ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 1st May, 2015

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 1 May 2015 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

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

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

Membership (13)

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

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UNRESTRICTED ITEMS

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present.

A3 Declarations of Interest by Members in items on the Agenda

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

A4 Minutes of the meeting held on 3 March 2015 (Pages 7 - 18)

To consider and approve the minutes as a correct record.

A5 Verbal updates (Pages 19 - 20)

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

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

B1 Kent and Medway Prison-based Substance Misuse service - contract extension (Pages 21 - 26)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the 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 for a further two years, until 30 September 2017.

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

C1 Update on addressing Health Inequalities in Kent (Pages 27 - 42)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on reducing health inequalities, which is fundamental to the delivery of the whole health improvement programme.

C2 Update on developing the Public Health Strategy Delivery Plan and Commissioning Strategy (Pages 43 - 52)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on a new strategy and aligned commissioning plan which have been developed from the County Council's experience of the contracts which transferred to it in April 2013, and commissioning activity undertaken since then.

C3 Public Health Campaigns and Press (Pages 53 - 60)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on its planned programme of campaigns in 2015/16, which will play a key role in delivering successful public health interventions.

C4 Review of Commissioning of Drug and Alcohol Services (Pages 61 - 66)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on the review of commissioning arrangements undertaken since drug and alcohol services became the responsibility of the County Council's Public Health team in October 2014.

D - Monitoring

D1 Work Programme 2015/16 (Pages 67 - 74)

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

E - FOR INFORMATION ONLY

E1 INFORMATION ITEM - Transition update (Pages 75 - 82)

To receive a report from the Cabinet Member for Specialist Children's Services, the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, which gives an update on developments relating to transition arrangement for disabled young people.

E2 INFORMATION ITEM - Distinctive, Valued, Personal - why Social Care matters: the next five years (Pages 83 - 104)

To receive a report from the Cabinet Member for Specialist Children's Services and the Corporate Director of Social Care, Health and Wellbeing, presenting a document developed by the Association of Directors of Adult Social Services (ADASS) to set out the vision of the sector's leaders of the next five years.

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
03000 416647

Thursday, 23 April 2015

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

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KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 3 March 2015.

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, Mr S J G Koowaree and Ms A Harrison

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), Mrs A Tidmarsh (Director, Older People & Physical Disability) and Mrs A Hunter (Principal Democratic Services Officer)

UNRESTRICTED ITEMS

33. Apologies and Substitutes
(Item A2)

Apologies for absence were received from Mrs Dagger and Mr Maddison. Ms Harrison attended as substitute for Mr Maddison.

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

(1) During the debate on Item D5 – Commissioning of Home Care Services in Kent, Mr Koowaree declared an interest as he had relatives in receipt of Direct Payments.

(2) There were no other declarations of interest.

35. Minutes of the meeting held on 15 January 2015
(Item A4)

RESOLVED that the minutes of the meeting held on 15 January 2015 are correctly recorded and that they be signed by the Chairman.

36. Verbal updates
(Item A5)

Adult Social Care

(1) Mr Gibbens said he had taken key decisions as follows:
14/00135 – Charging for Adult Care and Support
14/00136 – Deferred Payments and Temporary Financial Assistance

(2) He then provided an answer to a question about Troubled Families and mental health issues that Ms Cribbon had asked at the Council meeting on 12 February. He said that any young person referred to the Children and Young Persons' Mental Health Services was seen on the basis of clinical need regardless of their status as a looked after child or as a participant in the Troubled Families programme. Kent County Council also commissioned a specialist children in care team who worked within the Sussex Partnership Trust providing specific support for looked after children which was separate from the core mental health element of the service commissioned by the clinical commissioning groups.

(3) Mr Gibbens said there were a range of services available to adults who were part of the Troubled Families programme including psychological therapies commissioned by the clinical commissioning groups and details were available on the Live it Well website.

(4) Mr Gibbens also said that Kent County Council and the clinical commissioning groups were developing a new model of support for individuals with wellbeing and mental health needs and this would re-shape services to meet increasing demand, re-balance investment and ensure consistent support across Kent through a range of providers from the voluntary and statutory sectors. A consultation with the public to inform the new model was about to start and it was anticipated that the new model would be in place from April 2016.

Events

(5) Mr Gibbens said he had spoken at the Combatting Loneliness & Isolation Conference in London on 20 January and at the Social Care Forum in London on 5 February as well as attending the Melbourne Avenue PFI Scheme Cutting Ceremony in Ramsgate on 27 January and hosting the Kent Age UK Chairs' Annual Meeting on 24 February.

(6) Mr Ireland then gave an update on delayed transfers from hospital which had been discussed at the last meeting of the committee. He said there was still considerable pressure in hospitals in Kent and the pressure varied from week to week. NHS England had acknowledged that Kent was doing well compared with other areas. He also said that £0.5m additional funding had been allocated to Kent by the Department of Health which was being used to enable people to be discharged quickly to their own homes following an admission to hospital.

(7) Mr Ireland said the national publicity campaign about changes as a result of the Care Act 2014 was underway and this would be supplemented by local actions. He referred to the extensive training programme for staff to ensure the authority was ready for 1 April and said that there was unlikely to be an explosion of activity on day 1 of the new regime.

(8) In response to questions, Mr Ireland confirmed that, if demand for assessments was as predicted, there would be sufficient trained and qualified staff and Mrs Tidmarsh said that about 25% of assessments would be conducted by the voluntary sector with the balance being done in-house.

(9) Officers also said that external trainers had been used to train social care and legal staff; the Integrated Discharge team model that was very successful at the Darent Valley Hospital had been implemented in East Kent, integrated teams around GP Practices were being rolled out across Clinical Commissioning Group (CCG) areas and that contractual arrangements were in place to ensure consistency in the conduct of Carer's assessments by the voluntary sector which would be supplemented by random quality checks.

Public Health

(10) Mr Gibbens said he had taken three decisions relating to Public Health and they were:

14/00146 – Contract Extension for Kent Community Health Trust – Smoking Cessation Service

14/00147 – Contract Extension for Kent Community Health Trust – Health Trainers Service

14/00148 - Contract Extension for Kent Community Health Trust – Healthy Weight Service

(11) Mr Gibbens said he had attended the LGA Annual Public Health Conference on 11 February. He said the key points made by Simon Stevens (Chief Executive - NHS England were that: local authorities had a key role to play in ensuring the best start in life for all children; the NHS spent £3bn annually treating smoking related illness; the cost of alcohol misuse and its impact on families needed to be addressed; and that local authorities were well placed to work with clinical commissioning groups and health and wellbeing boards to undertake preventative work that would have a positive impact on the health of the nation.

(12) Mr Gibbens said Duncan Selbie (Chief Executive - Public Health England) spoke about the role of local authorities in ensuring every child had the best start to life, the role of education which also had an impact on health and the need for local authorities to work across directorates to avoid unnecessary admissions of older people to hospital and to reduce health inequalities.

(13) He concluded by saying Jess Mookherjee, Assistant Director of Public Health at KCC) had impressed delegates with her keynote speech and that the slides were available on request.

(14) In response to comment about the message sent to residents when they were being given health advice by elected Members who were themselves overweight or obese, Mr Gibbens said he would encourage Members to lead by example, and to have a health check. He also said that it was predicted that by 2050 obesity would be the largest single killer and the biggest single cost to the NHS. He suggested that the cabinet committee might wish to consider this in more detail at a future meeting.

(15) Mr Scott-Clark said there was not a single solution for obesity and a range of initiatives and activities through the various stages of life were required. He

also referred to the opportunities created by the new arrangements for the health visiting services and the ageing well programme.

(16) Mr Scott-Clark said the Thanet Aspiration Healthy Living Centre had been opened which was the fifth in the county along with three virtual centres. He said the health improvement teams would work closely with these centres as well as the centres outreaching to local communities. Funding for the Thanet Centre was in partnership with Aspire, Global Generation and Orbit South Housing and the centre was working with East Kent College.

(11) The verbal updates were noted.

37. Tendering for Integrated Community Equipment Service (ICES) and Section 75 agreement between Health and Social Care
(Item B1)

(1) Mrs Tidmarsh (Director of Older People and Physical Disability) introduced the report which asked the Cabinet Committee to consider and either endorse or make recommendations to the Cabinet Member on a proposed decision to enter into a Section 75 agreement for an Integrated Community Equipment Service with clinical commissioning groups and to delegate authority to officers to enter into the necessary contractual arrangements to put the service in place. She said that the proposed decision was in line with the objective of becoming a commissioning council and would provide an integrated service that was fit for purpose.

(2) In response to questions and comments, she said that the provider would be incentivised to re-cycle and reuse equipment and the arrangements for returning equipment would be made clear to users when it was provided.

(3) Mr Gibbens (Cabinet Member for Adult Social Care and Public Health) said that the proposed agreement would cover the provision of equipment across Adult Social Care, Specialist Children's Services and the Education and Young People's Services Directorate.

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

(a) the Integrated Community Equipment Service be delivered as an integrated service from 1 December 2015, jointly funded by Kent County Council and NHS Clinical Commissioning Groups and delivered by a preferred bidder identified, as a result of a competitive tendering exercise; and

(b) authority be delegated to the Corporate Director for Social Care, Health and Wellbeing, or other nominated officer, responsibility to enter all necessary contractual arrangements to formalise the joint funding arrangements. These will include, but not be limited, to:
(i) the signing and affixing of the Council seal to a section 75 agreement between Kent County Council and health partners;
(ii) the advertisement and management of a competitive tendering exercise and the award of contract to the preferred bidder, consulting

the Cabinet Member as required by the Council's scheme of financial delegation

be endorsed.

38. Proposed revision of rates payable and charges levied for Adult Services in 2015/16
(Item B2)

Miss M Goldsmith, Directorate Business Partner – Social Care, Health and Wellbeing, was in attendance for this item.

(1) Miss Goldsmith introduced the report which set out the proposed rates and charges for Adult Social Care Services for the forthcoming financial year, including proposed changes to the social care policy and asked the Cabinet Committee to consider and endorse or make recommendations to the Cabinet Member on the proposed decision.

(2) In response to comments and questions Miss Goldsmith and Mrs Tidmarsh said that:
  (a) Financial support from the Council for residential care was means tested and re-assessed every year;
  (b) Where one partner was in care, the income of the other was not taken into account; and
  (c) Under the Deferred Payments Scheme interest was applied to the debt as it accrued.

(3) RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health to
  (a) Approve the proposed increase to the rates payable and charges levied for adult services in 2015/16
  (b) Approve the introduction of the Deferred Payment Scheme as detailed in paragraphs 2.8-2.9 of the report; and
  (c) Agree that the Corporate Director of Social Care, Health and Wellbeing, or other suitable delegated officer, undertake the necessary actions to implement this decision

be endorsed.

39. Better Care Fund Section 75 Agreement
(Item B3)

Ms J Frazer (Programme Manager, Health and Social Care Integration) and Ms R Parsons (Graduate Trainee) were in attendance for this item.

(1) Mrs Tidmarsh introduced the report which asked the cabinet committee to consider and endorse or comment on a proposed decision to enter into a Section 75 agreement with Kent clinical commissioning groups to formalise the implementation of the Better Care Fund and establish the required pooled budget as well as delegating authority to the Corporate Director – Social Care Health and Wellbeing or other officer to arrange the sealing of the Section 75 agreement. She said the proposal had previously been discussed by the Kent

and Health and Wellbeing Board and that it supported the Kent Vision as a national Integration Pioneer.

(2) In response to comments about the importance of providing joined up services in the community, the valuable work of the Integrated Discharge Team and the Kent Re-enablement Services as well as the work being done to identify and co-ordinate community activities, Mrs Tidmarsh said that the BCF was just one element of the work with the NHS to integrate services and more information was available on the Integration Pioneer and Health and Wellbeing Board websites.

(3) In response to a question about the quality of care that could be provided by carers who made multiple short visits to the same person each day, Mr Lobban said the intention was to move from a "time and task" model to an outcome based model and this would be discussed further at Item D4 on the agenda.

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

(a) Agree that Kent County Council will enter into a Section 75 agreement with Kent clinical commissioning groups which will formalise the implementation of the Better Care Fund and establish the required pooled fund; and

(b) Delegate authority to the Corporate Director – Social Care Health and Wellbeing or other suitable delegated officer to arrange the sealing of the Section 75 agreement

be endorsed

40. East Kent Sexual Health Services - interim contract extension
(Item B4)

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

(1) The Chairman confirmed that Members of the committee had read the information contained in the exempt report and did not intend to ask questions relating to that information.

(2) Ms Sharp introduced the report which sought the committee's endorsement of a proposed decision to extend the existing contract for community sexual health services in East Kent until 31 July 2015. She said the proposal to award new contracts had been discussed at the meeting of the cabinet committee held on 4 December and contracts had been awarded for services in West and North Kent. There were, however, a number of issues, which had now been resolved, in relation to the East Kent contracts and a four month extension to the existing contract would allow a managed transition.

(3) RESOLVED that the proposed decision to extend the existing contract for sexual health services in East Kent until 31 July 2015 be endorsed.

41. Adult Social Care Transformation and Efficiency Partner update
(Item C1)

Ms K Ray, HR Business Partner – Social Care, was in attendance for this item.

(1) Mr Lobban introduced the report which provided an adult social care transformation and efficiency partner update including a staffing update. He said staff numbers had reduced by 23% in the Older People/Physical Disability Division (OPPD). He said the number of resignations following the voluntary redundancy process had been higher than expected and a recruitment campaign was underway. He also referred to the Phase 2 Design update set out in paragraph 3 of the report.

(2) In response to comments about the number of resignations and questions about the reasons for resignations and issues relating to recruitment Mrs Tidmarsh said:

(a) the aim had been to avoid compulsory redundancies and there were many reasons for resignations including the age profile of the workforce and personal decisions about transition to new ways of working;

(b) no recruitment had taken place during the consultation process and there was now an element of "catching up";

(c) there were difficulties in recruiting staff in some areas however the recruitment of case officers and managers had been successful;

(d) a targeted approach to recruiting senior staff was being developed;

(e) the Directorate aimed for a mix of external recruitment and developing existing staff;

(f) a new tool had recently been introduced bringing together information on activity and staffing levels for the first time.

(3) Mrs Tidmarsh also said that people were still choosing careers in adults' social care and the Directorate worked with colleges to provide work placements for students and with colleagues in Organisational Development and Learning and Development to identify future needs and meet staff training requirements.

(4) In response to a question, Ms Ray said that it was possible to amend employment contracts to prohibit staff working as agency staff for KCC within 12 months of resigning from a permanent post. She also said that work was already underway with Connect Kent to ensure former KCC staff were not put forward for KCC contracts.

(5) RESOLVED that:
(a) the information in the report be noted
(b) an update on staffing be provided to the Adult Social Care and Health Cabinet Committee every six months.

42. Update on the Good Day Programme
(Item C2)

(1) Mr Gibbens said he had taken a policy decision that all reports relating learning disability would be written an easy to read format.

(2) Ms Southern introduced the update on the Good Day Programme which had been requested by the cabinet committee. She outlined the objectives of the programme and said that the formal consultation stage was nearly at an end. She said: the consultation with carers and service users had been successful; lessons learned from the early consultations had resulted in changes to the later ones; further improvement was required to communications with people with complex needs; the provision of more sensory rooms and adult changing places needed further consideration; and appropriate hubs to create an appropriate and inclusive environment needed to be identified in some districts. She also said that enabling people with learning disabilities to have fulfilled lives in the community had an indirect but significant impact on reducing health inequalities.

(3) The update was welcomed by the cabinet committee and the importance of working with partners to provide adult changing places was emphasised.

(4) In response to questions, Ms Southern said that work was taking place with Day Service staff to ensure that feedback about the programme was recorded and to develop a sustainable way to retain information about the decisions made on the programme.

(5) She also said that Members were welcome to visit community hubs and more detailed information could be provided to Members about projects in their divisions.

(6) Mr Gibbens said he had discussed the provision of an adult changing place at Sessions House with the Cabinet Member for Corporate and Democratic Services.

(7) RESOLVED that the update be noted.

43. Care Act - consultation on the April 2016 changes
(Item C3)

Mrs C Grosskopf, Policy Manager, and Mr D Firth, Policy Officer, were in attendance for this item.

(1) Mr Firth said the Care Act 2014 was being implemented in two stages starting in April 2015 with the introduction of the new legal framework. The cap on care costs, the raising of the capital threshold, new rights for self-funders in relation to care homes and new appeal rights would be implemented in April 2016. The consultation related the changes to be implemented from 2016 and had been received in February, two months later than expected. He said the deadline for responses was 30 March and, to ensure the views of Members were included, a meeting had been arranged for 17 March. Any comments could also be sent directly to him or to Mrs Grosskopf.

(2) Mrs Grosskopf outlined the key points from the consultation including the cap on care costs, changes to the upper capital threshold, first party top-ups in residential care and a proposed new appeals system. She said the early indication from operational and other staff was that the current internal system for dealing with appeals was sufficient.

(3) Questions were raised about how the implications of the Care Act would be communicated to residents and it was confirmed that publicity had already started, staff were being informed and a planned programme of communications was a key work stream for the implementation of the Act.

(4) RESOLVED that the actions being taken in order to respond to the consultation by the deadline be noted.

44. Draft 2015/16 Social Care, Health and Wellbeing Directorate Business Plan and Strategic Risks
(Item D1)

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

(1) Mr Thomas-Sam introduced the report which included the draft Directorate Business Plan and Strategic Risks for the Social Care, Health and Wellbeing directorate.

(2) Resolved that:
(a) the draft 2015-16 Business Plan for the Social Care, Health and Wellbeing Directorate at Appendix 1 of the report be noted; and
(b) the directorate risk register be noted.

45. Public Health Performance - Adults
(Item D3)

The Chairman proposed that this item be considered before agenda item D2 and the committee agreed.

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

(1) Ms Sharp introduced the report which provided an overview of Public Health key performance indicators that relate to adults and said this report included performance indicators for substance misuse services in Kent which were being commissioned by Kent County Council with effect from 1 October 2014.

(2) She drew attention to indicators relating to health checks and smoking cessation as they had not achieved the targets set for quarter 3 and to the indicator for the proportion of adults successfully completing treatment for substance misuse. Nationally there had been a drop in the numbers accessing and completing treatment for dependence on drugs in 2012/13 and Kent's performance at 20.6% was above the national average of 15%.

(3) In response to a question, she said that performance targets for health checks had been set equally across the four quarters of the year and that for next year it was intended to take into account external factors and divide the annual target more realistically across the four quarters. She also said that some innovative arrangements were being put in place, such as a partnership with a pharmacy group and with Maidstone Football Club to encourage and conduct health checks.

(4) RESOLVED that the current performance and actions taken by Public Health be noted.

46. Adult Social Care Performance Dashboard
(Item D2)

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

(1) Miss Smith invited comments and questions on the report which included the draft Directorate Business Plan and Strategic Risks for the Social Care, Health and Wellbeing directorate.

(2) In response to a question about the percentage of people with mental health needs in employment, she said this was a national target and did not reflect the numbers of people who had been helped into voluntary or short term work. Further information could be provided on request.

(3) In response to a question about the number of completed promoting independence reviews, officers said this was a specialised review and targeted at those likely to benefit from it. Other reviews were carried out annually and further information could be provided on request. It was intended that more staff would be trained to conduct a less specialised form of independence review and that targets would be re-set for 2015/16.

(4) Resolved that the Adult Social Care Performance Dashboard be noted.

47. Commissioning of Home Care Services in Kent
(Item D4)

(1) Mr Lobban introduced the report which set out issues experienced during the mobilisation of contracts for home care services, the benefits and lessons learned to inform the future. He said having 23 contracted providers instead of the previous 130 was enhancing performance management and contributing to the objective of moving away from a time and task model to an outcome based model. There were improved patterns of care in place in some areas, however some providers had underestimated the cost of service provision in some isolated areas and there had been issues relating to the transfer of information during TUPE transfers and with the recruitment and retention of care staff particularly in West Kent.

(2) In response to questions he said: it was intended to provide performance information to Members; contractors were a mixture of large and small national and Kent based firms that, with the exception of one provider in Dartford

Gravesham and Swanley, had all previously worked in Kent; information about satisfaction with the service would be easier to collect as contracts were monitored by commissioning officers who were looking at innovative ways of collecting feedback as well as the Quality Care Commission's new enhanced role in inspecting domiciliary care.

(3) In response to questions about contracts he said they had been let for 12 months with a possible extension by 12 months and a further 12 months. He also said that preparations were being made to potentially re-tender contracts in some areas including Dartford, Gravesham and Swanley, rural Ashford and West Kent. He also said preparations were being made for implementation of phase 2 of the transformation programme which would start in May.

(4) RESOLVED that the paper and proposed next steps be noted.

48. Work Programme 2015/16
(Item D5)

RESOLVED that the committee's work programme for 2015/16 be agreed.

49. East Kent Sexual Health Services - interim contract extension (appendix to item B4)
(Item F1)

There was no discussion on this item as the information in the exempt report had been considered and informed the discussion recorded in minute 41 above.

50. Tribute to Sue Horseman

Mrs Tidmarsh said Sue Horseman would retire soon and paid tribute to the work she had done in relation to occupational therapy services for many years and the work she had done more recently on the contract for an integrated community equipment service.

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By: Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health

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

Mr A Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 1 May 2015

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

Classification: Unrestricted

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

Adult Social Care

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

Events

12 March - Spoke at the Transforming Adult Social Care Forum in London
18 March - Attended launch event for the Take Off Charity in Canterbury
15 April - Attended Governors visit to South East Coast Ambulance Service 111 Centre in Ashford

New Division - Disabled Children, Adults with a Learning Disability and Mental Health

As Members will have seen in the Business Plans that were discussed in the March meeting, Disabled Children's Services, Adults Learning Disability and Adult Mental Health Services have come together in a new division from the 1st of April 2015. Penny Southern will be the Director responsible for the division which is called Disabled Children, Adults with a Learning Disability and Mental Health. I am very pleased that this closer alignment will further improve the support for disabled young people as they become adults.

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

Adult Public Health

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

9 March - Signing of the Local Government Declaration on Tobacco Control
11 March - Attended the No Smoking Day - Charlton Athletic 'Kick the Habit' Roadshow in Canterbury
25 March - Spoke at the 'Tackling HIV Stereotypes' Impress Conference in Canterbury

Director of Public Health – Mr A Scott-Clark

1. Broadstairs Town Shed
2. Porchlight

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

1st May 2015

Subject: Kent and Medway Prison Based Substance Misuse service - contract extension

Classification: Unrestricted

Decision No.: 15/00044

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

Kent County Council, on behalf of NHS England, commissions substance misuse services in prisons across Kent. NHS England fully funds this service.

The current contract for the Kent and Medway Prison Based Substance Misuse Service contract is a three year contract, with the option to extend for a further two years. The initial three year period concludes on 30th September 2015. The current provider, the Rehabilitation of Addicted Prisoners Trust (RAPt) are a strongly performing provider who have demonstrated an ability to respond to service users' needs.

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 key decision to invoke the contract extension option within the Kent and Medway Prison Based Substance Misuse Service contract until 30th September 2017.

1. Introduction

1.1. The purpose of this paper is to seek the committee's endorsement of a proposed key decision to invoke the contract extension option within the Kent and Medway Prison Based Substance Misuse Service contract.

1.2. The current contract began 1st October 2012 and ends 30th September 2015, there is a 2 year extension clause built into the contract.

2. KCC commissions substance misuse services in prisons across Kent on behalf of NHS England. NHS England fully fund this service. NHS England have requested that this clause is invoked to extend the contract.

3. Background

3.1. The Kent and Medway Prison Based Substance Misuse Service is delivered into 7 secure establishments in Kent and 1 in Medway. These establishments are: Her Majesty's Prisons (HMP) Elmley, Swaleside, Standford Hill, Blantyre House, East Sutton Park, Maidstone and Rochester as well as Dover Immigration Removal Centre. The contract began in October 2012 and was awarded via a competitive procurement to RAPt.

3.2. The current contract is a three year contract with an option to extend for 2 years. At the time of award the contract was worth £4.75million per annum and covered 9 secure establishments, however in 2013, HMP Canterbury was closed and the contract varied to £4,260,400 per annum.

3.3. The contract is 80% core funding and 20% payment on service credits for achieving the required targets.

3.4. The funding tor this service is provided by NHS England through a Service Level Agreement.

3.5. Generally performance is good with higher than the national average of planned discharges from treatment, for example; 100% of all discharges at HMP Rochester in Quarter 2 of 2014-15 were planned discharges (N 147) compared to a national average of 93%.

3.6. In Quarter 1 2014-15, 100% of all discharges at HMP Elmley in Quarter 1 of 2014-15 were planned discharges (N 316) compared to a National average of 97%. The number of clients transferred in custody and picked up in treatment within 3 months within the receiving establishment is also above the national average across all establishments in Kent.

4. Contract extension

4.1. The current contract is performing well and is embedded within the prison healthcare environment. The service has responded well to changing service user needs within the differing establishments that make up the contract.

4.2. The service is funded entirely by NHS England, who have committed to funding this contract for the full length of the extension period. NHS England have requested that KCC extend this contract to allow for a reprocurement in 2016-17.

4.3. The table below provides a breakdown of the cost of the contract extension per annum:

4.4.

Cost Type	Cost (£)
Core contract	3,408,320
Activity based payment (service credits)	852,080
Total	**4,260,400** This cost is fully funded by NHS England

5. Risks and alternative options

5.1. The alternative option to the proposed contract extension would be to re-procure the service in time for 1st October 2015.

5.2. This option would be the most sensible option if the service was deemed to be underperforming or there were any significant concerns about the quality of the service.

5.3. In addition there are particular requirements in relation to Transfer of Undertakings Protection Employees (TUPE) for Her Majesty's Prison Service Staff (HMPS) which would need to be followed should the next procurement result in another TUPE arrangement.

6. Conclusion

6.1. KCC Public Health commissioners are seeking to extend the existing contract for Kent and Medway Prison Based Substance Misuse Services for 2 years (as per the contract) until 30th September 2017.

6.2. The contract will continue to deliver significant efficiency savings and represents good value for money for KCC and NHS England. Public Health therefore considers that the proposed contract extension represents the most favourable solution for KCC given the risks associated with any alternative course of action.

7. Recommendations

7.1. Members of the Committee are asked to:

comment and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed key decision to invoke the contract extension option within the Kent and Medway Prison Based Substance Misuse Service contract until 30th September 2017.

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	15/00044

For publication

Subject: Contract Extension for the Rehabilitation of Addicted Prisoners Trust (RAPt) - Kent and Medway Prison Based Substance Misuse service

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that the County Council invoke the contract extension option within the Kent and Medway Prison Based Substance Misuse Service contract until 30th September 2017

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 1st May 2015

Any alternatives considered:
A 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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By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

Date: 1st May 2015

Subject: Update on Addressing Health Inequalities in Kent

Classification: Unrestricted

Pathways: This is the first committee to consider this report

Electoral division: All

Summary:
Reducing health inequalities is fundamental to the delivery of the whole health improvement programme, and thus all commissioning across the system needs to be aimed at not only improving health and wellbeing, but also to reduce differences across and within communities.

Whilst populations across all quintiles are living longer, the data analysis suggests that the gap in life expectancy across most deprived and least deprived during 2006-2014 has not reduced. Thus requiring ongoing concerted effort and a systematic approach across the entire health and care system, with all partners having a role to play in addressing this.

Collectively the Kent Health and Wellbeing Board and local Health and Wellbeing Boards provide opportunities for CCGs and District / Borough Councils to work collaboratively to reduce health inequalities. To effectively address health inequalities it is intended that Public Health commissioning is aligned with commissioning of services across other parts of the system. As a result of this collective effort we aim to ensure that addressing health inequalities is embedded in both commissioning and provision of services to improve the population's health and wellbeing outcomes. Public Health is in the process of developing its strategic delivery plan in line with Council's commissioning priorities. During 2015-16 Public Health will work with partners to design models of services that are easily accessible and targeted to reduce health inequalities.

Recommendations:
Adult Social Care and Health Cabinet Committee Members are asked to:

a) Note the progress made to date in addressing health inequalities across Kent.
b) Support work by the Public Health team and partnership groups (including Local Health and Wellbeing Boards) at local level in designing commissioning models for future provision of public health services at a local level.
c) Support collaborative working between agencies such as the district authorities, police and health in promoting policy initiatives to reduce harm from issues such as alcohol and smoking.

d) Support work at policy level, such as in influencing spatial planning, licensing, housing etc to address health inequalities and promote health and wellbeing in all local policies.

1 Introduction

1.1 Health Inequalities are avoidable variations in the health status of groups and individuals and are a complex issue. Inequalities are ultimately measured by Life Expectancy at Birth, All Age All-Cause Mortality (AAACM) rates and a range of shorter-term performance indicators set by the Public Health Outcomes Framework, along with measuring slope index of inequalities and healthy life expectancy. There is evidence that populations in areas with high deprivation experience higher death rates and more burden of ill health during their life time, compared to those in areas with low deprivation (Marmot strategic review, 2010).

1.2 This paper provides an update to the Adult Social Care and Health Cabinet Committee, on progress regarding how Kent is addressing health inequalities.

1.3 In 2012 Kent produced an action plan "Mind the Gap, Building bridges to better health for all" to address health inequalities, which was agreed by the full Council in March 2012 and an update provided in January 2014. This strategy ends this year and a new strategy will be developed.

1.4 The plan illustrates a range of actions and initiatives undertaken by Kent County Council (KCC) and partners to address the wider social determinants of health inequalities across Kent. It demonstrates the contribution that district councils, community enterprises, voluntary sector and other statutory agencies make to improve healthy lifestyles and promote mental and emotional wellbeing among the Kent population, particularly in deprived communities and to the most vulnerable in society.

2. Measureable indicators of health inequalities

2.1 Life expectancy at the time of birth

This is a measure of health inequalities and refers to the average number of years a newborn is expected to live if mortality patterns at the time of its birth remain constant in the future. Populations across all quintiles are living longer; however, recent trend lines do not appear to show any convergence between the quintiles within the sexes. In fact the life expectancy gap between most deprived and least deprived has very slightly increased during 2006-2014 (figure1).

However, the table shows that when 2006-08 is compared with 2012-14, life expectancy for <u>males</u> is improving at a greater rate in the most deprived quintile: over this period, life expectancy in the worst quintile increased by 2.5%, whereas for the least deprived this was 1.5%. For females, there is no difference between the two quintiles: both increased by 1.3% (table 1).

Figure 1

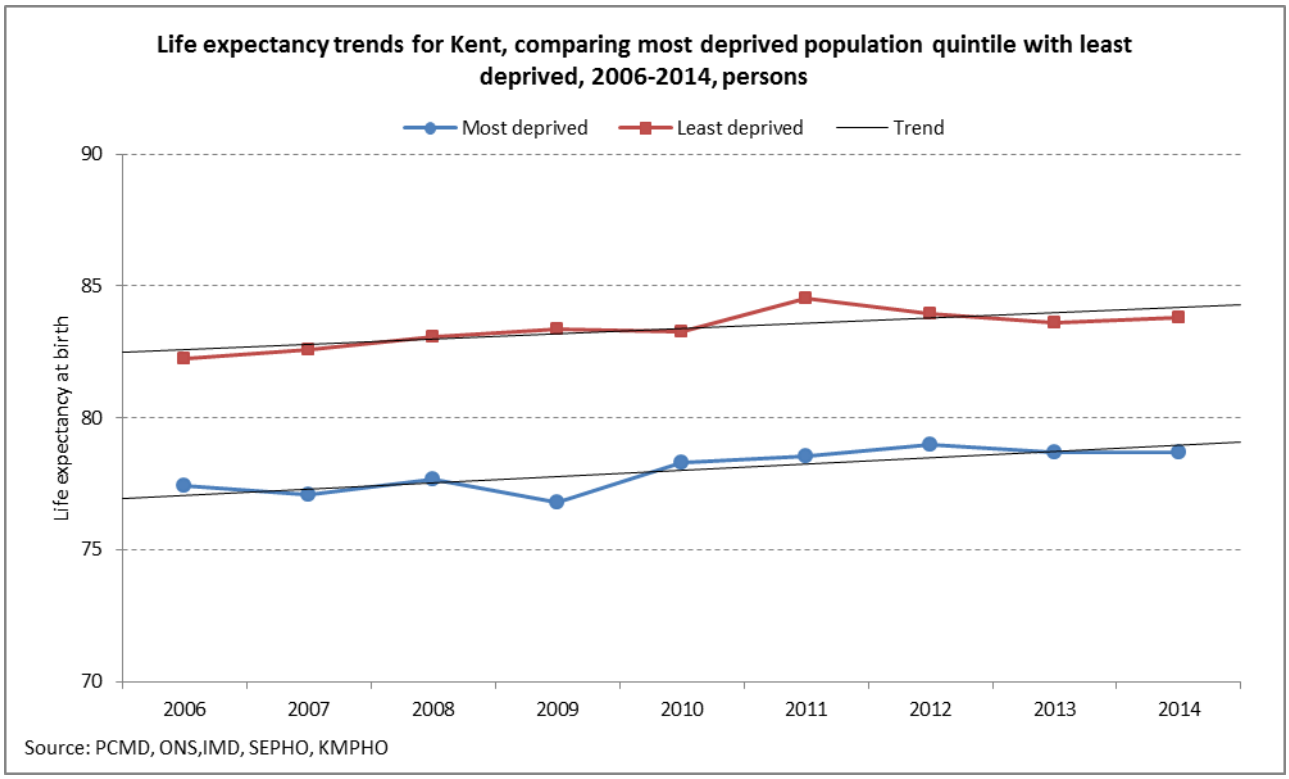


Table 1: Life expectancy at birth for areas in Kent by deprivation status comparing 2006-08 with 2012-14

	Life expectancy at birth (years)								
	Male		Female		Persons		Period percentage change		
Population	2006-08	2012-14	2006-08	2012-14	2006-08	2012-14	Male	Female	Persons
Most deprived (Q1)	74.6	76.5	80.0	81.0	77.4	78.8	2.5	1.3	1.8
Q2	78.4	79.0	82.5	83.6	80.5	81.3	0.8	1.3	1.0
Q3	79.3	80.1	82.1	83.3	80.7	81.8	1.1	1.5	1.3
Q4	80.2	81.1	83.2	84.1	81.7	82.6	1.2	1.0	1.1
Least deprived (Q5)	81.3	82.5	83.9	85.0	82.6	83.8	1.5	1.3	1.4
Kent	**78.8**	**79.9**	**82.4**	**83.4**	**80.6**	**81.7**	**1.4**	**1.3**	**1.3**

Source: PCMD, ONS,IMD, SEPHO, KMPHO

2.2 Routinely monitored indicators

At its meeting in January 2014, the members of the Adult Social Care Cabinet Committee agreed that health inequalities would be measured against agreed indicators. Table 2 summarises these indicators and Kent's current performance against these.

Table 2

Indicator	Current Status	Direction of travel
Reduction in the under -75 mortality rate from Cancer considered preventable (rate per 100,000).	2011-13 78.2	↑ gradual decrease from 2001-03 at 93.4
Reduction in the under -75 mortality rate from Respiratory Disease considered preventable (rate per 100,000).	2011-13 16.7	↔ overall little movement since 2001-03 although has decreased from 18.5 but not in a linear fashion
Increase in the proportion of people receiving NHS Health Checks of the Target number to be invited (proxy for under -75 mortality).	Q1 to Q3 14/15 46.6%	↑ An increase from 24.3% on the same time period in 2013/14
Increase in the number of people quitting smoking via smoking cessation services (number, proxy for under -75 mortality)	Q1 to Q3 14/15 3,008 people quitting at 4-weeks	↓ A decrease from the same period last year. Q1-Q3 13/14 was 4,478
Increasing Breastfeeding initiation rates	2013/14 71.3%	↔ overall little movement but a decrease from 72.5% in 2011/12
Increasing Breastfeeding continuance 6 – 8 weeks	2012/13 40.8%	No published figures to compare due to data validation concerns
Reduction in the number of pregnant women who smoke at time of delivery.	2013/14 13.0%	↑ A decrease from 16.8% in 2010/11

3. Addressing health inequalities through tobacco control

Smoking is still the main contributory cause of premature mortality and the greatest influence on health inequalities. Kent has invested nearly £3.3 million in tobacco control initiatives. As a result in quarter three of 2014-15 3,008 quits were achieved of 5,882 (51%) of those set.

Smoking prevalence rates are continuing to decline, nationally and across Kent (table 3). The National estimate for smoking prevalence is 18.4% and Kent is slightly above the national average at 19%.

Table 3:

Adult Smoking Prevalence	2011	2012	2013
England	20%	19.5%	18.4%
Kent	20.1%	20.9%	19%

Source: PHE Local Tobacco Control Profiles, March 2015

In Kent the highest smoking prevalence exists in the most deprived areas with a 28.4% smoking prevalence among routine and manual workers (table 4). People in routine and manual jobs are twice as likely to smoke as those in managerial and professional roles.

Additionally, manual and routine workers are less likely to quit smoking abruptly or access quit smoking services. Kent is currently exploring harm reduction (cut down to quit) programmes, which may be more effective targeted to these subgroups.

Table 4:

Routine & Manual Worker Smoking Prevalence	2012	2013
England	29.7%	28.6%
Kent	31.3%	28.4%

Source: PHE Local Tobacco Control Profiles, March 2015

Similarly, some women who smoke in pregnancy find it challenging to quit smoking and smoking status at time of delivery rates in Kent are 13% against a national average of 12% (table 5 and figure 2). Although we are RAG red, we are decreasing and have decreased the gap between Kent and National.

The Kent Babyclear programme operates a support programme to assist pregnant smokers quit smoking but is currently experiencing a high number of referrals being lost to service before agreeing to set a quit date. Although the reasons for this are still being explored it is apparent that some women are not ready to quit abruptly and without a harm reduction programme in place, are unable to be supported through the existing commissioned service.

Kent is also a pilot for a national smoking in pregnancy programme called ‘Baby Be Smokefree’, which is looking to reduce smoking in pregnancy amongst teenage pregnant women who smoke.

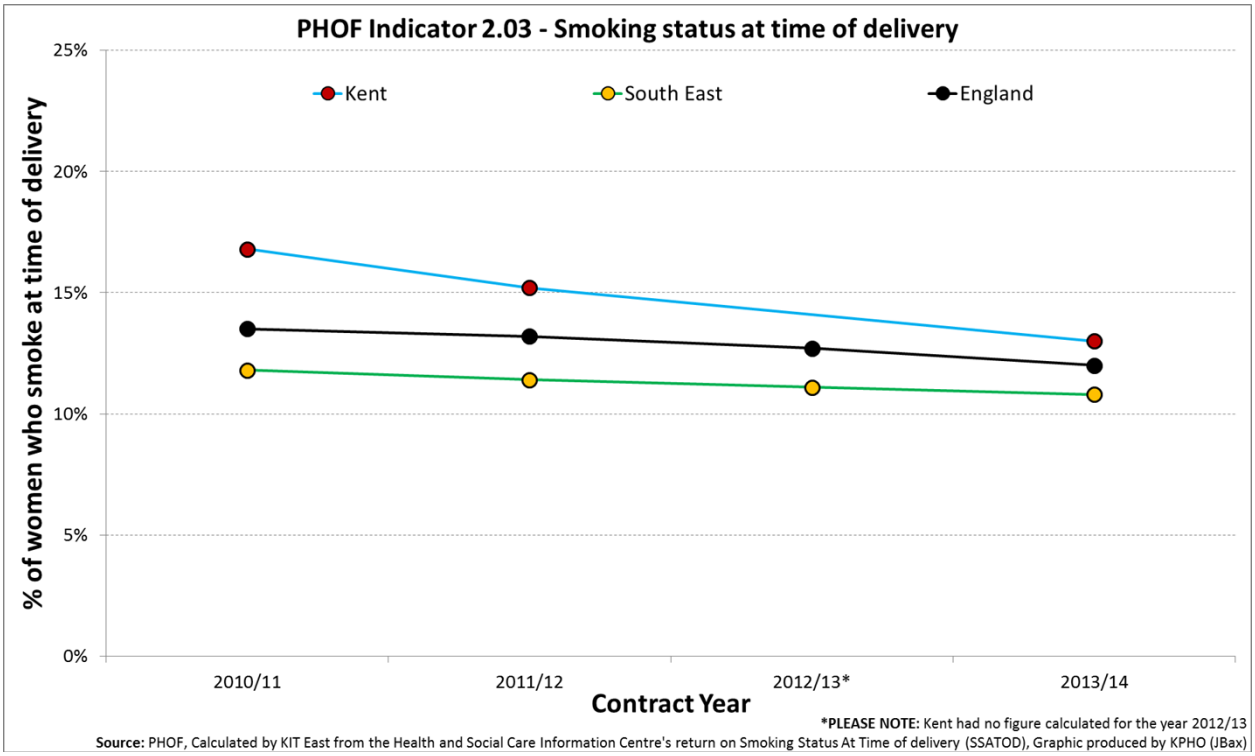
Additionally Kent has also implemented Family Nurse Partnership which is a family support programme, working with young families in most vulnerable communities to reduce smoking prevalence along with offering support in other areas, (further information in section 7.3).

Table 5: Smoking at the time of delivery

	2010/11	2011/12	2012/13	2013/14
Kent	16.8%	15.2%	*	13.0%
South East	11.8%	11.4%	11.1%	10.8%
England	13.5	13.2	12.7%	12.0%

* Poor data quality - not suitable for publication
Source: PHOF

Figure 2



4. Improving mental health services to address health inequalities

Improving mental health and wellbeing is an essential component for addressing health inequalities. Currently, primary care community link workers provide early intervention support to individuals with mental health distress to help them access community resources and to promote social inclusion. During 2014-15, Public Health has worked closely with colleagues from Social Care and Clinical Commissioning Groups to develop the Mental Health core offer of support and the new service will commence from April 2016. This is a priority programme and a leading example of a cross system approach. Public health is focussed on both the promotion of wellbeing, and effective early intervention. This will include a holistic wrap around primary care service to support those with greatest need living in Kent communities. The model needs to sit outside of secondary mental health services to ensure that there is no role dilution. It will form a key part of an integrated pathway across the voluntary sector, primary care mental health and social care and include public health initiatives to ensure there is appropriate, equitable, timely and cost effective interventions for vulnerable people in the community.

5 Front line action at district level

5.1 In 2013-14, additional resources were made available to assist district councils with the improved targeting and effective management of health inequalities programmes. Programmes submitted by districts were assessed using the impact assessment tool and funding was provided to deliver the actions identified from the screening toolkit.

5.2 Though the action plans were varied across Kent districts, the focus however, was given to outcomes related to 'Give every child the best start in life'. The summary of their focus is outlined in table 6 with further details in Appendix 1.

Table 6: Key focus from projects carried out within districts:

Districts	Key focus of projects of individual districts	Current status of programmes
Ashford	Plans to focus on reducing and alleviating child poverty.	Completed
Canterbury	Key focus was on reducing self-harm behaviours in young people	Completed
Dartford	Dartford's was varied but mostly focused on (a) giving every child the best start in life (b)education (c) employment opportunities (d) healthy and sustainable communities	Yet to commence
Dover	Dover and Shepway's outcome message was on (a) inactivity (b) achieving healthy weight by tackling overweight & obesity (c) reducing alcohol (d) smoking	Ongoing
Gravesham	Gravesham's focused on young adults from age 16 (or age 14 through the Gillick competence) to encourage (a) healthy weight by reducing obesity (b) learning disabilities and mental health through 6 ways to wellbeing.	Ongoing
Maidstone	Maidstone – focused on their priorities (a) Give every child the best start in life (pregnancy and early years), (b) children and families, (c) NEETs/employment and skills (d) healthy workplaces (e) healthy weight (f) self-harm (g) Excess winter deaths (h) falls prevention (i) alcohol	Completed and have now raised further funding for next financial year 2015/2016
Sevenoaks	Sevenoaks - (a) rural inaccessibility, (b) drug and alcohol (c) children and families (d) healthy places / communities	Due to complete in March 2015
Shepway	Dover and Shepway - focused on (a) inactivity (b) achieving healthy weight by tackling overweight & obesity (c) reducing alcohol (d) smoking	still ongoing
Swale	Continuation of previous projects such as 'Beats and Breathe' with support from Public Health	
Thanet	Thanet – (a) risk taking behaviours in young people (b) ethnic communities (c) LGBT needs for service development (d) learning disabilities and mental health	Completed
TMBC	Tonbridge and Malling – (a) pregnancy and early years (b) risk taking behaviours in young people (c) healthy workplaces (d) children and families in poverty	Completed
T Wells	Tonbridge Wells – (a) Excess winter deaths (b) self-harm reduction (c) Healthy weight (adult & child obesity reduction) (d) reduction in smoking in young people	Ongoing

6 Front line action at CCG level

It is a statutory duty of the CCGs to reduce health inequalities. Some examples of work that is being undertaken to address health inequalities at a local level are:

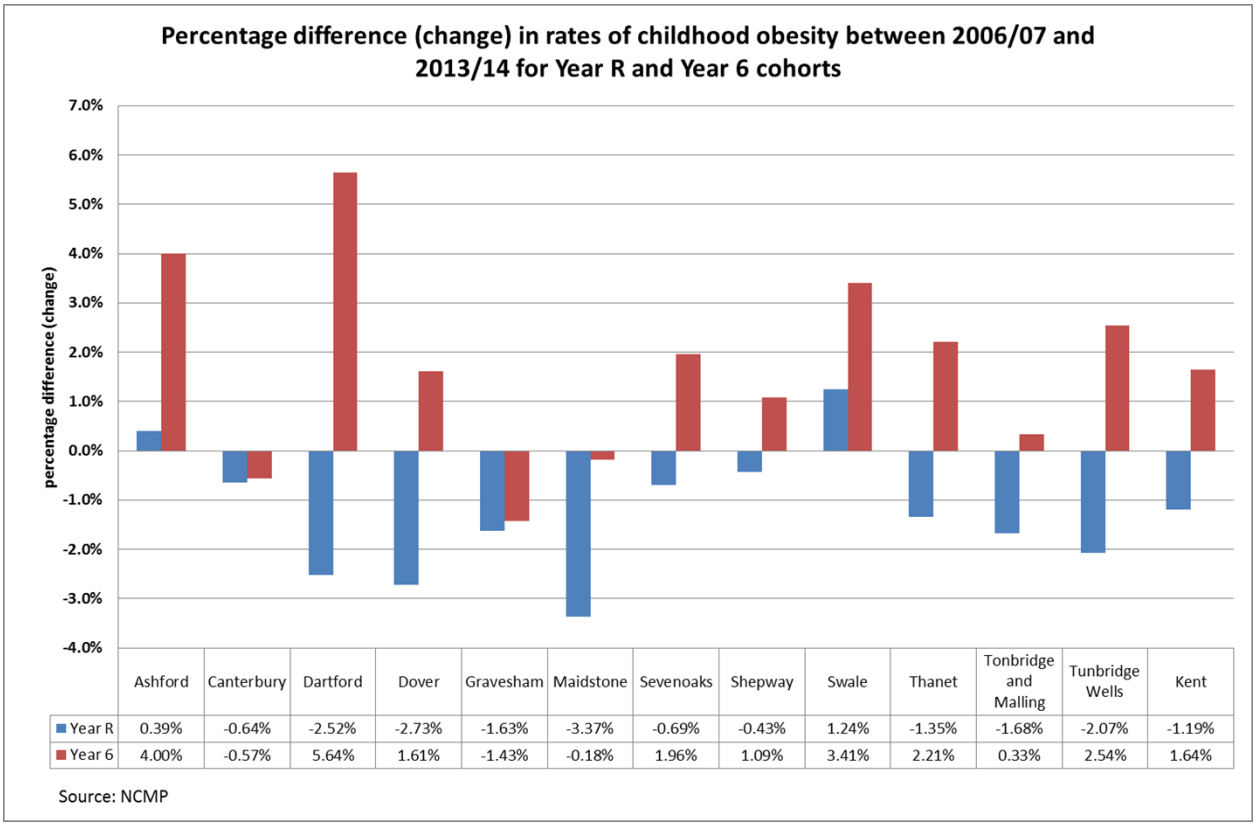
- tackling variations in treatment e.g. atrial fibrillation and stroke
- prioritising support and prevention in the most deprived areas by targeting health trainers
- developing integrated care pathways such as Chronic Obstructive Pulmonary Disease, including prevention and stop smoking
- working with partners across the system to address public health issues such as obesity, breastfeeding, mental health and tobacco control
- working with colleagues to set up local substance misuse steering group and work across all agencies to reduce crime and improve health outcomes
- proactive case-finding (identification) within the General Practice population of vulnerable groups and the undertaking of opportunistic brief advice using the guidance, treatment and referral pathways within the Alcohol Integrated Care Pathway (AICP)
- using community development approaches through programmes such as Margate Task Force and proactively work with local communities in addressing factors that affect health outcomes such as housing, substance misuse etc.

7. Addressing health inequalities in younger years

7.1 Childhood obesity

Childhood obesity particularly in Year R, is another area that has seen a percentage change at a population level in Kent. However, for children in Year 6 the majority of the districts have seen an increase (figure 3).

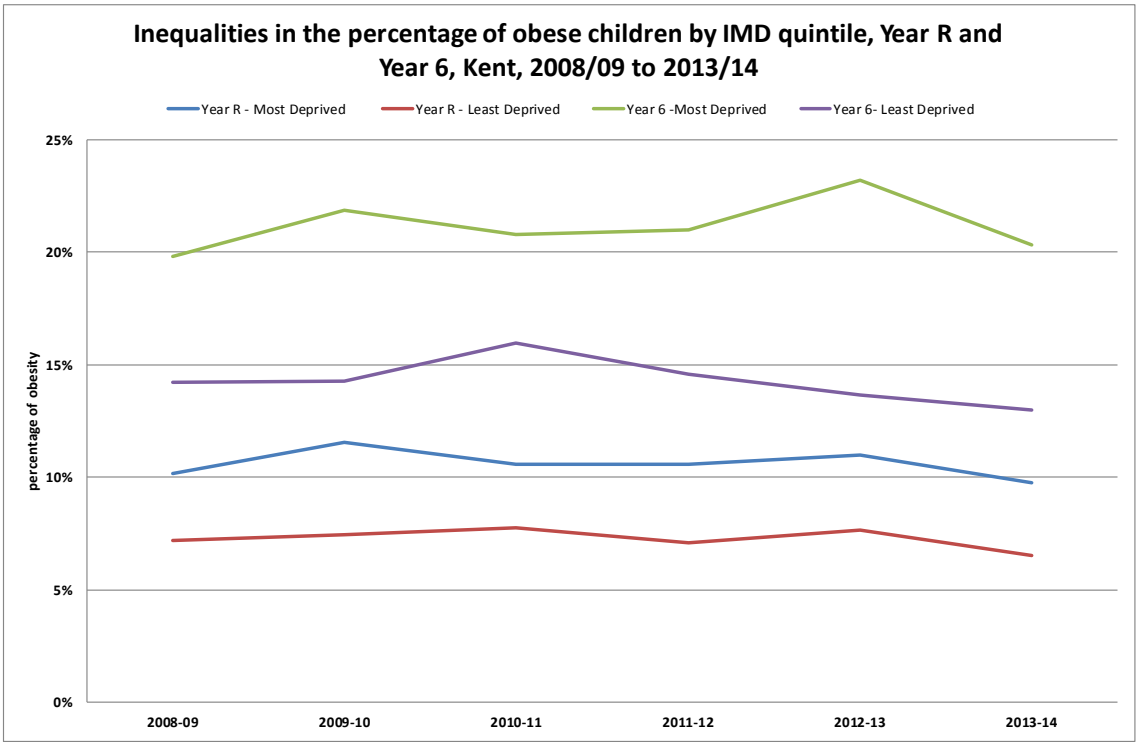
Figure 3



	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Kent
Year R	0.39%	-0.64%	-2.52%	-2.73%	-1.63%	-3.37%	-0.69%	-0.43%	1.24%	-1.35%	-1.68%	-2.07%	-1.19%
Year 6	4.00%	-0.57%	5.64%	1.61%	-1.43%	-0.18%	1.96%	1.09%	3.41%	2.21%	0.33%	2.54%	1.64%

When the gap between least and most deprived is considered over the last six years the analysis suggests that for Year R the gap has not increased whereas for Year 6 it has slightly increased (5.6% -7.3%) (figure 4).

Figure 4



Work is being undertaken at district level to address childhood obesity.

7.2 In October, Public Health will inherit the commissioning of Health Visiting from NHS England. Health visitors have a crucial role in the early years of a child's development providing ongoing support for all children and families. This provides an opportunity to impact on health inequalities by ensuring there is an enhanced focus on increasing breastfeeding, reducing childhood obesity and improving maternal mental health.

7.3 The Family Nurse Partnership (FNP) is a nurse led, evidence based, preventative programme offered to vulnerable young parents having their first baby under the age of 20. The offer of intense support over the first two and half years for the most vulnerable young people (offer to the family where possible) is vital in reducing and addressing health inequalities over both the short and long term.

7.4 Emotional wellbeing is recognised as having a crucial influence on children and young people's life chances and their ability to achieve positive outcomes across a range of domains, including educational engagement and attainment, social inclusion and physical health. Kent County Council, with its partners, has published Emotional Health and Wellbeing strategy that focuses on early help and support at the right time in the right place. This will support a series of actions in addressing health inequalities for children and young people.

8 Addressing health inequalities through housing

It is well evidenced that the condition and location of housing has a strong bearing on health inequalities. In response to addressing housing related health inequalities the Kent Housing Group and the Joint Policy and Planning Board for Housing have produced a separate action plan, focussing on housing issues referred to as 'Think Housing First', which has been recognised by DCLG. The plan seeks to take strategic actions to:

- reduce homelessness
- provide affordable housing provision
- tackle cold and hazardous housing
- promote safe and accessible housing
- promote referral schemes

Each of the priorities have tangible, measurable objectives to improve access to primary health care, falls prevention services and promote smoke free homes. Projects are also underway to improve staff skills to engage with the population, to provide interventions for supporting behaviour change.

9 Conclusion

9. 1 Evidence suggests that addressing health inequalities requires a systematic approach across the entire health and care system with all partners having a role to play. NHS England and CCGs are collectively responsible for commissioning health services that can make a difference to the early deaths in the 'at risk'

groups. Kent County Council and District / Borough Councils have responsibility for commissioning services that affect health outcomes. Collectively the Kent Health and Wellbeing Board and local Health and Wellbeing Boards provide opportunities for CCGs and District / Borough Councils to work collaboratively to reduce health inequalities. Members have a real understanding of the issues that matter to their local communities and can play a pivotal role in influencing partners to address health inequalities.

9.2 Each of Kent's district authorities have demonstrated a commitment to reducing health inequalities and developed a local plan to address health inequalities. This needs ongoing implementation and monitoring.

9.3 Public Health is in the process of developing its strategic delivery plan in line with Council's commissioning priorities. The delivery plan will be structured into three areas for improved outcomes, namely: starting well, living well and ageing well. The opportunity presented by the transfer of Health Visitors into the local authority, and the end of most of the major contracts for many of adult healthy lifestyle services will allow for application of the strategic principles and reshape the service design and commissioning.

It is intended that 2015-16 is one of development and change for the services commissioned by Public Health, during which we will work with our partners to design models of services that are easily accessible and targeted to reduce health inequalities.

9.4 To effectively address health inequalities it is intended that Public Health commissioning is aligned with commissioning of services across other parts of the system. As a result of this collective effort we aim to ensure that addressing health inequalities is embedded both in commissioning and provision of services and improve population's health and wellbeing outcomes.

10 Recommendations:

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

a) Note the progress made to date in addressing health inequalities across Kent.
b) Support work by the Public Health team and partnership groups (including Local Health and Wellbeing Boards) at local level in designing commissioning models for future provision of public health services at a local level.
c) Support collaborative working between agencies such as the district authorities, police and health in promoting policy initiatives to reduce harm from issues such as alcohol and smoking.
d) Support work at policy level, such as in influencing spatial planning, licensing, housing etc to address health inequalities and promote health and wellbeing in all local policies.

Background documents: None

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Appendix 1

Local details can be provided on individual pilots

Ashford District Council

Active Travel: focused on encouraging primary aged children and their parents to make use of active travel methods to and from schools.
Self-Harm Programme: focused to address the rise in issues of self-harm and mental health issues amongst young people.

Canterbury District Council

Focus on reducing self-harm behaviours in young people. This was called The Mind and Body Programme, which is a multi-component risk reduction programme for young people who are vulnerable to risk taking behaviours.

Dartford District Council

Focus on priority action of 'reduce the gap in health inequalities across the social gradient for priority public health issues'.

Dover District Council

Dover district council had an agreed South Kent Coast Health and Wellbeing strategy which highlighted health inequalities in health as part of its action plan. To tackle HI within a project, it was decided to focus on promoting walking as an effective intervention in tackling inactivity whilst supporting weight reduction.

Gravesham District Council

The focus of Gravesham District Council was on reducing the gap in the health status between the deprived and non-deprived communities, with the aim of improving health in deprived communities sooner to reduce gap in the life expectancy. The focus of programmes was healthy weight with maintenance of 5-10% body weight loss among overweight or obese adults from age 16 (or 14 if deemed appropriate through the Gillick Competence) and over and improving men's health.

Maidstone District Council

The funding in Maidstone was used for a programme aimed to reduce the number of young people between the ages of 16 and 25 who are Not in Education and in Training (NEET). The programme focused on engaging young parents in the programme with the aim at identifying what the barriers were for them to engage in training and education.

Sevenoaks District Council

Sevenoaks district council invested the HI funds into a project focused on healthy eating with focus being on fathers. The project was designed to engage with fathers across the

district, offering them the opportunity to spend quality time with their children whilst learning about healthy living through cookery classes. The main aim of the project was to improve confidence and skills in the preparation of a healthy meal on a small budget and looking at healthy weight, healthy lunch boxes, healthy snacks, and healthy meals in general.

Shepway District Council

Shepway District Councils have an agreed South Kent Coast Health and Wellbeing Strategy, which highlights inequalities in health outcomes in its action plan.

Tackling Inactivity
Reducing overweight and obesity
Reducing alcohol consumption
Reducing the numbers of people who smoke – particularly in Shepway

Shepway – Promoting healthy eating and cooking in priority primary schools, focus on exploring healthy eating and diet and confidence to cook in Primary Schools

Thanet District Council

The programme awarded the HI funds from PH to the Smoking Cessation outreach work in Thanet.

The aim of this project is to undertake outreach work with the diverse communities in the Cliftonville West ward in Thanet.

Tonbridge and Malling District Council

The funding was used for '**Counterweight'** a healthy weight management programme and supporting initiatives: **'Cook & Eat'** NHS Health Checks and Wellbeing Checks (for those not eligible for HC). One additional programme of **'Headspace'** a mental health programme for men has been funded to try and increase the uptake of men onto the weight management programme both at the MIND centre and the community programmes.

Tunbridge Wells District Council

The programme focused on Adult Healthy Weight and had specific target on three particular groups:

- people with learning disabilities (Move, Eat, Grow)
- pregnant women (Healthy Mums, Healthy Bumps)
- men (Man up, Shape up)

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

1st May 2015

Subject: Update on Developing the Public Health Strategic Delivery Plan and Commissioning Strategy

Classification: Unrestricted

Past Pathway: The Children's Social Care and Health Cabinet Committee considered this report on 21st April

Future Pathway: The Public Health Strategic Delivery Plan and Commissioning Strategy will return to this committee in July

Electoral division(s): All

Summary:

Since responsibility for Public Health transferred to KCC in April 2013, there has been a range of commissioning activity. This has built up an understanding of the potential and the limitations of the contracts that transferred to KCC. There are clear opportunities for a new approach.

Public health is developing a new strategy for Kent and an aligned commissioning plan. This will ensure that the future approach to public health will be based around the needs of the person as a whole, and wherever appropriate interventions are within integrated services. Crucially tackling health inequalities will underpin every programme of work.

Whilst this strategic review takes place, key programmes will continue to be commissioned, as detailed in this report. They are structured within a Starting Well, Living Well and Ageing Well approach.

2015/16 is a year in which a new approach to public health must be accelerated. We must move away from standalone provision, focused on one particular lifestyle issue, and focus on an integrated approach to delivering key outcomes for Kent.

1. Introduction

1.1. Nationally the importance of good prevention continues to be embedded in statutory and strategic guidance. The NHS 5 Year Forward View and The Care Act set out a Call to Action and a statutory framework for effective prevention.

1.2. During 2014/15 the KCC Public Health department have worked closely with colleagues across the Health and Wellbeing system in Kent, supporting prevention across the Council and with partners.

1.3. It has been a year of learning, analysing the resource available, drilling down into the performance of services, and reviewing the effectiveness of different approaches. Some good progress has been made, there are improvements in performance, integrated models of care have been developed and efficiencies have been driven on key contracts.

1.4. However, it is recognised that much of the approach is still based on outdated models of service, and that there are huge opportunities to improve the support and services available through the evolving integrated arrangements in health and social care.

1.5. The Public Health strategy is being developed and will be finalised in early 2015/16, and aligned to this will be a commissioning plan. This will set out how public health services can be reconfigured to support the approaches and accelerate the preventative work across Kent in the Health and Wellbeing system.

2. Drivers for Change

2.1 In developing the strategic delivery plan it is important to understand the drivers for change that are affecting the health and social care system across the country, and here in Kent. These are:

- NHS Five Year Forward View:
- The Care Act:
- Financial drivers:
- Demographics:
- Health inequalities:
- Kent Health and Wellbeing Strategy.

2.2 In addition to the drivers outlined, above the recently agreed five year vision for Kent
County Council, highlights three strategic outcomes:

- Children and young people in Kent get the best start in life
- Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality life
- Older and vulnerable residents are safe and supported with choices to live independently.

3. Our vision and strategy

3.1 Using the drivers for change outlined above, a proposed vision has been developed,
alongside the approaches that will be taken.

3.2 The proposed vision is: “to improve and protect the health and wellbeing of the people of Kent, enabling them to lead healthy lives with a focus on the differences in outcomes within and between communities”. To deliver the vision Public Health will:

- Provide strategic leadership to the prevention agenda

- Take a life course approach
  - Starting Well
  - Living Well
  - Ageing Well

- Align commissioning of health improvement and health protection programmes and the delivery at a local Health and Wellbeing Board footprint and work to co-commission public health programmes with Clinical Commissioning Groups. Prevention will be seen as part of the clinical pathway.
- Public Health work with colleagues to ensure the “organised efforts of society”

  - Across KCC Directorates
  - Across Clinical Commissioning Groups
  - Across District Authorities
  - Across Local District Health and Wellbeing Boards
  - With service providers and voluntary and community organisations

3.3 Using the life-course approach, which mirrors the County Council’s three strategic outcomes our supporting outcomes have been mapped against these stages, and the priority areas for action, namely:

- Smoking
- Healthy eating, physical activity and obesity
- Alcohol and substance abuse
- Wellbeing (including Mental Health and Social Isolation)
- Sexual Health, Communicable Disease
- Wider determinants of health

The resulting outcomes framework can be seen at appendix 1.

3.4 During the early part of 2015/16 we will be analysing how our services, and the wider system are working to deliver our supporting outcomes, including looking at the total resource that is impacting on them.

3.5 Following the discussion at both the Children’s Social Care and Health Cabinet Committee and the Adult Social Care and Health Cabinet Committee, there will be engagement with partners to discuss the approach outlined, and to understand how our commissioning strategy should be shaped to meet the challenges.

3.6 Public Health are also mandated to support Clinical Commissioning Groups in the planning work required to commission safe and effective health services. We will enhance this support over the next three years to ensure the public health planning work both strategically and locally is effective and contributes to better health outcomes for the Kent population.

3.7 Public Health will continue to support Pioneer and the integration of health and social care, building on the nationally leading work on integrated data sets, year of care tariff work and analysis and evaluation of interventions and outcomes across diverse health and care providers.

3.8 A further report will be brought to the July round of Cabinet Committees to seek approval for the strategic delivery plan.

4. Progress in commissioning in 2014/15

4.1. During 2014/15 Public Health have been focussed on delivering key outcomes identified in the Joint Kent Health and Wellbeing Strategy.

4.2. There has been a focus on contract management resulting in more efficient and better performing contracts. Contractual relationships have developed with new organisations in the community and a number of new services have been tendered.

4.3. The improvement in activity is matched with reduced spend, the activity based contracting approach used has delivered both efficiencies and improved performance.

4.4. During the development of new services, the commissioning team have worked to engage with the voluntary, community and social enterprise in particular for some of the smaller scale community based interventions.

4.5. Community Sexual Health Services have been re-tendered. The process has provided a number of challenges and learning for implementing new models of care. The model delivers some key improvements. Based on a hub and spoke model it is significantly more efficient. Capacity has been realigned with where the need for service is.

4.6. The commissioning of Drug and Alcohol services transferred to public health in October 2014. The commissioning approach has been audited and reviewed and the action plan relating to the audit have been implemented

5. Commissioning Intentions for 2015/16

5.1. It is intended that 2015/16 is one of development and change for the services commissioned by Public Health. A new model for core public health services will be driven to support the delivery of the Public Health strategic delivery plan and commissioning plan. This will fully assess the opportunities for alignment with KCC transformation agenda's and with partners of the Health and Wellbeing Board

5.2. During this time, there will be continued rigorous contract management in commissioned services, ensuring that they deliver the outcomes specified and that further efficiencies are driven.

5.3. In addition there will be a series of engagement events with community organisations and employers to re shape our approach.

6. Starting Well

6.1. In October, Public Health will inherit the commissioning of Health Visiting from NHS England. During the past months collaboration between the commissioners and providers has been growing to ensure that a smooth transition takes place. A particular focus of this work has been assessing progress that is being made to meet the workforce baseline and the quality of the current provision.

6.2. The transfer will also include the Family Nurse Partnership, a service that is widely valued for young parents who welcome additional intensive support for developing their parenting skills. There are opportunities to link in KCC provision for example to share the approach with similar services, such as the Troubled Families programme.

6.3. As part of every programme of work there must be a clear focus on Healthy weight in children. Increasing obesity in children is being recognised not just as a time bomb for demand on a range of health services, but also as a key underlying issue affecting emotional wellbeing. The response to this issue cannot be confined to the public health team but a whole system challenge requiring collaboration with education, health and social care colleagues but most importantly with families themselves.

6.4. Work will continue on breastfeeding rates, and the reduction of smoking in pregnancy. The breastfeeding support service (supplied by PS Breastfeeding) has been implemented, whilst interventions such as Baby Clear, are being closely monitored and will be supported by a social marketing campaign.

6.5. The Public Health team will also continue to work in partnership in the development of the Emotional Health and Wellbeing Strategy for young people, ensuring delivery of the prevention and early intervention actions, whilst continuing to jointly commission the Young Healthy Minds service and the new model of provision within the whole pathway of care.

7. Living Well

7.1. During 2015/16 we will engage in a whole system review of the service models to support people to live healthy lifestyles including the approach to healthy

weight, physical inactivity and smoking cessation services. This will be a core programme driven through Local Health and Wellbeing Boards.

7.2. The current models for delivery in drug and alcohol services, also need to be refreshed, with the current contracts expiring at the end of March 2016. Opportunities such as the remodelling of healthy lifestyle services and the implementation of the sexual health services are key to reshaping more integrated provision.

7.3. During 2014/15 we have been working closely with colleagues from Social Care and Clinical Commissioning Groups to develop the Mental Health core offer of support, to be tendered during 2015/16. This is a priority programme and a leading example of a cross system approach. Public health is focused on both the promotion of wellbeing, and also effective early intervention within the model, a great opportunity to build effective prevention.

7.4. Health Checks delivery will continue to be managed closely to further increase performance towards the governments stretch target. The service has been improving its targeting of Health inequalities which we continue to closely monitor.

7.5. As set out in the 5 Year vision there is huge opportunity to focus on health within the Workplace. In Kent there is a Healthy Business award and will continue to sign up new businesses. There is much more that can be done, across Kent within partner employees. In addition. KCC have strong links with a range of employers across the County both in public and private sectors. This is a great opportunity to drive a population level impact.

8. Ageing Well

8.1. The focus on supporting people to age well will continue. The new postural stability services doubles capacity utilising the DPS described above. This is a key preventative agenda for both Health and Social Care and the impact on reducing falls and demand for specialist services will be closely monitored.

8.2. The Keep Warm Keep Well campaign and associated services will help to support people to remain well, and in their own homes. Public health will continue to develop the relationship with NHS England Screening & Immunisation team, and will extend the Flu campaign that we developed in 2014/15.

8.3. Work will also begin with Social Care and Health colleagues on the Older peoples core offer, particularly in relation to Social Isolation. This will mirror the approach in the Mental health core offer working with partners to review the outcomes that all want achieved and developing a range of services, connected with each other that older people can access, integrated with community provision.

9. Conclusion

9.1. As outlined above, there is a huge opportunity over the coming twelve months to implement the Public Health strategic delivery plan and reshape how the Public Health services are delivered to ensure that we are achieving our outcomes.

9.2. Public Health commissioning has been delivering on the outcomes identified in the Joint Health and Wellbeing Strategy, working in partnership across the health and social care system to shape services, and deliver outcomes for the people of Kent. The coming years present an opportunity, through new responsibilities, and through the expiration of contracts, to reshape the commissioning strategy and the resulting services to meet the challenges of a changing landscape, and the shifting needs of the population.

10. Recommendation

10.1. The committee are asked to:

- note the progress made in Public Health in 2014/15
- comment on the proposed vision, strategy and commissioning intentions outlined in this paper.

Background documents

None

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Our vision is to improve and protect the health and wellbeing of the people of Kent, enabling them to lead healthy lives with a focus on the differences in outcomes within and between communities.

Prevention → Early diagnosis and intervention → Care and Treatment

	Starting Well	Living Well	Ageing Well
	↓	↓	↓
	Supporting Outcomes	**Supporting Outcomes**	**Supporting Outcomes**
Smoking	Reduce smoking prevalence at age 15 Reduce smoking prevalence at time of delivery	Reduce smoking prevalence in general population Reduce smoking prevalence in routine and manual workers	Reduce smoking prevalence
Healthy Eating, Physical Activity and Obesity	Increase levels of breastfeeding Increase physical activity in young people Reduce levels of excess weight in children Reduce levels of tooth decay	Increase levels of physical activity Reduce levels of excess weight	Reduce levels of excess weight Reduce injuries due to falls in over 65s Reduce hip fractures in over 65s
Alcohol & Substance Misuse	Reduce under 18 hospital admissions due to alcohol Reduce levels of drug taking and use of legal highs	Reduction in number of people drinking at problem levels Reduction in hospital admissions due to alcohol	Reduction in number of people drinking at problem levels Reduction in hospital admissions due to alcohol
Wellbeing (including Mental Health and Social Isolation)	Increasing emotional resilience in families and young people Reducing levels of self-harm and suicide rates Ensure levels of social and emotional development	Improve wellbeing of population Reduction is suicide rates	Improve wellbeing Reduce social isolation Improve early diagnosis rates of dementia and people are supported to live well People with mental ill health are supported to live well
Sexual Health, Communicable Disease	Reduce rates of Chlamydia Increase levels of childhood vaccination Reduce levels of teenage pregnancy	Increase early diagnosis of HIV Increase levels of flu vaccination uptake in vulnerable groups Reduce excess under 75 mortality rates	Increase levels of flu vaccination in over 65s
Wider determinants	Designing healthy communities School readiness Ready for emergencies	Designing healthy communities Ready for emergencies	Designing healthy communities Reduce excess winter deaths Ready for emergencies

Our Approaches – Make every contact count
Integrated commissioning for Integrated Services – shaped around people
Services delivered where people want them
Interventions accessible to all groups by making reasonable adjustments
Targeted services to reduce health inequalities

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

1 May 2015

Subject: Public Health Campaigns and Press

Classification: Unrestricted

Past pathway: The Children's Social Care and Health Cabinet Committee considered this report on 21st April 2015

Future pathway: This is the final committee that will consider this report

Electoral division(s) All

Summary

Marketing and communications is a key element in delivering successful public health interventions.

KCC Public Health recognised the need to increase delivery in this area, and have taken steps to increase the resource dedicated to campaigns in the coming year.

Recent campaigns have shown promising results in creating behaviour change, and the planned approach to campaign delivery will lead to a strong programme in 2015/16, aimed at bringing about behaviour change in the key areas of priority for public health.

1. Introduction

1.1. Marketing and Communications is a key element of supporting the public to maintain or improve their health.

1.2. During 2014/15 the KCC Public Health department have recognised that delivery in this area could be improved, and have been increasing the resource dedicated to delivery.

1.3. This paper will cover some of the recent campaigns, the coverage received and the early evidence of impact, before looking at the planning for campaigns in the future.

2. Campaigns and Press in 2014/15

2.1. When developing campaigns we look to identify the problem, or the behaviour change that is needed, then look at the audiences we need to reach, and what avenues we can use to get the message across.

2.2. Where possible, national campaigns are supported, and their reach extended where needed, rather than trying to create something new. The Public Health team work partners, and our suppliers, wherever possible to ensure a co-ordinated approach to communicating messages to the public.

2.3. During 2014/15 a series of campaigns were delivered, alongside targeted press releases that resulted in increased awareness of the role of KCC in delivering public health interventions.

2.4. Case Study – Flu Campaign

For the flu campaign which began in September 2014, Kent Public Health focused on the groups identified by Public Health England as priorities, namely pregnant women, children aged 2 – 4, people with long-term conditions, and over 65s. There was a particular focus on pregnant women, as this group had a particularly low uptake in Kent.

2.5. Messages were disseminated through a variety of outlets, including bus backs, billboards, press adverts, online e.g Mumsnet.

2.6. This was combined with press releases and media interviews, including using one of our pregnant public health registrars as an example of a pregnant women who received a vaccination.

2.7. The campaign ran from September until January. Early indications show that the campaign had some success in reaching the target audiences. For example the Facebook ads that we placed resulted in 776 views of the Kent.gov flu whilst 16,334 members of the campaign target group were exposed to the adverts.

2.8. Whilst, the other three categories showed little increase, there was a significant increase in the numbers of pregnant women being vaccinated, with over 40% of pregnant women being vaccinated, compared to only 32% in the previous year.

Case Study – HIV Campaign

2.9. KCC Public Health, along with NHS partners, and Canterbury Christ Church University have been a part of the IMPRESS Project funded by Europe to ascertain the reasons for late diagnosis of HIV in Kent. The research project was published in October 2014, and a final part of the project was to run a social marketing intervention to try and increase testing rates.

2.10. The report found that there was no particular target audience in Kent, and that in recent years the number of infections among heterosexuals was above that of men who have sex with men, whilst late diagnosis was more prevalent in the former group, as the latter group was more likely to get tested. The report also highlighted that GPs were missing opportunities to test for HIV.

2.11. The campaign that was developed ran for the whole month of November (including National HIV Testing Week), and was composed of three parts:

- Media campaign
- Outreach via mobile testing clinic
- Training for GPs, and online training video

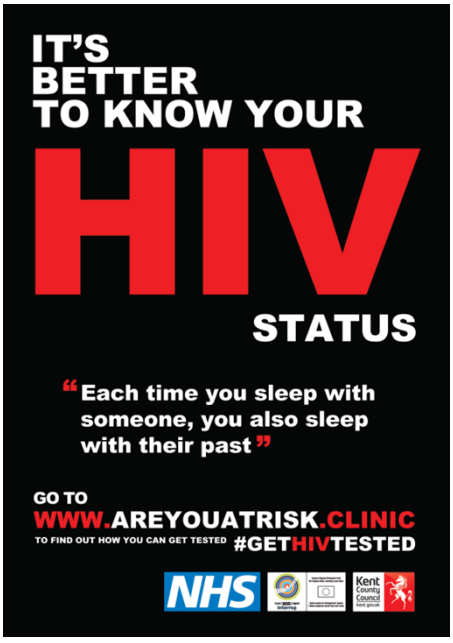
2.13 For the media campaign we identified the outcomes that the project was looking to achieve, namely it needed to:

- raise awareness of the behaviours that lead to a higher risk of HIV infection
- raise awareness of the treatments available and so the importance of an early diagnosis
- encourage engagement with outreach activities (mobile unit)
- encourage people who could have been at risk of HIV to get a test
- encourage healthcare professionals to offer an HIV test as part of routine care in specific settings and conditions (in line with present European guidelines)
- ultimately this was about getting tested for HIV especially if a person had increased their risk of infection through certain sexual activities.

2.14 The media engaged well with the campaign, and KMFM included a series of phone-ins with experts from our Sexual Health service providers during the week.

2.15 The social media campaign ran across Facebook and Twitter, with new visual messages every week, as well as live Tweets regarding the location of the mobile clinic/bus each day. Advertising statistics from the project Facebook page show the advertising brought in 158 website links with a total reach of 18,335 viewers.

2.16 The HIV and sexual health pages on Kent County Council's public health website were accessed 1,373 times during the campaign month of November 2014.



2.17 697 people accessed the 'find your clinic' with an average viewing time of 2 minutes 31 and seconds. 615 people accessed information about the bus location with an average viewing time of 2 minutes and 12 seconds. 343 people accessed 'the facts'

page with an average viewing time of 2 minutes and 11 seconds. 25% of users returned to the site for specific HIV information.

2.18 Indications are that this was a successful campaign, with 300 people tested on mobile clinic during the month (including visits to Maidstone, and Sevenoaks, and outreach in Tonbridge and Tunbridge Wells), and Maidstone and Tunbridge Wells Trust reporting a 50% increase in people requesting HIV tests compared to the same period in the previous year. The table below shows the latest six monthly data available, compared to testing in the previous year, with almost 2,000 additional tests conducted.

	1/10/13 – 28/2/14	1/10/14 – 28/2/15
Maidstone and Tunbridge Wells	4123	5083
Kent Community Health Trust	7032	8020
Kent Total	11,155	13,103

2.19 Early reports are that the level of GP testing has increased, in Maidstone and Tunbridge Wells area there were an extra 400 tests by GPs in the period 1/10/14 – 28/2/15, compared to the same period in the previous year.

3. Planning for 2015/16

3.1 As described above, a much stronger focus has been given to campaign work during the past few months, and this will bring Public Health into the new financial year in a much stronger position than 12 months ago. An outline timetable for next year is currently being finalised which is attached at Appendix 1.

3.2 During 2015/16 a three pronged approach will be taken in campaigns and marketing, these are:

- Service promotion – e.g. new sexual health services
- Education and awareness raising - e.g. HIV or Flu
- Social marketing interventions to change behaviour – e.g. smoking in pregnancy

3.2 Working with the relevant Public Health Consultant leads, integrated marketing and communications strategies and action plans are being developed for 2015/16, in the following areas:

- Quit smoking
- Alcohol harm reduction
- Healthy weight / tackling obesity
- Increasing physical activity
- Improving mental wellbeing

3.3 These will form the “always on” campaigns that will run throughout the year, with associated ready -made messages that can also be used to react to media requests.

3.4 Where appropriate, Public Health England national campaigns will be utilised (e.g Change 4 Life, which over 44,000 Kent families, and over 300 schools and nurseries have signed up to since 2009), and extend these campaigns further where the analysis of inequalities identifies a greater need.

3.5 Short burst campaigns will be developed, focussed around certain points of the year, in line with the campaigns on HIV or Flu as described above.

3.6 One such campaign that will be developed towards the end of 2015/16 will be focussed on reducing the number of suicides, in support of the suicide prevention strategy, particularly amongst males. This is an area where figures have been increasing in recent years.

Table 1: Annual number deaths from suicide and undetermined causes, CCGs in Kent & Medway, both sexes, 2002-2013 registrations

Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	14
NHS Canterbury and Coastal CCG	12	16	16	16	16	17	10	20	13	14	15	21
NHS Dartford, Gravesham and Swanley CCG	22	28	27	16	18	22	8	21	15	23	23	28
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	31
NHS South Kent Coast CCG	17	26	20	27	13	20	12	19	18	25	22	18
NHS Swale CCG	4	7	16	8	12	5	8	11	9	3	8	13
NHS Thanet CCG	9	15	15	8	12	17	11	13	8	17	14	9
NHS West Kent CCG	39	35	31	39	36	36	35	42	30	30	38	48
Kent & Medway	**139**	**148**	**148**	**146**	**137**	**148**	**102**	**151**	**114**	**132**	**145**	**182**

Source: PHMF, PCMD, KMPHO

3.7 As a part of the strategic planning work, analysis will be undertaken of the best way to maximise the existing assets through which we can deliver our messages. For example, in late March, the Public Health comms team visited three Children's Centres to understand how they deliver health interventions, and to identify what resources could jointly be developed to aid them in their work.

4. Conclusion

4.1. Well planned, targeted campaigns can have a positive impact on people's behaviour. The steps that KCC Public Health have taken during 2014/15 will ensure that 2015/16 will see a series of planned campaigns delivered to a strategic plan. However it is important to recognise that long term change requires long term, consistent messaging.

5. Recommendation

5.1. The committee is asked to:

- note the progress and impact of Public Health campaigns in 2014/15
- comment on the campaigns plan for 2015/16.

Background Documents
None

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PUBLIC HEALTH CAMPAIGNS CALENDAR 2015

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Starting Well			Summer Health	Summer Health	Summer Health						Sugar Swaps	
		Smoking prevention					Flu	Flu	Flu	Flu		
			Magic Moves	Magic Moves	Magic Moves							
						Safe Sleeping						
Living Well	Smoking in Pregnancy		Alcohol (diabetes week)	Heatwave			Flu	Flu	Flu	Flu		
	Sexual Health	Health checks	Dental Health		Breastfeeding	Health checks	Stoptober		Live Well PHE	ONE YOU (PHE)		
	Smoke-free homes		Summer Health	Summer Health	Summer Health		Alcohol (sober October)					
							Suicide prevention	Suicide prevention	Suicide prevention			
Ageing Well							Flu	Flu	Flu	Flu		
							Keep Warm Keep Well	Keep Warm Keep Well	Keep Warm Keep Well	Keep Warm Keep Well	Keep Warm Keep Well	
			Summer Health	Summer Health	Summer Health						Stroke	
		Falls Prevention									Early Diagnosis	
Always on	6 Ways of Wellbeing	6WW	6WW	6WW	6WW	6WW	6WW	6WW	6WW	6WW	6WW	6WW
	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score	Alcohol - Know your score
	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health	Dental Health
	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity	Physical Activity

To be developed

Smoking in pregnancy
Dental Health
Safe Sleeping
Be Clear on Cancer
Alcohol

Legal highs
Young Smoking

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

1st May 2015

Subject: Review of commissioning of Drug and Alcohol Services

Classification: Unclassified

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

Future Pathway: None

Electoral division(s): All

Summary: In December 2014 Cabinet Committee received a report regarding a transfer of commissioning arrangements for drug and alcohol services. Previously commissioning was within the Kent Drug and Alcohol Action Team (KDAAT), but responsibility transferred to Public health in October 2014.

Since the transfer the commissioning arrangements have been reviewed and this paper outlines some of the learning from that review. Prior to the transfer an audit was undertaken which outlined a series of action which needed to be undertaken and these actions have been in progress since the transfer of responsibility.

The commissioning arrangements have been re-audited and this paper outlines the result of that progress made. Kent Drug and Alcohol Action Team (KDAAT) services are due for re-tender in 2015/16 and the learning from the review will be embedded into the re-commissioning process.

Recommendation(s):

Adult Social Care and Health Cabinet Committee Members are asked to comment on the progress made against the audit of KDAAT commissioning arrangements and to endorse the future direction for drug and alcohol services.

1. Introduction

1.1. In October 2014 the commissioning of drug and alcohol services transferred into the KCC Public Health team. This transfer in arrangements provided an

opportunity to review the approach to commissioning and evaluate what has worked well and not so well.

1.2. Kent has been a high performing area against substance misuse key performance indicators. Both within commissioning and delivery there have been innovative approaches to improve outcomes for service users in terms of individual's health and also community safety.

1.3. An internal audit identified in October 2014 outlined concerns regarding some commissioning processes. These concerns have now been resolved and this report outlines the progress made to resolve the issues. The learning will be valuable for commissioning moving forwards.

2. Background

2.1. Prior to 2013 the funding for substance misuse services was multi agency and pooled into one budget. KCC hosted responsibility for commissioning through a commissioning arrangement called the Kent Drug and Alcohol Action Team (KDAAT). From April 2013 this changed and substance misuse funding was incorporated into the new Public Health grant allocated to local authorities.

2.2. The commissioned contracts are with Turning Point in the East of the County, and Crime Reduction Initiatives (CRI) in the West of the County for substance misuse services for adults. The contracts are with Kent Council on Addiction (KCA) for young person's services across the County. All services have been tendered through competitive process.

2.3. Kent has been a high performing area in relation to services for drug and alcohol misusers, both in adult and in young person's services. The key indicator is people who complete treatment free from drug dependence. The latest published data places Kent within the top quartile nationally on this measure of success.

3. Learning

3.1. An audit and review of commissioning arrangements has been undertaken before the transfer of commissioning into Public health in October 2014. This resulted in an action plan identifying some changes which needed to be made in the commissioning arrangements. The main changes are outlined below.

Commissioning in partnership

3.2. Like many other outcomes, substance misuse is an issue that cannot be tackled effectively by any one organisation in isolation. Problematic drug and alcohol misuse has a range of complex causes and has a severe and detrimental impact not only on individuals but families and communities across Kent.

3.3. KDAAT commissioning has worked well in partnership and showed that an integrated approach is critical to minimising the harms to individuals and communities associated with substance misuse. This means working together as strategic commissioners, and as providers of services, to ensure services are designed to address a wide range of needs, including drug and alcohol dependence, and also safeguarding, health and offending behaviour.

3.4. The KDAAT Board has operated to bring together commissioners from across KCC, safeguarding, health and criminal justice systems and jointly agree strategic priorities and align resource.

3.5. The board membership has been reviewed and the terms of reference re-drafted to reflect the new arrangements for partners, including within Kent County Council, and also with Clinical Commissioning Groups, NHS England and Criminal Justice partners as well as wider Health and Wellbeing Board partners. It is all partners that should drive the agenda for this Board, and ensure that new contracts reflect their strategic and operational priorities.

Payment for performance

3.6. KDAAT has tested several different contracting approaches to incentivising providers to improve performance, including setting and monitoring targets and adjusting payment in line with actual performance.

3.7. In 2012, West Kent was selected by the Department of Health to be one of eight pilot sites for Payment by Results (PbR) in drug and alcohol recovery. KDAAT used other payment for performance methods such as service credits and performance incentivisation payments in the contracts for prison substance misuse services and the East Kent community substance misuse service.

3.8. Each of these approaches have their respective advantages and disadvantages but a common theme in the review has been the importance of ensuring that targets are realistic, and that risk does not disadvantage Small and Medium sized Enterprises.

3.9. Public Health is reviewing the independent evaluation of the national PbR pilots including the West Kent contract alongside the other payment for performance mechanisms that have been applied on other contracts. Implementation of the

payment mechanism has been difficult locally in Kent for both commissioners and providers and a different approach is needed going forwards.

3.10. Key learning includes the need to ensure that there is accurate baseline data in place before implementation and that any risk within the performance related arrangements is properly understood and can be managed by providers. In addition strong contract management is needed to ensure that contracts are fairly and appropriately managed.

KCC Audit

3.11. The recent KCC internal audit of the governance and contracting arrangements within KDAAT highlighted some of the challenges that can arise in an integrated approach to commissioning. It signalled the importance of ensuring that the appropriate democratic processes and procurement procedures of the lead organisation are fully adhered to. The audit exposed a series of processes which had not been followed internally.

3.12. The key issues identified in the audit were in relation to:

- Governance including Clinical Governance.
- Compliance with internal process for financial management and contract management.
- Compliance with decision making process.
- The importance of robust contract management

3.13. A wide range of actions have taken place to address these concerns including the key decision taken by Cabinet members in December 2014 Cabinet Committee. A clinical governance policy has been agreed to ensure a roust process is in place and this is clearly linked with other quality governance structures. Contract management has been a particular focus, there have been a series of negotiations with relevant providers regarding the payment arrangements. This has been significant to ensure compliance with legal and procurement process, and also to ensure that services are financially stable and sustainable.

3.14. Public health has been audited in March 2015 against the agreed action plan. The table below shows the result of that audit. This shows that substantial progress against all actions has been made.

Audit	Date	Management Actions		Implemented/ In Progress*		Comment on Progress/ Improvement	Overall Opinion on Actions R.A.G.
		High	Medium	High	Medium		
KDAAT	07/2014	7	0	5 2*	0	Interim follow-ups in Jan and March 2015 indicate good progress on rectifying issues through robust improvement plans under new management. The two outstanding recommendations are in progress and nearing completion.	GREEN

4. Future Plans

4.1. Public Health will apply the learning from the KDAAT experience of commissioning drug and alcohol services along with learning from other commissioning projects in public health. The services are due for retender this year and this process will take account of all of the learning from the transfer and audit.

5. Conclusion

5.1. Public Health has sought to understand and learn from the review of the commissioning of drug and alcohol services. This analysis has highlighted a number of points of learning which are applicable, not only to future commissioning of drug and alcohol services, but also to commissioning more widely.

5.2. Public Health will apply the as it re-commissions both drug and alcohol services and other public health services designed to deliver improved public health outcomes and better value for money.

6. Recommendations

Recommendation(s):

Adult Social Care and Health Cabinet Committee Members are asked to comment on the progress made against the audit of KDAAT commissioning arrangements and to endorse the future direction for drug and alcohol services.

Background documents

None

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From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 1 May 2015

Subject: **Work Programme 2015/16**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

Summary: This report gives details of the proposed work programme for the Adult Social Care and Health Cabinet Committee.

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

1.1 The proposed Work Programme has been compiled from items on the Forthcoming Executive Decisions List, from actions arising from previous meetings and from topics identified at agenda setting meetings, held six weeks before each Cabinet Committee meeting, in accordance with the Constitution, and attended by the Chairman, Vice-Chairman and the Group Spokesmen. Whilst the Chairman, in consultation with the Cabinet Member, is responsible for the final selection of items for the agenda, this report gives all Members of the Cabinet Committee the opportunity to suggest amendments and additional agenda items where appropriate.

2. Terms of Reference

2.1 At its meeting held on 27 March 2014, the County Council agreed the following terms of reference for the Adult Social Care and Health Cabinet Committee:- '*To be responsible for those functions that sit within the Social Care, Health and Wellbeing Directorate and which relate to Adults.* *The functions within the remit of this Cabinet Committee are:*

Strategic Commissioning Adult Social Care
Quality Assurance of Health and Social Care
Integrated Commissioning – Health and Adult Social Care
Contracts and Procurement
Planning and Market Shaping
Commissioned Services, including Supporting People
Local Area Single Assessment and Referral (LASAR)
Kent Drugs and Alcohol Action Team (KDAAT)

Older People and Physical Disability
Enablement
In-house Provision – residential homes and day centres
Adult Protection
Assessment and case management

Telehealth and Telecare
Sensory services
Dementia
Autism
Lead on Health integration
Integrated Equipment Services and Disability Facilities Grant
Occupational Therapy for Older People

Transition planning

Learning and Disability and Mental Health
Assessment and case management
Learning Disability and mental health In-house provision
Adult Protection
Partnership Arrangement with the Kent and Medway Partnership Trust and Kent Community Health NHS Trust for statutory services
Operational support unit

Health - when the following relate to Adults (or to all)
Adults' Health Commissioning
Health Improvement
Health Protection
Public Health Intelligence and Research
Public Health Commissioning and Performance

2.2 Further terms of reference can be found in the Constitution at Appendix 2, Part 4, paragraph 21, and these should also inform the suggestions made by Members for appropriate matters for consideration.

3. Work Programme 2015/16

3.1 An agenda setting meeting was held on 19 March 2015, at which items for the May meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion to the agenda of future meetings.

3.3 When selecting future items, the Cabinet Committee should give consideration to the contents of performance monitoring reports. Any 'for information' or briefing items will be sent to Members of the Cabinet Committee separately to the agenda, or separate Member briefings will be arranged, where appropriate.

4. Conclusion

4.1 It is vital for the Cabinet Committee process that the Committee takes ownership of its work programme, to help the Cabinet Member to deliver informed and considered decisions. A regular report will be submitted to each meeting of the Cabinet Committee to give updates of requested topics and to seek suggestions of future items to be considered. This does not preclude Members making requests to the Chairman or the Democratic Services Officer between meetings, for consideration.

5. **Recommendation:** The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 201516.

6. **Background Documents**
None.

7. **Contact details**

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Last updated on: 23 April 2015

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

Agenda Section	Items
10 JULY 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **Kent Support and Assistance Service (KSAS) contract re-let** • **Suicide Prevention Strategy** – key decision following consultation • **Public Health Strategy/Commissioning Strategy** – key decision • **Community Hot Meals delivery service contract** – key decision
C – Items for Comment/Rec to Leader/Cabinet Member	• **Live it Well Strategy refresh** (was to 1 May but was still with CCGs at local level then) • **Update on Care Act implementation** – 6 monthly
D – Monitoring	• **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard** now to alternate meetings • **Complaints and Compliments annual report** • **Work Programme**
E – for Information, and Decisions taken between meetings	
11 SEPTEMBER 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• **Adult Advocacy contract re-let**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly*
D – Monitoring	• **Local Account Annual report** • **Mid-year business plan Monitoring** • **Safeguarding Vulnerable Adults annual report** • **Work Programme**
E – for Information, and Decisions taken between meetings	
3 DECEMBER 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** now to alternate meetings • **Work Programme**
E – for Information, and Decisions taken between meetings	
JANUARY 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Budget Consultation and Draft Revenue and Capital Budgets**
D – Monitoring	• **Work Programme**
E – for Information, and Decisions taken between meetings	
SPRING 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly (report of latest procurement stage)*
D – Monitoring	• **Directorate Business Plan and Strategic Risk report** • **Adult Social Care Performance Dashboards** now to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** now to alternate meetings • **Work Programme**
E – for Information, and Decisions taken between meetings	
EARLY SUMMER 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE	

DECISIONS AND MONITORING OF PAST DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Work Programme**
E – for Information, and Decisions taken between meetings	

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From: Peter Oakford, Cabinet Member for Specialist Children's Services

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

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

To: Adult Social Care and Health Cabinet Committee, 1 May 2015

Subject: **Transition Update**

Classification: Unrestricted

Past Pathway: Children's Social Care and Health Cabinet Committee, 21 April 2015

Social Care and Public Health Committee, 16 January 2014

Future Pathway: None

Electoral Division: All

FOR INFORMATION ONLY

Summary: This paper provides Members with an update on developments relating to Transition arrangements for disabled young people.

As agreed at the respective agenda setting meetings for the Adult and the Children's Social Care and Health Cabinet Committees, the report has had a substantive discussion at the 21 April Children's Social Care & Health Cabinet Committee. The report is presented to this committee for information only.

Introduction

1.1 A report was presented to the Social Care and Public Health Committee on 16 January 2014 regarding the transition arrangements for young people in education and social care who would meet the eligibility criteria for Adult Social Care. The report included a number of recommendations for further work. This paper updates the Children's Social Care and Health Cabinet Committee on the range of work undertaken since the report. It builds on that report rather than repeating the background and information contained in it.

1.2 Members of the Social Care and Public Health Cabinet Committee were asked to agree the planned actions for the Transition Steering Group – particularly:

- research and analysis to explore the strengths and weaknesses of different configurations of transition services;

- further work regarding adult social care services providing care leaver support to disabled care leavers who meet eligibility for adult social care services;

- monitoring and review of a pilot project to streamline Direct Payments for young people going through transition;

- continued preparation for the changes in the Children and Families Bill (2013) which will have implications for transition arrangements in Kent.

1.3 Members were also asked to receive a report back in 12 months with an update on the transition work. This report provides an update on the work.

2. Research and analysis to explore the strengths and weaknesses of different configurations of transition services.

2.1 The Transition Steering Group commissioned Gina Walton, Change Implementation Officer, to undertake a review of arrangements in other councils; to scope current activity in Kent; and to understand the transition process within KCC and Health (Mental Health and commissioning for young people were out of scope). Her paper was completed in February 2014.

2.2 Eighteen councils were explored as part of the desk top research with 5 detailed models of transition arrangements looked at. There was a wide range of approaches with no consistent pattern and no preferred or ideal model of delivery.

2.3 Data was also collected, over an 18-month period, about young people going through transition to Adult Social Care in Kent. This included young people turning 18 (268 young people) and those turning 19 (292 young people). Information was gathered about the source of referrals, whether they were already known to Social Care, and the outcome of the referrals.

2.4 The various transition pathways within KCC, both Social Care and Education, and in Health were outlined and the issues highlighted.

2.5 Having considered and analysed the information gathered, and with 2 major pieces of legislation affecting transition coming on to the statute book, the Children and Families Act 2014 and the Care Act 2014, it was recommended not to proceed to a wholesale restructuring of services at this time, but to take a more incremental approach.

2.6 Penny Southern, Director of Adult Learning Disability/Mental Health, has led on developing an Integrated Pathway describing the journey for those children and young people up to the age of 25 who have a range of disabilities and the services required to support them at different stages of their development. This has been reported to the 0-25 Transformation Board, and can be seen at the end of the document. Some of the further work arising from understanding the pathways is being managed through the work streams developed by Adult Services and Newton Europe (the Transformation Partner):

- Alternative models of care

- Care Pathways

- Short Breaks

2.7 A new division has been created within the Families and Social Care Directorate with the management of the Disabled Children service coming together with Adult Learning Disability/Mental Health with effect from 1 April 2015, under the Directorship of Penny Southern. Mark Walker will be the Assistant Director for the Disabled Children Service and Chris Beaney will be the Assistant Director for the Learning Disability Service. There will be no initial changes to either the Disabled Children or the Learning Disability team structures or locations.

2.8 This new division will assist with the planning and delivery of a smoother transition for young people reaching 18 who require ongoing support into adulthood, and increase the opportunities for joint commissioning across the age barrier to create more seamless services. It will also help to address the feedback from families about the cliff-edge experience of their young people reaching the age of 18 and the service changes, as well as the requirements of the 0-25 agenda. The support services in Specialist Children Service in relation to Safeguarding and Children in Care will remain available to the Disabled Children Service.

2.9 Transformation workstreams have already been set up within Adult Learning Disability as noted above in 2.6. Following the realignment with the Disabled Children Service a design team for Short Breaks has been established to look at the current Disabled Children and Learning Disability Short Break Services, redesign the LD Short Break Service to meet the needs of people with a LD across the county in a more effective way, and review the transition from children's to adults short breaks services to develop a better pathway for young adults.

2.10 Further work streams will be set up to progress changes to Day Care, Integrated Commissioning and the delivery of the Integrated Pathway. These workstreams will then determine whether and how any structural changes to the teams are required to deliver better outcomes, especially for young people going through transition.

3. Practice Guidance re Leaving Care

3.1 Practice Guidance was written in April 2014. Adult Social Care will take on responsibility for meeting the local authority responsibilities for the Care Leaver when they transfer to adult services at age 18, if they meet the eligibility criteria for ongoing support from Adult Social Care. This applies to all Adult Social Care teams. Andrew Ireland sent a communication to all Adult Teams to confirm the requirement to fulfil the leaving care responsibilities for care leavers. Those young people who have additional needs who do not meet adult eligibility criteria will be provided with support from the mainstream Leaving Care service with additional specialist advice and guidance as required eg with regard to sensory impairment.

4. Outcome of the Direct Payment Pilot Evaluation and Extension of Contract

4.1 The support service for Direct Payments for disabled children is commissioned externally from the Parents Consortium in Dartford.

4.2 A pilot project was undertaken between 1 October 2013 and 30 September 2014 by the Disabled Children Direct Payments Support Service (DPSS) to support 200 young adults aged 18-25 years. The purpose of the project was to support the young adults over the year with all aspects of the setting up and the on-going management and support of their direct payment.

4.3 Over the 12 month period 211 clients were referred to the service.

4.4 Families who were involved in the pilot appreciated the continuity of worker through what is often a very stressful and complex time. This also supported the Care Manager in the transfer of the care package as the DPSS Support worker already knew the family.

4.5 There were some technical issues which have been addressed through the pilot project. For example, the Direct Payment Support Service needed access to SWIFT, the Adult Social Care client database, which has been provided and this has made it easier to manage the interface with Adult Care Managers. The Service was also provided with secure Kent e-mail addresses to protect personal client information being exchanged with KCC staff.

4.6 The DPSS has needed to adjust their ways of working to take more account of the young adult client's views rather than working solely with their families.

4.7 There has been a divergence in payment rates between Adults and Children's Services. The hourly rates set for disabled children were originally benchmarked to the Adult Direct Payment rates. These have changed in Adult services but not in the Disabled Children service, so this requires further work to ensure they are re-aligned.

4.8 Given the need to plan any future contract jointly, the pilot has been extended for a year. This will enable procurement times for the contract to be synchronized and consideration can be given to joint commissioning the service.

5. Children and Families Act 2014 and Care Act 2014

5.1 The Special Educational Needs provisions in the Children and Families Act 2014 with the introduction of Education, Health and Care Plans has implications for transition, as young people could potentially have an EHC Plan up to the age of 25. Whereas previously Statements of Special Educational Need finished either when the young person left school at age 16 to move on to college, or at the age of 19 if in a special school, EHC plans can be taken on to college if the young person continues to have an Educational need. The plan has statutory force.

5.2 The Disabled Children Service, Adult Social Care and colleges have been on the implementation steering group led by Education for the new SEN legislation in the Children and Families Act. The steering group has also helped to shape the Local Offer which is now on KCC's website, and all the processes that sit alongside the EHC planning process. The new legislation relating to EHC plans came into force on 1 September 2014. Young people leaving school or transferring to college are being prioritised for transfer of their Statement to an

EHC plan in this academic year and transfer reviews are on schedule to deliver this target.

5.3 The Care Act 2014 makes provisions for the Adult Care and Support Needs for adults from the age of 18 with specific requirements about ensuring young people going through transition have their needs assessed prior to becoming 18. If they already receive a support package this must continue until arrangements are made within Adult Services to ensure no gap in provision during the transition to adult care and support. So for a group of young people aged 18-25 there is an overlap, being entitled to support through both pieces of legislation, and it will be important to ensure that there is no duplication of processes. A draft Transition Policy and Practice Guidance document has been produced for staff on the changes and training has been provided.

5.4 There are also provisions in the Care Act for adult carers and young carers. Local Authorities must assess the needs of adult carers where there is a likely need for support after the young person turns 18 and it is of significant benefit to the carer to do so. The same applies to young carers: Local Authorities must assess the needs of young carers as they approach adulthood. There is work being undertaken with the Voluntary Sector providers who undertake the adult Carers assessments and those who work with Young Carers to ensure that the requirements of the legislation are understood and to commission any further work arising from the legislation.

5.5 The emphasis in both Acts is on outcome focused, person-centred practice when considering assessment, planning and support as well as co-production with disabled young people and their families and multi-agency approaches to planning and commissioning. Much of what is included in the Care Act on transition puts good practice on a statutory footing.

6. Other Work pertaining to Transition

6.1 The Kent Emotional Wellbeing Strategy for children, young people and young adults aims to offer early help and support to them and their families if they are experiencing emotional difficulties; better access to support; and a positive transition to adult services. Many disabled children and young people require these early preventative services, and the needs assessment identified those with autism and/or ADHD as a vulnerable group within the strategy and they will be the focus of specific ongoing work in the delivery plan.

6.2 The Clinical Commissioning Groups (CCGs) have commissioned the South East Commissioning Support Unit (SECSU) to develop an all-age neuro-developmental pathway ie those people diagnosed with autism and/or ADHD. This work has started, with the aim of having more streamlined, efficient diagnostic and post-diagnosis support services. This should have an impact for disabled young people and adults across a wide spectrum of need, and links to the Emotional Wellbeing Strategy.

6.3 A paper produced by KCC Skills and Employability went to the Cabinet Education sub-Committee in December outlining the proposed Adult Learning and Skills Strategy to be launched in May 2015 with the aim of improving participation in training and employment amongst under-represented groups. This includes disabled young people. The strategy seeks to increase the

number of apprenticeships and employment for disabled adults, and builds on the existing work to deliver the 14-24 Skills and Employability Strategy.

6.4 The Special Educational Needs and Disability Strategy launched in 2014 has a focus on transition. One of the key aims is "to ensure that transitions are well managed, so that there is continuity of support and young people are well prepared. A key transition is into post 16 education or training, and at age 19 into employment and early adulthood. These transitions are challenging and our aim is to ensure young people with learning difficulties and those with disabilities up to age 25 are engaged in purposeful education and training, so that they are able to move on to skilled employment and adult life with support from adult social care services for those who need it." The changes arising from the implementation of Education, Health and Care Plans and the 14-24 strategy aim to deliver this.

6.5 Kent Supported Employment, who have in the past worked only with adults, have brought their age of involvement down to 16 and are preparing to run 4 pilots with young people in special schools. This project will prepare them for the world of work and support them through meaningful work experience with the aim of increasing their aspirations and opportunities to become employed and independent, thus intervening at an earlier age rather than waiting until they have left school or college.

6.6 There is joint working between SEN and Adult Social Care via a panel to consider all applications for Independent Specialist Placements for young disabled people leaving school, with the aim of ensuring better provision in Kent colleges and reducing the demand for expensive out of county independent placements, that do not necessarily prepare young people for adult life.

6.7 The Learning Disability Partnership Board has updated the "Becoming an Adult" booklet, with the content determined by young adults themselves. The booklet is suitable for use with people with a range of disabilities, not just Learning Disability, and is being widely used by Care Managers and schools. The Becoming an Adult group is about to undertake a survey of disabled young people going through transition to find out their views on planning for the future.

6.8 There have been transition workers in the Adult Learning Disability teams for a number of years. This model has now been extended to OPPD who have designated staff from January 2015 to have responsibility for transition for vulnerable young people leaving care as well as those with a physical disability currently managed in the Disabled Children Service.

7 Conclusion

7.1 From all of the above it is clear that there is much work going on to ensure that transition is managed well for young people with very varied needs. It is also clear that this is an area of work that cuts across Directorates, Divisions and Cabinet Committees and therefore requires a high level of joint work and planning to ensure that young people with additional needs receive the support they require, but always with the aim of making them as independent as possible as young adults.

7.2 Although there has been progress in improving the transition experience of disabled young people, there continue to be a number of challenges ahead to ensure services are compliant with the legislative changes and to ensure joint work, planning and commissioning across services and agencies, and will be the subject of ongoing work.

8. Recommendation

8.1 There is no recommendation for the Adult Social Care and Health Cabinet Committee as this report is for information only.

8.2 However, for completeness, the recommendations that were considered by the Children's Social Care and Health Cabinet Committee on 21 April 2015 were as follows:-

1. to note the contents of the report.

2. to support the ongoing work on transition, specifically:

i) Embed the Care Act changes relating to transition

ii) Implement and embed the changes to the Disabled Children and Adult Learning Disability teams

iii) Continue to develop the working arrangements with SEN in regard to EHC assessments and transfers

iv) Conduct the questionnaire of young people going through transition

9. Contact details

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Anthony Mort, Customer Care and Operations Manager

Relevant Directors: Philip Segurola, Director, Specialist Children's Services

Penny Southern, Director, Disabled Children, Adult Learning Disability/Mental Health

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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 – 1 May 2015**

Subject: **Distinctive, Valued, Personal – Why Social Care matters: the next five years**

Classification: **Unrestricted**

FOR INFORMATION ONLY

Summary: *Distinctive, Valued, Personal* has been developed by the Association of Directors of Adult Social Services (ADASS) to set out the vision of the sector's leaders of the next 5 years.

1.1 The attached paper sets out the Association of Directors of Adult Social Services (ADASS) vision for Adult Social Care and is designed as a mirror to the NHS 5 Year Forward View. This vision builds upon feedback and contributions from ADASS colleagues and partners. It highlights the distinctive contribution of social care and why it is important in responding to the changing needs of our population. The paper has a multitude of different audiences - professional, public and political; and is timed to coincide just ahead of the General Election and the potential next spending round.

1.2 The paper is being circulated to Cabinet Committee for information and to provide greater understanding of how the sector sees itself developing in the next five years. If members have queries about this or would like further information, please contact Andrew Ireland.

Background documents:

Appendix 1: Distinctive, Valued, Personal – Why Social Care matters: the next five years

Report Author

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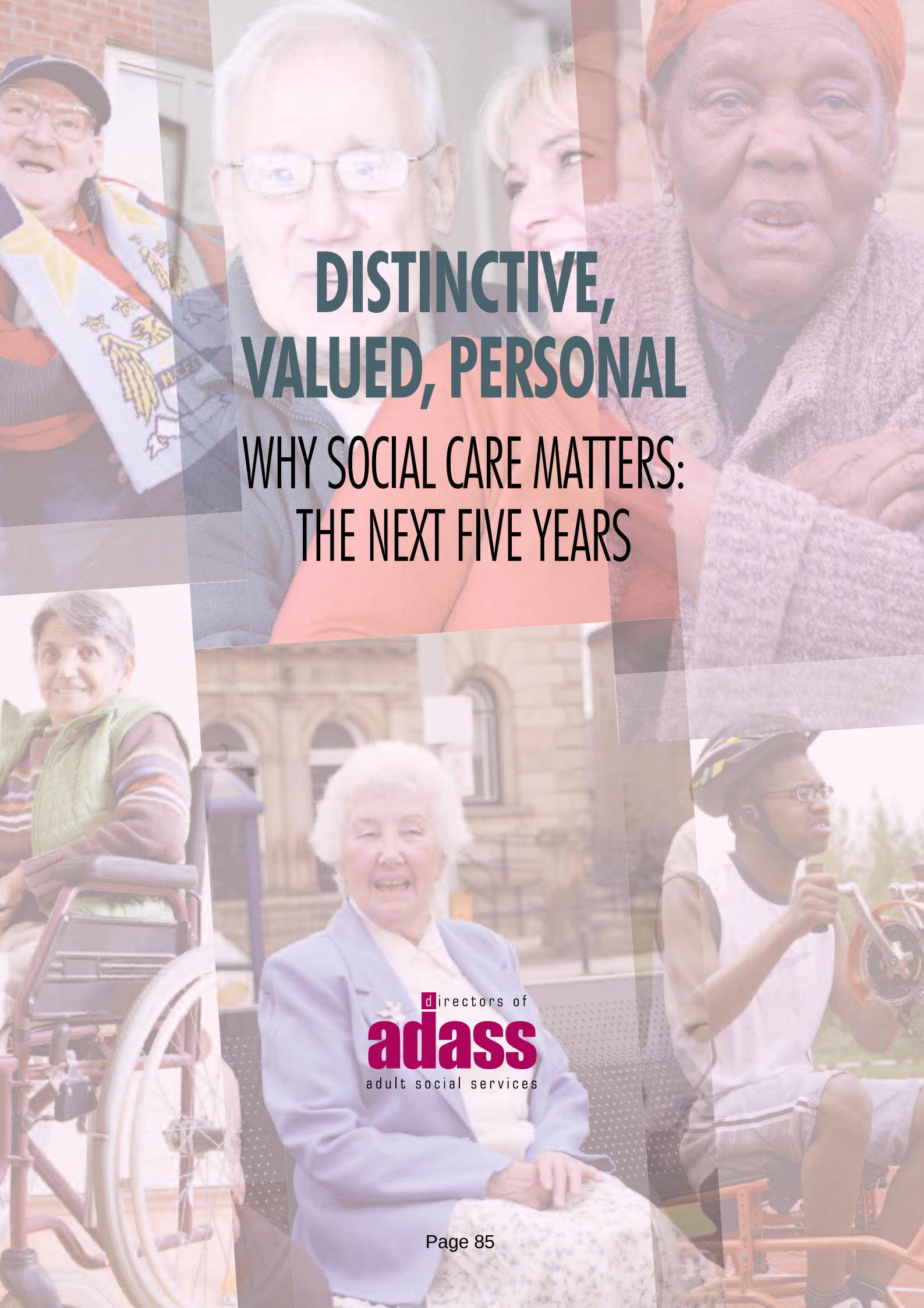

DISTINCTIVE, VALUED, PERSONAL

WHY SOCIAL CARE MATTERS: THE NEXT FIVE YEARS

directors of adass
adult social services

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Foreword

Social care provides care, support, and safeguards for those people in our communities who have the highest level of need and for their carers.

Good care and support transforms lives, helping people to live good lives, or the best they can, in a variety of circumstances. It enhances health and wellbeing, increasing independence, choice and control. It is distinctive, valued, and personal.

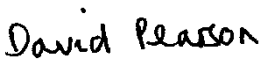
An independent YouGov poll indicates that 1 in 3 people either receive or are in touch with social care services. The same poll indicated that adult social care was the area in which the public would most like to see additional government investment, apart from the NHS.

2015 is an important time for adult social care services in England. We are living longer, which is a success story of our age that we should celebrate – but it has profound consequences for the kind of care and health services we need in the future.

There is not enough funding for social care and it has been reducing in real terms. The funding gap is estimated to reach £4.3 billion by 2020. More people are living longer; there are more people with disabilities who need care and support. Fewer and fewer of them are receiving public funding. This needs to be addressed.

We need adequately funded models of care that align – and re-design - care and health services effectively.

We urge politicians to act to meet the significant growth in the volume and complexity of needs faced by generations that rightly expect to lead longer more fulfilled lives.



David Pearson
President of the Association of Directors of Adult Social Services
March 2015

The Association of Directors of Adults Social Services is a charity. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services regardless of their backgrounds and status and
- Promoting high standards of social care services

Our members are current and former directors of adult care or social services and their senior staff.

Why Social Care matters – some key facts:

- **Social care responds to a wide range of needs - from an 18 year old with autism who needs support to leave home to an 80 year old with dementia who needs protection as well as personal care. It helps people to live as independently as possible, protects people from harm in vulnerable situations, balances risks with rights and offers essential help at times of crisis. The quality and sufficiency of these services is a key barometer of a good society.**

- **Social care touches the lives of millions of people – almost one fifth of the adult population of England has experience of social care - as part of the paid workforce (which is bigger than that of the NHS), as unpaid informal carers or as a recipient of services. Most of us at some point in our lives will need some kind of care and support. Social care is everyone's concern.**

- **Social care relies heavily on over 5.5 million unpaid carers – usually family members.**

- **Social care involves both public money and private spending. Local authorities spend £14billion: 35% of their total spending and the biggest single budget that councils control. Individuals spend at least £10billion of their own money on care services. Nearly half of care home fees, for example, are met by individuals with their own money.**

- **Social care is a vital 'connector' to other public services, especially the NHS but also local housing and community services. It works in partnership with community groups, voluntary and private providers and organisations that represent people who use services.**

- **Councils have important legal responsibilities to protect people's interests and rights in vulnerable situations - for example where people are being abused or neglected, where they lack the capacity to make decisions for themselves or where doctors are considering compulsory assessment or treatment of people in acute mental crisis. Councils work closely with the police and criminal justice system.**

- **Social care contributes to economic growth as well as meeting social needs. Most care providers are small businesses that form a sizeable chunk of the local economy in many places. It contributes as much as £43billion to the national economy and supports 1.5 million full time equivalent jobs. As the majority of spending is on staff, there is the potential for a significant multiplier effect to stimulate economic growth. Strong social care and a strong economy go hand in hand.**

Purpose and Context

This document sets out the distinctive role and value of social care in the 21st century, when we are living longer, often with multiple health conditions that need a focus on the whole person and not just a single disease. More of us need help and support to lead a good life. This applies just as much to younger people with disabilities and health conditions, for whom modern health care means longer lives, as it does to older people. It should be a cause for celebration that the need for social care is a consequence of success - of the social, economic and scientific progress that has made longevity possible – not a reaction to failure. The challenge now is to bring our services and systems up to date so they offer the right care and support, in the right place, at the right time.

This raises fundamental questions about how social care is organised, delivered, and funded. It is in the context of both the Care Act 2014, which sets out our nation's expectations of a care service fit for the 21st century, and the tightest squeeze on public finances since the 1970s. As more of us have a mixture of needs that involve medical care as well as social support that exceed the separate responsibilities of individual organisations, it is impossible to consider how we meet these challenges in isolation from the NHS. The Five Year Forward View published recently by NHS England looks ahead to consider the possible options and choices for health care.

In this document we describe why many of these questions apply also to our social care arrangements. Whilst there are some important differences between the NHS and social care, their futures are intertwined.

Social care's contribution goes well beyond that of a supportive adjunct to the NHS. Effective, personalised care and support helps reduce the impact and incidence of physical and mental ill-health –and it does so by supporting people to live better, more fulfilled lives as well as providing essential services to those of us who need them. Anchored within local government's responsibilities for promoting wider health and wellbeing, and the role of public health, the distinctive value of social care in local government is rooted in nurturing resilient, healthy families and communities that can reduce and prevent the need for formal services. Local government recognises and reflects the diversity of different places and communities, ranging from inner city housing estates to isolated rural communities.

As the burgeoning army of 'babyboomers' march towards later life, the quality of care of all kinds – from hospitals to home care - will attract increasing attention. Ensuring that services that are good enough for ourselves and our families will become a personal concern as well as a public issue.

So the questions facing social care over the next five years are no less urgent than those facing the NHS and will attract heightened political and public attention. Both systems will need to respond to higher expectations about greater control and choice over care, support, and treatment.

Executive Summary

1. What we describe today as social care has changed beyond recognition over our lifetime. Care has shifted away from remote long stay institutions towards community and home-based services, with a strong focus on supporting carers. There has been a revolution in the values based on individual human rights and the promotion of independence, dignity, and choice. The sector has risen to the challenge of new responsibilities, for example, the transfer of spiralling residential care spending from the social security system in the 1990 community care reforms, and the retreat of the NHS from long term care of older people. Its record of achieving efficiency is exemplary. 91% of people who use social care are satisfied with the help they receive – ratings that would be the envy of many private companies as well as other public services. Social care delivers.

2. There has been good progress in developing different models of care that enable people to live as independently as possible, for example through rehabilitation and reablement that avoids dependency on long term care and traditional services, developing recovery models in mental health services, and through supporting people with learning disabilities or mental health needs to engage in employment and leisure. There are many examples of innovative local services aimed at earlier intervention and prevention but they are hard to prioritise when money is tight. There is considerable scope to achieve better outcomes for people through the further development of these services along with the right mix of housing-based support, telecare and other technologies. The provision of information and advice will become more important in supporting individuals to manage their own health and care needs and access the right help.

3. The mainstream use of personal budgets is improving the choice and control individuals have over their care and support, and their lives. Extending these arrangements so that people can access a combined budget covering health as well as social care needs ('Integrated Personal Commissioning') creates the potential for integrated care to be driven as much by individuals as by organisations. Personal budgets help to ensure that public money is spent on what is really important to individuals.

4. Social care has a long history of joint working with the NHS in areas such as hospital discharge, and for people with mental ill-health or with a learning disability. Much care previously provided by the NHS is now delivered through the social care system. The coordination of primary and community health and social care support are vital for many people. Surveys conducted by ADASS with the NHS Confederation have shown high commitment by Clinical Commissioning Groups and councils to joint working but reported that the obstacles stem more from national policy differences than any lack of local will to work together.

5. The Care Act 2014 is an important step forward, replacing a historical ragbag of legislation - some of it dating back to the Poor Law - with a single modern statute that reflects 21st century needs and values. But legislation on its own is not enough – there remain major problems with the adequacy of the current system in facing up to new needs and challenges. These revolve around money, how care is delivered and joined-up with other services, the quality of care, and the workforce that provides it.

6. In recent years spending on social care has reduced significantly: 2014 is the fifth year of real term reductions, with £3.5billion less in council social care budgets since 2010. Councils have an exemplary track record of making efficiencies: 78% of budget reductions have been achieved in this way since 2010. Councils have also prioritised social care – it accounts for 35% of all their spending compared to 30% in 2010. However, funding has not kept pace with demography. 90% of councils are now only able to respond to people with critical and substantial needs. In 2005 it was 47%. At least 400,000 fewer people are getting publicly funded help. Reductions in access on

this scale to many other public services would cause public and political outrage. Our knowledge of the growing numbers of people who are 'lost to the system' (because they are not entitled to publicly funded care) is limited, but it seems inevitable that their unmet needs will be displaced to other places and people, such as unpaid carers and hospitals. This creates unnecessary human, as well as financial costs.

7. The financial challenges facing social care are not new. A succession of independent reviews and commissions (Sutherland, Wanless, Dilnot, Barker) over the last decade and beyond, have highlighted the structural fault lines between a universal NHS that is free at the point of use and used by most of the population, and social care that is rationed ever more tightly to those with the highest needs and lowest means.

8. The funding gap for social care is estimated to reach £4.3billion by 2020. Demography is the biggest single pressure, requiring an additional 3% per year to maintain services at their current level. Our estimate assumes savings of 1.5% in each of the next two years and 1% thereafter as savings become much harder to make. This is in addition to the 12% savings achieved during the current spending review period. It also assumes that the additional costs of the Care Act 2014 will be fully reflected in central government support and a £500million net benefit from continuation of the Better Care Fund.

9. The need to place the funding of care on a more sustainable basis is pressing and causing increasing difficulties for all concerned. The inter-dependency of NHS and social care resources means that the protection of the NHS from real term reductions, whilst leaving social care exposed to deep and significant reductions in local government spending, is a recipe for conflict when the overriding imperative is for collaboration and sharing of resources. The NHS can only be protected properly if social care is protected too. The case for a single, shared funding settlement, through the next spending review, that covers social care as well as the NHS and where social care is protected, is overwhelming.

10. Another area of concern arises from the need to maintain and improve the standard and quality of care in response to rising – and entirely reasonable – expectations of individuals and families. Every instance of poor care is one too many. The growth of social media, digital technology and better contract management, and safeguarding together with a more transparent approach to the inspection and regulation of services is leaving few hiding places for poor care.

11. This raises fresh questions about the sustainability of a workforce where levels of pay, training, skills and status are not keeping pace with changing and more complex levels of individual need. This demands renewed attention to how services are led, commissioned, and funded and what kind of job roles and career pathways should be designed to meet changing needs.

12. We agree with NHS England that more decisive steps are needed to break down the barriers within the NHS (between GPs and hospitals, between physical and mental health) and between the NHS and social care. The system is too complex and hard for people to understand and navigate. But as the Five Year Forward View notes, England is too diverse for a one-size fits all solution. What works in urban areas is completely different from the dynamics within our remotest rural communities. We welcome the opportunity to work with NHS colleagues in considering different options for care delivery models – the models outlined in the Five Year Forward View and the Dalton Review will be no more effective than current organisational models, if care and support needs are not an integral feature of their design.

13. Many people with care and support needs are clear that they want a life not a service. They want equal attention paid to their mental, physical, and all other forms of wellbeing. In pursuing closer integration of health and social care, care will be needed to avoid an over-medicalised approach to people whose needs are not primarily clinical. Co-ordination with other services, such as housing or the benefit system, may be much

more important. Equally it cannot be assumed that in the short term integrated care will be cheaper; this is not supported by national and international evidence. A proper transformation fund is needed to meet the double-running costs of developing community alternatives to hospital and long term care and making faster progress in developing the model of care and support we propose.

14. We see the role of government and national bodies creating the right framework of policies, funding, payment and contracting mechanisms, and regulatory regimes that encourage and incentivise local partners to achieve the best outcomes for their populations. The current system of payment by results in the NHS and the relative needs formula in local government no longer reflect the geographical diversity of different communities and the need to incentivise preventive, joined up services. Examples of policy changes that would help, include having a single outcome framework for health and wellbeing rather than separate frameworks for the NHS, adult social care and public health, and a single financial settlement for health, care and support.

    There is no appetite for a centrally-led national reorganisation to achieve integration. Instead priority should focus on how the intentions and resources of local authorities and their NHS partners can be better aligned to achieve better outcomes. Existing mechanisms for local decision-making and joint planning should be developed. Whilst recognising that Health and Wellbeing Boards are in a relatively early stage of their development, they offer the best prospects of crafting local solutions tailored to local needs and circumstances, based on strong partnerships between Clinical Commissioning Groups and local authorities. It may be necessary to review their membership, capacity and powers, and duties to ensure they can offer effective and shared system leadership.

15. We want to see a system that is protected, aligned, and re-designed. To achieve this there are five immediate priorities for action to build a stronger future:

    i. For central government to ensure that social care funding is protected and aligned with the NHS, including making provision for the £4.3billion gap in social care funding by 2020 alongside the £8billion gap in health service funding over the same period.
    ii. For all parties to focus relentlessly on ensuring that the level of quality is sufficient and that no services cause harm.
    iii. To ensure that new social and health care delivery models prioritise the need for:
        a. Good information and advice to enable us to look after ourselves and each other, and to get the right help at the right time as our needs change.
        b. The recognition that we are all interdependent and we need to build supportive relationships and resilient communities.
        c. Services that help us get back on track after illness or support disabled people to be independent.
        d. When we do need care and support, we need services that are personalised, of good quality, that address our mental, physical and other forms of wellbeing, and are much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.
    iv. Heightening the efforts of all parties to build a sustainable workforce to deliver this model.
    v. To strengthen local accountability and innovation by developing local Health and Wellbeing Boards as the places where partners bring together and lead commissioning, market shaping, resource allocation, and service delivery.

1. Why does our care system need to change?

About social care

Social care responds to a wide range of need – from an 18 year old with autism who needs support to leave home to an 80 year old with dementia who needs protection as well as personal care. It helps people to live as independently as possible, protects people from harm in vulnerable situations, balances risks with rights, and offers essential help at times of crisis. The quality and sufficiency of these services is a key barometer of a good society.

Social care touches the lives of millions of people – almost one fifth of the adult population of England has experience of social care - as part of the paid workforce (which is bigger than that of the NHS), as unpaid informal carers or as a recipient of services. Most of us at some point in our lives will need some kind of care and support. Social care is everyone's concern.

Our needs are changing

The success story that is our ageing population has been well documented. Our population is growing and more of us are living longer. This involves not just older people but younger people with disabilities and health conditions who are enjoying much longer life expectancies thanks to medical and care advances. The number of people with learning disabilities who will need social care services is likely to rise 25% by 2030. Sometimes their needs can be complex and expensive to meet. Nearly half of council social care spending is on services for people aged 18-65 years.

The pattern of need is changing dramatically as well. Deaths from cancer and heart disease are falling, but more of us experience chronic illness – 70% of the NHS budget is spent on long-term health conditions. Older people aged 75 years and over will have at least two such conditions ('co-morbidity'). The incidence of dementia and frailty in later life is soaring. Many more of us will have a mixture of needs to do with physical health, mental health, and perhaps, difficulty in making decisions for ourselves. They can only be met by well-coordinated 'joined-up' care.

However, our health service has traditionally been organised around single disease specialities and the treatment of one-off episodes of illness through general practice or hospital admission. It is becoming much harder for professionals to demarcate social care needs from those that are the responsibility of the NHS. The multiplicity of different organisations and functions between different parts of the NHS and social care is confusing and complex for people to understand and to navigate.

Building the right model of care and support

Social care is a vital 'connector' to other public services, especially the NHS but also local housing and community services. It works in partnership with community groups, voluntary and private providers, and organisations that represent people who use services.

The Care Act 2014 emphasises the need for preventative and co-ordinated care focusing on wellbeing. In recent years we have become much more aware that some care needs, like some health needs, can be reduced, avoided, or prevented. Supporting people to manage their own health conditions can reduce the need for hospital admission. Offering people rehabilitation and reablement after illness enables them to return to independent living and avoids the need for long term care. Supportive social networks and resilient communities are good for people's health and wellbeing. Too often however the care and health system is

better at reacting to crisis and relies too much on hospitals and long term care. This fuels a vicious circle of escalating demand, symptomised by over-stretched A&E departments and unsustainable pressures on local authority social care budgets. We need a different model.

Who pays for care?

Local authorities spend £14 billion, which is 35% of their total spending and the biggest single budget that council's control. But a profound change in our lifetime has been rising levels of private household wealth arising from post-war economic prosperity and the growth in house prices. Whereas health care has largely remained free at the point of use, more of us are responsible for the cost of our own care and support in a way that the architects of the means-tested 1948 settlement could not have imagined. Although the Care Act 2014 will help people with very high care costs, individuals will still make very considerable financial contributions. Individuals spend at least £10billion of their own money on care services. Individuals with their own money meet nearly half of care home fees. Yet public understanding of the funding system is poor, while options for planning ahead and the use of insurance are very limited.

The Barker Commission concluded that the profound difference between health care needs that are met free at the point of need, and social care that is heavily charged and means tested is becoming harder to justify. Public understanding of how these different services are funded has not kept pace with changes in private wealth and the historical legacy of means testing. The result is confusion and misunderstanding, and a strong perception that the current system is unfair.

Economic growth is also about a growing social care sector

Social care contributes to economic growth as well as meeting social needs. Most care providers are small businesses that form a sizeable chunk of the local economy in many places. It employs the equivalent of 1.5 million full time jobs. As the majority of spending is on staff, there is the potential for a significant multiplier effect to stimulate economic growth. Strong social care and a strong economy go hand in hand.

Funding needs to keep pace with needs, expectations, and the number of people needing care and support

The number of people needing care and support has been increasing over time and will continue to do so. Equally, we want more from our care and health services. Our expectations about the quality of care we want for ourselves and our family, the degree of choice and say in how our needs are met and the kind of information on which to base these decisions has changed beyond recognition. Every instance of poor care is one too many. Whereas previous generations may have been content to be passive recipients of care, today most of us will want to be active participants in shaping our own care and support arrangements. Digital technology and social media create new possibilities to address some of these challenges.

Resources are not keeping up with expectations or needs: the reverse is in fact the case. Spending on local authority social care has fallen by 26% since 2010 – five consecutive years of real term reductions. This amounts to overall cash savings in real terms of 12% over the current spending review period and savings needed to deal with 14% of increased need. Substantial efficiency savings have been made – 78% of budget reductions have been achieved in this way since 2010. Councils have prioritised social care – it accounts for 35% of all spending compared to 30% in 2010.

Funding has not kept pace with demography. 90% of councils are now only able to respond to people with critical and substantial needs. In 2005 it was 47%. At least 400,000 fewer people are getting publicly funded help. There are urgent questions about how we manage the growing gap between needs, resources, and expectations, which is estimated to reach £4.3billion by 2020.

The way that the NHS is funded (which has resulted in a shift of resources from primary and community care, which operate alongside social care, into acute hospitals) has made social care's ability to support people at home even more difficult.

"The provision of adequate adult social care poses a significant public service challenge. Demand for care is rising while public spending is falling."[i]

We are reaching a critical point

Despite the mounting pressures, people who use social care are generally very positive about their experience – in 2013/14, 91% were 'quite', 'very' or 'extremely' satisfied with their care and support (65% were 'extremely' or 'very' satisfied). But we cannot be confident about what happens to those who fall outside of the public system – either because their needs are not extensive enough or they are not poor enough. The National Audit Office is right to question how much longer the system in its current form can continue to cope.

In summary despite the best efforts of 1.4 million people who work in social care, the way we organise, deliver, and fund care and support has not kept pace with 65 years of rapid social, demographic, and technological change. Successive government white papers have recognised this but the scale of change has fallen short of what is needed to deliver care fit for the 21st century. A bolder strategy is needed, based on a different model in which all these separate services work as part of a single, whole system and revolve around the needs of each individual.

This is described in section 2.

2. What will the future look like? A new relationship with individuals, communities, and a joined-up care and health system

Our vision and ambitions

Adult social care services in England are distinctive, valued, and personal; they enable us to live our lives as independently and as well as possible, making us feel in control of what we do and how we live.

This section outlines a better model for care and support that will help achieve this. The principles of wellbeing, personalization, and integration enshrined in the Care Act 2014 offer the right foundation but on their own are not enough - good governance in our local areas and adequate resourcing are vital.

Our model for social care is based on a new relationship with citizens, but its core is the continuity of the social approach that recognises how our different individual needs sit within a wider network of personal and social relationships in the community. It sees us as individuals, living in relationships and as people living in communities.

Our **model** for care and support is based on four key elements:

- Good information and advice to enable us to look after ourselves and each other, and get the right help at the right time as our needs change.
- The recognition that we are all interdependent and we need to build supportive relationships and resilient communities.
- Services that help us get back on track after illness or support disabled people to be independent.
- When we do need care and support, we need services that are personalised, of good quality, that address our mental, physical, and other forms of wellbeing and are much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.

Good information and advice

Information and advice will enable us to look after ourselves and each other. The need for information and advice starts before we actually need care and support. Ideally we should all be thinking and planning ahead in the eventuality of having significant care needs. This might mean thinking about our finances, housing arrangements and care and support, and arranging Lasting Powers of Attorney so that our wishes can be enacted if, for any reason, we are unable to make decisions for ourselves.

Information and advice should enable us to make the most of a fit and active life, equipping us with information about particular health conditions and signposting us to sources of further information and support. This will help prevent or reduce the need for services and ensure we get the right help, at the right time, in the right place. It will put us in a better position to understand what the options might be and enable us to make better informed choices, so far as we are able to foresee, about arrangements for caring for each other and the end of our lives.

We should build on the growing range of innovations across the sector that have made information and advice more readily available and tailored to meet people's needs, such as highly dynamic websites, health and social care navigators who help connect people to

information, and strength based approaches to assessment which help people understand what advice is already available to them amongst friends and family.

Supportive families and communities

Most of us at some point in our lives will have some kind of care and support need. For many this will be so great that it will impact on our family and close personal relationships. If we do care for someone else, we need support ourselves to continue to live our lives, whether that is holding down a job, staying in touch with friends, or taking care of our own health and wellbeing. If we are caring for someone we also need recognition of our role and contribution. We may also need support if there is abuse or neglect in the household.

We are all interdependent and there needs to be a stronger role for resilient communities in upholding 'social health', a key part of our health and wellbeing. Social care is rooted in local government which has responsibility for many other services which help people stay independent and healthy. Local government has a critical leadership role in public health, as highlighted in the NHS Five Year Forward View, and in many other areas such as support to carers, engagement with employers, promoting dementia friendly communities, and through a variety of functions such as planning, design, housing, trading standards and community safety.

As the composition of our communities change, we need to make sure that they can be as supportive as possible to people with disabilities and long term conditions. Informal carers already provide at least £55billion of unpaid care and support for people in this country. The voluntary sector makes a significant and valuable contribution in helping to meet people's needs and enhance their quality of life. Initiatives such as Dementia Friends, 'Meet and Greet' volunteers (helping people successfully transition from hospital into their homes) and Good Neighbour Schemes need to grow as we build understanding and capacity in the future. It will be impossible to meet the challenges ahead without nurturing the potential of community-led and user-led services, including social enterprises.

Getting back on track: recovery, reablement, independence

We are all ill at times, and many of us have a disability or a mental health issue. However, that doesn't necessarily mean that we need care and support all the time. What we do need is the right support, care, and treatment at the right time in order to enable us to lead 'normal' lives that are as good as they can be. So that could mean episodic treatment from a GP, or it could mean services to help us to be independent, with a strong sense of wellbeing, in order to recover from illness and ensure the inclusion of disabled people. This is as true for our mental as for our physical health. These services will include access to employment for younger adults and independent living, recovery from illness, rehabilitation, and reablement for everyone.

Personalised Services

Too often people experience services that are fragmented, poorly coordinated, and hard to navigate. Instead we need services that are personalised, of good quality, and much better coordinated and joined-up around the needs of the individual, with a parity of emphasis on our physical, mental, and other needs. This will entail care coordination, integrated teams, shared assessment and records, and integrated personal commissioning.

For the 3 to 4 million people with multiple long term conditions requiring extensive health and/or social care and support by 2018, along with their carers, the need for person-centred,

coordinated care will be critical, including wherever possible, the use of integrated personal health and care budgets and/or commissioning. These will be used to meet most needs for long term health and care support, and is considered the most powerful way to join up health and care around individuals and families. The NHS England personal commissioning programme is a good opportunity to bring together personal health and care budgets so that individuals are empowered to be the integrators of their own care and support.

Social care has an important role to play as a navigator to access these supports, and as facilitator to improved independence and resilience. Integrated pathways are key, with social care working closely with partners (particularly the NHS) to help individuals experience seamless coordinated services that are effective and efficient.

Personalisation is central to the model we are proposing. It is not new, with roots in the disability rights and mental health survivor movements from the 1970s onwards, as well as being core to traditional social work values. Personalisation starts with the individual, rather than the service and recasts the relationship between professionals, organisations, and the people they serve.

Underpinning factors for delivering our vision: quality and workforce

Underlying our vision is our commitment to the rights to decent quality and safeguarding for all. The Care Quality Commission analysis is that there is too much poor care in a variable market and data shows that the price paid by councils for residential, nursing, and home care has not gone up in four years. Improving quality will require joint effort by providers, commissioners, and the regulator.

Alongside this, councils have important legal responsibilities to protect people's interests and rights when they are in vulnerable situations - for example, where people are being abused or neglected, where they lack the capacity to make decisions for themselves or where doctors are considering compulsory assessment or treatment of people in acute mental crisis. Councils work closely with the Police and criminal justice system. Social workers and occupational therapists in councils have crucial roles in helping people to live as independently as possible with choice and control, as well as working with them to safeguard them from unacceptable risk and harm.

Money on its own is not enough to ensure sustainability. None of this can be achieved without a stable, supported, and skilled workforce. We do not yet have this across the board. "Our experiences tell us that a well led, well trained workforce provides effective, high quality, person centred care and support. This means people accessing care and support can be independent and lead healthy lives, minimising demand on the NHS. Winning the hearts and minds of the workforce is the key to achieving integrated social care and health services working together to meet the individual needs of people in our communities."[ii]

We believe that the best people to build and deliver these approaches are local democratic leaders, clinicians, and other professionals, working closely with individuals and communities to design services that are best suited to local needs and circumstances.

Section 3 sets out how we propose this should be done.

3. How will we get there?

Designing a set of care and health services that work well together and reflect 21st century needs will be tough and take years to achieve. As noted earlier, successive governments have grappled with many of these issues with limited success. In the last fifteen years alone there have been nine white and green papers on social care.

Developing the model of social care described in section 2 should involve a staged approach, acknowledging that the social care sector is different from the NHS in that most services are delivered through over 17,000 different private and voluntary providers and a burgeoning number of personal assistants – directly employed by individuals using personal budgets – as well as smaller scale micro providers. How these services are joined-up with health is not straightforward and there is no one size fits all solution. The engagement of the independent sector in the planning, commissioning, and delivery of joined-up services will be essential.

There is little evidence – in the UK or from international experience - that nationally imposed reorganisation in itself would lead to better outcomes for people. Currently there is no appetite for further structural change, especially after successive reorganisations of the NHS. So we endorse the NHS Five Year Forward View's support for 'diverse solutions and local leadership' and assert the importance of the leadership role of local authorities across a wide range of services that impact on the health and wellbeing of their local population. These will build on the elements of our model.

Currently Health and Wellbeing Boards are the only local forum that brings together leaders from the NHS and local government, including public health. A succession of reviews and reports has argued that they could play a bigger role in overseeing the integration of local services and the development of a more integrated approach to the commissioning of services across health, social care, and local government. That is reflected in the requirement for Boards to sign-off local Better Care Fund plans.

The Boards are relatively new and their development is variable across the country, reflecting differences in the history of local relationships and between the cultures of the NHS and local government. It may be necessary to review the existing powers, duties, membership, and capacity of the Boards to ensure that each is ready and fit for purpose to take on a more significant decision-making role. With this proviso, the Boards offer the opportunity for an evolutionary approach based on partnership between Clinical Commissioning Groups (CCGs) and local authorities. CCGs would have a strong and continuing role in contributing to the work of the Boards in overseeing the commissioning of all local services, including those commissioned by the local authority, and the enhanced responsibilities of the Boards for ensuring that local services are coordinated around individual needs.

This next generation of Boards could then form the linchpin of agreed local governance arrangements through which the model of social care proposed in this document could be agreed and developed – and aligned with the care delivery models described in NHS Five Year Forward View. This would ensure a consistent and shared approach to change and could be tested through the vanguard programme. It would avoid the need for extensive structural reorganisation.

However, the success of developing the right local models of care will depend on a stronger and clearer national policy framework. We propose that this should have the following elements:

- The introduction of a single shared outcome framework for health care, public health, and social care, and better alignment of policy and performance measures that encourage better coordinated care closer to home and capture how well the local system (rather than individual organisations) are doing in meeting needs.
- Funding the gap facing social care by 2020 alongside that facing the NHS – neither can be considered in isolation because of their inter-dependence - and using the next spending review to work towards a single funding settlement for social care and the NHS.
- Addressing immediate pressures and the double-running costs of developing alternatives to hospital and long term care through a transformation fund in which investment is conditional on reform i.e. the introduction of new models of care.
- Ensuring that there is sufficient flexibility in the future to cover both the universal responsibilities which councils will have under the Care Act 2014 and also to reflect the diverse range of care markets and choices around the country, ranging from inner-cities to the most remote rural communities.

4. Conclusion

We want to see a system that is protected, aligned, and re-designed. To achieve this there are five immediate priorities for action to build a stronger future:

i. For central government to ensure that social care funding is protected and aligned with the NHS, including making provision for the £4.3billion gap in social care funding by 2020 alongside the £8billion gap in health service funding over the same period.

ii. For all parties to focus relentlessly on ensuring that the level of quality is sufficient and that no services cause harm.

iii. To ensure that new social and health care delivery models prioritise the need for:

   a. Good information and advice to enable us to look after ourselves and each other, and to get the right help at the right time as our needs change.
   b. The recognition that we are all interdependent and we need to build supportive relationships and resilient communities.
   c. Services that help us get back on track after illness or support disabled people to be independent.
   d. When we do need care and support, we need services that are personalised, of good quality, that address our mental, physical, and other forms of wellbeing and are much better joined-up around our individual needs and those of our carers. Personal budgets are central to this approach.

iv. Heightening the efforts all parties to build a sustainable workforce to deliver this model.

v. To strengthen local accountability and innovation by developing local Health and Wellbeing Boards as the places where partners bring together and lead commissioning, market shaping, resource allocation, and service delivery.

vi. The strength of social care is putting people in control: it is distinctive, valued, and personal:

"For me, social care means the support I need to have a full and meaningful life and to do the things I want and need to do, not just to get by"
Martin S. Yates

"The support I get from social care for my son means I can become a mum again"
Sally Percival, carer

"For me as a person who uses Adult Social Care services it is important that there is a safety net of care and support for people in need or at risk. Adult Social Care has never been more relevant or more challenged as we enter the dawn of the Care Act. Adult Social Care is very important as it has the responsibility and the influence to enable people who use its services to thrive not just to survive and to have a better life".
Clenton Farquharson MBE

"My wife has spinal cord injury and is paraplegic. Some years ago we were experiencing consistent poor service from the care company. They were turning up late most days and not at all some days. The Social Services were prompt in dealing with the problem and found us another care company very quickly. They also told us about direct payments and we have been on this for 3 years now. We find employing personal assistants a lot more reliable and caring is of a higher standard."
Bilgin Musannif

"The best part of personalisation is when you relapse and you're supported properly to get back on your feet. The support I received was home help and this ensured that everything required was in place and I was supported to resolve any difficulties."
Matt Langsford (mental health survivor and care leaver)

"…my situation has improved a lot since my last assessment and I now have a services configured around my real needs using direct payments. This supports my autonomy and independence and allows me to pursue my interests and sustain my health."
Larry Gardiner

"As someone with an acquired impairment I have had support from my local authority for 15 years. Over this time the support has changed dramatically and now by using direct payments I am able to use the same support more flexibly. My condition fluctuates quite a lot and now I can change around my support so that when I'm really unwell I can use more and then have less when I don't need so much. It means I can be more involved in my community and it is easier for me to stay in touch with my family."
Disabled person, north London (did not want to be named)

"It would not be overstating the case to describe social care as 'life support' for an increasing number of disabled people, older people and their carers, but we now stand at a critical point for the future of social care provision. Chronic underfunding has seen dramatic year-on-year rationing of social care support, and tightening eligibility criteria, leaving thousands without the support they need to do the basics, like getting up or out of the house. There is an urgent need to increase funding for social care and expand eligibility,

while thinking innovatively about the services that are provided. Failure to meet this increasing need will only exacerbate the negative impact on the NHS, disabled and older people, their carers and the wider economy. This chronic under-investment in social care is no longer sustainable. We need action to ensure that disabled and older people, and their carers get the support they need."
Richard Hawkes, Care and Support Alliance

"Our experiences tell us that a well led, well trained workforce provides effective, high quality, person centred care and support. This means people accessing care and support can be independent and lead healthy lives, minimising demand on the NHS. Winning the hearts and minds of the workforce is the key to achieving integrated social care and health services working together to meet the individual needs of people in our communities."
Sharon Allen, Skills for Care

"People who use multiple services over time need person centred coordinated care. The health system is still at first base in understanding this. As the drive for all local areas to integrate services continues, the future of social care must be to provide the essential resource of knowledge, experience and practice on getting personalisation right – and coproducing services with people and communities In this respect, we will all need social care!"
Don Redding, National Voices

"Social care is a facing unprecedented challenges and opportunities, and this is the right time to set out what adult social care should look like going forward. Knowledge is a valuable asset in setting this vision, which is too often over-looked when we consider the resources available to improve and personalise care and support. When resources are limited, it's even more important to understand what works in delivering effective, and efficient, care".
Tony Hunter, Social Care Institute for Excellence (SCIE)

"Social work makes a distinct contribution to the success of the wider social care system. Very many thousands of social workers across the country are using their skills to make joined up, personalised care and support a reality for people using services. The introduction of the Care Act is a further significant opportunity to move away from care management and back to real social work. Investing in social work means investing in communities."
Jo Cleary, Chair of The College of Social Work

Acknowledgements: We would like to thank Richard Humphries, ADASS Associate, who helped us with several versions of this paper, our partners and stakeholders who gave us constructive criticism and comments (including NHSConfed, Skills for Care, the County Councils Network and SCIE) and those individuals who provided quotes, some of whom also contribute to SCIE's projects and programmes as experts by experience.

[i] National Audit Office
[ii] Skills for Care

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