by the Government on 13 October and would help to make clear the extent of the challenge;

b) the required assessment of over 10,000 service users would be undertaken through a combination of in-house resources and with the assistance of external organisations, to ensure that all assessments were completed within the required timetable. *A report to the Committee's December meeting would set out the next stage of the process and how*

this would be achieved. Mr Ireland added that, at its December meeting, the Committee would be able to consider the first indications of the changes coming in 2016, although many significant issues would emerge after 2016; and

c) Members thanked the officer team for the enormous amount of work which had gone into analysing the complex new legislation and processing it and presenting it clearly to help Members to understand it. Kent was very lucky to have the experienced and capable officers that it had.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and assured them that he shared the concerns expressed about the cost issues. He agreed with Mr Ireland that the biggest challenges would come after 2016. He confirmed that the issue would be considered by the Cabinet following the Cabinet Committee's December meeting and that a number of key decisions would arise as the new legislation came into effect.

3. RESOLVED that progress on the implementation plan, in readiness for April 2015 changes, the latest costs estimates and the forecast of additional activity, the legal advice regarding eligibility and charging and the submission of the County Council's response to the consultation by the required deadline, be noted

16. Adult Social Care Annual Complaints Report
(Item D1)

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

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

a) it was difficult to say how Kent scored in comparison to other local authorities, or to rate it in a 'league table', as authorities differed in the way in which they defined complaints and publicised their complaints procedure. However, in an Ombudsman's national report of complaints received in 2013, Kent had showed up as having a good record;

b) the number of complaints received had decreased. The Care Act proposed the introduction of an appeals process in 2016 but the detail was not yet available. The increased number of assessments associated with the Care Act could possibly lead to more complaints;

c) the total of £98,966 paid out to complainants was made up from £51,500 paid in adjustments to clients' care accounts, for example where a charge had been disputed, and £47,370 in settlements. These payments were made either at the suggestion of the Ombudsman or as a gesture of goodwill where a service had not been to the expected standard;

d) there was a decrease in the number of complaints received in the last year, when it might have been reasonable to expect more, given the financial pressures and amount of change taking place. However, it showed that the County Council had held a very good, steady position; and

e) Members agreed that the Directorate had very good staff and officers who had performed very well in a difficult role at a difficult time, and placed on record their thanks to the officers concerned.

2. RESOLVED that:-

a) the information set out in the report, and given in response to comments and questions, be noted.

b) the Committee's thanks for good performance in a difficult role at a difficult time be conveyed to the staff concerned.

17. Kent and Medway Safeguarding Adults Annual Report April 2013 - March 2014
(Item D3)

Mr N Sherlock, Head of Adult Safeguarding, was in attendance for this item.

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

a) reports of abuse in hospitals and other health settings had almost doubled since 2011, due to greater public awareness and willingness to report concerns, partly as result of media coverage. This increased awareness and willingness to report concerns was to be welcomed;

b) the updated CQC inspection regime measured the quality of safeguarding practice, rather than the number of alerts or reports received; and

c) concern was expressed that fines imposed as punishment in cases of neglect were often too small to be of any real deterrent. Mr Sherlock explained that, for a care provider to have a fine imposed upon them, there would need to be a finding of criminal neglect or abuse. Very few such cases resulted in prosecution in a criminal court, and vulnerable people often lacked the capacity to give evidence in court, so police often made a judgement not to prosecute. However, the new Care Act had put safeguarding on a firmer legal footing in this respect.

2. RESOLVED that the information set out in the report, and given in response to comments and questions, be noted.

18. Kent County Council's Local Account for Adult Social Care for 2014
(Item D4)

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

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

a) Ms Smith received Members' compliments and praise for her and her team for the work which had gone into preparing the Local Account document;

b) in response to a question about accessibility and the intended circulation of the finished document, Ms Smith confirmed that it would be available online and would also be distributed to GPs' surgeries, libraries and hospitals; and

c) the section on a new mental health service for Kent was welcomed as this service was vitally important.

2. The Cabinet Member, Mr Gibbens, commented that there had been good discussion of the document content at a recent workshop event, which had been well attended by Members, and he hoped it would be as well received by the public and service users. Mr Ireland added that he had been pleased to hear Members' positive views on the document, which had been improved since previous years. He said he felt it presented a balanced and honest account of the strengths and weaknesses of the Directorate and that the publication of this annual document was an important part of the overall service.

3. RESOLVED that:-

a) the information set out in the report, and given in response to comments and questions, be noted; and

b) Members' compliments and praise of the work which had gone into preparing the Local Account document be conveyed to the staff concerned.

19. Annual Equality and Diversity Report
(Item D5)

Ms M Harrison, Programme Manager, OPPD Transformation, was in attendance for this item.

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

a) the clarity of the language used in the document, and its layout, were praised as they made it accessible for a broad audience to understand. Ms Harrison confirmed that the easy-read version would be made available to anyone who requested it, but the speaker then asked how service users would know that they could request it. It should be made available in accessible formats so that people did not have to ask for it;

b) similarly, the document would be made available in other languages when requested; and

c) only 4,000 of the estimated total of approximately 28,000 people in Kent with learning disabilities were receiving services from the County Council, but that did not mean that the rest had been 'missed'. Ms Harrison explained that learning disability was a very broad category and most people covered by it were in education, training or employment. Because these people were not supported directly by the County Council, they were not counted. What would be a challenge would be older people with

learning disabilities who needed to access County Council care when their elderly parents died or were no longer able to care for them. The number of future cases of this type could not be estimated.

2. RESOLVED that:-

a) current performance and the proposed changes to equality objectives be noted, and revised objectives be received at future meetings;

b) equality governance continue to be observed in relation to decision making;

c) the Committee continue to receive annual reports in order to comply with the Public Sector Equality Duty; and

d) a report on the service impact on client groups, broken down by age, gender, disability and ethnicity, be made to a future meeting of the Committee.

20. Risk Management - Adult Social Care
(Item D6)

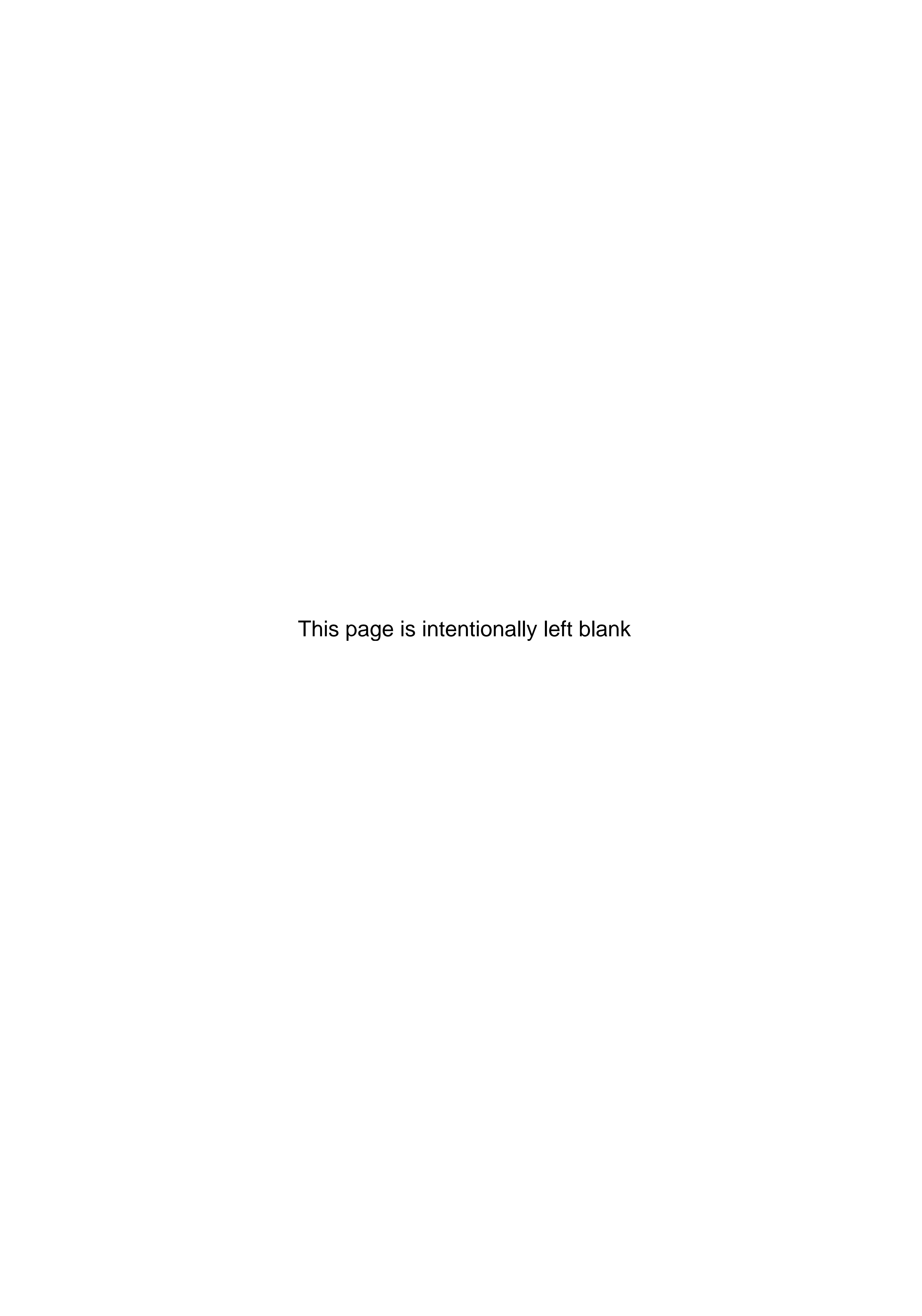
Mr A Mort, Customer Care and Operations Manager, was in attendance for this item.

1. Mr Mort introduced the report and responded to a question about strategic risk by explaining that adult safeguarding was one such risk in social care work which was always present but had to be managed as well as possible and minimised as far as possible. He also explained that the risk ‘scores’ quoted in the appendix to the report had been calculated by taking a score (of between 1 and 5) for the likelihood of a something happening and multiplying it by a score (of between 1 and 5) for the likely impact on the County Council, should the risk actually happen.

2. RESOLVED that the information set out in the report, and given in response to comments and questions, be noted.

21. Work Programme
(Item D7)

RESOLVED that the work programme for 2014/15 be agreed.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By: Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health

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

Mr A Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 4 December 2014

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

Classification: Unrestricted

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

Adult Social Care

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

Key Decisions

1. Wellbeing Charge in Extra Care Housing Schemes
2. Personal Health Budgets – Section 75 agreement
3. Swale Learning Disability Day Service
4. Local Account
5. Adult Social Care Transformation – Phase 2 Design Partner Appointment

Events

1. 7 October - Consortium for Assistive Solutions Adoption (CASA)/Innovage Final Conference in Brussels
2. 14 October - visited Compaid in Paddock Wood
3. 22 October - spoke at the Kent Seniors Forum at Sessions House
4. 12 November - attended Porchlight 40th Anniversary Conference in Canterbury
5. 12 November - attended Government Office for Science Future of Ageing Meeting at the University of Kent

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

1. Transformation update
2. Five Year Forward – emerging strategic direction of NHS and impact on social care
3. Feedback from staff briefings

Adult Public Health

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

Key Decisions
1. Health Checks Service - contract extensions
2. Contract awards for Community Sexual Health Service

Events
1. 1 October - attended Kent Malnutrition Conference at Ashford International Hotel
2. 10 October - attended Public Health Mental Wellbeing Celebration Day at Sessions House
3. 15 October - hosted Professor Chris Bentley Health Inequalities Members' Briefing at Sessions House
4. 19 November - spoke at the Wellbeing Symposium at Detling Showground
5. 26 November - attended Environment, Health & Sustainability Conference at Ashford International Hotel

Interim Director of Public Health – Mr A Scott-Clark

1. Campaigns update
2. Ebola update
3. Canterbury Christchurch University AGM

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

Andrew Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 4th December 2014

Subject: Smoking Cessation Service – proposals for future delivery

Classification: Unrestricted

Decision No.: 14/00146

Past pathway: This is the first committee by which this issue will be considered.

Future pathway: Key decision by Cabinet Member.

Electoral Division: All

Summary

Public Health have undertaken a review of the smoking cessation service and, in light of this review, Members of the Committee are asked to:

i) comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contract with Kent Community Health Trust for the smoking cessation service to 31st March 2016

ii) agree the timeline for tendering the service

1. Introduction

The purpose of this paper is to outline work streams that need to be undertaken to develop a new model for the smoking cessation service.

2. Background

Smoking remains one of the most significant public health challenges for Kent. The highest smoking prevalence is in the most deprived areas. KCC currently commissions Kent Community Health Trust to provide a smoking cessation service across Kent which aims to support smokers to set a quit date and then quit within 4 weeks, often with a combination of counselling and nicotine replacement therapy. The 4 week quit target that KCC set in 2013/14 was 9,249 quits. In the last financial year KCHT achieved 6,131 quits, 66% of the target.

3. Findings of the Rapid Review of Smoking Cessation Service

Public Health commissioned a Rapid Review of 'pathways to quit' smoking services, which explored evidence-based approaches to successful quit and harm reduction services. In addition the review also drew upon local insights, smoking prevalence and evaluation of the stop smoking services.

The aim of the review was to identify what was being commissioned and delivered and how this met Kent's ambitions to improve the health of the public and toreduce inequalities. The review also looked at where cessation support sat within the overall tobacco control programme and how that wider programme supports the delivery of effective stop smoking services. The review identified the following areas where more work needs to be done.

3.1 Model for the smoking cessation service

Develop a new model for supporting smokers in Kent to quit and/or reduce harm from tobacco use. The key areas which need to be considered in the model are:

- The role of the core smoking cessation team
- The role of and engagement with partner organisations e.g. general practice, pharmacy, secondary care and children's centres.
- A general population model and a targeted model aimed at pregnant women, young people, ethnic minorities, people with long term conditions, and manual and skilled workers.

3.2 Tobacco Harm Reduction Strategy

Develop a harm reduction strategy which reflects NICE guidance and encompasses

- cutting down prior to stopping smoking
- smoking reduction
- temporary abstinence from smoking
- Stopping smoking

3.3 New Tobacco Control Target

The current smoking cessation target was introduced in 2006 and was aimed specifically at achieving 4 week quits. NICE guidance recommends that 4 weeks quits should be part of the harm reduction approach rather than the only measure of success. In 2012 /13, KCHT, generated a 10% increase in referrals to the stop smoking service.

However, the number of people who successfully quit smoking over this period reduced by 37%. This highlights that the people accessing the services are finding it harder to give up smoking and harm reduction programmes may be better deployed to support heavy smokers who are not able to quit smoking completely. This will require a review of the current target and development of a new target that encompasses harm reduction.

3.4 E-cigarette policy

Develop an e-cigarette statement for KCC. The statement will need to consider e-cigarette use in the general population, young people, use in the workplace and the care/health settings. It would also need to address the potential use of e-

cigarettes in harm reduction and quitting along with prescribing of other Medicines and Healthcare Products Regulatory Agency (MHRA) approved nicotine replacement therapies (NRT).

3.5 Cost of the service

The current cost of the service is £2.6 million. This cost does not take into account any additional cost that will be incurred as part of the harm reduction work. Public Health will need to understand the costs of any proposed model(s) and the associated return on investment.

3.6 Gaps in knowledge

Identify areas requiring further research and investigation such as supporting young people to quit and supporting those with dual addictions.

4. Future delivery

An extension of the existing delivery model would also allow time for Public Health to work with providers to:

4.1 Pilot and evaluate a series of innovation projects which aim to deliver the required step change in developing a harm reduction approach, particularly among the most deprived areas, which contribute to health inequalities in the county.

4.2 Understand and analyse the learning from harm reduction models elsewhere . There is a significant amount of work underway across the country in developing a new model for the smoking cessation services that incorporate harm reduction.

4.3 Develop and shape the provider market for the smoking cessation service to ensure that KCC can ensure value for money in the longer term, through competitive tendering

4.3 Start to work with the provider to implement the harm reduction strategy and identify the new target.

4.4 These actions can be undertaken in the next year so that a competitive tendering process can begin in April 2015 and put new contracts in place by April 2016. The current contract is due to expire in March 2015, so a key decision to extend the existing arrangements would be required. A commissioning timeline is laid out at appendix 1

5. Risks of tendering the service immediately

5.1 Cost

Analysis of full costs will need to be undertaken, especially as more expensive targeted programmes will need to feature in a new contract. Without accurate costing and funding available, the quality of service will be compromised and targets will not be achieved or delivered.

5.2 Lack of suitable alternatives providers

The market will need to be tested to ascertain other interested providers before a notice is served on the existing contract. Tendering the service now will not give sufficient time to prime the market and create competition.

6. Risks of extending the contract

6.1 Performance

There is a risk that an extension of the existing delivery model beyond 2014/15 will mean that the current performance of the provider deteriorates even further. This risk will be managed by sustaining the focus on performance, regular contract monitoring meetings with the provider and taking prompt remedial action to address any areas of underperformance.

7. Financial Implications

The current indicative budget for the smoking cessation service in Kent is £2.6 million.

8. Conclusion

The current smoking cessation service has been set a target to achieve the 4 week quits. In light of recent advances in research and guidance, and the review of the service, the smoking cessation services should also be incorporating harm reduction approaches in the existing programme. This will require time to develop a harm reduction strategy, new service model, e-cigarette statement and a new target that measures harm reduction alongside the 4 week quits.

9. Recommendations

Members of the Committee are asked to:

i) comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contract with Kent Community Health Trust for the smoking cessation service to 31st March 2016

ii) agree the timeline for tendering the service

9. Background documents

None

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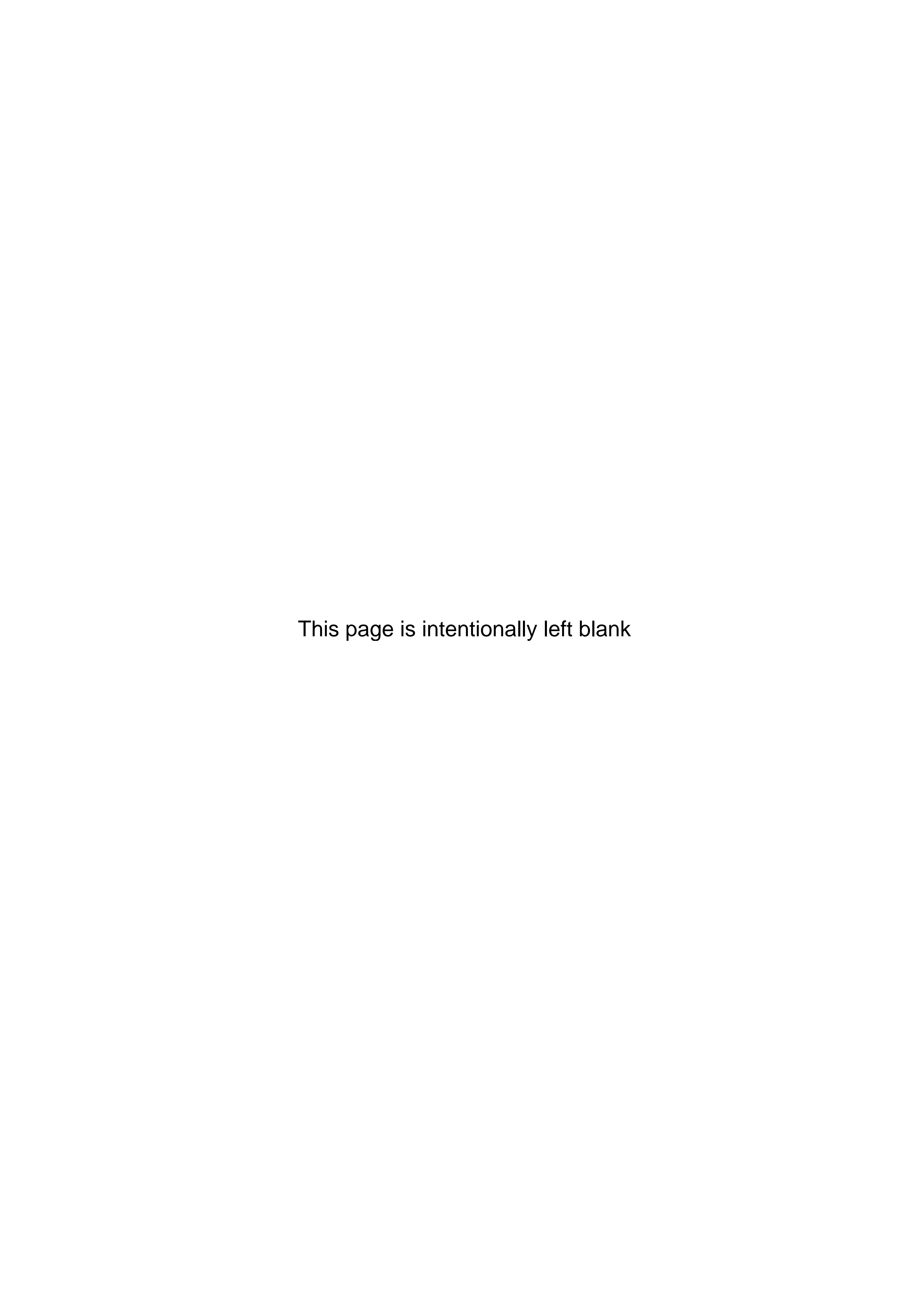
Appendix 1

Proposed commissioning time line

Service Review and Needs Assessment	**June 2014 – December 2014**
Service Planning	**December 2014 – June 2015**
Tender Process	**July 2015- December 2015**
ITT issued	**July 2015**
Contract awarded	**December 2015**
Mobilisation	**December 2015- 1st April 2016**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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	14/00146

For publication

Subject: Contract Extension for Kent Community Health Trust – Smoking Cessation Service

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that the County Council extend the current contract with Kent Community Health NHS Trust (KCHT) to deliver the Smoking Cessation service until 31st March 2016, pending competitive tender of the Smoking Cessation service.

Reason(s) for decision:
Decision exceeds key decision financial criteria

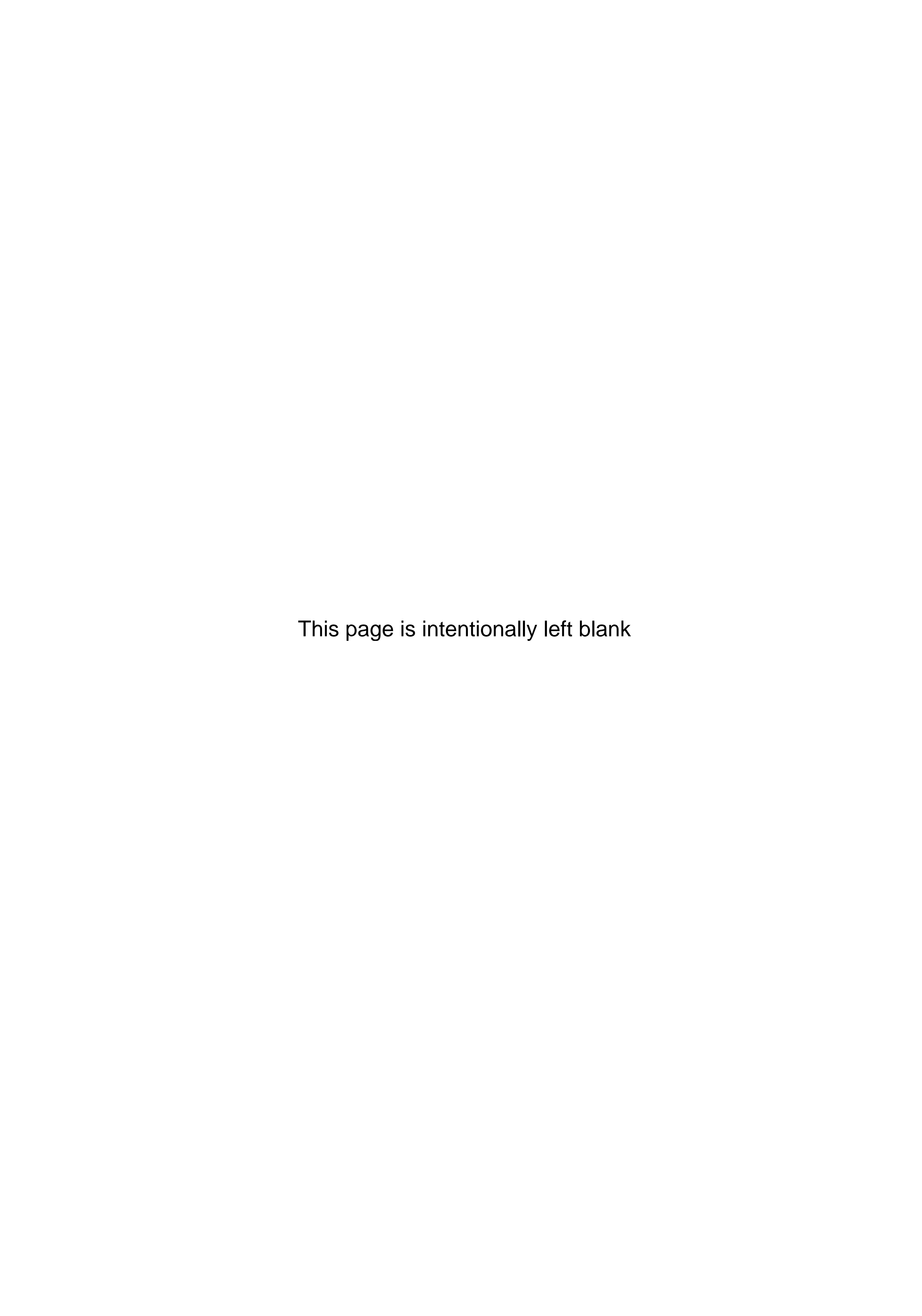
Cabinet Committee recommendations and other consultation:
The Adult Social Care & Health Cabinet Committee will consider the matter at its meeting of 4th December 2014

Any alternatives considered:
An earlier competitive tendering process was considered, but for the reasons outlined in the accompanying report this was not followed

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

....
signed

....
date



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

Andrew Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee

4 December 2014

Subject: Adult Healthy Weight Commissioning Plan

Classification: Unrestricted

Decision No.: 14/00148

Past pathway: This is the first committee by which this issue will be considered.

Future pathway: Key decision by Cabinet Member.

Electoral Division: All

Summary:

Obesity is a major public health challenge. In Kent it is estimated that approximately 28% of the Kent adult population is obese (354,022).

This is not an issue that can be tackled solely by the commissioning of services from the public health grant. This will benefit from the concerted effort of the whole public sector system.

In the timetable currently agreed, healthy weight services funded by the public health grant need to be procured immediately. This paper recommends delaying this procurement until a whole system review has taken place. The development of the Public Health strategic framework, with supporting strategic delivery plans (including a Healthy Weight strategy), will show where commissioning healthy weight services will be most effective in supporting this whole system approach.

This report outlines the timetable for developing a Healthy Weight whole-system strategy, and recommends the re-procurement timetable that will be needed to align with this strategy.

Recommendation(s):

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

1.	Support the approach for developing a system-wide strategy for Healthy Weight in Kent and a revised commissioning timeline.
2.	Comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contracts for Tier 1 and Tier 2 weight management services to 31 January 2016.

1.0 Introduction

1.1 Obesity is a major public health challenge with, nationally, two-thirds of English adults obese or overweight. In Kent it is estimated that approximately 28% of the Kent adult population is obese (354,022).

1.2 The move of public health functions into local authorities provides an opportunity to engage more effectively with the wider determinants of unhealthy weight. For example, planning, housing, leisure and recreation, early years and schools, and it is essential that a whole-system approach is utilised to tackle this challenging issue.

1.3 In May 2014, a paper was presented to the Adult Social Care and Health Cabinet Committee outlining a timeline for the commissioning of a stand-alone healthy weight service.

1.4 Since the presentation of that paper, there has been an increasing consensus amongst stakeholders that obesity needs to be tackled as a whole-system issue, and it was identified as such in the Joint Kent Health and Wellbeing Strategy, considered by this committee in July 2014, and agreed by the Health and Wellbeing Board in the same month.

1.5 The finalisation of the Health and Wellbeing Strategy, and the timetable for the development of the Public Health Healthy weight strategy, provides the opportunity to have a strategic plan to address obesity that complements these documents. It would therefore make sense to delay procurement until this strategy is finalised. This would enable commissioners to:-

- Run a series of consultation events with all stakeholders including colleagues from Clinical Commissioning Groups, District Councils, and KCC colleagues and the Voluntary sector involved in physical activity services

- Map and align resource across the system which can be coordinated to ensure the maximum capacity in a new approach including resource to address physical inactivity. This will include Healthy Living Centre resource and programmes, such as the Community Chef.

- Analyse data from the service review, including the National Child Measurement Programme data.

- Review the results of the consultation. Headlines are included in Appendix 1

- Run a series of market engagement events to explore the range of services available.

1.6 An initial stakeholder engagement event to begin this process will be held on 8 December at which this work will be planned in partnership.

2. Revised Timeline

2.1 In order to deliver the activity outlined above, Members are asked to approve a new timeline for the procurement of Healthy weight services.

Current approved time line

Service Review and Needs Assessment	01/11/2014-04/04/2014
Service Planning	07/04/2014-25/07/2014
Tender Process	28/07/2014-02/01/2015
ITT issued	22/09/2014
Contract awarded	02/01/2015
Mobilisation	05/01/2015-01/04/2015

New proposed time line

Service Review and Needs Assessment	01/07/14-16/12/14
Service Planning	17/12/14-22/04/15
Tender Process	23/04/15-01/10/15
ITT issued	12/05/2015
Contract awarded	01/10/2015
Mobilisation	02/10/2015-01/01/2016

2.2 As a consequence of this revised time line, there will be a need to extend the current contracts for an additional nine months, to January 2016.

3 **Conclusion**

3.2 Obesity is a major public health problem that needs to be tackled by a range of partners if a significant impact is to be delivered. Approval of a revised time line for the procurement of public health funded services will enable the model for these services to be developed in line with a whole system review.

3.3 Approval of the new timeline to deliver this review requires the current contractual arrangement to be extended until 31 January 2016.

4 **Recommendations:**

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

1. Support the revised approach for developing a system wide strategy for Healthy Weight for the population of Kent.

2. Comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contracts for Tier 1 and Tier 2 weight management services to 31 January 2016.

5 **Background Papers**

Adult Healthy Weight Review presented to Adult Social Care Cabinet Committee in May 2014.

6 **Contact Details**

Report Authors

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Relevant Director

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Appendix 1

Findings from Healthy Weight Consultations

Extending the timeline has enabled us to extend the adult consultation and subsequently to consult about healthy weight services for children.

The adult healthy weight consultation closed on 18 September and has now been analysed. 602 responses were received. This exceeds the sample size needed to represent the population. However, there may be some bias resulting in the way information about the survey was circulated.

73% of responses were from women; this reflects the gender breakdown of service usage. The majority of responses were from 36-55 and 66-75 age groups, the mean age of current commissioned service users is 50. 10% of respondents were non-white British and 11% of respondents considered that they had a disability.

Over 50% of respondents said they wanted to lose over a stone in weight. Nearly 50% gave the reason that they wanted to feel better about themselves and 40% were worried about the risk to their health/wanted to have a healthier lifestyle. 48% of people stated that they are already trying to make these changes and 25% are in the early stages. The main reasons given for not being able to make changes are pressures from their job and cost.

The majority of people stated that they would like some group support. Being more active and moving more was identified as the area where most people felt they would require support. The majority said they would attend weight management support if it was free. 59% of people stated that they would travel by car and 3% (16 people) said that they were not able to travel at all. The least common way that people stated they wanted to receive support was telephone and on-line support. All groups were in favour of attending leisure facilities such as gyms and swimming pools.

The majority of people stated that they wanted to be able to cycle or walk near where they live, however, this was reported more in the older age groups. All groups stated that they thought providing advice on healthy eating was important, this was most apparent in the 76+ age group. A significant minority of people did not believe that sport was important.

We specifically asked questions on what the public's view was on healthy walks, food champions and health trainers .The majority of respondents were in favour of these interventions.

We also asked a specific question about whether providing weight management classes for pregnant women was important and the majority of all groups were in agreement, although 30% of men reported not knowing.

Nearly 80% of respondents were in favour of receiving information about exercise classes suggested by a GP.

Finally we asked the public where they would like to receive information about services. 82% were in agreement with having a Kent-wide website advertising a range of services, 82% were in agreement with having a web-site specifically for healthy weight related information. 64% were in agreement with having a page on the Kent County Council website. 80% said they would like to see leaflets in a range of settings including libraries and GP surgeries. 77% would like information provided by a GP, pharmacist or other health professional.

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	14/00148

For publication

Subject: Contract Extension for Kent Community Health Trust – Healthy Weight Service

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that the County Council extend the contracts for Tier 1 and Tier 2 weight management services to 31st January 2016 (including the contract with Kent Community Health NHS Trust (KCHT) to deliver the Healthy Weight service until 31st January 2016), pending competitive tender of the Healthy Weight service.

Reason(s) for decision:
Decision exceeds key decision financial criteria

Cabinet Committee recommendations and other consultation:
The Adult Social Care & Health Cabinet Committee will consider the matter at its meeting of 4th December 2014

Any alternatives considered:
An earlier competitive tendering process was considered, but for the reasons outlined in the accompanying report this was not followed

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

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signed

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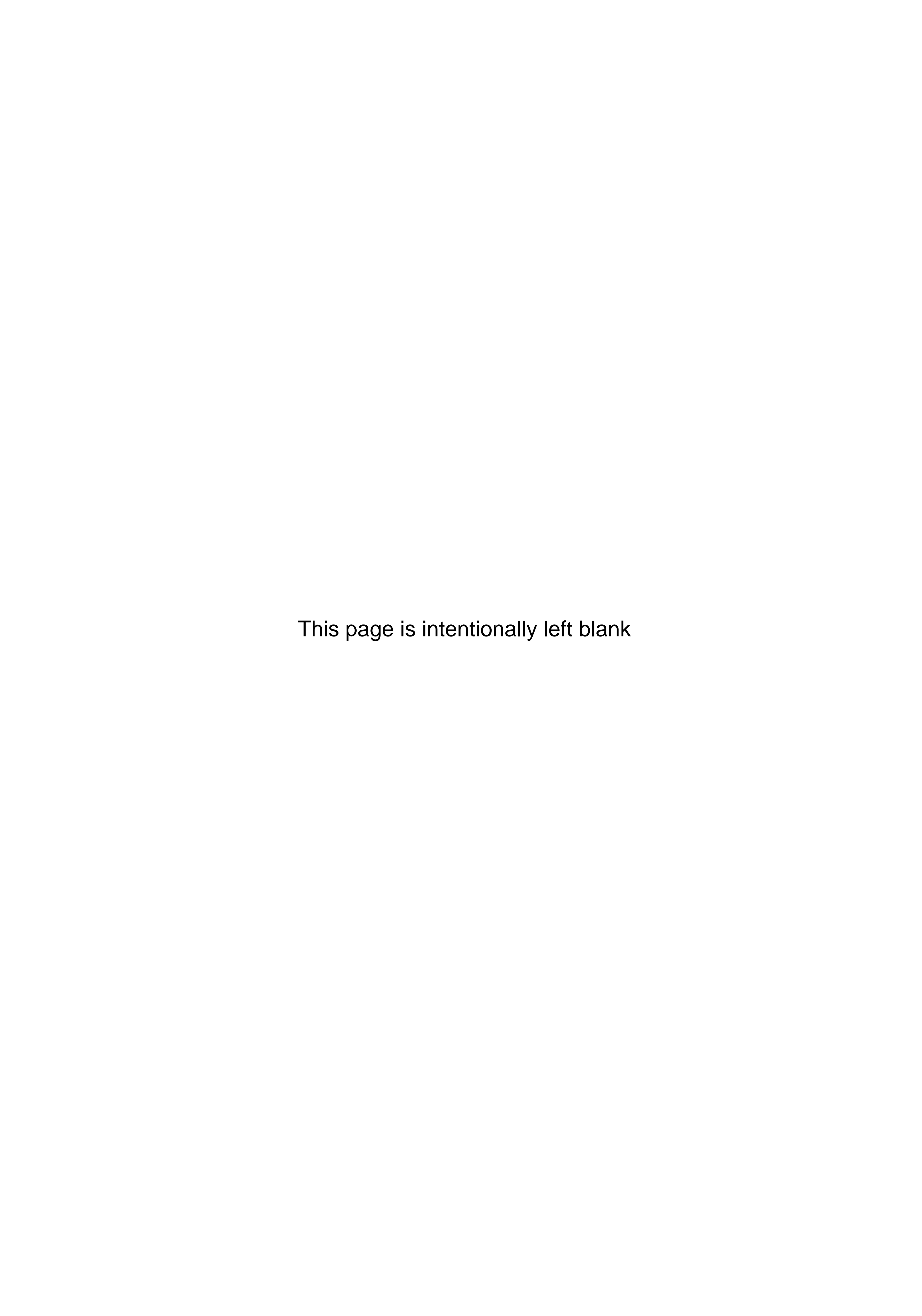
date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By: Graham Gibbens
Cabinet Member, Adult Social Care and Public Health

Andrew Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee

4th December 2014

Subject: Tendering outcome for Community Sexual Health Services

Classification: Unrestricted

Decision No.: 14/00143

Past pathway: This is the first committee by which this issue will be considered.

Future pathway: Key decision by Cabinet Member

Electoral Division: All

Summary
The initial round of competitive tendering for the community sexual health services has now concluded following the committee's approval of the key decision in May 2014. Four contracts have been awarded to Kent Community Health NHS Trust and Metro who submitted the highest scoring bids. The outcome of the subsequent round of tendering for the remaining services is presented in the accompanying exempt report.

Members of the Committee are asked to:

i. Note the identity of the providers that have been awarded sexual health service contracts in the first round of tendering (Lots 3 to 6)

ii. to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Adult Social Care and Public Health, to award contracts to the bidders identified in the accompanying exempt report, to deliver Community Sexual Health services

1. Introduction

1.1. The purpose of this paper is to provide details of the outcome of the procurement process for community sexual health services in Kent, which was approved by the committee in May 2014. The results of a subsequent round of tendering for sexual health services for lots 1 and 2 are still commercially sensitive and are therefore presented in the accompanying exempt report.

2. Background

2.1. In May 2014, the committee approved a proposal to award contracts for community sexual health services following a competitive tendering process for seven service lots.

3. Procurement Process

3.1. The tender evaluation process resulted in contracts being awarded for Lots 3, 4, 5 and 6, as outlined in the table below:

Contract	Successful provider
Lot 3. Psychosexual counselling services	➢ Kent Community Health Trust
Lot 4. Community Pharmacy co-ordination service	➢ Kent Community Health Trust (in partnership with Kent Community Pharmacy Partnership)
Lot 5. Co-ordination and monitoring of Chlamydia Screening Programme	➢ Kent Community Health Trust (in partnership with Terrence Higgins Trust)
Lot 6. Free Condom programme	➢ Metro (in partnership with University of Greenwich)

3.2. The evaluation panel concluded that none of the bids received for the remaining three lots (listed below) were suitable:

- Lot 1. Genito-urinary Medicine Service (GUM) with Contraception and Sexual Health Services (CASH)
- Lot 2. Young People's Sexual Health Services
- Lot 7. The Establishment and Facilitation of a Clinical Network in Kent

3.3. Public Health and KCC Procurement had a number of detailed discussions with the unsuccessful bidders, with a view to revising the service specifications and re-issuing invitations to tender.

3.4. Several bidders provided very detailed feedback which was incorporated in new specifications for the following two new service lots:

- Lot 1. North and West Kent
- Lot 2. East Kent

3.5. This change also provided the opportunity to incorporate requirements for HIV outpatient services and cervical screening (currently commissioned by NHS England) in line with recent national guidance on sexual health service commissioning. The

requirement for a clinical network (previously Lot 7) has been incorporated into the revised requirements for Lots 1 and 2.

3.6. Tenders for these revised lots were submitted on 31st October 2014 and have been evaluated by a panel of commissioners from KCC and NHS England. The outcome of the tender evaluation is presented in a separate exempt report.

4. Financial Implications

4.1. The maximum combined value of the four contracts that have been awarded will be £2,654,680 over two years. Payments will depend on activity and volume, so the actual amounts paid may be lower.

4.2. A maximum annual budget of £8.5m (including a notional allocation for treatment) has been set for remaining services lots.

5. Conclusion

5.1. The procurement process for community sexual health services has resulted in contracts being awarded for three lots (3, 4, 5 and 6). Public Health reconfigured the service specifications for lots 1 and 2 and incorporated the former lot 7 as no suitable bids were submitted in the first round. This second process has now concluded and the successful bidders are identified in a separate exempt report to the committee.

5.2. The decision to award the contracts for lots 1 and 2 will be a key decision for the Cabinet Member for Adult Social Care and Public Health, following the committee on 4th December , and taking into account any comments made at that meeting.

6. Recommendations

6.1. Members of the Committee are asked to

i. Note the identity of the providers that have been awarded sexual health service contracts in the first round of tendering (lots 3-6)

ii. to consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member for Adult Social Care and Public Health, to award contracts to the bidders identified in the accompanying exempt report, to deliver Community Sexual Health services

Background documents

Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV, Public Health England, September 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351123/Making_it_work_FINAL_full_report.pdf

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	14/00143

For publication

Subject: Contract Awards for Community Sexual Health Services

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that Kent County Council to enter into a contract with the organisations, as named in the accompanying exempt report, to deliver Community Sexual Health Services for the administrative area of Kent County Council.

Reason(s) for decision:
Financial

Cabinet Committee recommendations and other consultation:

The Social Care and Public Health Cabinet Committee agreed to support the tendering exercise at their meeting of 4th October 2013. An update on progress of the tender exercise, and the decision to award Lots 3-6, was discussed at the 2nd May meeting of the Adult Social Care and Health Cabinet Committee.

The proposal to award Lots 1 and 2 will be discussed by the Adult Social Care and Health Cabinet Committee at its meeting of 4th December 2014

Other consultation planned or undertaken:
A service review and stakeholder consultation and market engagement exercise was undertaken in 2013.

Any alternatives considered:
A competitive tendering exercise is underway

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

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signed

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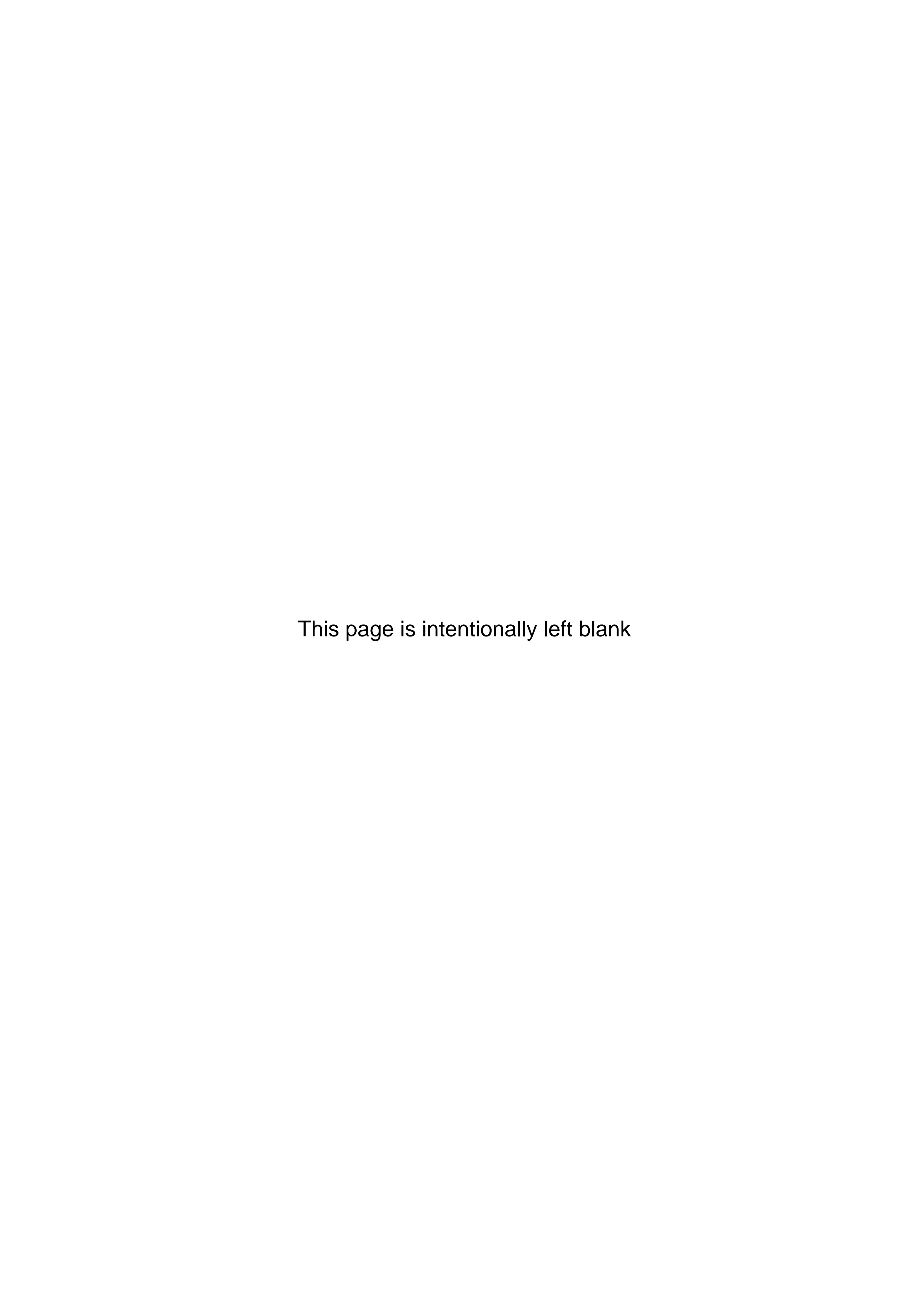
date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From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee

4th December 2014

Subject: Extending the Current Contract for Health Trainers by Nine Months (from March 2015 to January 2016).

Classification: Unrestricted

Decision No.: 14/00147

Past pathway: This is the first committee by which this issue will be considered.

Future pathway: Key decision by Cabinet Member.

Electoral Division: All

Summary:

This paper presents the case to extend the current service contract for Health Trainers (currently with Kent Community Health Trust) by nine months. The current contract runs to the end of March 2015. This is proposed because there are concurrent commissioning intentions and potential alignments that exist within Adult Social Care and Clinical Commissioning Groups (CCGs).

However Adult Social Care and CCGs have not yet finished their scoping and service design. Therefore, extending the current contract will give the benefit of easier alignment when the models of social care and well-being via a range of identified community ‘agents’ are in place. It will also enable Public Health to co-design the service together with other health and social care commissioners and get better value for the existing contracts.

Recommendation(s):

The Adults Social Care and Health Cabinet Committee is asked to comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contract with Kent Community Health Trust to 31st January 2016

1.0 Introduction - The Value of the Health Trainer Service

1.1 Health Trainers are a key front-line public health workforce. They are often members of a community of people with poor health outcomes. They have been trained in basic health and behaviour change skills (somewhat like 'health coaches') and accredited to City and Guilds Level 3. They gain the trust of local people and work with them to reach their health goals, such as quitting smoking, losing weight or reducing alcohol intake.

1.2 The current contract is a historical one that rests with Kent Community Health Trust. It has the block contract value of £1,462,000 per year although this will be reviewed for 2015/16, in line with established workforce numbers and hours of delivery. Currently, this buys approximately 30 full time equivalent Health Trainers together with area-based Co-ordinators and a service management structure linked to related Health Improvement programmes (although numbers of workers are greater due to the fact that many are part-time). It is the view of public health commissioners that greater benefit can be obtained from the contract if it is understood more fully in the context of the health and social care 'transformation agenda'. Local Clinical Commissioning Groups are also keen to co-design the Health Trainer role to tackle the health inequalities within their populations.

1.3 Currently Health Trainers are viewed by many partners and the public as a key public health workforce but the circa. £1.5 million pound contract is currently only buying 30 front-line FTE Health Trainers across Kent. Therefore they are delivering good outcomes but to relatively few people. KCHT also currently deploy Health Trainer staff in conjunction with the NHS Health Check outreach Programme. There is an opportunity to re-model and add value to this service.

2.0 Ensuring that the Right Model of Health Trainers is in place

2.1 It is the intention of the Public health Commissioning team to review the Health Trainer role, taking into account the following commissioning priorities:

- CCG 'Better Care' and Integrated Care Teams – to tackle health inequalities proactively and systematically;
- Social Care Transformation and Care Navigators – to ensure that people understand how to self-care and are properly signposted to the right service. There is a review taking place to understand the many commissioned posts across KCC which have 'care navigation' within their remit;
- Asset Mapping and Community asset development – with the reduction of funds in the public sector, a review of local community assets and infrastructure is taking place alongside local districts;
- Public Health commissioning is also reviewing the links between obesity, mental health, substance misuse and other risk-taking behaviours in order to make the best use of the public health grant;

Industrialisation of the Health Trainer role may be a far better and cost effective way to deliver systematic health improvement across Kent. If all front line 'care

navigators' have a health trainer/ health coaching approach – this would mean far more than simply 30 whole-time equivalents taking on this role.

3.0 Time Frames and Options

3.1 Time frames for commissioning.

- The work outlined above is not yet finished. This paper proposes that the service contract with the current provider be extended from March 2015 to the end of January 2016;
- This will require the contract to be tendered in April/May 2015;
- The results of the Social Care review of Health navigators is likely to be available in March/April 2015;
- By March/ April 2015, discussions with the CCGs on the design of the integrated care organisations will also be clearer and will have had time to mature;
- This will then enable sufficient time to design a better model of Health Trainers, assess value for money, carry out stakeholder and public consultation and develop the potential provider market.

Conclusion

Options

A. Keep to existing contract time scales and start tender process immediately, ready to deliver a new service to start in April 2015.

- Benefits : The current contract is re-tendered quickly in line with existing time frames with new contract in place by March 2015.
- Risks: There is no opportunity to redesign the service or test the market, and a similar service is procured.

B. Extend current contract to the end of January 2016 in order to have time to incorporate KCC reviews and evidence and to co-design the service with CCGs and other social care commissioners.

- Benefits: The service will be enhanced and take into account health system needs and be part of the wider integration of health and social care.
- Risks: The current service may be destabilised with the skills and experience of trained community health champions and health coaches lost or subject to complex TUPE processes.

These risks will be mitigated through carefully planned market development work and consultation, including co –design with CCGs, so that local expertise is retained.

Recommendations:

The Adult Social Care and Health Cabinet Committee is asked to comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the contract with Kent Community Health Trust to 31st January 2016.

Background documents: none

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	14/00147

For publication

Subject: Contract Extension for Kent Community Health Trust – Health Trainers Service

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that the County Council extend the current contract with Kent Community Health NHS Trust (KCHT) to deliver the Health Trainers service until 31st January 2016, pending competitive tender of the Health Trainers service.

Reason(s) for decision:
Decision exceeds key decision financial criteria

Cabinet Committee recommendations and other consultation:
The Adult Social Care & Health Cabinet Committee will consider the matter at its meeting of 4th December 2014

Any alternatives considered:
An earlier competitive tendering process was considered, but for the reasons outlined in the accompanying report this was not followed

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

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signed

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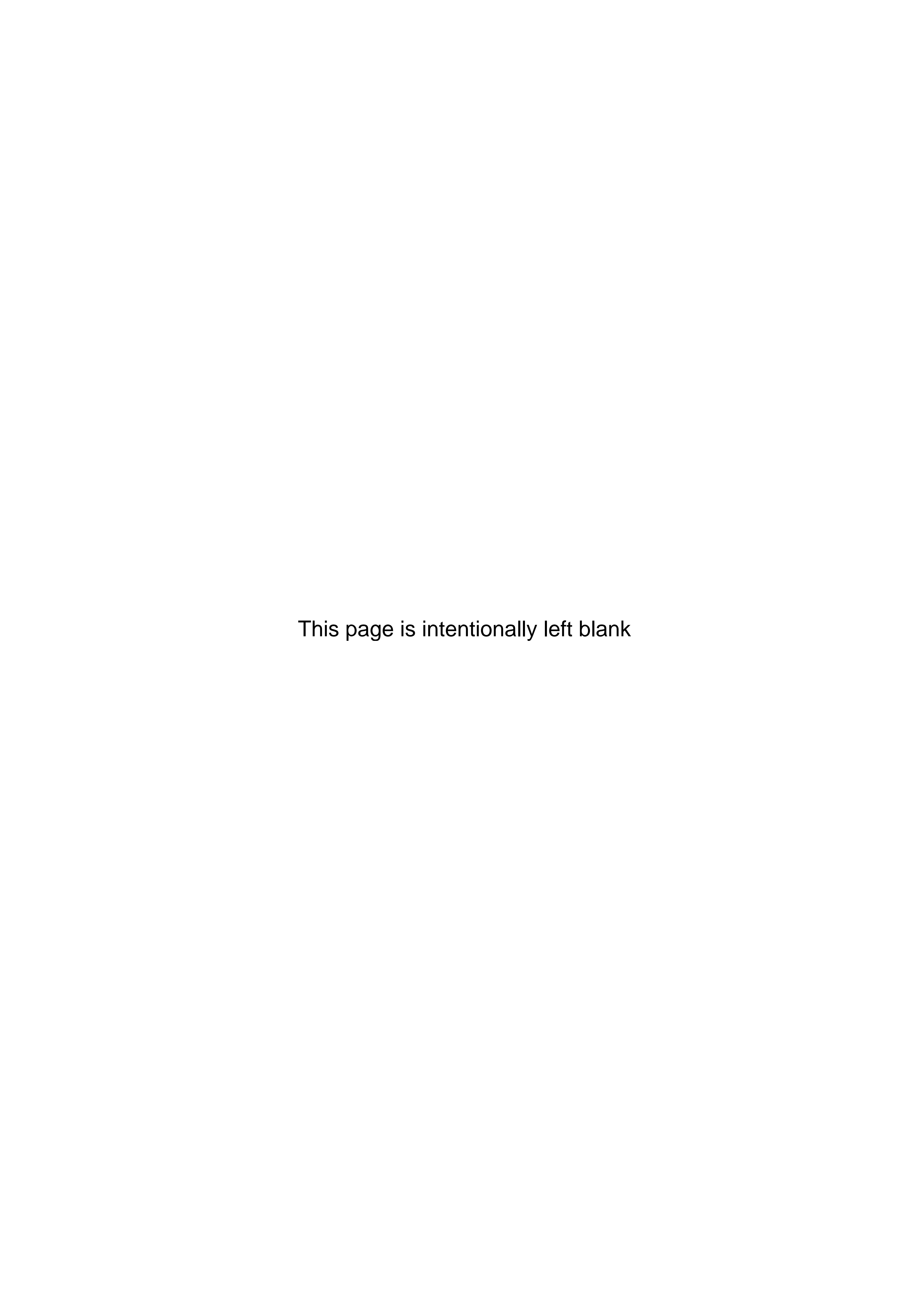
date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From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

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

Decision No **14/00138**

To: Adult Social Care and Health Cabinet Committee - 4 December 2014

Subject: **LOCAL WELFARE ASSISTANCE FUTURE OPTIONS**

Classification: Unrestricted

Past Pathway: Adults Transformation Board – 22 Oct 14
CMT – 11 Nov 14
Cabinet – 1 Dec 14

Future Pathway: Recommendation report to Cabinet Member

Electoral Division: All

Summary: This paper sets out information about the council's local welfare assistance programme Kent Support & Assistance Service (KSAS). This discretionary service provides essential items for vulnerable groups facing exceptional pressure because of an emergency or crisis. The paper seeks discussion about future options for local welfare provision in advance of more detailed work.

FOR DECISION

The Cabinet Committee is asked:
a) To CONSIDER and DISCUSS the future of local welfare assistance in the context of the options explored
b) To ENDORSE option 3 for further work and development of a full business case with a view to future decision by the Cabinet Member.

Introduction

1. (1) In response to the report submitted to the Cabinet Committee in July 2014 about the future of the Kent Support and Assistance Service (KSAS), further investigation of future options for the service have been explored.

(2) This report provides evidence about the existing. It provides key information to enable decision makers give a view about any future iterations of a local assistance service in Kent and the merits of this kind of provision.

(3) Extensive evidence has been gathered to support the exploration of these options and this is available in Appendix 1.

(4) Whilst the county council does not have a statutory obligation to continue with this provision, it is clear that for the most vulnerable families there are not

alternative sources of help for some elements of the service that may be required e.g. energy. Any absence of this help would prompt an increase in demand in statutory services such as adults' and children's' social care.

(5) Any future provision must continue to be auditable and deliver a strong preventative benefit

(6) At the time of writing, the provision of a local welfare assistance service has no government funding from 31 March 2015. Following a legal challenge by LB Islington, the government is conducting a review of future funding arrangements. The outcome of this review is expected in time for the settlement announcement in December.

The current position

2. (1) The appendix attached describes the current model of provision and the demand experienced in the first 15 months of operation from residents who cannot access help elsewhere. It describes the assessment criteria that ensures that the service is targeted at those most in need i.e. those with children who are in need of food and emergency travel. It finds that the highest demand has been in the most deprived areas of the county.

(2) The evidence suggests that while the costs of the individual awards made to vulnerable people is low, the preventative savings to the wider authority are significant, with awards forming a fraction of the cost of statutory interventions. The service has been successful in meeting the short and medium term needs of people in crisis who otherwise would have progressed to draw on statutory services.

Future Options

3. (1) In examining options for alternative provision, the evidence finds that outside of the KSAS commissioned provision, supply for some types of award e.g. food and furniture does not match the existing and escalating need. There is no provision for emergency gas and electricity.

(2) Four options for the future were considered:-

Option 1 End the service on 31st March 2015.
It is clear that the service has already prevented the needs of many vulnerable people escalating to each statutory levels. Whilst the ending of the service would save the council money in the very short term, needs would quickly escalate. It is very likely that higher, more long term costs would be borne by statutory services within the authority i.e. within children's and adults' social care.

Option 2 Provide a further year of the service built on the coordinated model so far established. A diminution of the service would be necessary. Each diminution option presents risks to health and wellbeing of vulnerable groups. The provision of a further year of the service will raise expectations for Year 4 and may further the council's difficulty in considering future options.

Option 3 Commissioning service delivery. This model enables the council to continue to commission a coordination, advice and guidance service that would link people to their local communities. The service would connect local voluntary groups, organisations and community agents together and build on community capacity, linking and building upon the work already being undertaken within Kent in this regard. The provision of goods and services could be scaled according to funding commitment available. Grants could be made available to local voluntary organisations. Performance indicators would enable the county council to see the effectiveness its investment in the service. This model would enable the council to deliver on its ambitions to be a strategic commissioned authority whilst empowering and supporting the third sector to become suppliers, delivering outcomes detailed in a specification. This tailored approach would become self-sustaining within 4 years.

Option 4 Grant fund to voluntary organisations. This option is unlikely to deliver the current outcomes as it is uncoordinated and piecemeal. As shown in Appendix 1 coverage and capacity of existing charities is inequitable cannot meet the demand. The level of funding is likely to be restricted to the level of underspend within the current service and this would be insufficient to have any real impact once diluted countywide.

Policy Context

3. (1) The Government devolved responsibility for the Social Fund to local authorities in April 2013. The funding stream for welfare provision was not ring-fenced and current central government funding is at the present time intended to cease at the end of the financial year 2014/15. The outcome of the government's funding review is not due until December.

(2) The continuation of a support and assistance service is at the discretion of each local authority. Consultation with other local authorities suggests that whilst a small number have taken the step to cease the service, others have secured funding to retain it and most continue to explore options to do so.

(3) There is a possibility that following its review, government may choose to reinstate the ring-fence to local welfare assistance by top slicing the general grant. Whilst the level of funding within that ring-fence cannot be known it is unlikely that this will exceed the level of spend for 14/15. Should the government decide to fund provision in this way the council will face decisions about how to deal with the subsequent pressure on its budget.

Financial Implications

4. (1) The current (14/15) funding from central government is as follows
   - £2,863,798 for awards
   - £554, 678 for administration

(2) The most recent forecast shows running costs for the service is as follows
   - £1,897,000 for awards
   - £549,300 for administration

(3) The budget is currently underspent by £2.69m, which includes an amount of £1.722m rolled forward from 2013/14.

Recommendations

5. The Cabinet Committee is asked:

    a) To CONSIDER and DISCUSS the future of local welfare assistance in the context of the options explored
    b) To ENDORSE option 3 for further work and development of a full business case with a view to future decision by the Cabinet Member.

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Background Information:
CMM Report July 2014
KSAS Evaluation Report June 2014

Appendix A Evidence Base
Appendix B Case Histories

Appendix A KSAS Future Options Evidence Base

Authored by the Kent Support and Assistance Service,
Commissioned Services, Health & Social Care Directorate
V5
9/30/2014

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Executive Summary

This report provides evidence about the existing form, function and operation of the Kent Support and Assistance Service. It provides key information to enable decision makers to form a view about any future iterations of a local assistance service in Kent and the merits of this kind of provision.

The report sheds light on the current model of provision and the demand experienced in the first 15 months of operation from residents who cannot access help elsewhere. It describes the assessment criteria that ensures that the service is targeted at those most in need i.e. those with children who are in need of food and emergency travel. It finds that the highest demand has been in the most deprived areas of the county. Demand for food and energy are the most frequent awards requested, but among the cheapest to deliver.

The evidence suggests that while the costs of the individual awards made to vulnerable people is low, the preventative savings to the wider authority are significant, with awards forming a fraction of the cost of statutory interventions. The service has been successful in meeting the short and medium term needs of people in crisis who otherwise would have progressed to draw on statutory services and resources such as those under Section 17.

In examining options for alternative provision, it finds that outside of the KSAS commissioned provision, supply for some types of award e.g. food and furniture does not match the existing and escalating need. There is no provision for emergency gas and electricity.

In examining the three options of a future for the service it finds:-

Option 1 Using the underspend to provide a further year of the service. A diminution of the service would be necessary. Each diminution option presents risks to health and wellbeing of vulnerable groups. The provision of a further year of the service will raise expectations for Year 4 and may further the council's difficulty in considering future options.

Option 2 Commissioning service delivery. This model enables the council to deliver on its ambitions to be a strategic commissioned authority whilst empowering and supporting the third sector to become suppliers delivering outcomes detailed in a specification. This tailored approach would become self-sustaining within 4 years.

Option 3 Grant fund to voluntary organisations. This option is unlikely to deliver the current outcomes. Coverage and capacity of existing charities is inequitable and cannot meet the demand. The level of funding proposed would be insufficient to have any real impact once diluted countywide.

1.0 Overview of the Kent Support and Assistance Service (KSAS)

The Kent Support and Assistance Service went live on April 01 2013, as the discretionary elements of the Department of Work and Pensions' (DWP) Social Fund (Crisis Loans and Community Care Grants) were ceased and responsibility for local welfare assistance was devolved to local authorities. The county council's discretionary service differs substantially from the DWP scheme which simply offered cash to all applicants, the majority of whom were single people under 35. For those in crisis or emergency, the council's KSAS scheme seeks to offer to Kent residents advice and support in their own community to alleviate their difficulty.

The grant funding awarded to the county council to devise and run a local service was as follows:-

2013/14: Administration £605,142
Grants £2,863,798

2014/15: Administration £554,678
Grants £2,863,798

Specialist, trained advisors connect enquirers to the sources of support and help to which they are eligible, including signposting to Jobcentre Plus, referrals to housing support or linking enquirers with local voluntary support groups. Where there is no other recourse to help, the service offers assistance with the goods they need. The service is accessible online or by phone and supports Kent households in a crisis and

- Enables people to move back into the community from institutional care or step down from intensive supportive settings.
- Prevents from moving into institutionalised support or care.
- De-escalates crisis or emergency and dependence on statutory services.

The council has adopted a mixed economy approach to commissioning its local welfare assistance programme. The KSAS operational team was commissioned internally from Contact Point and have specialist training in benefits advice and signposting to relevant agencies to tackle the root causes of customer difficulty and prevent recurrence. The KSAS staff have access to KCC's internal recording systems such as Liberia and Swift and to the DWP benefit data, CIS.

The KSAS offer comprises:-

- **Furniture and equipment** - provided by a consortium of reuse social enterprise, led by West Kent Extra;
- **Food and welfare items** - 7 day parcels of nutritionally balanced food and welfare items such as soap, washing powder and sanitary items, provided by ASDA supermarkets
- **Energy vouchers** - provided by PayPoint for 7 day emergency supply of gas/electricity
- **Emergency cash awards** - for those at immediate risk of harm these are supplied by PayPoint and rarely provided.

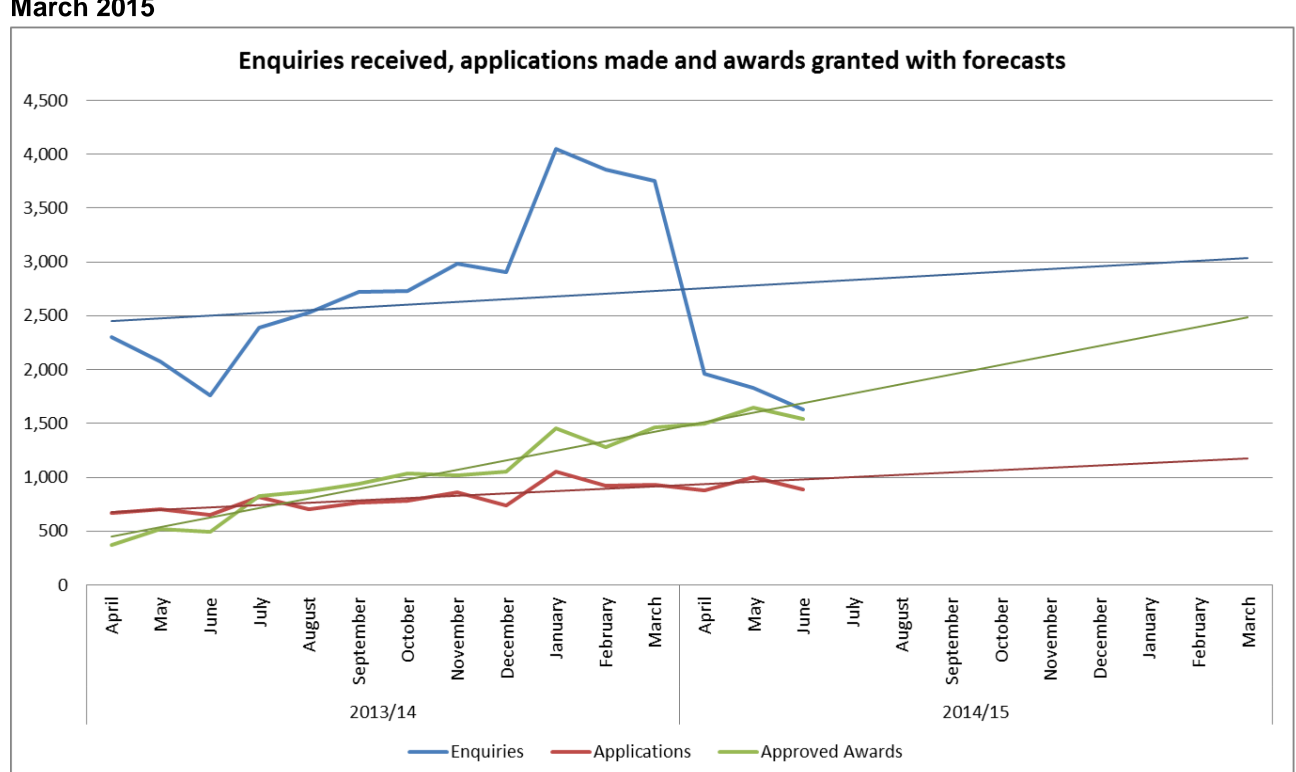
All the awards are specific to the customers' needs and uniquely deal with immediacy of need not provided elsewhere.

Vulnerable households in crisis or emergency can be offered a single or combination of awards to support them through their crisis and prevent future escalation of their needs. In its first year of operation, KSAS received over **34,000** enquiries, **9,600** applications and approved **6,133** awards. The value of awards given to households was **£1,140,911**.

As the service has continued into 2014/15, records show an increase in the number of applications received on the previous year and a significant increase in the number of awards being approved, as more relevant applications are received. Forecasts predict further rises as the financial year progresses.

As **Figure 1** shows, towards the end of this financial year, there are expected to be approximately 3,000 enquiries received, 1,200 applications made and 2,500 awards approved each month.

Figure 1: Enquiries received, applications made and awards granted with forecasts: April 2013 to March 2015



2.0 Who uses KSAS?

The customer demographic differs substantially from those using the DWP scheme. In Quarter 1 of 2014/15, KSAS helped 2,055 separate vulnerable households, half of whom (53%) lived with children. It helped 768 people with physical disabilities and 611 with mental health problems.

There are a range of circumstances that lead individuals to contact KSAS for support. In many cases residents approach the service for advice and can be signposted to supporting agencies or alternative sources of help such as DWP Budgeting Loans or Short Term Advances. Where the candidate is ineligible for other sources of help, an application can be made. An applicant may be fleeing domestic abuse or experiencing exceptional pressure because of an emergency or crisis such as fire or flood. They may also be in need of support to move on into, return to, or stay in, the community rather than remaining or entering a care or institutional setting. Awards are both *reactive* in alleviating an immediate short-term need and *preventative*, to prevent the further escalation of support required by statutory services and the resulting costs incurred.

A sample examination of the 911 applications received for June 2014 suggests that almost 80% of households applying for support through KSAS are otherwise unknown to KCC. KSAS plays a significant role in providing preventative support to these applicants, granting awards and signposting to help in their own communities to enable them to remain independent and less likely to require statutory services in future.

Figure 2 provides a breakdown of the number and proportion of the 21% of applicants who applied to KSAS in June and were already known to KCC services. As the chart shows, of these the majority (17%) were known to Children Social Services.

Figure 2: KSAS applicants otherwise known to Kent County Council: June 2014

Of the 481 children in the above households, 155 were known to Children Social Services. Of these, 124 were seeking support with food and energy. There were 171 applications from households with disabilities and 145 with mental health problems; of these 38 households were known to Adult Social Services.

The geographic demand for the KSAS service is shown below:

Figure 3: KSAS demand across Kent, April 2013 to March 2014

Figure 3 highlights hotspot areas of demand for the KSAS service, with those making the highest number of awards being represented in red. Those placing a lower demand on the KSAS service are represented in dark blue.

N.B. Although Medway is one of the areas showing demand, this relates to 10 awards to eligible Kent residents who were being re-housed from Districts across Kent into accommodation in Medway.

An overview of demand by district is provided in **Appendix 2** of this report.

3.0 Targeting those most in need

The service employs an assessment matrix that enables fair and consistent access to awards and ensures the service directs its resource to those in highest and most urgent need. The assessment matrix balances the risk in the household against the nature of the need within it, according to prescribed criteria. The scores are aggregated to arrive at priority rating for award.

The assessment matrix is shown in **Figure 4** below. The highest household risk categories are shown in red; the highest need scores are similarly shown in red.

Figure 4

Does the household need:-

Does the household include:-	Food	Energy	Equipment	Emergency Travel	Cookers	Clothes	Priority Rating
children aged under 5?							High
3 or more children?							High
include a disabled child?							High
child in the home							Low
person with a terminal illness							Medium
homelessness							Low
a disabled adult*							Low
young parents? [under 21]							Low
fleeing domestic abuse							High
lone parents?							Low
people over 65?							Low
pregnant women?							Low
carers?							Low
grandparents caring for children?							Medium
Risk Rating	H	M	L	H	L	L	

For example, applicants with children and those experiencing domestic abuse attract the highest household risk score; those requiring food or emergency travel attract the highest need score.

Figure 5 Priority Rating

		Household Risk		
		High	Medium	Low
Household Need	High	1 working day	Up to 4 working days	4 working days
	Medium	1 working day	Up to 4 working days	10 working days
	Low	Up to 4 Working days	10 working days	

The above risk and priority targets now form Key Performance Indicators for the service. These have been measured and reported upon since April 2014.

Analysis completed by KCC's Business Intelligence, Research and Evaluation Team identified that KSAS is attracting applications from the Mosaic groups who are in most need, and therefore the primary target for the service. Awards are also targeted to these groups.

4.0 Impact of local welfare provision

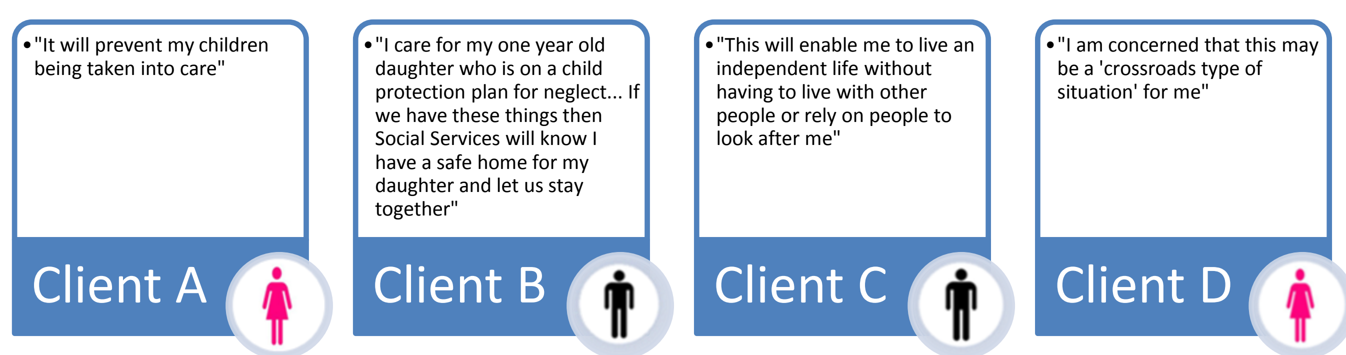
An initial Health Inequality Assessment has indicated an impact on a range of vulnerable groups including the young, older people, women, those in areas of highest multiple deprivation indices, those in poor physical or mental health, those with long term conditions, those experiencing violence or abuse, offenders and service veterans.

Views have been sought from a wide range of stakeholder groups such as probation, supported living services, districts and boroughs and the voluntary sector in Kent. All have expressed concern about the non-continuation of a local welfare assistance service in Kent.

Feedback from the voluntary sector indicates that they view their strength to be in working with local communities to identify needs and create innovative and low cost solutions, then lobbying or applying for funding to make it a comprehensive service. They have tailored their support to people who fell outside that original DWP remit.

DWP and District councils have stated that when faced with customers who have welfare problems, children in need, adult disabilities etc. that they would normally signpost to the council's welfare service, KSAS. In the absence of a local welfare assistance service, they will continue to either signpost to the county council or treat as a safeguarding referral.

Quantitative evidence from KSAS customers also demonstrates the positive impact of the service. The record of KSAS customer feedback for the financial year 2013-14 shows that the overwhelming majority of comments are compliments. Feedback from KSAS customers has also indicated the longer term benefits of the scheme:



An example of a typical case history is attached at **Appendix 1.**

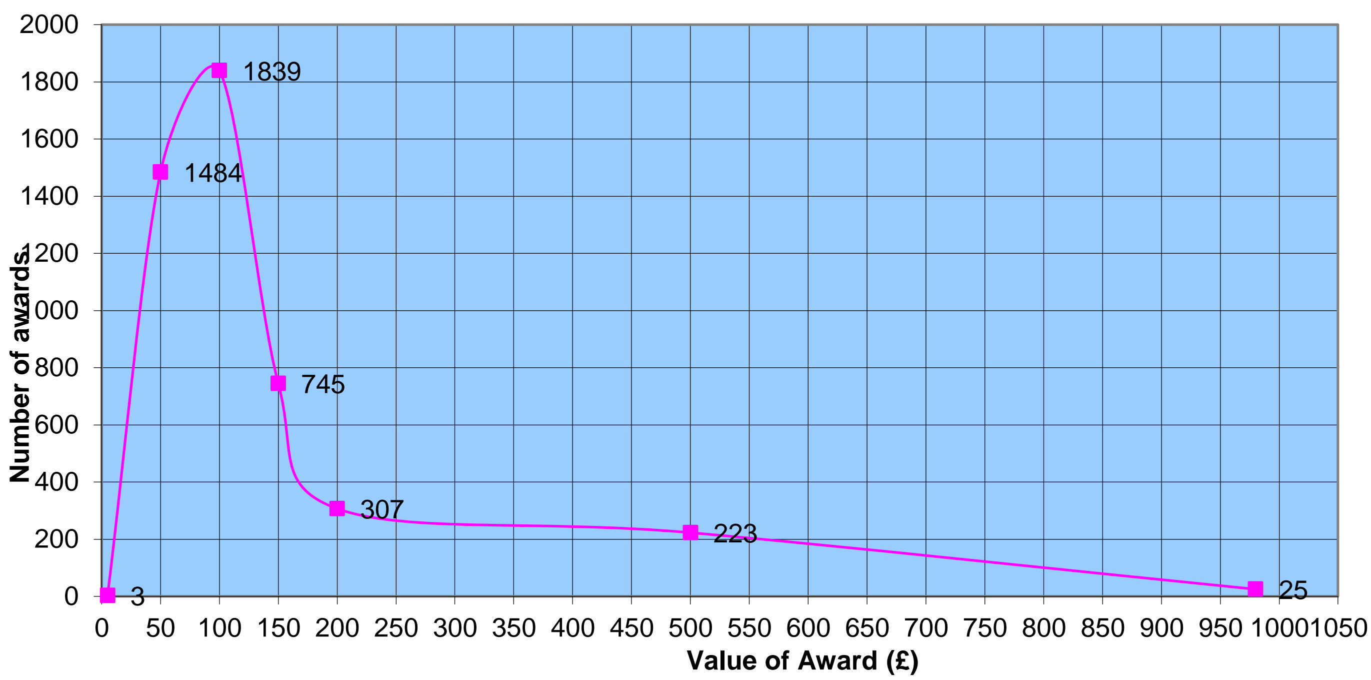
The council has a statutory responsibility to support:

1. Care Leavers and Children in Need, 16-17 year olds who are homeless
2. Families with children experiencing exceptional hardship (section 17)
3. Vulnerable adults experiencing exceptional hardship (domestic abuse victims, Mental Health, Learning Disability, Physical Disability, Older People)

KSAS has been proven to alleviate short term hardship within these client groups, preventing the need for households not known to the council to call on statutory services. It has also supported households known to the council who need immediate short term assistance.

The Personal Social Services Research Unit published a report in 2013[1] to assist those involved in health and local authority planning and commissioning with information on the costs of services. As can be seen from Figures 6, 7 and 8 below, the average cost of a KSAS unique award is far lower than a week's Social Care support provided for those with vulnerabilities, namely those with physical disabilities, mental health problems and older people, and for children. These types of clients are supported by KSAS to stay in the community and are prevented from going on to use resources of higher cost to the Council.

Figure 6: Value award: Quarter 1 2014/15



As the above chart shows 4,375 awards (95%) were valued less than £200.

[1] 'Unit Costs of Health and Social Care', 2013, Personal Social Services Research Unit (PSSRU)

Figure 7: KSAS costing vs other Children's Health and Social Care costs[2]

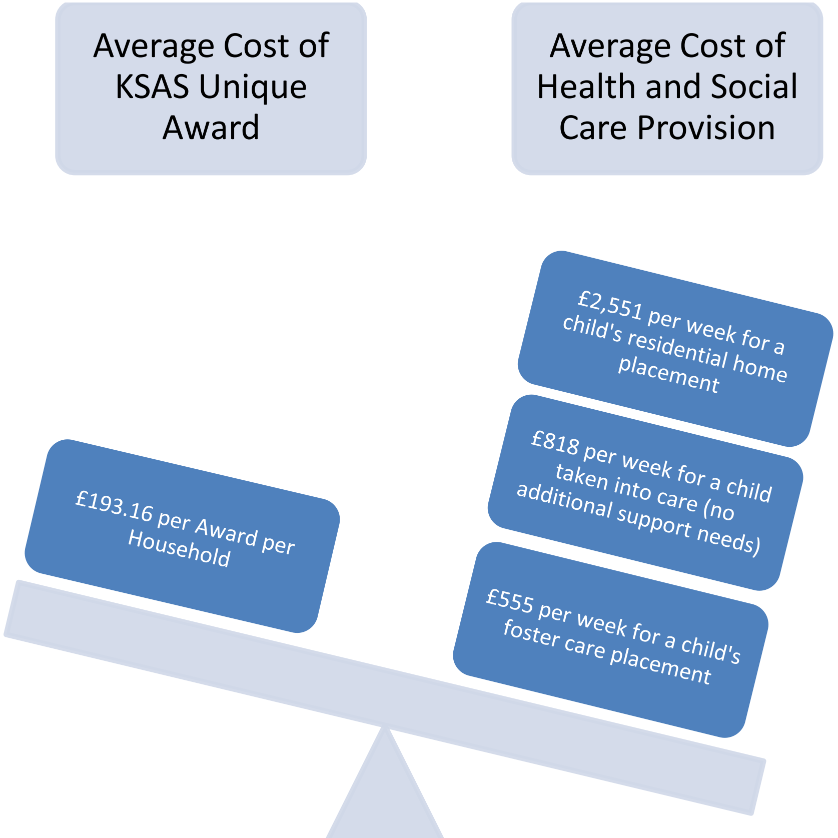
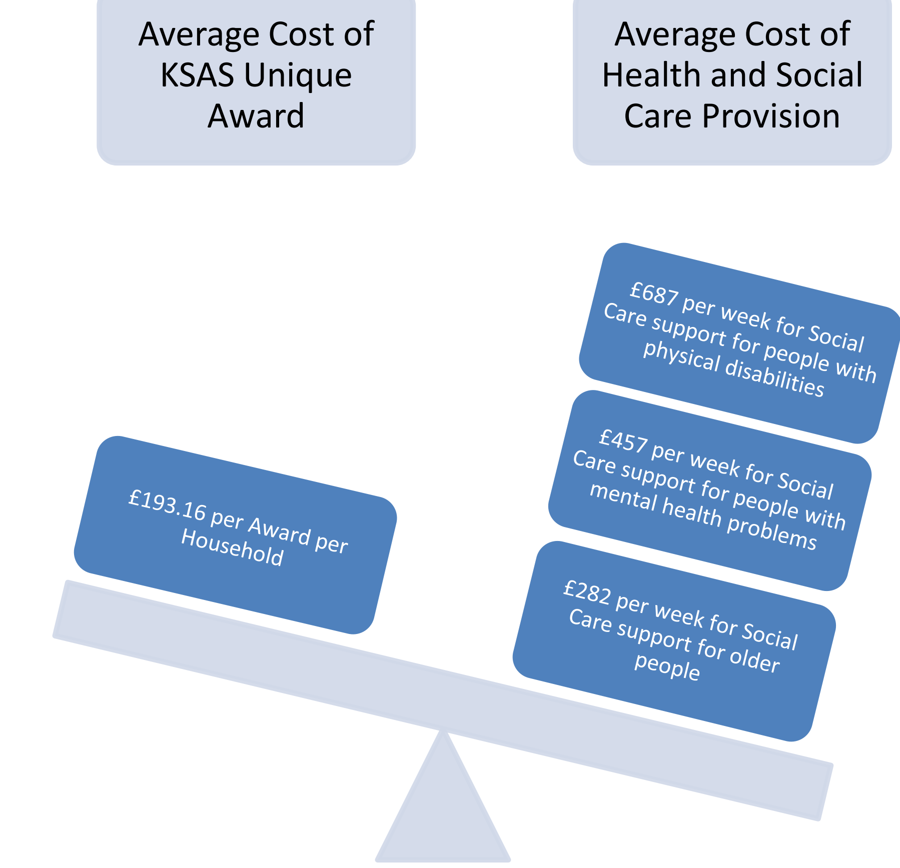


Figure 8: KSAS costing vs other Adult Health and Social Care costs[3]



[2] The care packages described are drawn from the National Evaluation of the Individual Budgets Pilot Projects (IBSEN).
[3] The care packages described are drawn from the Troubled Families Costs Database.

5.0 Options for future provision

The Government funding stream for local welfare provision is intended to cease at the end of the financial year 2014/15. The following future options are considered in greater detail in response to the Cabinet Committee in July 2014.

a) **Option 1 – Use the underspend to retain service for a further year.**

The most recent forecast (14/15) shows running costs for the service is as follows

- £1,897,000 for awards
- £549,300 for administration

The service is forecast to generate a total underspend of 2014/15 of £2.69m, which includes a rolled forward amount of £1.7m from 2013/2014. The spend on awards has increased from Year 1 to Year 2 and continues to rise in 2014/15.

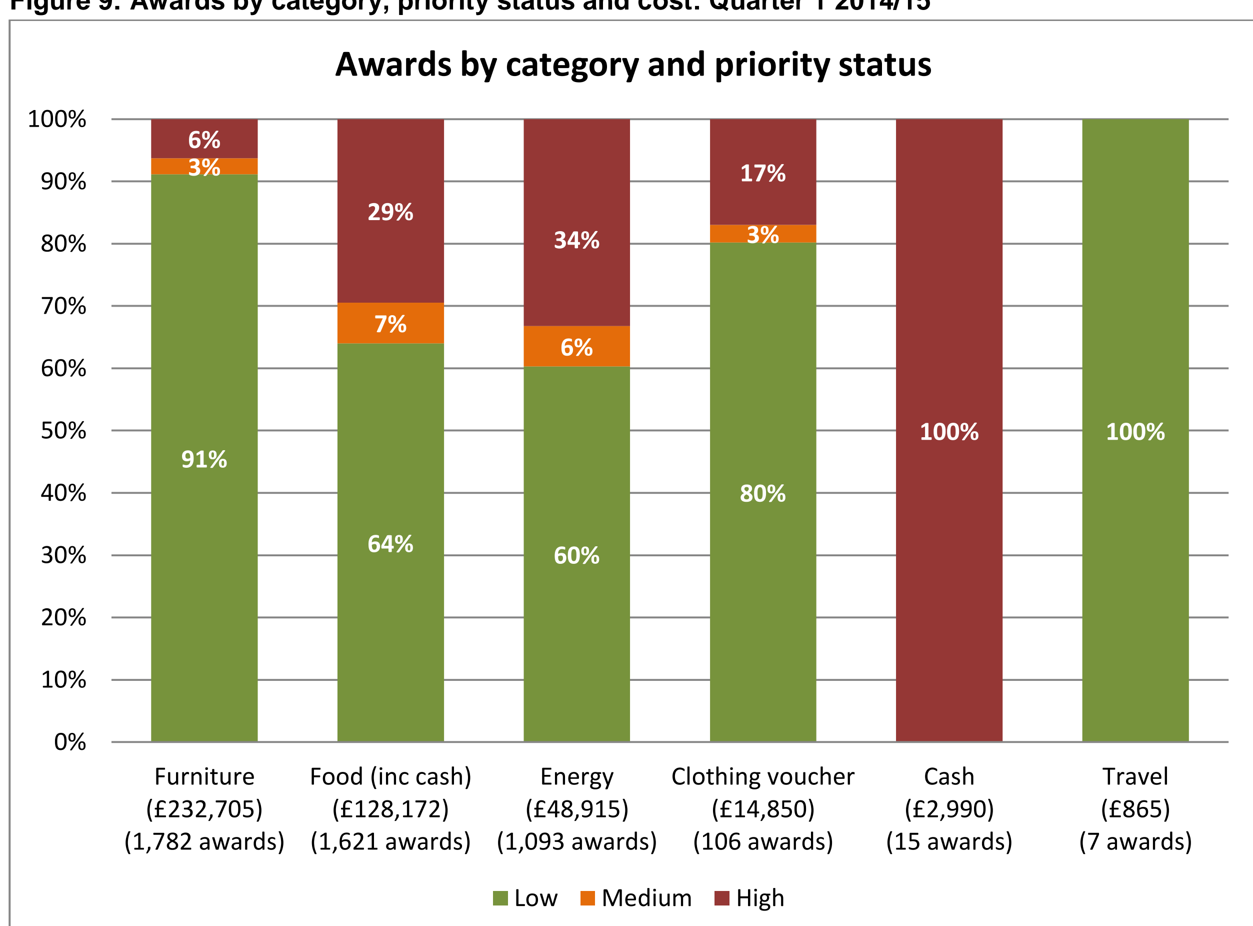
To meet future demand from this underspend, there is likely to be a need for a diminution of the current service. This section looks at current service delivery and scopes the opportunities and risks of reducing each aspect of the service.

i) **Cease provision to low priority applicants**
ii) **Removing a category of Award (Furniture, Food, Energy, Clothing, Travel)**

Context: In the first quarter of 2014/15 the total cost of awards delivered was **£428,498**. **Figure 9** illustrates an analysis of the awards made by priority status.

The figure shows that the greatest spend was made on furniture with the lowest category of priority. A greater proportion of high priority applicants were awarded food and energy, though these cost significantly less.

Figure 9: Awards by category, priority status and cost: Quarter 1 2014/15



i) - Ceasing provision to low priority applicants

Of the awards that are delivered through KSAS 30% are assigned as High or Medium risk. The priority status of awards differs between award categories with only 9% of Furniture awards assigned as high risk compared to almost 40% for both Food and Utilities.

The total cost of awards in **Quarter 1 was £433,448**. If KSAS were to restrict the provision of awards for only those banded as high or medium priority, the cost of awards, across categories, would have been reduced to **£91,991 in Quarter 1**. A review of the priority and risk may be required to include what would be considered high priority to the Council.

At present, low risk households in need of equipment would include a person over 65 in need of a cooker, a pregnant woman requiring a fridge, a carer requiring a bed.

Potential benefits

- Significant short term savings in the cost of awards

Potential risks

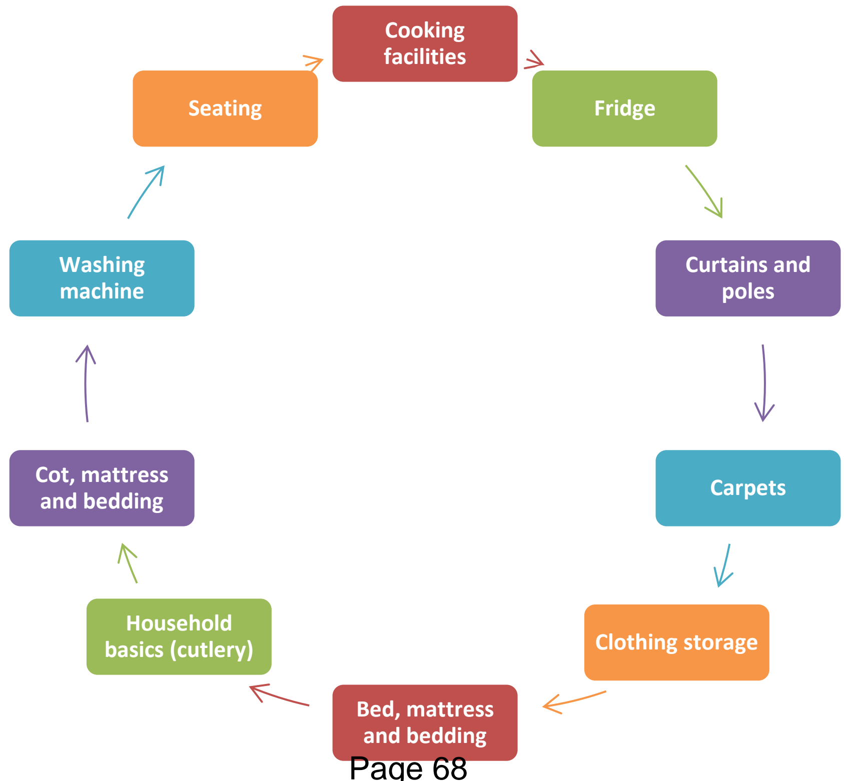
- Fewer opportunities to signpost customers to preventative/alternative services.
- Individuals assigned as low priority are unable to obtain the furniture items required e.g. cookers, fridges.
- Low risk applications escalate to high risk, duplicating administration of applications.
- Escalation of risk factors to individuals and potential for required statutory interventions.

ii) Removing a category of award

Furniture awards

Furniture awards currently account for almost 40% of all approved awards and over 50% of award expenditure. There is a wide range of items grouped within the umbrella term of furniture from fridges and washing machines to curtains and seating. **Figure 10** provides an illustration of the breadth of items that have been supplied in furniture applications.

Figure 10: Types of Furniture awards



The following quotes from applications for these awards demonstrate the need and subsequent risk, both directly and indirectly, of not providing some of these key items:

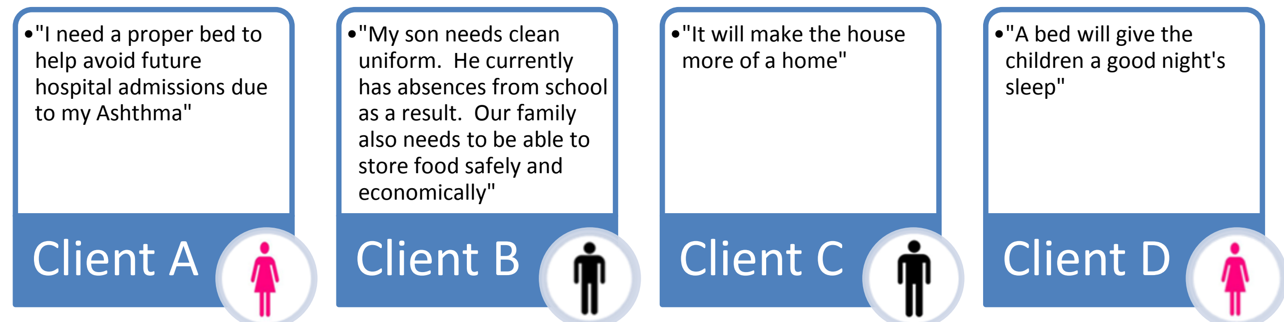
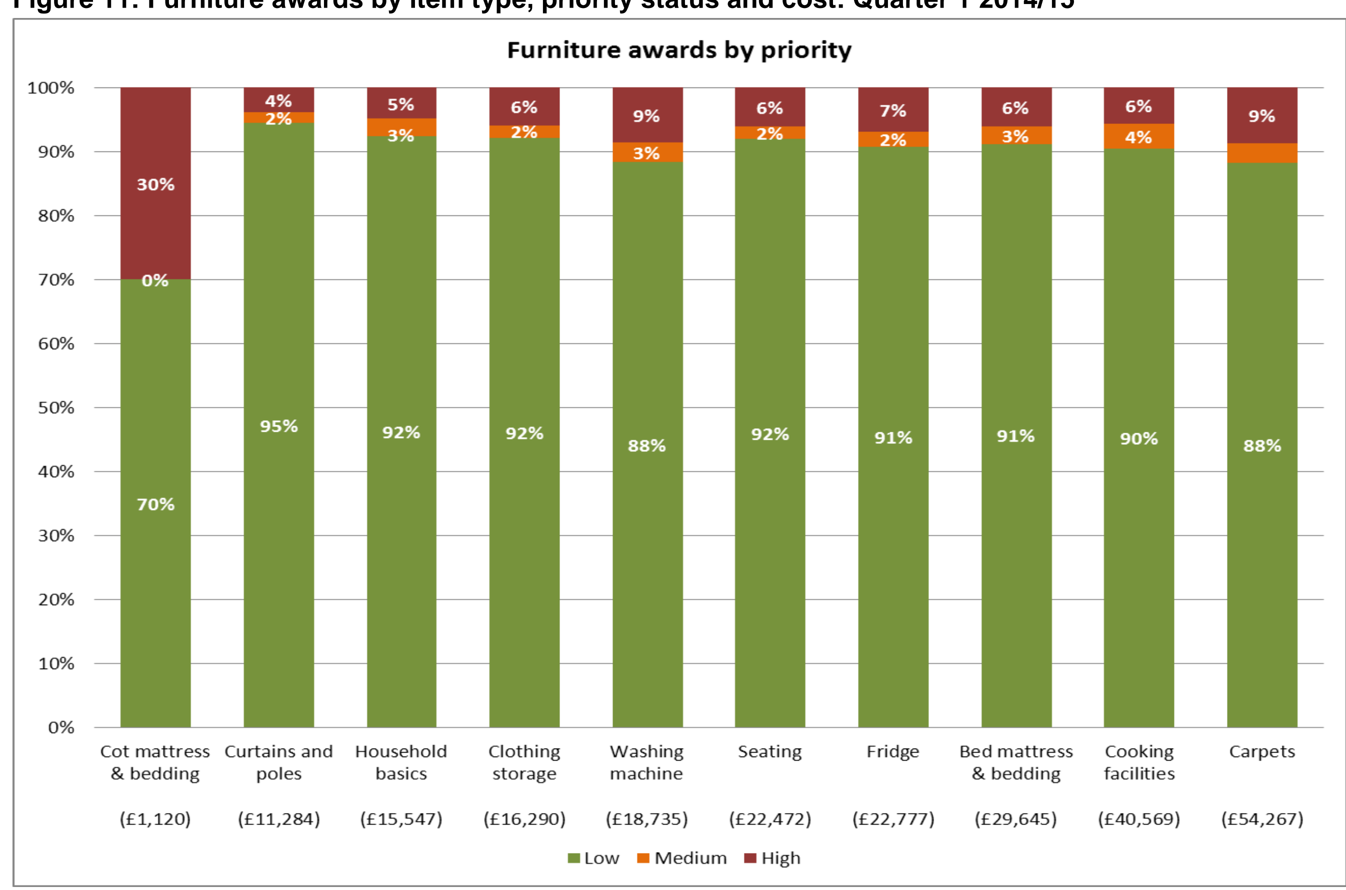
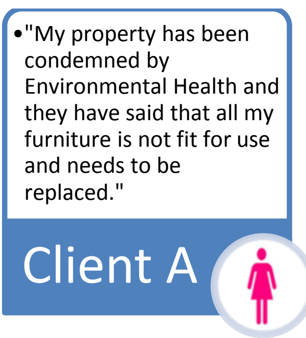


Figure 11 below indicates the proportionately high number of high priority awards for cots, cot mattresses and bedding. An elimination of the furniture category would have an impact on provision of cots, mattresses and bedding to vulnerable families. The cost of each furniture item is a further consideration. Despite cots, cot mattresses and cot bedding having the largest proportion of high priority awards, it is also the cheapest furniture item type. Carpets (including delivery and fitting) are the most expensive furniture item, costing **£54,267 in Quarter 1.** Carpets are only awarded in households where there are infants and babies or where there is a risk related to disability e.g. epilepsy.

Figure 11: Furniture awards by item type, priority status and cost: Quarter 1 2014/15



In considering the removal of this category, there will remain some vulnerable applicants in exceptional circumstances who will need items of furniture and equipment such as the below example:



Alternative supply arrangements

Under existing KSAS commissioning arrangements, successful applications for furniture and white goods are passed to West Kent Extra to coordinate the ordering and delivery of goods via a consortium of furniture reuse outlets throughout the county. The benefit of using this coordinated consortium approach is that the supply of goods is not restricted to the stock in the immediate vicinity of the application. This is of greatest benefit in areas where supply of reused items is low and cannot meet the high demand (e.g. Thanet). In these circumstances the consortium can draw on supply in other outlets. The furniture reuse sector is largely comprised of charitable organisations that generate income from their supply of furniture and household items to KSAS.

Figure 12: Furniture Re-use Outlets availability vs demand for furniture: April 2013 to March 2014

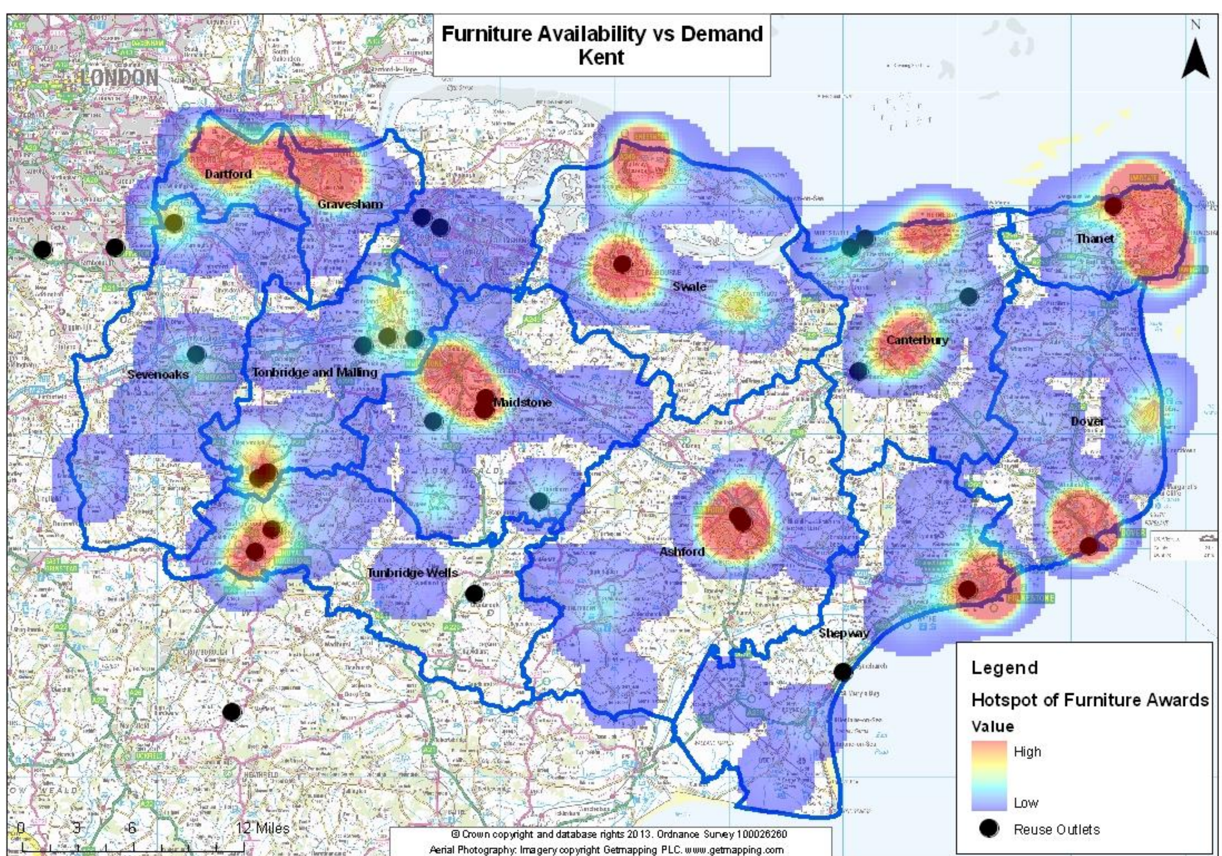


Figure 12 above highlights the areas in which approved furniture re-use outlets are currently utilised; this supply is cross-matched with a further illustration of the demand for furniture from KSAS applicants in 2013/14, shown as hotspot areas.

Whilst many of the main hotspot areas highlighted in red on the map appear to match the provision available, it is also evident that some areas of high demand do not have local provision. This includes large proportions of the Dartford and Gravesham Districts and Sheerness. Rural coverage is also sparse. The scale of demand in Thanet does not appear equally matched with the one re-use outlet currently known.

A Local Government Association report published in March 2014[4] indicates concerns about the sustainability of the reuse sector and found that

> *"price [was] the most significant motivating factor for consumers in choosing to purchase a second-hand product. This poses a challenge to reuse groups wishing to expand and which can often only raise additional revenue through increasing prices, which can undermine sales."*

The report continues to highlight the difficulties faced by reuse outlets in terms of increased demand:

> *"Voluntary and community sector and commercial organisations carrying out reuse activity often operate at the edge of viability and can find expansion and the associated increased expenditure challenging to justify."*

In the absence of a KSAS offer on furniture, local and national charities would be unable to subsidise the supply of the required items on the scale required at zero cost, as this is an important means of generating income. Households would need to source funds to purchase their own furniture and equipment through re-use outlets. Residents would also need to fund any delivery charges. The absence of the coordinated consortium is likely to lead to problems with supply as local re-use outlets cannot be guaranteed to have the required furniture in stock. The effect is most likely to be felt in the east of the county and in Thanet in particular.

Potential benefits

- Potential reduction in award costs by half, all furniture awards are ceased

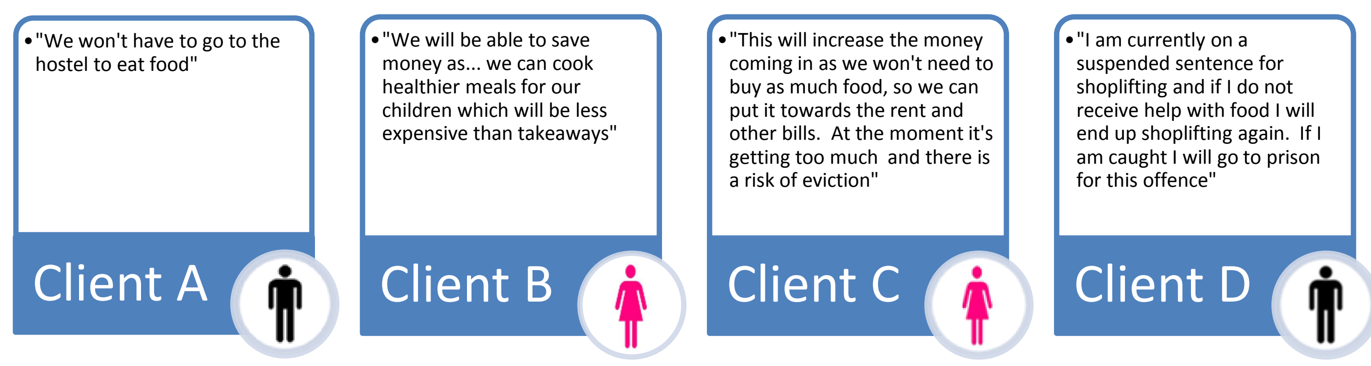
Potential risks

- Fewer opportunities to signpost customers to preventative/alternative services.
- Inadequate and unequal supply; supply unable to be sourced at zero cost to applicant
- Impact on individuals' immediate health and wellbeing without items such as fridges, cooking facilities and washing machines. This is a particular concern for vulnerable customer cohorts such as children and those with physical disabilities or mental health problems.
- Potential increased uptake of payday loans and unsecured loans to purchase these items, or proliferation of high-interest stores on the High Street risking debt and further deprivation.
- Potential increased contact and interventions required from statutory services.

Food awards

Food (including personal and household hygiene) awards accounted for a third of the overall spend on awards in Quarter 1 with over 1,600 individual awards made to households in Kent. Of those awards, over half (56%) were for households living with children. Timely provision of food is of the essence and currently KSAS works closely with ASDA to provide food awards within the time period set, according to the risk status of the award. Almost a third of food awards are assigned high risk. In these circumstances a decision will be made within 1 working day and food delivered to those homes within 24 hours.

As well as added health benefits, wider life benefits of food packages were highlighted by many of the clients applying via KSAS for food and hygiene items.



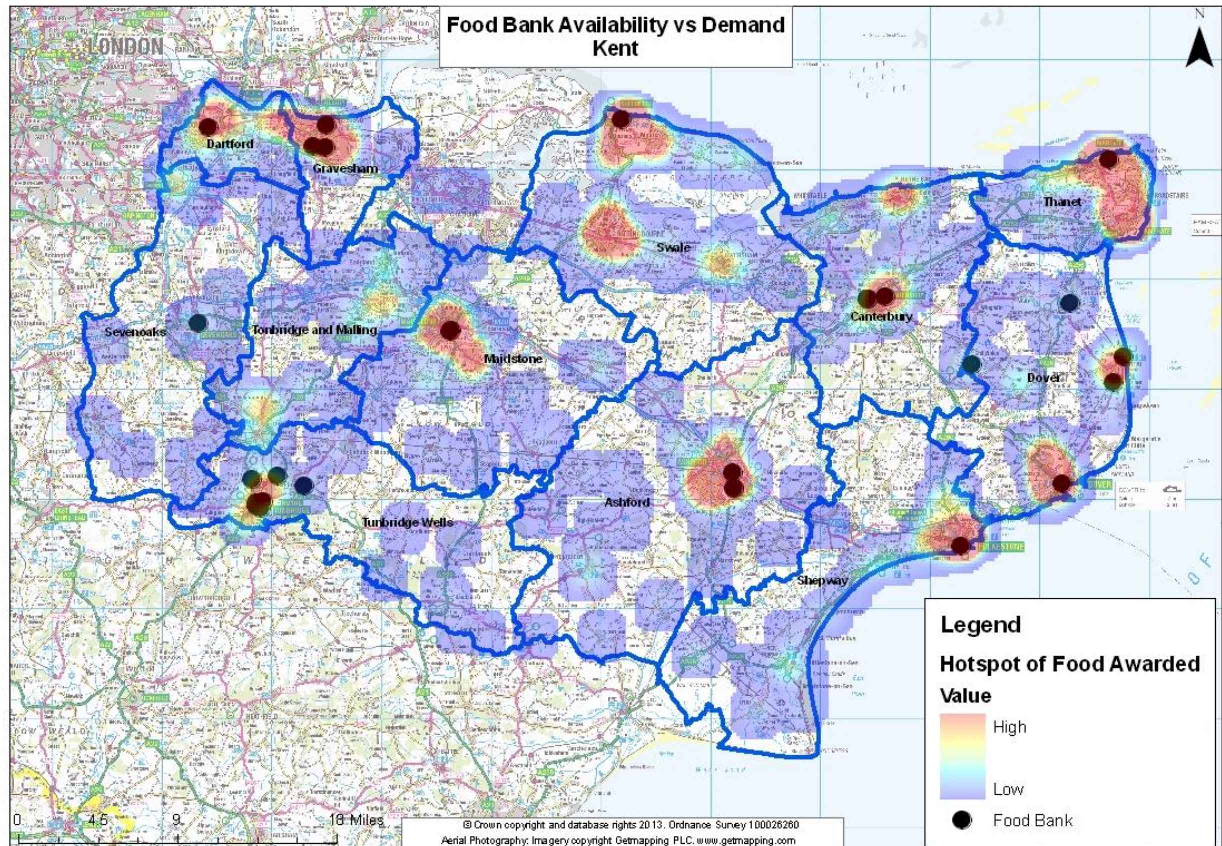
[4] 'Routes to Reuse, Maximising Value from Reused Materials', Local Government Association, March 2014.

Alternative supply arrangements

Figure 13 below illustrates the current provision of known food banks available to the public in Kent, cross matched with the location of residence of food awards approved by KSAS. These food banks operate a voucher system whereby the local council, social services or partner organisation issue the applicant a voucher to permit attending the food bank to request food. It is common practice to issue a 3 day food parcel per person and is generally made up of dried or tinned goods of food available at that time according to donations made. There are additional, discrete local church groups who deliver food on a very small scale in very limited geographical areas in their immediate area.

As can be seen from the map, known food banks accessible by the general public when issued with a voucher are not evenly distributed across the County. Demand exists across Kent in many areas, including isolated rural areas, where there is no availability. Similarly, in less deprived areas with lower demand there is a greater supply of food banks.

Figure 13: Food bank availability vs demand for Food: April 2013 to March 2014

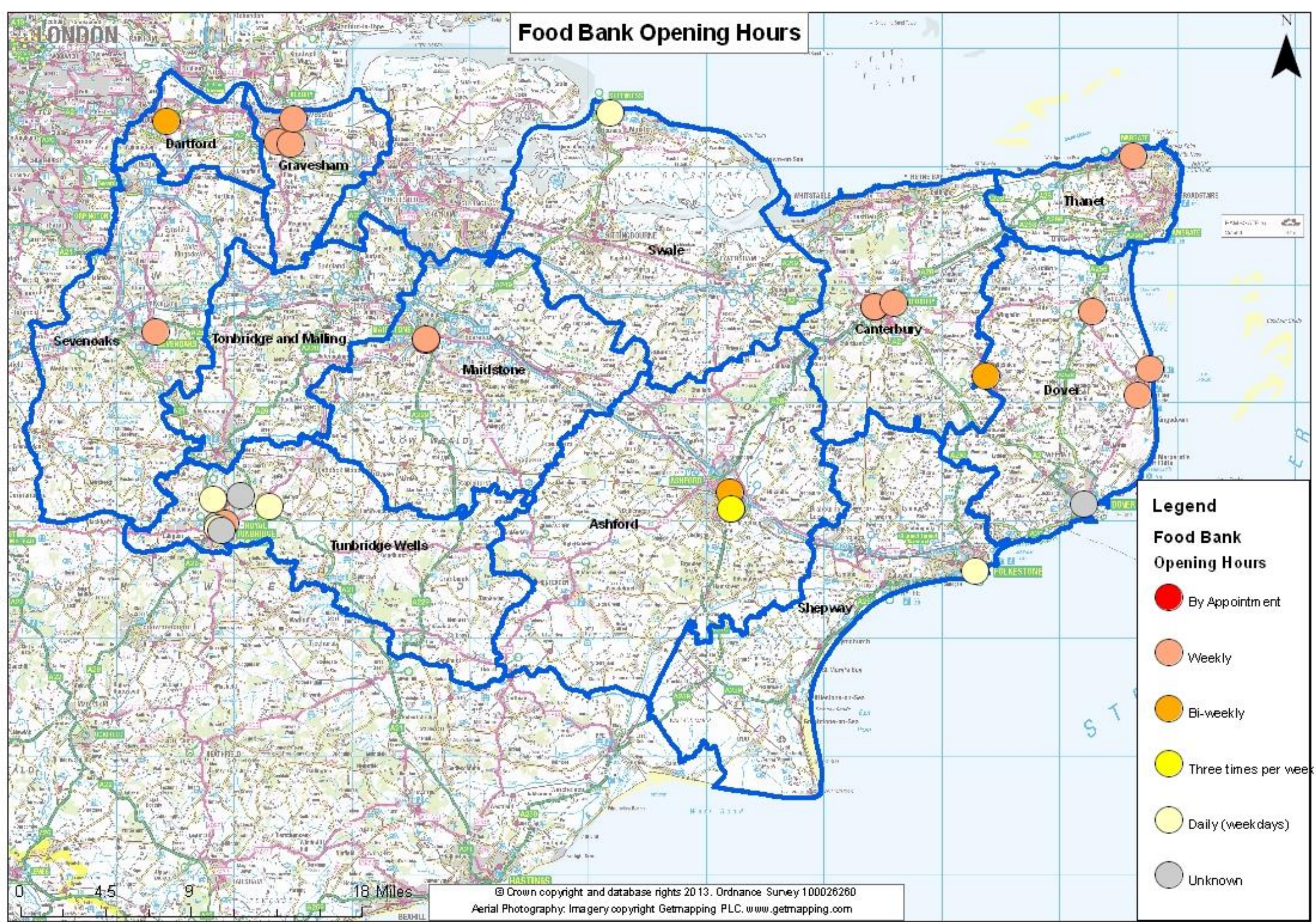


As **Figure 13** demonstrates, Food Bank provision is not equitable across Kent; there is low provision in areas of high demand and high provision in areas of low demand.

> **Example:** *In Thanet, currently only one food bank (Thanet Food Link) operates between the hours of 10:30 – 12:00 each Thursday. In an area which is shown to have the highest demand for food, this limited operation would not be sufficient to meet the high demand. Other areas of high demand include Sittingbourne, Faversham and Herne Bay, none of which appear to have any food bank provision in place.*
>
> *Conversely, in Tunbridge Wells District there were a total of 7 known food banks at the time of writing. Areas such as Sandwich, Aylesham and Sevenoaks all have food bank provision but this is not matched by the level of demand.*

Figure 14 provides an illustration of each food banks known operating hours. Most food banks across the county are only open once a week. The opening times themselves vary, with most food banks operating over a two hour period only, some by appointment only.

Figure 14: Food Bank opening hours



The Trussell Trust estimates that nationally two new food banks are launched each week to meet the growing demand[5]. It is evident from the analysis above that not all food banks will have the capacity to service the general population.

For example, some Children's Centres do supply small parcels of food for a family in need; however, these are akin to small-scale distribution centres or satellites for other larger food banks, with only around 3 parcels kept on-site at the Children's Centre at any one time. Furthermore, eligibility is restricted to existing known families with a child under 6. Operations within these locations would not service wider demands from all areas or sections of the community.

In DEFRA's report from February 2014, 'Household Food Security in the UK', its researchers suggest that

> *"there is no evidence to support the claim that increased food aid provision is driving demand. All available evidence, both in the UK and internationally, points in the opposite direction. Put simply, there is more need and informal food aid providers are trying to help"*[6].

This statement appears corroborated by the demand in Kent, which outweighs current supplies from food bank provision. Food banks will have a limited capacity to meet the demand in Kent.

Potential benefits

- Potential reduction in award costs by approximately a third.

Potential risks

- Fewer opportunities to signpost customers to preventative/alternative services.
- Little alternative sustainable food provision currently available in Kent to meet the demand.

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[5] http://www.trusselltrust.org/stats#Apr2013-Mar2014

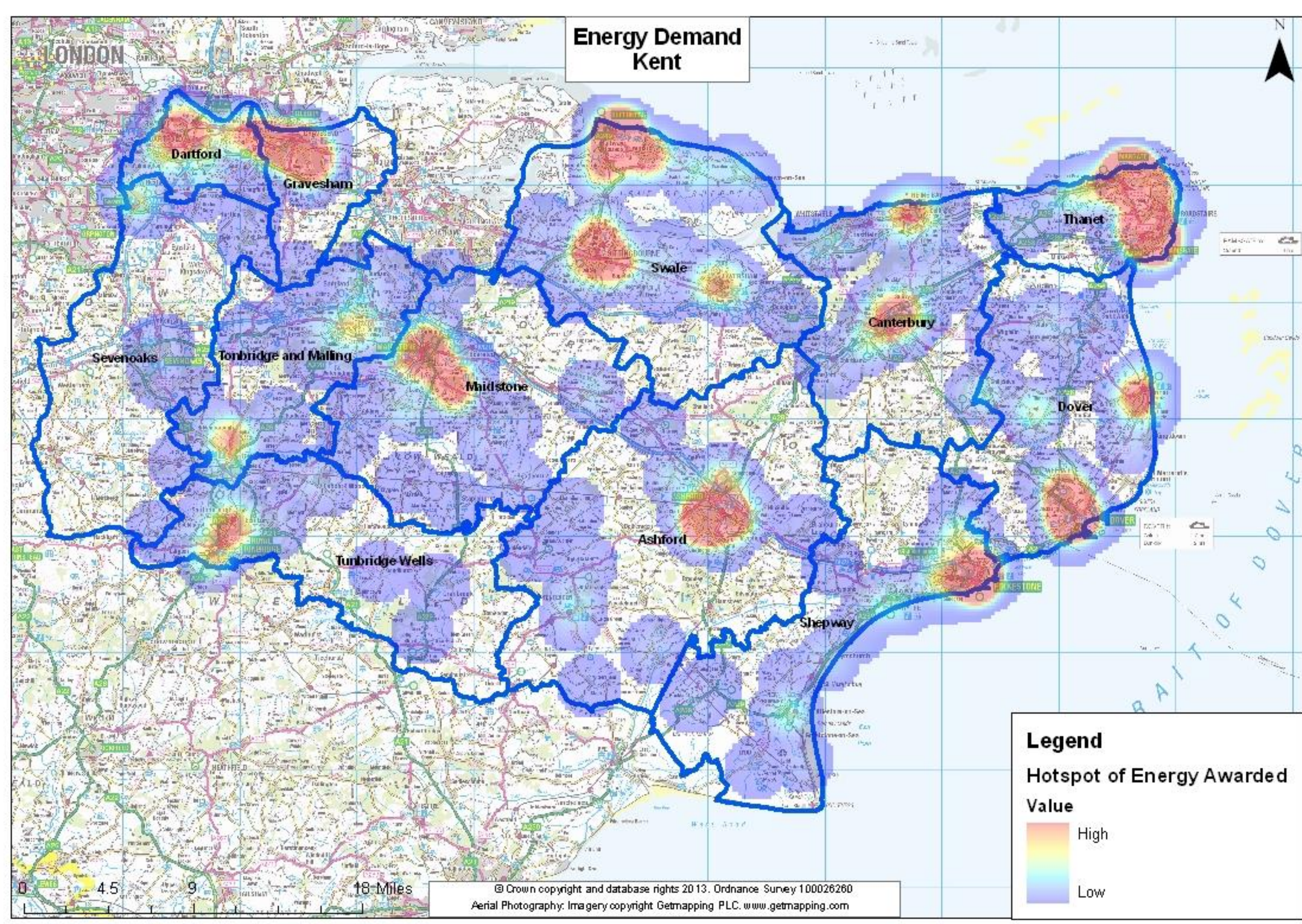
[6] *The Guardian, Families turn to food banks as last resort* 'not because they are free' February 2014: http://www.theguardian.com/society/2014/feb/20/foodbank- review-undermines-ministers-claim

- Impact on individuals' immediate health and wellbeing.
- Potential increased contact and interventions required from statutory services.
- Negative publicity due to the ceasing of food provision. 56% of awards in Quarter 1 were for households living with children.
- Greater impact on high risk households.

Energy awards

Figure 15 below illustrates the demand for assistance with energy across Kent.

Figure 15: Energy demand: April 2013 to March 2014



The cost of individual energy awards are comparatively low (£45 per award) in the context of other award types. These awards generally accompany high risk awards of food. The availability of gas and electricity is vital for basic household tasks including warming the home, cooking and cleaning. KSAS approved over 1,000 awards for energy in Quarter 1; of these, 33% were assigned a high priority, the largest proportion of any award category.

PayPoint are commissioned to provide energy vouchers and cash in exceptional circumstances. PayPoint is the provider of a national scheme that allows the issuing of vouchers for a specified value to be printed out for recipients, or sent to their mobile phone and redeemed for energy charge on their pre-pay account keys. In exceptional circumstances, households in immediate risk of harm can be sent a cash award by text or voucher for immediate redemption. Recipients redeem their voucher at one of the 926 PayPoint outlets in Kent. 99.3% of the UK population live within one mile of an outlet in urban areas and within five miles in rural areas. The outlets are generally open 7 days a week and extended hours (e.g. 7am – 11pm) making them highly accessible to residents in crisis.

Alternative provision

Other than KSAS, research has revealed no other known source of funding for gas and electricity for Kent residents in crisis or emergency situations. A number of large energy companies offer grant schemes to help

households in fuel debt, but these are inappropriate for the KSAS customer base who require help in the form of an immediate energy supply.

An example is the British Gas Trust[7], a charitable trust funded by British Gas for any resident of England, Scotland or Wales. The Trust awards grants to clear domestic gas and electricity debts owed to British Gas and other suppliers. The grant is awarded only to those who have accumulated an unmanageable debt.

Most applicants would not be eligible for these grants as they require urgent short term top–up for their pre-pay meters for gas and electricity. A further deficiency with the national energy schemes is the speed at which grant applications are assessed and decided upon for those who are eligible. The KSAS service works to deliver awards in a timely manner; high risk awards are granted within 24hrs and in most cases the same business day. The national schemes cannot provide this assurance leaving even those households that are eligible without gas or electricity during a lengthy assessment and application process.

Potential benefits

- Potential reduction in award costs by approximately a tenth.

Potential risks

- Fewer opportunities to signpost customers to preventative/alternative services.
- No alternative provision currently available in Kent to provide cash or energy grants for pre-pay meters.
- Inability to heat a house, cook food and clean clothing may impact on individuals' immediate health and wellbeing.
- Over one third of individuals receiving energy awards have a physical or mental health problem. The withdrawal of energy awards may increase the contact and interventions required from statutory services.
- Greater impact on higher risk households.

Clothing voucher awards

In emergency situations individuals can apply to KSAS for clothing vouchers. Approximately half of all clothing voucher awards granted in Quarter 1 were recorded as being for customers with generic need. The remaining awards were split between those requiring clothing in the event of a disaster such as the Yalding Floods and those fleeing domestic abuse.

In comparison with other award types, the provision of clothing is low with less than £15,000 spent in the first Quarter of this financial year.

KSAS also provides generic school wear for children in eligible families. This enables children to attend school rather than be absent as they have suitable clothing.

Alternative Supply

There are no current services known to KSAS that supply free clothing or clothing voucher grants to all members of the public in need. The Local Authority, under Section 17, can provide cash to those leaving abusive situations to purchase new clothes for children. There is a good supply of charity shops in the High Street that will provide used clothing at a cost but are unlikely to be able to do so at zero cost.

Potential benefits

- Potential reduction in award costs by approximately 3%.

Potential risks

- Fewer opportunities to signpost customers to preventative/alternative services.
- No alternative provision currently available in Kent to provide cash or clothing voucher grants to individuals in need of free new, or used clothing.
- Potential increased contact and interventions required from statutory services.

[7] http://www.britishgasenergytrust.org.uk/help/grants-for-individuals-help-pages/how-can-the-trust-help

Travel awards

KSAS has awarded only 7 individuals with travel awards in the first Quarter of 2014/15. These were provided in the form of travel tickets or in very exceptional circumstances, cash. Four customers required this assistance to travel to funerals with the remaining requiring assistance to travel to hospital. Travel vouchers are also used to enable Kent residents and their children to safely flee domestic abuse.

Alternative supply

There are no current services known to KSAS that provide travel grants to all members of the public in need. Whilst some public bodies have the ability to award travel warrants, the coverage and eligibility for accessing these resources is very restricted.

Potential benefits

- A negligible sum of money is spent on travel awards through KSAS and the savings made by ceasing this type of award would be minimal.

Potential risks

- Fewer opportunities to signpost customers to preventative/alternative services.
- No alternative provision currently available in Kent to provide travel assistance grants to all in need. There are a number of services that provide travel assistance, however only to selective cohorts.
- High risk households, including those where there is domestic abuse, will be more greatly impacted.

Option 1 – Summary

On reflection of the detail above, should diminution of the services be considered the greatest saving can be made by removing the provision of Clothing and Travel, along with all Furniture items except for cooking facilities, fridges, washing machines and beds (including cots).

In Quarter 1, this would have saved the council 31% of KSAS award costs (£135,575).

Food and Energy are the most critical categories of awards for customers due to the potential impact on the health and wellbeing of individuals of any withdrawal. Whilst costly, the total expenditure of both award types in Quarter 1 was approximately £185,000, comparatively cheaper than the cost of Furniture (£232,705) and reaching many more vulnerable people.

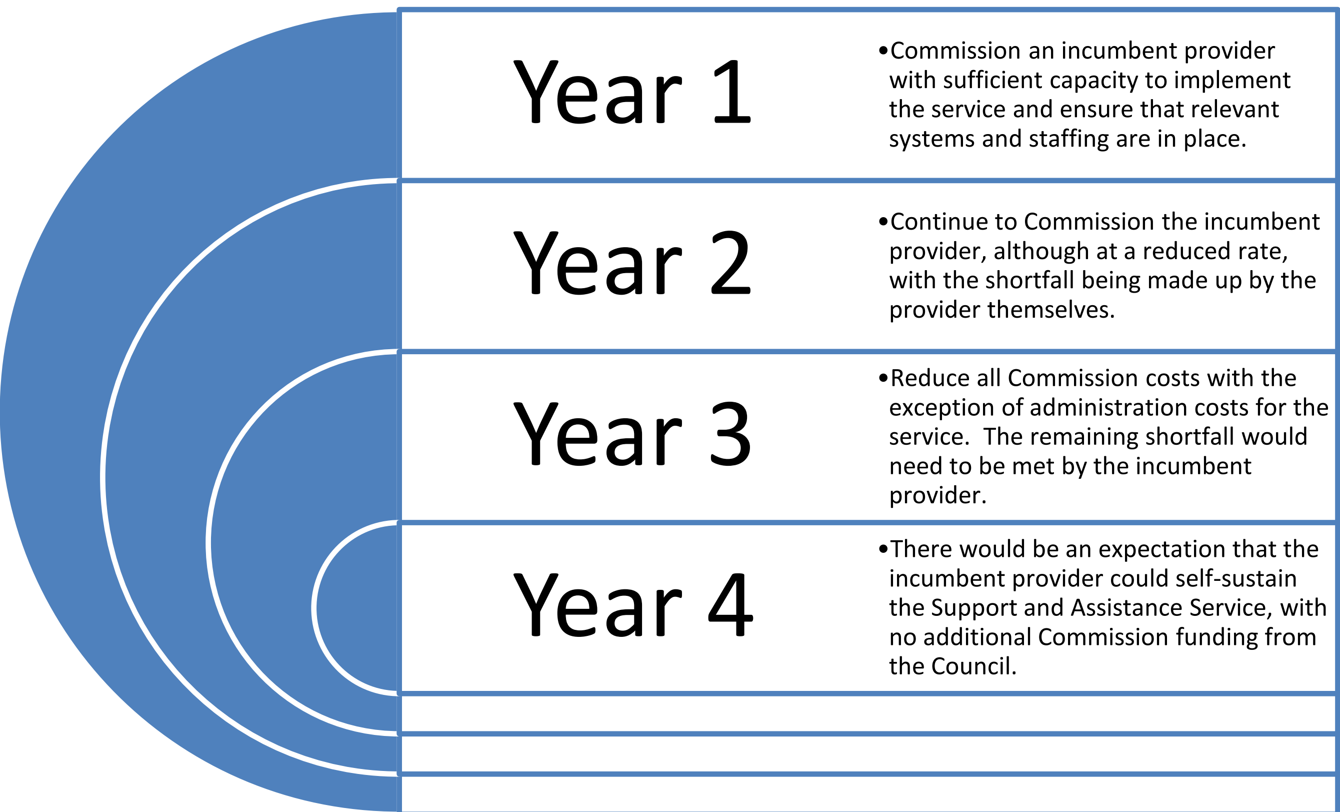
As **Figures 13** and **14** demonstrate, Food Bank provision is not equitable across Kent, neither would it satisfy the demand from vulnerable households in Kent. In addition, energy trusts will not meet the needs evidenced by KSAS.

Food and Energy have the highest proportion of high priority cases than any other category **(Figure 9).**

b) Option 2 – Commission service delivery

The council may choose to commission the provision of service delivery from the third sector, charity or voluntary organisation(s).This option will minimise costs incurred by the Council, by developing a commissioning model which places some risk and cost onto the provider organisation:

Figure 16: Proposed commissioning model for voluntary sector delivery



An outcomes' focussed commissioning model could be tendered by KCC; staff would need to be employed to support the commissioning element of KSAS, both in the initial tendering stages and throughout the course of the contract. In addition, time will need to be spent in managing the transition of the scheme from its current form. Costs of £78,460[8] per annum would therefore need to be factored into Council budgets accordingly.

As KCC moves towards becoming a strategic commissioning authority this option sits well with the Council's vision for the future.

Potential benefits

- Increasing reduction in spends over a period of time.
- The utilisation of other providers meets the Council's vision for the future; to become a strategic commissioning authority.

Potential risks

- Costs will still need to be incurred by the Council, albeit these will diminish over time.
- KCC would still need to commit to providing staff to manage the KSAS contract throughout the commissioning cycle.
- Difficulties may be experienced in getting providers to work jointly with the service. Administration costs attributed to the service may not make it a viable financial proposition for outside agencies to take on.
- There may be a lack of interest from potential providers when the service is tendered, leading to little competition.

[8] KSAS Evaluation Report 2014

c) Option 3 – Grant fund to local voluntary organisations

The council may choose to use the underspend to issue grants to local organisations to deliver welfare assistance across Kent. To achieve longevity, the total grant fund could be set at £500k per annum, enabling provision to be spread across five years.

It is clear that such grants could not match or sustain the current level of provision. Similarly, there is no certainty that the suppliers of such services exist in areas of greatest need which could lead to an inequality of provision (see **Figures 12** and **13**). It is unlikely that any provision for emergency gas and electricity could be found.

A bidding or selection process would be necessary with robust outcomes and criteria. There is a risk that should a number of awards be made each year that they are too small to be impactful and deliver transformational outcomes, particularly the higher cost elements of the services such as furniture. In granting funding to many smaller organisations, there is a risk that there is a higher proportion of the spend used for overheads rather than direct provision.

The services would not have access to the current data systems such as CIS, Liberi, and SWIFT and robust fraud and safeguarding controls would need to be in place.

However at ward level, these organisations are well embedded in their local areas and know and understand the needs of their local neighbourhoods.

Appendix 1 Case Study

A mother with a 12yr old daughter, who had fled an abusive relationship made an approach to the assistance scheme as she had no food, insufficient clothing, serious rent arrears and suffering depression. The child was not attending school because she did not have suitable clothing to fit her child. KSAS supplied cash for emergency food, clothing vouchers, a seven day food parcel and energy vouchers were also issued. The service signposted her to specialist Floating Support who set about assessing her needs, worked with the local housing benefit office to arrange back payment of benefit and reduce rent arrears. They further negotiated a reduction in rent with her landlord. A CAF was set up to ensure support for the mother and child across agencies.

In assessing her needs, KSAS became aware that in the midst of this crisis, the applicant was also the sole carer for her elderly parents. Her parents, themselves vulnerable as the mother had a chronic illness and the father a terminal illness, were also in crisis and at risk of homelessness as a result of harassment due to their ethnicity.

It was clear this household was under considerable strain. Without help with her own issues and those of her daughter and parents, her ability to continue caring for herself, her daughter and parents was in jeopardy. KSAS awarded food and energy to the parents and again signposted to floating support to help the older couple.

Outcome

This intervention, including the signposting to supporting agencies, prevented the customer losing her home and enabled her to get the help she needed to manage her own affairs. KSAS provided immediate support with provision of food and clothing which protected the health of the customers and allowed the daughter to return to school and stabilise their living arrangements.

Her parents' health was protected by being supported with food, energy and equipment. With the assistance of Floating Support both households were made safe from eviction and the customer recovered sufficiently to continue as Carer for her parents allowing them to continue to live independently in the community without any statutory involvement.

Cost to KSAS

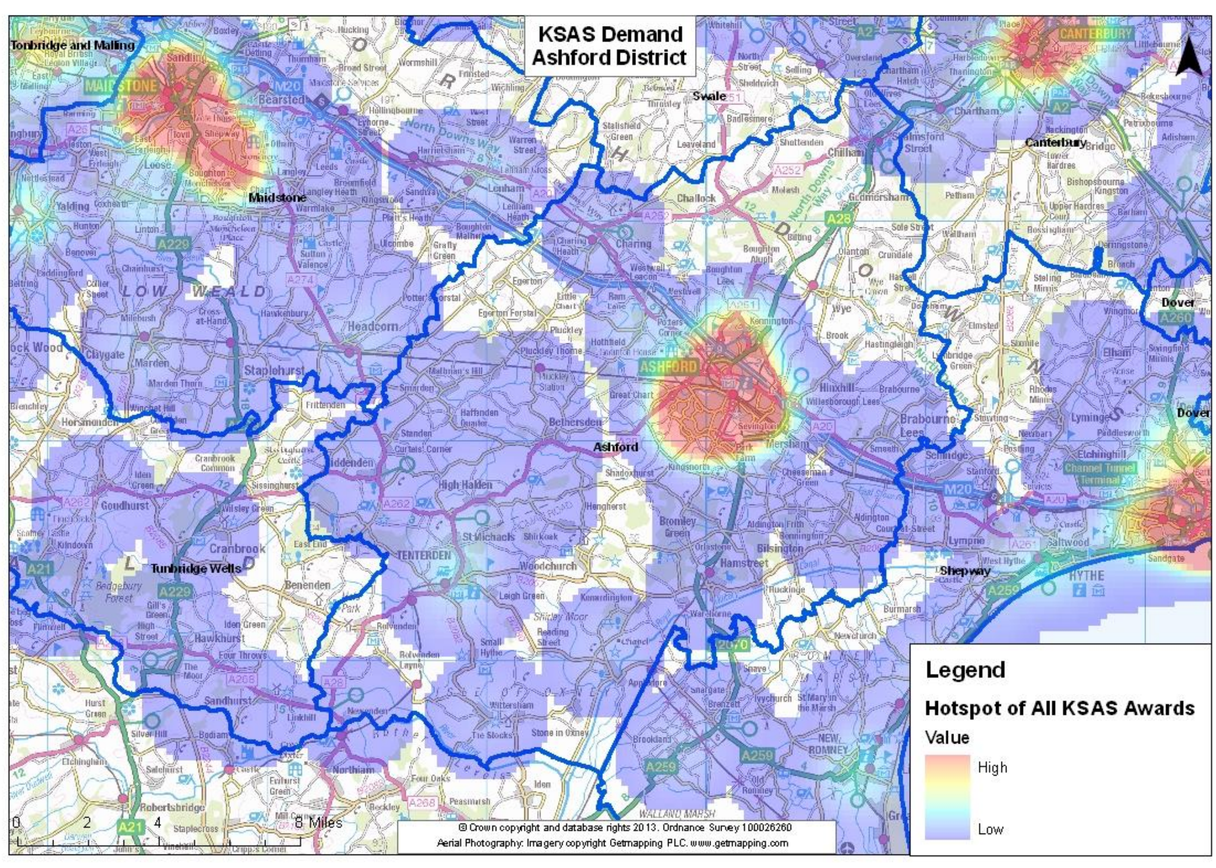
Cost of food, clothing, energy, furniture and equipment for the mother and child was £747.12. Cost to support parents was £304.32.

Potential savings to KCC statutory services

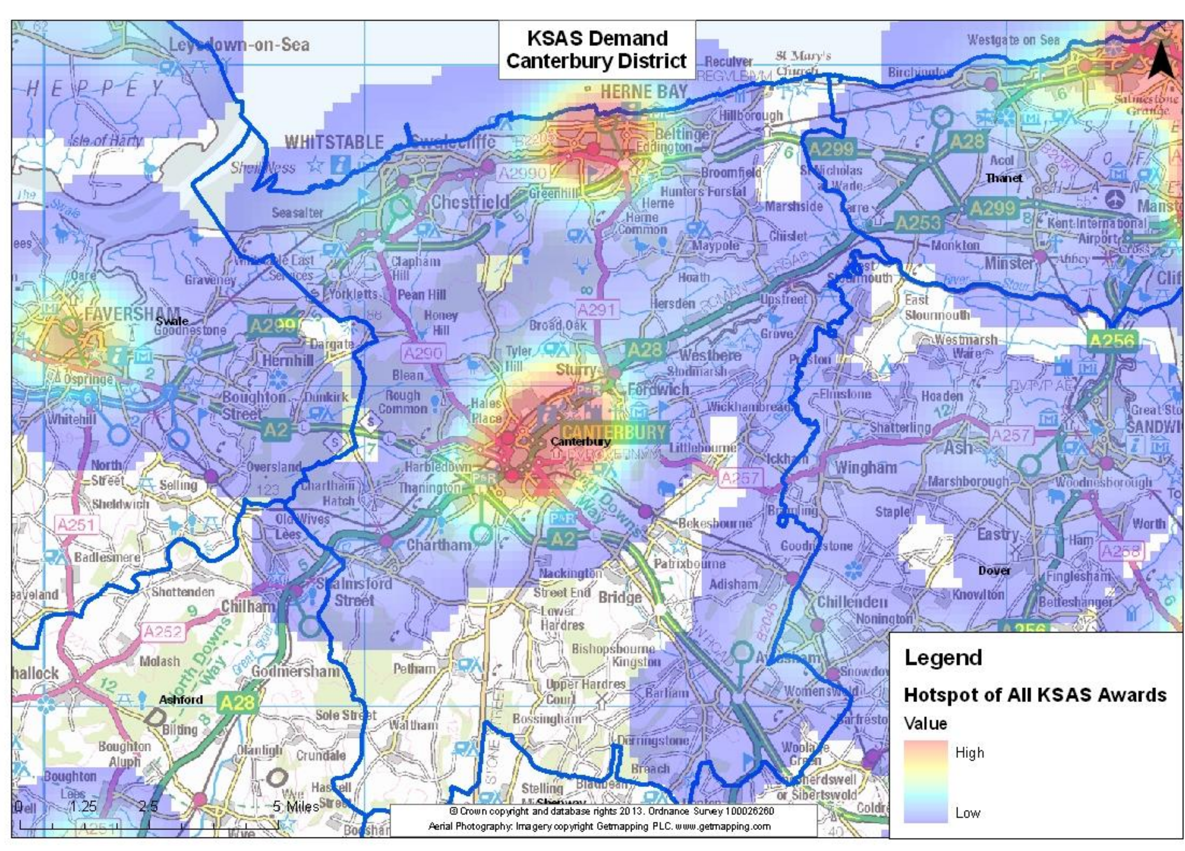
- £2,551 per week for a child's residential home placement, or
- £818 per week for a child taken into care, or
- £555 per week for a child's foster care placement;
- £457 per week Social Care support for people with mental health problems
- £687 per week for Social Care support for people with physical disabilities, or
- £282 per week for Social Care support for older people

Appendix 2 KSAS Demand by district/borough

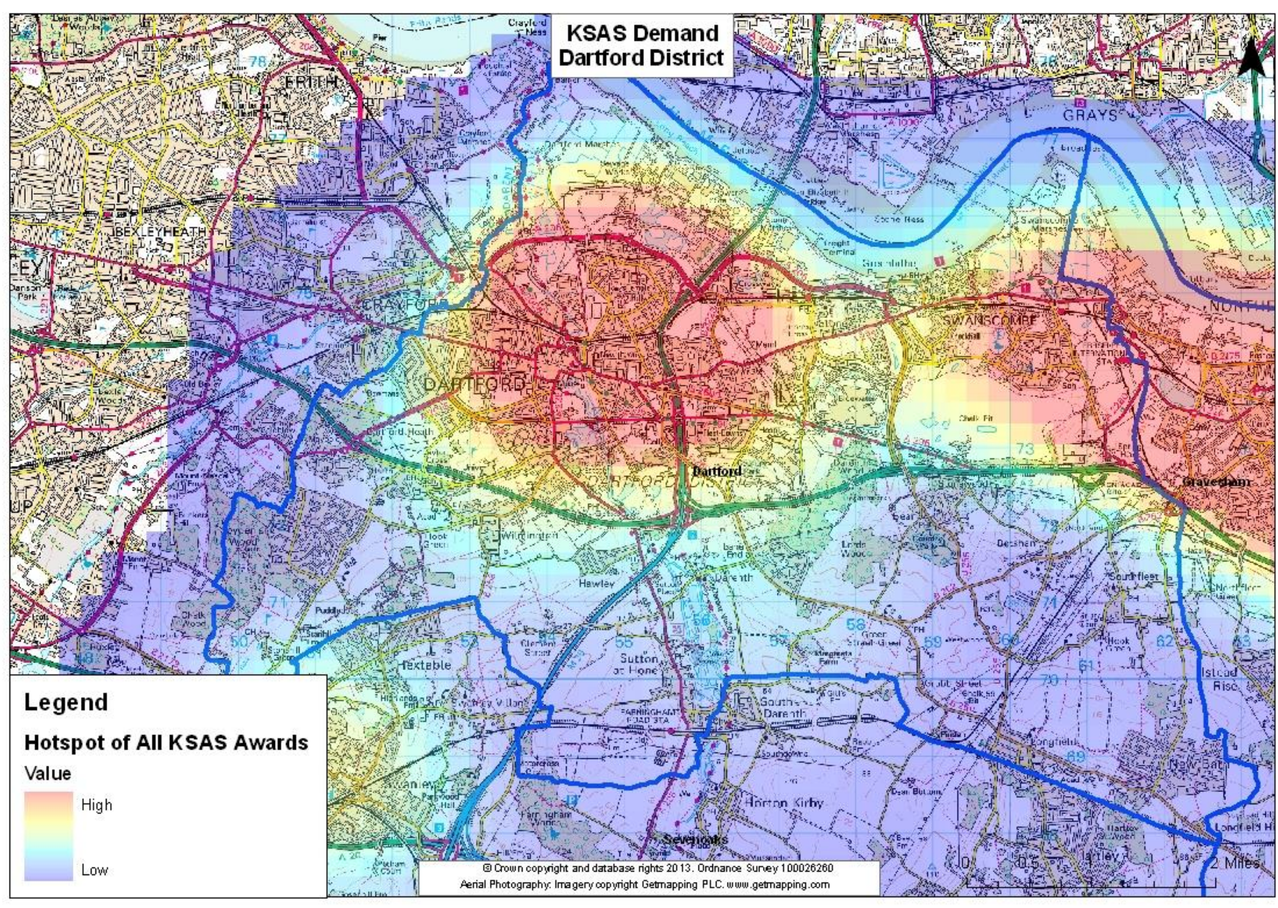
KSAS Demand, 2013/14 in Ashford District



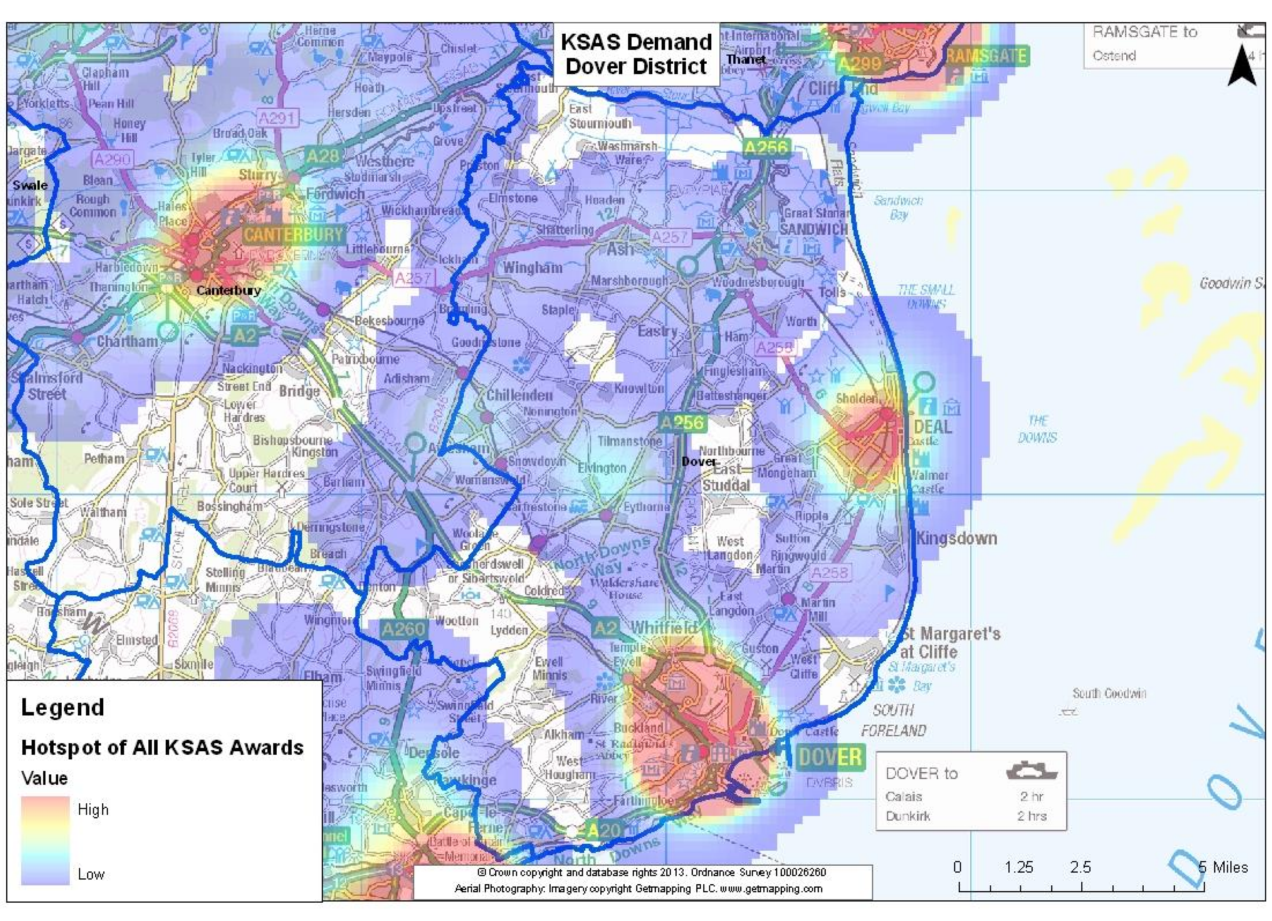
KSAS Demand, 2013/14 in Canterbury District



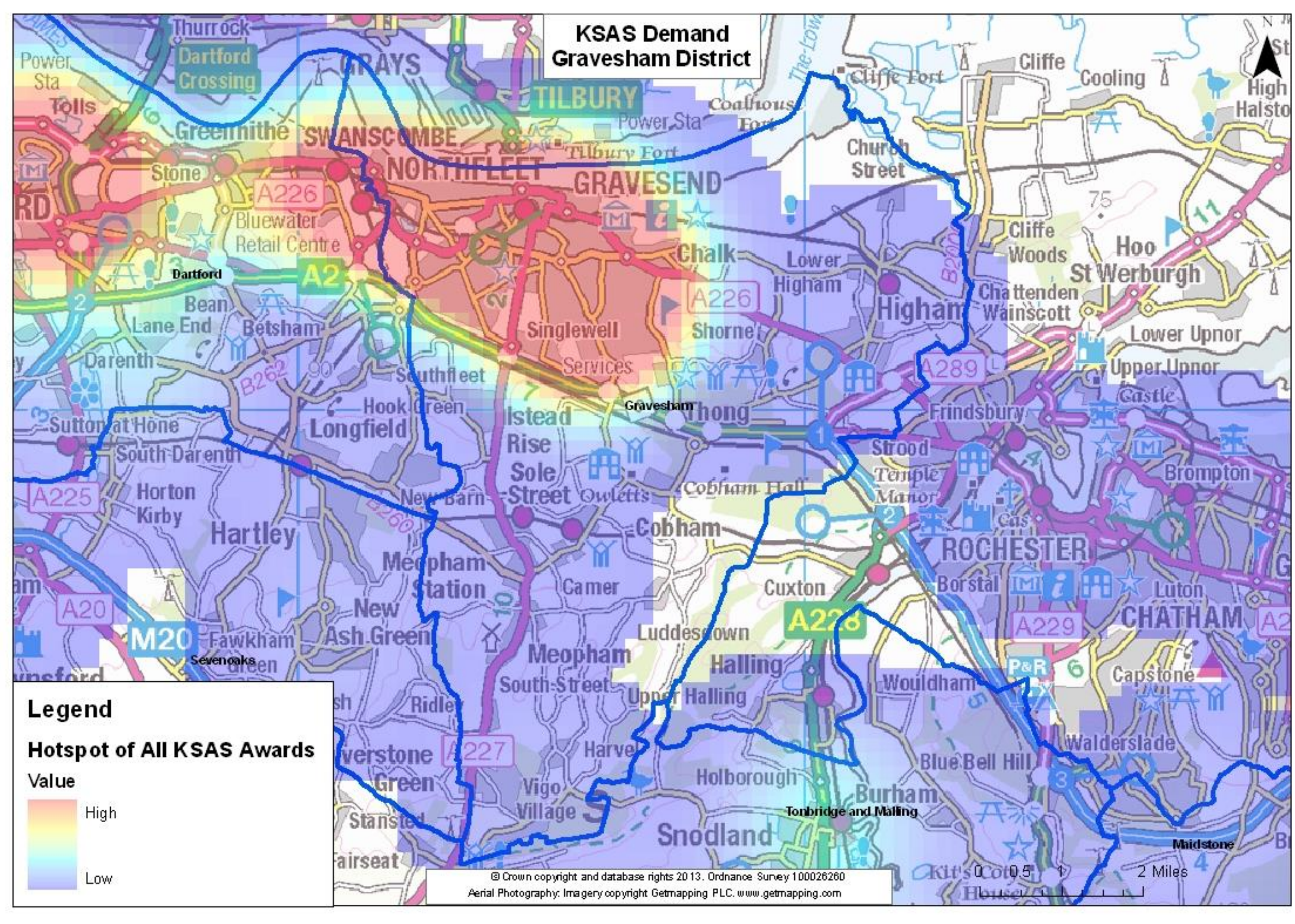
KSAS Demand, 2013/14 in Dartford District



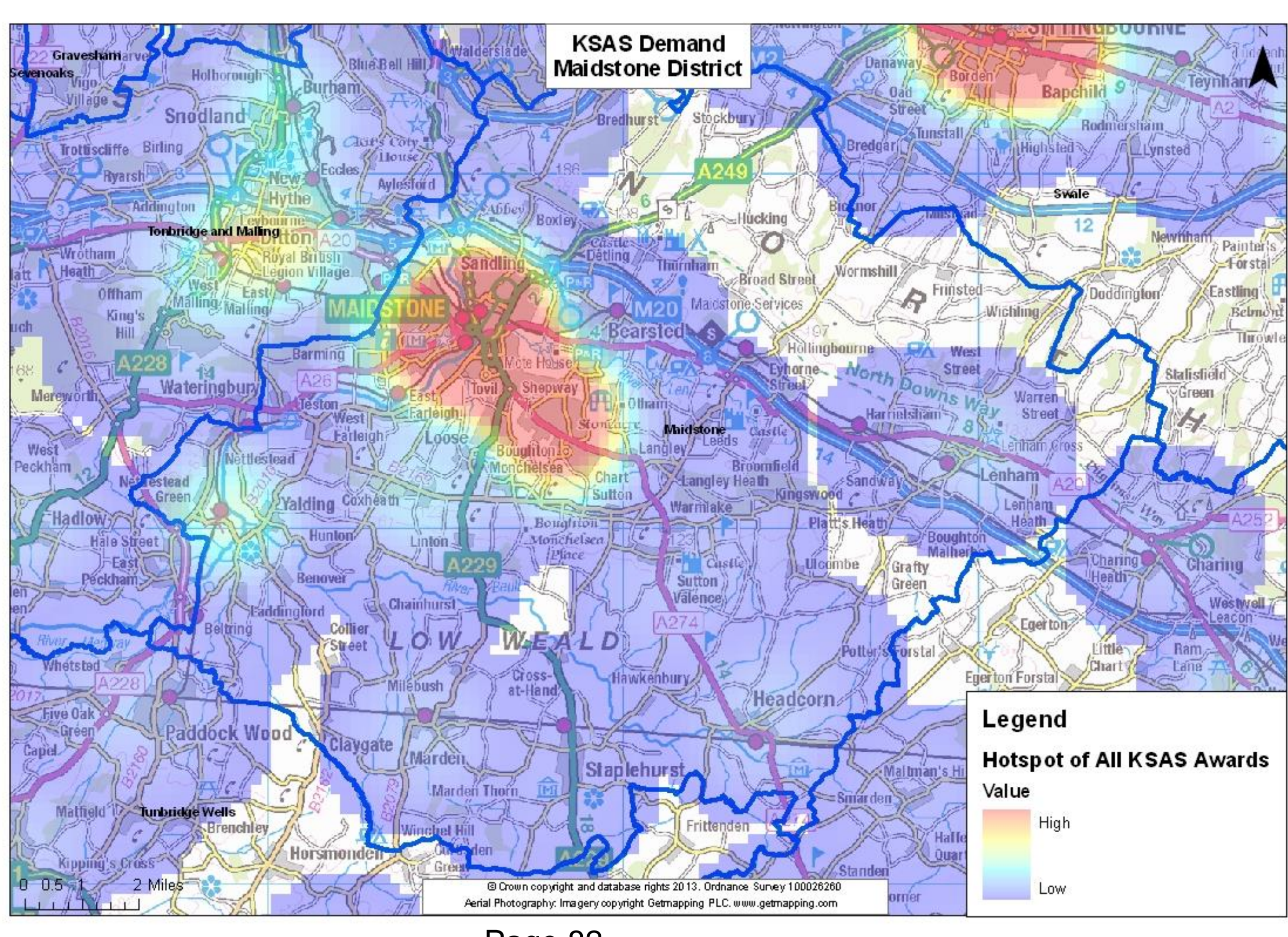
KSAS Demand, 2013/14 in Dover District



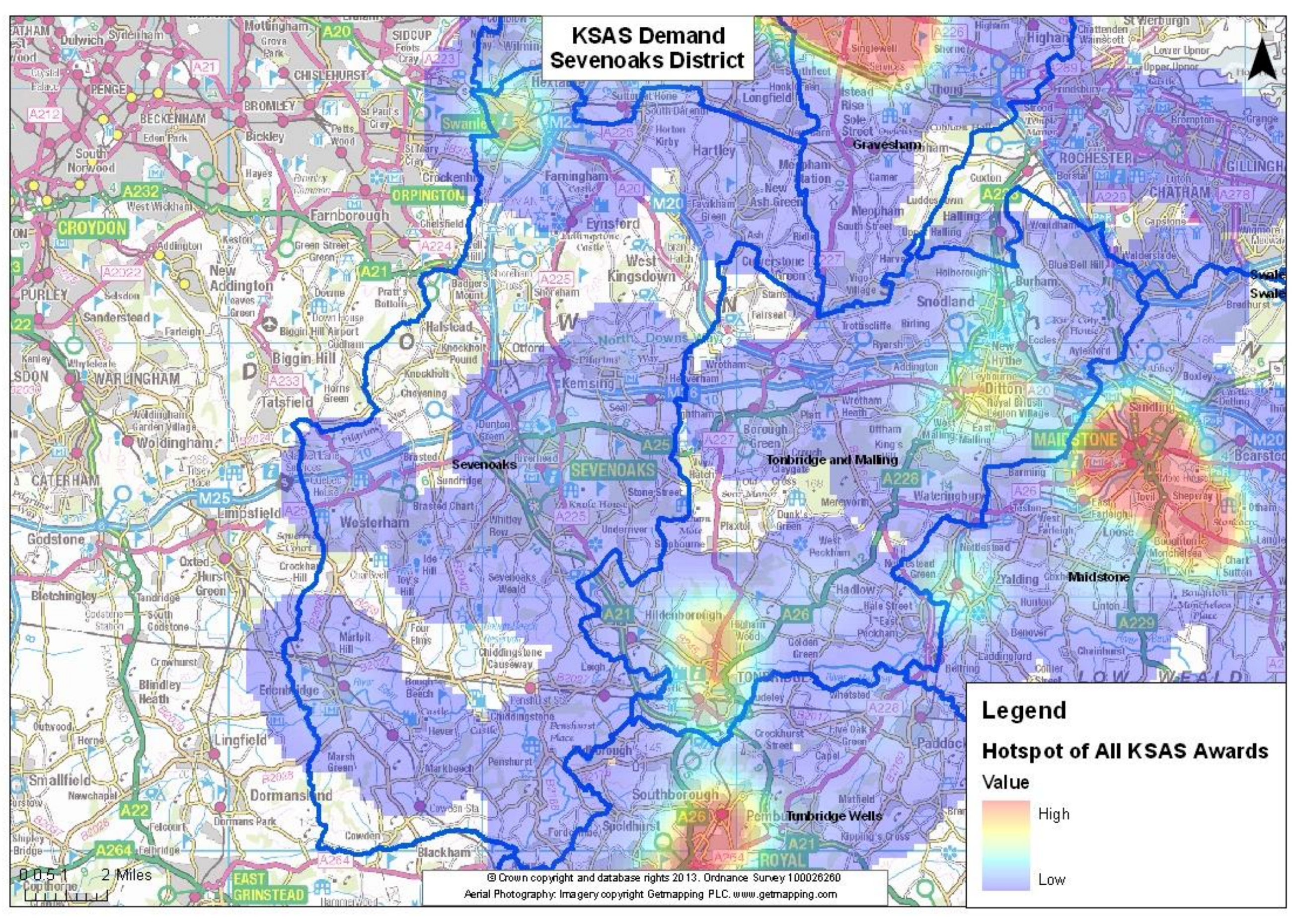
KSAS Demand, 2013/14 in Gravesham District



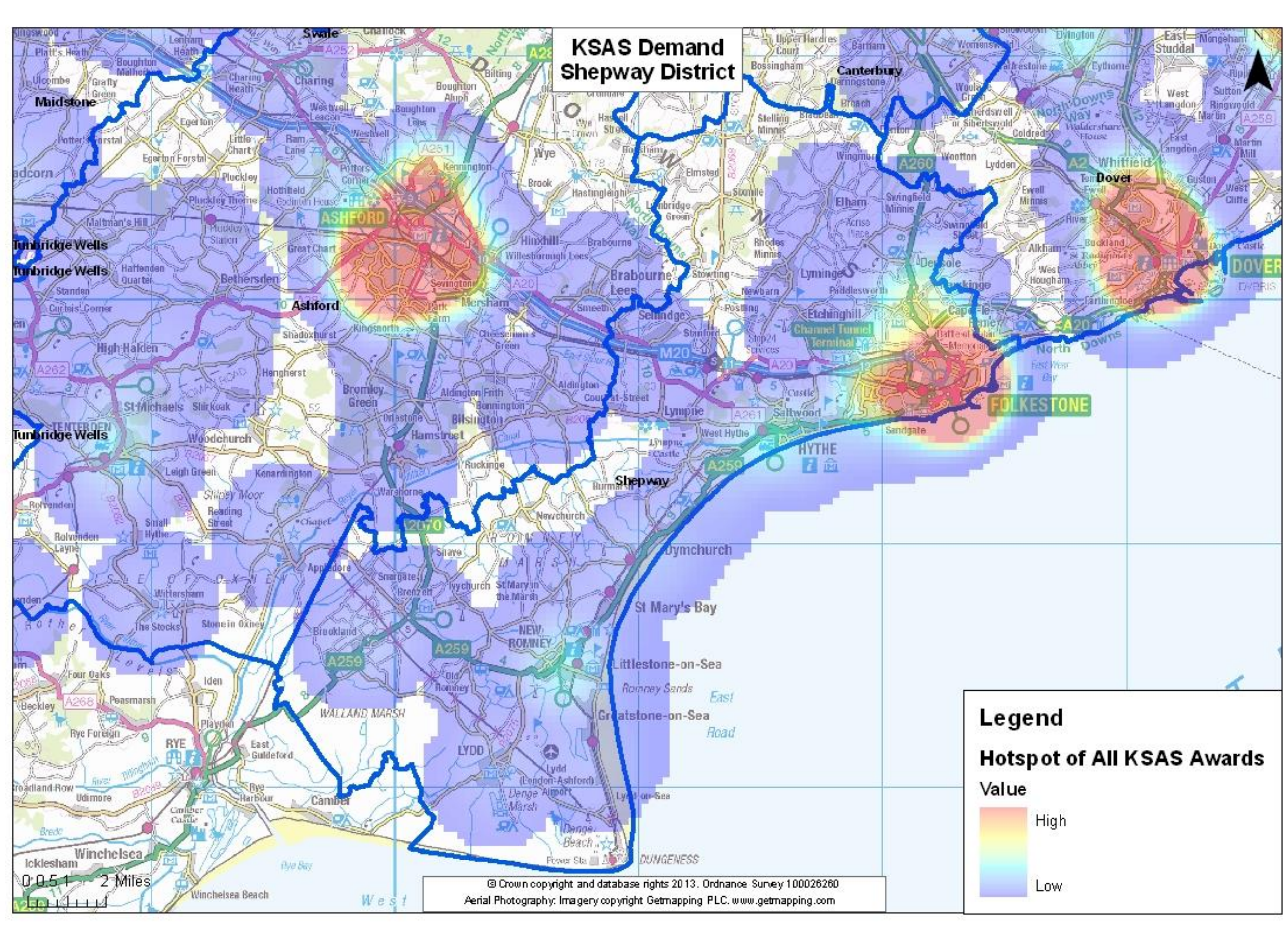
KSAS Demand, 2013/14 in Maidstone District



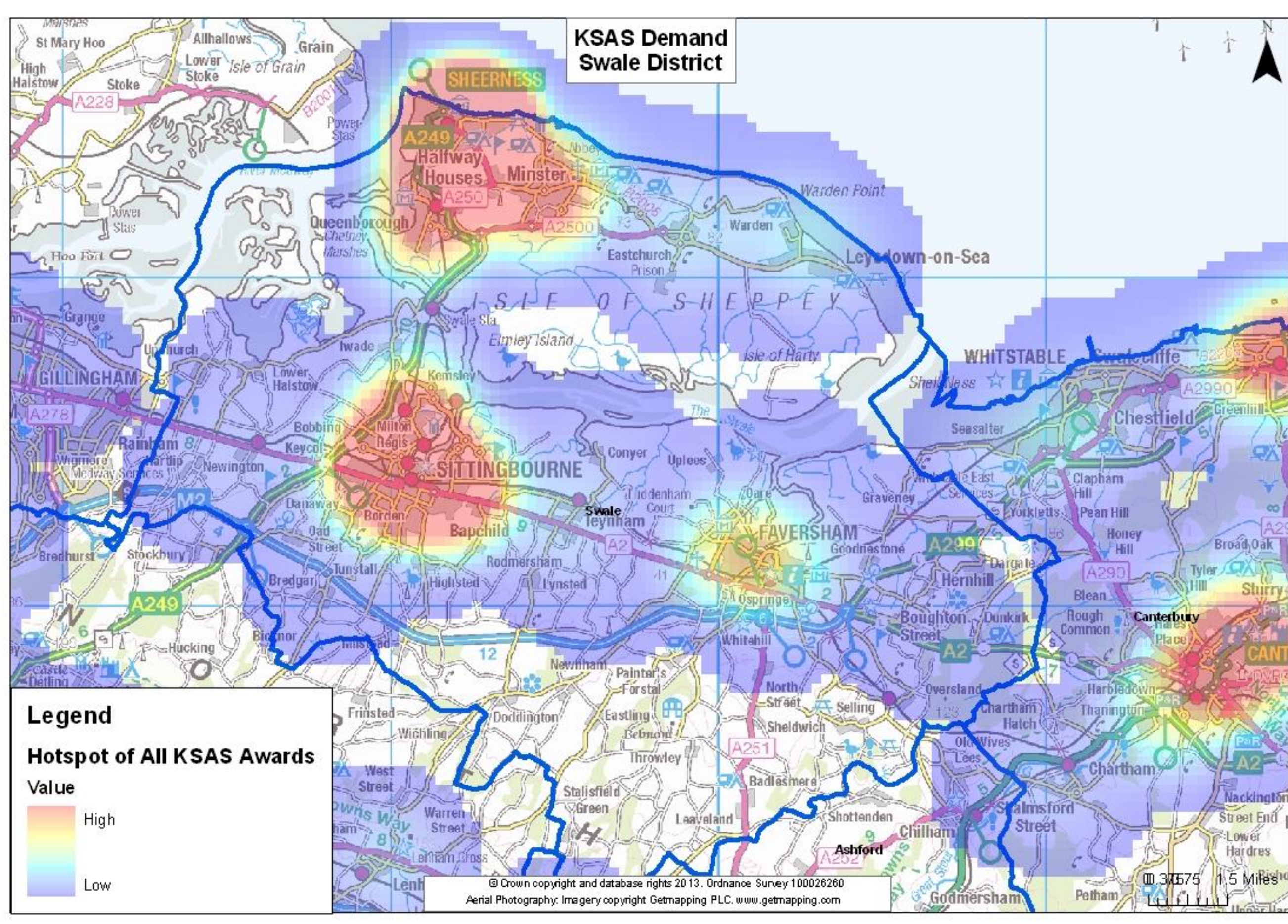
KSAS Demand, 2013/14 in Sevenoaks District



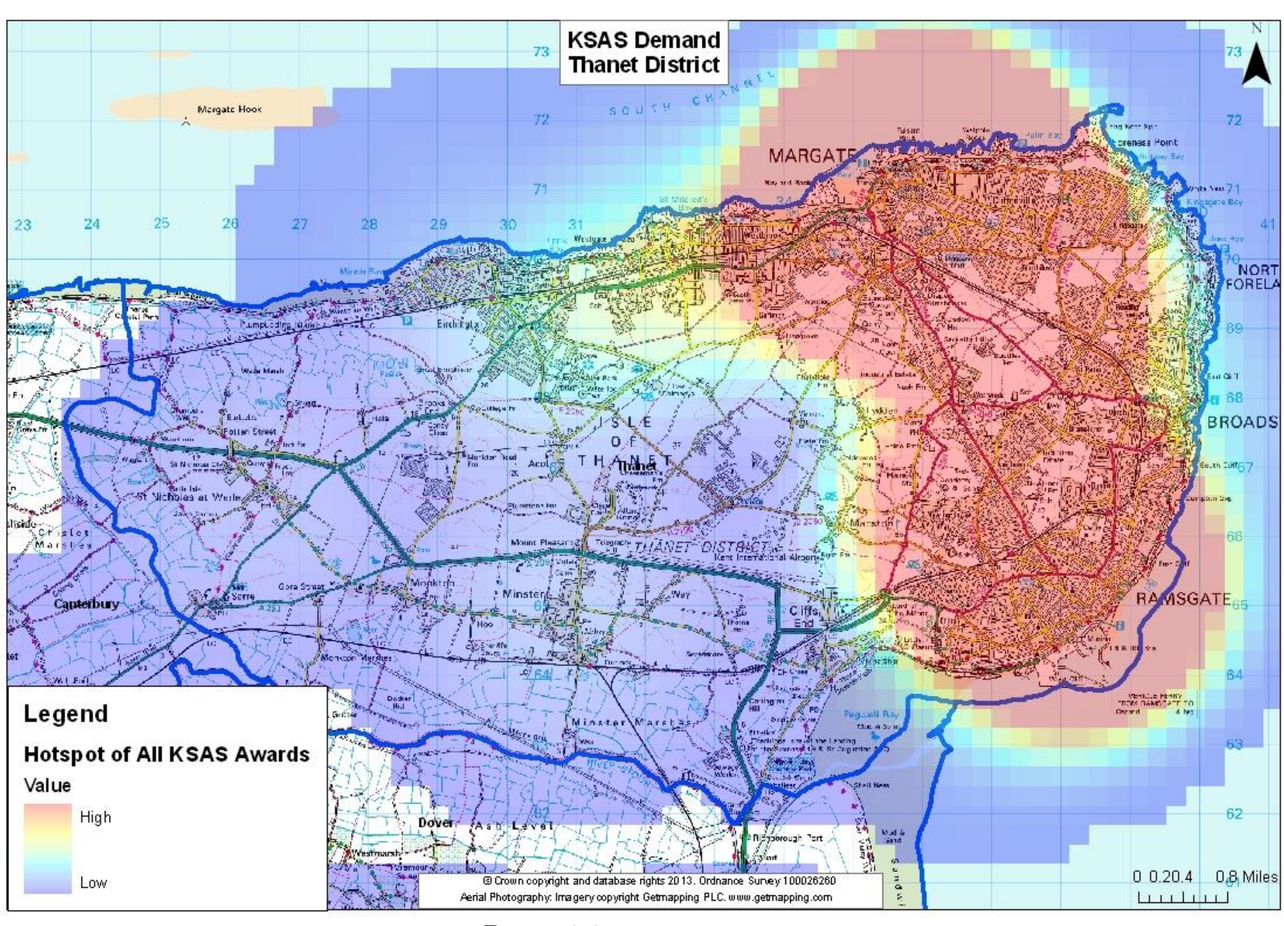
KSAS Demand, 2013/14 in Shepway District



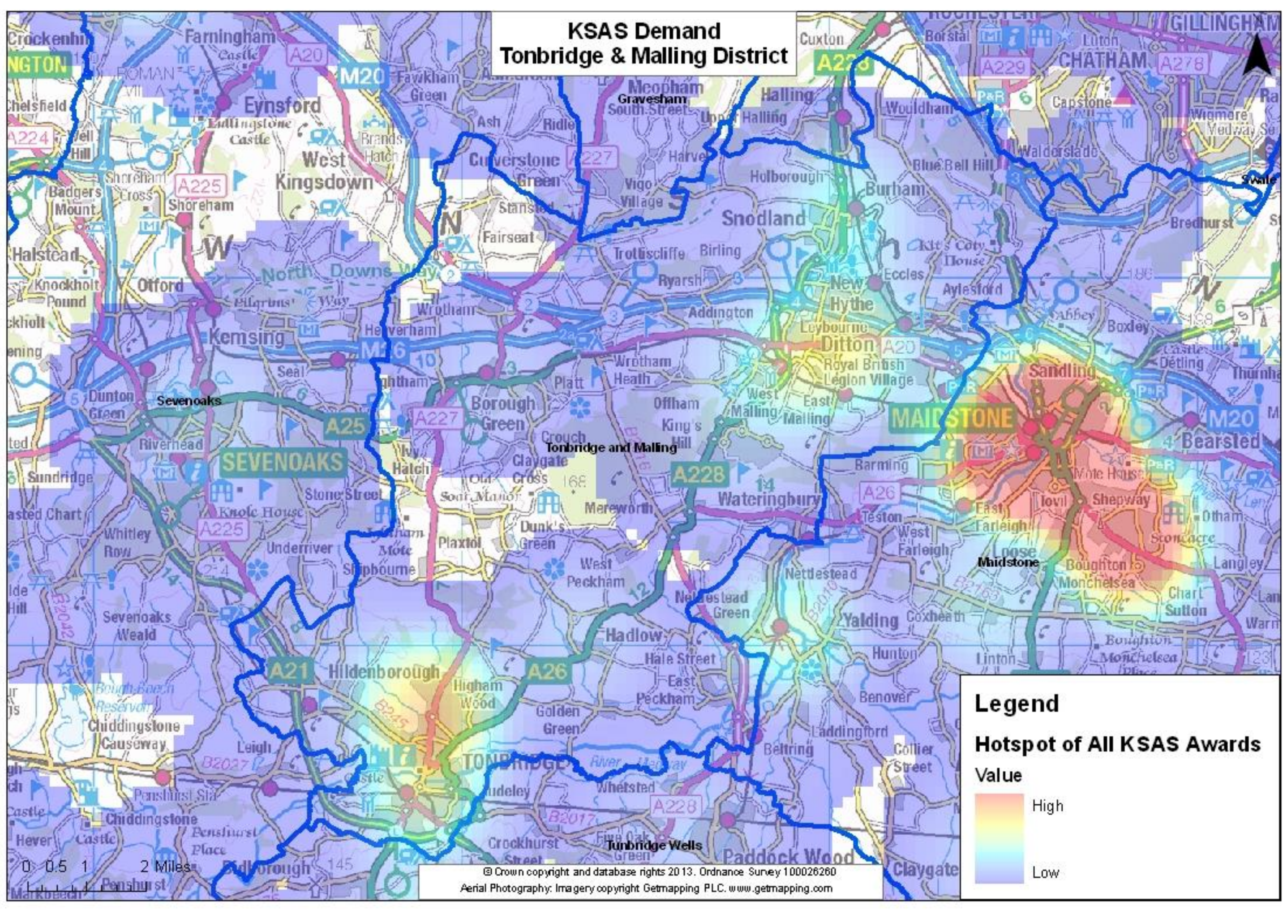
KSAS Demand, 2013/14 in Swale District



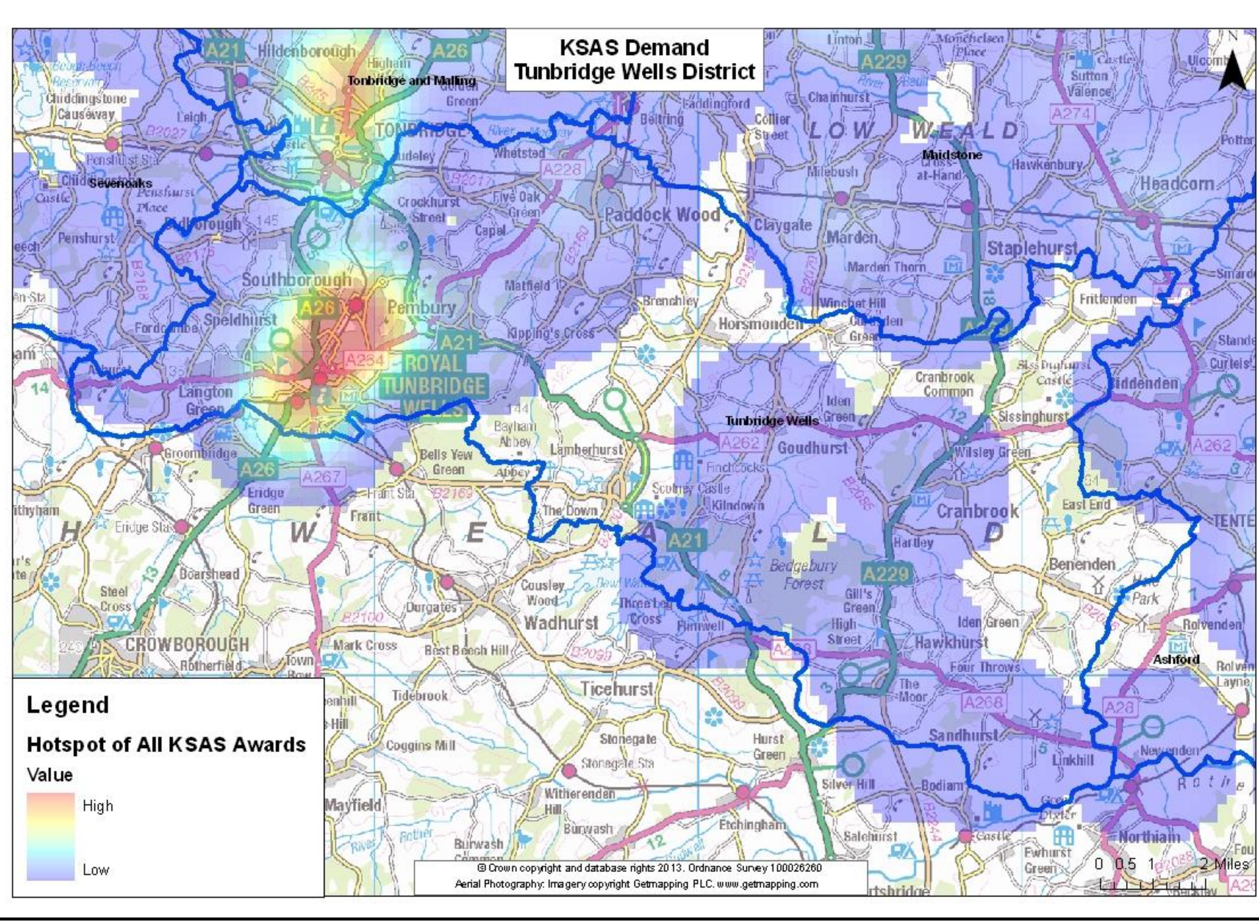
KSAS Demand, 2013/14 in Thanet District

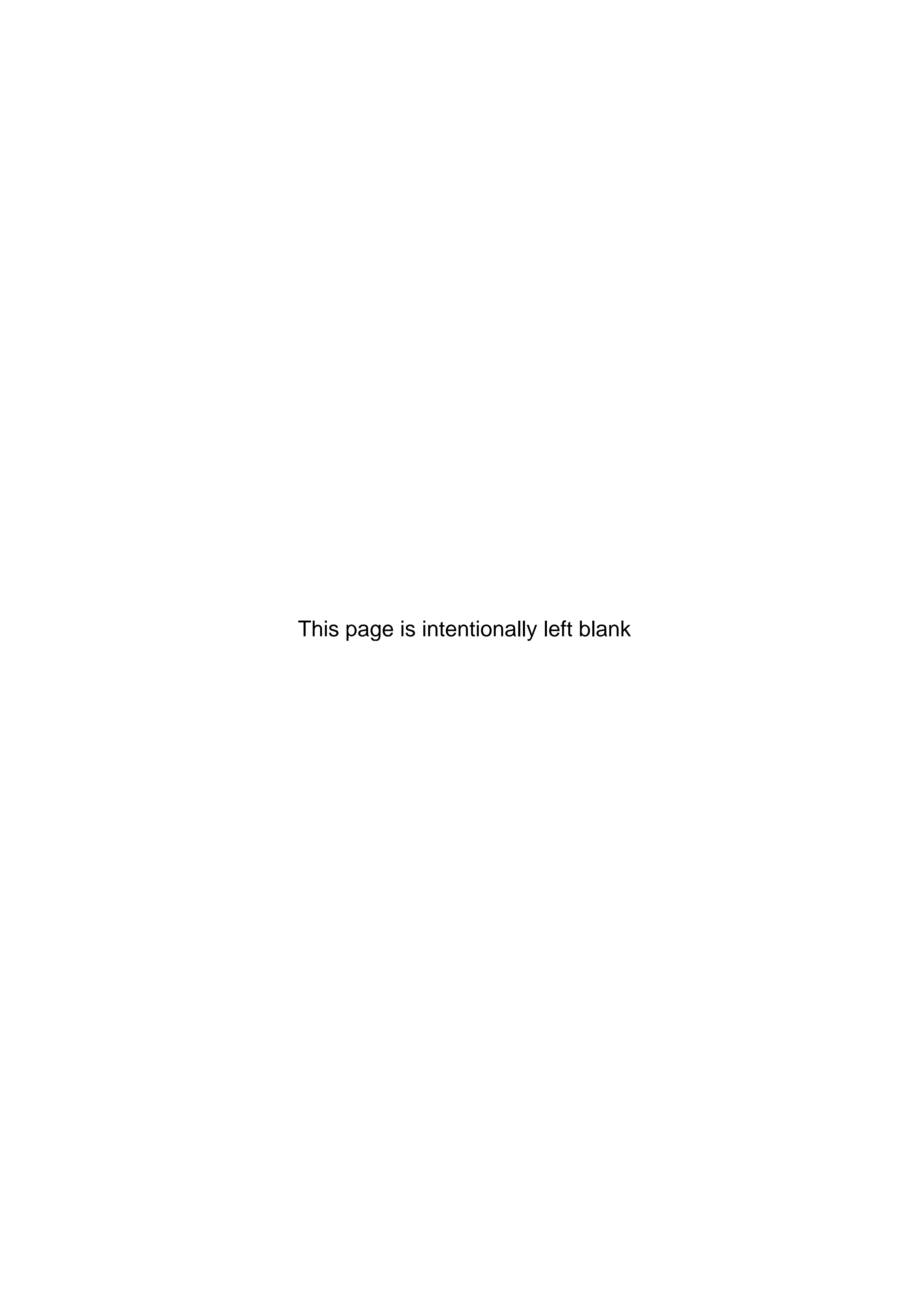


KSAS Demand, 2013/14 in Tonbridge & Malling District



KSAS Demand, 2013/14 in Tunbridge Wells District

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Appendix B Case Study

A mother with a 12yr old daughter, had fled an abusive relationship and made an approach to KSAS assistance scheme with no food, insufficient clothing, serious rent arrears and suffering depression. The child was not attending school due to not having clothes that could fit her. KSAS supplied cash for emergency food. Clothing vouchers, a seven day food parcel and energy vouchers were also issued. The service signposted her to specialist Floating Support who set about assessing her needs, worked with the local housing benefit office to arrange back payment of benefit and reduce rent arrears. They further negotiated a reduction in rent with landlord. A CAF was set up to ensure support for the mother and child across agencies.

In assessing her needs, KSAS became aware that in the midst of this crisis, the applicant was also the sole carer for her elderly parents. Her parents, themselves vulnerable as the mother had a chronic illness and the father a terminal illness, were also in crisis and at risk of homelessness as a result of harassment due to their ethnicity.

It was clear this household was under considerable strain. Without help with her own issues and those of daughter and those of her parents, her ability to continue caring for herself, her daughter and her parents was in jeopardy. KSAS awarded food and energy to the parents and again signposted to floating support to help the older couple.

Outcome

This intervention including the signposting to supporting agencies prevented the customer losing her home and get the help she needed to manage her own affairs. KSAS provided immediate support with provision of food and clothing which protected the health of the customers and allowed the daughter to return to school and stabilise their living arrangements.

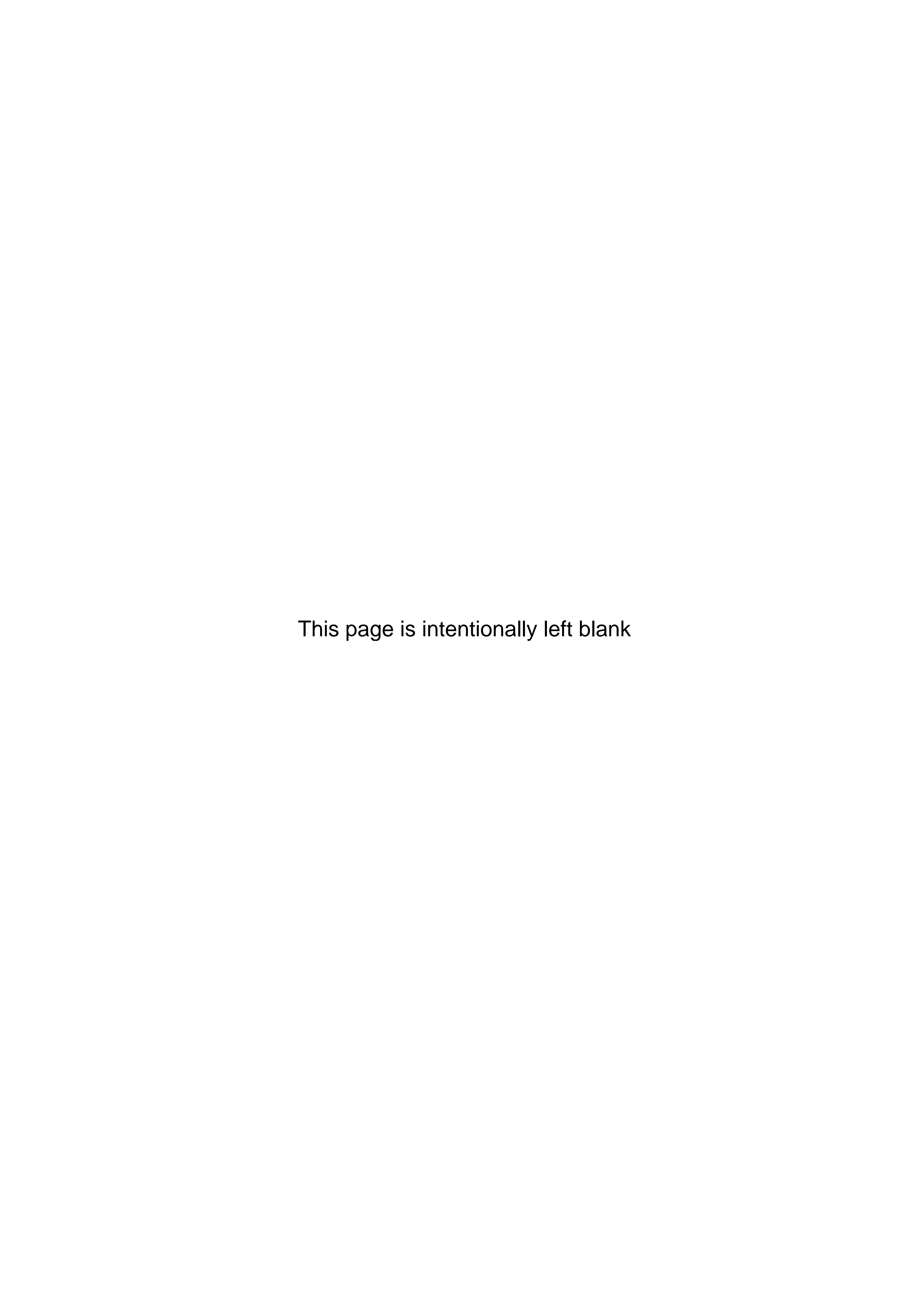
Her parent's health was protected by being supported with food, energy and equipment. With the assistance of Floating Support both households were made safe from eviction and the customer recovered sufficiently to continue as Carer for her parents allowing them to continue to live independently in the community without any statutory involvement.

Cost to KSAS

Cost of food, clothing, energy, furniture and equipment for the mother and child was £747.12p. Cost to support parents was £304.32.

Potential savings to KCC statutory services

- £2,551 per week for a child's residential home placement, or
- £818 per week for a child taken into care, or
- £555 per week for a child's foster care placement;
- £457 per week Social Care support for people with mental health
- £687 per week for Social Care support for people with physical disabilities, or
- £282 per week for Social Care support for older people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From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

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

To: Adult Social Care and Health Cabinet Committee
4 December 2014

Subject: **PROVISION OF SUPPORT TO SOCIALLY EXCLUDED GROUPS**

Classification: Unrestricted

Past Pathway: None

Future Pathway: None

Electoral Division: All

Summary: The commissioning of housing related support has been transferred to Social Care Health and Wellbeing, providing excellent opportunities to integrate with the wider social care transformation agenda. Housing related support is also commissioned to assist groups of vulnerable people outside of the traditional social care groups such as victims of domestic abuse, rough sleepers and offenders. The paper seeks views on the County Council's ongoing commitment to these groups in order that future commissioning and governance arrangements can be planned.

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

a) **CONSIDER** the information provided about the preventative services for socially excluded groups

b) **AGREE** whether the Council should continue to support these groups with such services to enable future work to be done to reshape them

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1. Introduction

1.1 Following the dissolution of the Customer and Communities Directorate in April 2014 the Commissioned Services function has been transferred to Social Care Health and Wellbeing. Commissioned Services are responsible for the commissioning of housing related support services for a wide range of vulnerable people.

- **Services for young people**, including young offenders, young people leaving care and teenage parents
- **Services for older people and people with disabilities;** these include support within sheltered accommodation, community support and alarm

services. Also included are services for people with learning disabilities, physical disabilities, sensory impairments and people with mental health problems.

- **Services for people considered socially excluded**; these include vulnerable homeless people including homeless families and rough sleepers, offenders including mentally disordered offenders, people at risk of domestic abuse, people from BME communities, gypsy/travellers and ex-service personnel

1.2 A recent review of housing related support services noted synergies between most housing related support services and commissioning intentions for adults and children's social care. Prevention and early intervention services such as housing related support are integral to the county council's strategies for children's and adult social care. It is sensible that these services should be considered in the wider context of social care transformation.

1.3 The commissioning of housing related support for Mental Health, Learning Disability, Older People and Physical Disability is best considered under the governance of the County Council's Adults Transformation Portfolio.

1.4 The commissioning of housing related support for Young People should be considered under the governance of the county council's Children's Transformation Portfolio.

1.5 The commissioning of services for those vulnerable people considered socially excluded does not directly fit into either of these arrangements. Further consideration of provision to this group of vulnerable people is warranted.

2. Policy Context

2.1 The Supporting People programme was introduced nationally in 2003. It brought together disparate funding streams from health, social care, probation and local housing authorities to establish a ring-fenced budget to fund and strategically commission housing related support services. These services are targeted at those ineligible for statutory services and aim to tackle social exclusion, preventing crisis and more costly service interventions by reducing dependency rather than simply meeting existing need.

2.2 Housing Related Support develops or sustains the capacity of a vulnerable person to maintain their current level of independence in their own home, or to move to more independent, stable and sustainable housing. It enables vulnerable people recover from homelessness and move towards social inclusion and settled accommodation, by developing skills, resilience and capacity without drawing upon statutory services such as social care.

2.3 The services are intended to be enabling and preventative such as those duties outlined in the Care Act. They help vulnerable people to avoid, delay or move on from institutional services and to live as independently as possible for as long as possible. Housing-related support services are services provided over and above basic housing management services but they do not include personal care services.

2.4 This is achieved by delivering targeted, tailored, practical help and advice to:-

- Find or maintain safe, suitable and settled housing
- Budget and manage money
- Acquire independent living skills that support good physical and mental health and wellbeing
- Find work or access education or training
- Establish social, health and community links such as with GPs, voluntary organisations

2.5 Housing related support is tenure neutral and is available to vulnerable people whether they live in their own homes or in rented accommodation belonging to local Authorities, other registered social property owners, e.g. Housing Associations, or private landlords.

3. Current Context

3.1 The Council spends £7.4m on services in the socially excluded category for vulnerable people who are:-

- **Vulnerable Homeless** – singles or families, including ex service personnel and rough sleepers (£4.64m)
- **Offenders** (£648k)
- **People at risk of Domestic Abuse** (£1.74m)
- **People from Black and Ethnic Minority Communities** (£83k)
- **Gypsy Travellers** (£18k)

3.2 Those who use these services present with highly complex needs and histories, and chaotic back grounds including mental health problems, offending, problematic use of drugs and alcohol, learning difficulties which is at the heart of their homelessness. Whilst they may not reach the threshold for statutory services, such as social care, without help their needs will escalate to levels that do require these more costly interventions.

3.3 Homelessness is governed by legislation and is the statutory responsibility of the district and borough councils. Vulnerable homeless people who access KCC's services do not meet the priority need for accommodation and are not entitled to anything other than advice and guidance from housing authorities. Whilst district and borough housing department will always try to help even where there is no duty to so, without support tenancies will break down leading to repeat homelessness, and an escalated call on public services including adult social care.

3.4 Further detail of the services currently provided are given in Appendix 1.

4. Key Issues

4.1 The authority has the opportunity to consider its ongoing commitment to the socially excluded vulnerable groups it has supported since the national programme of Supporting People was incepted. The annual cost of that commitment is currently £7.4m annually. Most of the contracts for these services end in March 2015.

4.2 Whilst these individuals in these groups do not meet statutory thresholds, the provision of this preventative support has successfully diverted demand away from statutory services for some time, benefitting the authority directly and its strategic partners.

4.3 The cessation of these services would, in the short term, lead to a saving, but in the absence of the protection that this preventative programme delivers, the council's frontline services such as Specialist Children's Services, Adults Social Care, particularly Mental Health Services, and Safeguarding, Public Health are likely to quickly come under mounting pressure as the complex unmet needs of these cohorts escalate beyond the eligibility threshold.

4.4 Similarly, the frontline services of strategic partners such as the Police, districts, probation, CCGs and other acute health partners are also likely to experience a sharp rise in demand, as needs escalate and reach crisis.

4.5 As a strategic commissioning authority, KCC may choose to reshape these services in a more efficient manner and look to co-commission them with other partners who are beneficiaries of outcomes they achieve. A recent needs analysis of housing related support needs in Kent conducted by the Chartered Institute of Housing identified opportunities to co-commission, reduce duplication and deliver outcomes more cost effectively, allowing the authority to retain and further the preventative benefit of these services whilst reducing their cost.

5. Financial Implications

5.1 The net budget allocation for all housing related support for vulnerable people for 2014/15 is £22.4m. At the time of writing, services are delivered via over 250 contracts, held with a diverse range of providers from sole traders, voluntary organisations and large national social housing organisations. (Appendix 1)

5.2 The MTFP included a target of £2.4m for 2014/15, across all cohorts, including socially excluded groups, which has been achieved. A £1m target has been set for 2015/16 from this group.

5.3 The "Housing Related Support Commissioning Plan 2014-17" built upon the needs analysis conducted by the Chartered Institute of Housing. The plan set a course to reshape, reconfigure and recommission housing related support services over the coming years through a thematic redesign of integrated, preventative and co-commissioned services by service user group and take advantage of commissioning opportunities in a broader context.

5.4 Whilst the future allocation was not known, substantial savings were expected to be achieved.

- reduction in the overall contracted values and contracts,
- reduce duplication within the local authority and its key partners,
- defining and aligning and improving a clear preventative role to reduce demand on more expensive statutory services.
- Increase in capacity by erasing the artificial boundaries between accommodation based services and community based services and delivering 3 pipeline supported housing schemes

- Savings delivered would be phased through the timetable as each cohort was to be recommissioned in turn, reducing the number of contracts from 250 to less than 20.

5.5 In order to plan the delivery and extent of future savings, it is essential to establish the authority's commitment to socially excluded groups.

6. Legal Implications

6.1 Most of the contracts for socially excluded groups expire in March 2015. If they are to be reshaped and relet, it will be necessary to let single source tenders to ensure continuity of service whilst the recommissioning is planned and carried out.

7. Equality Impact Assessment

7.1 An equalities impact assessment will be necessary for any substantive change or diminution of service provision.

8. Alternatives and Options

8.1 The delivery of housing related support services requires continued effective partnerships with Districts and Boroughs, not least as housing authorities. The interdependencies in other areas of the council's business which rely upon cooperation of the partners should also be taken into account e.g. Accommodation Strategy. The authority remains committed to working alongside its district and borough partners and their views will continue to be sought throughout any transition.

8.2 In a recent meeting of the Commissioning Body, assurances were sought about KCC's intention for the level of investment in services for socially excluded groups. It was agreed that prior to any such assurance, it was necessary to establish a view about the continued provision of service to this varied group which could be shared with the Body in its January meeting.

8.3 Other similar upper tier authorities have also chosen to take the opportunity to integrate services for statutory groups with their existing provision and have retained services for socially excluded groups in recognition of their preventative benefit. Whilst some authorities have taken the opportunity to reshape and simplify their services as proposed, others have not yet done so.

9. Implementation Proposals

9.1 The Adult Social Care and Health Cabinet Committee's views will be shared with the Commissioning Body in January. If appropriate, future options for governance for the new arrangements will be drawn together. A series of consultations with providers, carers and services users will follow in order to support service change, where necessary.

9.2 The provision of support to these groups may be considered a topic suitable for a future Select Committee Review.

10. Recommendations

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

a) **CONSIDER** the information provided about the preventative services for socially excluded groups

b) **AGREE** whether the Council should continue to support these groups with such services to enable future work to be done to reshape them

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Background Information:

Select Committee report on Domestic Abuse
CIH Needs Analysis of Housing Related Support in Kent
Housing Related Support Commissioning Plan 2014-17
Appendix 1 Contract Summary

Appendix 1 Service Summary

1 Vulnerable Homeless People

(1) The authority currently spends £4.64m on providing services to vulnerable people who are homeless or at risk of homelessness including homeless families and rough sleepers. These services have the capacity to support 1432 households at any one time. In 2013/14 these services supported 2184 households, which contained a further 170 children.

(2) There are 20 contracts for support services for single homeless clients and 1 for homeless families. These services are provided in a range of settings from hostel style provision with 24 hour support to smaller capacity services with lower staffing levels. Accommodation costs are met by the local housing authority.

(3) There are 2 street-based rough sleeper support services covering the county, working with up to 75 people with entrenched street lifestyles to support them into settled accommodation

(4) There are 2 large floating support services that can help up to 1015 households at one time. These services are tenure neutral and focus on those who are homeless or threatened with homelessness. They include people who are sofa-surfing or other, very temporary and unsustainable housing situations.

(5) These services have successfully focussed on enabling people to move on into more settled, accommodation with the skills and abilities they need to lead an independent life, usually in the private rented accommodation. They are supported to sustain their tenancies by learning to manage money, understand their tenancy obligations, find or prepare for work, access and develop self-reliance and resilience skills by making connections in their own communities. They are helped to take responsibility for making significant improvements in their health and wellbeing, through for example accessing primary healthcare services and to comply with treatment or criminal justice requirements.

(6) In 13/14, 27% of rough sleepers were supported off the streets in just 14 days and a further 15% within just one month, contributing not just to the outcomes for the individual but also to reductions in antisocial behaviour and improvements in community safety. Of this group 96% improved their physical health and 90% improved the mental health.

(7) The services are delivered by 10 providers including local charities, voluntary and other third sector organisations, employing over 60 FTE.

2 Domestic Abuse

(1) The authority currently spends £1.74m annually on providing housing related support services for victims of domestic abuse. These services have the capacity to support 264 households at any one time.

(2) There is refuge provision in all but one district in the county totalling 100 household units. Planning permission for the development of the remaining borough

is well underway. Accommodation costs are met by the local housing authority. In 2013/14 175 women and 142 children were supported within refuge accommodation.

(3) In providing structured support in safe accommodation, these services provide a valuable resource to children's social care, minimising the interventions required by social services, particularly in relation to the removal of children from violent and dangerous household environments.

(4) Whilst refuge accommodation provides an immediate place of safety for women and their children, it is the support provided that enables them to recover from their traumatic experiences and to go to live safe, healthy and successful lives. Those entering refuge often have little experience of managing money and need help to access to healthcare, training and employment as well therapeutic services and education for their children

(5) Refuge providers in Kent deliver supplementary services, such as playworkers, support groups and counselling that build upon and complement those commissioned by KCC. Funded is attracted through other charitable grants such as Comic Relief or the Big Lottery fund. These deliver significant added value to the services commissioned through Kent County Council particularly in the reduction of repeat future victimisation in both adults and children.

(6) Refuges prepare women for managing the transition into safe independent accommodation which include taking on a new tenancy, transferring to a different refuge, or returning to their home in a safe and controlled manner to a life free from abuse. In 2013/14, 126 households were supported to move on in this way.

(7) In addition to refuge provision, there are two floating support services for men or women who are experiencing domestic abuse. These services are able to help those who have fled, are planning to flee or who need help to stay in their own accommodation, safe from the perpetrator. The services can help up to 164 households at one time and in 13/14 helped 314 households.

(8) In addition to reducing demand on emergency services and in particular Accident and Emergency departments, by enabling victims and their families to remain at home, floating support services play a key role in improving future resilience for victims and reduce the long term effects and costs of disrupted education for children associated in these households.

(9) The domestic abuse services in Kent are delivered by a range of 6 specialist providers including local charities, voluntary and other third sector organisations, employing over 40 FTE.

3 Offenders

(1) The authority currently spends £648k on housing related support services to vulnerable offenders whose housing support needs arise from their offending. Services work closely with probation services to identify those offenders who are in need of support and ensure they are targeted for the services. Offenders present with complex and multiple needs including substance misuse, mental health problems and social isolation, some have CPA and MAPPA arrangements in place.

(2) There are 11 contracts for these services across the county, with the capacity to support 138 households at any one time. In **2013/14** these services supported 291 offenders.

(3) The Care Act places new responsibilities on the authority to consider the social care needs of those in prisons. There are six prison establishments in Kent.

(4) There are 9 contracts for small, specialist supported housing for offenders with capacity for 80 service users. These short term services are available for up to two years, during which time skilled support workers enable service users to settle into their community, find work, manage bills and understand their obligations under their tenancy agreement as well as comply with any treatment or statutory orders. Offenders are supported to move on into independent accommodation and continue in a life away from crime.

(5) Whilst the majority of offenders move on into independent accommodation, for a small number their stay is supported housing is part of a planned programme to prepare for final release. They will return to prison after a short stay in supported housing in order to ensure they are skilled and ready for release into the community.

(6) There are two floating support services covering east and west Kent respectively. They have capacity to help 58 people at any one time. The services work with vulnerable offenders who are in very temporary living arrangements to enable them to find and sustain settled accommodation.

(7) Services for offenders in Kent are delivered by a range of 4 specialist providers including local charities, voluntary and other third sector organisations, employing approximately 21 FTE. Some services additionally have a peer mentoring schemes which provide employment opportunities within the services for former service users.

4 People from BME Communities

(1) The authority currently spends £83k on housing related support services to vulnerable people from black and ethnic minority communities whose housing support needs arise from their cultural needs and experiences and are harder to reach in other services. These specialised services are highly skilled to address the very wide range of needs that are presented such as homelessness, mental health problems, domestic abuse, “honour” based violence, in the context of an in-depth understanding of the needs of these communities.

(2) There are 2 floating support contracts for these services across the county, with the combined capacity to support 42 households at any one time. In 2013/14 these services supported 93 households.

(3) Both of these contracts are held by a specialist charitable organisation with specific expertise in the needs of these communities.

5 Ex service personnel

(1) Whilst there are not yet any specialist housing related support services for ex-service personnel, both the latest needs analysis and commissioning plan signal a need to address this deficit.

(2) In 2013/14, 61 former members of the armed forces benefitted from the existing services commissioned. The majority of these were supported in services for socially excluded vulnerable homeless people, as follows:-

- 36 in floating support
- 12 in rough sleepers services
- 12 in homeless hostels/women's refuges

This is indicative that many had been found to be living in very temporary living conditions such as rough sleeping, sofa surfing, living in outbuildings etc

6 Gypsy Travellers

(1) The county council currently holds just one contract to deliver housing related support to gypsies or travellers to the value of £18k.

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

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

To: Adult Social Care and Health Cabinet Committee
4 December 2014

Decision No: **14/00134**

Subject: **CARE ACT IMPLEMENTATION – ELIGIBILITY CRITERIA FOR ADULT CARE AND SUPPORT**

Classification: Unrestricted

Past Pathway: Adults Transformation Board 22 October 2014, CMT 11 November 2014, Cabinet 1 December 2014

Future Pathway: Recommendation Report to the Cabinet Member

Electoral Division: All

Summary: This report follows on from the previous report that was presented to the Adult Social Care and Health Cabinet Committee on 26 September 2014 and sets out the detail of the Key Decision on the Eligibility Criteria policy that is required to be made in readiness for April 2015. In summary, it is recommended that the County Council adopts the new national minimum eligibility criteria as Kent's offer from April 2015.

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

a) **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in this report and in Appendix 1.

1. Introduction

1.1 The Care Act 2014 received Royal Assent in May this year. It will be implemented in two stages starting in April 2015 with the introduction of the new legal framework. The majority of the reforms will come into effect in April 2015 but the key 'Dilnot' reforms (cap on care costs and raising of the capital threshold) and new rights for self-funders in relation to care homes will not be instituted until April 2016 (subject to final decisions by the Government).

2. Eligibility Criteria for Care and Support

2.1 One of the major planks of the Care Act is the introduction from April 2015 of a new national minimum eligibility criteria for adults with care and support needs which all councils must adhere to (section 13 of the Act). The detail of the new criteria is contained in The Care and Support (Eligibility Criteria) Regulations 2014, the final version of which was released in October 2014.

2.2 In summary an individual with care and support needs will meet the minimum eligibility if:

(a) their needs arise from or are related to a physical or mental impairment or illness **AND**
(b) as a result they are unable to achieve two or more specified outcomes **AND**
(c) as a consequence there is, or is likely to be, a significant impact on their wellbeing, as defined under section 1 of the Care Act.

An adult's needs are only eligible if they meet all three of the above conditions.

2.3 It is important to note that eligibility is to be assessed without regard to the support provided by a carer. Therefore, a person may be eligible under the Care Act without KCC necessarily having to provide significant services. In practice most people assessed as eligible will probably have their needs met by a combination of care provided by the council and their carer, if they have one. The increased rights for carers under the Act should help carers to perform this role on a sustainable basis. Support from the voluntary sector and the wider community can also be an appropriate way of meeting needs in some cases.

2.4 It is also important to note that safeguarding has separate criteria and therefore if safeguarding issues are identified, care and support can if necessary be provided regardless of whether the individual meets the minimum eligibility for care and support.

2.5 The final version of the Eligibility Regulations differs slightly from the draft version released for consultation on 6 June 2014 (and which was discussed at previous Cabinet Committees). The main change is that in order to meet the eligibility criteria a person must be unable to meet two or more specified outcomes rather than "an outcome" as stated in the draft regulations. In addition, the previous version contained a mixture of outcomes and basic care activities, whereas in the final version everything has been framed as outcomes. Appendix 2 contains a full description of the new criteria and how it compares to the existing 'Moderate' level applicable in Kent.

2.6 Despite the changes, it is still the considered view of officers working on this issue that the new criteria create a threshold that is lower than the current substantial level, and is more in line with the moderate level which applies in Kent. It is therefore recommended that the council adopts the new national minimum eligibility criteria as the Kent eligibility criteria for care and support from April 2015. As the new minimum is thought to offer a similar threshold for accessing care and support as the current "moderate" level applicable in Kent, it is thought to be reasonable to adopt the national minimum as Kent's offer.

2.7 In considering the above proposal, the key questions for KCC and Kent residents are as follows:

(a) Will current service users assessed as 'Moderate' continue to be eligible after April 2015?
(b) Will an individual who would be assessed as 'Moderate' if they were assessed now, still be assessed as eligible if they come forward for the first time after April 2015?

2.8 It is believed that both of the above questions should be answered in the affirmative. The evidential basis for this view is a combination of analysis of the precise wording of the new criteria, a review of DH commissioned research and an exercise comparing actual cases against both the current and new criteria. Further details are provided in the following sections.

2.9 As stated above, Appendix 2 contains details of how the current eligibility criteria compares to the new minimum. Appendix 3 considers a number of anonymised cases currently assessed as 'Moderate' or lower to show how they would be assessed under the new criteria. It demonstrates that a case assessed now as meeting the 'Moderate' criteria is likely to meet the new national minimum.

2.10 In order to compare the criteria against actual cases an exercise will be carried out with operational staff who will assess current 'moderate' cases against the new national minimum. The results of this exercise will be available to the Cabinet on 1 December 2014, the Cabinet Committee on 4 December 2014 and the Cabinet Member before the decision is made.

2.11 The Department of Health commissioned the Personal Social Services Research Unit (PSSRU) at the London School of Economics (LSE) to evaluate the various drafts of the new Eligibility regulations against current practice.[1] Current practice for the majority of councils (130 out of 152) means providing to the 'Substantial' level in theory. However, as the DH's impact assessment acknowledges, [2] an earlier report in 2012 by the PSSRU [3] demonstrated that councils interpret the current criteria very widely and that there is not a clear correlation between the level applied in a particular council and the level of needs supported.

2.12 PSSRU's current research indicates that the new eligibility criteria will lead to an extra 4,000 individuals becoming eligible. However they clearly state that because of their earlier research, they expect the impact to be felt on all councils and not just those with the more, on the face of it, restrictive eligibility.[4]

2.13 In order to explain the thinking on eligibility and gather views from service users, carers and organisations that represent them, some engagement will take place over the next few weeks. The results of this will be made available to the Cabinet Member before any decision is taken.

2.14 With regard to current service users, it is proposed that they continue to be recorded as eligible under the new national minimum criteria without the need for a reassessment unless their needs have clearly changed. This approach is clearly supported by the final version of the statutory guidance (paragraph 23.11).

2.15 Discussions are currently being held with some of the other local authorities that offer support for 'Moderate' needs. The results of this will be made available to the Cabinet Member before the decision is taken.

2.16 In order to have an independent legal opinion on how Kent's current eligibility compares to the new national minimum and also on the requirement for

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[1] DH Impact Assessment: 'The Care Act 2014: Regulations and guidance for implementation of Part 1 of the Act in 2015/16' (IA no. 6107) 16.10.2014
[2] Ibid
[3] PSSRU report : **'S**urvey of fair access to care services (FACS) assessment criteria among local authorities in England' 2012
[4] Ibid

consultation, external legal advice has been sought. This will be made available to the Cabinet Member to consider before a final decision is taken.

2.17 The Cabinet Committee is asked to consider and endorse the proposal that the Cabinet Member takes the Key Decision detailed in Appendix 1 below.

3. Alternative Options

3.1 All local authorities from April 2015 must, by law, meet the unmet eligible needs of individuals who meet the national minimum criteria. There are therefore only two lawful alternatives:

(a) For Kent's eligibility criteria to be set at the level of the new national minimum

OR

(b) For Kent's eligibility criteria to be set at a lower level than the national minimum.

3.2 If option (b) was chosen as the preferred alternative, a possible way to achieve this would be to state that an individual had to be unable to achieve only one of the specified outcomes (see Appendix 2 below).

3.3 Option (b) is not recommended as it would seem to set the bar at a lower level than currently operates in Kent. It is also believed to be unnecessary as it will still be possible in exceptional cases to arrange care and support for people who fall below the minimum eligibility criteria if it is deemed to be appropriate to prevent or delay the development or increase in needs. In individual cases Case Managers always have the discretion to accept a person as eligible even when they do not strictly meet the criteria and this is thought to be sufficient to cover those cases, as now, that may be on the borderline of eligibility.

4. Recommendation

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

a) **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in this report and in Appendix 1

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Background documents:
Care Act 2014
Statutory Regulations 2014 – released October 2014
Statutory Guidance 2014 – released October 2014

Appendix 1 – Proposed Record of Decision

DECISION TO BE TAKEN BY **Graham Gibbens, Cabinet Member for Adult Social Care and Public Health**	DECISION NO. **14/00134**

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

Subject: : **Eligibility Criteria for Care and Support (Adults)**

Decision:

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

That Kent County Council should adopt the National Minimum Eligibility Criteria for determining which adults with care and support needs meet Kent's eligibility criteria from 1 April 2015.

Any Interest Declared when the Decision was Taken

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

One of the major planks of the Care Act is the introduction from April 2015 of a new national minimum eligibility criteria for adults with care and support needs which all councils must adhere to (section 13 of the Act). The detail of the new criteria is contained in The Care and Support (Eligibility Criteria) Regulations 2014, the final version of which was released in October 2014.

In summary an individual with care and support needs will meet the minimum eligibility if they meet all three of the following conditions:
(a) their needs arise from or are related to a physical or mental impairment or illness AND
(b) as a result they are unable to achieve two or more specified outcomes AND
(c) as a consequence there is, or is likely to be, a significant impact on their wellbeing, as defined under section 1 of the Care Act.

It is considered that the new criteria create a threshold that is lower than the current substantial level, and is more in line with the moderate level which applies in Kent. It is therefore recommended that the council adopts the new national minimum eligibility criteria as the Kent eligibility criteria for care and support from April 2015. As the new minimum is thought to be as generous as the current "moderate" level applicable in Kent, it is not thought necessary to widen eligibility beyond the national minimum in order to maintain the current level of eligibility. It is recommended that existing service users be passported to eligibility under the new national minimum criteria from 1 April 2015, unless there is evidence that their needs have clearly changed.

The only lawful alternative to the above is for Kent's eligibility criteria to be more generous than the national minimum. A possible way to achieve this would be to state that an individual had to be unable to achieve only one of the specified outcomes rather than two

or more. This is not recommended as it would seem to set the bar at a lower level than currently operates in Kent. It is also believed to be unnecessary as it will still be possible in exceptional cases to arrange care and support for people who fall below the minimum eligibility criteria if it is deemed to be appropriate to prevent or delay the development or increase in needs. In individual cases Case Managers always have the discretion to accept a person as eligible even when they do not strictly meet the criteria and this is thought to be sufficient to cover those cases, as now, that may be on the borderline of eligibility. **Background Documents:** Recommendation report from Corporate Director to Cabinet Member
Cabinet Committee recommendations and other consultation: The proposed policy will be considered by KCC Cabinet on 1 December 2014 and by the Adult Social Care and Public Health Cabinet Committee on 4 December 2014.
Any alternatives considered: See above.
Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

Appendix 2 – Comparison of the current 'Moderate' and new eligibility criteria

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<u>Definition of the current 'Moderate' level of eligibility</u>

In general, councils may provide community care services to individual adults with needs
arising from physical, sensory, learning or cognitive disabilities, or from mental health needs. The needs should be assessed according to the risk to independence and well-being and should support the outcomes an individual wants to achieve. The four bands (Critical, Substantial, Moderate and Low) describe the seriousness of the risks to independence and wellbeing if the needs are not addressed. The criteria for **Moderate** is as follows:

• there is, or will be, an inability to carry out <u>several</u> personal care or domestic routines; and/or
• involvement in <u>several</u> aspects of work, education or learning cannot or will not be sustained; and/or
• <u>several</u> social support systems and relationships cannot or will not be sustained; and/or
• <u>several</u> family and other social roles and responsibilities cannot or will not be undertaken.

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<u>Definition of the new national minimum eligibility from April 2015</u>

In summary an individual with care and support needs will meet the minimum eligibility if:

(a) their needs arise from or are related to a physical or mental impairment or illness AND
(b) as a result they are unable to achieve a two or more specified outcomes AND
(c) as a consequence there is, or is likely to be, a significant impact on their wellbeing, as defined under section 1 of the Care Act.

The specified outcomes are:

(a) managing and maintaining nutrition;
(b) maintaining personal hygiene;
(c) managing toilet needs;
(d) being appropriately clothed;
(e) being able to make use of the adult's home safely;
(f) maintaining a habitable home environment;
(g) developing and maintaining family or other personal relationships;
(h) accessing and engaging in work, training, education or volunteering;
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and
(j) carrying out any caring responsibilities the adult has for a child.

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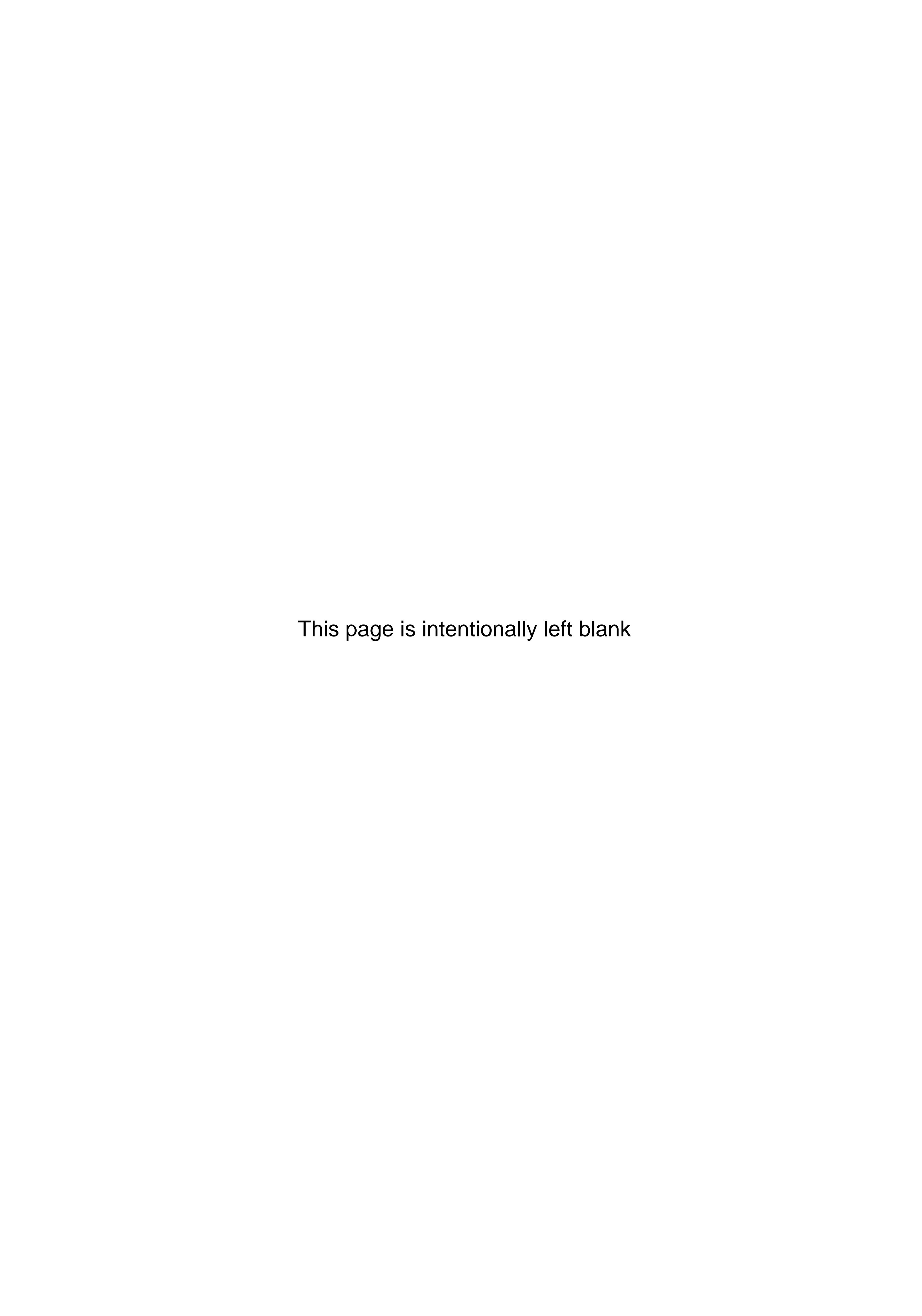
Appendix 3 – Case Studies

The following table contains case studies of individuals who meet and don't meet the current Kent 'Moderate' criteria and looks at whether they would be eligible under the new national minimum criteria to be introduced in April 2015. It should be stressed that once an individual is assessed as eligible, there might be various ways to meet needs which do not only include the provision of services by KCC on an ongoing basis. Also, eligibility should be assessed without reference to any care provided by a carer. What the carer can or cannot do only comes into the equation after the eligibility decision, during the care and support planning stage.

Case details	Current moderate eligibility	New national minimum
Mrs A – an 80 yr old lady who lives alone; she has arthritis and is somewhat at risk of falling; she is also socially isolated, gets anxious and is at risk of becoming low in mood. At the moment her daughter visits twice a day and Mrs A tends to spend all day Sunday with her daughter, but there is a danger of the carer role breaking down.	YES She is unable to safely get showered, in and out of bed and perform some domestic routines; she also cannot maintain social support systems and relationships without help. The above does pose a risk to her independence and wellbeing.	YES She is unable to achieve outcomes (b), (e), (f), (I) and possibly (g) (so at least 2); it is clear this is already having a significant impact on her wellbeing – she is at risk of falling and becoming socially isolated and low in mood. Therefore without any help the impact would be very significant.
Miss B is a 56 yr old lady with Down's syndrome who lives with her 90 yr old father in a private house. She needs supervision and prompting with managing personal care and domestic tasks; she is socially isolated and needs social stimulation.	YES She is unable, without prompting, to carry out several personal care and domestic routines and also needs help overcoming her social isolation.	YES She is unable to achieve outcomes (b), (c), (d), (f), (g) and (i) without assistance, and (h) may be relevant (so at least 2). This is already having a significant impact on her wellbeing even with the help she gets from her father. Therefore without any help the impact would be very significant.
Mr C is a 60 yr old man who lives alone in a first floor flat; he suffers from chronic obstructive pulmonary disease, gets breathless on exertion and is prone to chest infections; he is also very down about the recent break-up of his marriage; his needs (mainly help with washing and dressing) fluctuate depending on his condition.	YES Looking at his needs over a longer period we can conclude that he is unable to carry out several personal and domestic routines; he also has difficulty sustaining work and developing personal relationships.	YES He is unable to achieve outcomes (b), (e) and (f) on a regular basis (although at times he can self-manage) and probably also (h) (so at least 2). Without help this is likely to have a significant impact on his wellbeing
Ms D is a 70 yr old lady who suffers from osteoarthritis. She manages most of her	NOT ELIGIBLE She falls below the	YES For the reason that she is unable

personal care herself except for having a shower as she is unsteady at times and prone to falling.	'Moderate' eligibility level as she does not have an inability to carry out several personal care or domestic routines. However she may be provided with a one-off adaptation to minimise the risk of falling.	to achieve outcomes (b) maintaining personal hygiene and (e) being able to make use of the home safely (so at least 2 outcomes). The pain she experiences and the impact of not being able to shower is having a significant impact on her wellbeing. NB: although eligible, it may be that her needs can be met, as now, without the need for ongoing care and support, by providing equipment and adaptations to the home.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From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Ireland, Corporate Director Social Care, Health and Wellbeing

To: Adult Social Care and Health Cabinet Committee
4 December 2014

Decision No: **14/00135, 14/00136**

Subject: **CARE ACT IMPLEMENTATION – CHARGING AND DEFERRED PAYMENTS**

Classification: Unrestricted

Past Pathway: Adults Transformation Board 22 October 2014, CMT 11 November 2014, Cabinet 1 December 2014

Future Pathway: Recommendation Report to the Cabinet Member

Electoral Division: All

Summary: This report follows on from the previous report that was presented to the Adult Social Care and Health Cabinet Committee on 26 September 2014 and sets out the detail of the Key Decisions required to be made in readiness for April 2015 with regard to charging and Deferred Payments. The decisions are as follows:

1. To put the current charging arrangements for adults in respect of residential care and non-residential services on a new statutory footing under the Care Act 2014.

2. To approve in outline terms the new Deferred Payments Scheme from April 2015 and further to agree that the current Temporary Financial Assistance scheme should cease from 31 March 2015.

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

a) **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decisions on Charging Policies for Adult Care and Support and Deferred Payments and Temporary Financial Assistance as set out in this report.

1. Introduction

1.1 The Care Act 2014 received Royal Assent in May this year. It will be implemented in two stages starting in April 2015 with the introduction of the new legal

framework. The majority of the reforms will come into effect in April 2015 but the key 'Dilnot' reforms (cap on care costs and raising of the capital threshold) and new rights for self-funders in relation to care homes will not be instituted until April 2016 (subject to final decisions by the Government).

2. Power to charge for care and support

2.1 The current legal framework governing charging for adult care and support involves a mixture of duties and powers. Councils are under a duty to charge for residential care under section 22(1) of the National Assistance Act 1948 and have a power to charge for non-residential services under section 17 of the Health and Social Services and Social Security Adjudication Act 1983. These powers and duties will cease from April 2015 and are being replaced by a power to charge under section 14 of the Care Act 2014.

2.2 As charging will be a power only from April 2015, KCC has to actively make a decision about which services it will charge for. Having taken such a decision, the way charges are to be worked out (i.e. the rules around means-testing) will be broadly the same as currently. These are to be governed by The Care and Support (Charging and Assessment of Resources) Regulations 2014 and the accompanying Statutory Guidance. It is important to note that the significant increase in the capital threshold for residential care charging does not come into force until April 2016.

2.3 It is recommended that for 2015-16 we preserve the status quo and continue to charge the same groups of people and for the same services as we currently do. However, it will be necessary for a Key Decision to be taken by the Cabinet Member in order for charging to be put on a firm legal basis under the new legal framework. Kent Legal Services have endorsed this view.

2.4 With regard to public consultation, it is believed that this is not required at this stage as no substantive changes are to be made to Kent's charging regime. Any minor changes to the rules on charging are those that have been prescribed by Government and these do not significantly affect service users' contributions.

2.5 The Cabinet Committee is asked to consider and endorse the proposal that the Cabinet Member takes the Key Decision detailed in Appendix 1 below.

3. Deferred Payments and Temporary Financial Assistance

3.1 The Care Act 2014 introduces a new Universal Deferred Payments Scheme which all local authorities must introduce from April 2015. The relevant sections of the Act are sections 34 and 35. Further details are provided in The Care and Support (Deferred Payment) Regulations 2014 and in the statutory guidance, the final versions of which were issued in October 2014. The Act confers a duty on local authorities to develop a mandatory scheme based on national regulations. Kent will institute a scheme from April 2015 in accordance with these criteria. Appendix 3 gives a brief overview of what the mandatory scheme will involve.

3.2 In addition to the mandatory scheme, the Act gives the local authority the power to offer Deferred Payments to a wider group of people on a discretionary basis. It is envisaged that the criteria for the discretionary scheme will encompass, at the very

least, the sort of situations currently covered by the Kent Temporary Financial Assistance (TFA) scheme and may even be wider in scope. Appendix 4 gives a brief overview of the discretionary scheme.

3.3 In view of the above, it is not believed to be necessary to continue the local TFA scheme and it is recommended therefore that the TFA scheme end for new clients from 31 March 2015.

3.4 It is important to note that when the new Deferred Payment scheme starts on 1 April 2015, existing Deferred Payment and TFA agreements will not be affected and will continue. There are currently (as at 29.10.14) 119 Deferred Payments agreements and 43 TFA agreements extant.

3.5 Further information about the current TFA scheme is available in the report to the Cabinet Committee on TFA dated 11 July 2014.

3.6 The Cabinet Committee is asked to consider and endorse the proposal that the Cabinet Member takes the Key Decision detailed in Appendix 2 below.

4. Recommendation:

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

a) **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decisions on Charging Policies for Adult Care and Support and Deferred Payments and Temporary Financial Assistance as set out in this report.

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

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Appendix 1 – Draft Record of Decision on Charging

KENT COUNTY COUNCIL - PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY **Graham Gibbens, Cabinet Member for Adult Social Care and Public Health**	DECISION NO. **14/00135**

Charging for Adult Care and Support

Decision:

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

That Kent County Council exercises its power under Section 14 of The Care Act 2014 to charge from 1 April 2015 for the same services that it currently charges for as at 31 March 2014.

Any Interest Declared when the Decision was Taken:

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

The current legal framework governing charging for adult care and support involves a mixture of duties and powers. Councils are under a duty to charge for residential care under section 22(1) of the National Assistance Act 1948 and have a power to charge for non-residential services under section 17 of the Health and Social Services and Social Security Adjudication Act 1983. These powers and duties will cease from April 2015 and are being replaced by a power to charge under section 14 of the Care Act 2014.

As charging will be a power only from April 2015, KCC has to actively make a decision about which services it will charge for. Having taken such a decision, the way charges are to be worked out (i.e. the rules around means-testing) will be broadly the same as currently. These are to be governed by The Care and Support (Charging and Assessment of Resources) Regulations 2014 and the accompanying Statutory Guidance. It is important to note that the significant increase in the capital threshold for residential care charging does not come into force until April 2016.

It is recommended that for 2015-16 we preserve the status quo and continue to charge the same groups of people and for the same services as we currently do. However, it will be necessary for a Key Decision to be taken by the Cabinet Member in order for charging to be put on a firm legal basis under the new legal framework. Kent Legal Services have endorsed this view.

Background Documents:
Recommendation report from Corporate Director to Cabinet Member

Cabinet Committee recommendations and other consultation: The proposed policy would be considered by KCC Cabinet on 1 December 2014 and by the Adult Social Care and Health Cabinet Committee on 4 December 2014.
Any alternatives considered: An alternative might be to continue charging from April 2015 in the same way as currently without taking a Key Decision over the use of the section 14 power. However it is believed this would potentially leave KCC open to an accusation that we are charging without the proper legal backing, not having taken a decision to exercise the power to charge under the Act.
Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

Appendix 2 – Draft Record of Decision on Deferred Payments and TFA

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY	DECISION NO.
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	**14/00136**

Subject: : Deferred Payments and Temporary Financial Assistance

Decision:

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

That Kent County Council should adopt the proposed Deferred Payments scheme (both the mandatory and discretionary elements) from 1 April 2015 and that the current Temporary Financial Assistance scheme should end for new clients on 31 March 2015.

Any Interest Declared when the Decision was Taken:

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

The Care Act 2014 introduces a new Universal Deferred Payments Scheme which all local authorities must introduce from April 2015. The relevant sections of the Act are sections 34 and 35. Further details are provided in The Care and Support (Deferred Payment) Regulations 2014 and in the statutory guidance, the final versions of which were issued in October 2014. The Act confers a duty on local authorities to develop a mandatory scheme based on national regulations. Kent will institute a scheme from April 2015 in accordance with these criteria.

In addition to the mandatory scheme, the Act gives the local authority the power to offer Deferred Payments to a wider group of people on a discretionary basis. The criteria for the discretionary scheme will be in place by January and it is envisaged that this will encompass, at the very least, the sort of situations currently covered by the Kent Temporary Financial Assistance (TFA) scheme and **is likely to be** wider in scope.

In view of the above, it is not believed to be necessary to continue the local TFA scheme and it is recommended that the TFA scheme end for new clients from 31 March 2015.

It is important to note that when the new Deferred Payment scheme starts on 1 April 2015, existing Deferred Payment and TFA agreements will not be affected and will continue. There are currently (as at 29.10.14) 119 Deferred Payments agreements and 43 TFA agreements extant.

Background Documents:
Recommendation report from Corporate Director to Cabinet Member

Cabinet Committee recommendations and other consultation:

The proposed policy will be considered by KCC Cabinet on 1 December 2014 and by the Adult Social Care and Health Cabinet Committee on 4 December 2014.
Any alternatives considered: None.
Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

Appendix 3 – Overview of the Deferred Payments mandatory scheme

1. From April 2015 KCC will be required to enter into a Deferred Payment agreement if the following criteria are met:

a) The individual with care and support needs meets the minimum eligibility criteria. *

b) The care and support plan specifies that the needs are going to be met by the provision of accommodation in a care home.

c) The individual has a legal or beneficial interest in a property which is their main or only home and that interest falls to be taken into account in the financial assessment. It appears that this could include jointly-owned property provided the legal charge can be registered (i.e. the other joint owners would have to agree).

d) The value of any other capital (i.e. apart from the interest in the property) does not exceed £23,250.

e) Adequate security can be obtained for the deferred amount and any interest and administration costs which can also be deferred. For the purposes of the mandatory scheme "adequate security" means a charge by way of a legal mortgage which is capable of being registered as a first legal charge in favour of the local authority.

f) The costs of care and support deferred are what the local authority considers it necessary to meet the adult's needs.

2. Interest can be charged on the deferred amount but this can be no more than 0.15% above an amount to be set and updated regularly by Government (this will be the weighted average interest rate on conventional gilts).

3. The costs of administration and legal procedures can be charged and added to the deferred amount.

* It is not yet clear if this will include people who arrange their own care due to the delay in implementation of section 18(3)(b) of the Care Act.

Appendix 4 – Overview of the Deferred Payments discretionary scheme

1. From April 2015 KCC will be permitted, if it so decides, to enter into a Deferred Payment Agreement in a wider set of circumstance than those that apply to the mandatory scheme. However the following criteria must still be met:

a) The individual with care and support needs meets the minimum eligibility criteria. *

b) The care and support plan specifies that the needs are going to be met by the provision of accommodation in a care home or supported living accommodation.

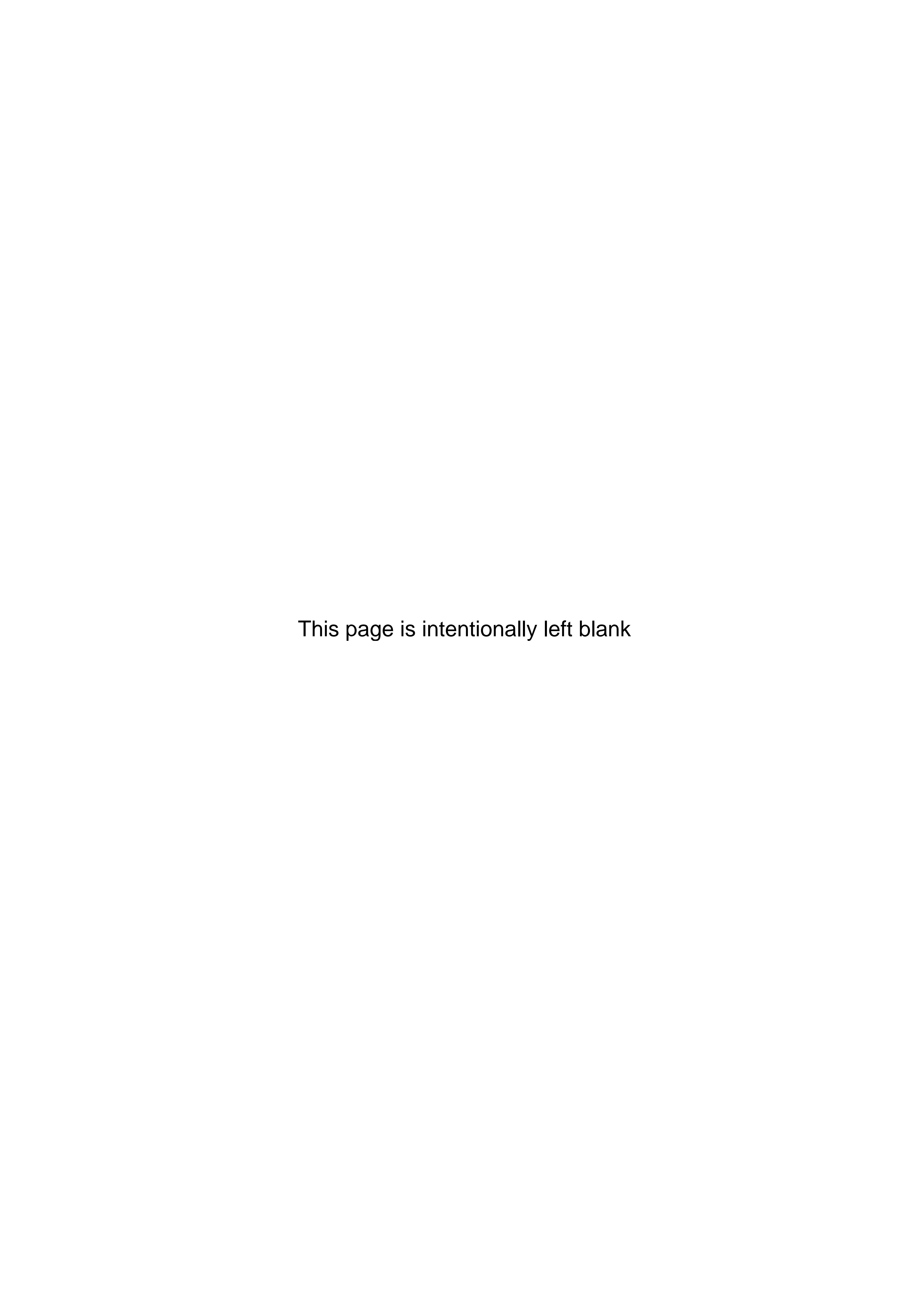
c) Adequate security can be obtained which may include a legal charge on a property but may also include other security that is considered sufficient.

2. In addition to the costs of care and support deferred being what the local authority considers it necessary to meet the adult's needs, an additional top-up may also be deferred if this is considered appropriate.

3. Interest can be charged on the deferred amount but this can be no more than 0.15% above an amount to be set and updated regularly by Government (this will be the weighted average interest rate on conventional gilts).

4. The costs of administration and legal procedures can be charged and added to the deferred amount.

* It is not yet clear if this will include people who arrange their own care due to the delay in implementation of section 18(3)(b) of the Care Act.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Who this paper is from:

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

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

Who it is to: Adult Social Care and Health Cabinet Committee

Date: 4 December 2014

What it is about:

- An update on the Joint Health and Social Care Self-Assessment Framework (JHSCSAF) for 2013/14
- national comparison and progress to date
- action plan for the local implementation of Winterbourne View Joint Improvement Programme
- Transition for people with a learning disability
- How we are doing – the wider agenda for learning disability

Pathway of Paper:

Health & Wellbeing Board – 19th November 2014

Classification: Unrestricted

Summary:

This paper gives an overview of:

- what the Kent Learning Disability Partnership Board do and its work on the Joint Health and Social Care Self-Assessment Framework for 2013/14 (JHSCSAF)

- what has been done since we received our JHSCSAF results

- how Kent compares with the rest of the country and how the Joint Health and Social Care Self-Assessment Framework will be signed off for 2014/15

- an update on the Kent Action Plan for the local implementation of Winterbourne View Joint Improvement Programme

- Performance for Learning Disability services

- And transition services (people moving from children's to adult's social services).

Recommendations:

Adult Social Care and Health Cabinet Committee is asked:

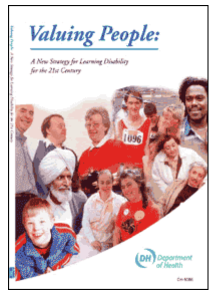
1. To comment on the 2013/14 national comparison Action Plan including the progress made in the red indicators of the RAG (this is a list with red, amber and green next to it) rating.

2. To comment on the way in which Kent is approaching the 2014/15 JHSCSAF.

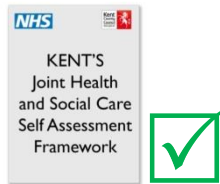
3. To comment on the Kent Action Plan for Winterbourne View.

4. To comment on the wider issues for learning disability in Kent.

1. The Kent Learning Disability Partnership Board

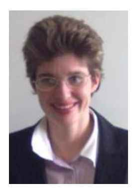


The Kent Learning Disability Partnership Board agrees and checks that the changes and improvements around the Government White Paper Valuing People (March 2001) and Valuing People Now (January 2009) are happening in Kent.



This is measured by the Joint Health and Social Care Self-Assessment Framework, which looks at how well services are being run.

The Board meet 4 times a year and members include people with learning disabilities, carers, voluntary sector and senior people from the main public services who make decisions.



There are 2 Co-chairs of the Board – an elected member of Kent County Council and a person with a learning disability. The Kent Learning Disability Partnership Board also links with the Health and Wellbeing Board and the Safeguarding Board in Kent.

1.2 The Kent Learning Disability Partnership Awards

Kent County Council held its first Learning Disability Partnership Awards in September to celebrate people who are making a difference to the lives of others.

More than 160 nominations were received for people, businesses and services and the panel of judges were impressed by those who are going the extra mile to support and improve the lives of people with learning disabilities.

The winners of the 5 categories attended a ceremony on 2 September 2014 at County Hall to receive their awards from KCC leader Paul Carter and co-chair of the Kent Learning Disability Partnership Board Tina Walker.

The 5 award categories closely reflected the aims of the SAF. The categories were: employer of people with a learning disability; supported housing; supporting people with a learning disability; citizenship; people's award. This helped to highlight some of the work that people with learning disabilities, their carers, employers and people who support them do to help improve their environment and help others understand what can be done to help.

2. What is the Joint Health and Social Care Self-Assessment Framework?

The Joint Health and Social Care Self-Assessment Framework is a tool that supports Clinical Commissioning Groups (CCGs), and Local Authorities (LAs), to assure NHS England, the Department of Health and the Association of Directors of Adult Social Services on the following:

- *Key priorities in the:*
  - Winterbourne View Final Report Annex B (WBV)
  - Adult Social Care Outcomes Framework 2013-14 (ASCOF)
  - Public Health Outcomes Framework 2013-16 (PHOF)

- National Health Service Outcomes Framework 2013-14(NHSOF)

- *Key points for the improvement of health and social care services for people with learning disabilities*
  - Equality Delivery System
  - Safeguarding Adults at Risk requirements
  - Health & Wellbeing Boards
  - Consultation and co-production with people with learning disability and family carers
  - Progress report on Six Lives and the provision of public services for people with learning disabilities.

The Joint Health and Social Care Self-Assessment Framework is a way to make sure people with learning disabilities get equal access to services so they can **stay healthy**, **keep safe** and **live well**.

3. Uses of the framework

The findings from the JHSCSAF are used in Kent and the rest of the country.

Nationally, it used to report to the public and to Ministers on the progress in giving services in every part of the country to meet two plans these are called *Healthcare for All* and *Transforming care: A National Response to Winterbourne View*.

In Kent, it is used to inform:

- Joint Strategic Needs Assessments
- Health and Wellbeing Strategies
- Commissioning intentions/strategy
- Winterbourne View Kent Local Action Plan
- Learning Disability Partnership Board work programmes

At the heart of the JHSCSAF is to engage with people with a learning disability, their families and carers, and of strengthening their voice.

The arrangements set out below are designed to support this.

4. Governance structure

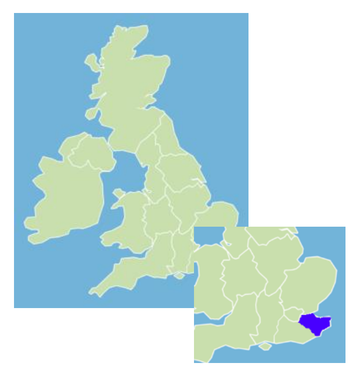
There is a process (set of rules) used to make sure the JHSCSAF is done properly. This is called a governance structure.

It is designed to help in the reporting, planning and listing of what needs to be done.

Local Authorities and Clinical Commissioning Groups, through their Health and Wellbeing Boards, give local leadership.

The geographical arrangements for the JHSCSAF are based on Local Authority/ Health and Wellbeing Board Boundaries.

5. National Comparison



The Kent submission was sent to NHS England and ADASS in January 2014.

Feedback was made available about how well we did in comparison to the 154 other submissions in June.

You can see all the main figures in the table on the next page

6. National Comparison

The Kent submission was sent to NHS England and ADASS in January 2014. Feedback was made available about how well we did in comparison to the 154 other submissions in June.

Note: A full description of all the indicators is provided in the appendix
All measures in **section A** (A1-A9) are **Staying Healthy**
Measures in **section B** (B1-B) are **Keeping Safe**
Measures in **section C** (C1-C9) are **Living Well**

Majority Rating Highlighted Yellow

Measure	Total Responses	GREEN	%	AMBER	%	RED	%	KENT Rating	(For Printing purposes)	Below National Average?
A1	148	52	35.14%	78	52.70%	18	12.16%		AMBER	NO
A2	148	41	27.70%	72	48.65%	35	23.65%		RED	YES
A3	149	14	9.40%	100	67.11%	35	23.49%		AMBER	NO
A4	144	24	16.67%	54	37.50%	66	45.83%			
A5	148	36	24.32%	76	51.35%	36	24.32%		RED	YES
A6	146	32	21.92%	71	48.63%	43	29.45%		AMBER	NO
A7	148	86	58.11%	56	37.84%	6	4.05%		AMBER	YES
A8	147	16	10.88%	122	82.99%	9	6.12%		AMBER	NO
A9	146	20	13.70%	89	60.96%	37	25.34%		AMBER	NO
B1	150	30	20.00%	59	39.33%	61	40.67%		AMBER	NO
B2	150	45	30.00%	69	46.00%	36	24.00%		RED	YES
B3	140	56	40.00%	77	55.00%	7	5.00%		AMBER	NO
B4	150	73	48.67%	76	50.67%	1	0.67%		AMBER	NO
B5	151	23	15.23%	103	68.21%	25	16.56%		AMBER	NO
B6	150	52	34.67%	94	62.67%	4	2.67%		AMBER	NO
B7	150	64	42.67%	72	48.00%	14	9.33%		GREEN	NO
B8	150	65	43.33%	81	54.00%	4	2.67%		GREEN	NO
B9	149	61	40.94%	83	55.70%	5	3.36%		AMBER	NO
C1	149	89	59.73%	59	39.60%	1	0.67%		GREEN	NO
C2	147	51	34.69%	94	63.95%	2	1.36%		AMBER	NO
C3	148	81	54.73%	67	45.27%	0	0.00%		AMBER	YES
C4	147	89	60.54%	58	39.46%	0	0.00%		GREEN	NO
C5	150	54	36.00%	82	54.67%	14	9.33%		GREEN	NO
C6	149	39	26.17%	89	59.73%	21	14.09%		AMBER	NO
C7	148	39	26.35%	98	66.22%	11	7.43%		GREEN	NO
C8	148	51	34.46%	97	65.54%	0	0.00%		AMBER	NO
C9	147	60	40.82%	82	55.78%	5	3.40%		AMBER	NO
Total	3997	1343	33.60%	2158	53.99%	496	12.41%	Overall	AMBER	NO

7 What we are doing to improve outcomes

7.1 Staying Healthy (Section A of the JHSCSAF)

Public Health, South East Commissioning Support Unit, the local team of NHS England KCC and Public Health England are working together to look at how to get more people with learning disabilities to have health checks and screening.

This is what needs to be looked at and done;

- share information between organisations to make sure people with a learning disability are not missed
- develop training for GPs so they understand the barriers for people with learning disabilities to use health checks and that the GP is given the tools to overcome this;
- develop an audit of screening practice in GP surgeries for people with learning disabilities with colleagues from Public Health England.

The Needs Assessment has been refreshed this year and has identified where we need to fix gaps in health improvement services.

As a result a number of projects have been developed to undertake health improvement initiatives.

This is to make sure people with learning disabilities get the same equal health care as everyone else.

7.2 Keeping Safe (Section B of the JHSCSAF)

There are visits being done by staff who commission services to make sure providers of services are meeting the terms of their contracts.

This involves an introductory visit for new service providers; in person full monitoring reviews at the service; a virtual review in terms of a self-assessment for the service. These will be carried out every year.

A Red, Amber Green (RAG) rating tool has been produced to include a quality assessment of learning disability residential services and if the service meets future requirements.

The RAG rating of all learning disability residential services has been carried out with the outcome informing both the Accommodation Strategy and the reshaping of the residential market through the Transformation Programme.

KCC have asked the Institute of Public Care (IPC) to create a Quality in Care (QiC) framework. The framework will:

- Develop a shared vision of Quality in Care across its partner organisations.
- Develop an overarching QiC framework outlining the principles to which the partner organisations stick to; Roles and responsibilities of the partner organisations in contributing to the QiC framework. High level reports and a Key Performance Indicators by which partners can monitor services over time.

Community Learning Disability Teams and health partners will test the new framework, including defining roles and responsibilities within health and social care teams and providers of commissioned services.

7.2.1 The Kent Action Plan for Winterbourne View

A total of 77 clients, placed in a range of secure and non-secure hospitals, have been assessed to see if they can move into the community. The results of the assessments were that:

- 41 clients were appropriately placed in hospital
- 36 clients need to move into the community

Of the 36 clients that need to move into the community:

- 12 clients have moved into the community
- 12 clients have plans in place to move by the end of the year
- 8 clients are waiting for the right placement to be found
- 4 clients need forensic outreach support to move but this is not currently available.

To help more clients who need to move into the community and to help stop people having to be admitted to hospital, Kent and Medway Partnership Trust (KMPT) and Kent Community Health Trust (KCHT) will have more staff to work in a new enhanced community care pathway from January 2015.

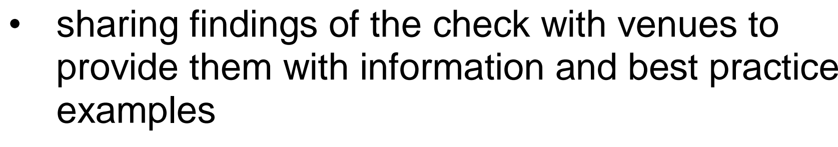
However, further support is needed for forensic clients in the community before they can be discharged. We have told NHS England that there is

not enough forensic outreach support for people who urgently need it.

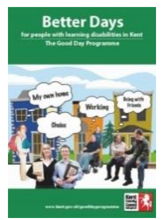
7.3 Living Well (Section C of the JHSCSAF)

The Kent Valuing People Partnership has developed a plan to check that arts and culture are accessible. They will start to work on it in 2015.

The outcomes of this work include:



- sharing findings of the check with venues to provide them with information and best practice examples
- promote museums and galleries who make provision for people with a learning disability
- promote the showing of autism friendly films in cinemas.



The Good Day Programme supports people in all parts of Kent to find local services and activities that suit their needs. During its life, the programme has increased the range of opportunities available in various locations but one particular example is Folkestone Sports Centre.

7.3.1 The case for change

We are looking at how we commission Health & Social Care Services for people with a Learning Disability with an aim of an integrated approach to commissioning with all partners.

This includes looking at different models to deliver integrated commissioning.

A report is going to the Clinical Commissioning Groups in December 2014 to decide what model is best for the future.

This will mean we can jointly commission Health & Social Care services for people with learning disabilities that are a good quality and value for money.

This will be checked on regularly in a report to the Learning Disability Management Team.

8. How we are monitoring (checking) what we are doing

All the work on the Joint Health and Social Care Self-Assessment Framework is being monitored by the Kent Learning Disability Partnership Board.

Each of the three areas of the JHSCSAF are checked off by:

- the Good Health Group for Section A (Staying Healthy),
- the Winterbourne Steering Group and the Safeguarding Divisional Management Team check Section B(Keeping Safe)
- and the District Partnership Groupscheck section C (Living Well).

The Kent Learning Disability Partnership Board looks at progress across the whole document.

9. When will these things be happening by?

Timeframe for submitting the 2014/15 JHSCSAF

The Association of Directors of Adult Social Services (ADASS) and NHS England confirmed in September that the Joint Health and Social Care Self-Assessment Framework will continue for the coming year.

The following timescale and activity have been published and highlight the activity for the year ahead for the 2014/15 JHSCSAF.

Date	What is happening
End January 2015	Local Authorities and CCG Leads to complete initial submission of 2014/15 JHSCSAF. This must be approved by the Learning Disability Partnership Board and signed off by the Health and Wellbeing Board
February 2015	Regional improvement work. NHS England and ADASS leads for regional work. Leading to regional action plans/sector led improvement
End March 2015	Presentation to Health and Wellbeing Boards – leading to a local action plan.

End March 2015	Review questions and launch 2014/15 JHSCSAF

Update from 19th November 2014 Health & Wellbeing Board

We are in the process of collecting data for the submission of the 2014/15 JHSCSAF. We are on schedule to submit the information board in January 2015.

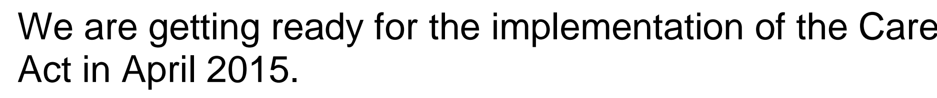
10. Becoming an Adult (transition from children's to adults services)

Learning disability services have worked closely with colleagues in SEN(D) services to prepare for the introduction the of the Local Offer, the Education, Health& Care Plans.

These came into force in September 2014 as part of the Children and Families Act.
A draft document has been done to show a person's journey through social services.

Guidance has been done for the support of Disabled Care Leavers.

Training for staff that they can do online is almost ready and will be made available soon.



We are getting ready for the implementation of the Care Act in April 2015.

The Act includes new duties and powers in relation to the transition arrangements for young people with care and support needs and their carers.

A pilot project has been in progress to make better the arrangements for young adults aged 18 to 25 who are in receipt of Direct Payments. The pilot project will help to inform future decisions on this service.

Disabled Children's Services will be aligned to the Adult Learning Disability and Mental Health Division from January 2015 which will provide greater links around transition.

11.0 How are we doing?

We review our performance at regular meetings between ourselves and our partners at KCHT (Kent Community Health Trust) and KMPT (Kent and Medway Partnership Trust).

We look at the following measures to see how we are doing:

- Safeguarding
- Contact, referrals and assessments
- Caseload
- Personal Budgets
- Carers
- Support Plans
- Reviews completed
- Reviews overdue
- Learning Disability Employment

- Equalities
- Learning from complaints

We are starting work to transform Learning Disability services with our partner organisation: Newton Europe. This will mean that we are looking at how well we are doing now across a number of our services for people with a learning disability and we will look at what we can do better.

12.0 Recommendations

Adult Social Care and Health Cabinet Committee is asked:

1. To **comment** on the 2013/14 national comparison Action Plan including the progress made in the red indicators of the RAG rating.

2. To **comment** on the way in which Kent is approaching the 2014/15 JHSCSAF.

3. To **comment** on the Kent Action Plan for Winterbourne View.

4.To comment on the wider issues for learning disability in Kent.

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Appendix

Joint Health & Social Care Self-Assessment Framework

Explanation of measures & red, amber, green (RAG) ratings

Staying Healthy: A1-A9

Measure	Guidance Notes
A1 **Current Rating:** **Amber**	There is concern that many people with learning disability are unknown to services and do not subsequently get access to the healthcare that they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disability. Using available prevalence data will allow some indicative benchmarking around whether numbers of people on registers are likely to be accurate. All people with learning disability are not being identified via the QOF and therefore local data needs to be scrutinised and systems put in place within primary care to ensure that all people are put onto the QOF register irrespective of if they are known to social services, or not. **Red**: The numbers of people on Learning Disability (LD) and Downs Syndrome Registers reflect the requirements outlined in QOF **Amber**: Learning Disability and Down Syndrome Registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity) **Green**: Learning Disability and Down Syndrome Registers reflect prevalence data. Data stratified in every required data set (e.g. age / complexity / Autism diagnosis / BME etc.)
A2 **Current Rating:** **Red**	Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability. **Red:** Evidence that people with learning disability are accessing disease prevention, health screening and health promotion in each of the following health areas: Obesity, Diabetes, Cardio vascular disease Epilepsy but NO COMPARATIVE DATA of the population that do not have a learning disability **Amber:** Comparative data in some of the health areas listed in the descriptor at LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP level **Green:**Comparative data in all of the health areas listed in the descriptor at each of the following levels; LOCAL AREA TEAM CLINICAL COMMISSIONING GROUP,INDIVIDUAL GP PRACTICE

A3 **Current Rating:** **Amber**	Whilst many practices sign up to the LD DES there is significant variability in the numbers of annual health checks that are actually completed. Underlying health conditions continue to be missed leading to poor health, sometimes death and long term costly interventions. Annual health checks have been shown to effectively reduce health inequality and improve health outcomes. Therefore a population wide 'roll out' at a local level is an essential action required to secure long term and consistent improvement in the health of this vulnerable group. **Red:** Registers not validated since set up. 25% of people with learning disability on the GP DES Register had an annual health check. **Amber**: Registers Validated within past 12 months. 50% of people with learning disability GP DES Register had an annual health check. **Green**: Validated on a minimum of an annual basis and process in place for all people aged 18 or over to be put on register.80% of people with learning disability GP DES Register had an annual health check.
A4 **Current Rating:** **Nil return**	The LD DES guidance puts the onus on GPs to generate meaningful health action plans at the time of the annual health check to address health priorities. Integrated annual health checks and health action plans will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which can support reduction inappropriate secondary care referrals. It also provides the person with a learning disability (and their Carer, if appropriate) with a clear understanding of what needs to happen over the next 12 months. **Red:** No evidence that the Annual Health Check and Health Action Plans are integrated. **Amber:** GP Annual health check data indicates that a Health Action plan has been completed, directly as a result of an AHC, in the current year for 70% of patients. **Green:** GP Health Action Plan (HAP) contains specific health improvement targets identified during the AHC for 50% of patients (to be captured through AHC template
A5 **Current Rating:** **Red**	Currently there is little specific comparative data between the health of people with learning disability and the non-learning disabled population, yet we know that people with learning disability have poorer access to healthcare and die younger than their non-learning disabled peers. This means that there is a lack of robust data from which the JSNA and Health & Well-Being Strategy can be informed. This indicator looks at one specific clinical area where there may be an inequity of access to health screening and subsequent prevention of disease. Gathering this data enables us to respond more effectively to individual clinical needs and be in a very strong position for future strategic planning of reasonably adjusted health services for people with learning disability. **Red:** Unable to produce data for people with a learning disability in each and every screening group a, b & c. **Amber:** Numbers of completed health screening for eligible people who have a learning disability; AND some comparative data but

	not for every screening group requested. **Green:** Numbers of completed health screening for eligible people who have a learning disability in every screening group; AND comparative data of screening rates in the non LD population for every screening group; AND Scrutinised exception reporting and evidence of reasonably adjusted services
A6 **Current Rating:** **Amber**	Healthcare providers frequently state that having no prior warning of somebody's learning disability and specific needs resulting from their disability, prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be made trackable as identified within primary and secondary care. By including LD status in your referral you will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will lead to a potential reduction in DNA's, length of stay and inappropriate repeat attendances. **Red:** There is no LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals **Amber:** There is evidence of a LOCAL AREA TEAM/CLINICAL COMMISSIONING GROUP wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed **Green**: Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the ld identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed
A7 **Current Rating:** **Amber**	In Healthcare for All (recommendation 10) the value of advocacy, including learning disability liaison is clearly described, as well as a clear call for Trust Boards to publicly report that they have effective systems to deliver reasonably adjusted health services. Many Trusts have appointed learning disability liaison nurses though there is more than one way in which the learning disability liaison function can be delivered. This indicator seeks to explore the full extent of the learning disability liaison function in acute settings within the localities in England. Of particular importance is whether providers and commissioners are gathering and using HES data to inform decisions on where the greatest need for an LD function may be given trends and evidenced need. **Red:** No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site **Amber**: Designated learning disability liaison function or equivalent process in place and details of the provider sites covered has been submitted.Providers are not yet using known activity data to effectively employ LD liaison function against demand. **Green:** Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes

A8 **Current Rating:** **Amber**	Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator will capture examples of where this is happening well in the wider primary care community. In order for reasonable adjustments to occur routinely services need a way to both record patients' learning disability status and describe the required reasonable adjustments. This measure is about universal services **NOT** those services specifically commissioned for people with a learning disability. **Red:** People with learning disability accessing/using these services are not flagged or identified. There are no examples of reasonable adjusted care **Amber:** Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements. **Green:** All people with learning disability accessing/using service are known and patient experience is captured.All of these services are able to provide evidence of reasonable adjustments and plans for service improvement
A9 **Current Rating:** **Amber**	Evidence suggests 7% of the prison population - and greater number in the criminal justice system, have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform Provision, regarding: what is available including prevention, development required and ensuring health services are accessible. **Red:** There is no systematic collection of data about the numbers of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability **Amber**: An assessment process has been agreed to identify people with LD in all offender health services e.g. learning disability screening questionnaire. Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system. **Green**: Local Commissioners have good data about the numbers /prevalence of people with a learning disability in the CJS. Local commissioners have are working with regional, specialist prison health commissioners. Good information on health needs of people with LD in local prisons /wider criminal justice system and a clear plan on how needs can be met. Prisoners and young offenders with LD have had an annual health check, or are scheduled to have one within 6 months (either as part of custodial sentence or following release , as part of GP health check cycle). They are offered a Health Action Plan.

Section B: Keeping Safe

Measure	Guidance Notes
B1 **Current Rating:** **Amber**	Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way. **Red**: Less than 90% of all care packages including personal budgets reviewed at least annually **Amber**: Evidence of at least 90% of all care packages including personal budgets reviewed at least annually **Green:** Evidence of 100% of all care packages including personal budgets reviewed at least annually
B2 **Current Rating:** **Red**	This measure asks localities to demonstrate how thorough their contracting processes are. This is important as contract monitoring is one of the first methods of scrutiny and assurance. **Red:** Less than 90% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance **Amber:** Evidence of at least 90% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health & social care. **Green:** Evidence of 100% of health and social care commissioned services for people with learning disability have: had full scheduled annual contract and service reviews; demonstrate a diverse range of indicators and outcomes supporting quality assurance.Evidence that the number regularly reviewed is reported at executive board level in both health & social care
B3 **Current Rating:** **Amber**	Following the publication of Healthcare for All in 2008 (Sir Jonathan Michael) the CQC developed a number of essential standards for healthcare providers to meet in order to assure a minimum standard of care, to be offered to people with learning disability. Subsequently MONITOR (the independent regulator of Foundation Trusts) adopted the same standards into their compliance framework. As these are minimal quality standards it would be expected that all FTs should be meeting these. This indicator not only seeks confirmation that this is the case but expects commissioners to demonstrate the evidence gathered from providers to confirm this and the evidence that where trusts strive to achieve foundation status, commissioners support the attainment of monitor standards. **Red:** Commissioners do not assure themselves of the ongoing compliance, via monitor returns and EDS, for each foundation trust

	OR For non-foundation trusts, commissioners are not aware of the trusts position in working towards monitor & EDS standards and foundation trust status **Amber:** Commissioners review monitor & EDS returns of foundation trust providers. Evidence that commissioners are aware of and working with non- foundation trusts in their progress towards monitor level & EDS compliance. **Green**: Commissioners review monitor returns and & EDS review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non- foundation trusts in their progress towards monitor level & EDS compliance.
B4 **Current Rating:** **Amber**	Governance, safety, quality and monitoring. Learning from Winterbourne View Review and good commissioning practice have identified failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safety and safeguarding for people with learning disability in all provided services and support. **Red:** No Board Assurance and Learning points not identified. Action plan(s) either not in place, or not yet discussed with partners **Amber:** Regular Board Reporting and key points and lessons learned are included in action plans. Evidence that Learning Disability Partnership Board(s) and/or health sub group(s) involved in reviewing progress. The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service have assured their board that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. **Green:** Evidence of robust, transparent and sustainable governance arrangements in place in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well- Being Boards and Clinical Commissioning Executive Boards. The provider can demonstrate delivery of Safeguarding adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service have assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the learning disability agenda
B5 **Current Rating:**	This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training. **Red:** No evidence of commissioning and provider practice that demonstrates involvement of people with learning disability and

Amber	families in the recruitment and training of staff **Amber:** LD specific services: evidence of 90% of services involving people with learning disability and families in recruitment/ training and monitoring of staff. Some evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services. **Green**: LD specific services: evidence of 100% of services involving people with learning disability and families in recruitment/ training and monitoring of staff including advocates. Strong evidence of commissioners specifically raising the need for LD awareness training and reasonable adjustment within universal services in line with consultation by people with a learning disability and family carers. Strong evidence of universal services embedding LD awareness training and making reasonable adjustments for people with a learning disability and family carers to access and use the services AND of universal service providers sharing good practice and experience.
B6 **Current Rating:** Amber	Commissioners can demonstrate that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the confidential enquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this. **Red:** No evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce **Amber:** LD Specific Provision: Some evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce. No clear evidence of this approach in relevant universal services **Green**: Clear evidence of commissioning practice that drives providers to demonstrate compassionate care and value base recruitment & management of the workforce. Evidence of this approach in relevant universal services
B7 **Current Rating:** Green	This measure is about how effectively your locality assesses and addresses the needs and support requirements of people with learning disabilities through local authority strategies with clear reference to current and future demand. **Red:** Not all strategies are up to date and there are not Equality Impact Assessments in place for every strategy. **Amber:** Up to date Commissioning Strategies and Equality Impact Assessments are in place. **Green:** Evidence of Commissioning Strategies and associated Equality Impact Assessments being presented to people who use services and their families and clear plans in place for the development of Care, Support and Housing for people with learning disabilities based on evidence of current and future demand.

B8 **Current Rating:** **Green**	This standard requires evidence of a learning organisation that integrates, learning from complaints, incidents, patient, carer and staff feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities. Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements. **Red:** No evidence of commissioning practice that demonstrates changed practice as a result of complaints and whistleblowing **Amber:** Evidence that 50 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate. **Green:** Evidence that 90 % of commissioned practice and contracts require evidence of improved practice, based on the use of patient experience data, and the review and analysis of complaints. There is evidence of effective use of a Whistle-blowing policy where appropriate.
B9 **Current Rating:** **Amber**	Mental Capacity Act (MCA). MENCAP's report Death by Indifference: 74 Deaths and Counting, highlighted the inconsistent application of the MCA 2005. This standard requires evidence that the five principles of the MCA are understood and consistently embedded within and across organisations to ensure safe, equal and high quality healthcare people with learning disability. Organisations are asked to demonstrate that there is evidence of routine monitoring across the whole organisation of implementation of MCA principles. **Red:** There is no evidence that organisations routinely check implementation of MCA guidance relating to decision making, capacity, and restrictions **Amber:** There is limited evidence that the implementation of MCA guidance relating to decision making, capacity, and restrictions is checked within contract monitoring and commissioning. **Green**: All appropriate providers have well understood policies in place and routinely monitor implementation of these in relation to, the Mental Capacity Act (including restraint, consent and deprivation of liberty). The provider can evidence action taken to improve and embed practice where necessary.

Section C: Living Well

Measure	Guidance
C1 **Current Rating:** **Green**	This measure looks for the evidence that formal arrangements are in pace that foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented. **Red:** There is no evidence of integrated governance structures such as Section 75 or 37 agreements. There are no joint commissioning functions in place. **Amber:** Commissioners can provide evidence of integrated governance structures. Monitoring is undertaken jointly and key partners are involved at Partnership Board level. Joint commissioning functions are in place. **Green:** There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of pooled budgets or pooled budget arrangements, joint commissioning structures, intentions, monitoring and reporting arrangements.
C2 **Current Rating:** **Amber**	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. **Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places. **Amber:** Local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places. **Green:** Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully and build / maintain social networks e.g. support to use local transport services, Changing Places in shopping centres, Safe Places and evidence that such schemes are communicated effectively.

C3 **Current Rating:** Amber	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. **Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals. **Amber:** Few examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals. **Green:** Numerous examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively.
C4 **Current Rating:** Green	This measure asks for evidence of reasonable adjustment within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. **Red:** No examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups etc. **Amber:** Local examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups etc. **Green:** Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted facilities and services that enable them to participate fully e.g. local parks, leisure centres, swimming pools, walking groups, designated participation facilitators with learning disability expertise etc. and evidence that such facilities and services are communicated effectively.
C5 **Current Rating:** Green	This measure is about the importance of occupation and the equity that needs to be shown for people with a learning disability. Evidence of initiatives, data of the actual local picture are important. **Red:** No data and commissioning intentions in place **Amber:** Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months AND Employment activity of people with learning disability is linked to data **Green:** Relevant data available and collected. The targets nationally and locally determined (See ASCOF) have been met for people with learning disability supported into employment in the past 12 months.Employment activity of people with learning disability is linked to commissioning intent for future services. Commissioning is clearly linked to proportionate local need.

C6 **Current Rating:** **Amber**	Delivering effective transitions for young people is recognized as a way of addressing the difficulties confronted by young people with learning difficulties and their families at transition. Previous research has demonstrated that information is a key need at this time. Information relates to co-production of local services driven by parent and user involvement as well as having a sound knowledge base of future need to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health services needed to support young people approaching adulthood - and their families. This measure touches upon the national Single Education, Health and Care Plan for people with learning disability. This policy is one of your key ways of evidencing success in this area. **Red:** No evidence of a Single Education, Health and Care Plan for people with learning disability.Little or no evidence of transition planning or structures to support effective transitions in health & social care **Amber:** Evidence of at least 50% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014. There is evidence of effective plans, strategy, service pathways and multi- agency involvement across Health and Social Care **Green:** Evidence of 85% of people with learning disability has a current and up to date Single Education, Health and Care Plan by 2014. There is evidence of well- established and monitored strategy, service pathways and multi-agency involvement across Health and Social Care. There is evidence of very clear transition services or functions that have joint health & social care scrutiny and ownership.
C7 **Current Rating:** **Green**	Community inclusion and Citizenship are core to the need for people with a learning disability to be equal members of our community. This measure asks you to evidence that you have asked what inclusion and citizenship means to your local population, evidence that you are responding to such consultation and evidence that people actually feel part of the local community. **Red:** No reference to indicatorsof social exclusion, hate& mate crime, natural support or isolation of people with learning disability in Joint Strategic Needs Assessments or Public Health data.No clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability **Amber:** Some evidence of data and findings of social exclusion, hate & mate crime, natural support or isolation of people with learning disability in Joint Strategic Needs Assessment. Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, including the support of friendship development and maintenance **Green:** Clear commissioning intentions or action plans that address the social inclusion and citizenship needs of people with a learning disability, linked to data and Joint Strategic Needs Assessments. Commissioning intentions and processes are aligned across both health & social care, supported by joint commissioning arrangements. Clear evidence of strong consultation with local

	communities in developing what it means to be a citizen
C8 **Current Rating:** **Amber**	People with learning disability and family carer involvement in service planning and decision making including personal budgets This measure seeks to stimulate areas to examine what co-production means and demonstrate clear and committed work to embedding this in practice. **Red:** There is no evidence that people with learning disability and families have been involved in co- production of service planning and decision making. **Amber:** Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice. Inconsistent or no evidence of co-production in universal services **Green:** Clear evidence of co-production in universal services that the commissioners use this to inform commissioning practice
C9 **Current Rating:** **Amber**	Family Carers – Consultation on the JHSCSAF raised a strong call for family carers to be given a place to specifically contribute about their needs in the measures. This measure asks for evidence that family carers are involved not only in service design and commissioning, but in wider strategies as not all people with learning disabilities and family carers are known to or use services but need a voice in the shaping of the community. **Red:** Commissioners do not have clear information on the numbers of registered carers in the locality.There is little evidence of formal arrangements to allow carer voice to shape commissioning intentions and provider delivery **Amber:** Commissioners have clear information on the numbers of registered carers in the locality including the number of carers offered and in receipt of a carers assessment. There is clear evidence of a carers strategy and that this has been consulted upon.There is clear evidence that providers of LD services involve family carers in service development. **Green**: Commissioners are using needs assessment information relating to carers to shape services and provide a range of support. There is clear evidence of a carers strategy that has been co-produced with family carers and that this has been consulted upon. There is clear evidence that providers of LD services involve family carers in service development. There is clear evidence that such involvement has led to service improvement.

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

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

To: Adult Social Care and Health Cabinet Committee
4 December 2014

Subject: **ADULT SOCIAL CARE PERFORMANCE DASHBOARD**

Classification: Unrestricted

Previous Pathway: Social Care, Health and Wellbeing DMT

Future Pathway: None

Electoral Division: All

Summary: The performance dashboard provides Members with progress against targets set for key performance and activity indicators for September 2014 for Adult Social Care.

Recommendation: Members are asked to **REVIEW** the Adult Social Care performance dashboard

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1. Introduction

1.1 Appendix 2 Part 4 of the Kent County Council Constitution states that:

"Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

1.2 To this end, each Cabinet Committee is receiving a performance dashboard.

2. Performance Report

2.1 The main element of the Performance Report can be found at Appendix A, which is the Adults Social Care dashboard which includes latest available results for the key performance and activity indicators

2.2 The Adult Social Care dashboard is a subset of the detailed monthly performance report that is used at team, DivMT and DMT level. The indicators included are based on key priorities for the Directorate, as outlined in the business plans, and include operational data that is regularly used within Directorate. The dashboard will evolve for Adults Social Care as the transformation programme is shaped.

2.3 Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes, and this will be a key element for reviewing the dashboard

2.4 A subset of these indicators is also used within the quarterly performance report, which is submitted to Cabinet.

2.5 As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

2.6 Performance results are assigned an alert on the following basis:

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

Amber: Performance is below current target but above minimum standard.

3. Financial Implications

3.1 Not applicable

4. Legal Implications

4.1 Not applicable

5. Equalities Implications

5.1 Not applicable

6. Recommendations

6.1 Members are asked to:

a) **REVIEW** the Adult Social Care performance dashboard.

Report Author
Name: Steph Smith
Title: Head of Performance for Adult Social Care
Tel No: 01622 221796
Email**:** steph.smith@kent.gov.uk

Background documents
None

Adult Social Care Dashboard

September 2014

APPENDIX A

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
↓	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Adult Social Care Indicators

The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet. This is clearly labelled on the summary and in the detail.

Some indicators are monthly indicators, some are annual, and this is clearly stated.

All information is as at September 2014 where possible, with a few indicators still requiring some update, with new targets and indicators being chosen.

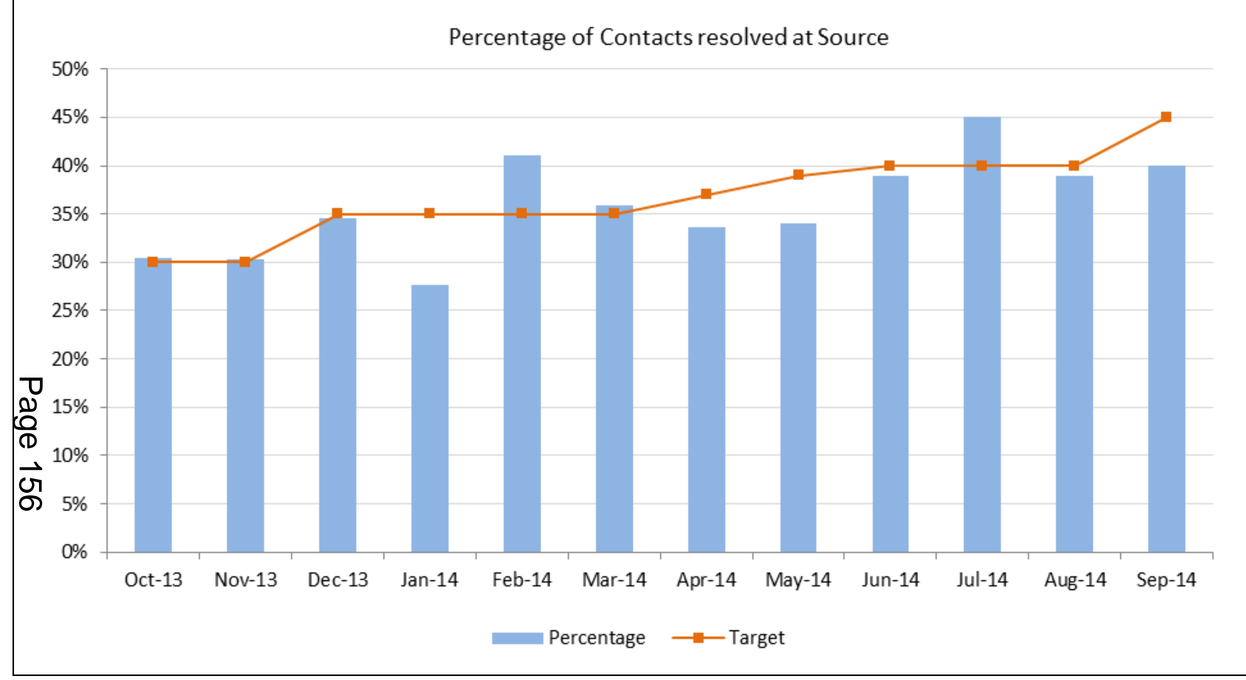
Following months will provide all information.

APPENDIX A

Indicator Description	SCHW SPS	QPR	2013-14 Outturn	Current 14-15 Target	Current Position	Data Period	RAG	Direction
1. Percentage of contacts resolved at source (ASC01)	Y	Y	35.9%	39%	**40.0%**	Month	AMBER	↑
2. Number of completed Promoting Independence Reviews		Y	350	638	**330**	Month	RED	↓
3. Number of adult social care clients receiving a Telecare service (ASC02)	Y	Y	3238	TBC	**4088**	Cumulative	GREEN	↑
5. Referrals to enablement (ASC03)	Y	Y	700	700	**842**	Month	GREEN	↑
6. Delayed transfers of care			5.73	5.40		12M	AMBER	↓
7. Admissions to permanent residential or nursing care for people aged 65+			149	130	**101**	12M	GREEN	↑
8. Number of people aged 65+ in permanent residential care (AS01)	Y	Y	2845	2793	**2661**	Snapshot	GREEN	↑
9. Number of people aged 65+ in permanent nursing care (AS02)	Y	Y	1429	1428	**1357**	Snapshot	GREEN	↑
10. Number of people aged 65+ receiving domiciliary care (AS03)	Y	Y	5161	4977	**3988**	Snapshot	GREEN	↑
11. Number of people with a learning disability in residential care (AS04)	Y	Y	1243	1258	**1222**	Snapshot	GREEN	↑
12. Number of people with a learning disability receiving a community service			1343	1197	**1438**	Snapshot	GREEN	↑
13. Percentage of adults in contact with secondary mental health in settled accommodation			86%	75%		Quarterly	GREEN	↑

APPENDIX A

1. Percentage of contacts resolved at source (ASC01)			AMBER ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



Data Notes.
Data Source: SWIFT report but this will be monitored using the Area Referral Management Service information.

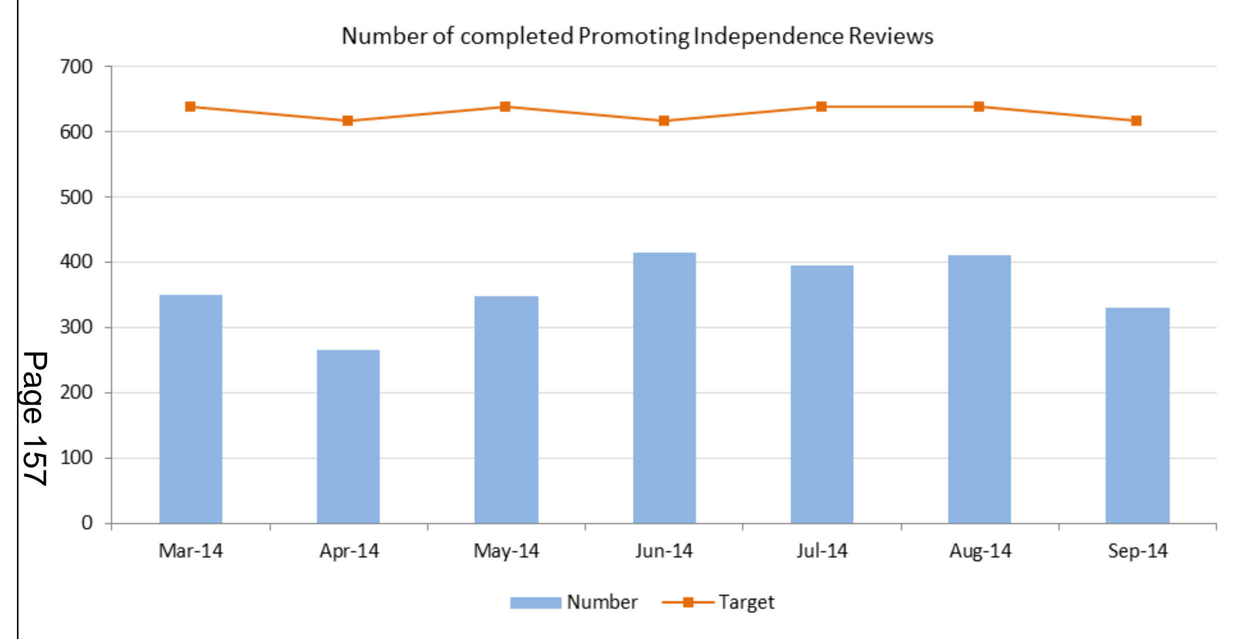
Quarterly Performance Report Indicator

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Target	**30%**	**30%**	**35%**	**35%**	**35%**	**35%**	**35%**	**35%**	**40%**	**41%**	**43%**	**45%**
Percentage	30.43%	30.28%	34.50%	27.71%	41.00%	35.90%	33.61%	34.00%	39.00%	45.00%	39.00%	40.00%
RAG Rating	GREEN	GREEN	AMBER	AMBER	GREEN	GREEN	AMBER	AMBER	AMBER	GREEN	AMBER	AMBER

Commentary

A key priority for Adult Social Care is to respond to more people's needs at the point of contact, through better information, advice and guidance, or provision of equipment where appropriate. Although performance in March was on target, and has since improved, as stretching targets for improvement have been set for this year, current performance is now very slightly behind target.

2. Number of completed Promoting Independence Reviews			RED ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
The information collected shows the number of review completed as at Monday of every week and is presented weekly within DivMT dashboards. Due to the target for this indicator being weekly, when it is presented in a monthly format the target will vary because of the number of days in the month. If a particular week falls across two months, the number of reviews is proportionate.

Data Source: Newton Europe PIR Tracker

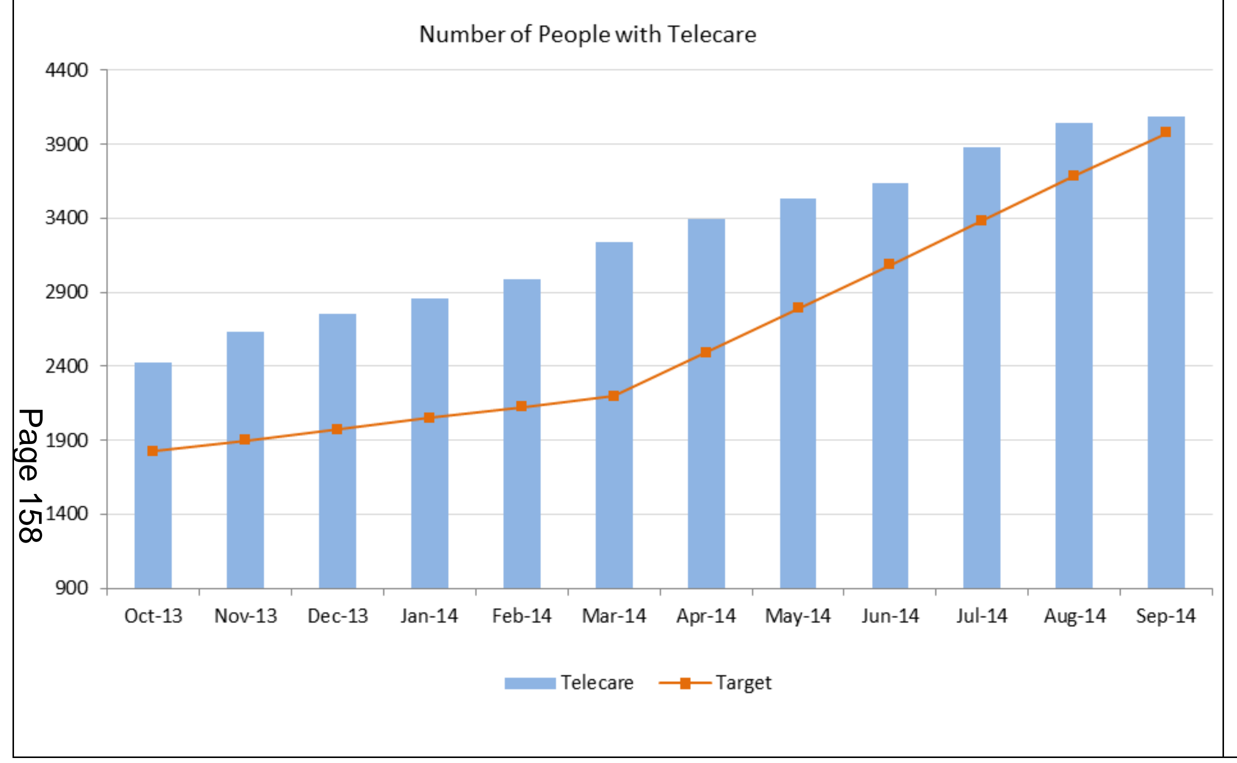
	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
Target	**638**	**617**	**638**	**617**	**638**	**638**	**617**	**638**	**617**	**638**	**638**	**576**
Number	350	265	349	414	395	411	330					
RAG Rating	RED	RED	RED	RED	RED	RED	RED					

Commentary

The current phase of the Transformation programme involves the staffing consultation, mobilisation of home care and staff reduction and these issues are influencing performance in the short term. Discussions continue to take place on a regular basis to ensure that any operational issues are identified and resolved.

APPENDIX A

3. Number of adult social care clients receiving a Telecare service (ASC02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability/ Learning Disability and Mental Health



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Data Notes.

Units of Measure: Snapshot of people with Telecare as at the end of each month

Data Source: Adult Social Care Swift client System

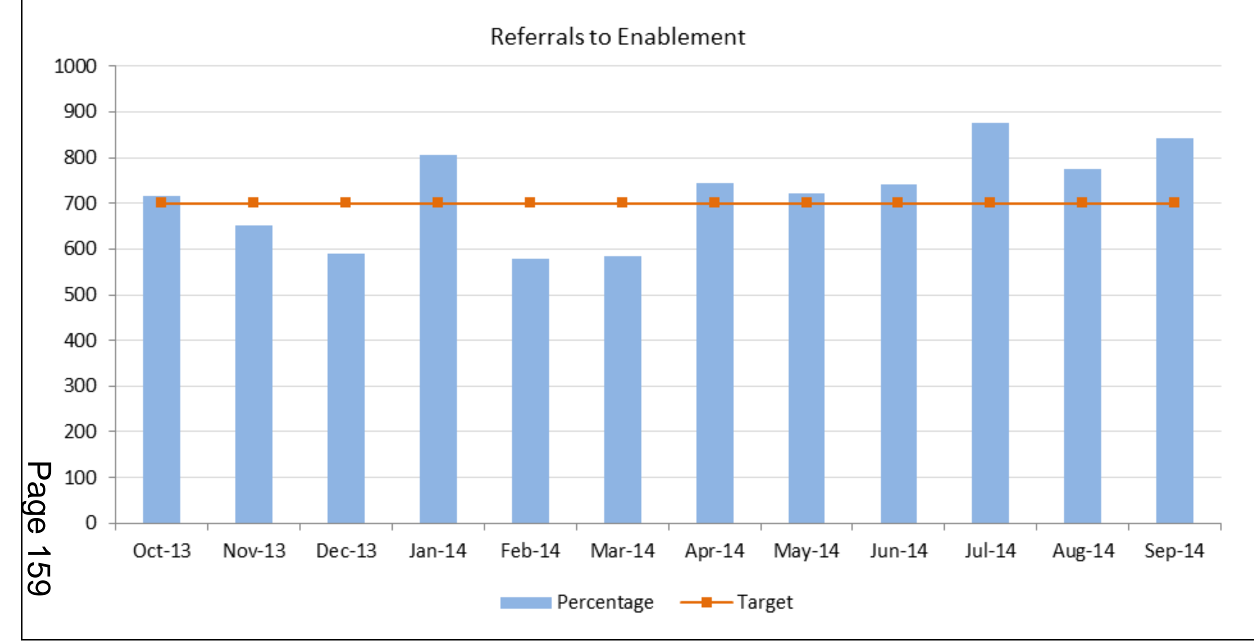
Quarterly Performance Report Indicator

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Target	**1825**	**1900**	**1975**	**2050**	**2125**	**2200**	**2275**	**2350**	**3084**	**3385**	**3686**	**3978**
Telecare	2426	2634	2754	2859	2992	3238	3392	3531	3637	3877	4041	4088
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

he number of people in receipt of a Telecare service continues to exceed target. Telecare is being promoted as a key mechanism for supporting people to live independently at home, including within Personal Budgets. The availability of new monitoring devices (for dementia for instance) is expected to increase the usage and benefits of telecare. Awareness training continues to be delivered to staff to ensure we optimise the opportunities for supporting people with more complex and enabling teletechnology solutions.

APPENDIX A

5. Referrals to Enablement (ASC03)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Number of people who had a referral that led to an Enablement service
Data Source: Adult Social Care Swift client System – Enablement Services Report

Quarterly Performance Report indicator

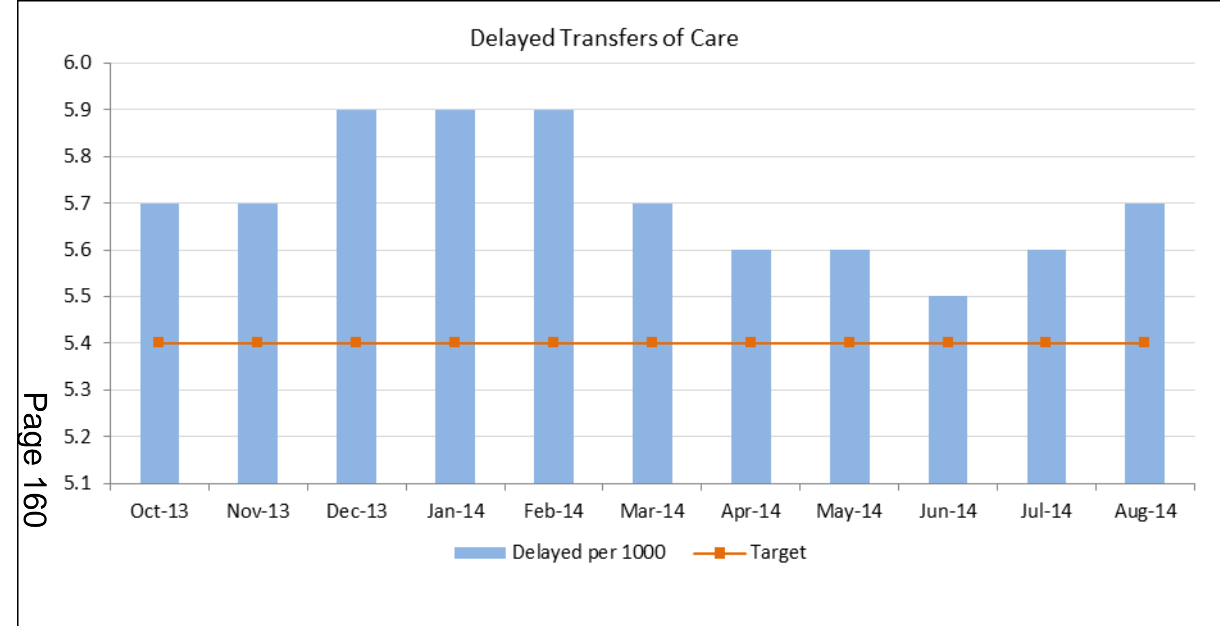
Trend Data	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Enablement Referrals	716	652	589	805	578	585	745	722	742	875	775	842
Target	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**
RAG Rating	GREEN	AMBER	RED	GREEN	RED	RED	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

- Referrals are higher in September than August. Targets and performance are monitored on a weekly basis through the operational teams. More clients are now expected to receive an enablement service, with a stronger focus on short term interventions, to reduce the need to provide long term care packages.

APPENDIX A

6. Delayed transfers of care			AMBER ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
This indicator is displayed as the number of delays per month as a rate per 100,000 population.

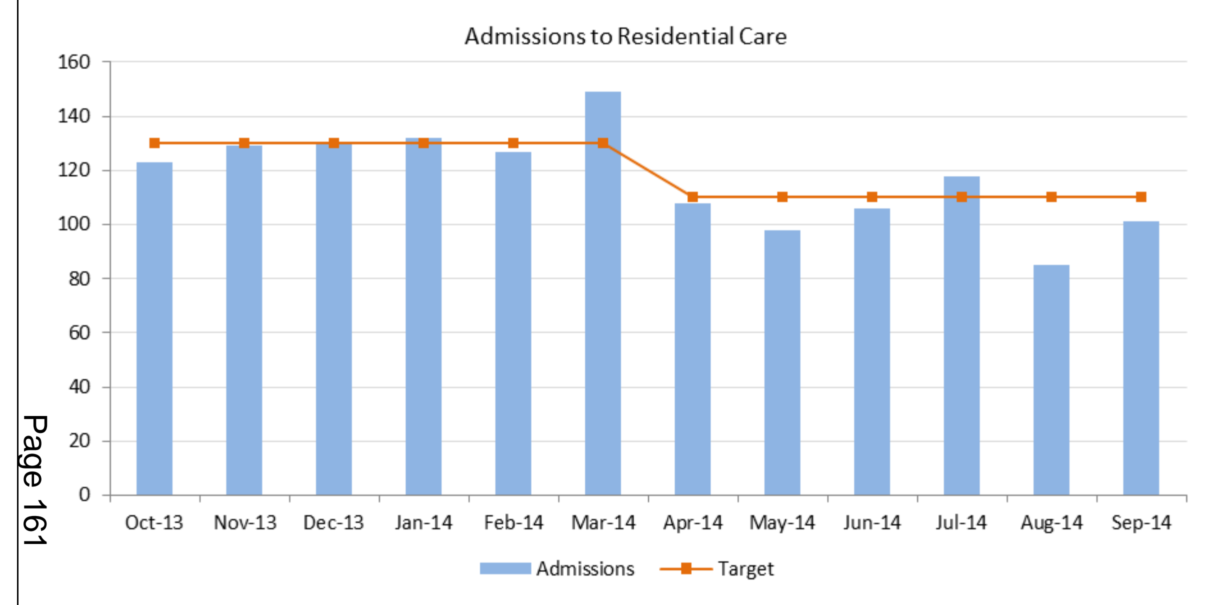
	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Target	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**
Delayed per 1000	5.7	5.7	5.9	5.9	5.9	5.7	5.6	5.6	5.5	5.6	5.7	
RAG rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently about 25% delays are attributable to Adult Social Care. The top three reasons for delays includes: Waiting NHS non-acute care, patient choice and then Social care assessment.

APPENDIX A

7. Admissions to permanent residential or nursing care for people aged 65+			GREEN ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.
Units of Measure: Older People placed into Permanent Residential Care per month.
Data Source: Adult Social Care Swift client System – Residential Monitoring Report

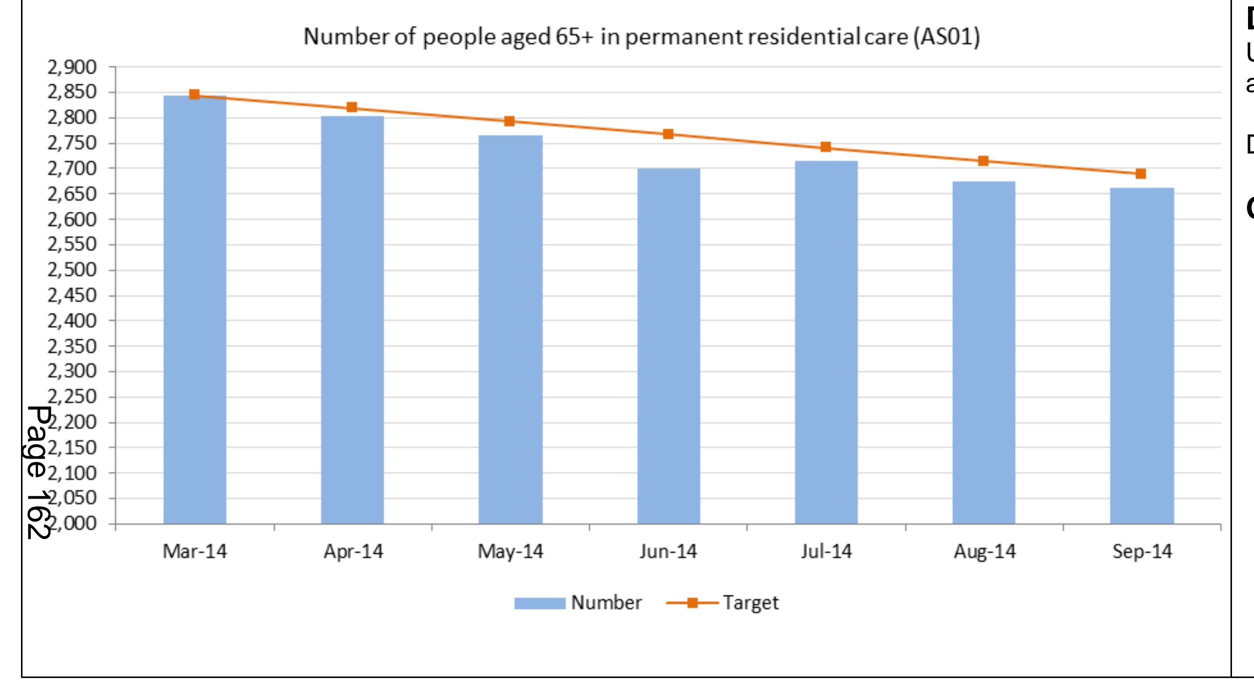
	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Target	**130**	**130**	**130**	**130**	**130**	**130**	**110**	**110**	**110**	**110**	**110**	**110**
Admissions	123	129	130	132	127	149	108	98	106	118	85	101
RAG rating	GREEN	GREEN	GREEN	AMBER	GREEN	RED	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN

Commentary

Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. As part of the monthly budget and activity monitoring process, admissions are examined, to understand exactly why they have happened. The objectives of the transformation programme will be to ensure that the right services are in place to ensure that people can self manage with these conditions, and ensure that a falls prevention strategy and support is in place to reduce the need for admission. In the meantime, there are clear targets set for the teams which are monitored on a monthly basis, and an expectation that permanent admissions are not made without all other alternatives being exhausted.

APPENDIX A

8. Number of people aged 65+ in permanent residential care (AS01)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



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Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

Data Source: MCR summary report – SWIFT

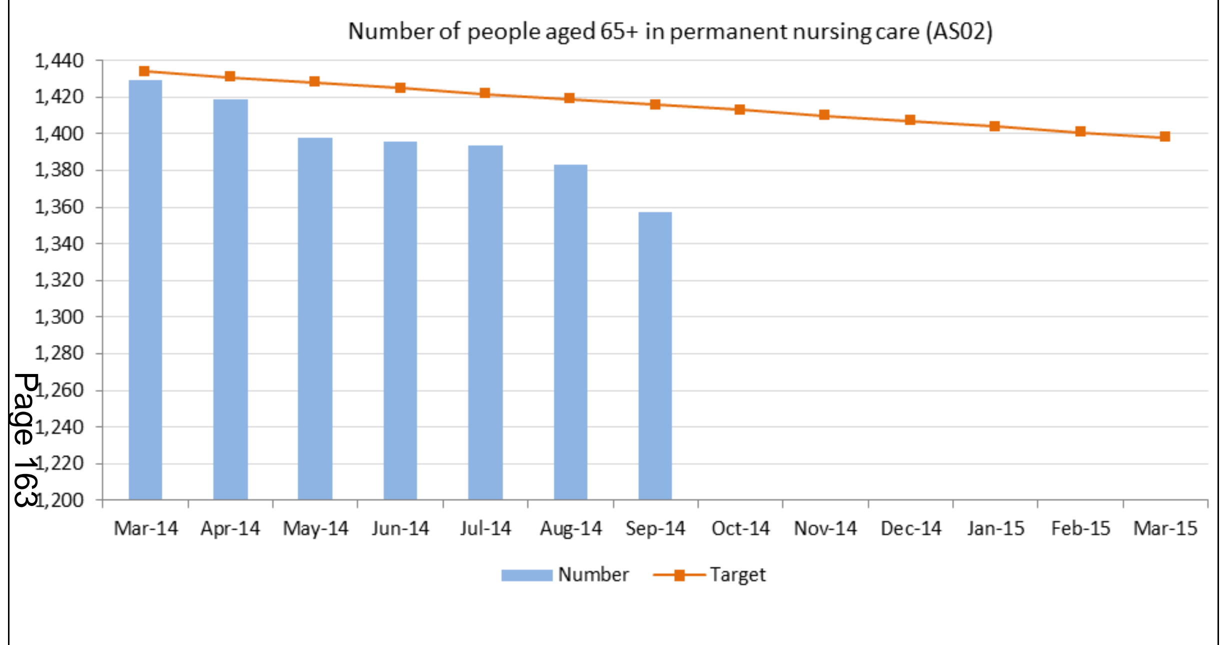
Quarterly Performance Report indicator

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**2845**	**2819**	**2793**	**2767**	**2741**	**2715**	**2689**	**2663**	**2637**	**2611**	**2585**	**2559**	**2536**
Number	2845	2803	2765	2699	2715	2674	2661						
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN						

Commentary

With increasing use of enablement services and telecare support, together with reduced admissions to residential and nursing care, we would expect overall levels to decrease.

9. Number of people aged 65+ in permanent nursing care (AS02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

Data Source: MCR summary report – SWIFT

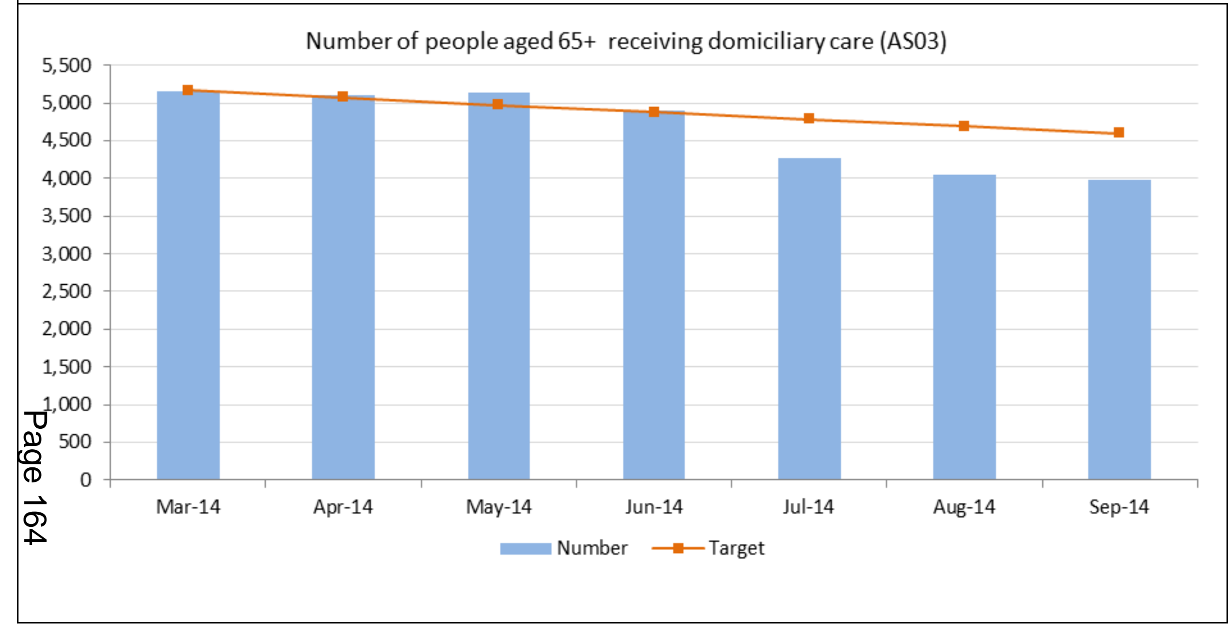
Quarterly Performance Report indicator

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**1434**	**1431**	**1428**	**1425**	**1422**	**1419**	**1416**	**1413**	**1410**	**1407**	**1404**	**1401**	**1398**
Number	1429	1419	1398	1396	1394	1383	1357						
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN						

Commentary

With increasing use of enablement services and telecare support, together with reduced admissions to residential and nursing care, we would expect overall levels to decrease.

10. Number of people aged 65+ receiving domiciliary care (AS03)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.
Units of Measure: End of month snapshot of the number of people aged 65+ receiving domiciliary care

Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

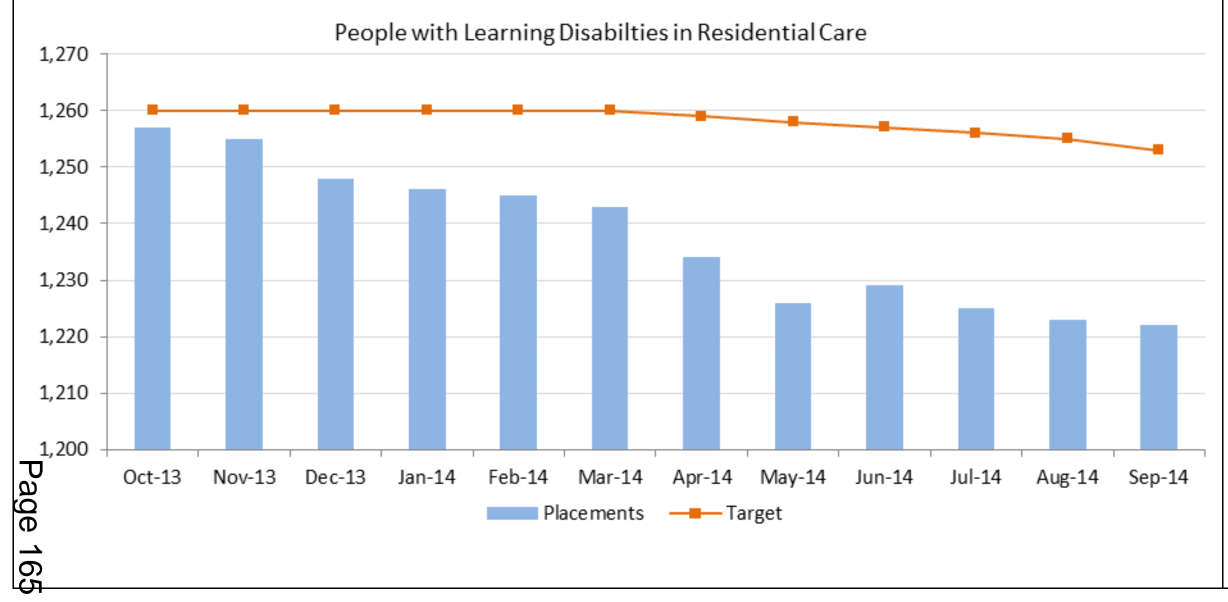
Trend Data	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**5165**	**5071**	**4977**	**4883**	**4789**	**4695**	**4601**	**4507**	**4413**	**4319**	**4225**	**4131**	**4037**
Number	5161	5112	5133	4892	4274	4052	3988						
RAG Rating	RED	AMBER	RED	AMBER	GREEN	GREEN	GREEN						

Commentary

As a result of intervention through enablement and telecare, as well as the increase in the number of people taking a direct payment, the numbers of people receiving homecare through Adult Social Care has continued to decreased.

APPENDIX A

11. Number of people with a learning disability in residential care (AS04)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Learning disability



Data Notes.
Units of Measure: Number of people with a learning disability in permanent residential care as at month end.
Data Source: MCR summary

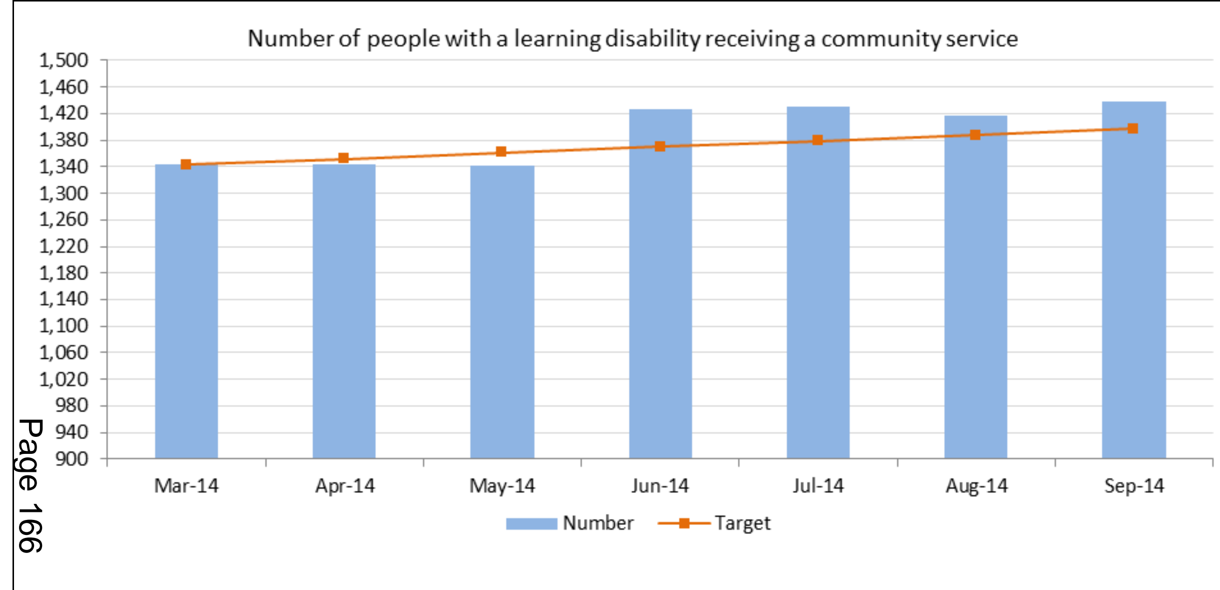
Quarterly Performance Report indicator

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Target	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1259**	**1258**	**1257**	**1256**	**1255**	**1253**
Number	1257	1255	1248	1246	1245	1243	1234	1226	1229	1225	1223	1222
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

It is a clear objective of the Directorate to ensure that as many people with a learning disability live as independently as possible. All residential placements have now been examined to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. In addition, the teams continue to work closely with the Children's team as young people coming into Adult Social Care through transition from the majority of the new residential placements.

12. Number of people with a learning disability receiving a community service			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Learning Disability



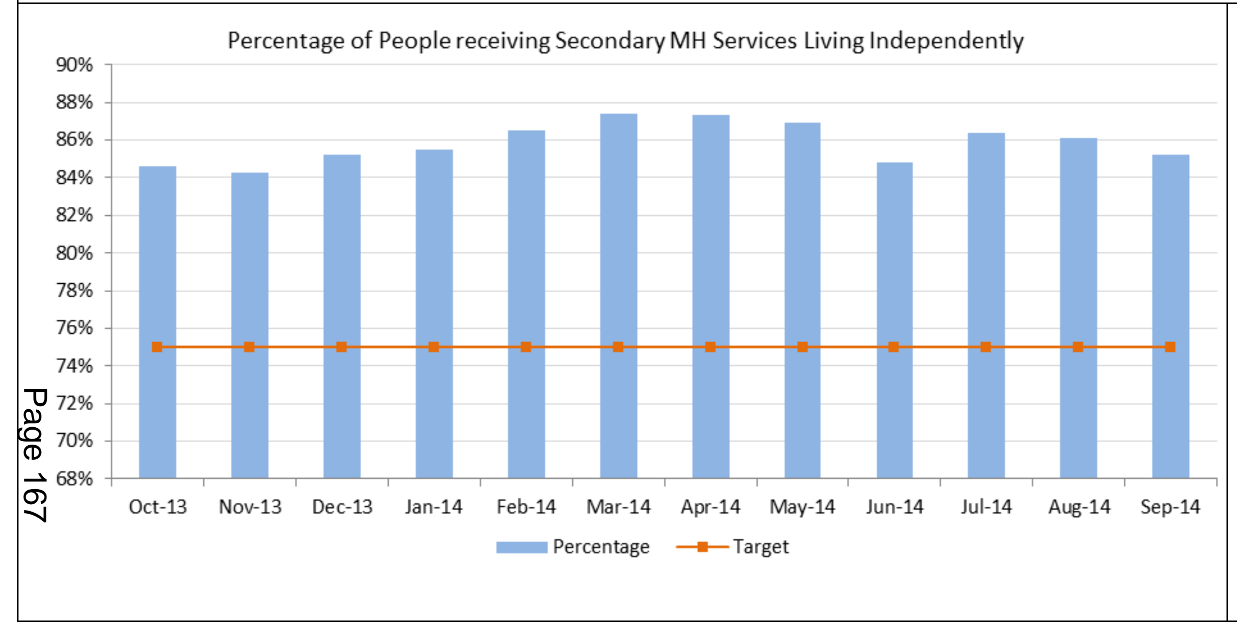
Data Notes.
Units of Measure: Number of people with a learning disability receiving supported living, supporting independence or shared lives service as at month end.
Data Source: MCR summary

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**1343**	**1352**	**1361**	**1370**	**1379**	**1388**	**1397**	**1406**	**1415**	**1424**	**1433**	**1442**	**1451**
Number	1343	1343	1342	1427	1431	1417	1438						
RAG Rating	GREEN	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN						

Commentary

With a reduction in residential placements for people with a learning disability and a focus to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence, the numbers of people supported within the community continues to increase.

13. Percentage of adults in contact with secondary mental health services living independently, with or without support			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	People with Mental Health needs

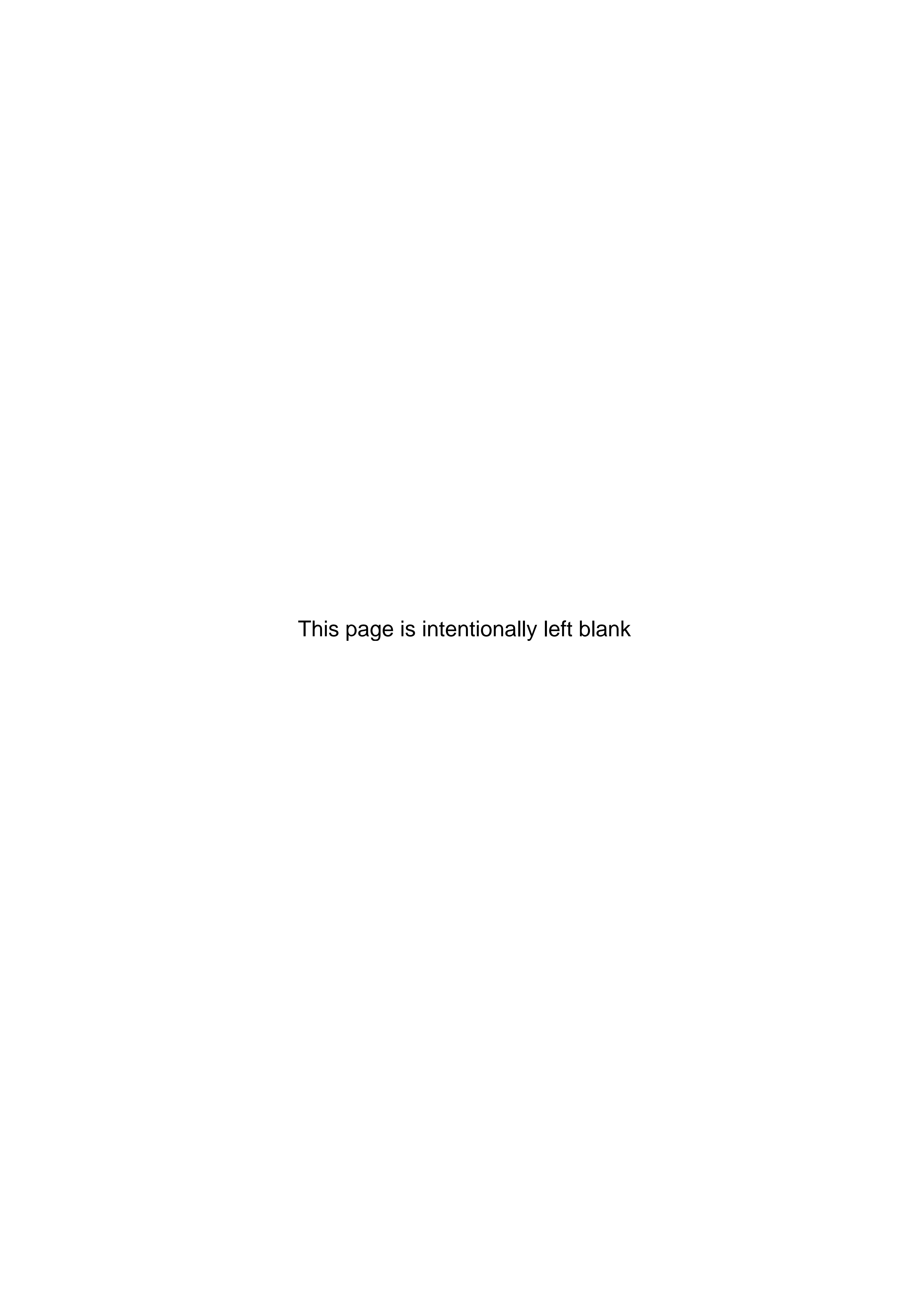


Data Notes.
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Percentage	84.60%	84.30%	85.20%	85.50%	86.50%	87.4%	87.3%	86.9%	84.8%	86.4%	86.1%	85.2%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Latest data available is as at February 2014. The performance indicator remains consistently above target throughout 2013/14 and this is expected to continue. Settled accommodation “Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence.” It provides an indication of the proportion of people with mental health needs who are in a stable environment, on a permanent basis.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From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Interim Director of Public Health

To: Adult Social Care and Health Cabinet Committee

4th December 2014

Subject: Public Health Performance - Adults

Classification: Unrestricted

Summary: This report provides an overview of Public Health key performance indicators which specifically relate to adults.

Performance of the NHS Health Checks has improved substantially in recent months with the targets being met in Quarter 1 and Quarter 2. Community Sexual Health Services continue to provide the required levels of access and Health Trainers continue to engage the expected number of new clients.

A broader range of indicators has been included in this report to highlight some of the important wider trends in public health in Kent. Future reports will include performance indicators relating to the commissioned Substance Misuse Services.

Recommendation: The Adult Social Care and Health Cabinet Committee are asked to note the current performance and actions taken by Public Health

1. Introduction

1.1 This report provides an overview of the key performance indicators for Kent Public Health which relate to services for adults; the report includes a range of national and local performance indicators.

1.2 There is a wide range of indicators for Public Health, including some from the Public Health Outcomes Framework (PHOF). This report will focus on the indicators which are presented to KCC Cabinet, and which are relevant to this committee.

1.3 Following the transition of the Kent Drug and Alcohol Action Team (KDAAT) to the Public Health Department, future reports to the Cabinet Committee will include a number of indicators focusing on the key activity and outcomes of the commissioned substance misuse services across Kent.

2 Performance Indicators

2.1 The table below sets out the performance indicators for the key public health commissioned services which deliver services primarily for adults. The RAG status relates to the target. A more detailed analysis of the performance where the RAG status is Red is included at Appendix 1.

Indicator Description	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Direction of Travel[1]
Prescribed and non-prescribed Data Returns								
Percentage of annual target population completing a health check	10.5% (R)	7.3% (R)	9.9% (R)	7.8% (R)	12.0% (A)	11.3% (G)	15.0% (G)	⇧
Clients accessing community sexual health services offered an appointment within 48 hours	98.5% (G)	97.8% (G)	96.6% (G)	97.4% (G)	99.9% (G)	100% (G)	100% (G)	⇔
Chlamydia positivity rate per 100,000	1,517 (R)	1,376 (R)	1,735 (R)	1,625 (R)	1,949 (R)	1,514 (R)	Not Available	⇩
Proportion of smokers successfully quitting, having set a quit date	47% (A)	50% (A)	50% (A)	51% (A)	57% (G)	51% (A)	Not Available	⇩
Local Indicator								
Health Trainers – Proportion of new clients against target	163% (G)	77% (R)	109% (G)	95% (A)	109% (G)	125% (G)	Not Available	⇧

2.2 The provider of NHS Health Checks in Kent has exceeded the quarterly targets for the number of invitations and the number of completed checks in the first half of the year. For Q1 and Q2, a total of 81,020 invitations were sent, this covered 91% of the eligible population for the year. Over this period, 23,438 health checks were given, which exceeds the 6 month target of 20,150. In total, 26.4% of the estimated annual eligible population for 2014/15 has received an NHS Health check.

2.3 In September this year, the committee endorsed the proposal to extend the existing contracts for NHS Health Checks for 9 months. This will allow more time for the improved performance to continue but will also provide an opportunity to evaluate the impact of pilot projects which have been commissioned to further increase uptake of health checks in designated areas. Public Health has been working this year to provide active feedback to Clinical Commissioning Groups (CCGs) on local results of the programme.

2.4 GUM (Genito-urinary Medicine) clinics in Kent consistently offer the majority of clients an appointment within 48 hours, performing above the target of 95%. GUM service is open access and available to all ages. This indicator is being monitored in quarterly performance monitoring meetings with the commissioned providers. Integrated sexual health services, including GUM, contraceptive services and HIV outpatient services are currently out for tender. The new services are due to start operating from April 2015 and access targets will be included in the new contracts.

2.5 The Chlamydia positivity rate remains below the national target level of 2,300 per 100,000 of 15-24 year old population. The provider has implemented an action plan to tackle the shortfall. The campaign includes radio messaging, promotional materials and the establishment of improved and focused internal performance measures and targeting of at risk groups/communities.

[1] Key to direction of travel arrows is at Appendix 1

2.6 Figures for Q1 2014/15 on chlamydia positivity indicate a rate of 1,514 per 100,000. Although remaining below target this quarter is higher than Q1 2013/14 on the number of tests given, positives found and the positivity percentage and rate.

2.7 Smoking quit rates fell slightly below the target in Q1; 51% of those setting a quit date reported that they were still not smoking after 4 weeks, compared to a target of 52%.

2.8 Smoking rates among adults in Kent have declined in recent years as have the number of people that access the Stop Smoking Services that are commissioned by Public Health. However, smoking remains one of the most significant causes of premature death in the county, particularly in the most deprived areas. Public Health is currently reviewing the current Stop Smoking Services with a view to commissioning a reshaped service which is well targeted and can respond effectively to a rapidly changing environment that includes increasing use of electronic cigarettes.

2.9 The health trainer service continues to engage new clients and work with those in the most deprived areas of Kent; Public Health is working with the provider to report and monitor outcomes.

3 Annual Public Health Outcomes Framework (PHOF) Indicators

3.1 The table below presents the most recent nationally-verified and published data; all indicators now include data up to 2013. The RAG is in relation to National figures.

Annual PHOF Indicators	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	DoT
Under 75 mortality rates for:							
Cardiovascular diseases considered preventable per 100,000	61.2 (G)	59.8 (G)	57.4 (G)	55.9 (A)	52.3 (A)	49.3 (A)	⇧
Cancer considered preventable per 100,000	85.6 (G)	84.3 (G)	83.7 (G)	82.6 (G)	80.5 (G)	78.2 (G)	⇧
Liver disease considered preventable per 100,000	12.8 (G)	12.4 (G)	12.1 (G)	12.0 (G)	12.4 (G)	13.2 (G)	⇩
Respiratory disease considered preventable per 100,000	16.8 (A)	17.4 (A)	17.4 (A)	17.6 (A)	16.6 (A)	16.7 (A)	⇩
Suicide rate (all ages) per 100,000	8.4 (A)	8.4 (A)	7.7 (A)	8.4 (A)	8.1 (A)	9.2 (A)	⇩
Proportion of people presenting with HIV at a late stage of infection (%)	Not available	Not available	Not available	49.0 (A)	46.8 (A)	Not available	⇧
	2008	**2009**	**2010**	**2011**	**2012**	**2013**	
Percentage of adults classified as overweight or obese	Not available	Not available	Not available	Not available	64.6 (A)	Not available	-
Prevalence of smoking among persons aged 18 years and over (%)	Not available	Not available	21.7 (A)	20.7 (A)	20.9 (A)	19.0 (A)	⇧
Opiate drug users successfully leaving treatment and not re-presenting within 6 months (%)	Not available	Not available	14.6 (G)	14.6 (G)	10.9 (G)	10.3 (G)	⇩

	2008/09	2009/10	2010/11	2011/12	2012/13	

	2008/09	2009/10	2010/11	2011/12	2012/13	
Alcohol related admissions to hospital per 100,000. All ages	Not available	Not available	574 (G)	557 (G)	565 (G)	⇩
Proportion of adult patients diagnosed with depression (%)	Not available	Not available	Not available	Not available	5.57	-

3.2 Rates of preventable premature mortality of liver disease in Kent continue to increase, however, currently, Kent continues to show a lower rate than national; increases have occurred in Canterbury, Dartford, Dover, Gravesham, Sevenoaks, Shepway, Swale and Thanet (please refer to PHOF for detail).

3.3 The latest available data show a significant reduction in smoking prevalence has reduced to 19.0% of the adult population; this reduction is similar to the national trend. All but four districts (Ashford, Dover, Gravesham and Thanet) have decreased in the proportion of adults smoking between 2012 and 2013; the highest rates are in Thanet (24.8%) and Dover (24.3%).

3.4 While the national rate of alcohol-related admissions to hospital has decreased between 2011/12 and 2012/13, Kent has increased. The highest rate within Kent was for Shepway at 715 per 100,000, although this is a decrease from 2011/12.

4. Conclusions

4.1 The performance data for the first half of 2014/15 highlight improved performance in some critical areas, including NHS Health Checks. Public Health is working to ensure that this improved performance is maintained and that weaker performance in other areas, such as smoking cessation and chlamydia positivity, is addressed through target improvement plans.

5. Recommendations

Recommendation**:** The Adult Social Care and Health Cabinet Committee is asked to note the current performance and actions taken by Public Health

6. Background Documents

6.1 None

7. Contact details

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Relevant Director:

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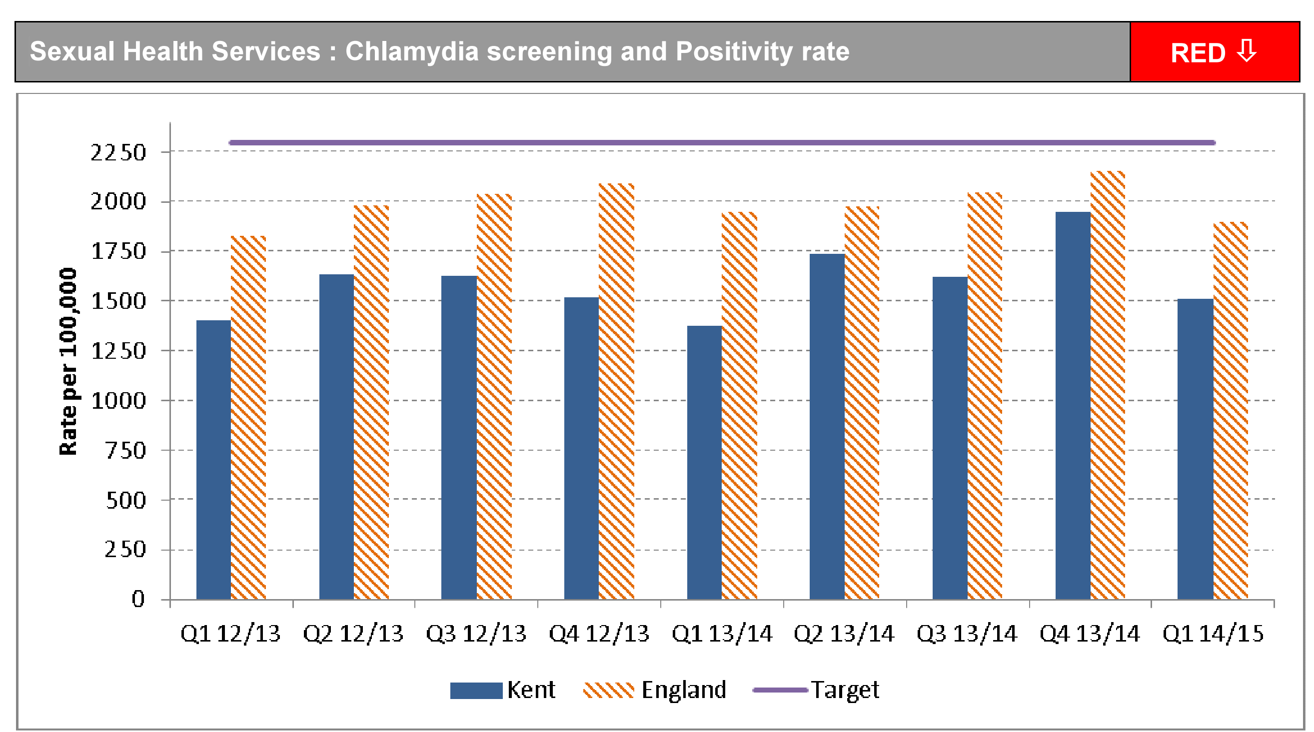
Appendix 1:

Key to KPI Ratings used:

(G) GREEN	Target
(A)	Perform
(R) RED	Perform
⇧	Perform
⇩	Perform
⇔	Perform

Data quality note: Data included in this report is provisional and subject to later change. This data is categorised as management information.

Sexual Health Services : Chlamydia screening and Positivity rate	RED ⇩

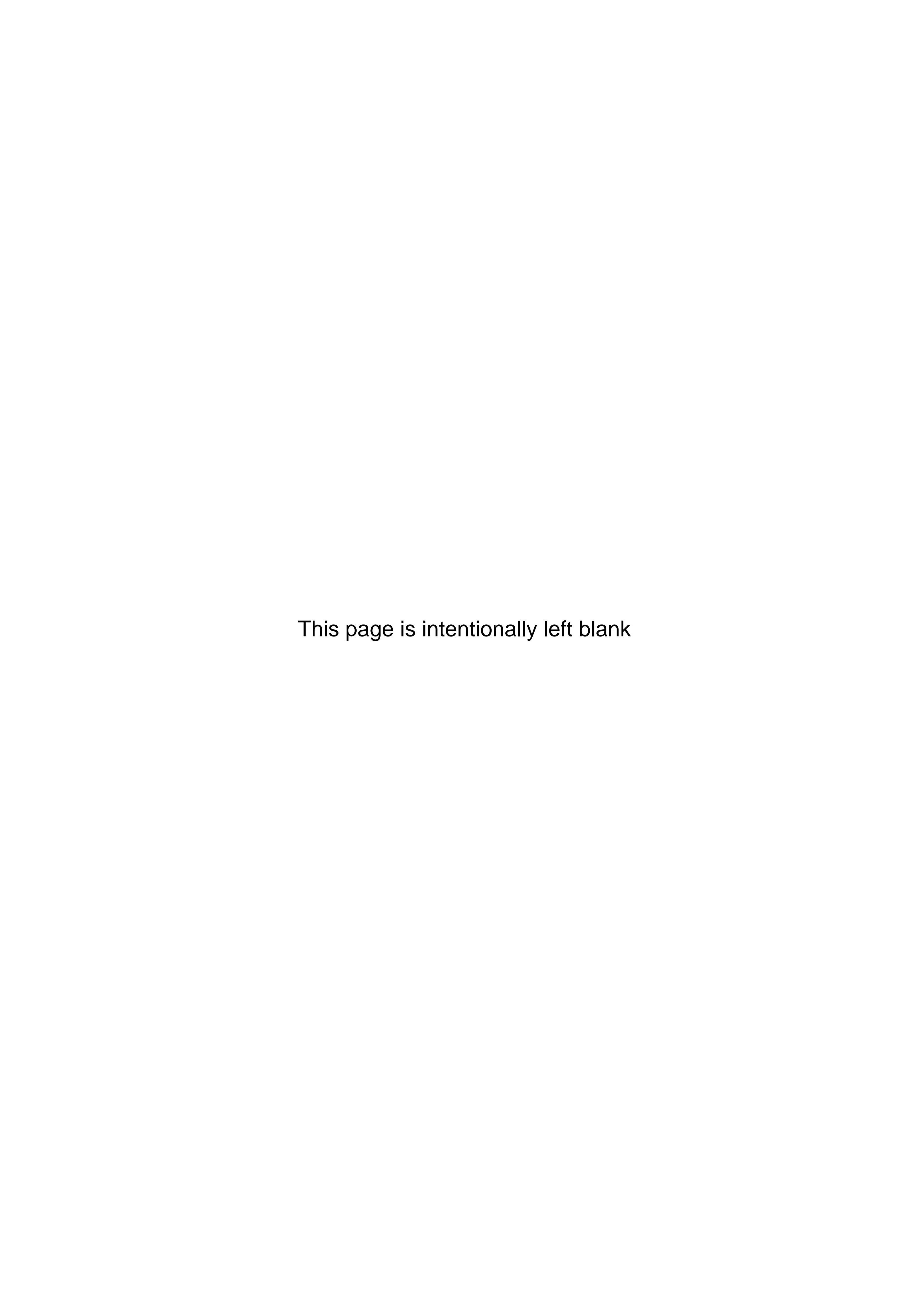


Trend Data –by Quarter	Target	Q1 13/14		Q2 13/14		Q3 13/14		Q4 13/14		Q1 14/15	
Screening Uptake	-	9,013		10,690		10,095		11,829		9,105	
Positive tests reported	7%	636	7.1%	802	7.5%	751	7.4%	901	7.6%	700	7.7%
rate per 100,000 15-24 year olds	2,300	1,376		1,735		1,625		1,949		1,514	
RAG of Positivity Rate	-	Red		Red		Red		Red		Red	
England rate per 100,000 15-24 year olds	2,300	1,947		1,974		2,048		2,154		1,901	

Concerns have been identified regarding performance of this service. The provider implemented an action plan to tackle the shortfall of positivity; this included public health campaign activity, radio messaging, promotional materials and the establishment of improved and focused internal performance measures and targeting of at risk groups/communities. All local Authorities in England have a nationally-set target for positive Chlamydia tests of 2,300 per 100,000 of the 15-24 year old population. For Kent, using the diagnosis rate calculator tool, 60,752 tests are required, covering 32.9% of 15-24 year olds, with 4,253 positives to meet the target rate each year.

A new contract for this service is being awarded to commence from April 2015. Chlamydia Diagnoses is PHOF Indicator 3.02

Data Notes: Higher values are better. Data Source: CTAD. Indicator Reference: PH/SH/02



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From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 4 December 2014

Subject: **Work Programme 2015**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

Summary: This report gives details of the proposed work programme for the Adult Social Care and Health Cabinet Committee.

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

1. Introduction

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decision List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six weeks before each Cabinet Committee meeting in accordance with the Constitution and attended by the Chairman, Vice-Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Member, is responsible for the final selection of items for the agenda, this item gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Terms of Reference

2.1 At its meeting held on 27 March 2014, the County Council agreed the following terms of reference for the Adult and Social Care and Health Cabinet Committee:- '*To be responsible for those functions that sit within the Social Care, Health and Wellbeing Directorate and which relate to Adults. The functions within the remit of this Cabinet Committee are:*

Strategic Commissioning Adult Social Care
Quality Assurance of Health and Social Care
Integrated Commissioning – Health and Adult Social Care
Contracts and Procurement
Planning and Market Shaping
Commissioned Services, including Supporting People
LASAR (Local Area Single Assessment and Referral)
KDAAT (Kent Drugs and Alcohol Action Team)

Older People and Physical Disability
Enablement
In-house Provision – residential homes and day centres

Adult Protection
Assessment and Case management
Telehealth and Telecare
Sensory services
Dementia
Autism
Lead on Health integration
Integrated Equipment Services and Disability Facilities Grant
Occupational Therapy for Older People

Transition planning

Learning and Disability and Mental Health
Assessment and Case management
Learning Disability and mental health In-house Provision
Adult Protection
Partnership Arrangement with the Kent and Medway Partnership Trust and Kent Community Health NHS Trust for statutory services
Operational support unit

Health - when the following relate to Adults (or to all)
Adults' Health Commissioning
Health Improvement
Health Protection
Public Health Intelligence and Research
Public Health Commissioning and Performance

2.2 Further terms of reference can be found in the Constitution at Appendix 2 Part 4 paragraph 21, and these should also inform the suggestions made by Members for appropriate matters for consideration.

3. Work Programme 2015

3.1 An agenda setting meeting was held on 22 October 2014, at which items for the September meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to considered for inclusion to the agenda of future meetings.

3.3 When selecting future items the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any 'for information' or briefing items will be sent to Members of the Cabinet Committee separately to the agenda or separate member briefings will be arranged where appropriate.

4. Conclusion

4.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme to help the Cabinet Member to deliver informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions for future items to be considered. This does not preclude

Members making requests to the Chairman or the Democratic Services Officer between meetings for consideration.

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

6. **Background Documents**
None.

7. **Contact details**

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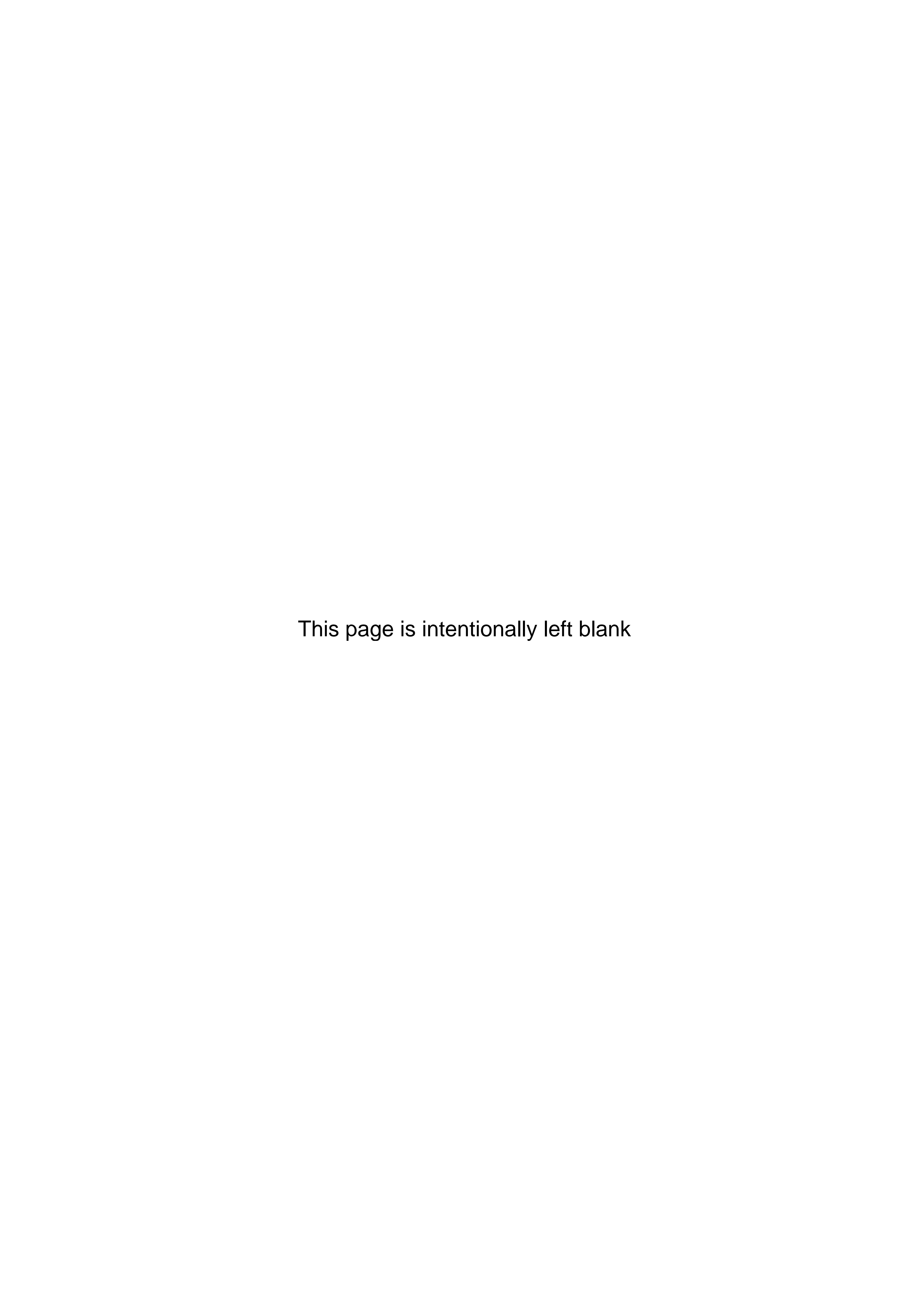
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Last updated on: 20 November 2014

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE – WORK PROGRAMME 2015

Agenda Section	Items
15 JANUARY 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **Suicide Prevention Strategy** decision report for endorsement or rec (part-exempt) • **Healthy Living Pharmacies** decision report for endorsement or rec (part-exempt) • **Alcohol Strategy for Kent** • **Live it Well Strategy refresh** (timing tbc) • **Care Act – decisions arising – Delegation of Assessment for Self-funders and Prisoners** • **KDAAT** decision report for endorsement or rec (part-exempt)
C – Items for Comment/Rec to Leader/Cabinet Member	• **Health Inequalities update** *(12 months on from report at Jan 2014 mtg)* • **Budget Consultation and Draft Revenue and Capital Budgets 2015/16** • **Dynamic Purchasing System – briefing note?** • **Update on the progress of learning disability day services (those which have been modernised)** – requested by George Koowaree at September mtg • **Recruitment and Care training to meet future needs** (requested by Tom Maddison) –*if not to December mtg*
D – Monitoring	• **Local Account Annual report** • **Work Programme** • **Business Planning/Strategic Priority Statement –** timing tbc at P&R Cabinet Cttee in December
E – for Information - Decisions taken between meetings	
3 MARCH 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **Suicide Prevention Strategy** decision report for endorsement or rec (part-exempt) • **Domiciliary Care Review** –*Emma Hanson, 10 min presentation* • **Mental Health core offer – 2 phases** – will be key decision (Emma Hanson will advise timing)
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly* • **Update on the progress of learning disability day services (those which have been modernised)** – requested by George Koowaree at September mtg *to January or March*
D – Monitoring	• **Strategic Priority Statements** incl **Risk Registers** • **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard - Health Improvement Programme Performance report** now to alternate meetings • **Work Programme**
E – for Information - Decisions taken between meetings	
1 MAY 2015	

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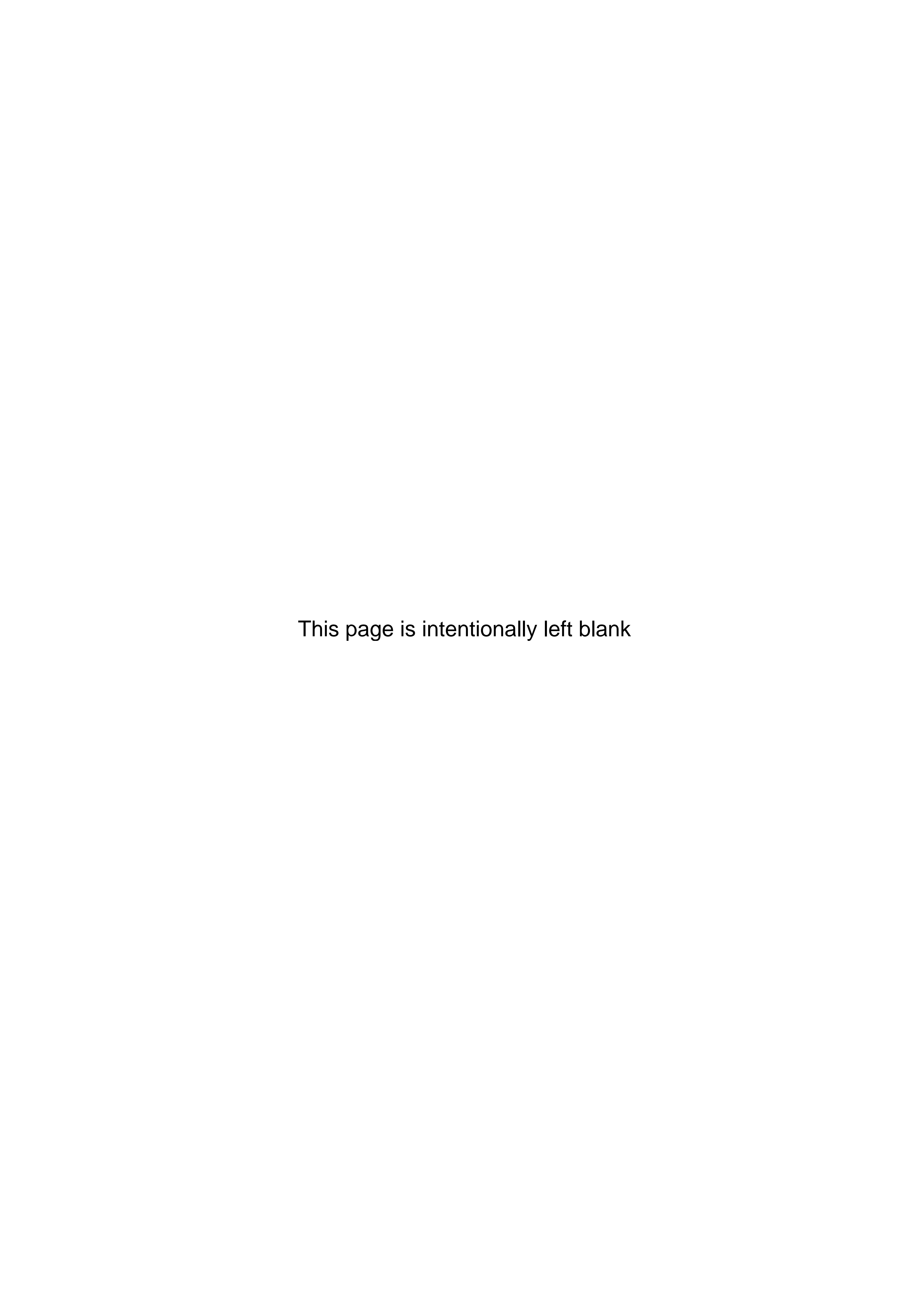
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Risk Registers** • **Work Programme**
E – for Information - Decisions taken between meetings	
10 JULY 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard - Health Improvement Programme Performance report** now to alternate meetings • **Work Programme** • **Local Account Annual report** • **Complaints and Compliments annual report** • **Safeguarding Vulnerable Adults annual report**
E – for Information - Decisions taken between meetings	
11 SEPTEMBER 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Work Programme**
E – for Information - Decisions taken between meetings	
3 DECEMBER 2015	

Last updated on: 20 November 2014

B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings **and mid-year business plan Monitoring** • **Public Health Performance Dashboard - Health Improvement Programme Performance report** now to alternate meetings • **Work Programme**
E – for Information - Decisions taken between meetings	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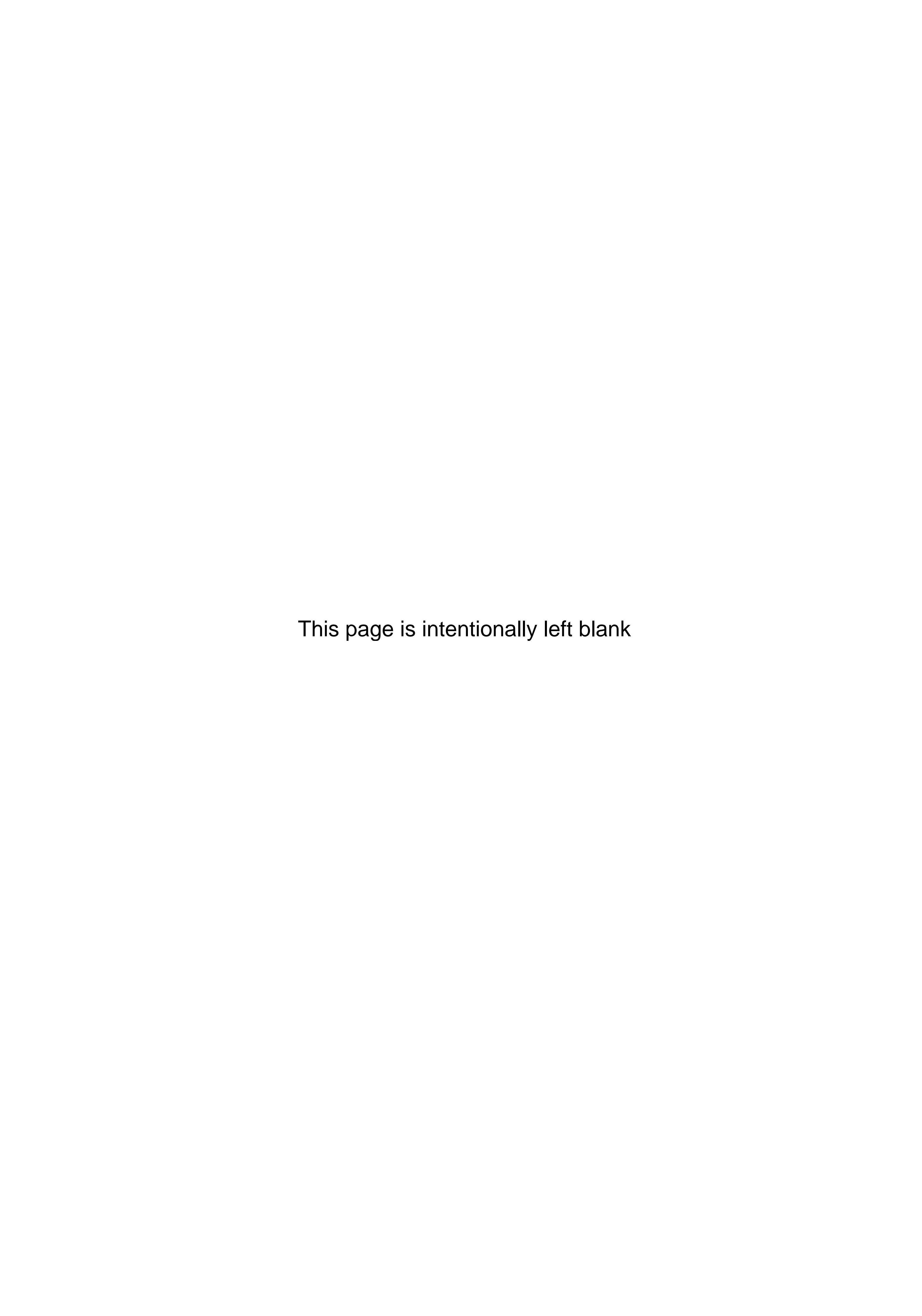

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