ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Friday, 10th July, 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, 10 July 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, Mr P J Homewood and Mrs C J Waters
UKIP (2)	Mr H Birkby and Mr A D Crowther
Labour (2)	Mrs P Brivio and Mr T A Maddison
Liberal Democrat (1):	Mr S J G Koowaree

Webcasting Notice

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

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

UNRESTRICTED ITEMS

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Membership - to note that Mr P J Homewood and Mrs C J Waters have joined the Committee to fill the two vacancies

A3 Apologies and Substitutes

To receive apologies for absence and notification of any substitutes present

A4 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

A5 Minutes of the meeting held on 1 May 2015 (Pages 7 - 16)

To consider and approve the minutes as a correct record

A6 Verbal updates (Pages 17 - 18)

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 The 2015 - 2020 Kent and Medway Suicide Prevention Strategy and Action Plan (Pages 19 - 66)

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 adopt the 2015 – 2020 Kent and Medway Suicide Prevention Strategy and Action Plan.

B2 The Public Health Strategic Delivery Plan and Commissioning Strategy (Pages 67 - 88)

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 contracts, set out in the report, to 30 September 2016. This item will include a presentation on the Public Health Transformation programme.

B3 Local Welfare Assistance future options update (Pages 89 - 92)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing and to endorse the proposed course of action to extend the current arrangements.

B4 Kent Community Hot Meals tender (Pages 93 - 100)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to award a contract to the bidder identified in the exempt appendix to the report.

B5 Commissioning of Advocacy Services for Vulnerable Adults (Pages 101 - 110)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to re-commission advocacy services for vulnerable adults.

C - Items for comment/recommendation to the Leader/Cabinet

Member/Cabinet or officers

C1 Care Act - update on phase 1 and plans for phase 2 (Pages 111 - 114)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing, which Members are invited to discuss.

C2 Adult Social Care Transformation and Efficiency Partner update (Pages 115 - 120)

To receive an update report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing.

C3 Kent Drug and Alcohol services - Commissioning Plans (Pages 121 - 130)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health on the proposed approach to the re-commissioning of community drug and alcohol services.

C4 Integrated Commissioning for Learning Disability in Kent (Pages 131 - 136)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing, setting out future plans for the formal commissioning arrangements for these services.

D - Monitoring

D1 Adult Social Care Performance Dashboard (Pages 137 - 154)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing outlining the performance, which Members are asked to review.

D2 Public Health Performance - Adults (Pages 155 - 160)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, outlining current performance and actions taken by Public Health.

D3 Adult Social Care Annual Complaints Report, 2014 - 2015 (Pages 161 - 178)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Social Care, Health and Wellbeing, on which Members are invited to comment.

D4 Work Programme (Pages 179 - 186)

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

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

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

EXEMPT ITEM

E1 Kent Community Hot Meals tender (exempt appendix to item B4) (Pages 187 - 190)

Peter Sass
Head of Democratic Services
03000 416647

Thursday, 2 July 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.

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 1 May 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, Mrs V J Dagger, Mr S J G Koowaree and Mr T A Maddison

ALSO PRESENT: Mr G K Gibbens and Ms C J Cribbon

IN ATTENDANCE: Mr M Lobban (Director of Commissioning), Mr A Scott-Clark (Director of Public Health), Ms K Sharp (Head of Public Health Commissioning) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Apologies and Substitutes
(Item A2)

There were no apologies for absence and no substitutes.

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

Mr S J G Koowaree made a declaration of interest as a young relative was in the care of the County Council.

3. Minutes of the meeting held on 3 March 2015
(Item A4)

RESOLVED that the minutes of the meeting held on 3 March 2015 are correctly recorded and they be signed by the Chairman. There were no matters arising.

4. Verbal updates
(Item A5)

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

12 March - Spoke at the Transforming Adult Social Care Forum in London – this was linked to the Active Lives initiative, an excellent programme which Kent should seek to expand. Briefings by Penny Southern's team could be arranged for any Members who wished it.
18 March - Attended launch event for the Take Off Charity in Canterbury – the Take Off charity ran networking events for people with mental health problems, based on preparing and enjoying food. The simple concept of cooking and eating together could give much needed enjoyment, company and moral support.

15 April - Attended Governors visit to South East Coast Ambulance Service 111 Centre in Ashford – this visit had been enlightening and he had been very impressed to see how the 111 system worked, at one of the two South East centres.
New Division - Disabled Children, Adults with a Learning Disability and Mental Health - Disabled Children's Services, Adults Learning Disability and Adult Mental Health Services had come together in a new division on 1 April 2015. Penny Southern would be the Director responsible for the new division, called 'Disabled Children, Adults with a Learning Disability and Mental Health'. Mr Gibbens said he was very pleased that this closer alignment would further improve the support for disabled young people becoming adults, and said that it also had the full support of the Cabinet Member for Adult Social Care and Public Health. The problems experienced by this group were a nationwide challenge which should be helped in Kent by the creation of the new Division.

2. Members welcomed the creation of the new division, as the problems faced by young people, particularly those in care and leaving care, in the transition period from children's to adult services had long been a concern of the committee.

3. In place of the Director of Social Care, Health and Wellbeing, Mr M Lobban, Director of Commissioning, then gave a verbal update on the following issues:-

Introduction of the Care Act on 1 April 2015 – most elements of this had now been introduced, with the remainder being required to be introduced in April 2016. Good communications were essential to help those affected by the changes to eligibility criteria, extended carers' rights and advocacy services to understand the new arrangements.

Public information had been particularly effective in relating the changes. A leaflet had been issued to 15,000 service users to reassure them that the services they received would not be affected by the changes, and subsequent queries had been fewer than had been expected.

The level of resource required to introduce and run advocacy services was expected to present a challenge. The 'Advocacy for All' group had written to the County Council say how pleased they had been with the way in which the County Council had introduced and explained the changes.

The County Council had asked the Local Government Association to undertake a 'deep dive' study of its processes and had received very good feedback as a result.
The excellent work done by staff and partners in making this happen smoothly was particularly to be welcomed.

Transformation – the design phase had now ended, and an update on transformation work would be made to the Commissioning Advisory Board on 15 May. Mr Lobban suggested that all Members of this committee be invited to attend *and an invitation was subsequently issued.*

4. He responded to comments and questions, as follows:-

a) one speaker said that attendees at a local Senior Citizens' Board had reported that they found the publicity available to be very helpful and they felt they had a good understanding of the Act and its changes; and

b) asked if the Local Government Association (LGA) deep dive had produced any recommendations, Mr Thomas-Sam explained that the study had looked in particular at the information the County Council issued and the extent to which the Council worked with its providers, as the Act affected NHS services as well as those delivered by the County Council. One area in which, the LGA had suggested, other local authorities could learn from Kent's best practice was the extent to which the information used for self-assessment could be accessed online, making the process much faster.

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

9 March - the Local Government Declaration on Tobacco Control had been signed by the County Council Leader, the Head of Paid Service and the Director of Public Health. The World Health Organisation had endorsed the declaration.
11 March - Attended the No Smoking Day - Charlton Athletic 'Kick the Habit' Roadshow in Canterbury – smoking remained a major public health issue to be addressed. Canterbury had recorded a wide disparity in life expectancies and the main cause of this was smoking. Mr Gibbens had used some of his individual Member grant money to support anti-smoking campaigns, and he reminded Members that they too could use their grant money to support community initiatives to address this and other public health work.
25 March - Spoke at the 'Tackling HIV Stereotypes' Impress Conference in Canterbury

6. Members made the following comments:-

a) one speaker said he had been involved in 2014 in a campaign with the Darent Valley Hospital to encourage expectant mothers to stop smoking;

b) another speaker added that parents needed to be aware of the risk of smoking in terms of fire risk at home, and suggested that the Kent and Medway Fire and Rescue Service be approached to become involved; and

c) asked what action the signatories to the declaration on tobacco control would take to follow it up, as Kent had a particular issue with cheap, illegal imports of cigarettes from Europe, Mr Gibbens said he hoped to be able to work with Trading Standards colleagues to address this as it had a particularly heavy impact on young people. He suggested that an update report on work to address tobacco control be made to a future meeting of this committee *and this was added to the work programme.* Mr Scott-Clark added that joint work was ongoing between the public health team and the Growth, Economic Development and Transport Directorate to address illegal imports.

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

Broadstairs Town Shed – this mental health support network project was now available to both men and women. Committee Members were encouraged to visit and view the work of local Shed projects in their divisions.
Porchlight – a recent meeting between the public health team and the Porchlight homelessness charity had strengthened links and joint working. Porchlight had good

support from GPs and an impressive record of helping the homeless. 1,500 people accessed their services last year and 89% of these had reported positive outcomes in terms of being better able to manage their mental health problems and having increased self-esteem.

8. He responded to comments and questions, as follows:-

a) a recent community engagement day at a Shed project in Dover had shown what excellent support work the projects did, and the extension of the original men's project to include both men and women was welcomed;

b) Porchlight's work was also excellent in helping the increasing number of people sleeping rough. The charity made weekly reports on its work to the housing service at Dover District Council; and

c) asked how the services of Porchlight were viewed by GPs around the county, Mr Scott-Clark explained that GPs were very keen to support it.

9. RESOLVED that the verbal updates be noted, with thanks.

5. Kent and Medway Prison-based Substance Misuse service - contract extension *(Item B1)*

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

1. Ms Sharp introduced the report and explained that the proposal to extend the contract arrangements for a further two years was covered by an option clause built in to the current contract. She responded to comments and questions, including the following:-

a) as the County Council commissioned the service on behalf of NHS England, it benefitted from a reciprocal arrangement of having two full-time posts in the public health team fully funded by NHS England;

b) the commissioner had contact with women's prisons in Kent, Surrey and West Sussex, giving an opportunity to make and strengthen connections between services delivered in prisons and services delivered in the community;

c) when the contract came to be re-let in the future it was likely that other providers might bid, as the current provider had not been the only bidder on the previous occasion;

d) the proposed decision, on which the committee was being asked to comment, was to take up the option of extending the existing contract for a further two years, making five years in total. The contract would then be re-tendered in time to re-let the services at the end of the five-year period; and

e) a view was expressed that the proposed extension seemed to be the most sensible option as the reported performance of the current provider had been good.

2. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to invoke the contract extension option within the Kent and Medway Prison-based Substance Misuse Service contract, until 30 September 2017, taking account of comments made by the committee, be endorsed.

6. Update on addressing Health Inequalities in Kent
(Item C1)

Members of the Children's Social Care and Health Cabinet Committee had been invited to attend for this item.

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

1. Ms Varshney introduced the report, which set out progress on addressing health inequalities. Measures to address health inequalities, eg health checks, were increasing, and further alignment of commissioning intentions of public health and other service commissioners would add to the ongoing work. Ms Varshney and Mr Scott-Clark responded to comments and questions from Members, as follows:-

a) the message about the need for healthy eating and exercise to address obesity needed to be reinforced, as many people seemed not to have taken note of it. Ms Varshney supported the point and explained that clear objectives needed to be set which included both diet and exercise. She reassured Members that this issue would indeed be included in key targets;

b) asked about the recommendation that the County Council support work to influence spatial planning, Ms Varshney explained that a national policy framework included guidelines on spatial planning and how planners should take account of public health issues, eg the need for green and open space and good walking and cycling paths, when considering planning permissions. This national guidance was a useful tool which professionals could use to address public health issues;

c) it was emphasised that public health considerations should be taken into account in this way, but the Chairman advised that public health professionals did not appear among the statutory consultees. Mr Scott-Clark added that public health issues could be planned into development, in the same way in which crime could be planned out. As well as the need for external provisions, listed above, the internal structure of new homes could include features to help older and less mobile people to continue to live independently in their homes for longer without the need for future adaptations;

d) it had been difficult to make any progress on green space issues at district level. Trees removed had not been replaced, and there should be a policy not only to replace trees lost but to plan them in to road schemes and developments, to improve air quality. One speaker suggested that Members could use their individual Member grants to support local tree-planting schemes;

e) to play an active local role, Members needed to be able to understand the health inequalities issues in their areas, so would need to been given information about local issues and what was being monitored. Mr Scott-Clark undertook to include information in the regular Member Information Bulletin to tell Members how to access the local profiles which were prepared by Public Health England;

f) as each area had different health inequality issues, a pilot scheme could be run in each area to tackle local issues. Ms Varshney explained that some themes, eg smoking and take-up of health checks, were common to many areas. Information collated from local reports could be circulated to committee Members, with progress reports. The County Council could then liaise with district councils to address issues identified; and

g) one Member of the committee made a personal pledge to lose one stone in weight by September 2015.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and added that health inequalities across Kent were widening. Although most people were now living longer, there was a growing disparity across areas of the county in the quality of life they enjoyed. The County Council's 'Mind the Gap' Strategy, issued in 2012, would be rewritten in 2015, and a series of briefings was planned to coincide with the launch of this. He suggested that data about health inequalities, life expectancy, etc, could be shared with Members at area briefings.

3. RESOLVED that the progress made to date in addressing health inequalities across Kent be noted, and support be given to:

a) 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;

b) collaborative working between agencies such as district councils, police and health in promoting policy initiatives to reduce harm from issues such as alcohol and smoking; and

c) 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.

7. Update on developing the Public Health Strategy Delivery Plan and Commissioning Strategy
(Item C2)

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

1. Ms Sharp introduced the report, which gave the committee an early opportunity to comment on the strategies. As the public health function had now been within the County Council for two years, and a new Director of Public Health, Mr Scott-Clark, had recently been appointed, the time was right to take a strategic view of services and the investment of the public health grant. Ms Sharp and Mr Scott-Clark responded to comments and questions from Members, including the following:-

a) the chart of target outcomes appended to the report included areas of work, eg reducing levels of excess weight in children, in which the County Council was aiming to exceed national performance targets. It was important to look deeper into issues, beyond the headline performance data, to see what was being done and how well it was being done;

b) concern was expressed that some GPs' surgeries were not convinced of the value of health checks. Mr Scott-Clark assured Members that the health checks programme was based on population, so if a local GP surgery was not willing to deliver checks, local arrangements could be made for alternative ways of delivering the programme, using patient records kept by the Family Health Service to identify eligible people. He assured Members that the rate of uptake of health checks had increased in the last year, and that the outcomes of checks would be reported back to a patient's GP for any necessary follow-up investigation or treatment needed; and

c) schools were in charge of their own budgets, including the pupil premium, which they could use at their discretion, and many used it to fund physical activity initiatives. Some public health grant was paid into Early Help and Preventative Services to be used for physical activity and healthy weight programmes for children from Reception to year 6. A big advantage of public health funds being within the County Council was that the Council had scope to use them more effectively.

2. RESOLVED that progress made in Public Health in 2014/15, and the proposed vision, strategy and commissioning intentions outlined in the report, be noted.

8. Public Health Campaigns and Press
(Item C3)

Mr W Gough, Business Planning and Strategy Manager, was in attendance for this item.

1. Mr Gough introduced the report and explained that campaigns were an important part of the public health strategy. Campaigns took three forms – service promotion (eg breastfeeding), education and awareness raising (eg HIV and flu vaccination), and social marketing to change behaviour (eg smoking in pregnancy). He responded to comments and questions from Members, including the following:-

a) it was vital that the rate of recorded suicides, particularly among men over 40, was addressed as soon as possible, and the emergence of the new suicide prevention strategy later in 2015 would be instrumental to this. GPs' surgeries could be used to promote a campaign. Mr Gough agreed that GPs' surgeries could be useful in steering a campaign but would need to be encouraged to promote it actively, as the public health team could not control how its campaigns were delivered via local surgeries. Social media could also be an effective medium by which to promote a campaign.

2. RESOLVED that the progress and impact of Public Health campaigns in 2014/15, and the campaigns planned for 2015/16, set out in the report, be noted.

9. Review of Commissioning of Drug and Alcohol Services
(Item C4)

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

1. Ms Sharp introduced the report and reminded the committee that drug and alcohol addiction services had transferred to Public Health in October 2014, before which there had been a thorough audit. This audit identified a number of issues which needed urgent action in relation to the governance of the contracts, which had been addressed. Ms Sharp and Mr Scott-Clark responded to comments and questions from Members, including the following:-

a) asked about the governance arrangements of the service, Ms Sharp reminded Members that the Cabinet Member for Adult Social Care and Public Health had taken an urgent decision in December 2014 to ensure that contracting arrangements were appropriately formalised. That decision had been reported to this committee in January 2015, and all future decision-making relating to the service would be brought to this committee so Members would have a chance to comment on it;

b) asked about powers to sequester funds from drug crime to contribute towards drug treatments, Ms Sharp explained that the County Council had no power to do this. She undertook to check the position nationally and advise the speaker of the arrangements in place; and

c) Mr Scott-Clark added that the public health team had done much work on developing needs assessments and that arrangements were being put in place to re-commission drug and alcohol addiction services in April 2015.

2. The Cabinet Member, Mr Gibbens, thanked Ms Sharp, Mr Scott-Clark and the Public Health team for their leadership and work in addressing the issues which had existed within the service as it transferred into local authority control, putting it on a much better footing for future work.

3. RESOLVED that progress made against the audit of Kent Drug and Alcohol Team (KDAAT) commissioning arrangements be noted, and the future direction for drug and alcohol services, set out in the report, be endorsed.

10. Work Programme 2015/16
(Item D1)

RESOLVED that the committee work programme for 2015/26 be agreed.

11. INFORMATION ITEM - Transition update
(Item E1)

1. The report included the recommendation which had been made to, and agreed by, the Children's Social Care and Health Cabinet Committee on 21 April 2015, including support for ongoing work on transition. This included the conduct of a

questionnaire of young people going through transition, and Mr Lobban responded to a request that a copy of this questionnaire be sent to Members of the committee.

2. RESOLVED that the information set out in the report be noted, with thanks.

12. INFORMATION ITEM - Distinctive, Valued, Personal - why Social Care matters: the next five years
(Item E2)

1. The committee was asked to note the content of the report, which was presented for information. A comment was made about the importance of the document and its conclusions and that the five priorities listed therein would need to continue to be supported by the next Government, following the 7 May general election.

2. It was suggested that the committee send a letter to the appropriate new Minister, applauding and supporting the document's recommendations and making the point above, and the Chairman undertook to look into this.

3. RESOLVED that the information set out in the report be noted, with thanks.

This page is intentionally left blank

By:	Mr G K Gibbens, Cabinet Member for Adult Social Care and Public Health
	Mr A Ireland, Corporate Director of Social Care, Health and Wellbeing
	Mr A Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee – 10 July 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

1. 20 May - Attended Shared Lives Family Visit at Dungeness Lifeboat Station
2. 2 July - Visit to Brockhill Performing Arts College

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

1. 10 June - Spoke at the Kent Sheds Celebration Event at Riverside Centre, Gravesend
2. 30 June - Spoke at Public Health Champions Celebration Event, Detling Showground.

Director of Public Health – Mr A Scott-Clark

1. Public Health Champions
2. Work Place Health
3. Campaigns

This page is intentionally left blank

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

To: Adult Social Care and Health Cabinet Committee – 10 July 2015

Decision No: 15/00055

Subject: The 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan

Classification: Unrestricted

Past Pathway of Paper: Previous versions of the Suicide Prevention Strategy have been to this Cabinet Committee on 11th July 2014 and 15th January 2015

Future Pathway of Paper: Cabinet Member decision

Electoral Division: Kent and Medway wide

Summary:

Kent County Council is the lead partner within the Kent and Medway Multi-Agency Suicide Prevention Steering Group. The Group is responsible for the oversight and implementation of the current Kent and Medway Suicide Prevention Strategy which runs from 2010-2015.

On the 11th July 2014, this Committee agreed that officers should begin the process of updating the Suicide Prevention Strategy.

On 15th January 2015 this Committee agreed an earlier draft of the strategy should be tested by public consultation.

This paper provides a report on the consultation process and asks the Committee to recommend the adoption of the 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan.

Recommendation(s)**:**

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

1. comment on and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to approve the adoption of the 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan.

1. Introduction

1.1 The effect of someone committing suicide is devastating for families and friends of the individual concerned. The impact can be felt across the whole community. This report details the final draft of the Kent and Medway Multi-Agency Suicide Prevention Strategy 2015-2020 that has completed its engagement and consultation. The strategic priorities are:

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring.

These are detailed in the attached paper.

1.2 There were 182 coroner verdicts of suicide or death by undetermined causes[1] in Kent and Medway during 2013. As shown in Table 1, this is an increase from 145 in 2012 and the largest annual number for over a decade.

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

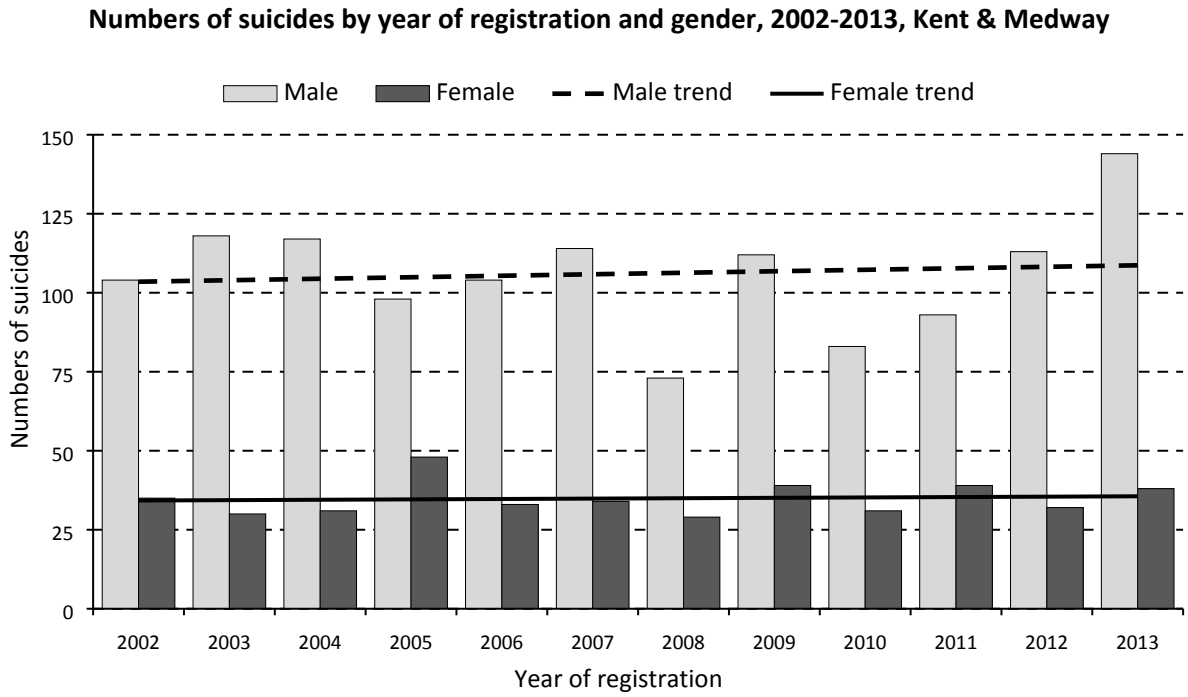
Area	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
NHS Ashford CCG	13	9	3	11	7	9	4	6	7	7	5	14
NHS Canterbury and Coastal CCG	12	16	16	16	16	17	10	20	13	14	15	21
NHS Dartford, Gravesham and Swanley CCG	22	28	27	16	18	22	8	21	15	23	23	28
NHS Medway CCG	23	12	20	21	23	22	14	19	14	13	20	31
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

1.3 Men aged between 30 and 60 is the group most likely to take their own life, and as Figure 1 shows, the majority of the recent increase has been due to suicides amongst men.

[1] Undetermined cause is a category of coroner verdict that is counted along with suicide by the Office of National Statistics and is regarded as 'probable suicide'

Figure 1: Number of suicides by year of registration and gender 2002-2013, Kent & Medway



Source: PHMF, PCMD, KMPHO

1.4 The rate of suicide is a Public Health Outcomes Framework indicator.

- The national rate is 8.8 suicides per 100,000
- In Kent the rate is 9.2 suicides per 100,000[2]

1.5 Due to the premature nature of deaths by suicide there is a very high cost in terms of years of life lost (i.e. deaths under the age of 75). Between 2011-2013 there were approximately 4,000 years of life lost due to suicides in Kent and Medway.[3]

2. Financial Implications

2.1 There is no direct budget attached to the Suicide Prevention Strategy, although it will be used to influence interventions both within Kent County Council and with partners.

3. Equalities implications

3.1 An Equalities impact assessment was undertaken as part of the Strategy and this is attached at the end of the Strategy document.

[2] Suicide rates per 100,000 between 2011-13 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/0/par/E12000008/are/E10000016 (England, 2004)

[3] KMPHO, 2014 Suicide Update

4. Strategic Statement

4.1 Working in partnership to prevent suicides will support each one of KCC's Strategic Outcomes as contained in the Strategic Statement and directly relates to the following Supporting Outcomes:

- Children and Young People have better physical and mental health
- Physical and mental health is improved by supporting people to take more responsibility for their own health and wellbeing
- People with mental health issues and dementia are assessed and treated earlier and are supported to live well.

4.2 This decision does not relate to a plan or strategy set out in the Council's Policy Framework (see Appendix 3 of the Constitution).

5. The Report

5.1 In January 2015, this Committee agreed that an earlier draft of the 2015-2020 Kent and Medway Suicide Prevention Strategy should be put out to public consultation. This paper provides a report on the consultation process and the final draft of the Strategy (and associated Action Plan) is attached for the Committee's consideration.

5.2 *Report from public consultation*

5.3 The consultation process on the draft 2015-2020 Suicide Prevention Strategy consisted of three main features:

5.4 *A stakeholder event focusing on the issue of self-harm (26th February 2015)*

5.5 Hosted by Medway PH, stakeholders discussed a wide variety of issues relating to self-harm. There was a presentation given by Medway Public Health and two organisations (KCA and VAWK) discussed how they were tackling the issue in different parts of Kent. The main points to come out of the discussion were:

- The need for early identification and intervention in relation to self-harm,
- Need for greater use of peer support,
- Need for continued education for parents and staff,
- Need to address the gap between school counselling and CAMHS,
- Need for more funding and a higher profile.

5.6 *A stakeholder event to develop the action plan relating to the draft Suicide Prevention Strategy (18th March 2015)*

5.7 Hosted by KCC Public Health, over 60 stakeholders (including service users, carers, charities, treatment providers and voluntary groups) discussed the priority groups which should be addressed by the Strategy and Action Plan, as well as prioritising some of the potential actions. Presentations were given by KCC Public Health, the Samaritans and KMPT. The main points to come out of the session were:

- There was overwhelming support for the draft priorities within the draft strategy.
- There was a high level of agreement that the key groups identified by the draft strategy are the right ones to focus on. However there was a strong feeling that the strategy shouldn't focus on particular groups to the detriment of population level measures.
- There was strong agreement that bereaved families and carers should be supported better, with suggestions as to how that could happen.

5.8 *An online consultation*

5.9 The KCC Engagement Team hosted an online survey on the KCC website in relation to the draft strategy for approximately nine weeks. Although there were a disappointing number of responses it was decided by the Suicide Prevention Steering Group not to extend the consultation period because:

- There was very good stakeholder engagement at the two consultation events and as part of the steering group
- The responses that were received were very supportive of the strategic approach and the draft priorities
- The online consultation was advertised widely through the Mental Health Action Groups and Kent Healthwatch.

5.10 Although there was strong support for the strategic approach, a number of respondents to the online survey criticised the care that individuals were currently receiving, particularly those experiencing mental health crisis.

5.11 *Updates to the Strategy and Action Plan following the public consultation*

5.12 The Strategy and Action Plan has been updated following the comments received from, and the discussion generated by, the public consultation.

5.13 Major impacts have included:

- Adding "People bereaved by suicide" and "People with new diagnosis of disability or terminal illness" to the list of people being at higher risk of poor mental health
- Including an action in the Action Plan to develop a campaign targeted at men to raise awareness of how to access mental health support. This campaign is likely to use sports organisations as a way to reach a male audience
- Adding an action to the Action Plan which commits Kent and Medway Public Health teams to share the outcomes of the Self-Harm consultation event with Emotional Health and Wellbeing Groups and review the self-harm pathway (with a particular emphasis on early intervention)
- Inviting a representative from Survivors of Bereavement by Suicide (SoBS) to join the Steering Group
- Public Health and KMPT committing to examine whether to adopt a "Zero-Suicide" ambition.

6. Conclusions

The development of the 2015-2020 Suicide Prevention Strategy and Action Plan is now complete and is attached for the Committee's consideration

7. Recommendation(s)

Recommendation(s)**:**

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

1. comment on and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to approve the adoption of the 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan.

8. Background Documents:

None

9. Appendices:

2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan

10. Contact Details

Report Authors

Tim Woodhouse, Public Health Programme Manager
tim.woodhouse@kent.gov.uk
03000 416857

Jess Mookherjee, Public Health Consultant
jessica.mookherjee@kent.gov.uk
03000 416493

Relevant Director

- Andrew Scott-Clark, Director of Public Health
  03000 416659
  andrew.scott-clark@kent.gov.uk

KENT AND MEDWAY MULTI-AGENCY SUICIDE PREVENTION STRATEGY 2015-2020

Final draft (v.15) for approval

This draft strategy has been updated following the public and stakeholder consultation in early 2015.

Acknowledgments

Thanks to all the members of the Kent and Medway Suicide Prevention Steering Group for their support in developing this strategy. Membership of the group includes individuals from the following organisations:

British Transport Police
Canterbury Christ Church University
Carers Representatives
Kent Coroners
Kent and Medway Partnership Trust (KMPT)
Kent County Council
Kent Police
Medway Council
Network Rail
NHS England
Rethink Mental Illness
The Samaritans
West Kent Clinical Commissioning Group (West Kent CCG)

Thank you too, to the many individuals and organisations who took part in the consultation events and completed the online consultation survey.

Contents

1. *Introduction*

1.1 Every suicide is a tragic event which has a devastating impact on the friends and family of the victim, and can be felt across the whole community. While the events and circumstances leading to each suicide will be different, there are a number of areas where action can be taken to help prevent loss of life.

1.2 This strategy is a continuation of work undertaken as a result of the 2010-2015 Kent and Medway Suicide Prevention Strategy. While there has been progress in many areas, sadly suicide still accounts for approximately 1% of all deaths in Kent and Medway every year. Kent and Medway also has a higher rate of suicide than the national average (9.2 per 100,000 compared to 8.8 per 100,000 2011-2013 pooled data).

1.3 This strategy combines evidence from suicides in Kent with national research and policy direction. It is clear from both local and national experience that suicide prevention is not the sole responsibility of one agency; most progress can be made when the public sector, charities and companies work together to deliver a range of measures.

1.4 This is why this strategy has been developed by the Kent and Medway Suicide Prevention Steering Group which consists of a range of partners doing what they can (both individually and together) to reduce the number of suicides in Kent and Medway. A wider consultation process (featuring two consultation events and an online survey) took place between January and March 2015 to ensure that the widest number of individuals and organisations had their chance to input. (A review of the responses to the consultation is included as Appendix ii).

1.5 To ensure that this strategy does not discriminate unfairly against any particular group within Kent and Medway, an equality impact assessment (EqIA) was also undertaken during the drafting process. (The EqIA is included as Appendix iv).

1.6 The Suicide Prevention Steering Group will co-ordinate the delivery of the action plan and monitor progress against the strategic priorities at regular meetings and by providing updates to the Adult Social Care and Health Committee of Kent County Council (KCC) and the Medway Health and Wellbeing Board.

2. *National policy context*

2.1 Since the publication of Kent and Medway's 2010-2015 Suicide Prevention Strategy in 2010, the Coalition Government has published the *Preventing Suicide in England*[1] national strategy in 2012 and a '*One Year On'* progress report in January 2014[2]. The priorities contained within the 2012 national strategy match the strategic priorities within the *Kent and Medway Suicide Prevention Strategy 2010-15* very well, however the '*One Year On'* national progress report identified six issues which will need further examination in a Kent and Medway context. These are;

- Self-harm
- Supporting people's mental health in a financial crisis
- Helping people affected or bereaved by suicide

[1] *Preventing suicide in England; A cross-government outcomes strategy to save lives*
[2] *Preventing suicide in England: One year on*

- Improve wellbeing and access to services for middle aged men
- Improve wellbeing and access to services for children and young people
- Improve data and information from coroners

2.2 In September 2012 the Department of Health published "*Prompts for local leaders on suicide prevention*"[3] which is a checklist of questions designed to aid the development and implementation of local suicide prevention policies.

2.3 Other relevant policy developments have included Public Health England publishing the *Public Health Outcomes Framework 2013-2016*[4] in November 2013 (which includes indicators on both suicide and self-harm), and the National Institute for Health and Care Excellence (NICE) issuing new guidance on self-harm in June 2013[5].

2.4 In April 2014, the Coalition Government published an update to its mental health strategy[6]. It seeks 'Parity of Esteem' for people with mental health disorders and recommends that public services should reflect the importance of mental health in their policy planning by putting it on a par with physical health.

2.5 In 2014, The World Health Organisation produced a global report on suicide prevention (WHO 2014). It highlights that suicide occurs all over the world and can take place at almost any age. Globally, suicide rates are highest in people aged 70 years and over, although this does vary depending on the country. The report is a call for action to address suicide and it emphasises the importance of reducing access to means of suicide and ensuring that there is responsible reporting of suicide in the media and early identification and management of mental and substance use disorders in communities and by health workers in particular. WHO Member States have committed themselves to work towards the global target of reducing the suicide rate in countries by 10% by 2020.

2.6 In August 2014 the Chief Medical Officer's Annual Report on Public Mental Health Priorities found that "It is increasingly apparent that suicide prevention in geographical areas must have sound backing from local authorities, including public health. Such agencies can provide the stimulus for important local initiatives and their evaluation".[7]

2.7 More recently, (September 2014) Public Health England has published "*Guidance for developing a local suicide prevention action plan*". The document gives local authorities further advice about how to develop a suicide prevention action plan, monitor data and trends as well as improving mental health in the area.

2.8 In February 2015 the Coalition Government published "Preventing suicide in England: Two years on". This document highlighted three areas of England which have adopted a "Zero Suicide" ambition and asked other areas to consider the concept. As a result, the consultation process for this strategy did consider it, and more work will be done in the first year of the strategy to understand how the best elements of the approach can help Kent and Medway.

2.9 The development of this strategy has been shaped by the themes and principles contained within all of the documents referenced above.

---

[3] *Department of Health Prompts for local leaders on suicide prevention*
[4] *Public Health Outcomes Framework 2013-2016*
[5] *NICE Guidance Quality Standard 34 self-harm*
[6] *Making mental health services more effective and accessible*
[7] *Chief Medical Officers Annual Report p 243*

3. Kent policy context

3.1 Since the development of the 2010-2015 Kent and Medway Suicide Prevention Strategy the context of mental health commissioning has changed greatly. CCGs have replaced PCTs and have assumed system leadership of mental health services, KCC and Medway Council remain the leads for social care and the respective Public Health departments lead on prevention and wellbeing. Health and Wellbeing Boards have been established and commissioning arrangements in relation to the criminal justice system, and drug and alcohol treatment services have also changed considerably.

3.2 The current strategy for mental health commissioning in Kent is the "Live It Well" strategy. This is due for a refresh in 2015. When considering the Suicide Prevention Strategy, it is important to note that it forms a part of a wider mental health strategy.

3.3 During the development of this Strategy, the Kent and Medway Crisis Care Concordat has been signed by over 30 agencies and organisations all committing to give better support to those individuals who experience a mental health crisis. The Suicide Prevention Steering Group will maintain close links with the Concordat to share learning and ensure the impact of any actions are maximised.

4. Current statistics

4.1 There has been an increase in the annual number of people taking their own life in Kent and Medway. This section sets out a number of statistics relating to those suicides and the information has been used to shape the strategic priorities contained in Section 5 of this strategy.

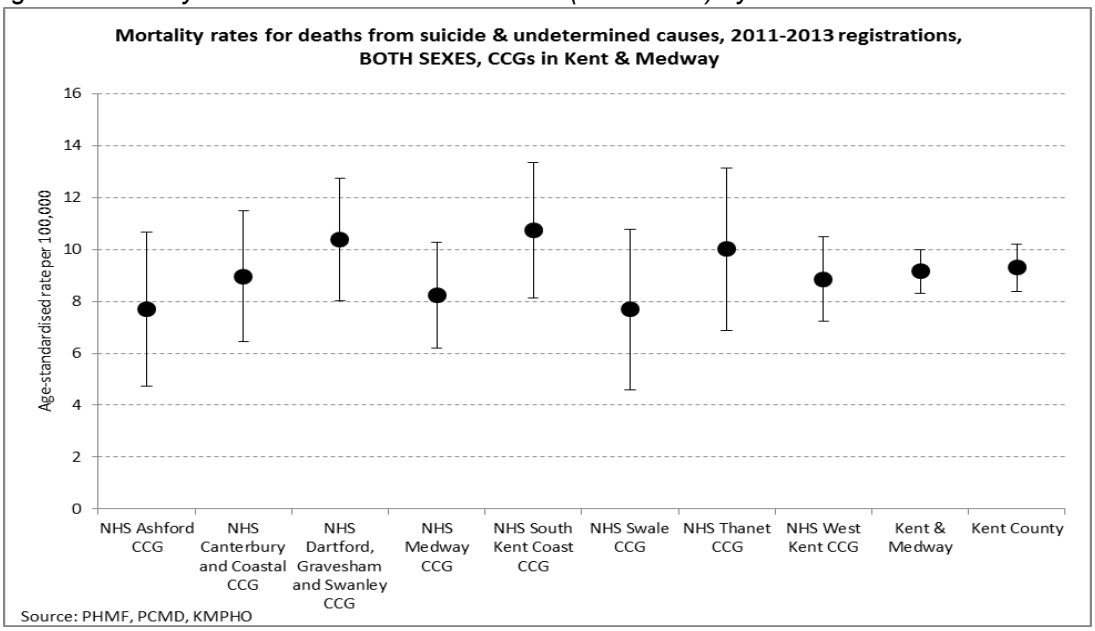
Table 1: Annual number of deaths from suicide and undetermined causes, CCGs in Kent & Medway, both sexes, 2002-2013 registrations

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

4.2 The data in Table 1 shows the number of deaths from suicide and undetermined causes for the different Clinical Commissioning Groups (CCGs) across Kent and Medway. There was a considerable increase in the overall number of suicides in 2013 compared to any of the previous years. The rates of suicide across Kent CCG's (Fig 1 on next page) show that Thanet, South Kent Coast and Dartford, Gravesham and Swanley CCG's have higher rates than the Kent average.

Figure 1 Mortality rates from deaths from suicide (2011-2013) by Kent CCGs.



4.3 The Kent and Medway rate of 9.2 suicides per 100,000 population (2011-2013 pooled data) is higher than the national rate of 8.8 per 100,000 (2011-13 pooled data).

4.4 However these rates mask the gender differences in suicide. Males are more likely to commit suicide then females (Figs 2 & 3). The rate for males in Kent and Medway (2011-13) is 14.5 deaths per 100,000 people. Nationally the rate is 13.8 per 100,000 for men. For females in Kent and Medway, it is 4.2 deaths per 100,000 compared to 4.0 nationally. This highlights the need for prevention services to be targeted towards men, who traditionally are low users of services such as talking therapies.

4.5 For males the rates are higher in Canterbury and Coastal, Dartford, Gravesham and Swanley, South Kent Coast and Thanet CCGs. Rates for females are highest in West Kent and Ashford CCGs.

Figure 2. Mortality rates from suicide and undetermined causes, Kent & Medway, by year of registration and gender, 2002-2013

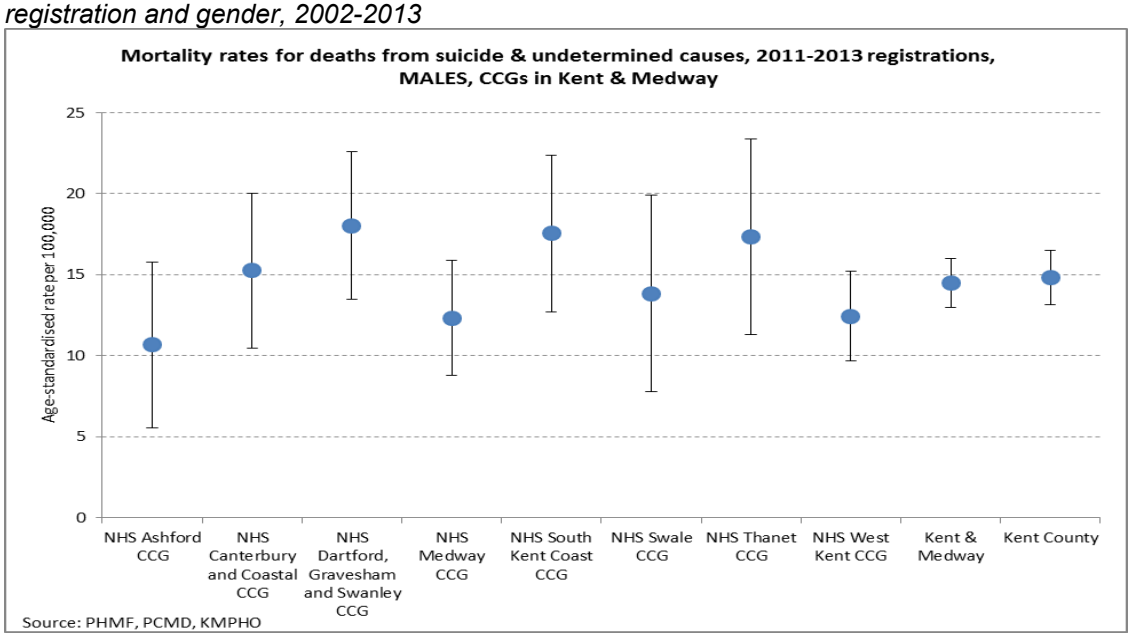
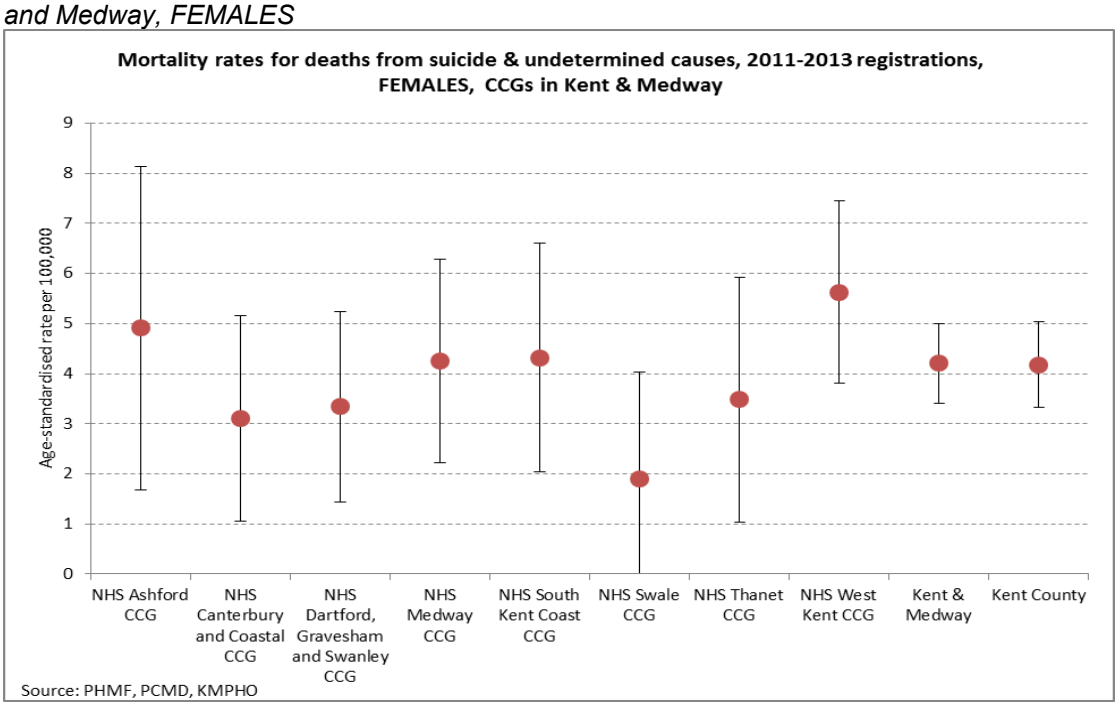


Figure 3: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, FEMALES



4.6 Gender and age

Figures 4 and 5 show the number of deaths from suicide and undetermined causes for Kent & Medway, by age band and gender between 2002-2013 and the number of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender. The data show that the suicide numbers are considerably higher in men for all age categories. The highest numbers are in men aged between 40 and 54 years old.

Figure 4 Numbers of suicide by year of registration and gender

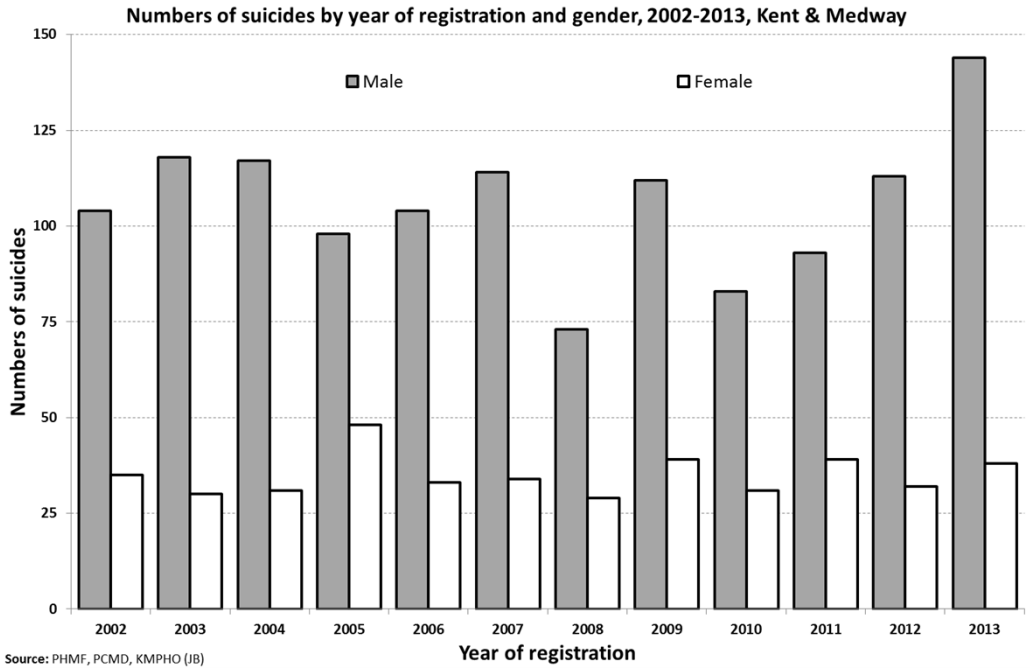
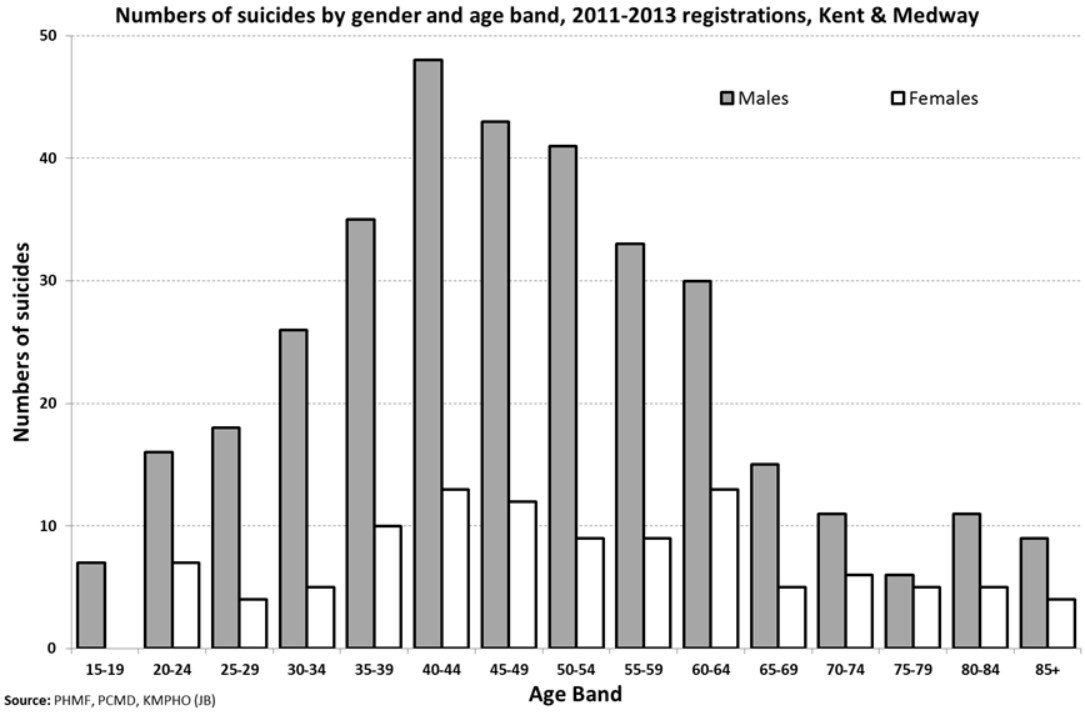


Figure 5: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender, 2011-2013 registration.



4.7 Country of birth

Coroners do not currently record ethnicity on death certificates, however they do record country of birth. While this is not a good indication of ethnicity, in order to see if there were any notable trends, the Kent and Medway Public Health Observatory has examined the country of birth of 1730 individuals in Kent who took their life between 2002 and 2013. The vast majority were born in England, and the next two most frequent countries of birth were Scotland and Wales. However eleven people born in Poland, nine born in India, and eight born in Germany have killed themselves in Kent between 2002 and 2013.

4.8 As part of the implementation of this strategy, the Steering Group will monitor suicide statistics relating to country of birth and work with other agencies (both locally and nationally) to try and improve the ability to assess the risk of suicide within ethnic groups.

4.9 Occupation

The coalition Government's 2012 Preventing Suicide in England strategy identified that "some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers and other agricultural workers are at higher risk probably because they have ready access to the means of suicide and know how to use them."[8]

4.10 However it goes on to say that "Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly."[9]

[8] P.19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

[9] Same reference as 7

4.11 It is for this reason that during the preparation of this Strategy, the Kent Public Health Observatory examined the occupation (as written by the Coroner on the death certificate) of 1730 individuals in Kent who took their life between 2002 and 2013.

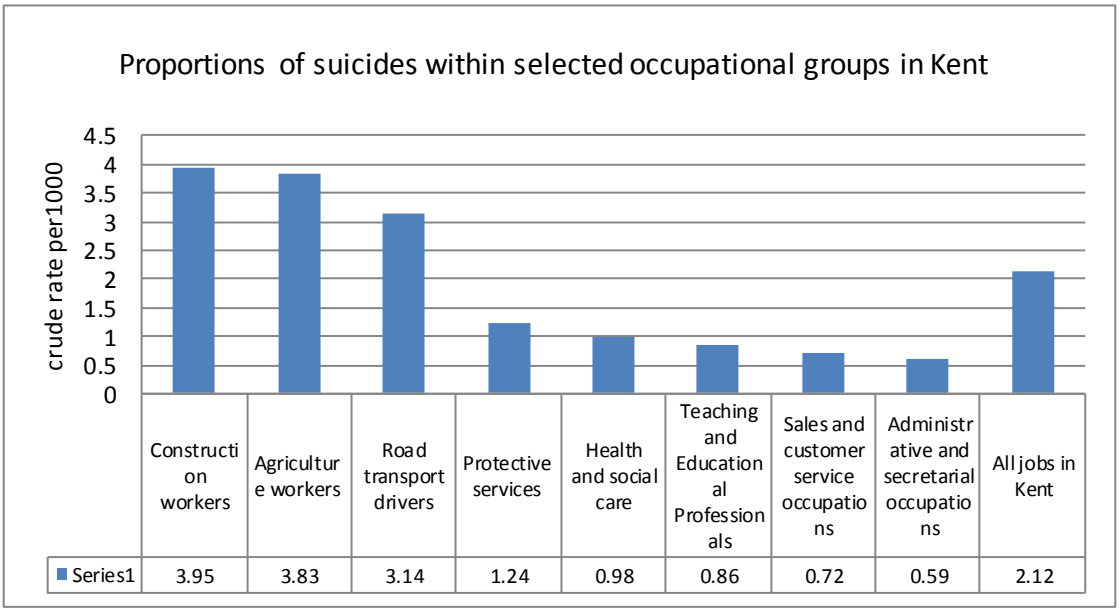
4.12 The following table groups the occupations into categories, and shows that the highest numbers of suicides are within the "Professional and managerial" and the "Construction, transport and building trades" categories.

Table 2 Occupations of suicide victims in Kent between 2002-2013 KMPHO

Occupation type	Numbers of suicides in Kent between 2002 and 2013
Professional and managerial	497
Construction, transport and building trades	462
Sales, services and administration	290
Health and personal services	105
Leisure, media and sport	74
Agriculture	50
Protection services	42
IT, Science and Engineering	41
Unknown	169
Total	**1730**

4.13 It is important to note that these are *numbers* rather than *rates* and do not take into account the scale of the differences within these occupations in Kent. The chart below matches the numbers of suicides with the number of people within each occupation in Kent (as taken from the 2011 Census) to calculate a crude rate. Although this data should be met with some caution, it does give an indication of which occupations are more vulnerable.

Figure 6 Proportion of suicides within selected occupational groups in Kent 2002-13



Source: Kent Public Health 2014 and the 2011 Census

4.14 Figure 6 shows that construction workers had the highest crude rates of suicide of any occupation group between 2002-13, closely followed by agricultural workers. Road transport drivers also had a rate well above the average for all jobs in Kent and Medway. Agricultural workers were one of the high risk occupations identified nationally, however construction workers and road transport drivers were not. Health workers in Kent and Medway have a comparatively low rate despite being one of the nationally highlighted high risk occupations.

4.15 Method of suicide

Figure 7 shows the total numbers of deaths from suicide and undetermined causes broken down by method. It compares the 2004-2008 period with 2009-2013. The data show that between 2009-2013, there were more suicides via hanging and jumping in comparison to 2004-2008, although there were fewer people taking their own life via gas and smoke.

Figure 7 Total numbers of deaths from suicide and undetermined causes, comparing 2004-8 with 2009-13, males and females, main suicide method, Kent and Medway

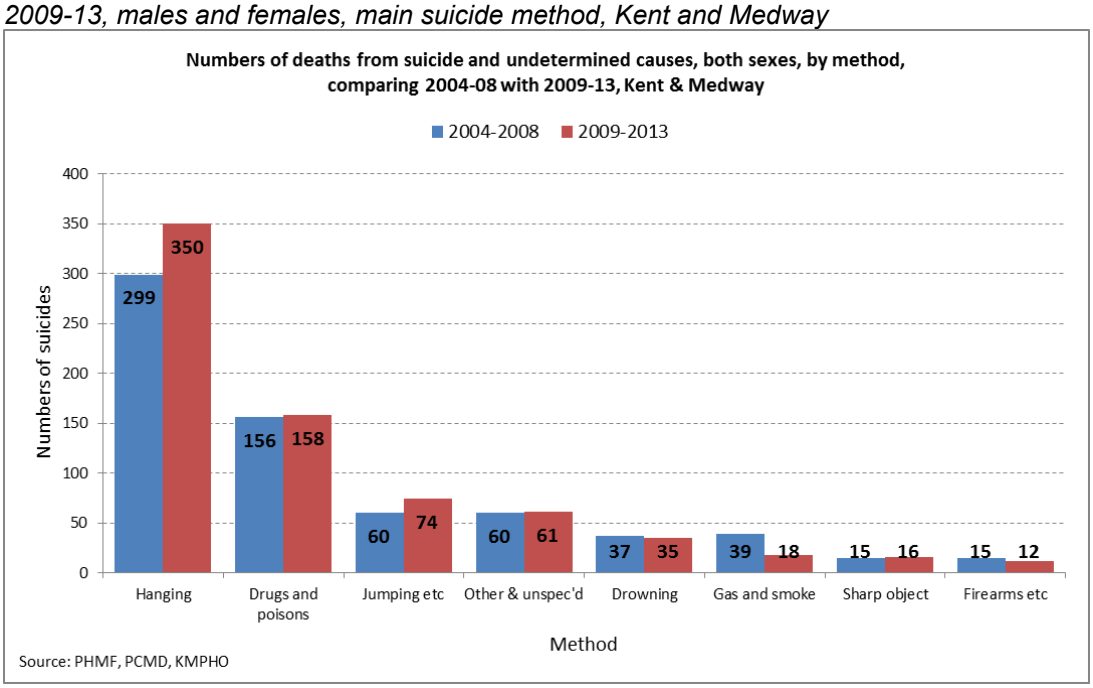
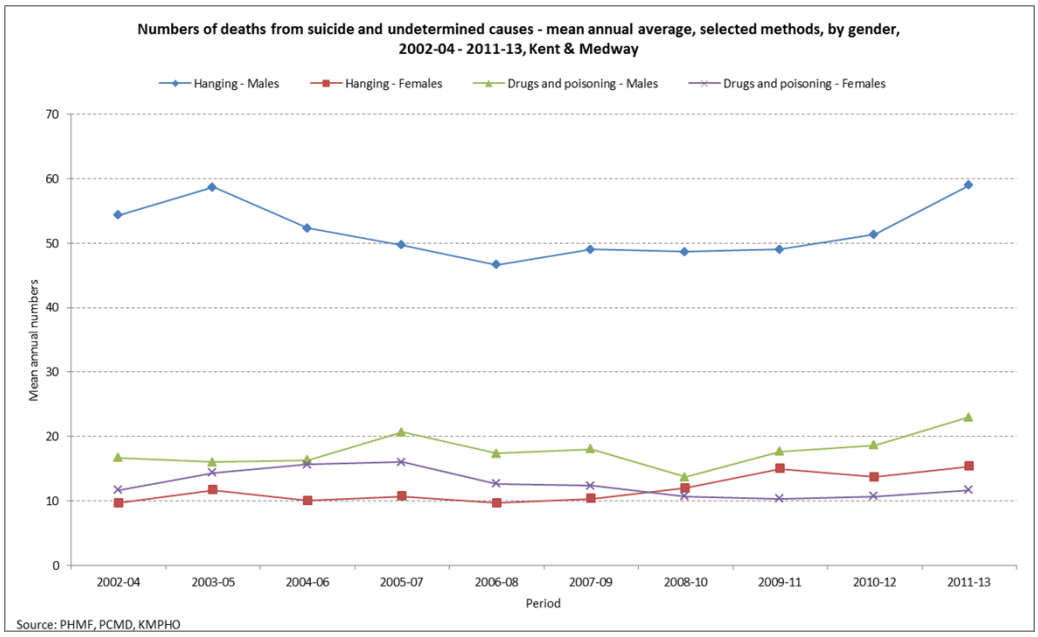


Figure 8 (following page) shows the annual average numbers of deaths from suicide and undetermined causes from selected causes for males and females between 2002 and 2013.

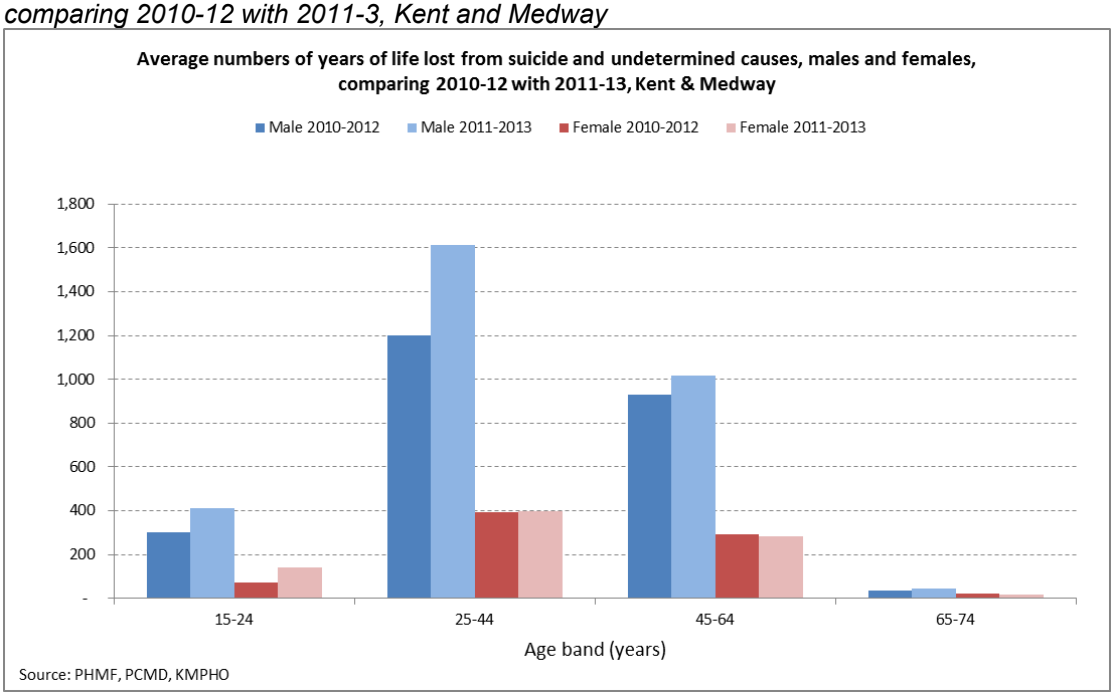
Figure 8: Annual average numbers of deaths from suicide and undetermined causes, 2002-4 – 2011-13, males and females, main suicide method, Kent and Medway



4.16 Years of life lost

Figure 9 shows the annual average years of life lost from suicide and undetermined causes, males and females comparing 2010-12 with 2011-13. As one would expect, the average years of life lost is considerably greater in younger men aged between 25 and 44 years of age. However, the number of life years lost in men in this age group increased by 33% in 2011-2013.

Figure 9: Annual average years of life lost from suicide and undetermined causes, males and females comparing 2010-12 with 2011-3, Kent and Medway



4.17 Self-harm

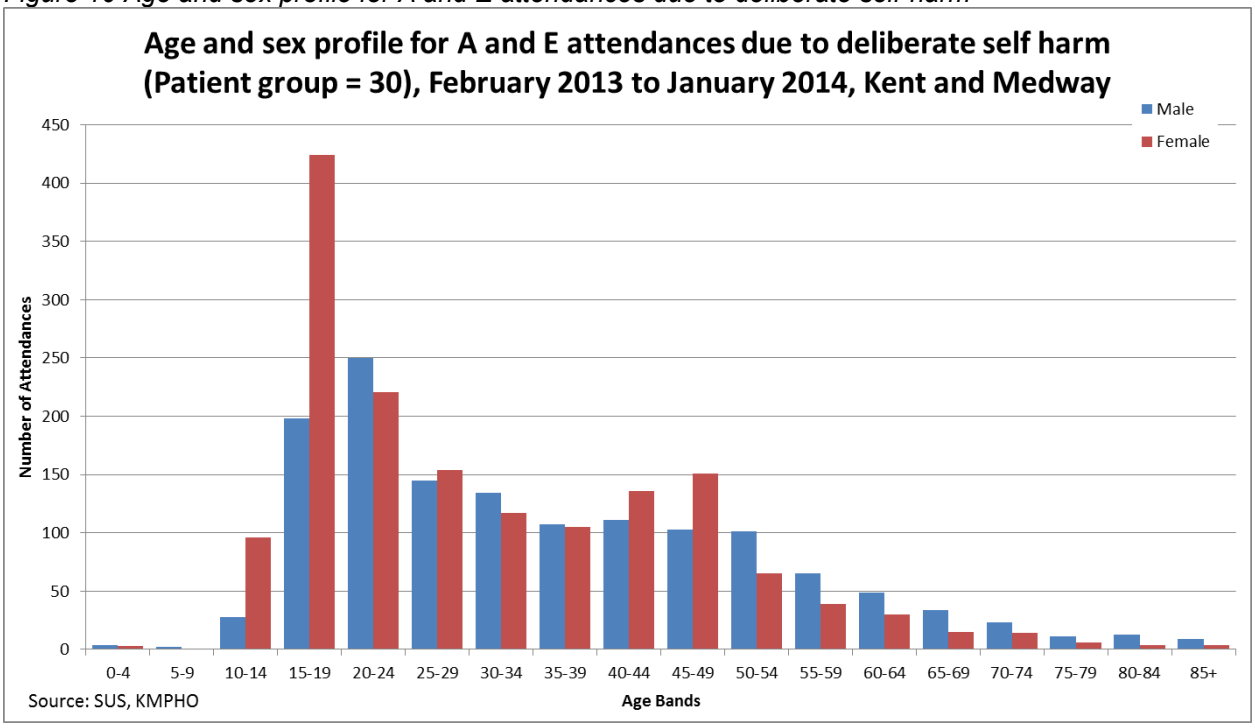
Not everyone who self-harms is suicidal, and not everyone who takes their own life self-harms first. However for some people self-harm can be an indicator that they are suffering from depression or another mental illness. Across England the average rate of admissions as a result of self-harm amongst 10-24 year olds is 346.3 per 100,000. Table 3 shows that the Kent rate in the same time period was 364.2, and increased in the following year.

Table 3 Age-Standardised Rate (ASR) per 100,000 10-24 year olds for hospital admissions as a result of self-harm

Persons	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
	ASR	ASR	ASR	ASR	ASR
NHS Ashford CCG	306.7	314.7	282.0	260.7	440.9
NHS Canterbury & Coastal CCG	397.1	409.8	374.8	313.7	395.0
NHS Dartford, Gravesham & Swanley CCG	405.5	428.7	395.8	360.2	354.9
NHS South Kent Coast CCG	462.1	376.3	386.7	496.8	506.3
NHS Swale CCG	516.6	379.5	485.2	233.0	311.7
NHS Thanet CCG	541.2	627.9	618.0	473.7	475.5
NHS West Kent	479.5	399.8	376.1	365.1	439.8
Kent	443.2	415.2	400.5	364.2	416.3

4.18 Figure 10 shows that the highest number of A&E attendances for deliberate self-harm come from young women between the ages of 15 and 19.

Figure 10 Age and sex profile for A and E attendances due to deliberate self-harm



5. Review of 2010-2015 Strategy

5.1 The 2010-15 Kent and Medway Suicide Prevention Strategy focused on the following priorities:

- To reduce risk in key high risk groups
- To promote wellbeing in the wider population
- To reduce the availability and lethality of suicide methods
- To improve the reporting of suicidal behaviour in the media
- To ensure appropriate monitoring of suicide statistics and audit of services.

5.2 During the lifetime of the strategy, progress in relation to each of the priorities has included the following;

- **To reduce risk in key high risk groups**
    - Men's sheds, and other men's health groups, have been established across Kent and Medway to being men together to put their practical skills to good use and encourage them to be more socially active and improve mental wellbeing
    - Primary Care Mental Health link workers have been commissioned in Kent to provide extra support to people with mental health conditions in the community
    - KMPT have developed a suicide prevention strategy and action plan. A number of actions have been completed including a ligature audit with appropriate actions implemented, a GRIST risk assessment tool (a psychological model of how people think and reason) being piloted and training on Applied Suicide Intervention Skills has been delivered
    - Kent Drug and Alcohol Action Team serious incident review panel have reviewed all cases of suicide in contact with alcohol and drug services at the time of death
    - Research has been conducted into Suicide and Older People within Kent by Canterbury Christ Church University
    - Health professionals in Kent and Medway have been offered a variety of training around self-harm awareness and suicide prevention (safe assessment, triage, providing an immediate response).

- **To promote wellbeing in the wider population**
    - Kent County Council has commissioned Sevenoaks Area Mind to deliver a series of free to access Mental Health First Aid training courses. These courses are designed to help people recognise mental health problems and encourage someone to seek help
    - Free to access psychological support is available across Kent and Medway through the IAPT 'Talking therapies' programme
    - Kent County Council and Medway Council have both launched wellbeing programmes to help people take little steps and make a big difference to their wellbeing. (Kent has Six Ways to Wellbeing, while Medway has Five Ways to Wellbeing)
    - "Help is at Hand" suicide bereavement support packs have been distributed across Kent and Medway including to GP surgeries for people bereaved by suicide
    - ASIST (Applied Suicide Intervention Skills Training) has been delivered in Medway and Kent
    - SAFE is a youth-led project delivered by Voluntary Action Within Kent (VAWK). It seeks to raise awareness of mental health, reduce suicide, break down stigma, and encourage young people to talk about their feelings, recognise the danger signs and to seek support - if and when they need it.

SAFE has been set up within three Medway schools with the help of volunteers from the Upper Years and Sixth Form.

- **To reduce the availability and lethality of suicide methods**
  - Work has been undertaken with local agencies to identify hotspots and take appropriate action to minimise further suicides. Examples include, Kent County Council working with Samaritans regarding sign installation at a bridge over the M20 in Ashford, Medway Council has put up Samaritans signage and is also considering further hardening measures at Brook car park in Chatham.

- **To ensure appropriate monitoring of suicide statistics and audit of services.**
  - Relationships with National Rail, Kent Police, KMPT and the Coroner have been developed and improved and agencies regularly share statistics (where appropriate) so that trends can be monitored.

5.3 There is potential to continue to make improvements in a number of areas through the 2015-2020 strategy including;

- More activity focussing on the issue of self-harm
- Supporting families bereaved by suicide
- Implementing the results of evidence reviews around suicide and older people

6. Strategic priorities

6.1 When deciding on the strategic priorities, consideration has been given to both local statistics, and national guidance. While local insight will shape how each priority is delivered within Kent and Medway, the Kent and Medway Suicide Prevention Steering Group has agreed that there is nothing particularly different about suicidal behaviour locally which would mean that national objectives would not be appropriate here. This decision was very strongly supported through the consultation process. Therefore the strategic priorities that this strategy adopts mirror the national areas for action almost exactly. They are as follows;

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring

6.2 More details about how each of these strategic priorities will be shaped and delivered in Kent and Medway is given below, and they form the structure for the draft action plan which is attached to this report.

6.3 <u>Priority i. Reduce the risk of suicide in high-risk groups</u>

The national strategy identified the following high risk groups as priorities for action:

- Young and middle aged men
- People in the care of mental health
- People with a history of self-harm

- People in contact with the criminal justice system
- Specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers.

6.4 A year after the national strategy was launched, the coalition published their *One Year On* report which identified that middle age men (aged 35-54) were now the group with the highest suicide rate. The One Year On report also suggested that Children and Young People should also now be a particular focus for national prevention work.

6.5 Having considered the nationally identified high-risk groups, as well as local data and the results of the public consultation, the Kent and Medway Suicide Prevention Steering Group have identified the following groups as being of particular concern in Kent:

- Those in contact with mental health services
  The 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that between 2002 and 2012 suicides by people known to secondary *mental health services accounted for 28% of the total number of UK suicides.[10] In Kent and Medway there were 36 coroner confirmed suicides in 2013 who had had contact with KMPT in the previous 12 months.*

  The Steering Group will continue to engage with the Mental Health Crisis Concordat Steering Group and providers of secondary mental health services in Kent and Medway to help them with them efforts to reduce suicides in this population. Specific actions to address this issue are included in the accompanying action plan.

- Those who have self-harmed
  During the early stages of the consultation process for this strategy, stakeholders raised a particular concern regarding levels of self-harm. As a result, Medway Public Health hosted a consultation event focusing entirely on this issue. During the event over 70 stakeholders discussed the reasons why people self-harm and statistics relating to the local prevalence of self-harm. The event identified that more support needs to be given to people who self-harm before they reach a level where they attend A&E or are admitted to hospital. Specific actions to address this issue are included in the accompanying action plan.

- Offenders
  During the development of this strategy it became apparent that there has been a sharp increase in the national number of prisoners taking their own lives while in custody. Discussions with local prison representatives and NHS England (who commission health services in prison) confirmed that this was a trend that was also being seen in Kent and Medway. The Howard League for Penal Reform identified that HMP Elmley (in Sheppey) and HMP Wandsworth (in London) had both seen four inmate suicides in 2013 which is the higher than any other prison in England.[11] Specific

10 http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/report_press_release_2014.pdf

actions to address this issue are included in the accompanying action plan.

- Middle aged and older men
  The suicide rate for men in Kent and Medway (2011-13) is 14.5 deaths per 100,000 people. Nationally the male rate is 13.8 per 100,000. As Figure 5 on page 6 shows, middle aged and older men have the highest rates of suicide in Kent and Medway. This fits the national pattern and it is often believed that it is a result of this group not accessing support services as readily as other groups, and also because they choose more violent (and likely to complete) methods of suicide attempt. This group was a priority under the previous strategy and a number of initiatives (like Men's Sheds) have already started. Further specific actions to address this group (such as a communications campaign) are included in the accompanying action plan.

- High risk occupation groups such as construction, agriculture and road transport drivers
  The research undertaken as part of this strategy development has identified that certain occupation groups have higher suicide rates than others. The Steering Group will identify the best way to work with these occupations and specific actions to address these groups will be included in future versions of the action plan.

6.6 There was a strong feeling amongst some stakeholders that the strategy shouldn't focus too heavily on particular groups in case it missed opportunities to intervene in the general population. Therefore the Steering Group will ensure that it monitors statistics and trends in all groups, as well as the general population, and will review which and how many groups it prioritises regularly.

6.7 Priority ii. Tailor approaches to improve mental health and wellbeing in Kent and Medway

Not everyone who has a mental illness will be suicidal, and not everyone who takes their own life will have been diagnosed with a mental illness. Therefore as well as ensuring that mental health services provide the best possible support to those they come in contact with, wider support to improve the mental health and well-being of other groups and the general population is needed.

6.8 The Live It Well mental health strategy is designed to improve mental health across Kent and Medway. As well as helping people stay well, it focuses on ensuring that people with mental health needs – which will be one in four of us at some point in our lives – get the care they need. It sets out a vision for promoting mental health and well-being, intervening early and providing personal care when people develop problems, and focusing on helping people to recover.

6.9 The Live it Well strategy is supplemented by a detailed website (www.liveitwell.org.uk) which is an excellent source of information, help and guidance and is designed to help people connect with their local communities. It also provides the contact details of over 400 charities, community groups and supports services which provide help to individuals with a wide range of mental health issues.

[11] http://www.howardleague.org/suicide-in-prison/

6.10 As part of the Live it Well strategy, Kent County Council launched the Six Ways to Wellbeing campaign and Medway Council has launched the Five Ways to Wellbeing campaign. Both campaigns are designed to raise the levels of wellbeing by helping individuals to make small actions which make a big difference to their mood and mental resilience.

6.11 The campaigns are based on research undertaken by the New Economics Foundation Scientific (2010). The research points to five steps that can improve mental wellbeing. They are;

- Taking notice
- Connecting
- Giving
- Keep learning
- Being active

6.12 Kent's Six Ways of Wellbeing also include Caring (for the planet) as an additional step.

6.13 Mental Health First Aid (MHFA) training is one way to increase awareness and reduce stigma about mental illness and the Steering Group will continue to promote the MHFA courses being funded by KCC Public Health, and those being delivered by Medway Public Health.

6.14 Raising awareness of mental illness, reducing stigma and ensuring that individuals have easy ways to access support for low level mental health conditions is an important way of reducing the likelihood that they will need more intensive support in the future. The Steering Group will continue to promote campaigns and services such as the Mental Health Matters 24hr support line and the wide range of NHS talking therapies.

6.15 In addition to campaigns aimed to improve the mental health of the whole population, the Steering Group and the public consultation identified that the following groups are at particular risk of poor mental health and therefore need specific activities to address their needs. The Steering Group doesn't have capacity to develop specific interventions for each of these groups, however by identifying them in this strategy the Steering Group recommends that commissioners and service providers do provide extra support wherever possible. Groups which aren't on the list will not be ignored, and the list will be reviewed regularly.

- Socially excluded and deprived groups
- BME communities
- Domestic abuse victims and survivors
- Women during and after pregnancy
- Young people leaving care
- Children and young people
- Students
- Older people (especially those who have recently lost long term partners)
- People who misuse drugs and alcohol
- Veterans
- LGBT
- People experiencing financial crisis
- People experiencing relationship difficulties

- Offenders/ex-offenders
- People bereaved by suicide
- People with new diagnosis of disability or terminal illness

6.16 Priority iii Reduce access to the means of suicide

Research has shown that work to reduce the availability and lethality of suicide methods is effective in preventing deaths. Suicidal intent can fluctuate with time and therefore actions which make it more difficult for people to take their own life can prevent deaths by deterring suicide until the level of intent subsides.

6.17 At the national level, restrictions on the amount of paracetamol products which can be bought in one transaction, and the fitting of catalytic converters on cars as standard, have been credited with reducing the number of suicides by poisoning and inhalation respectively.

6.18 At a local level, the Suicide Prevention Steering Group includes members from KMPT and Network Rail, two organisations who continue to take action to make it more difficult for individuals to take their own lives. For instance KMPT undertake regular audits of their wards to reduce the number of ligature points, and Network Rail monitor incidents on tracks and at stations and take action to make it more difficult for members of the public to access railway lines.

6.19 The Suicide Prevention Steering Group will regularly monitor statistics concerning the method and location of suicides in Kent to establish whether further action is needed to reduce the access to particular means of suicide.

6.20 Priority iv Provide better information and support to those bereaved or affected by suicide

Losing a loved one in any circumstance is difficult, losing someone to suicide can bring additional layers despair. It is not surprising that family and friends bereaved by suicide are at an increased risk of mental health and emotional problems.

6.21 This subject was the focus of a detailed session at the consultation event hosted by Kent Public Health, where over 60 stakeholders discussed what support families and friends need when they lose a loved one to suicide. These were the key points from the consultation:

- Specialist bereavement by suicide counselling should be offered rather than general counselling
- Support should be offered in an ongoing manner, rather than as a one off
- There should be better promotion of support groups such as Survivors of Bereavement by Suicide (SOBS) and Slideaway
- Family counselling needs to be available

6.22 Voluntary sector charities and organisations can be particularly effective in supporting bereaved families and GPs, primary care professionals and other agencies need to be attentive to the vulnerability of family members and aware what support is available.

6.23 Post-suicide interventions for schools have also been created by organisations such as the Samaritans and Voluntary Action Within Kent. The SAFE initiative encourages young people within their schools to consider their mental health and signpost those

who would like to seek more support. Through peer to peer support and signposting, the project aims to break down the stigma surrounding mental health.

6.24 During the development of this strategy discussions were had with a representative of the Survivors of Bereavement by Suicide (SOBS) charity who have a number of support groups running across the county. SOBS have been invited to join the Steering Group to give expert advice about how families can be supported better. Further specific actions to address this group are included in the accompanying action plan.

6.25 Priority v Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The media have a significant influence on behaviours and attitudes and there is evidence that the reporting and portrayal of suicide can lead to copycat behaviour among young people and those at risk.

6.26 It is important that the media is supported to raise awareness to prevent suicides. For example, campaigns focused on World Suicide Prevention Day could be promoted each year. The media also needs to be monitored in relation inappropriate reporting of suicide and support should be given to help them improve their coverage.

6.27 The Suicide Prevention Steering Group will continue to monitor local media and aims to develop relationships with representatives of the media in order to support improved reporting of suicide coverage in the media.

6.28 While the internet can be used to provide excellent support to vulnerable individuals who would otherwise be reluctant to access services, there is growing awareness of the use of social media and websites to promote suicidal ideology and risky behaviours such as self-harm. As a local Suicide Prevention Group there is very little that the Steering Group can do to police what is available on the world wide web, but it will support the efforts of the KCC e-Safety Officer and others to raise awareness of professionals and parents about what is online and how they can help to reduce the likelihood that young people in Kent and Medway will access it. Just as importantly, the Steering Group will also support efforts to raise awareness amongst young people themselves so that friends are better able to support each other.

6.29 Priority vi Support research, data collection and monitoring

6.30 Ensuring that there is reliable and timely data on suicides and self-harm is vital when deciding how to prioritise actions. The Suicide Prevention Steering Group will regularly review and share available data on suicides in Kent and Medway to be sure that the correct priorities are being addressed.

6.31 The Group will also utilise other data sources that are not routinely or systematically reported. This is likely to include data from the coroner's office, Kent Police, Network Rail and Kent and Medway Social Care Partnership Trust (KMPT). The data should be regularly monitored by key partners and relevant actions will be taken.

6.32 Having an awareness of the research that has been conducted around suicide prevention is also fundamental to improve understanding of risk groups and developing and evaluating interventions that can be effective in preventing suicides. This awareness can be improved by utilising working relationships with academic institutions, who could disseminate relevant research, journal articles, reports and publications to key stakeholders working to prevent suicides in Kent and Medway.

6.33 For example, in 2014 Canterbury Christ Church University undertook a research project on older people and suicide. This work has been presented to the Steering Group and has been considered as part of this strategy development process.

Appendix i Suicide Prevention Action Plan

Priority 1: To reduce risk in key high risk groups

The following key high risk groups have been identified by Kent and Medway Suicide Prevention Steering Group following the public consultation:

- Those in contact with mental health services
- Those who have self-harmed
- Offenders
- Middle aged and older men
- High risk occupation groups such as construction, agriculture and road transport drivers

	Action needed	Lead agency/contact	Estimated completion date
1)	KMPT to implement and continually review their suicide prevention strategy	KMPT	Ongoing
2)	Support and promote the Kent and Medway Crisis Care Concordat - Work with partners to implement the Concordat and associated action plan to support people in crisis due to a mental health condition	Kent Police, West Kent CCG	Ongoing
3)	Kent and Medway Public Health to meet with KMPT to discuss "zero-suicide" concept	KCC, Medway Public Health and KMPT	Summer 2015
4)	Suicide Prevention Steering Group members to share learning from the consultation event with the Emotional Health and WellBeing Strategy Groups and contribute to their review of the self-harm pathway	KCC and Medway Public Health	Summer 2015
5)	Public Health to examine how early intervention schemes for self-harm can be rolled out across the county	Public Health	
6)	Canterbury Christ Church University to review the current statistics relating to suspected suicides in Kent prisons and consider what more can be done to prevent future suicides	Canterbury Christ Church University	Summer 2015
7)	KCC Public Health to develop a campaign with partners to raise awareness of mental health issues amongst men	KCC Public Health	September 2015 – May 16
8)	Continue to develop a network of Men's Sheds across Kent and Medway	Public Health	Ongoing
9)	Establish contact with appropriate representatives within each high risk occupation group and consider what interventions may be appropriate to reduce the risk of suicide	Public Health	Autumn 2015

Priority 2: Tailor approaches to improve mental health and wellbeing in Kent and Medway

As well as including wellbeing interventions aimed at the whole population, the Kent and Medway Suicide Prevention Steering Group has identified the groups which may need additional support to improve their mental health and wellbeing.

- Socially excluded and deprived groups
- BME communities
- Domestic abuse victims and survivors
- Women during and after pregnancy
- Young people leaving care
- Children and young people
- Students
- Older people (especially those who have recently lost long term partners)
- People who misuse drugs and alcohol
- Veterans
- LGBT
- People experiencing financial crisis
- People experiencing relationship difficulties
- Offenders/ex-offenders
- People bereaved by suicide
- People with new diagnosis of disability or terminal illness

10) KCC and Clinical Commissioning Groups to develop a new Community and Wellbeing Service to support people with wellbeing and mental health needs	KCC and CCGs	April 2016
11) Work with Kent Police to provide frontline officers with awareness and information cards relating to local mental health services	Public Health and Kent Police	December 2015
12) Commission free to access Mental Health First Aid training	Public Health	Ongoing
13) Continue to roll out the Five / Six Ways to Wellbeing campaigns in Medway / Kent respectively	Public Health	Ongoing
14) Continue to promote NHS Talking Therapies (also known as IAPT)	Public Health	Ongoing
15) All agencies to share relevant information to enable timely monitoring and response of suicide and suicide attempts in Kent and Medway	All	Ongoing

PRIORITY 3: Reduce access to the means of suicide		
16) All agencies to work together to identify and manage hotspots for both completed suicide and suicide attempts in a timely manner	All agencies	Ongoing
17) Relevant agencies to take appropriate measures in relation to common suicide methods and at identified hotspots	All agencies	Ongoing
PRIORITY 4: Provide better information and support to those bereaved or affected by suicide		
18) Invite a representative from Survivors of Bereavement by Suicide to join the Steering Group	Steering Group Chair	Complete
19) Investigate the issue at a future meeting of the Steering Group to develop further actions	Steering Group Chair	Autumn 2015
20) Ensure that the support pack “Help is at Hand” and details of local support groups such (as SOBS) are distributed to as many frontline staff in appropriate occupations (eg health, police) as possible	Public health	Ongoing
PRIORITY 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour		
21) KCC Communications department to re-define search terms of media monitoring to ensure that coverage of suicides are analysed	Public Health	Complete
PRIORITY 6: Support research, data collection and monitoring		
22) Prepare and present regular suicide statistics and trends based on research and statistics provided from all relevant agencies, service providers and other available sources	KMPHO	Ongoing

Appendix ii Review of Responses to the Public Consultation

Consultation Process
The consultation process on the draft 2015-2020 Suicide Prevention Strategy consisted of three main features;

1) A stakeholder event focusing on the issue of self-harm (Feb 26th 2015)

Hosted by Medway PH over 70 stakeholders discussed a wide variety of issues relating to self-harm. There was a presentation given by Medway Public Health and two organsations (KCA and VAWK) discussed how they were tackling the issue in different parts of Kent. The main points to come out of the discussion were;

- The need for early identification and intervention in relation to self-harm
- Need greater use of peer support
- Need continued education for parents and staff
- Need to address the gap between school counselling and CAMHS
- Need more funding and a higher profile

2) A stakeholder event to develop the action plan relating to the draft Suicide Prevention Strategy (March 18th 2015)

Hosted by KCC Public Health, over 60 stakeholders (including service users, carers, charities, treatment providers and voluntary groups) discussed the priority groups which should be addressed by the Strategy and Action Plan, as well as prioritised some of the potential actions. Presentations were given by KCC Public Health, the Samaritans and KMPT. The main points to come out of the session were;

- There was overwhelming support for the draft priorities within the draft strategy
- There was a high level of agreement that the key groups identified by the draft strategy are the right ones to focus on. However there was a strong feeling that the strategy shouldn't focus on particular groups to the detriment of population level measures
- There was strong agreement that bereaved families and carers should be supported better, with suggestions as to how that could happen

3) An online consultation

The KCC Engagement Team hosted an online survey on the KCC website in relation to the draft strategy for approximately nine weeks. Although there were a disappointing number of responses (only 11) it was decided by the Suicide Prevention Steering Group not to extend the consultation period because:

- There was very good stakeholder engagement at the two consultation events and as part of the steering group
- The responses that were received were very supportive of the strategic approach and the draft priorities
- The online consultation was advertised widely through the Mental Health Action Groups and Healthwatch

Although there was strong support for the strategic approach a number of respondents to the online survey which criticised the care that individuals were currently receiving, particularly those in crisis.

Impact to the Strategy and Action Plan following the public consultation

Consultation response – there was virtually unanimous support for the proposal to adopt the national priorities as the framework for the Kent and Medway Strategy
Impact – The national priorities have been adopted as the framework for the Kent and Medway Strategy

Consultation response – There was widespread support for the groups identified as a) being at higher risk of suicide and b) being at higher risk of poor mental health. However there was strong feelings that “People bereaved by suicide” and “People with new diagnosis of disability or terminal illness” should be added.
Impact - “People bereaved by suicide” and “People with new diagnosis of disability or terminal illness” have been added to the list of people being at higher risk of poor mental health

Consultation response – There needs to be better early intervention support for people who self harm
Impact – An action has been included in the Action Plan which commits Kent and Medway Public Health teams to share learning with Emotional Health and Wellbeing Groups and to contribute to the review of the self-harm pathway

Consultation response – There needs to be better support for families bereaved by suicide.
Impact – A representative from Survivors of Bereavement by Suicide has been invited to join the Steering Group and the issue will be discussed in detail at a future meeting

Consultation response – Mental health providers need to provide better continuity of care to service users and need to involve service users and carers more in decisions about care plans
Impact – Service users and carers were able to make these points directly to senior members of staff within mental health providers as part of the consultation events. The Steering Group will retain close links to the Mental Health Crisis Concordat and ensure these points get picked up in the work surrounding the Concordat

Consultation response – There was a mixed response to whether the Kent and Medway Suicide Prevention Strategy should include a “Zero Suicide Ambition”
Impact – An action has been included in the Action Plan which commits Kent and Medway Public Health teams to meet with KMPT to discuss the pros and cons in more detail

Appendix iii Trends in suicide rates by CCG

Figures 11-18 show the trends in mortality from suicide and undetermined causes from between 2002 and 2013 for the different CCGs across Kent and Medway. The highest numbers are in South Kent Coast and Thanet, and the lowest in Ashford and Medway, although no CCG areas are statistically higher or lower than any others for the given time period.

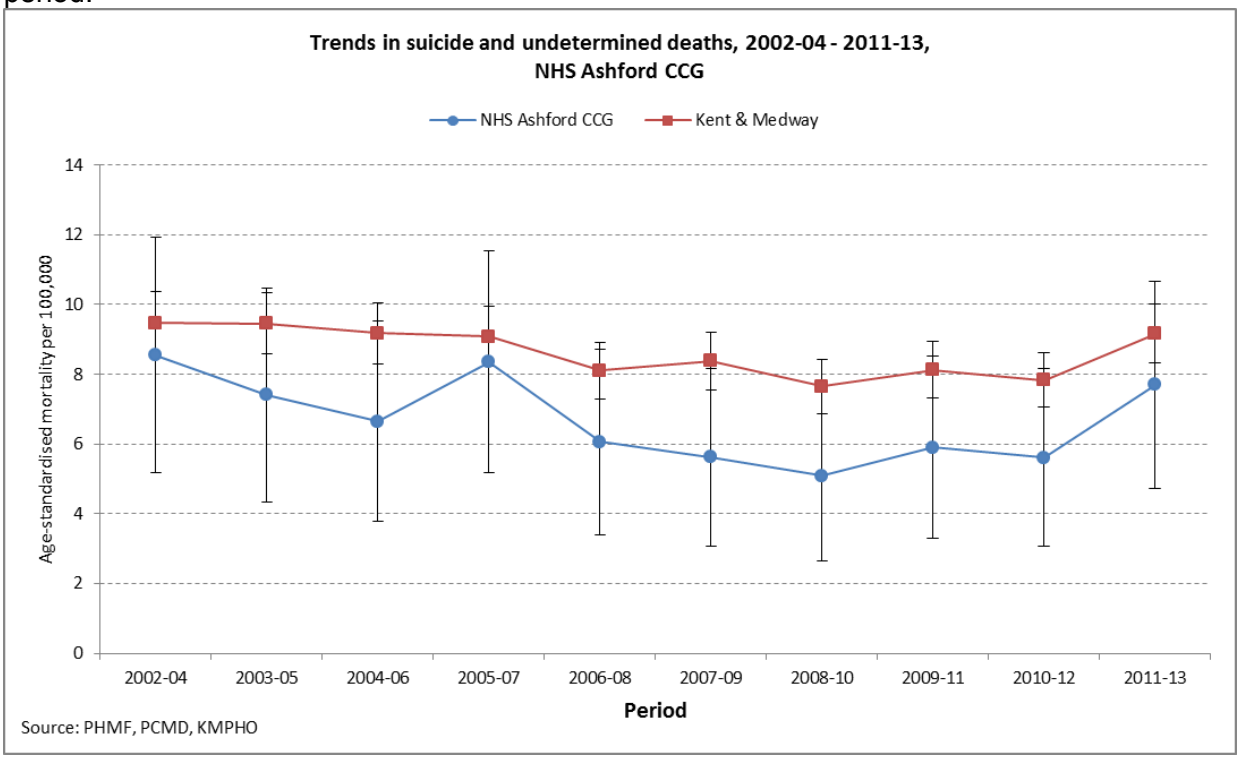


Figure 11 : Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Ashford CCG

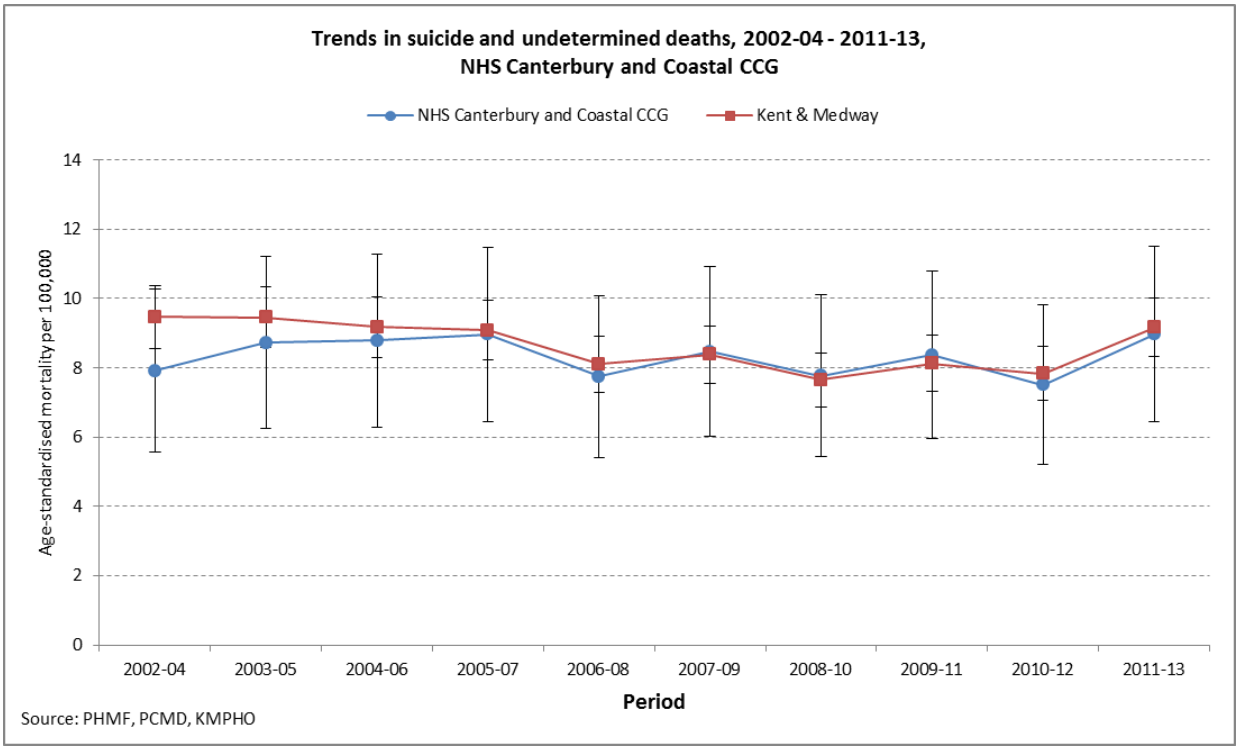


Figure 12 :Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Canterbury and Coastal CCG

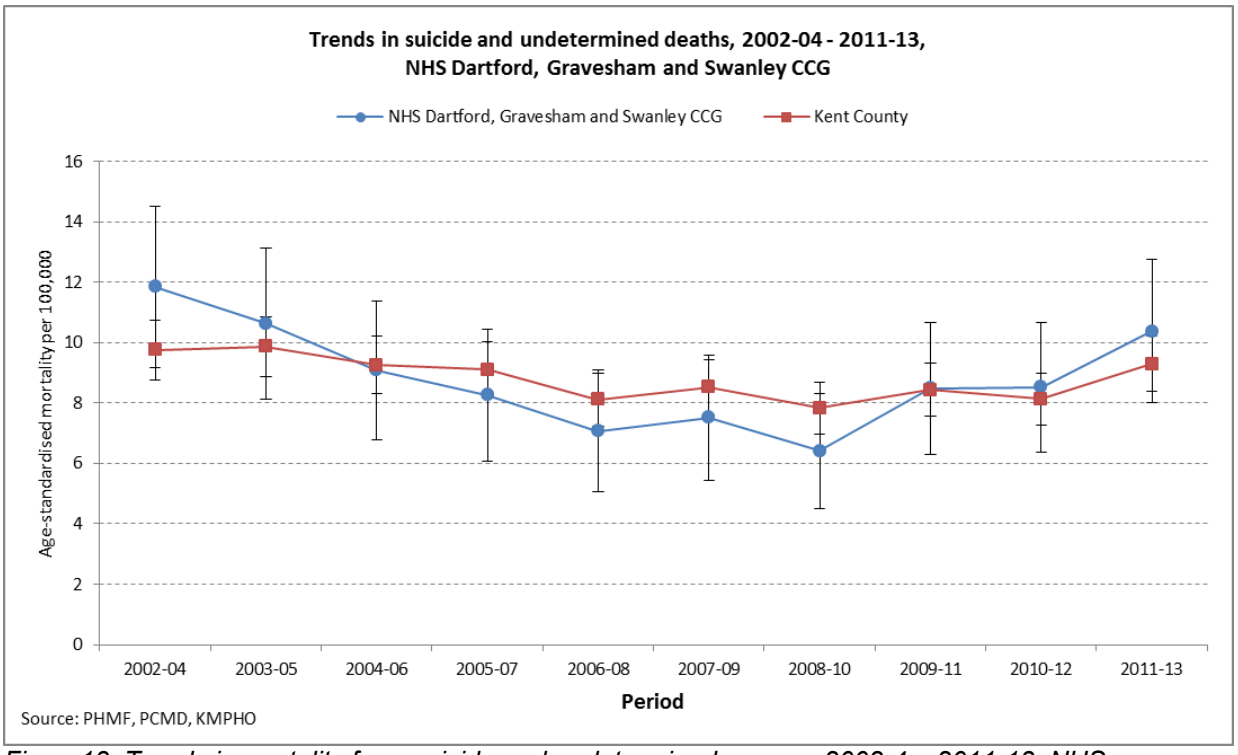


Figure13 :Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Dartford, Gravesham and Swanley CCG

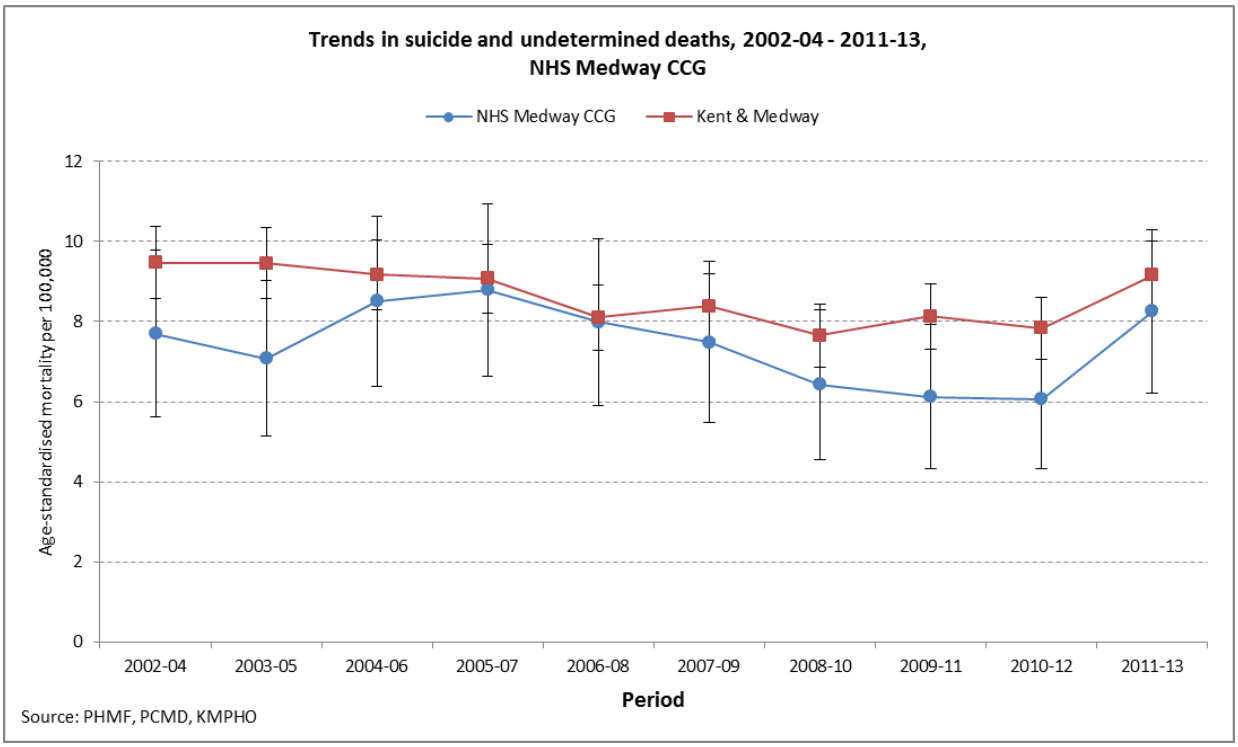


Figure 14:Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Medway CCG

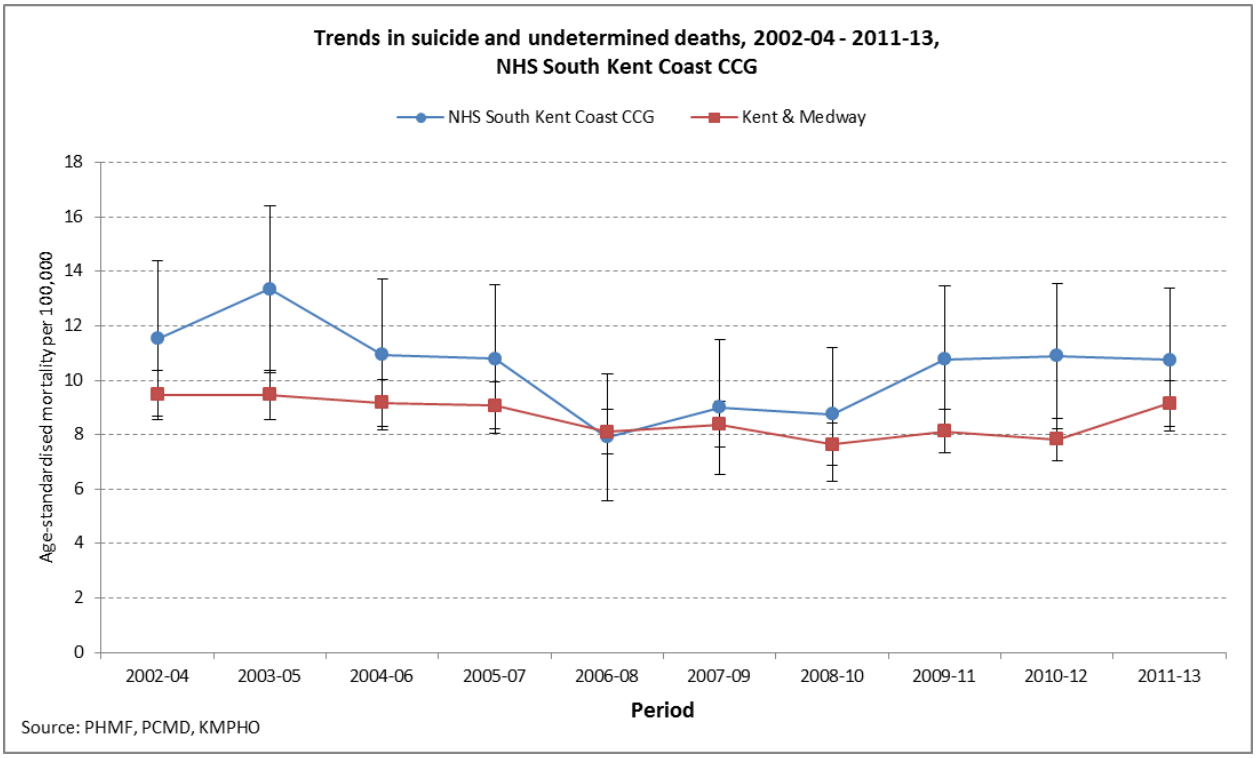


Figure 15:Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS South Kent Coast CCG

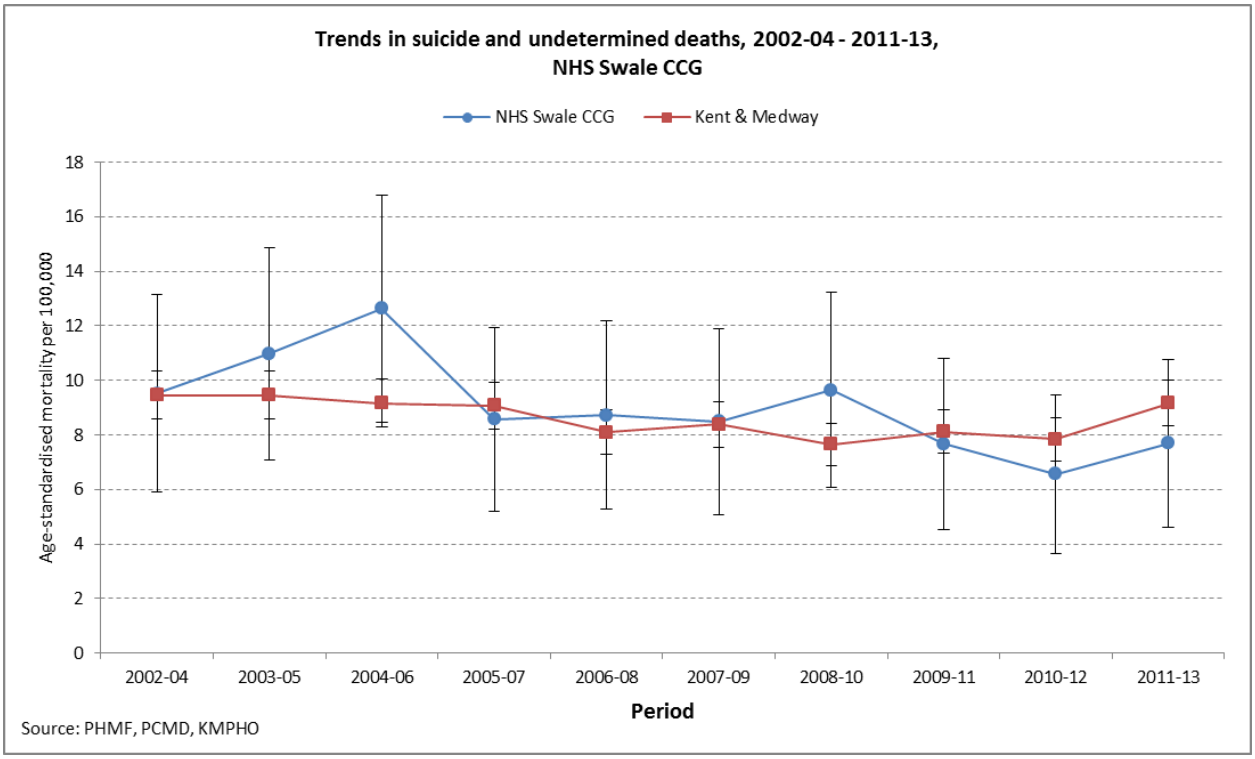


Figure 16: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Swale CCG

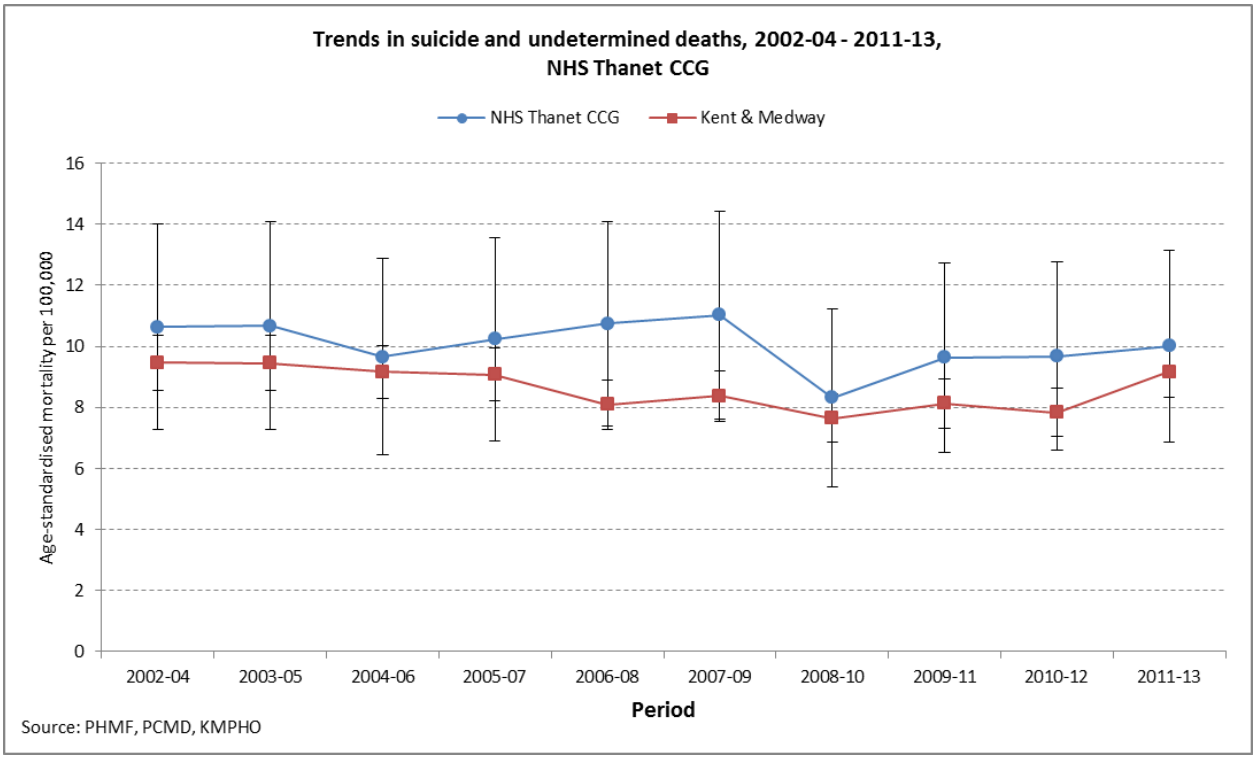


Figure 17: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS Thanet CCG

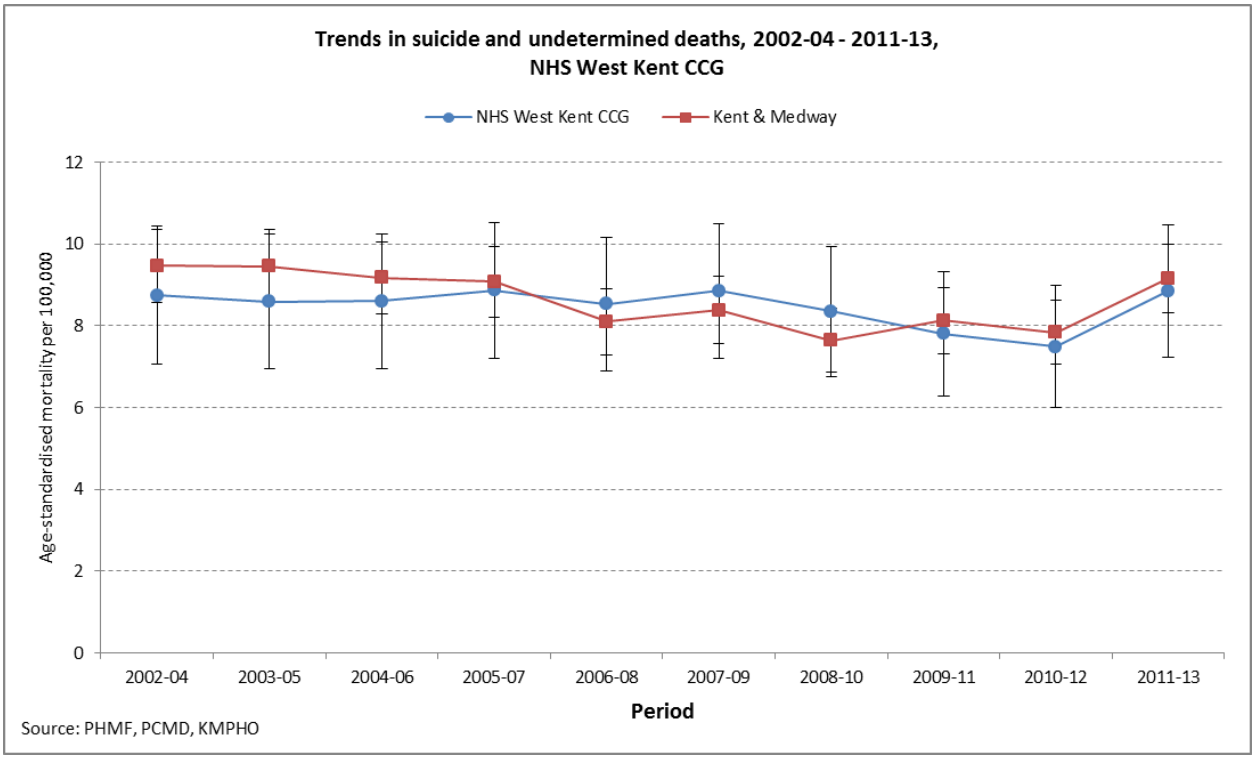


Figure 18: Trends in mortality from suicide and undetermined causes, 2002-4 – 2011-13, NHS West Kent CCG

Appendix iv Equality Impact Assessment

KENT COUNTY COUNCIL
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)

This document is available in other formats, Please contact
tim.woodhouse@Kent.gov.uk or telephone on 07710 368080

Directorate:
Public Health

Name of policy, procedure, project or service
The Kent and Medway Suicide Prevention Strategy 2015-20

What is being assessed?
The Kent and Medway Suicide Prevention Strategy 2015-20
(This is an update of the Kent and Medway Suicide Prevention Strategy 2010-15)

Responsible Owner/ Senior Officer
Jess Mookherjee / Tim Woodhouse

Date of Initial Screening
November 2014

Date of Full EqIA :
TBC

Version	Author	Date	Comment
v.1	Tim Woodhouse	6.11.14	
V2	J Hill	5/1/15	E & D comments

Screening Grid

Characteristic	Could this policy, procedure, project or service, or any proposed changes to it, affect this group less favourably than others in Kent? YES/NO If yes how?	Assessment of potential impact HIGH/MEDIUM LOW/NONE UNKNOWN		Provide details: a) Is internal action required? If yes what? b) Is further assessment required? If yes, why?	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO - Explain how good practice can promote equal opportunities
		Positive	Negative	Internal action must be included in Action Plan	If yes you must provide detail
Age	No	Medium	Low	a) No b) No	Yes - suicide is most common in the 40-49 age group, therefore this age group is selected by the strategy as a focus for targeted interventions.
Disability	No	Medium	Low	a) No b) No	Yes – people in the care of mental health services are at high risk of suicide, therefore this group is selected by the strategy as a focus for targeted interventions. Physical illness and long-term conditions are also associated with increased risks of suicide
Gender	No	Medium	Low	a) No b) No	Yes – suicide rates for men are higher than for women, therefore men are selected by the strategy as a focus for targeted interventions.
Gender identity	No	Low	Low	a) No	Yes – the EQIA for the

				b) No	national suicide prevention strategy states that there are some indications that transgender people may have higher rates of mental health problems and self harm. The consultation for this Strategy will consider whether this group should be selected for targeted interventions.
Race	No	Unknown	Unknown	a) Yes – the coroner does not record ethnicity on the death certificate, therefore we are unable to accurately assess the ethnic breakdown of people who take their own life. The strategy commits to undertaking further work to assess whether we can gain this information in a different way. b) No	
Religion or belief	No	Low	Low	a) No b) No	The EQIA for the national suicide strategy states that there is a wide range of evidence to suggest that religious participation may be a protective factor against suicidal behaviour.
Sexual orientation	No	Low	Low	a) No b) No	Yes – the EQIA for the national suicide prevention strategy states that lesbian, gay and bisexual people are at higher risk of suicidal ideation. The consultation for this Strategy will consider whether this group should be

					selected for targeted interventions
Pregnancy and maternity	No	Low	Low	a) No b) No	Yes – the EQIA for the national suicide prevention strategy states that while the statistical risk of suicide is low for pregnant women and new mothers mental health problems are more common for those groups of women. The consultation for this Strategy will consider whether this group should be selected for targeted interventions.
Marriage and Civil Partnerships	No	Low	Low	a) No b) No	The EQIA for the national suicide prevention strategy reported that people who are married have a lower risk of suicide. It also found that any increase in higher risk amongst those in civil partnerships is likely to be associated with their sexual orientation rather than their civil partnership status.
Carer's responsibilities	No	Medium	Low	a) No b) No	Yes. Improving the support to bereaved families is a key priority of the draft strategy

Part 1: INITIAL SCREENING

Proportionality - Based on the answers in the above screening grid what weighting would you ascribe to this function?

Low	Medium	High
Low relevance or Insufficient information/evidence to make a judgement.	Medium relevance or Insufficient information/evidence to make a Judgement.	High relevance to equality, /likely to have adverse impact on protected groups

Assessment - Low
There is no evidence to suggest that the updating of the Suicide Prevention Strategy will have an adverse impact on individuals because of any protected characteristic.

The strategy has been developed to target more support at those groups within the population who are currently at increased risk.

Context
The Kent and Medway Suicide Prevention Strategy is overseen by the Kent and Medway Suicide Prevention Steering Group. The Group provides regular updates to the Kent and Medway Health and Wellbeing Boards.

Aims and Objectives
The aim of the strategy is to prevent suicides in Kent and Medway. It contains the following priorities;

i Reduce the risk of suicide in key high-risk groups
ii Tailor approaches to improve mental health in specific groups
iii Reduce access to the means of suicide
iv Provide better information and support to those bereaved or affected by suicide
v Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi Support research, data collection and monitoring

Beneficiaries
The intended beneficiaries are those people in any of the groups identified as high-risk of suicide, or in need of support to improve their mental health. There are also likely to be interventions targeted at improving the wellbeing of the whole Kent and Medway population.

Information and Data
In the development of the draft strategy, the Kent and Medway Public Health Observatory has produced the following tables and charts.

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

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

The data in Table 1 shows the number of deaths from suicide and undetermined causes for the different Clinical Commissioning Groups (CCGs) across Kent and Medway. There was a considerable increase in the overall number of suicides in 2013 compared to any of the previous years.

Gender and age

Figures 1 and 2 show the number of deaths from suicide and undetermined causes for Kent & Medway, by age band and gender between 2002-2013 and the number of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender. The data show that the suicide numbers are considerably higher in men for all age categories. The highest numbers are in men aged between 40 and 54 years old.

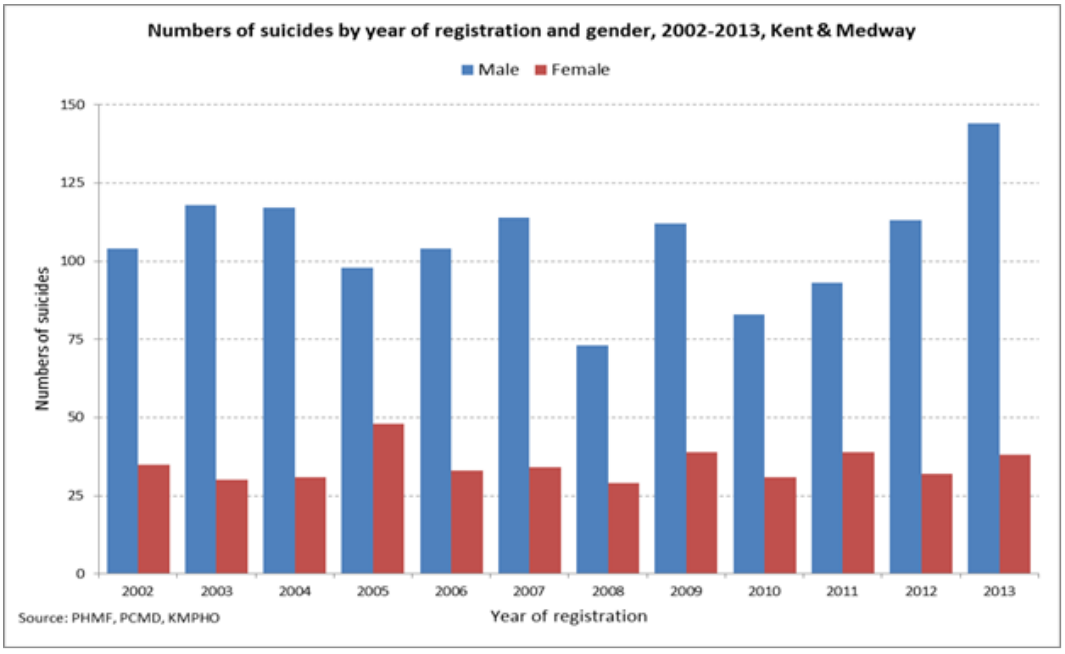


Figure 1: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by year of registration and gender, 2002-2013

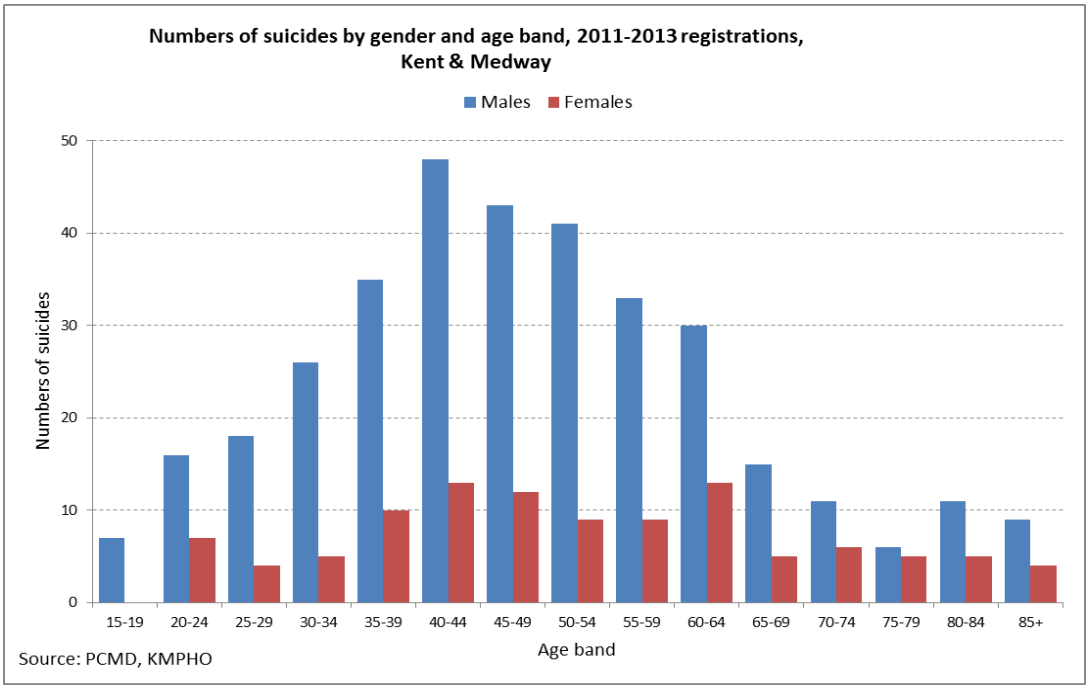


Figure 2: Numbers of deaths from suicide and undetermined causes, Kent & Medway, by age band and gender, 2011-2013 registrations

Country of birth

Coroners do not currently record ethnicity on death certificates, however they do record country of birth. While this is not a good indication of ethnicity, in order to see if there were any notable trends, the Kent and Medway Public Health Observatory has examined the country of birth of 1730 individuals in Kent who took their life between 2002 and 2013. The vast majority were born in England, and the next two most frequent countries of birth were Scotland and Wales. However eleven people born in Poland, nine born in India, and eight born in Germany have killed themselves in Kent between 2002 and 2013.

As part of the implementation of this strategy, the Steering Group will monitor suicide statistics relating to country of birth and work with other agencies (both locally and nationally) to try and improve the ability to assess the risk of suicide within ethnic groups within Kent.

Occupation

The coalition Government's 2012 Preventing Suicide in England strategy identified that "some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers and other agricultural workers are at higher risk probably because they have ready access to the means of suicide and know how to use them."[12]

However it goes on to say that "Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly."[13]

[12] P.19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

[13] Same reference as 1

It is for this reason that during the preparation of this Strategy, the Kent and Medway Public Health Observatory examined the occupation (as written by the Coroner on the death certificate) of 1730 individuals in Kent who took their life between 2002 and 2013.

The following table groups the occupations into categories, and shows that the highest numbers of suicides are within the “Professional and managerial” and the “Construction, transport and building trades” categories. It is important to note that these are *numbers* rather than *rates* and don’t take into account the different numbers of people working within these occupations in Kent. More research is needed to establish whether the comparatively lower numbers of suicides within categories such as Agriculture show increased risk within those groups given the lower number of people working in those occupations.

Occupation type	**Numbers of suicides in Kent between 2002 and 2013**
Professional and managerial	497
Construction, transport and building trades	462
Sales, services and administration	290
Health and personal services	105
Leisure, media and sport	74
Agriculture	50
Protection services	42
IT, Science and Engineering	41
Unknown	169
Total	**1730**

Suicide numbers by occupation in Kent 2002-2013 - Source KMPHO 2014

Gender by CCG

Figures 3 and 4 show the mortality rates for suicide and undetermined causes between 2011 and 2013 for males and females for the CCGs in Kent and Medway. (Full trends in mortality from suicide and undetermined causes in each CCG area can be found in Appendix 1 of the strategy).

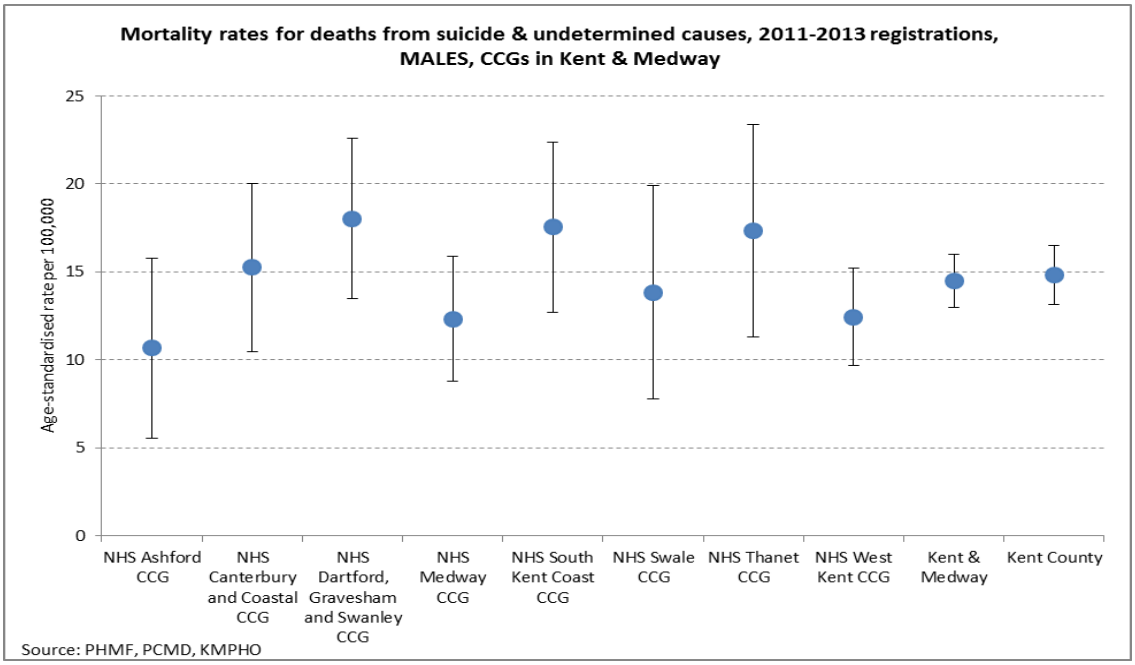


Figure 3: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, MALES

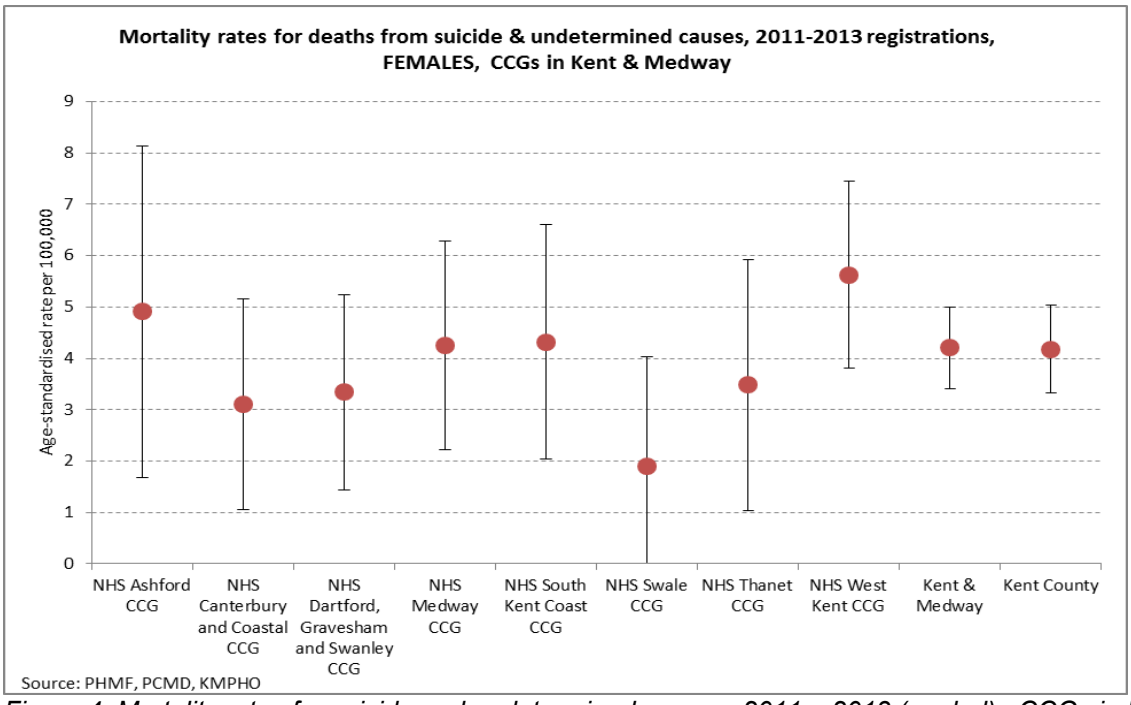


Figure 4: Mortality rates for suicide and undetermined causes, 2011 – 2013 (pooled), CCGs in Kent and Medway, FEMALES

Involvement and Engagement

We are planning to hold consultation events and issue a consultation questionnaire as part of this process.

Potential Impact
There is no evidence to suggest that the updating of the Suicide Prevention Strategy will have an adverse impact on individuals because of any protected characteristic.

The strategy has been developed to target more support at those groups within the population who are currently at increased risk.

The public consultation will help to determine which groups should be a particular focus.

Race and Religion – There is very little information regarding ethnicity or religion, mainly because the coroner doesn't record it on the death certificate. Therefore we are unable to accurately assess the ethnic breakdown of people who take their own life, or whether this strategy will have an adverse impact. The strategy commits to undertaking further work to assess whether we can gain this information in a different way.

Adverse Impact:

None
Positive Impact:
The strategy has been developed to target more support at those groups within the population who are currently at increased risk. Actions to maximise the positive impact will be included in the Action Plan for the strategy.

JUDGEMENT

Option 1 – Screening Sufficient **NO**

Option 2 – Internal Action Required **YES -** See action plan

Option 3 – Full Impact Assessment **YES**
Although we believe there is no evidence that this refresh of the Suicide Prevention Strategy will lead to any negative impact we will undertake a full impact assessment because we are going to out to public consultation on it. (It is a KCC requirement that public consultations must be accompanied by Full Impact Assessments).

Monitoring and Review
The action plan will be monitored by the Kent and Medway Suicide Prevention Steering Group.

Sign Off

I have noted the content of the equality impact assessment and agree the actions to mitigate the adverse impact(s) that have been identified.

Senior Officer

Signed: Name:

Job Title: Date:

DMT Member

Signed: Name:

Job Title: Date:

Equality Impact Assessment Action Plan

Protected Characteristic	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
Race	There is very little information regarding the ethnicity of those people who take their own life. (Mainly because the coroner doesn't record ethnicity on the death certificate). Therefore we are unable to accurately assess the ethnic breakdown of people who take their own life, or whether this strategy will have an adverse impact.	As part of the strategy development process a public consultation and a review of national literature will both examine the impact of ethnicity race on suicide.	There is evidence to suggest the rates of severe mental illness are higher amongst some ethnic groups, however it isn't known whether this automatically implies there are higher rates of suicide.	Tim Woodhouse	Prior to Strategy sign off	N/A

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	15/00055

For publication

Subject: 2015-2020 Kent and Medway Suicide Prevention Strategy

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to approve the adoption of the 2015-2020 Kent and Medway Suicide Prevention Strategy and Action Plan

Reason(s) for decision:
Amendment to a strategy

Cabinet Committee recommendations and other consultation:

On the 11th July 2014, the Adult Social Care and Health Cabinet Committee agreed that officers should begin the process of updating the Suicide Prevention Strategy.

On 15th January 2015 the Committee agreed an earlier draft of the strategy should be tested by public consultation.

The final proposed strategy will be discussed by the Committee at its meeting of 10th July 2015.

Other consultation:

The consultation process on the draft 2015-2020 Suicide Prevention Strategy consisted of three main features:

- A stakeholder event focusing on the issue of self-harm (26th February 2015)
- A stakeholder event to develop the action plan relating to the draft Suicide Prevention Strategy (18th March 2015)
- An online consultation

Any alternatives considered:
The strategy has been adjusted to take account of comments received during the consultation

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

..... signed

..... date

This page is intentionally left blank

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

To: Adult Social Care and Health Cabinet Committee – 10 July 2015

Decision No: 15/00062

Subject: The Public Health Strategic Delivery Plan and Commissioning Strategy

Classification: Unrestricted

Past Pathway of Paper: This topic was discussed by the Cabinet Committee at its meeting of 1st May 2015

Future Pathway of Paper: Cabinet Member decision

Electoral Division: All

Summary:

Since KCC undertook responsibility for Public Health in April 2013, continuous review has been undertaken of the approach to public health and the contracts that transferred.

Public Health has recently been developing a new strategy for Kent and an aligned commissioning plan. This is to ensure that the future approach to public health will be based around the needs of the person, encourage personal responsibility and, wherever appropriate, be delivered within integrated services. Most importantly, activity must reduce health inequalities.

The experience of other areas in the country has been examined, and market engagement events have been held to understand the latest developments in the market.

It is clear that a new approach is needed, and Public Health will engage and explore the opportunities with all partners.

To deliver the planned transformation effectively and smoothly, current contracts will need to end at the same time, to bring about the opportunity to commission a new model. It is therefore proposed that the Cabinet Member for Adult Social care and Public Health take a decision to extend the current contracts for the Smoking Cessation, Health Checks, Health Trainers and Healthy Weight services to run until 30th September 2016.

Recommendations:

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

i) comment on the emerging thoughts around future public health interventions; and

ii) comment on and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the current contracts for the Smoking Cessation, Health Checks, Health Trainers and Healthy Weight services to run until 30th September 2016.

1. Introduction

1.1 The Adult Social Care and Health Cabinet Committee has been shaping the development of the emerging public health strategic plan and commissioning strategy, and this will be the third time that the topic has been discussed by the committee.

1.2 In the previous discussion, the drivers for change for the work were outlined, and the committee was asked to comment on the emerging Kent Public Health Outcomes Framework.

1.3 Since that discussion, a large amount of analysis work has been undertaken to inform potential models of transformation. This work will be summarised in an attached presentation to Members; 'Public Health Transformation'. In addition, a new financial settlement for the Kent public health grant is being worked through and any transformation programme will need to deliver against the final budget settlement.

1.4 Following discussions with Members at the July 2015 meetings of both the Adult Social Care and Health Cabinet Committee and the Children's Social Care and Health Cabinet Committee, it will be necessary to engage with partners and stakeholders on the emerging findings and potential new models of intervention.

1.5 The research shows that any new model should integrate healthy lifestyle interventions rather than sustaining an approach which has lots of different services for different lifestyle issues. The current approach is shown to be inefficient, and potentially increases health inequalities. For this purpose, the proposal to extend the current contracts grouped them together under the 'Living Well/Ageing Well' heading.

In order to develop this new model of intervention it is therefore necessary to harmonise our current contracts, which, at present have different end dates. It is also important that there is time to engage with the wider health and wellbeing system, and engage it to develop new approaches. It is therefore proposed to extend the contracts detailed in paragraph 2.1 to 30th September 2016 and begin a new model from October 2016.

1.6 The committee will also be asked to consider the process for Drug & Alcohol commissioning under a separate report at this meeting. This includes a

proposed approach which would enable commissioners to amend the scope of the Drug and Alcohol contracts. This would allow interventions to be added or removed, and services grouped in order to bring in a wider range of providers, if necessary.

This flexibility will be crucial to ensure that the wider changes in health improvement services discussed here can effectively address drug and alcohol misuse, especially those relating to people drinking at increasing or higher risk levels.

1.7 The slides attached as Appendix A detail the process to date, and findings from the analysis work, and will form the basis of a presentation to the committee at the meeting.

2. Financial Implications

2.1 The Living Well/Ageing Well contracts that are proposed to be extended currently have annual values as follows:

- Health Checks (currently expires January 2016) - £1,940,912
- Healthy Weight (currently expires January 2016) - £2,010,724
- Smoking Cessation (currently expires March 2016) - £1,873,207
- Health Trainers (currently expires January 2016) - £1,434,222
- Drug and alcohol (discussed in a separate report) - £12,800,000

3. Timeline

3.1 The work to transform public health services has been divided into three phases as follows

3.2 **Phase 1: March 2015 – September 2015**

- Member briefings and Cabinet Committee
- Outcomes agreed
- Analysis and Review
- Market engagement
- Stakeholder consultation
- Health and well being board consultation
- Contract alignment and management

3.3 **Phase 2: October 2015 – April 2016**

- New models of provision and specifications agreed.
- Key decisions taken.

- Resource levels agreed.
- Invitations to tender issued.
- Procurement processes starts.
- KCC Making Every Contact Count

3.4 **Phase 3: April 2016 – September 2016:**

- Transition to new service models
- Staff reconfiguration
- Change management and communication
- New model formal start date October 2016

3.5 To deliver within this timescale requires the new model to start by October 2016.

Progress will be reported back to this committee in the autumn, where there will be an opportunity to input into how the service specification(s) are shaped prior to any tendering process starting.

4. Conclusion

4.1 Development of a new approach is needed to meet the challenges faced in public health, the changing needs of the population and the financial envelope of the public health grant.

The next step of this process is to engage with partners on the emerging findings and build a new model with them. In order to deliver this programme smoothly and successfully, there is a need to synchronise the start and end dates of relevant Living Well/Ageing well contracts, set out in paragraph 2.1, above.

5. Recommendation(s)

Recommendations:

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

i) comment on the emerging thoughts around future public health interventions; and

ii) comment on and either endorse or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend

the current contracts for the Smoking Cessation, Health Checks, Health Trainers and Healthy Weight services to run until 30th September 2016.

6. Background Documents

Update on Developing the Public Health Strategic Delivery Plan and Commissioning Strategy, presented to Adult Social Care and Health Cabinet Committee on 1st May 2015

7. Contact details

Report Author

Karen Sharp
Head of Public Health Commissioning
03000 416668
Karen.sharp@kent.gov.uk

Relevant Director

Andrew Scott-Clark, Director of Public Health
03000 416659
Andrew.scott-clark@kent.gov.uk

This page is intentionally left blank

Public Health Transformation

Kent County Council
kent.gov.uk

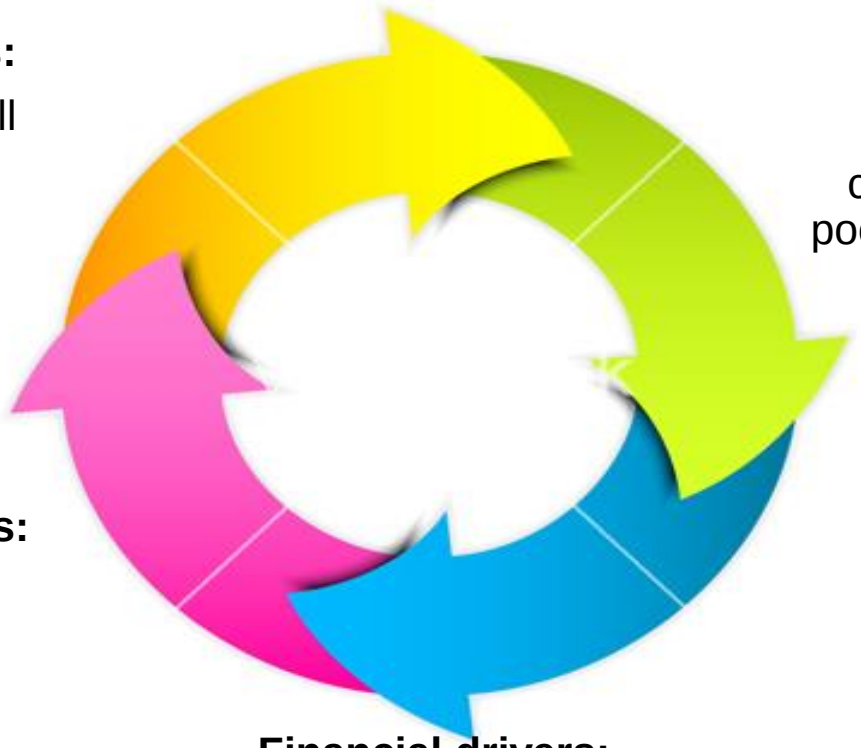
Public Health Transformation programme
Drivers for Change

Health inequalities:

Underpins all services.

NHS Five Year Forward View:

NHS seeing the consequences of poor lifestyle choices



Demographics:

A growing, ageing and diversifying population

Financial drivers:

Pressure on system health and social care system

Reduction in grant 15/16

Care Act:

LA have a responsibility to provide services that prevent the population care needs from becoming more serious, delay the impact of care needs on the system

Public Health Transformation
Key Questions

- Are our services fit for purpose?
- Do we invest our grant in the right way?
- What is mandated and what is discretionary?
- How many people and do the right people benefit from our services?
- How do our services perform?
- Do they suit the person or the structure?
- How efficient is the approach, what are the opportunities for integration?
- How do we make Every Contact Count?
- Are we impacting on Health Inequalities?
- Are we fully working with colleagues across KCC?
- Are we planning for the future?

Timeline

Phase 1:
Whole system engagement and consultation

March – September 2015:

- Member briefings and Cabinet Committee
- Stakeholder consultation
- Outcomes agreed
- Analysis and Review
- Health and well being boards consultation
- Market engagement
- Contract management

Phase 2:
Revised models Procurement

October 2015 –April 16

- New models of provision and specifications developed.
- Key decisions taken.
- Resourcing agreed.
- Invitations to tender issued.
- Procurement processes run.
- KCC Making Every Contact Count

Phase 3:
Transition to new service models

April 2016 onwards:

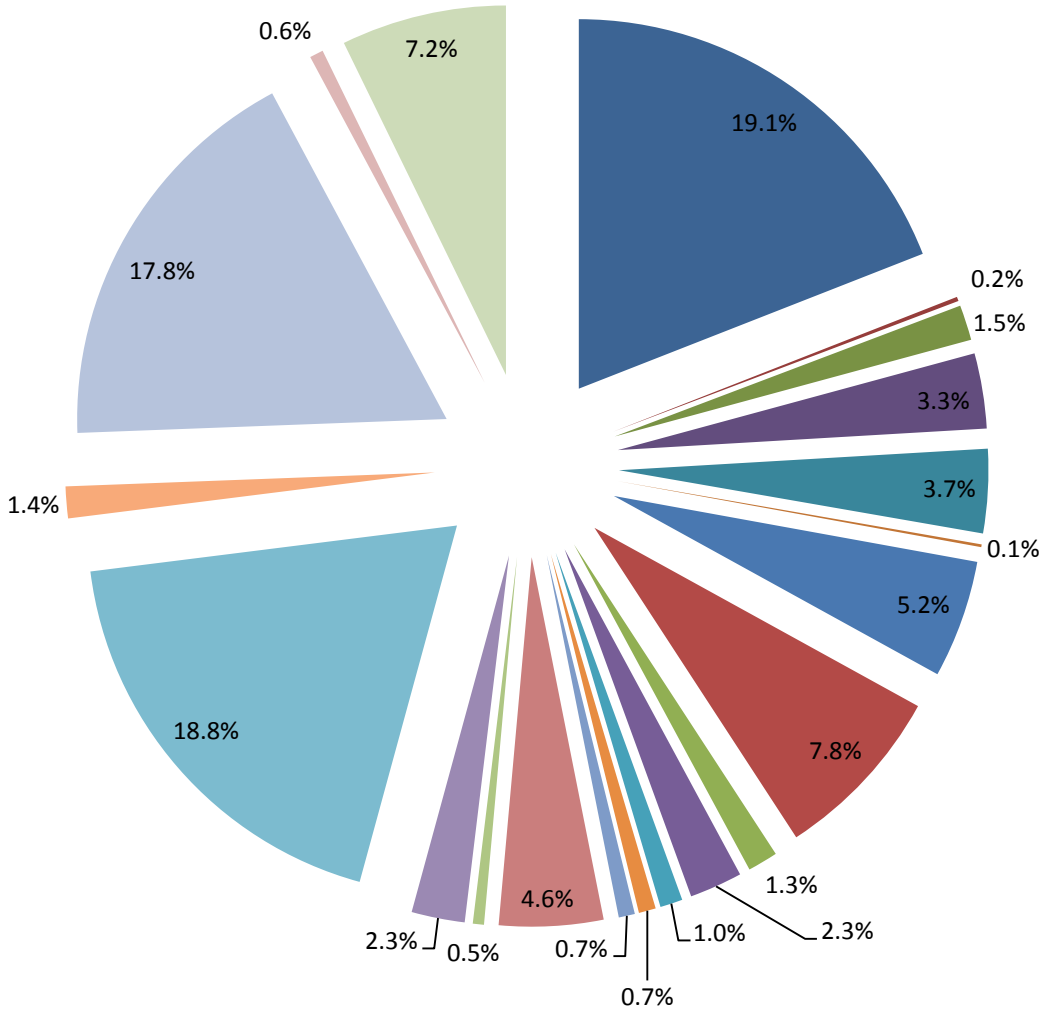
- Transition to new service models
- Staff reconfiguration
- Change management and communication

ANALYSIS

- Reviewed
  - Spend
  - Performance of services
  - Health profiles across Kent
  - Wider system priorities
  - Customer insight
  - The Market
  - National developments and Key research

- Structured into Starting Well, Living Well, and Ageing Well (in line with KCC Strategic Statement)

Public Health Grant by service area



Commissioned Services Performance
Adults

Indicator Description	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Proportion of annual target population with completed NHS Health Check (rolling 12 month basis)	36%	41%	46%	51%	51%
Proportion of clients accessing community sexual health services offered an appointment to be seen within 48 hours	99.9%	100%	100%	100%	100%
Chlamydia positivity detection rate per 100,000 for 15-24 year olds	1,949	1,545	1,540	1,635	Expected September
Proportion of smokers successfully quitting, having set a quit date	57%	53%	52%	54%	57%
Local Indicator					
Proportion of new clients seen by the Health Trainer Service from the two most deprived quintiles (highest deprivation)	54%	52%	53%	57%	51%

Substance Misuse Services	2009/10	2010/11	2011/12	2012/13	2013/14
% of adult treatment population that successfully completed treatment	22.6%	26.0%	26.0%	20.6%	17.2%
National Figures for comparison:	11.5%	13.7%	15.1%	15.0%	15.1%
	Dec 12-Nov 13	Jan 13-Dec 13	Mar 13-Feb 14	Apr 13-Mar 14	May 13-Apr 14
% of opiate users completing treatment successfully who do not return to treatment within 6 months, of all in treatment. (rolling 12 month basis)	10.4%	10.3%	9.7%	9.7%	9.5%
National Figures for comparison:	7.8%	7.8%	7.7%	7.8%	7.7%

Market Engagement Event

- Real appetite to engage – 80 organisations over 2 days
- Different models emerging nationwide : many providers come with knowledge wider than Kent & keen to share what has and hasn't worked elsewhere.
- Keenness to collaborate between public private and voluntary sector providers .
- Providers are keen to explore new contract opportunities, in many cases beyond services that they are already providing i.e. many providers are keen to diversify the service offer
- Suggestions that go beyond traditional 'service-based' approaches e.g. using behavioural science and marketing approaches to generate motivation.
- Many providers are thinking about their strategies and in some cases re-focusing their service offer in order to respond to the potential market for health improvement
- A number of different providers suggested commissioning a generic 'behaviour change service'
- Pharmacies keen to be more engaged

Public Health (Grant) Outcomes.

	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** *(health check assessment)* **Reduce smoking prevalence in routine and manual workers** *(health check assessment)*	**Reduce smoking prevalence** *(health check assessment)*
Healthy Eating, Physical Activity & Obesity	**Reduce levels of excess weight in children** *(weighing & measuring of children)* Increase levels of breastfeeding Increase physical activity in young people Reduce levels of tooth decay	**Reduce levels of excess weight** *(health check assessment)* Increase levels of physical activity	**Reduce levels of excess weight** ***(**health check assessment)***
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** *(health check assessment)* Reduction in hospital admissions due to alcohol Reduction in drug misuse	**Reduction in number of people drinking at problem levels** *(health check assessment)* Reduction in hospital admissions due to alcohol
Wellbeing (including Mental Health and Social Isolation)	Increasing emotional resilience in families and young people Ensure levels of social and emotional development Reducing levels of self-harm and suicide rates	**Improve wellbeing of population** **(health check assessment)** Reduction in suicide rates Reduction in domestic violence	**Improve wellbeing** **(health check assessment)** Reduce social isolation People with mental ill health are supported to live well
Sexual Health & Communicable Disease	**Reduce rates of Chlamydia** *(sexual health services)* **Reduce rates of STIs** *(sexual health services)* **Reduce levels of teenage pregnancy** *(sexual health services)*	**Increase early diagnosis of HIV** *(sexual health services)* **Reduce rates of STIs** *(sexual health services)* **Reduce excess under 75 mortality rates** *(health check assessment)*	**Reduce rates of STIs** ***(sexual health services)***
System Assurances	**Public health advice service** **Protecting the health of the local population** Increase levels of childhood vaccination *(NHS England lead responsibility – KCC supported)* School readiness Sustainability – air pollution Designing healthy communities Ready for emergencies	**Public health advice service** **Protecting the health of the local population** Increase levels of flu vaccination uptake in vulnerable groups *(NHS England lead responsibility – KCC supported)* Sustainability – air pollution Designing healthy communities Ready for emergencies	**Public health advice service** **Protecting the health of the local population** Increase levels of flu vaccination in over 65s *(NHS England lead responsibility – KCC supported)* Reduce injuries due to falls in over 65s *(social care lead responsibility)* Reduce hip fractures in over 65s *(social care lead responsibility)* Improve early diagnosis rates of dementia and people are supported to live well *(CCGs lead responsibility)* Reduce excess winter deaths Sustainability – air pollution Designing healthy communities Ready for emergencies

Public Health agreed principles

1. Based on cost + value
   - Cost of Programme
   - No in target group
   - Where does the value sit
   - How quickly do we see the return
2. Prioritise high impact groups to target health inequalities
3. Ease of access/ person centred/responsive
4. Work with the system, collaborative commissioning + collaborative delivery.
5. Define which part of the system does what making every contact count
6. Market maturity - providers have suitably high standard to deliver real quality
7. Working towards integrated care records at every opportunity.

Current

- Approach encouraging reliance on services
- Siloed service provision
- Open access provision
- Focus on targets & outputs
- ££ spent on current commissioned services

Alternative approaches

- Enabling individual and family responsibility , choice and control
- Integrated service provision and links to community assets
- Targeted to reduce health inequalities
- Focus on outcomes
- More efficient use of PH grant

Commissioning Approach

- Commission an effective Lifestyle system that reflects best evidence and the needs of priority groups
- Commission a system that addresses lifestyle multiple risk
- Collaborate with other stakeholders that can influence how service users access the system e.g. 3rd sector, Supporting people
- Commission a value for money model, reflective of national standards
- Open and transparent procurement and tendering that enables the most appropriate organisations to be commissioned (inc. market stimulation and opportunity for collaboration.

A New Model Should:

- Incorporate a system of linked services with an integrated hub, supported through effective triage, which therefore maximises health gain from each client contact.
- Have an increased focus on populations with greatest need and can be treated or managed through lifestyle interventions
- Provide improved prevention through targeted service
- Maximise the role of Primary Care and other organisations that come into contact with those that would benefit from lifestyle services

Key Decisions

Activity	Description	Cabinet committee
Strategies		
Public Health Delivery Plan and Commissioning Strategy	Development of a plan to deliver public health outcomes and priorities, alongside a commissioning strategy to transform services to meet changing needs	July 2015
Starting Well Commissioning		
School nursing	Decision over the extension of contract, and retendering timetable	• July 2015 for extension • January 2016 for pretender • May 2016 for contract award (for October 2016 start)
Health Visiting	Authority to enter into contract with KCHFT (on inheriting of contract), potential to retender for October 2016 (TBC)	• July 2015 • *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Young peoples' drug and alcohol service	Decision to extend contract to 30 September 2016, to align with other contract end	• July 2015 • *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Young healthy minds	Decision on retendering contract (in line with new CAMHS service?)	• *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Living and Ageing well commissioning		
Drug and Alcohol services	Commissioning of Drug and alcohol services	• July 2015 for pretender • December 2015 for contract award
Smoking cessation	Contract extension to bring into line with other health improvement services followed by retender in line with outcome of Commissioning strategy work	• July 2015 • *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Health trainers	Contract extension to bring into line with other health improvement services followed by retender in line with outcome of Commissioning strategy work	• July 2015 • *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Healthy weight	Contract extension to bring into line with other health improvement services followed by retender in line with outcome of Commissioning strategy work	• July 2015 • *January 2016 for pretender* • *May 2016 for contract award (for October 2016 start)*
Health checks	Contract extension to bring into line with other health improvement services followed by retender in line with outcome of Commissioning strategy work	• July 2015 • *January 2016 for pretender* *May 2016 for contract award (for October 2016 start)*

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care & Public Health	**15/00062**

For publication

Subject: Contract Extensions for Living Well/Ageing Well services – Smoking Cessation, Health Checks, Health Trainers and Healthy Weight – to 30 September 2016

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to agree that the County Council extend the current contracts for the Living Well/Ageing Well services outlined in the attached recommendation report to 30th September 2016, to allow for harmonisation of the contract end dates, prior to a transformation of the approach and subsequent competitive tender services.

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 10th July.

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

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

.....
signed

.....
date

This page is intentionally left blank

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health
	Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care and Health Cabinet Committee - 10 July 2015
Subject:	**Local Welfare Assistance Future Options Update**
Classification:	Unrestricted

Summary:	This paper gives an update on the progress made in the provision of local welfare assistance.
Recommendation:	The Adult Social Care and Health Cabinet Committee is asked to consider and either endorse or make a recommendation to the Cabinet Member on the proposed decision to: a) extend the current arrangements for local welfare assistance in the context of the options explored, as set out in paragraph 3.(8) (b); and b) endorse the coordination and integration of the future design, commissioning and provision of any revised model for local welfare provision with that of the larger scale transformation projects.

Introduction

1. (1) In its December meeting, the committee considered evidence about the impact of the provision of local welfare assistance via the Kent Support and Assistance Service (KSAS) and discussed future options for delivery of local welfare assistance. The committee agreed that a commissioned model should be scoped for future consideration.

(2) The model would enable the council to continue to commission a coordination, advice and guidance service that would link people to their local communities. The service would connect local voluntary groups and organisations together.

(3) At the time of the meeting government's plans for the future funding for welfare assistance remained unclear.

(4) In a late announcement, the authority's revenue support grant was increased to provide funding for welfare provision to the value of £1.481m

(5) The budget proposal for 2015/16 was amended to reflect this and approved by the County Council on 12 February 2015.

The current position

2. (1) The call handling, assessment and coordination of awards is currently conducted by a small specialist team of 9 officers within KCC's Contact Point. The commissioning of this service and that of the providers of the goods and services that make up the awards are overseen by Strategic Commissioning.

(2) The arrangements with the Contact Point end on 31 August 2015 to coincide with the procurement process for the contact centre as a whole.

(3) Due to efficiencies in the processing of awards and a shift to online applications, the costs in the administration of awards has decreased significantly for 15/16.

(4) The Access to the Department of Work and Pensions back office data system has proven to be efficient in establishing applicants' identity and eligibility.

Future Options

3. (1) The committee previously highlighted the importance of the sustainability of any future model and redesign for local welfare provision and that it should have having community action at its heart; it should be integrated and dovetail with other transformation work being undertaken within the authority, particularly the Information, Advice and Guidance work (IAG); a significant element of the Care Act work stream.

(2) Similarly, work is being undertaken to align the Council's approach to economic wellbeing across all directorates from which platform, any future strategic commissioning of local welfare provision may be considered.

(3) Close links have been made with other, peer authorities to establish their future plans for local welfare provision (LWP) to establish a will to either co-commission or to be commissioned on their behalf to deliver LWP in neighbouring areas. It is clear from this dialogue that there is an appetite to work together. Exploration is underway to establish the possibility of delivering local welfare provision solutions on behalf of other authorities, which could generate income for KCC. Kent is unique among its peers in its streamlined approach to assessment and eligibility and this is attractive to other authorities. Additionally, initial research amongst the voluntary and community sector has not identified an interest in that sector to provide this sort of service.

(4) Opportunities to attract investment or income from outside the authority to fund welfare provision e.g. from energy companies, are also being sought.

(5) It has become clear in the work undertaken so far that the market for this provision is rapidly changing and adapting to the revised landscape. A market engagement event is planned for the coming weeks.

(6) There is a co-dependency and a requirement to coordinate the reshaping of LWP with the reshaping and recommissioning of the council's other large scale transformation projects. The timetable for implementation of the large scale projects

such as IAG is not yet clear or agreed, and as a result an interim solution to local welfare provision is necessary into 16/17. Continued access to DWP's CIS system would be required in a future model including any interim arrangements will require this.

(7) In the first instance an extension to the current arrangements is sought until 31 March 2016

(8) In order that the eligibility, assessment and information function continues as the future procurement of Contact point progresses, the two interim options are :-

(a) Transfer the entire KSAS team (10.8 FTE) into Contact Point and the wider procurement of this service. As access to CIS (the Department of Work & Pension's database) will not be granted to a third party supplier, this would precipitate an immediate necessity for the delivery model to be changed. The council's ability to use CIS to safeguards against fraud and maintain process efficiency will be lost.

(b) Return the Customer Service Advisors into Contact Point (2FTE) and the wider procurement, whilst retaining the assessment team and absorb into Strategic Commissioning in the short term (8.8 FTE). The CIS function and the efficiency derived could be retained. This option is in keeping with the IAG obligations of the Care Act and the KCC approach of specialist service being offered only where necessary. Retaining the element of the service most attractive to other authorities could support a future commercial opportunity for KCC.

(9) The second interim option is recommended. This enables continuity of service, within the budget efficiencies in the current budget allocation. It positions any interim arrangement to be positioned appropriately for alignment with future large scale projects such as IAG.

Financial Implications

4. (1) The current (15/16) funding from RSG is £1,481,500. This will be allocated as follows:-

- £1,148,500 for awards
- £333,000 for administration

(2) This compares with an outturn figure from 2014/15 as follows:-

- £1,436,323 for awards
- £554,000 for administration

Recommendations

5. The Adult Social Care and Health Cabinet Committee is asked to consider and either endorse or make a recommendation to the Cabinet Member on the proposed decision to:

a) extend the current arrangements for local welfare assistance in the context of the options explored, as set out in paragraph 3.(8) (b); and

b) endorse the coordination and integration of the future design, commissioning and provision of any revised model for local welfare provision with that of the larger scale transformation projects.

Contact: *Mel Anthony, Commissioning and Development Manager*
03000 417208, melanie.anthony@kent.gov.uk

Mark Lobban, Director of Strategic Commissioning
03000 415259, mark.lobban@kent.gov.uk

Background Information:
ASCH Committee report December 2014
CMM Report July 2014

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 – 10 July 2015

Decision No: 15/00045

Subject: **KENT COMMUNITY HOT MEALS TENDER**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Cabinet Member Decision

Electoral Division: All

Summary:

This report sets out the case to award the Kent community hot meals delivery contract to commence on 1October 2015. It outlines the background information which has led to the procurement process and the reasons for recommending the award of the contract.

The outcome of the procurement process is:
no bids were received for Lot 1 (East Kent)
one bid was received for Lot 2 (West Kent)

Due to only one bid being submitted negotiation commenced to reach a solution that will ensure a hot meal service is available with the best terms and conditions possible and achieves best value for money.

Recommendation(s):
The Adult Social Care and Health Cabinet Committee is asked to consider and endorse, or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to:-

a) **AWARD** the Kent community hot meals delivery contract to the preferred bidder identified in the exempt appendix to this report, once the negotiations described are successfully concluded. The contract will commence on 1 October 2015; and

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

1. Introduction

1.1 This meals tender sits within the wider work stream of Building Community Capacity. In March 2014 Kent was successful in becoming one of five national pilot areas for the Malnutrition Task Force (MTF) project. The MTF is funded by the Department of Health and supported by Age UK, Nutricia, The British Association of Parenteral and Enteral Nutrition (BAPEN), The Royal Voluntary Service and Apetito. The MTF was set up in June 2012 to look at the issues relating to the prevention and treatment of malnutrition, within hospitals, care home and community settings.

1.2 The vision for Kent is to address malnutrition in the community by developing a diverse and wide ranging market for meals. A stakeholder group has been meeting regularly with representatives from:

- Age UK, national and local
- The Royal Voluntary Service
- East Kent Hospitals University Foundation Trust
- Kent Community Health Foundation Trust
- Apetito
- Kent County Council

1.3 Meals are not a statutory service although Kent County Council has a duty of care to ensure that vulnerable people have access to food and nutrition. The Kent wide contract for community hot meals delivery was awarded in 2006 and has been extended four times. Any further extensions would leave KCC open to potential legal challenge.

2. Financial Implications

2.1 The decline in the numbers of people requiring the service has led to KCC being charged for meals that have not been delivered. The new contract will ensure that KCC only pays for meals that are delivered and will not be linked to set volumes.

2.2 Through the negotiation of this tender, it is anticipated that this contract will produce a lower unit price per meal.

3. Policy Context

3.1 The community hot meals delivery service supports KCC's vision to:

- Tackle disadvantage
- Reduce avoidable demand on health and social care services
- Focus on improving lives by ensuring that every penny spent in Kent is delivering better outcomes for Kent's residents, communities and businesses
- Improve people's outcomes by increasing their independence
- Enable adults in Kent to lead independent lives, safely in their own community

4. The Report

4.1 KCC's current hot meals contract with Apetito began in April 2006. At the contract start volumes were circa 547,500 meals per annum. Since that time demand has consistently reduced and the current volume is circa 70,000 per annum.

4.2 Discussions with other local authorities indicate that this is a national trend, due in part to increased availability of other meal options such as lunch clubs, frozen meals, fresh supermarket ready meals and other home delivery options.

4.3 On 1 April 2014 KCC and Apetito agreed an 18 month contract extension until 30 September 2015. The meal volume was fixed at 120,000 meals (a negotiated reduction from 150,000) at the standard unit price of £7.31.

4.4 Options considered and dismissed

End the community meals delivery contract

KCC would need to provide an alternative arrangement such as replacing with a lunchtime domiciliary care call to prepare a meal which would be significantly more expensive.

Extend the current community meals delivery contract

KCC could be open to legal challenge due to non-compliance with procurement law. This option also did not provide value for money for KCC due to the decline in volume being likely to continue.

5. Legal Implications

5.1 Only one bid was submitted; with advice and support from procurement a period of negotiation has commenced in order to finalise the contract.

6. Equality impact assessment

6.1 An equality impact assessment concluded that the risk to those people with protected characteristics is low.

7. Current position

7.1 The community meals tender was divided into two geographical lots:

Lot 1 (East Kent) - no bids received
Lot 2 (West Kent) - one bid received

7.2 The West Kent bidder stated if they were successful they would also consider providing a service in relation to East Kent.

7.3 The bidder put forward a caveat that KCC re-consider a volume related price. They also stated should meal volumes for Lot 2 drop below an annual volume of 60,000 meals it will be deemed that the contract has been terminated and the bidder will recover any termination costs from KCC. KCC is not prepared to accept this as it creates an unacceptable commercial risk.

7.4 Due to only one bid being submitted negotiation commenced to reach a solution that will ensure a hot meal service is available with the best terms and conditions possible and achieves best value for money.

7.5 Negotiations have been positive and a way forward is emerging based on the following:

- A unit price for a three year contract for both lots with two, one year extensions, or a unit price for a five year contract, in which the unit price for a meal is likely to be less if the contract length is longer;
- To move the client contribution to a direct debit initiated by the bidder. Controls will be put in place for those for whom this option is not suitable. This is seen as a positive move as it will reduce the debt KCC has liable for under the current contract where client contribution has not been recoverable for the current provider.
- Review the need for a when meals would be delivered; this would align the KCC contract to the arrangement the provider has with their private customers.
- Robust contract management to trigger negotiations on price if volumes change in any way, up or down.

7.7 Negotiations at this point have been positive and there is confidence that we will reach a mutual beneficial contractual arrangement with equal level of risk sharing.

8. Conclusion

8.1 The demand for a community hot meal service has significantly reduced in Kent over a number of years. There are currently 279 people in receipt of a delivery of a hot meal; there is a requirement to ensure access to a hot meal remains available but this must also represent value for money.

9. Recommendations

Recommendations:

The Adult Social Care and Health Cabinet Committee is asked to consider and endorse, or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to:-

a) **AWARD** the Kent Community Hot Meals delivery contract to the preferred bidder identified in the exempt appendix to this report, once the negotiations described are successfully concluded. The contract will commence on 1 October 2015; and

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

Contact details

11. Lead Officer:
Director: Mark Lobban, Director of Commissioning, Strategic Commissioning, Social Care, Health and Wellbeing Tel: 03000 415393
Email: mark.lobban@kent.gov.uk

12. Report prepared by:
Emma Hanson, Head of Commissioning -
Strategic Commissioning, Social Care Health & Wellbeing Tel: 03000 415342
Email: emma.hanson@kent.gov.uk

Paula Parker, Commissioning Manager, Strategic Commissioning, Social Care Health and Wellbeing Tel: 03000 415342
Email: paula.parker@kent.gov.uk

Martin Field, Commissioning Officer, Strategic Commissioning, Social Care Health and Wellbeing Tel: 03000 415342
Email: martin.field@kent.gov.uk

This page is intentionally left blank

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	15/00045

For publication

Key decision*

Affects more than 2 Electoral Divisions

Subject: Award for Kent community hot meals contract

Decision to be taken:

a) award the Kent community hot meals delivery contract to the preferred bidder identified in the exempt appendix to this report, once the negotiations described are successfully concluded. The contract will commence on 1 October 2015; and

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

Reasons for decision:

The Kent wide contract for community hot meals delivery was awarded in 2006 and has been extended 4 times. Any further extensions would leave KCC open to potential legal challenge.

The existing contract is linked to volume, the decline in numbers of people requiring the service has led to KCC being charged more as unit cost was linked to set volumes. It was therefore decided to tender for a contract in which KCC will pay a unit price per meal and this would not be linked to set volumes.

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed by the Adult Social Care and Health Cabinet Committee on 10 July 2015 and the outcome of this included in the decision paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered:

End the community meals delivery contract

This option would have meant that for those people who are currently in receipt of a delivered hot meal, KCC would need to provide an alternative arrangement such as replacing with a lunchtime domiciliary care call to prepare a meal which would be significantly more expensive.

Extend the current community meals delivery contract

This would have meant that KCC could be open to legal challenge due to non-compliance with procurement law. This option also did not provide value for money for KCC due to the decline in volume being likely to continue.
Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

....

signed date

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

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

To: Adult Social Care & Health Cabinet Committee 10th July 2015

Decision No: **15/00063**

Subject: Commissioning of Advocacy Services for Vulnerable Adults

Classification: **Unrestricted**

Past Pathway: Social Care Health and Wellbeing DMT 18th March 2015

Future Pathway: Procurement Board 22nd July 2015,
Adult Social Care & Health Cabinet Committee 3rd Dec 2015

Electoral Division: County wide

Summary:

There is a mixed economy of advocacy provision across Kent for vulnerable adults provided through grants and contracts. The Care Act has placed new duties on the local authority to provide advocacy services and changes to Deprivation of Liberty Safeguards (DOLs) have led to increase in demand and requirements for accountable, timely services. Alongside this emerging picture of demand several of the advocacy services are ending in April 2016. This has provided an opportunity to rethink what the Local Authority and the public need from advocacy services and, with approval, commission a new model.

Recommendation:

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

Consider and endorse, or make recommendations to the Cabinet Member on the proposed decision set out below;

That the Cabinet Member will be asked to agree:

1. To the re-commissioning of advocacy services for vulnerable adults; and

2. Agree to delegated authority for the Corporate Director, Social Care, Health and Wellbeing to authorise the letting of the contract.

1. Introduction

1.1 Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to:

- Have their voice heard on issues that are important to them
- Defend and safeguard their rights

- Have their views and wishes genuinely considered when decisions are being made about their lives

1.2 Kent County Council Adult Services has a history of commissioning both statutory and non-statutory advocacy services. These services have been commissioned using both contracts and grants on an ad-hoc basis to meet specific local need, or to meet requirements of legislation for statutory advocacy. This range of services is currently being delivered via 17 different providers. Services are not aligned or standardised and some client groups are under-represented and have fallen through the gaps between services.

1.3 Statutory advocacy provision is governed by legislation and is therefore reasonably well structured and managed. The non-statutory provision, mainly grant funded, is a collection of different interpretations of advocacy and is therefore less clear cut in terms of what is delivered, by whom, and to what standard.

1.4. New requirements under the Care Act 2015 and the ending of current NHS Complaints Advocacy Contract and Independent Mental Capacity Advocacy (IMCA) contract in April 2016 have provided us with the opportunity to revisit the current model and commission something different that works for people regardless of client categories and to ensure consistency of supply and quality. We have worked closely with users of advocacy services, Advocacy providers and practitioners to design a new way to deliver advocacy services.

2. Financial Implications

2.1 By bringing together the current spend on Advocacy across grants and contracts, together with £482k of new money from the Care Act Grant, officers have identified a budget of up to £1.49m which could be used to re-commission Advocacy services. This spend is set out in Appendix 1.

2.2 There will be impact on a number of voluntary sector organisations where their activity will be decommissioned and their funding for advocacy delivery will be reallocated to the advocacy contract. These organisations are aware of this and have been involved in a range of co-production events and discussions with commissioners.

3. Links to KCC's Strategic Framework

3.1 Strategic Outcome

Older and vulnerable residents are safe and supported with choices to live independently

Particularly Supporting Outcomes:

- Those with long term conditions are supported to manage their conditions through access to good quality care and support
- People with mental health issues and dementia are assessed and treated earlier and are supported to live well
- Families and carers of vulnerable and older people have access to the advice, information and support they need
- Older and vulnerable residents feel socially included
- Residents have greater choice and control over the health and social care services they receive

4. Scope of Proposed Advocacy Contract

4.1 The scope of advocacy covered in this document is limited to:

- Statutory provision: IMCA, IMHA, Care Act Independent Advocacy and Health Complaints Advocacy; and
- Specialist community advocacy for people with particular support or communication needs due to disability, frailty or other vulnerability. The type of advocacy used should depend on what is best suited for the person who seeks it, rather than belonging to a particular client category.

4.2 The Learning Disability Advocacy service is outside the scope of this report. There are still two years remaining on the existing contract with Advocacy for All, which is providing a value for money and high standard of service. Following discussions at DMT it was agreed that before the end of the LD contract we will undertake an options appraisal and stakeholder engagement to consider the most appropriate options to re-commission the service.

5. Statutory responsibilities

5.2 Community advocacy exists to ensure vulnerable adults are supported to understand and explore choices and make their views known when dealing with issues relating to housing, employment and welfare benefits. Local authorities also have a number of statutory duties, established in legislation, to ensure people can access advocacy**:**

- The Mental Capacity Act 2005 introduced the right to an Independent Mental Capacity Advocate (IMCA), which gives some people who lack capacity a right to receive support to make specific decisions.
- The Mental Health Act 2007 introduced the Independent Mental Health Advocacy (IMHA) service to safeguard the rights of people detained under the Act and those on community treatment orders and to enable qualifying users to understand the legal provisions to which they are subject and to exercise their rights to participate in decisions about their care and treatment.
- The Health and Social Care Act 2012 introduced the Health Complaints Advocacy Service. Responsibility for commissioning the Health complaints advocacy service transferred from Department of Health (DoH) to local authorities, from 1st April 2013. The aim of this service is to support people who want to make a complaint about a health service, delivered through the NHS or privately sourced.
- The Care Act 2014 introduced a new statutory duty, from April 2015, in provision of Independent Advocacy to strengthen the voice of people and their carers going through assessment, care and/or support planning and care review processes, as well as those people who are being supported through the adult safeguarding process. Care Act Guidance suggests that advocates should be trained and qualified to a certain standard which will be included in our specification. Temporary arrangements have been put in place with current Providers of IMCA until end of March 2016.

6. Gaps in existing provision

6.1. There are identified service gaps in the current advocacy provision. It is proposed that these unmet needs will be covered by remodelling the

provision, and apportioning the existing funding pool according to need in each CCG area. Factors for consideration will include: population, and prevalence of certain conditions, such as dementia, learning disability and mental health needs. The following areas have been identified:

- **Sensory impairments** – there is no commissioned advocacy for people with sensory impairments. This service is spot purchased on an individual needs basis, and is not currently universally available. Year to date there have been 32 referrals through deaf services and 7 through deaf/blind services.

- **Autistic Spectrum Conditions** (ASC) – Currently only people with ASC and diagnosed Learning Disability can be supported though the LD contract. People with ASC at the high functioning end of the spectrum do not qualify. Year to date there have been 10 referrals.
- **Dementia advocacy** is currently only available in West Kent, provision needs to be accessible across the county.
- There is low level of funding to support people with **physical disabilities**, through peer support advocacy. The advocates are not professionally qualified, but are able to support people with disabilities using own knowledge and life experiences.
- **Prisons** – the duty to involve people in their care and support planning and therefore to an Independent Advocate applies in all settings, including prisons.

7. Advocacy and Safeguarding

7.1. Advocacy is an integral part of the safeguarding process, and the Care Act now makes it a statutory duty to provide individuals with an independent advocate, regardless of whether they are assessed to lack capacity. Historically there have been issues with referrals to advocacy during safeguarding, partly due to the fact that some practitioners are not aware of what advocacy provision is available and how to make a referral. The fact that we currently commission advocacy from 17providers explains some of the confusion.

7.2. It is our intention that as part of re-commissioning advocacy provision, we will standardise the referral to advocacy during the safeguarding process. This will enable the authority to simplify the process for practitioners, provide better and timely support of an advocate during the safeguarding process and therefore give greater control and influence for the individual going through the safeguarding process.

8. Demand and population trends

8.1. Increases in the whole population figures indicate that there are likely to be significant increases in the number of people who may need to access advocacy services. The highest needs are expected to be for older persons over 85 years old, people with dementia, learning disability or mental health needs. Further work will be carried out to assess the need for people with sensory impairments, Autistic Spectrum Conditions, and for people in custody. There is significant increase in current demand for IMCA DoLS services following legal rulings on the meaning of deprivation of liberty. The Equality Impact assessment has shown that there will be positive impacts for people with protected characteristics having access to advocacy services.

9. The proposed model

9.1. Two co-production events were held with stakeholders in February and March 2015. Further events are planned with people who have experience of using advocacy services and Providers to develop the model. The emerging approach is to create a prime contractor hub model where all referrals are received and triaged from a central access point, and sub-contracting a network of local advocacy partners who have trained qualified advocates with specialist skills, such as British Sign Language, understanding of autism or supporting people with dementia. This model should help to secure the skills of small, local providers whilst giving scale to ensure best value, quality control and ease of access for the public and professionals. This model will continue to be co-produced with providers and people who have experience of using advocacy at an event on 3rd July and finalised on August 5th. The tendering process is then due to begin in September with implementation from April 1st 2016.

10. OTHER OPTIONS CONSIDERED

10.1 Do nothing, i.e. continue to grant fund existing grant funded services, and contract as per existing arrangements. The main risks of this approach are;

- The local authority will not be Care Act compliant and may not be able to cope with demand.
- There is no additional resource to meet identified gaps in provision, the service will not be able to meet the needs of people, currently excluded, who may need advocacy.
- The existing arrangements may be in breach of procurement law, as the level of funding will exceed EU thresholds

10.2 Commission a range of specialist provision, providing a number of different contracts through different providers, separating IMHA, IMCA, Care Act, Health Complaints and variety of Community advocacy services – whilst this model leads to strong service identity; it does not address the gaps in provision, and heavily relies on the good will of providers to link up their services. It also increases management overheads as we replicate back office functions.

10.3 Generic provision – contract with a single provider. This will remove barriers to access and provide a simplified access route, but it can lead to loss of specialist skills and providers may lack the communication skills needed to facilitate people's involvement. Furthermore, commissioning of a single generic organisation may destabilise the existing market and create the risk of losing potential replacements for the service.

11. Recommendation

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

Consider and endorse, or make recommendations to the Cabinet Member on the proposed decision set out below;

That the Cabinet Member will be asked to agree:

1. To the re-commissioning of advocacy services for vulnerable adults; and

2.	Agree to delegated authority for the Corporate Director, Social Care, Health and Wellbeing to authorise the letting of the contract

Contact details

Karen Cook
Commissioning Manager
karen.cook@kent.gov.uk
07540672904

Emma Hanson
Head of Community Based Services
emma.hanson@kent.gov.uk
03000415342

Background Documents

Appendix 1 – Current spend on Advocacy Services
Appendix 2 – Proposed Record of Decision

Appendix 1 – Current Spend on Advocacy Services

Advocacy Service	Statutory	Client Group	Coverage	Funding Type	End Date	Extension Period	Funding 2014/15 £'000	% of Total Spend	Notes
IMCA	Yes	All	Countywide	Contract	31/03/2016	2 years	£125	8%	Projected forecast
IMHA & Community MH	Yes	All	Countywide	Grant	31/03/2016		£487	33%	Includes £39K for secure settings and out of area placements
Care Act IA	Yes	All	Countywide	Contract	31/03/2016		£482	32%	£482k identified for 15/16 -
NHS Complaints	Yes	All	Countywide	Contract	31/03/2015		£237	16%	Arrangements from April 2015 tbc
Dementia	No	OPPD	WK	Grant	31/03/2016		£44	3%	
CROP (OP)	No	OPPD	Kent except DGS	Grant	31/03/2016		£20	1%	Total grant £99.7k for IA & A
CARM (StOP)	No	OPPD	Romney Marsh	Grant	31/03/2015		£23	2%	Ends 31 March 2015
PD	No	OPPD	Countywide	Grant	31/03/2016		£76	5%	
Total							£1,494	100%	

This page is intentionally left blank

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Graham Gibbens, Cabinet Member for Adult Social Care and Public Health	15/00063

For publication

Key decision*

Expenditure of more than £1million

Subject: Commissioning of Advocacy Services for Vulnerable Adults

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

- the re-commissioning of advocacy services for vulnerable adults; and
- delegated authority for the Corporate Director for Social Care, Health and Wellbeing to authorise the letting of the contract

Reason(s) for decision:

There is a mixed economy of advocacy provision across Kent for vulnerable adults provided through grants and contracts. The Care Act has placed new duties on the local authority to provide advocacy services and changes to DoLS have led to increase in demand and requirements for accountable, timely services. Alongside this emerging picture of demand several of the advocacy services are ending in April 2016. This has provided an opportunity to rethink what the Local Authority and the public need from advocacy services and, with approval, commission a new model

Cabinet Committee recommendations and other consultation:

It is being considered by Adult Social Care and Health Cabinet Committee on 10 July, to seek recommendation to the Cabinet Member on the proposed decision. Consultation has taken place with the public and users of services and Providers of services at 2 events on the 13th February and 25th March 2015. 2 more events are planned.

Any alternatives considered:

1. Do nothing, i.e. continue to grant fund existing grant funded services, and contract as per existing arrangements. The main risks of this approach are;
   - The local authority will not be Care Act compliant and may not be able to cope with demand.
   - There is no additional resource to meet identified gaps in provision, the service will not be able to meet the needs of people, currently excluded, who may need advocacy.
   - The existing arrangements may be in breach of procurement law, as the level of funding will exceed EU thresholds

2. Commission a range of specialist provision, providing a number of different contracts through different providers, separating IMHA, IMCA, Care Act, Health Complaints and variety of Community advocacy services. Whilst this model leads to strong service identity; it does not address the gaps in provision, and heavily relies on the good will of providers to link up their

services. It also increases management overheads as we replicate back office functions.

3 Generic provision – contract with a single provider. This will remove barriers to access and provide a simplified access route, but it can lead to loss of specialist skills and providers may lack the communication skills needed to facilitate people's involvement. Furthermore, commissioning of a single generic organisation may destabilise the existing market and create the risk of losing potential replacements for the service.

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

....

signed date

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
10 July 2015

Subject: **CARE ACT – UPDATE ON PHASE 1 AND PLANS FOR PHASE 2**

Classification: Unrestricted

Past Pathway: Not applicable

Future Pathway: Not applicable

Electoral Division: All

Summary: This report provides an update on the Care Act Programme, what has been implemented so far, early indications of activity and the plans for the Phase 2 reforms to be implemented from April 2016.

Recommendations:

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

a) **NOTE** the information provided on Phase 1 of the programme and the plans being implemented for Phase 2.
b) **DISCUSS** any of the issues raised in the report.

1. Introduction

1.1 The majority of the reforms contained within the Care Act 2014 came into effect in April this year. This includes the new legal framework for assessment, eligibility, how needs are met and the new duties towards carers. Further changes, including the cap on care costs, raising of the capital threshold, new rights for self-funders in relation to care homes and the new appeal rights will not be instituted until April 2016 (subject to final decisions by the Government).

1.2 This report provides a progress report on the implementation of the 2015 reforms and provides details of the plans for the 2016 changes.

2. Implementation of the 2015 reforms

2.1 In order to ensure that the Care Act reforms were successfully implemented, the Care Act Programme was set up in 2014. This contained several projects and workstreams covering all the main areas where change to existing policies and processes was required.

2.2 In April a review of the implementation of Phase 1 was carried out. This concluded that, although there were a few specific activities that were not quite concluded, the county council had implemented the minimum requirements to be Care Act compliant from 1 April 2015. The outstanding activities are on course to be completed by July, with the exception of the new version 29.1 of Swift which is now due to be in use by August.

2.3 Areas to highlight as being successfully implemented include:

- The adoption of the new national minimum eligibility criteria
- The new rights for carers to receive support in their own right
- The new rights to independent advocacy
- The new Deferred Payments scheme for those in residential care with a property
- The new responsibilities for prisoners with care and support needs
- Information and advice about the new reforms and how they will affect current and new service users

3. Impact on performance indicators

3.1 Both the Department of Health and the county council are actively monitoring key indicators in order to determine the impact of the reforms, such as the numbers eligible for care and support and the demand for carers assessments.

3.2 The table below shows activity in some key areas for April and May 2015. Further data will be brought to future Cabinet Committees along with a comparison with previous year's data.

Indicator	**April and May 2015**
Number of adults assessed for social care	3,993
Number who met the eligibility criteria	3,348
Number of carers assessed	377
Number of carers who received services/support	325
Number of people for whom an independent advocate was arranged under the Care Act	53
Number of prisoners assessed	9
Number of prisoners who met the eligibility criteria	9
Number of requests for a Deferred Payment	42
Number of Deferred Payments agreed	13

3.3 It is too early to draw any firm conclusions based on the above figures. Monitoring will continue and a more complete picture presented to future Cabinet Committees. This will also put the data in the context of wider transformation activity.

4. Phase 2 Programme plans

4.1 Phase 2 of the programme covers those sections of the Care Act that are to be implemented and are planned to come into effect from April 2016. A detailed plan and governance arrangements have been signed off by the Adults Portfolio Board and detailed work has begun.

4.2 The Phase 2 Programme Plan is based on the Act and the draft Regulations and Guidance. The final versions are not due to be published until October, although the Government has indicated that they will provide further details following the July Budget. In view of the timescales involved, it is necessary to develop and begin implementing the plan now. If necessary, changes can be made following the release of the final Regulations and Guidance in October.

4.3 Phase 2 of the Programme involves the key 'Dilnot' reforms (cap on care costs and raising of the capital threshold), new rights for self-funders in relation to care homes and the new appeal rights. Details are set out in the table below.

OUTCOMES	**DESCRIPTION**
Cap on Care Costs: a system that is compliant with Care Act requirements (for both service users and self-funders) to be in place by April 2016 (with some elements in place for early assessment by October 2015).	The cap on care costs provides for an absolute limit to be put on how much an individual has to spend on their eligible care and support needs in their lifetime. From April 2016, for individuals who are assessed as having eligible needs from the age of 25 and above, this will be £72,000. The amount that counts towards the cap is what the reasonable cost to the local authority would be if it were to meet these needs. NB: Those who are assessed as having eligible needs before the age of 25 will have a zero cap – i.e. they will be provided with free care and support for those needs throughout their lifetime.
New policies and procedures for charging and residential placements compliant with the Care Act: the new requirements to be embedded in policies	There are several significant changes to the charging (financial assessment) rules including an increase to the capital thresholds – in residential care this is increasing to £118,000 (except where the person benefits from a disregard on their former home in which case the threshold will be £27,000); in the community it is increasing to £27,000. In addition there may be new rules regarding self-funders in residential care who wish KCC to meet their needs, new rights to self "top-up" and

and procedures by April 2016.	to receive a Direct Payment in a care home.
New appeals system: an appeals system which is compliant with the Care Act to be in place by April 2016.	It is expected that an independent appeals system will be set up, which will include the use of Independent Reviewers if the issue cannot be resolved within the local authority.

5. Local Government Association Deep Dive

5.1 As part of their review into how the Care Act is being implemented, Local Government Association representatives visited KCC on 24 April as part of their deep dive pilot. The feedback was very positive and KCC was praised for how we have embraced the opportunities and challenges posed by the Care Act.

6. Recommendations

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

a) **NOTE** the information provided on Phase 1 of the programme and the plans being implemented for Phase 2

b) **DISCUSS** any of the issues raised in the report.

Report author:
Christine Grosskopf
Policy Adviser (Strategic)
Strategy, Policy, Relationships and Corporate Assurance Division
Corporate Services, KCC
Tel: 03000 416 181
chris.grosskopf@kent.gov.uk

Background Documents
None

From:	**Graham Gibbens, Cabinet Member for Adult Social Care and Public Health** **Andrew Ireland, Corporate Director Social Care, Health and Well Being**
To:	**Adult Social Care and Health Cabinet Committee 10 July 2015**
Subject:	**Adult Social Care Transformation and Efficiency Partner Update**
Classification:	**Unrestricted**
Electoral Division:	**All divisions**

Summary: This report provides an update on Adult Social Care Transformation and the work with the efficiency partner, including plans for implementation.

Recommendation:

No specific decision is required.

The Cabinet Committee is asked to note the information provided in the report.

1. Background

1.1 Following the decision to appoint Newton Europe as the adult social care transformation and efficiency partner, a commitment was made to provide the Social Care and Public Health Committee with regular updates.

1.2 As outlined to Cabinet Committee in March 2015 a number of opportunities for phase 2 savings and transformation have been identified and Newton Europe worked with KCC staff between October 2014 and June 2015 to design how these opportunities will be realised.

1.3 This paper outlines the outcomes from the design phase and plans for implementation.

2. Phase 2 design update

2.1 **Acute Demand** – design has looked at the acute hospital discharge process and short term pathway model with the aim of reducing the number of service users requiring a long term placement or short term bed.

In the design phase, work was done with independent practitioners who reviewed the cases of service users in a long term setting. For service users whose pathway started in hospital followed by a short term bed placement and who had subsequently been placed in a long term setting, the review judged that in up to 90% of cases other factors, such as family wishes or service availability, rather than actual need had led to the long term placement. Improvements to decision making processes implemented during the design period reduced inappropriate onward referrals to short term and

trial placements by more than 30% which resulted in a 30% reduction in long term placements.

2.2 **Enablement** – design has looked at the enablement delivery model to make processes more efficient. Variation in process and practice between different localities means there is opportunity to increase the efficiency of Kent Enablement at Home (KEAH) teams as well as further improve outcomes for service users who have access to the service.

This will be achieved through improved scheduling (making better use of Support Workers' time on a day to day basis) and rota-ing (matching staff availability to demand) which will free up time to help reduce the number of service users we reject on a weekly basis as well as help to accept additional referrals coming from Hospitals teams as a result of the acute work. In the design phase, operational efficiency was increased in the Canterbury office by over 11%. This helped reduce rejections to the lowest observed level since 2014.

Variation observed in service user outcomes was found to be independent of the level of need at the end of Enablement. The design phase helped standardise outcomes and align them to measured need.
At the end of the design phase, over 90% of service users left the Ashford KEaH team without a domiciliary care package. Previously this was only 75% of service users. Replicating this result across all the localities in implementation will result in an additional 1000 people every year being enabled to independence.

2.3 **Demand Management** – adult social care currently invest approximately £9m in preventative services delivered through the voluntary sector in Kent, to older people and people living with dementia. It is widely believed that such services promote wellbeing and support individuals to remain independent longer, reducing demand on statutory social care services. However, this has been difficult to evidence. Further, under the Care Act 2014, KCC has an obligation to promote services which prevent or delay the need for care or support. In order to understand the effectiveness of current services, and in order to make informed decisions about the future commissioning of preventative services, the design phase focused on developing a methodology to measure the effectiveness of the different services and organisations by capturing information about the needs presented by a service user when they contact the Area Referral Management Service (ARMS) teams.

The measure of effectiveness of that service or organisation is the time between the initial contact and any subsequent contact *for the same need*. If this service prevents an individual receiving a statutory service, then this is a saving or cost avoidance to KCC. However, since the rate at which people are referred to the voluntary sector from ARMS is low, data collected during the design phase has been supplemented with an analysis of historical data. The data collection methodology is now being used in all ARMS, but additional data is required before any conclusions can be drawn. Once sufficient data has been captured, decisions can be made about which needs are best met through voluntary sector services and which services and organisations are most effective in delaying entry into social care. This will allow KCC to optimise its use of the most effective services from the voluntary

sector, improving value for money on our current investment and also will inform the re-commissioning of preventative services in the voluntary sector.

2.4 **Alternative Models of Care (AMOC)** – there are over 1200 service users with a learning disability in residential care in Kent. Initial scoping with care managers and with support from the KCC design team identified that there may be a proportion who may have improved outcomes in alternative settings. One such alternative setting is Shared Lives which is similar to fostering in that a person with a learning disability lives with a host family for an extended period of time. The work of AMOC is in line with the outcomes expected through the Joint Health and Social Care Self-Assessment Framework (SAF) to make sure people with learning disabilities get equal access to services so they can stay healthy, keep safe and live well. The design phase identified the extensive work required with services users, families, and providers to enable consideration of any appropriate move. This will be addressed in implementation.

2.5 **Pathways to Independence** – the Kent Pathway Service is a new service which aims to improve independence for service users and prevent care package increases for those service users who have had a change in circumstances, through 6-12 weeks intensive training programme. The design phase, built on a pilot run 12 months previously, used case reviews and work in Dover and Thanet to identify potential demand that would be suitable for the service and any additional demand through multiple referrals and new service users. This identified over 500 service users who were suitable to go through the Kent Pathways Service.

3. Phase 2 Implementation

3.1 **Acute Demand** – implementation aims to standardise the decision making process across all the hospitals in Kent and once the most appropriate pathways are being selected, the work stream will also aim to ensure these services are available. This will improve the short term pathways as well as reduce the use of ineffective Short Term Beds. The result will be to sustainably improve long term outcomes for service users after a spell in an acute setting with a saving target of £2.34M p.a.

Implementation will be grouped by area and split into two phases with Newton Consultants working alongside Short Term Pathway Team Leads and Senior KCC resource who will be responsible for introducing an improved process, visibility of performance and supporting governance.

3.2 **Enablement** – implementation will be comprised of two main work streams. The first will aim to increase the efficiency of KEaH support workers by improving the process by which service user visits are scheduled. Two main opportunities were identified during the design phase; time was being lost because the planned visit duration often exceeded the required time that the support worker would spend with the service user. The second opportunity was in reducing the amount time at the end of a shift that went unbooked. Reducing the frequency of these problems will increase the team utilisation. The second aspect that will be standardised is the total amount of enabling time that each service user requires. This is dependent on the number of visits and the average duration of each visit. This will be monitored to ensure that teams do not spend an unnecessarily large amount of time with service

users but also so that the time is not reduced to the point where Outcomes are affected. Combining the utilisation and amount of enabling time per service user provides a measure of efficiency (the number of service users KEaH are able to see for every paid hour of Support Worker time). The project aims to increase this measure by 5% which would result in 10 fewer rejections per week which introduces a domiciliary care pathway saving of £1.64M p.a.

The second work stream will aim to further improve Service User outcomes for those accessing the service. This will be achieved with the introduction of daily review meetings where Senior Practitioners and Occupational Therapists can help Supervisors identify a target level of independence they feel each service user entering the service should be able to achieve. This daily meeting will also help agree the additional support that might be required for this service user to get to this agreed target. During design this was things like additional equipment, Telecare, access to voluntary organisations or giving the supervisors more confidence and support to engage the family and overcome pressure that the family may have exerted on them. As well as targeting more independent outcomes earlier on, paperwork that support workers fill in will also be updated to give Supervisors better visibility of the progress being made against the identified goals. This progress is reviewed on a weekly basis to ensure any problems are identified. This process helped reduce the average hours of domiciliary care in the Ashford KEaH team by an average of 0.5 hours per SU per week (equivalent to helping an additional 1 in 10 Service Users avoid starting a 5 hour per week care package). Replicating the same improvement across the county in implementation will further reduce domiciliary spend by a target of £3.35M p.a.

3.3 **Demand Management** – as part of the design phase several opportunities have been identified for an implementation phase. These include: diverting more people to the voluntary sector, making sure that those diverted are referred to the most effective services, identifying other services and referring to them and re-commissioning services delivered through the voluntary sector using information gathered through the data capture process in conjunction with other sources of information, such as service user engagement. At the moment, there is insufficient data to draw conclusions about which approach will be most effective for implementation. Therefore, data collection will continue on an ongoing basis, and Older Person's Divisional Management team will receive regular updates regarding progress on data collection and the results produced.

3.4 **Alternative Models of Care** – the work within learning disability has been aligned to ensuring outcomes under the Self-Assessment Framework (SAF) and ensures delivery of the LD Partnership Strategy as a number of outcomes have been aligned to the implementation of phase 2 work.

The approach to implementation would be to review an initial set of service users and their residential homes and to collate their desired outcomes and the available service capacity to provide appropriate new care settings. This would begin to build more confidence in financial benefit, number of users who may be able to move and any homes at risk through transfers. Implementation would be set up with carefully managed stage gates to pass through depending on output on each stage with a KCC project manager to provide central coordination. There will be ongoing engagement throughout

implementation with principles and governance and regular communication with service users and families.

3.5 **Pathways to Independence** – the proposal for implementation is a three stage approach starting with 3 months to sustain existing work and prepare for roll out, then roll out in East Kent followed by West Kent. Capacity modelling has been carried out to understand resourcing requirements for the service and further capacity modelling in implementation will lead to early decision on required organisational structure through roll out.

3.6 **Shared Lives** – implementation will require 3 months upfront support to improve approval processes, monitor recruitment and set up Shared Lives champions. This can be monitored up to point at which first host families are available in 6 months and the transfer process can be managed under AMOC.

4. Financial Implications

4.1 The table below outlines the current opportunity matrix for the implementation of Phase 2 Design.

Area	Project	Design			Years to Reach Full Run Rate
		Target Total	Target (£m)	Stretch (£m)	
Reshaping the Market	Alternative Models of Care (One-Off)	£4.58	£3.23	£5.20	3.8
	Alternative Models of Care (Recurrent)		£0.51	£1.01	11.1
	Reshaping support contracts				
	Shared Lives (One-Off)		£0.72	£1.15	3
	Shared Lives (Recurrent)		£0.12	£0.17	9
Kent Pathways Service (KPS)	KPS - Cost Saving (One-Off)	£1.28	£0.43	£0.60	TBC
	KPS - Cost Avoidance (One-Off)		£0.59	£0.83	
	KPS - Cost Saving (Recurrent)		£0.03	£0.04	3.4
	KPS - Cost Avoidance (Recurrent)		£0.23	£0.32	
Acute	Short Term Beds Reduction	£2.34	£0.37	£0.53	0.2
	Acute outcome improvement		£1.97	£2.25	4.3
Outcomes & Process	Enablement Volume	£6.25	£1.64	£2.63	3.6
	Enablement Outcomes		£3.35	£4.69	
	Enablement Efficiency				N/A
	Enablement Outsourcing				
Demand Management	VolOg Dom Substitution	£0			N/A
	VolOg Resi Delay				
Total (excl. Outsourcing)			**£13.20**	**£19.42**	

5. Legal Implications

5.2 Although no significant impacts have been identified any subsequent legal impacts arising from phase 2 implementation will be managed through Adult Transformation Portfolio Board within the existing risk management approach.

6. Equality Implications

6.1 Equality Impact Assessments have been carried out as part of Phase 2 Design and there are no significant implications for equality. Copies of all EqIAs for Phase 2 are attached as an appendix.

7. Recommendation

Recommendation:

No specific decision is required. The Cabinet Committee is asked to note the information provided in the report.

6. Background Documents

6.1 Item 9 – Kent County Council, 17th May 2012 Adult Social Care Transformation Blueprint and Preparation Plan, May 2012
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=113&MId=3905&Ver=4

6.2 Item B2 - Social Care and Public Health Cabinet Committee, 21 March 2013 - 13/00010 - Appointment of a Transformation and Efficiency Partner - Adult Social Care Transformation Programme
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=747&MId=5129&Ver=4

6.3 Item B3 – Social Care and Public Health Cabinet Committee, 4 October 2013 - Adult Social Care Transformation and Efficiency Partner Update
https://democracy.kent.gov.uk/documents/s42746/B3%20-%20ASC%20Transformation%20Update%20October%202013%20v0.2.pdf

6.4 Item C2 – Social Care and Public Health Cabinet Committee, 2 May 2014 - Adult Social Care Transformation and Efficiency Partner Update
https://democracy.kent.gov.uk/documents/s46410/C2%20-%20Adult%20Social%20Care%20Transformation%20Update.pdf

6.5 Item B7 - Social Care and Public Health Cabinet Committee, 26 September 2014 - Adult Social Care Transformation - Phase 1 Update and Appointment of Partner for Phase 2 Design
https://democracy.kent.gov.uk/documents/b13911/Adult%20Social%20Care%20Transformation%2026th-Sep-2014%2009.30%20Adult%20Social%20Care%20and%20Health%20Cabinet%20Committe.pdf?T=9

6.6 Item b4 - Social Care and Public Health Cabinet Committee, 21 March 2015 - East Kent Sexual Health Services - interim contract extension
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=829&MId=5992&Ver=4

7. Contact details

Report Author:
Jo Frazer, Head of Adult PMO, SCHWB
03000 415320, jo.frazer@kent.gov.uk

Relevant Director:
Mark Lobban, Director of Strategic Commissioning, SCHWB
7000 4934, mark.lobban@kent.gov.uk

From:	Graham Gibbens Cabinet Member, Adult Social Care and Public Health Andrew Scott-Clark, Director of Public Health
To:	Adult Social Care and Health Cabinet Committee
Date:	10th July 2015
Subject:	Kent Drug and Alcohol Services – Commissioning Plans
Classification:	Unrestricted
Past Pathway of Paper:	This is the first committee to consider this paper.
Future Pathway of Paper:	A progress report will be presented to the committee in September 2015.
Electoral Division:	All

Summary

Drug and alcohol misuse continues to have a significant impact on individuals, families and communities in Kent. Drug and alcohol services in the county are currently funded by a combination of the Public Health grant and historic financial reserves which will no longer be available from 2016/17. In addition, the recent needs assessment shows there have been changes in population need for substance misuse services.

Public Health plan to re-commission these services to bring them onto into a financially sustainable footing whilst maintaining the strong performance of the service. Public Health proposes to adopt a commissioning and procurement approach which will enable the team to engage with citizens, service users and providers in order to co-design a new more efficient and cost-effective service.

Recommendations

1.1. Members of the Committee are asked to:

i. Note the level of efficiency savings that need to be achieved through the re-commissioning of adult community drug and alcohol services in Kent

ii. Comment on the proposed commissioning approach (option 2 in paragraph 6.1) and procurement plan designed to achieve savings and required outcomes.

1. Introduction

1.1. Kent County Council is responsible for commissioning drug and alcohol services across Kent as part of its Public Health responsibilities.

1.2. The conditions of Kent's Public Health grant states that in using the grant, KCC must 'have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services'.[1]

[1] Local Authority Circular LAC(DH)(2014)2,page 8

1.3. This paper aims to provide information about the current performance and outcomes of the current services and sets out commissioning plans for services from April 2016 onwards.

2. Background

2.1. Continuing drug misuse among the population causes substantial harm to individuals, families and communities in Kent. There is good evidence that drug treatment is very cost-effective with research showing that every £1 spent on drug treatment delivers £2.50 of savings for society.

2.2. Current performance in terms of treatment outcomes for people who access the services tend to be very good and above the national average although there are some areas of the current system that perform less well and require further investigation and evaluation.

2.3. Performance of drug treatment services will also affect future Public Health funding levels through the Health Incentive Premium Scheme will aim to 'reward communities for progress made against the completion of the drug treatment indicator'[2].

2.4. Adult community drug and alcohol services in Kent are currently delivered by CRI in West Kent and Turning Point in East Kent via a contract with KCC Public Health. The West Kent contract was set up as one of eight national Payment by Results (PbR) pilots in 2012 and the East Kent service started in April 2013 following a competitive tendering process.

3. Current and Future Needs

3.1. The recently completed substance misuse needs assessment highlighted a continuing need for drug and alcohol services in Kent.

3.2. Alcohol misuse is increasing in Kent and is causing substantial harm. Severity of alcohol problems varies widely from lower risk drinking through the high risk and binge drinking right through to severe alcohol dependence (alcoholism). Around 3.5% of the Kent population is 'moderately dependent' and 0.1% of the population is 'severely dependent' on alcohol.

3.3. Mortality rates for alcohol specific deaths in Kent districts are broadly similar to the England Average (15 per 100,000) but this masks considerable variation, with Thanet and Swale appearing as outliers. Alcohol misuse also contributes to many other chronic conditions e.g hypertension.

3.4. Kent's deaths from illegal drug use and addiction are higher than the national average. Hospital admissions for drug related mental health problems have increased by 75% in Kent over a 5 year period (2009-2013). There are also emerging new drug issues e.g 28% of CRI surveyed domestic violence victims reported the perpetrator was using anabolic steroids; there is a national issue surrounding novel psychoactive substances (legal highs) and emerging trends of prescribed opioids and benzodiazepine misuse.

3.5. The demand for drug and alcohol services has changed in several respects in recent years. Opiate use has steadily declined but continues to cause substantial harm both

[2] Local Authority Circular LAC(DH)(2014)2 page 5

to the individuals affected but to their families and communities not least because of the strong link to drug related crime.

3.6. The emergence of an increasing range of novel psychoactive substances (often referred to as legal highs) may well lead to changing patterns of demand for services. The substance misuse needs assessment highlight that the proportion of young adults (those aged 18-25) are far less likely to access community treatment services compared to older adults. This low level of engagement may be for a number of different reasons, but suggests that opportunities to intervene are being missed.

3.7. There is some evidence of gaps in service gaps in relation to people with more complex needs such as drug or alcohol misuse combined with mental health problems (known as dual diagnosis). Kent also has a higher than average proportion of people entering prison with substance dependency who were not previously known to community treatment services.

4. Financial Context

4.1. KCC currently spends £12.8 million per annum on adult community drug and alcohol services. However, this spend includes funding from historic underspends (reserves) which have been used to fund some of pilot initiatives as well as some of the annual operating costs of the treatment services.

4.2. These financial reserves will no longer be available for substance misuse services from 2016/17 onwards; this will mean that the services will need to operate on an annual recurring budget of £10 million (including prescribing costs of approximately £1.3 million). A full breakdown of the budget is included at Appendix A.

4.3. The last time that substance misuse services were retendered in 2011/12 and 2012/13, the contracts for West and East Kent were awarded at a combined value of £10 million, excluding prescribing costs. This suggests that it is feasible to bring the commissioning budget into balance from 2016/17 through a commissioning process if the services can achieve efficiency savings that are sufficient to absorb the drug and alcohol treatment prescribing costs.

5. Commissioning Approach

5.1. The West Kent Substance Misuse Service contract is due to expire in March 2016 and will therefore need to be competitively retendered. The initial three-year term of the East Kent contract is also due to expire at the same time but has provision for a contract extension of up to two years. This also takes place in the context of serious overall constraints on the entire public health budget.

5.2. Kent has taken an innovative approach to substance misuse services including piloting the use of payment by results (PbR) as well as a number of other initiatives designed to meet the needs of particular vulnerable groups such as those with a dual diagnosis or other complex needs.

5.3. There is substantial body of evidence about what works in drug and alcohol treatment. Kent is well placed apply this learning by taking a co-design approach to future service design and specification.

5.4. Drug and alcohol services will need to change over the next three to five years in order to deliver cost efficiency savings whilst maintaining strong service performance and meeting changing population needs. This means that contracts will need to be flexible and responsive to these changing requirements. The initial proposed service categories that could form the basis of the outline service specification and co-design are listed at Appendix B.

5.5. These categories and service interventions would be subject to wider consultation ahead of the procurement process and would be subject to change over the life of the contract. This would mean that commissioners could amend the scope of the contracts to add or remove interventions or group the services in order to bring in a wider range of providers if necessary.

5.6. This flexibility will be crucial to ensure that the wider changes in health improvement services (discussed in a separate paper) can effectively address drug and alcohol misuse, especially those relating to people drinking at increasing or higher risk levels.

5.7. The changes to drug and alcohol services would need to be implemented in West Kent through a competitive tender process as the current contract is due to expire in March 2016. Public Health commissioners are exploring whether the changes could be implemented in East Kent through a contract change and extension in East Kent. If this is not feasible, it would be necessary to re-tender the East Kent contract at the same time as West Kent.

6. Procurement Options

6.1. There are two different procurement routes to adopting the co-design approach to commissioning the new drug and alcohol services:

- **Option 1:** Work with stakeholders to co-design a service specification with input and suggested from a range of different potential service providers and then select a service provider through a competitive tender process.

- **Option 2:** Select a service provider as a strategic partner, through a competitive tender process, and then work together to co-design an efficient service model after contract award within certain parameters.

6.2. Each option has advantages and disadvantages. Public Health considers that the range and complexity of the services and the need to make substantial efficiency savings make Option 2 the preferable choice.

6.3. This option will allow commissioners to select a strategic partner on a range of criteria including:

- Track record and experience of delivering effective drug and alcohol services

- Capability to manage change effectively

- Proposals for engaging service users and stakeholders in the co-design process

- Proposals for managing transition to a new service model whilst maintaining required performance levels

- Value for money and proposals for efficiencies and innovation.

6.4. The successful provider would then be contracted to deliver the commissioned drug and alcohol services, participate in the co-design process and manage the transition to a new service model.

6.5. An outline procurement timetable is included at Appendix C.

7. Risks

7.1. The key risks associated with the proposed commissioning and procurement approach are likely to be:

- lack of market appetite or ability to meet the identified needs
- failure to select a suitable provider to engage in the co-design process and subsequently manage the transition to a new, lower cost service model
- failure to realise the required cost savings without causing negative impacts elsewhere e.g. increased drug related crime, poorer treatment outcomes.

7.2. Early market research and engagement indicates that there is a competitive market for drug and alcohol services in Kent. Many service providers also have a good track record of managing service transitions successfully and engaging their service users in on-going service development and improvement.

7.3. The possibility of not being able to realise the required efficiency savings will continue to present a risk through the early stages of the new contract. Public Health commissioners will continue to manage this risk and report performance and outcomes to the committee through the Public Health performance report.

8. Conclusion

8.1. Drug and alcohol misuse continues to have a significant impact on individuals, families and communities in Kent.

8.2. Public Health is planning to re-commission drug and alcohol services in the county in order to bring the services onto a financially sustainable footing whilst maintaining the strong performance and cost-effective outcomes for those who access the services.

8.3. Public Health is proposing to take a co-design approach in developing new services in order to ensure that the new services are as efficient and effective as possible. This commissioning approach will require a competitive tendering process certainly in West Kent and possibly in East Kent if it is decided that the changes cannot be achieved through the existing contract.

8.4. The key risks with this commissioning and procurement approach have been identified and will be managed through the Public Health commissioning structures and reported to the committee as the commissioning programme progresses.

9. Recommendations

9.1. Members of the Committee are asked to:

iii. Note the level of efficiency savings that need to be achieved through the re-commissioning of adult community drug and alcohol services in Kent

iv. Comment on the proposed commissioning approach (option 2 in paragraph 6.1) and procurement plan designed to achieve savings and required outcomes.

Background documents

Local Authority Circular LAC(DH)(2014)2 available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388172/final_PH_grant_determination_and_conditions_2015_16.pdf

Report Authors:

Karen Sharp, Head of Public Health Commissioning
Karen.Sharp@kent.gov.uk
03000 416668

Jess Mookherjee, Consultant in Public Health
Jessica.Mookherjee@kent.gov.uk
03000 416493

Mark Gilbert, Commissioning and Performance Manager, Public Health
Mark.Gilbert@kent.gov.uk
03000 416148

Appendix A – Drug and Alcohol Service Commissioning Budget

	Budget (£000s)	
	2015/16	2016/17
Expenditure	12,816	10,050
Core contract	10,000	8,554
Adult Substance Misuse - East Kent	6,000	5,132
Adult Substance Misuse - West Kent	4,000	3,422
Prescribing costs	1,296	1,296
Adult Substance Misuse - East Kent	840	840
Adult Substance Misuse - West Kent	456	456
Pilot projects	1,070	
Adult Substance Misuse - East Kent	296	
Drug and Alcohol Nurse Liaison - East Kent	188	
Adult Substance Misuse - West Kent	494	
Drug and Alcohol Nurse Liaison - West Kent	92	
Other costs	450	200
Identification and Brief Advice	100	100
FDAC	260	0
Prescribing costs contingency	75	100
Campaigns	15	
Balance to be drawn down from reserves	**12,816**	**10,050**

Appendix B – Proposed Service Blocks

Category	Service Interventions
Prevention	Education and Campaigns e.g. Alcohol Awareness, Know Your Limits, Information on NPS Workforce awareness training e.g. use of the Alcohol Use Disorders Identification Test (AUDIT)
Early Intervention	Alcohol Identification and Brief Advice (delivered through primary care and wider health and care workforce) Links to Early Help and Troubled Families programme
Treatment and Recovery	Assessment and recovery planning Harm Reduction for problematic drug use (including needle and syringe programmes, physical health assessments and motivational support) Pharmacological Treatment (i.e. opiate substitution therapy, alcohol detoxification) Psychosocial Interventions (counselling) Specialist Substance Misuse support for people with complex needs (including dual diagnosis clients) Referral and access to inpatient detoxification and residential rehabilitation Peer led initiatives (including use of Naloxone) Support for Mutual Aid (e.g. Alcoholics Anonymous, Narcotics Anonymous) run alongside wraparound programmes

Appendix C – Procurement Timeline

Dates	Task
June – August 2015	Engagement, Consultation and Planning
September 2015	Cabinet Committee updated on commissioning proposals
September – November 2015	Tender Process
December 2015	Cabinet Committee Review of Contract Award Proposal Key Decision to award contract(s) Contract Award
January – March 2016	Transition Phase
April 2016	New contract(s) start

This page is intentionally left blank

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

Andrew Ireland, Corporate Director Social Care, **Health and Well Being**

To: **Adult Social Care and Health Cabinet Committee – 10 July 2015**

Subject: **Integrated Commissioning for Learning Disability in Kent**

Classification: **Unrestricted**

Past Pathway: DMT/Accountable Officers and CCG meetings in 2014/15

Future Pathway: Adult Social Care & Health Cabinet Committee – 11 Sept 15
CCG Governance Committees in Sept 15
Kent Learning Disability Board, October 2015
Kent Health and Wellbeing Board November 2015;

Electoral Division: All divisions

Summary:

This project has been established to explore possible integrated commissioning arrangements between KCC and the 7 CCGs in Kent for adult learning disability. This has been jointly commissioned by KCC's officers and by the Clinical Commissioning Groups' Accountable Officers.

This report provides an outline of the content of a paper that will be submitted to governing committees in KCC and CCGs in September 2015 to seek a decision to continue to develop the formal arrangements and the scope of those arrangements with a view to final sign off in January 2016 for implementation in April 2016.

Recommendation(s):

No specific decision is required

The Cabinet Committee is asked to note the information provided in the report.

1. Introduction

1.1 This report summarises the project to develop an integrated commissioning arrangement for learning disability between Kent County Council (KCC) and the 7 Clinical Commissioning Groups (CCGs) in Kent, which if approved would become operational from 1st April 2016 with KCC leading on behalf of the CCGs under a Section 75 Agreement.

1.2 The project will focus on services and support commissioned for adults with a learning disability but will make links with children's services and ensure that the arrangements are cognisant of the need to deliver a seamless response across the 0-25 age range.

1.3 Whilst the integrated commissioning arrangements will focus on areas where there is dedicated expenditure on services for people with a learning disability it will set out a framework for commissioning which will ensure that people with a learning disability will be able to access the full range of health and social care services with appropriate reasonable adjustments. Thus it will address the relationships with and roles of Public Health, NHS England (NHSE) and CCGs in relation to support provided to people with a learning disability.

1.4 The potential to operate with a pooled budget will be examined to see if such an arrangement would be beneficial to all parties and to look at options for the scope of the pooled budget. It will look at the governance arrangements for the operation of a pooled budget to assure all partners of the accountability arrangements.

1.5 The commissioning plan for learning disability will be developed for all partners to agree which will set out priorities for action over the next 3 – 5 years that is consistent with both KCC and CCG strategic plans.

1.6 The future contracting arrangements will be examined, particularly for dedicated NHS Learning Disability services, currently provided by Kent Community Health Foundation Trust (KCHFT) and Kent and Medway Partnership Trust (KMPT), to see if these can be improved to ensure the delivery of integrated care for people with a learning disability.

1.7 An integrated performance framework will be developed which will enable KCC and the CCGs to be assured of the performance and outcomes of their commissioned services and to measure the impact of those services.

2. Financial Implications

2.1 There is potential for up to £145 million of KCC budget to be pooled with approximately £30 million of CCG budgets. A consideration of whether NHSE funding could be included in the pool would also be made.

3. Policy Framework

3.1 The Integrated Commissioning for Learning Disability in Kent project will be developed in line with the Councils' Commissioning Framework and ten supporting principles.

4. Progress

4.1 Since the publication of Valuing People in 2001 KCC and the NHS in Kent have had well established integrated community learning disability teams. These are recognised as an example of good integrated care across the county. These operate under a Section 75 Agreement, which was agreed by KCC with the former East and West Kent Primary Care Trusts (PCTs), with a management

agreement between KCC, Kent Community Health Trust (KCHT) and KMPT describing how they work together to deliver the integrated teams. With the advent of CCGs, the commissioning of these teams now relies upon 8 partners agreeing to continue this arrangement. As CCGs and KCC increasingly focus on local integration agendas there is a risk of fragmenting the county wide model of community LD teams without the expertise of a county wide commissioning team to lead the learning disability commissioning and provide advice to partners.

4.2 Until April 2015 the CCGs commissioned the South East Commissioning Support Unit (SECSU) to work on their behalf and advise them in relation to learning disability services. As CCGs reviewed the commissioning support they purchased from SE CSU it became evident that it would be increasingly difficult to sustain LD commissioning advice from the CSU.

4.3 There is a track record of collaborative commissioning between the NHS in Kent and KCC – the latest example being the Winterbourne programme of action.

4.4 The proposal for an integrated commissioning arrangement was discussed with KCC Social Care, Health and Wellbeing Directorate Management Team (SCHW DMT) / CCG Accountable Officers throughout 2014. The project was also proposed to the Kent Health and Wellbeing Board (HWBB) in 2014 and the Kent Learning Disability Board. There was broad support from all parties to proceed to develop the arrangements.

4.5 In April 2015 two staff with LD expertise was seconded from the SE CSU to KCC to continue providing the commissioning support to CCGs whilst also leading the development of an integrated commissioning arrangement.

4.6 The change in CCG commissioning support for learning disability, described above, meant that the status quo could no longer be sustained. With the national direction of travel towards greater integration between health and social care it was timely to consider an integrated approach across the county for LD commissioning.

4.7 An integrated commissioning arrangement will need to consider the appropriate legal powers under which it can operate. This will most likely require a Section 75 Agreement. Consideration will be given as to whether it can be included in the existing Section 75 for the Better Care Fund or its successor should it continue.

4.8 There is a duty upon all public bodies to make reasonable adjustments under the Equality Act 2010. It could be argued that the creation of an integrated commissioning arrangement with a single team would provide a team with critical mass of specialist expertise to advise the CCGs and KCC of their responsibilities towards people with a learning disability. One of the points of learning from the Winterbourne programme has been the loss of that expertise in some parts of the country which has contributed to some of the difficulties with progressing the necessary developments in those areas. When Kent was scrutinised by the national Winterbourne Joint Improvement Team it was recognised as an area with expertise and good joint working.

4.9 It is recognised that Public Health has a critical role in ensuring that the health inequalities faced by people with a learning disability are addressed across the system. It is known that people with a learning disability are likely to have greater health needs (70% of people with a LD in Kent have one or more long term conditions in addition to their learning disability), will find it harder to access health care and are likely to have poorer health outcomes (the average life expectancy of a person with LD in Kent is 55 years – source: Joint Needs Assessment). The project aims to set out a commissioning framework to describe the role and relationships of all partners, including Public Health, towards people with a learning disability.

4.10 There are no implications for the Council's property portfolio of the suggested action.

4.11 As part of any formal decision to move to integrated commissioning, there will need to be clarity as to who will have authority to make decisions on behalf of KCC and of the CCGs. The work that is ongoing is establishing various partners preferred way of dealing with this and this will be part of the final recommendation report. Within KCC the formal decision will be taken by the Cabinet Member for Adult Social Care and Public Health with responsibility to complete any necessary section 75 agreement and the subsequent work being delegated to the Corporate Director of Social Care, Health & Wellbeing.

4.12 A paper will be submitted in September giving more details of the proposed direction of travel towards an integrated commissioning arrangement for learning disability before a final decision is taken in January 2016.

5. Conclusions

5.1 An integrated commissioning arrangement for learning disability will be the logical next step following a track record of collaborative commissioning between the KCC and NHS and will formalise the partnership between KCC and the 7 CCGs ensuring that people with learning disabilities in Kent are served by an experienced and knowledgeable team, maintaining a critical mass of expertise to advise all partners. This project will also ensure that the resources of all partners can be effectively and efficiently used to deliver good quality integrated care for people with learning disabilities, whilst reducing the health inequalities which they currently experience.

6. Recommendation(s):

The Cabinet Committee is asked to note the information provided in the report.

7. Background Documents

7.1 None

8. Contact details

Report Author:
Susan Gratton, Project Manager – Integrated Commissioning for Learning Disability
Telephone number: 07766 902479
Email address: sue.gratton@kent.gov.uk / suegratton@nhs.net

Relevant Director:
Penny Southern, Director, Disabled Children Adult LD/MH Social Care Health and Wellbeing
Telephone number: 03000 415505
Email address: penny.southern@kent.gov.uk

This page is intentionally left blank

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
10 July 2015

Subject: **ADULT SOCIAL CARE PERFORMANCE DASHBOARD**

Classification: Unrestricted

Previous Pathway: Social Care, Health and Wellbeing DMT

Future Pathway: None

Electoral Division: All

Summary: The performance dashboard provides Members with progress against targets set for key performance and activity indicators for March 2015 for Adult Social Care.

Recommendation: Members are asked to **REVIEW** the Adult Social Care performance dashboard

---

1. Introduction

1.1 Appendix 2 Part 4 of the Kent County Council Constitution states that:

"Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

1.2 To this end, each Cabinet Committee is receiving a performance dashboard.

2. Performance Report

2.1 The main element of the Performance Report can be found at Appendix A, which is the Adults Social Care dashboard which includes latest available results for the key performance and activity indicators

2.2 The Adult Social Care dashboard is a subset of the detailed monthly performance report that is used at team, DivMT and DMT level. The indicators included are based on key priorities for the Directorate, as outlined in the business plans, and include operational data that is regularly used within Directorate. The dashboard will evolve for Adults Social Care as the transformation programme is shaped.

2.3 Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes, and this will be a key element for reviewing the dashboard

2.4 A subset of these indicators is also used within the quarterly performance report, which is submitted to Cabinet.

2.5 As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

2.6 Performance results are assigned an alert on the following basis:

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

Amber: Performance is below current target but above minimum standard.

3. Financial Implications

3.1 Not applicable

4. Legal Implications

4.1 Not applicable

5. Equalities Implications

5.1 Not applicable

6. Recommendations

6.1 Members are asked to:

a) **REVIEW** the Adult Social Care performance dashboard.

Report Author
Name: Steph Smith
Title: Head of Performance for Adult Social Care
Tel No: 01622 221796
Email**:** steph.smith@kent.gov.uk

Background documents
None

Adult Social Care Dashboard

Q4 March 2015

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
↓	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Adult Social Care Indicators

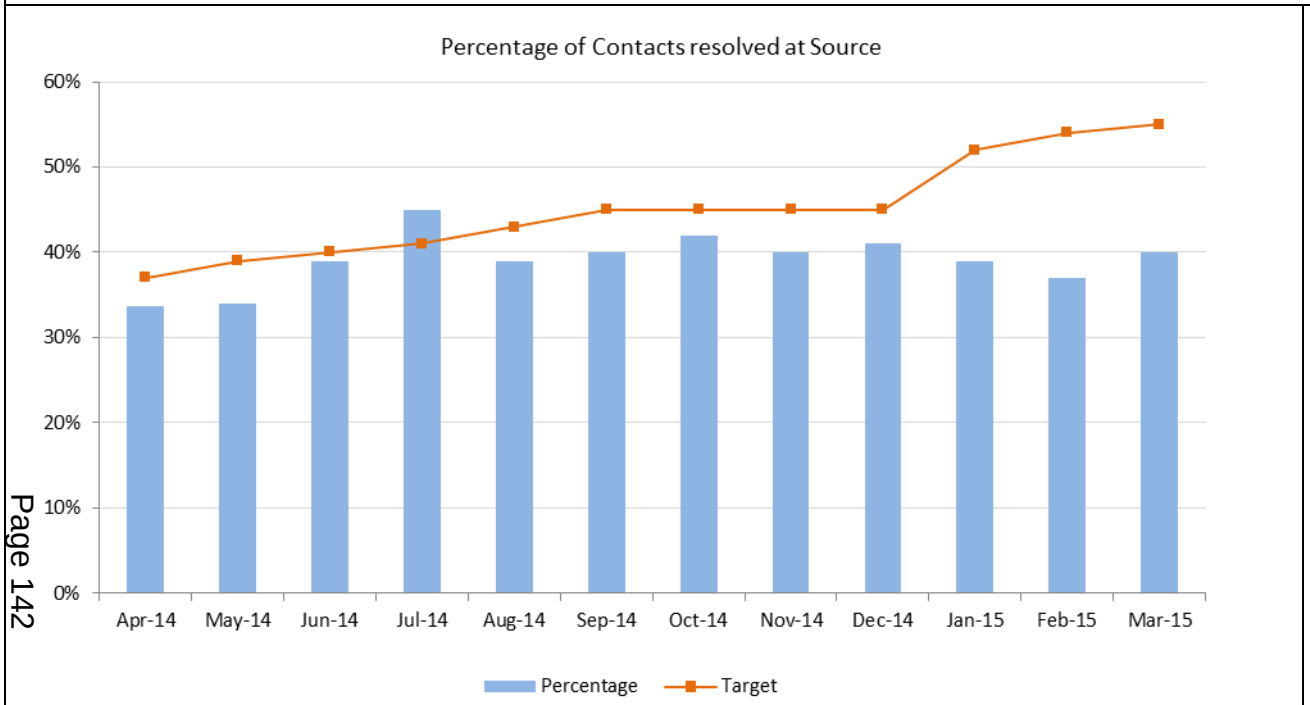
The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet. This is clearly labelled on the summary and in the detail.

Some indicators are monthly indicators, some are annual, and this is clearly stated.

All information is as at December 2014 where possible.

Indicator Description	SCHW SPS	QPR	2013-14 Outturn	Current 14-15 Target	Current Position	Data Period	RAG	Direction
1. Percentage of contacts resolved at source (ASC01)	Y	Y	35.9%	55%	**40.0%**	Month	**RED**	↑
2. Number of completed Promoting Independence Reviews		Y	350	638	**390**	Month	**RED**	↓
3. Number of adult social care clients receiving a Telecare service (ASC02)	Y	Y	3238	3907	**4694**	Cumulative	**GREEN**	↑
4. Referrals to enablement (ASC03)	Y	Y	700	700	**741**	Month	**GREEN**	↑
5. Delayed transfers of care			5.73	5.40	**5.3**	12M	**GREEN**	↑
6. Admissions to permanent residential or nursing care for people aged 65+			149	130	**36**	12M	**GREEN**	↑
7. Number of people aged 65+ in permanent residential care (AS01)	Y	Y	2845	2793	**2409**	Snapshot	**GREEN**	↑
8. Number of people aged 65+ in permanent nursing care (AS02)	Y	Y	1429	1428	**1179**	Snapshot	**GREEN**	↑
9. Number of people aged 65+ receiving domiciliary care (AS03)	Y	Y	5161	4977	**3849**	Snapshot	**GREEN**	↓
10. Number of people with a learning disability in residential care (AS04)	Y	Y	1243	1258	**1231**	Snapshot	**GREEN**	↓
11. Number of people with a learning disability receiving a community service			1343	1197	**1542**	Snapshot	**GREEN**	↑
12. Percentage of adults in contact with secondary mental health in settled accommodation			86%	75%	**83%**	Quarterly	**GREEN**	↓
13. Percentage of adults with a mental health needs in employment			-	13%	**11.9%**	Quarterly	**AMBER**	-

1. Percentage of contacts resolved at source (ASC01)			RED ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
Data Source: SWIFT report but this will be monitored using the Area Referral Management Service information.

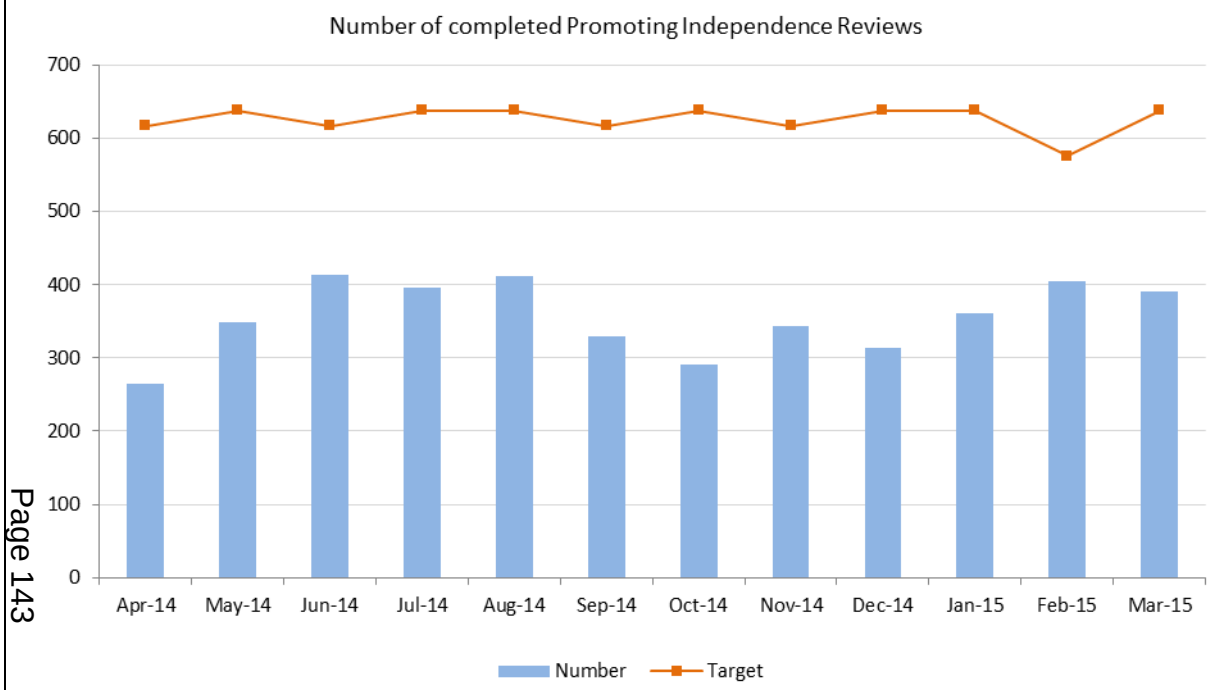
Quarterly Performance Report Indicator

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**37%**	**39%**	**41%**	**43%**	**45%**	**46%**	**48%**	**49%**	**50%**	**52%**	**54%**	**55%**
Percentage	33.61%	34.00%	39.00%	45.00%	39.00%	40.00%	42.00%	40.00%	41.00%	39.00%	37.00%	40.00%
RAG Rating	AMBER	AMBER	AMBER	GREEN	RED	RED	AMBER	AMBER	AMBER	RED	RED	RED

Commentary

Performance has dropped off slightly this quarter but is still significantly ahead of the position eighteen months ago. Demand and referrals from hospitals have been lower recently and this will impact on this indicator. It is a key priority for Adult Social Care to respond to more people's needs at the point of contact, through better information, advice and guidance, or provision of equipment where appropriate. This will continue to be a focus as we move into phase 2 of transformation. In addition we will be working on working with the hospitals to ensure that we support the discharge process more efficiently.

2. Number of completed Promoting Independence Reviews			RED ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
The information collected shows the number of review completed as at Monday of every week and is presented weekly within DivMT dashboards. Due to the target for this indicator being weekly, when it is presented in a monthly format the target will vary because of the number of days in the month. If a particular week falls across two months, the number of reviews is proportionate.

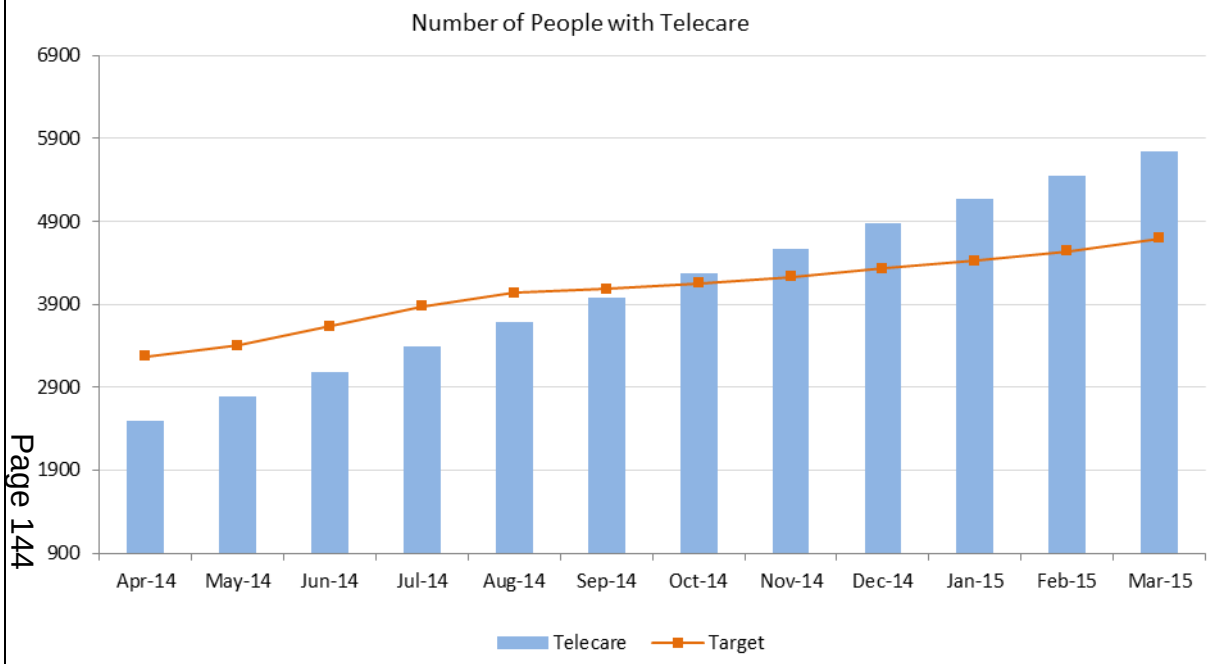
Data Source: Newton Europe PIR Tracker

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**617**	**638**	**617**	**638**	**638**	**617**	**638**	**617**	**638**	**638**	**576**	**638**
Number	265	349	414	395	411	330	291	343	313	360	404	390
RAG Rating	RED	RED	RED	RED	RED	RED	RED	RED	RED	RED	RED	RED

Commentary

Performance remains below the target level set. In order to improve this, the PIR teams are being reviewed to ensure that they are being as efficient as possible, but also to ensure that they focus only on promoting independence reviews. It is hoped that this will improve performance, although it should be noted that 1.Phase one of the transformation programme involving the staffing consultation, mobilisation of the new home care contracts and staff impacted on the timescales for rolling out the Promoting Independence Reviews. 2. Promoting Independence reviews are not imposed on everyone, but are focussed on people who will benefit from them and this can vary.

3. Number of adult social care clients receiving a Telecare service (ASC02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



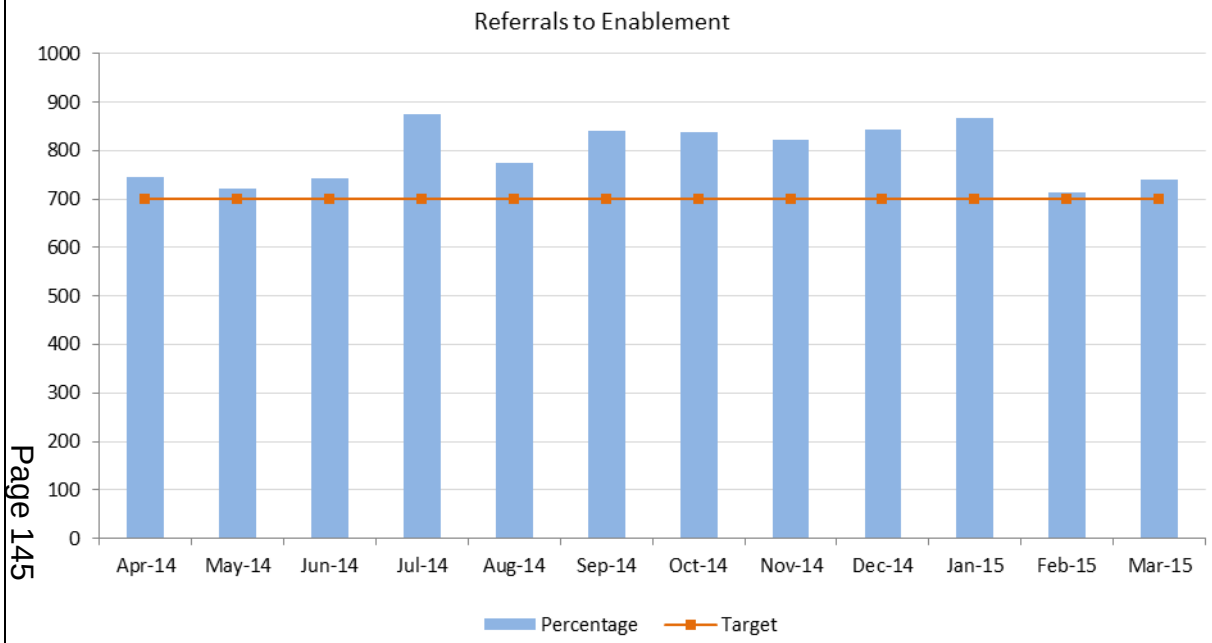
Data Notes.
Units of Measure: Snapshot of people with Telecare as at the end of each month
Data Source: Adult Social Care Swift client System

Quarterly Performance Report Indicator

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**2491**	**2793**	**3405**	**3471**	**3537**	**3573**	**3638**	**3700**	**3740**	**3856**	**3880**	**3907**
Telecare	3392	3531	3637	3877	4041	4088	4151	4234	4332	4427	4540	4694
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

The number of people in receipt of a Telecare service continues to exceed target. Telecare is being promoted as a key mechanism for supporting people to live independently at home, including within Personal Budgets. The availability of new monitoring devices (for dementia for instance) is expected to increase the usage and benefits of telecare. Awareness training continues to be delivered to staff to ensure we optimise the opportunities for supporting people with more complex and enabling teletechnology solutions.

4. Referrals to Enablement (ASC03)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Number of people who had a referral that led to an Enablement service
Data Source: Adult Social Care Swift client System – Enablement Services Report

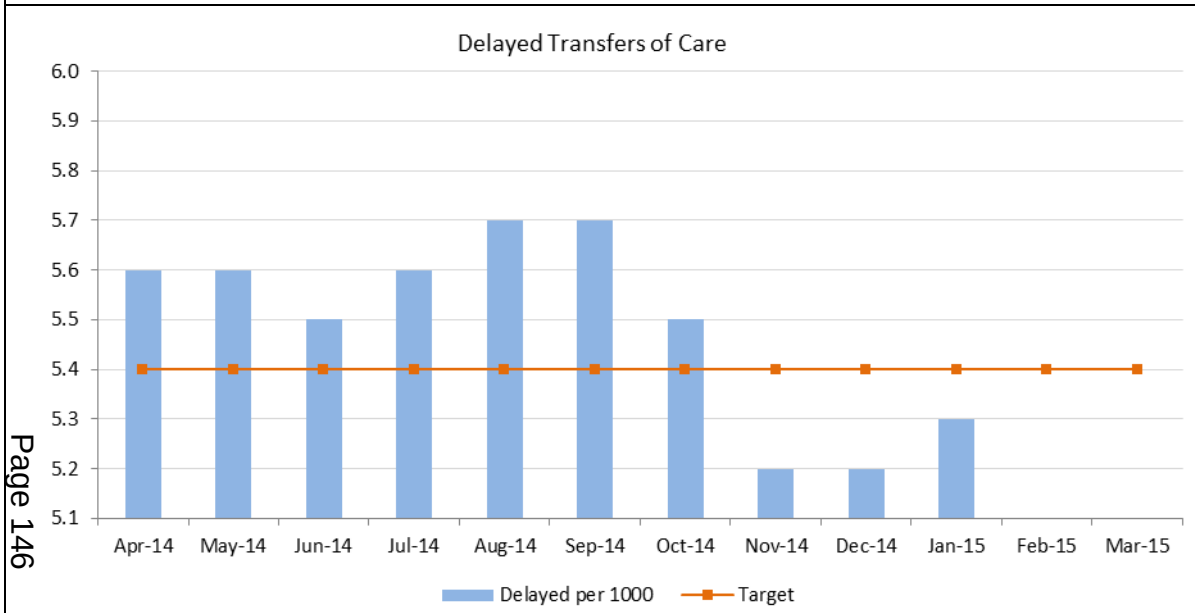
Quarterly Performance Report indicator

Trend Data	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**
Enablement Referrals	745	722	742	875	775	842	838	822	844	867	713	741
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Enablement continues to be above target.

5. Delayed transfers of care			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



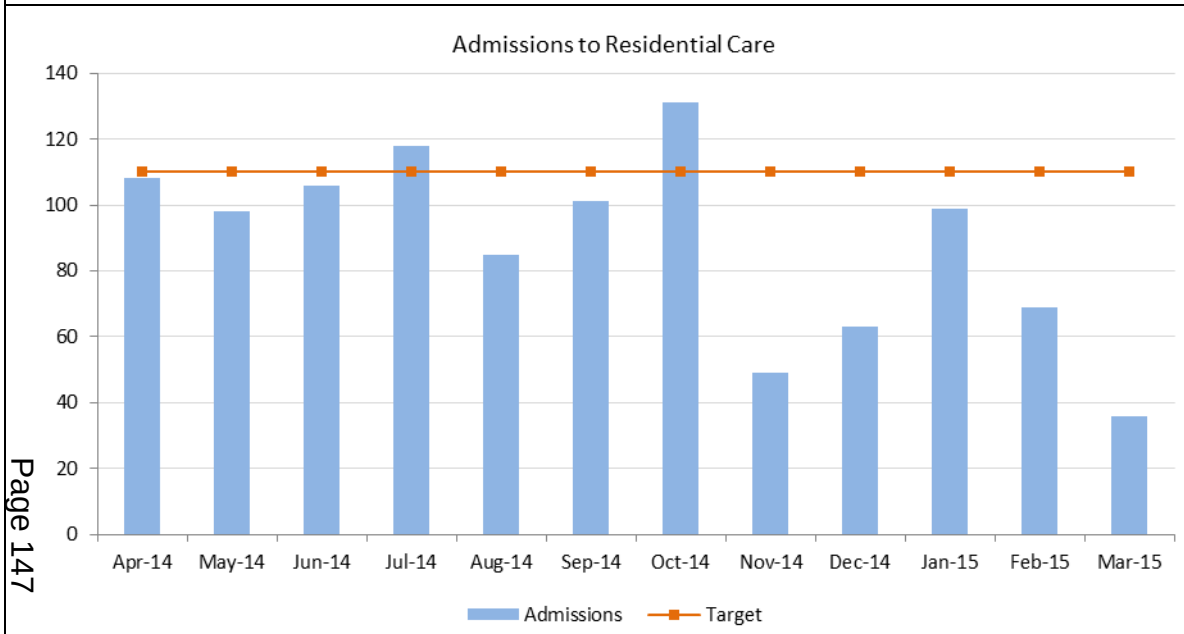
Data Notes.
This indicator is displayed as the number of delays per month as a rate per 100,000 population.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**	**5.4**
Delayed per 1000	5.6	5.6	5.5	5.6	5.7	5.7	5.5	5.2	5.2	5.3		
RAG rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	GREEN	GREEN	GREEN		

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently about 25% delays are attributable to Adult Social Care. The top three reasons for delays includes: Waiting NHS non-acute care, patient choice and then Social care assessment.

6. Admissions to permanent residential or nursing care for people aged 65+			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: Older People placed into Permanent Residential Care per month.

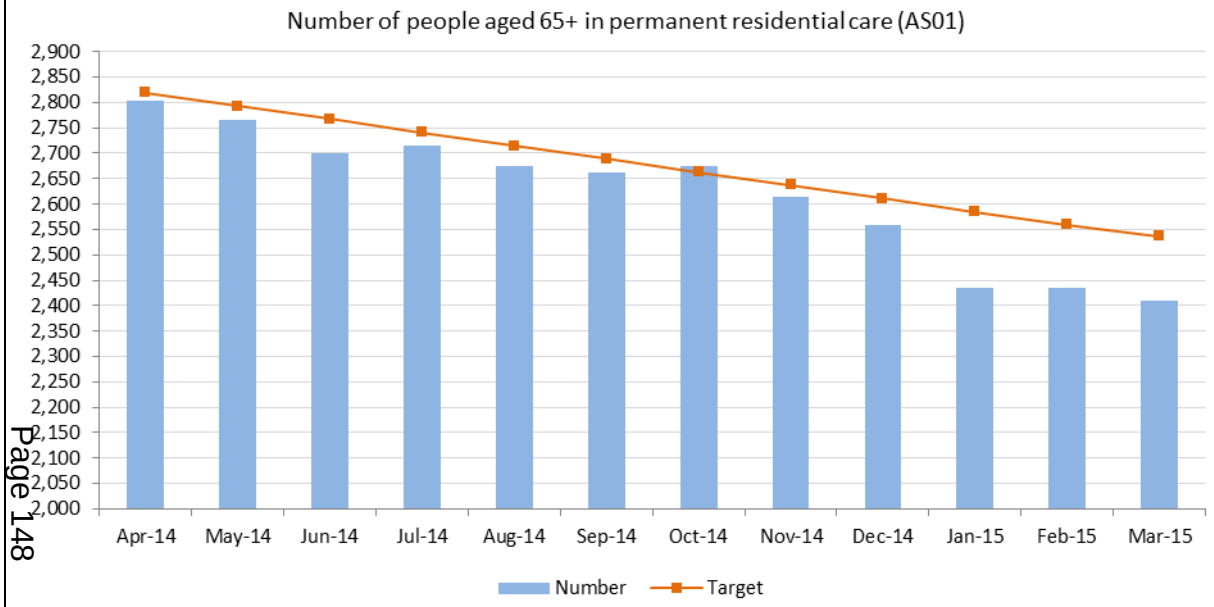
Data Source: Adult Social Care Swift client System – Residential Monitoring Report

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**110**	**110**	**110**	**110**	**110**	**110**	**110**	**110**	**110**	**110**	**110**	**110**
Admissions	108	98	106	118	85	101	131	51	63	99	69	36
RAG rating	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN	RED	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. As part of the monthly budget and activity monitoring process, admissions are examined, to understand exactly why they have happened. The objectives of the transformation programme will be to ensure that the right services are in place to ensure that people can self manage with these conditions, and ensure that a falls prevention strategy and support is in place to reduce the need for admission. In the meantime, there are clear targets set for the teams which are monitored on a monthly basis, and an expectation that permanent admissions are not made without all other alternatives being exhausted.

7. Number of people aged 65+ in permanent residential care (AS01)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.
Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

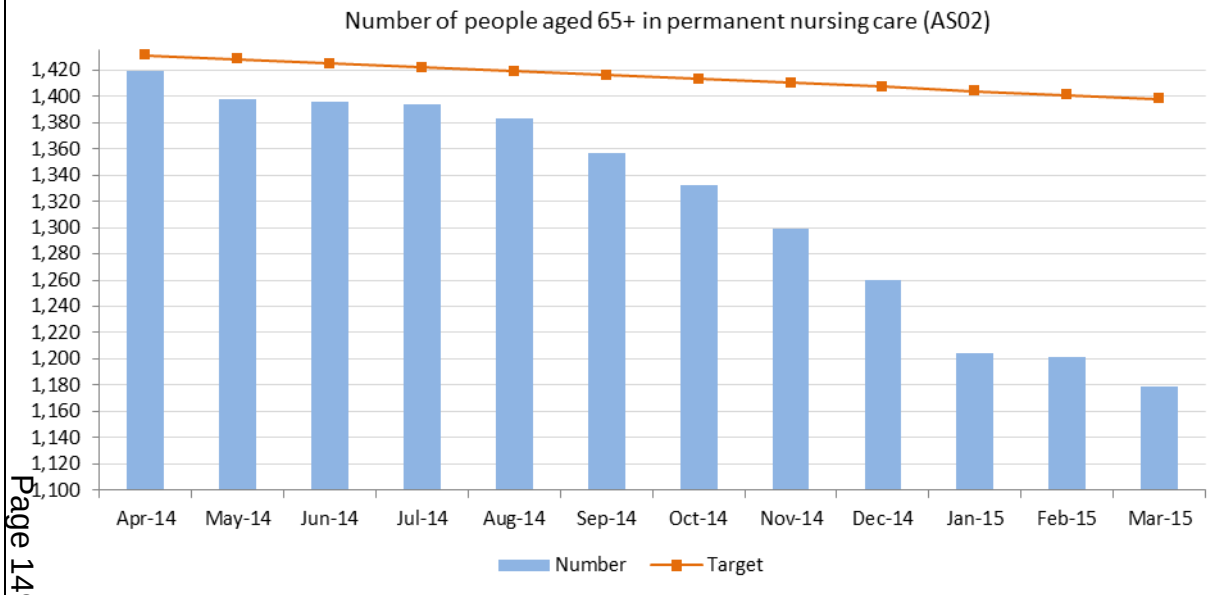
Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**2819**	**2793**	**2767**	**2741**	**2715**	**2689**	**2663**	**2637**	**2611**	**2585**	**2559**	**2536**
Number	2803	2765	2699	2715	2674	2661	2675	2614	2559	2434	2435	2409
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

8. Number of people aged 65+ in permanent nursing care (AS02)			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ in permanent residential care

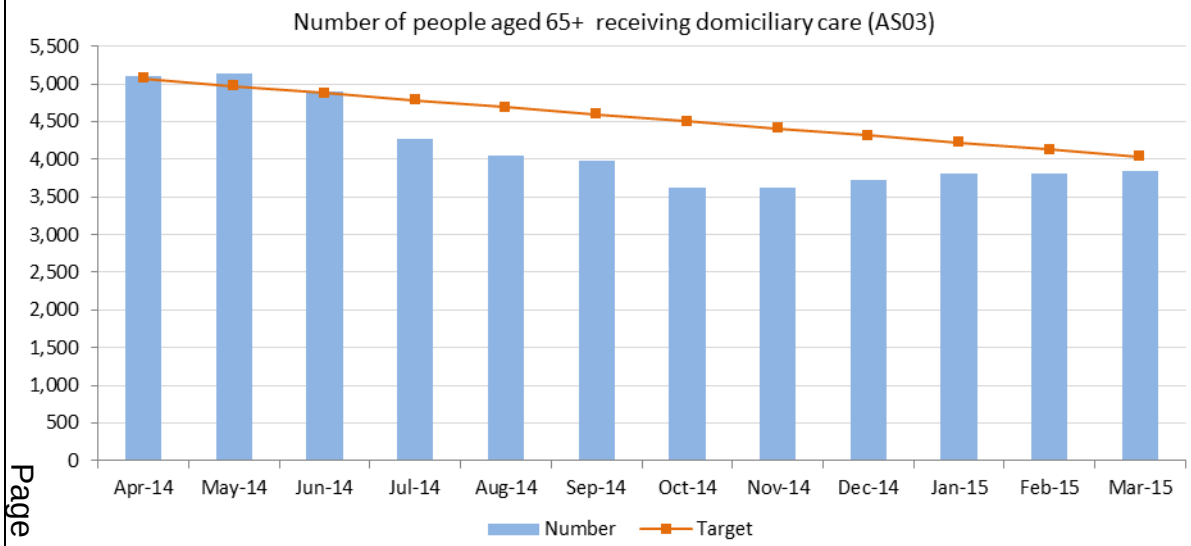
Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**1431**	**1428**	**1425**	**1422**	**1419**	**1416**	**1413**	**1410**	**1407**	**1404**	**1401**	**1398**
Number	1419	1398	1396	1394	1383	1357	1332	1299	1260	1204	1201	1179
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

9. Number of people aged 65+ receiving domiciliary care (AS03)			GREEN ⇩
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People & Physical Disability



Data Notes.

Units of Measure: End of month snapshot of the number of people aged 65+ receiving domiciliary care

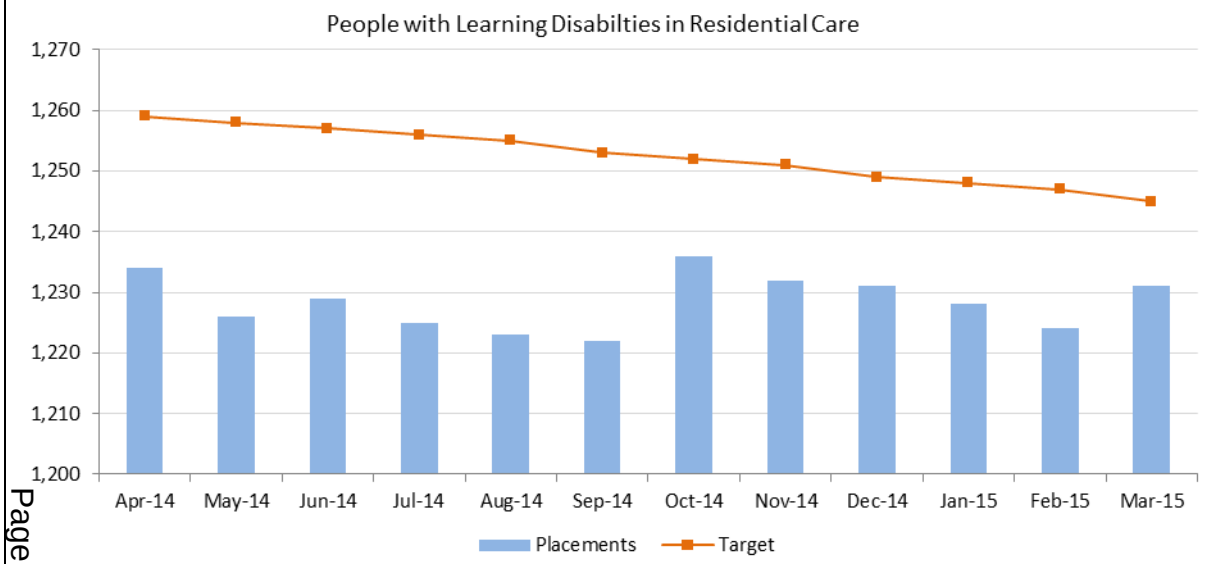
Data Source: MCR summary report – SWIFT

Quarterly Performance Report indicator

Trend Data	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**5071**	**4977**	**4883**	**4789**	**4695**	**4601**	**4507**	**4413**	**4319**	**4225**	**4131**	**4037**
Number	5112	5133	4892	4274	4052	3988	3617	3629	3730	3816	3812	3849
RAG Rating	AMBER	RED	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

10. Number of people with a learning disability in residential care (AS04)			GREEN ⇩
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Learning Disability



Data Notes.

Units of Measure: Number of people with a learning disability in permanent residential care as at month end.
Data Source: MCR summary

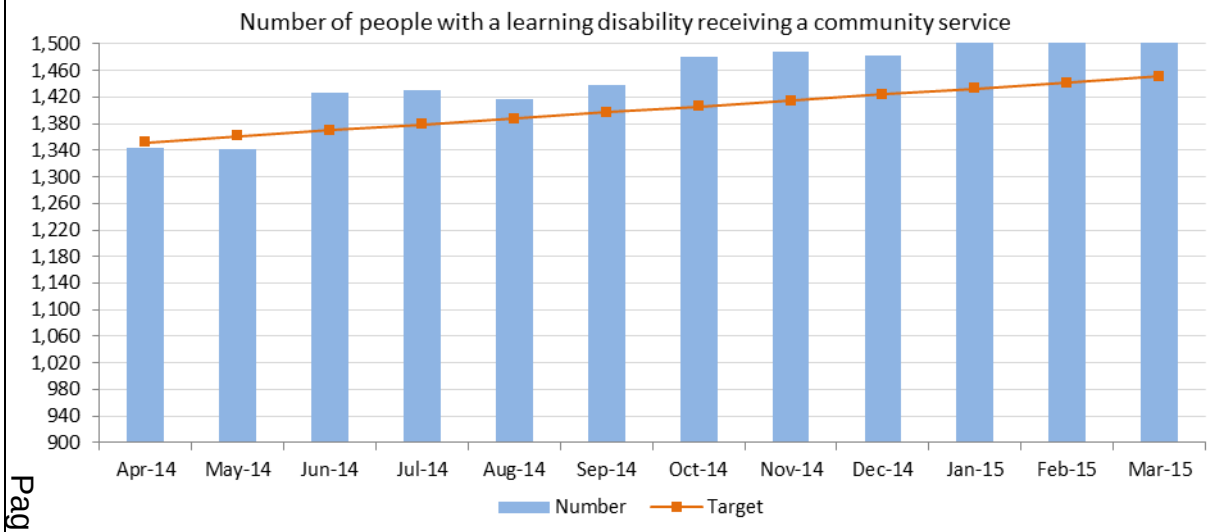
Quarterly Performance Report indicator

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-14	Feb-14	Mar-15
Target	**1259**	**1258**	**1257**	**1256**	**1255**	**1253**	**1252**	**1251**	**1249**	**1248**	**1247**	**1245**
Number	1234	1226	1229	1225	1223	1222	1236	1232	1231	1228	1224	1231
RAG rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

It is a clear objective of the Directorate to ensure that as many people with a learning disability live as independently as possible. All residential placements have now been examined to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. In addition, the teams continue to work closely with the Children's team as young people coming into Adult Social Care through transition from the majority of the new residential placements.

11. Number of people with a learning disability receiving a community service			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Learning Disability



Data Notes.

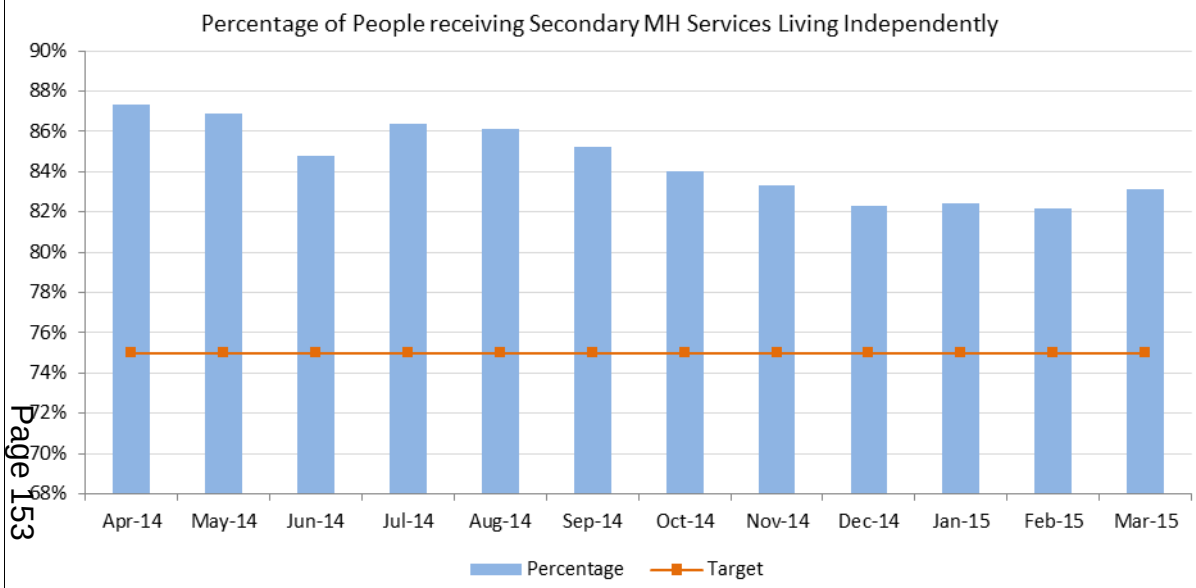
Units of Measure: Number of people with a learning disability receiving supported living, supporting independence or shared lives service as at month end.

Data Source: MCR summary

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**1352**	**1361**	**1370**	**1379**	**1388**	**1397**	**1406**	**1415**	**1424**	**1433**	**1442**	**1451**
Number	1343	1342	1427	1431	1417	1438	1481	1489	1483	1504	1514	1542
RAG Rating	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

12. Percentage of adults in contact with secondary mental health services living independently, with or without support			GREEN ⇧
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Mental Health



Data Notes.

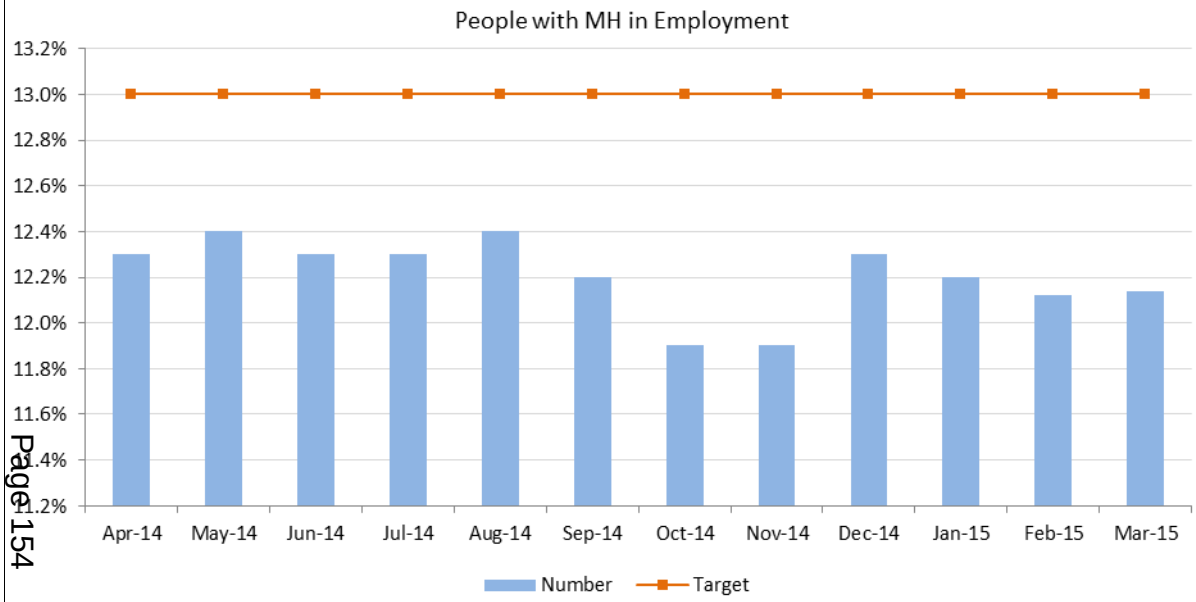
Units of Measure: Proportion of all people who are in settled accommodation

Data Source: KPMT – quarterly

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
Percentage	87.3%	86.9%	84.8%	86.4%	86.1%	85.2%	84.0%	83.3%	83.2%	82.4%	82.2%	83.1%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

13. Percentage of people with mental health needs in employment			AMBER ⇩
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Mental Health



Data Notes.

Units of Measure:

Data Source: KPMT – quarterly

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**
Percentage	12.3%	12.4%	12.3%	12.3%	12.4%	12.2%	11.9%	11.9%	12.3%	12.2%	12.1%	12.1%
RAG Rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

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

July 10th 2015

Subject: Public Health Performance - Adults

Classification: Unrestricted

Previous Pathway: DMT

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of Public Health key performance indicators which specifically relate to adults.

The annual targets for the number of NHS Health Checks completed and the availability of open access sexual health services were met.

Public Health are awaiting final full-year figures for stop smoking services and chlamydia positivity rates in line with national submission deadlines.

Outcomes for people accessing drug and alcohol treatment in Kent remain above the national average but have fallen in 2014/15. Public Health continues to contract manage the providers closely in order to address any performance issues and drive improvement in treatment outcomes.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to note the current performance and actions taken by Public Health

1. Introduction

1.1. This report provides an overview of the key performance indicators for Kent Public Health which relate to services for adults; the report includes a range of national and local performance indicators.

1.2. There are a wide range of indicators for Public Health including some from the Public Health Outcomes Framework (PHOF). This report will focus on the indicators which are presented to Kent County Council Cabinet, and which are relevant to this committee.

2. Performance Indicators of Commissioned Services

2.1. The table below sets out the performance indicators for the key public health commissioned services which deliver services primarily for adults. The RAG status relates to the target.

Indicator Description	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Proportion of annual target population with completed NHS Health Check (rolling 12 month basis)	36% (R)	41% (R)	46% (A)	51% (G)	51% (G)
Proportion of clients accessing community sexual health services offered an appointment to be seen within 48 hours	99.9% (G)	100% (G)	100% (G)	100% (G)	100% (G)
Chlamydia positivity detection rate per 100,000 for 15-24 year olds	1,949 (R)	1,545 (R)	1,540 (R)	Available mid-June	Expected September
Proportion of smokers successfully quitting, having set a quit date	57% (G)	52% (G)	50% (A)	51% (A)	Available mid-June
Local Indicator					
Proportion of new clients seen by the Health Trainer Service from the two most deprived quintiles (highest deprivation)	54%	52%	53%	57%	51%

Substance Misuse Services	2009/10	2010/11	2011/12	2012/13	2013/14
% of adult treatment population that successfully completed treatment	22.6%	26.0%	26.0%	20.6%	17.2%
National Figures for comparison:	11.5%	13.7%	15.1%	15.0%	15.1%
	Dec 12-Nov 13	Jan 13-Dec 13	Mar 13-Feb 14	Apr 13-Mar 14	May 13-Apr 14
% of opiate users completing treatment successfully who do not return to treatment within 6 months, of all in treatment. (rolling 12 month basis)	10.4% (G)	10.3% (G)	9.7% (G)	9.7% (G)	9.5% (G)
National Figures for comparison:	7.8%	7.8%	7.7%	7.8%	7.7%

NHS Health Checks

2.2. To provide a more accurate picture of progress of the NHS Health Checks programme, the figures will now be reported as 12 month rolling. Since KCC took on the commissioning responsibility for the programme, there has been a steady increase in numbers of invited and checks completed. In 2014/15 45,623 people received an NHS health check compared to 29,845 in 2012/13.

2.3. Public Health is committed to driving further improvement in uptake of health checks and has agreed a minimum target for the programme to deliver 48,893 checks for Kent residents in 2015/16.

2.4. Public Health expects this increase to be delivered through a combination of improved uptake in response to invitations from general practices as well as opportunistic checks in targeted outreach settings or health and wellbeing

events, especially in areas of low uptake and high preventable cardiovascular mortality.

Sexual Health

2.5. Community sexual health clinics in Kent continue to consistently offer clients an appointment within 48 hours, performing above the target of 95%. Integrated sexual health services, including GUM, contraceptive services and HIV outpatient services commenced operation from April 2015 and access targets have been included in the new contracts.

2.6. There continues to be a delay on the national reporting of the Chlamydia positivity detection rate, Public Health have been informed that Q3 14/15 rates should be released mid-July, which is outside the time for inclusion in this report; Public Health have requested an explanation from the responsible Public Health England unit.

Smoking

2.7. The Stop Smoking Service narrowly missed its 'quit-rate' target for 2014/15. The target is for 52% of people accessing the service and setting a quit date to have quit smoking for 4 weeks by the end of the programme. The actual performance in quarter 2 and 3 was 50% and 51% respectively. Public Health are commissioning various changes to ensure that the Stop Smoking Service meets the changing needs of the population in relation to smoking but also delivers best value for money for KCC. These changes include a targeted 'cut down to quit' programme which is designed to engage people who are less likely to quit without more prolonged support. This approach is being trialled in three areas and will be assessed to inform decisions on any wider roll-out.

2.8. The Stop Smoking Service also remains focused on reducing health inequalities across Kent; year to date (Q1-Q3) there were 259 people who had never worked or were unemployed for over a year who quit within 4 weeks of setting a quit date; 612 who had retired, 177 who were sick/disabled and unable to return to work, 792 in routine and manual occupations, and 141 in prison (please note that these are not exclusive categories).

Health Trainers

2.9. The Health Trainer service continues to exceed the target of new clients engaged with their service and has sustained working with at least 50% of their clients being from the 2 most deprived quintiles in Kent; the target set for 2015/16 aims to challenge the provider to further target their work at the most deprived quintiles and see 62% for quintiles 1 and 2.

Substance Misuse

2.10. As outlined in the previous performance report to this Committee, the Local Authority Circular (LAC (DH) (2014)2. Dated 17th December 2014) places a new condition on the use of the Public Health grant, that Local Authorities have regard to the need to improve the outcomes from their drug and alcohol misuse treatment services.

2.11. Kent has continued to experience a fall in the number of successful completions, from 2010/11 at 904 to 482 in 13/14; this is a sharper fall than the number in treatment. Nationally the figures have remained stable for both successful exits and numbers in treatment. Public Health is working with drug and alcohol treatment providers in Kent via regular performance monitoring meetings to identify and address any performance issues. Despite these reductions in the number of people in treatment, Kent remains above the national average on the critical performance indicator of opiate clients completing treatment as a proportion of all in treatment.

3. Annual Public Health Outcomes Framework (PHOF) Indicator

3.1. The table below presents the most recent nationally verified and published data; the RAG is in relation to National figures.

Annual PHOF Indicators	**2007-09**	**2008-10**	**2009-11**	**2010-12**	**2011-13**
Under 75 mortality rates for:					
Cardiovascular diseases considered preventable per 100,000	**59.8 (G)**	**57.4 (G)**	**55.9 (A)**	**52.3 (A)**	**49.3 (A)**
Cancer considered preventable per 100,000	**84.3 (G)**	**83.7 (G)**	**82.6 (G)**	**80.5 (G)**	**78.2 (G)**
Liver disease considered preventable per 100,000	**12.4 (G)**	**12.1 (G)**	**12.0 (G)**	**12.4 (G)**	**13.2 (G)**
Respiratory disease considered preventable per 100,000	**17.4 (A)**	**17.4 (A)**	**17.6 (A)**	**16.6 (A)**	**16.7 (A)**
Suicide rate (all ages) per 100,000	**8.4 (A)**	**7.7 (A)**	**8.4 (A)**	**8.1 (A)**	**9.2 (A)**
Proportion of people presenting with HIV at a late stage of infection (%)	Not available		**49.7 (A)**	**47.0 (A)**	**50.5 (A)**
		2010	**2011**	**2012**	**2013**
Percentage of adults classified as overweight or obese		Not available		**64.6 (A)**	Not available
Prevalence of smoking among persons aged 18 years and over (%)		**21.7 (A)**	**20.7 (A)**	**20.9 (A)**	**19.0 (A)**
Opiate drug users successfully leaving treatment and not re-presenting within 6 months (%)		**14.6 (G)**	**14.7 (G)**	**10.9 (G)**	**10.3 (G)**
	2009/10	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Alcohol related admissions to hospital per 100,000. All ages	**568 (G)**	**574 (G)**	**557 (G)**	**565 (G)**	Not available
Proportion of adult patients diagnosed with depression (%)	Not available			**5.6**	**6.4**

3.2. The Kent suicide rate for persons masks the difference between genders, with significantly higher rates for males at 14.6 per 100,000 (2011-13) compared to

4.1 per 100,000 for females. Public Health has a suicide prevention strategy, which is on the agenda for this Committee today, and commissions wellbeing programmes specifically targeted at men, and example of which is the Kent Sheds programme. Public Health commission alongside a range of other mental health commissioning in Social Care, CCGs and NHS England.

3.3. Whilst the proportion nationally of people presenting with HIV at a late stage of infection has been decreasing, Kent experienced an increase between 2010-12 and 2011-13 and was performing above the benchmark of 50% at 50.5%. The goal on the PHOF is to be below 25%.

3.4. The new Community Sexual Health Services contracts will offer testing for a range of sexually transmitted infections including HIV as well as targeted outreach. The services are designed to engage particular groups of the population who can be at risk of HIV but are less likely to access mainstream sexual health services. This targeted provision along with widening access to sexual health services and relevant campaigns and promotion are expected to lead to improvements (reductions) in the numbers of HIV tests offered and taken up.

3.5. It is expected that the social marketing campaign to raise awareness of HIV and promote testing in Kent during November as part of an HIV late diagnosis research programme, will show an increase in the incidence of late diagnosis of HIV over the coming months.

4. Conclusions

4.1. The NHS Health Checks programme met its 2014/15 target for the number of health checks completed in the year. Community Sexual Health services also reached the target on availability of waiting times for open access appointments. Public Health are awaiting final figures on Cessation and Chlamydia detection but data for the first part of 2014/15 indicates that the targets for these programmes will not have been met.

4.2. Commissioning and contract management of substance misuse treatment services continues to identify and address performance issues and improve treatment outcomes in these areas.

5. Recommendations

Recommendation**:** The Adult Social Care and Health Cabinet Committee is asked to note the current performance and actions taken by Public Health

6. Background Documents

6.1. None

7. Contact Details

Report Author

- Karen Sharp: Head of Public Health Commissioning
- 03000 416668
- Karen.sharp@kent.gov.uk

Relevant Director:

- Andrew Scott-Clark: Director of Public Health
- 03000 416659
- Andrew.scott-clark@kent.gov.uk

Data quality note**:** Data included in this report is provisional and subject to later change. This data is categorised as management information.

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

Andrew Ireland, Corporate Director for Social Care Health and Well Being.

To: Adult Social Care and Health Cabinet Committee 10 July 2015

Subject: **ADULT SOCIAL CARE ANNUAL COMPLAINTS REPORT (2014-2015)**

Classification: Unrestricted

Summary: This report provides Members with information about the operation of the Adult Social Care complaints and representations procedure between 1 April 2014 and 31 March 2015.

Recommendation: Members are asked to NOTE and COMMENT on the contents of this report.

Introduction

1 (1) Local Authorities have a statutory duty to have in place a complaints and representations procedure for Adult Social Care services. Furthermore, each local authority that has a responsibility to provide social services is required to publish an annual report relating to the operation of its complaints and representations procedure.

(2) This report provides an overview of the operation of the complaints procedure for Adult Social Care services. It includes summary data on complaints and enquiries received during the year. It also provides Members with examples of the lessons learned from complaints which are used to inform and improve future service delivery.

Policy Context and Procedures.

2 (1) The NHS and Community Care Act 1990 placed statutory requirements on local authority social service departments to have a complaints procedure in place. The legislation and associated statutory guidance was prescriptive about how the procedures should operate in practice.

(2) For Adult Social Care there was a significant change to the complaints procedure in 2009 with the introduction of Regulations with the objective of delivering a consistent approach to complaints handling for both Health and Social Care.

(3) The key principles of the procedure are **Listening** – establishing the facts and the required outcome; **Responding** – investigate and make a reasoned decision based on the facts/information and **Improving** – using complaints data to improve services and influence/inform the commissioning and business planning process.

(4) Wherever possible complaints that involve health and social care are dealt with via a single co-ordinated response. To facilitate this, a joint protocol was developed by the Complaints Managers in Kent and Medway.

(5) For Adult Social Care the complaint response needs to be proportionate to the issues raised. The only timescale in the process relates to the acknowledgment of the complaint which is within three days from receipt. Thereafter the response time is agreed with the complainant and reflects the circumstances and complexity of the complaint. When appropriate an independent investigator will complete an investigation into the complaint.

Total Representations received by Adult Social Care.

3 (1) Appendix one contains information about the number and type of complaints received.

(2) The figures show an increase in the number of complaints and enquiries received in 2014/15 compared with previous years (538 complaints in 2014/15 compared with 399 in 2013/14 and 407 enquiries in 2014/15 compared with 340 the previous year). This reflects the increased demand and pressures on services during a time of transformation and change and a time of financial constraint.

(3) The number of statutory complaints received 538, is relatively small when put in the context that there were 28,617 open adult social care cases at the start of 2014-15 and a further 23,426 referrals were received during the course of the year.

(4) In 2014/15, 760 compliments (or merits) were logged. The compliments provide useful feedback where people have had written to Adult Social Care with positive comments about their experience of using the service.

Performance against timeframes

4 (1) The average response time for statutory complaints set within a complaint plan timeframe of 20 working days is 19 working days. Complex cases that require either an off-line/external investigation or a joint response with health colleagues are identified at the commencement of the complaint and a longer timeframe is negotiated.

(2) 67% of complaints were responded to within the 20 day timescale agreed with the complainant and 86% of complaints were acknowledged within the statutory timescale of three working days.

Themes identified arising from complaints.

5 (1) It has been a challenging year in terms of the number of complaints and enquiries received. The Transformation agenda, budgetary pressures and significant organisational change have led to pressures on services. However, the increase in complaints is a general increase rather than attributable to any one factor. Changes such as the tender for home care services and the introduction of promoting independence reviews have taken place and have led to some complaints but not as many as might have been expected.

(2) Communication is a theme that crops up in many complaints. This can take many forms such as problems being able to make telephone contact with a member of staff or people not being kept informed or not happy with the way information was communicated. One example was where a person was being discharged from a unit but the case manager was on leave and other staff were not aware that the change in circumstances was taking place. Another example is where a safeguarding investigation was completed but the family felt they hadn't been informed of the outcome.

(3) Complaints are also received as a result of disputed decisions. Examples include where people consider they require more support than has been agreed or where the support has been decreased following a review of needs or where someone is unhappy about the level of charging.

(4) Delay was a factor in approximately 98 complaints. Examples include delays in adaptations being completed and delays in services being arranged.

The Outcome of Complaints

6 (1) The Local Authority is required to report on the number of complaints received that are considered to be "well-founded", in Kent these are logged as "upheld complaints". This is not always clear as the nature and contents of complaints can vary considerably and many responses provide an explanation where there might be a misunderstanding or a lack of clarity. Nevertheless, 206 complaints were upheld; 133 were partially upheld and 170 were not upheld.

Learning the Lessons

7 (1) Receiving a complaint provides an opportunity to resolve an issue where the service might not have been to the standard required or expected. In addition complaints, along with other customer feedback provides valuable insights that can be used to improve service performance.

(2) Reports on complaint management issues are produced for the Divisional Management Teams. Also, the Quality and Good Practice Group provides a forum to reflect on issues arising from complaints and an opportunity to identify lessons.

Operational teams identify a representative for the group who then takse a lead role within their teams for good practice and sharing lessons.

(3) Some of the lessons/issues arising in 2014/15 and discussed at the Quality and Practice Group included:

- The production of a booklet entitled “Your Care Bill Explained”. This was produced as a consequence of a number of complaints and enquiries received from the public about the difficulty in understanding the information contained in the invoices people received about their charges.

- It was evident from some complaints that relatives/family members sometimes felt they were not communicated with regarding decisions or changes in circumstances. (Although the client’s right to confidentiality also has to be recognised). There were a number of complaints relating to safeguarding where families did not feel they were kept sufficiently informed. The Making Safeguarding Personal initiative has helped to address this.

- One complaint highlighted the need to ensure that all assessed eligible care needs should be taken into account when reviewing a person’s needs so that the care package is not reduced and needs are not left unmet.

- Any delays in the provision of support should be addressed where a need has been identified and the Support Plan is agreed. This includes where a Direct Payment has been agreed but there is a delay in the support being arranged.

- Complaints provided a reminder that good record keeping should be maintained, particularly where decisions are made or a significant change takes place for the service user.

(4) Lessons are also learned from the investigation of complaints. Following independent or “off line” investigations, there are adjudication meetings where actions are agreed and the outcomes and any lessons from the complaints are shared more widely as appropriate.

(5) The outcomes from complaints can also lead to training or specific actions both for individuals or teams.

Off-line and external investigations

8 (1) There were seven off line investigations carried out during the year. The responses to complaints need to be proportionate and an external investigator is

usually appointed when the complaint issues are particularly complex or where communication has broken down or confidence in the organisation has been lost. In these cases, the complainant has felt their complaints have been taken seriously and an independent view has been offered.

Financial

9 (1) A total of £104,367 has been paid out to complainants (compared to £98,966 in 2013/14); this figure includes financial adjustments and settlements. A financial adjustment is made when an error has occurred with the charging process and it is then resolved as part of the complaint remedy. A financial settlement is when an amount of money is offered to provide redress or as a gesture of goodwill to recognise the anxiety and time and trouble to pursue a complaint.

Complaints via the Local Government Ombudsman (LGO)

10 (1) There were a total of 38 new referrals about KCC Adult Social Care made to the LGO during the year. Additional cases were carried forward from the previous year and settled during the reporting year (these are not included in the figures). This is a slight increase from the previous year when 32 new referrals were made.

(2) Of those complaints, where a final decision was received the outcome was:-

- 4 cases where the LGO closed the case after initial enquires and there was no further action.
- 2 cases closed after initial enquiries and the complaint was outside the LGO's jurisdiction.
- 7 cases that were not upheld.
- 8 cases where the complaint was considered premature.
- 2 cases where there was maladministration but no injustice
- 6 cases where there was maladministration and injustice.
- 9 cases which are currently with the LGO

(3) A summary of the cases where the Local Government Ombudsman found fault with injustice, is provided in the appendices.

Complaints operations

11 (1) The regulations require the complaints procedures to be publicised. The, "Have your Say" complaints leaflet is made available in hard copy and information is provided on the KCC website. An easy-read version of the complaints booklet is also available.

(2) In 2014, changes were made to the Directorate's "Respond" complaints database to ensure compatibility to other software used in KCC. The system continues

to provide an invaluable resource to log complaints and enquiries, to manage the workflow and to produce management reports.

(3) The complaints team has delivered training events for managers. The training has covered the complaints processes, investigating complaints and learning the lessons from complaints.

(4) The complaints team continues to work closely with the Patient Experience Team in the Kent and Medway Partnership Trust which handles complaints about mental health services. Also the Adult Social Care team is proactive in working with health partners to facilitate joint working and joint responses to complaints that have a health and social care element.

(5) During 2014 the complaints process was reviewed to benchmark it against the LGO Good Practice Standards and to ensure the processes are streamlined. The review also included a questionnaire of a sample of 40 complainants. The feedback was relatively positive given that the sample group were people who had expressed dissatisfaction with the wider service.

Care Act 2014

12 (1) The Department of Health has conducted a consultation regarding a proposal for an Appeals Process as part of the Care Act. If the proposal is accepted it would be for implementation in April 2016. There are some reservations about the proposals. At this stage it is not clear how it would sit alongside the existing statutory complaints procedure and how it would fit with inter-agency complaints that are cross–cutting. The proposed appeals process seems more bureaucratic and potentially more costly to the public purse than the current arrangements (albeit that the investigator costs would be met by the DH).

(2) As part of the April 2015 Care Act changes, there is an emphasis on advocacy and the right for individuals who cannot take up issues themselves, to make a formal representation through an advocate.

Special Educational Needs and Disability Tribunals.

13 (1) The Children and Families Act 2014 introduced reforms to Special Educational Needs and Disability Services (SEND). One of the reforms was to introduce Education, Health and Care Assessments and Plans to replace SEN statements. In March 2015 the Department for Education produced Regulations to enable pilot areas to have Tribunals which take a wider view to include the health and social care elements of the plans. Kent is one of the pilot areas for the Tribunals

(2) The SEND reforms cover the children and young people with special educational needs and disability in the 0 to 25 age group. Potentially therefore the Tribunals could consider the care element of someone's Education, Health and Care Plan. Adult Social Care is working with colleagues in SEN and Children's Services on the plans for the Tribunals and the protocols for joint working in cases going to Tribunal.

Report Conclusion

14 (1) In 2014/15, the Directorate continued to operate a robust and effective complaint's procedure to meet its obligations under the statutory regulations. The complaints team has logged, administered and responded to complaints, enquiries and compliments.

(2) The emphasis in complaints management is on bringing about a resolution and putting things right for the individual if the service has not been to the standard required. It is also about learning the lessons from complaints to prevent similar complaints from arising again. Complaints are taken seriously by the management team who receive regular reports as well as taking an active role in complaints resolution.

(3) Significant changes are taking place in adult social care including the transformation programme, greater integration with health, the realignment of services and the tendering for home care and residential services. There are also significant budget pressures on services. There has been an increase in the number of complaints and enquiries received, nevertheless, managers continue to focus on delivering a high standard of service and dealing effectively with complaints is part of this.

(4) It is expected that there will be changes to the adult social care complaints process as a consequence of the Care Act (although the introduction of an appeal process may not occur until 2016). Planning is taking place to ensure conformity and compliance with the regulations when these are issued.

Recommendations

15. (1) Members are asked to NOTE and COMMENT on the contents of this report.

Anthony Mort Customer Care and Operations Manager 03000 415424.
Background documents: None

Appendix One

Complaints and Enquiries received 1/4/14-31/3/15

Number received	
Statutory Complaint	538
Enquiry	407
Compliments	760
Safeguarding	36
Total	1741

Comparison with previous years					
	2010-11	2011-12	2012-13	2013-14	2014-15
Complaints	459	425	417	399	538
Enquiries	266	295	296	340	407
Compliments	598	575	744	816	760
Total	1323	1295	1457	1555	1705

Time scales for responding to complaints and enquiries				
	Total done	Average Time	Done within Standard	Percentage done within standard.
3 Day Acknowledgement	538	1	464	86.2%
20 Day resolution	468	19	314	67.09%
3 Day Enquiry acknowledgement	407	1	372	91.4%
Enquiry Response	394	16	255	64.7%

Complaints Outcomes		
Meeting offered	5	0.9%
Not upheld	170	31.9%
Partially upheld	133	24.9%
Upheld	206	38.5%
Withdrawn	17	3.2%
Other agency	3	0.6%
Total	534	

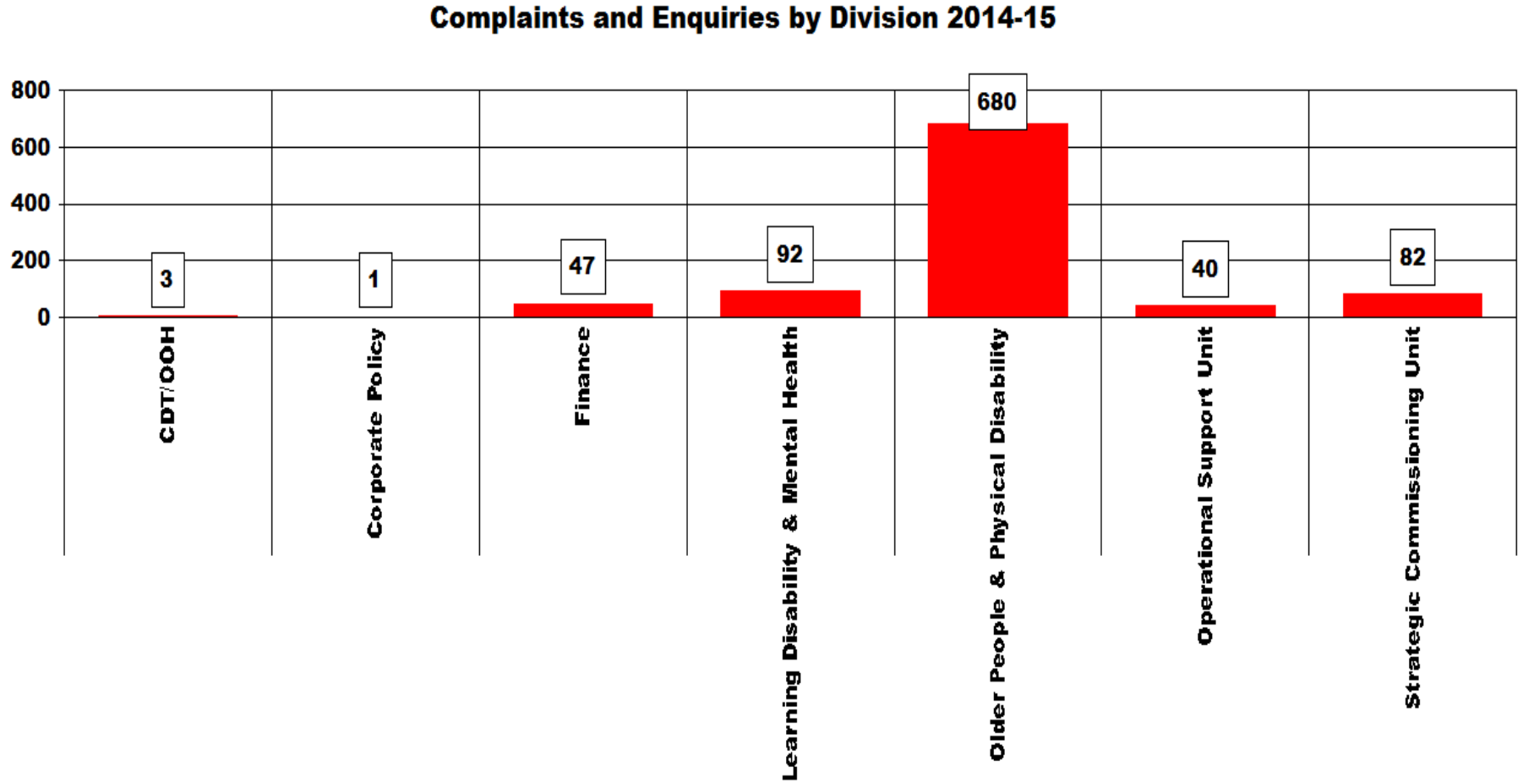
Subject of Complaint.		
Subject	Complaints	Enquiry
Behaviour	113	34
Care Act	0	1
Change of service	22	20
Charging dispute	45	9
Claim for compensation	9	0
Closure	1	8
Communication	202	65
Data Protection	0	0
Delay	98	61
Disputed Decision	185	75
Eligibility Not Met	7	2
Equality Issue	2	0
Funding (Organisations)	0	3
Information request	24	90
Lack of cover for absence	12	4
Quality of Care	69	31
Request for service	34	85
Safeguarding process	4	2
Service not meeting needs	10	14
Service reduced	18	5
Total	855	509

(Complaints and enquiries can include one or more subjects).

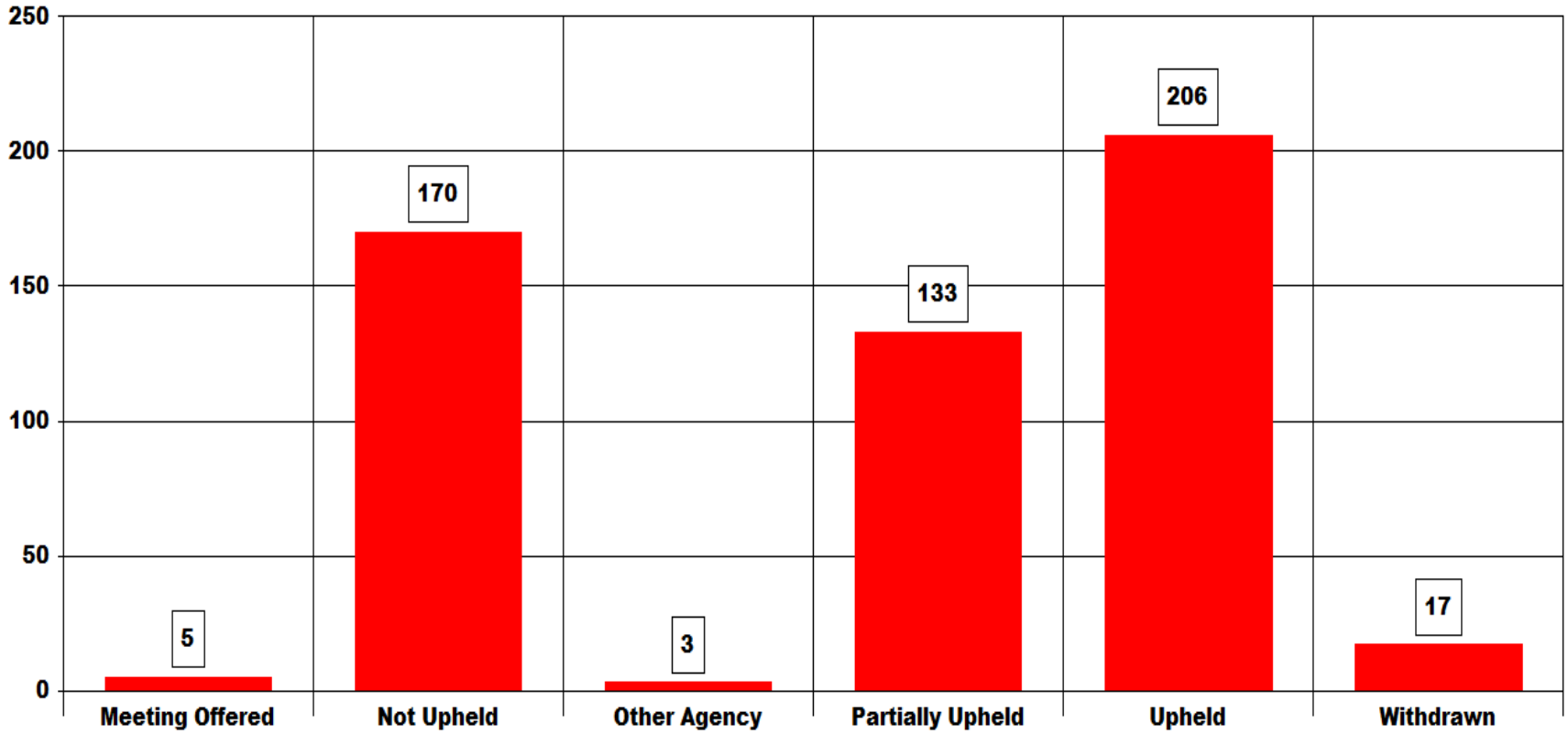
38 referrals made to LGO 1/4/14 – 31/3/15

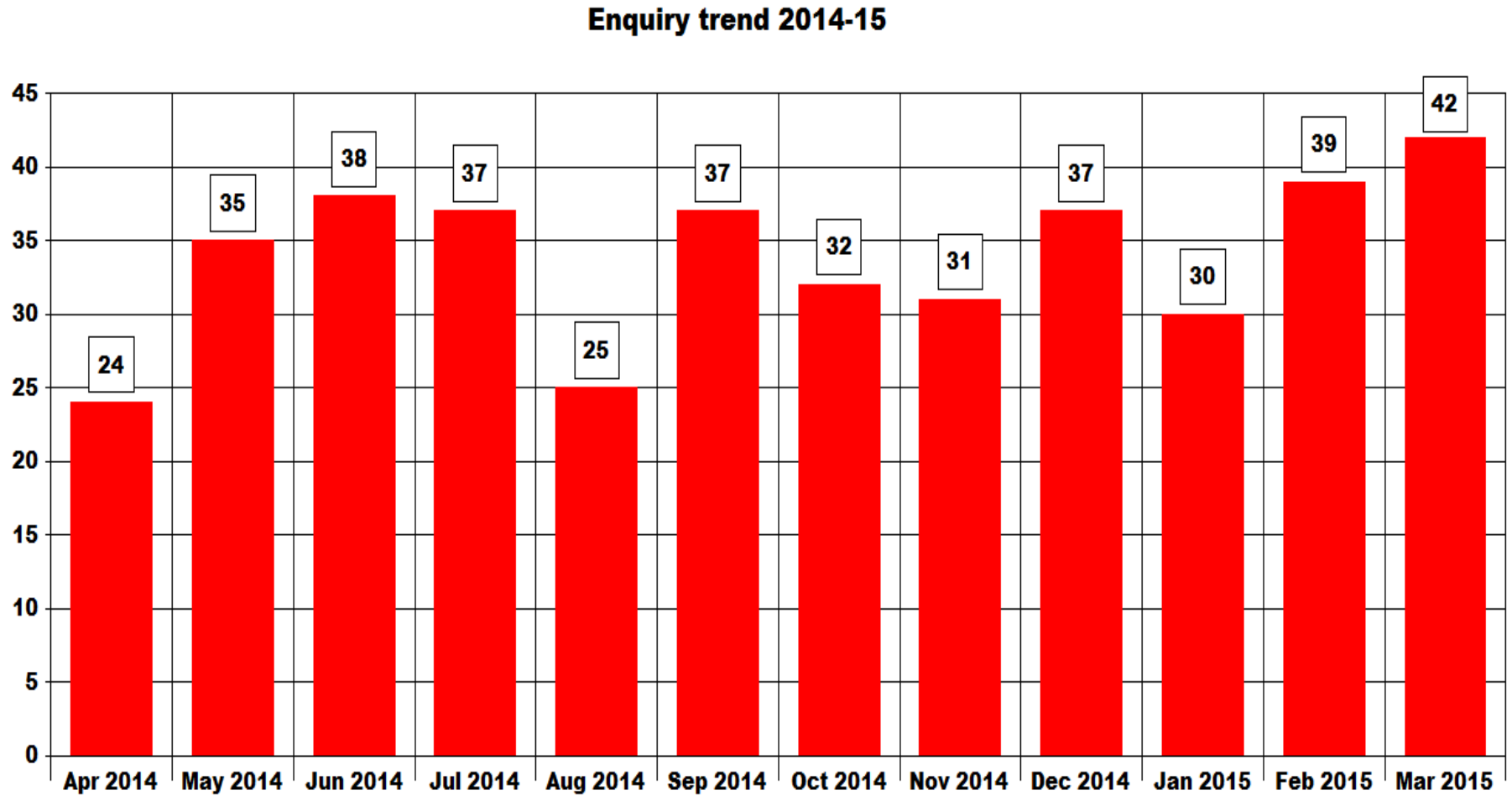
LGO outcomes for Adult Social Care complaints	
Closed after initial enquiries no further action	4
Closed after initial enquiries out of jurisdiction	2
Not upheld – no maladministration	7
Premature Complaint	8
Upheld Maladministration and injustice	6
Upheld Maladministration no injustice	2
Awaiting a decision	9
Total	38

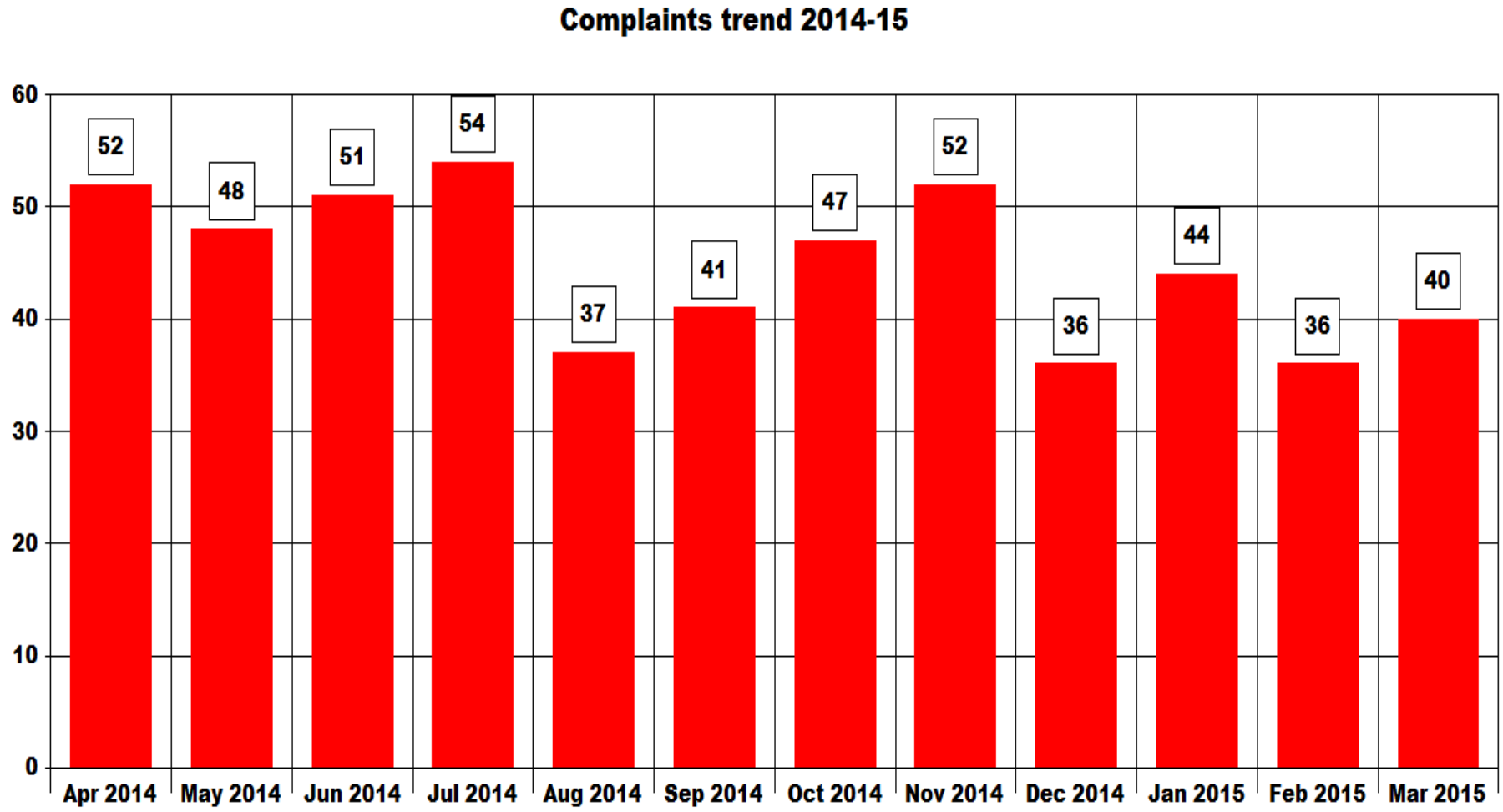
Service	Complaint	Enquiry
Access to services	15	19
ARMS/Central Duty Team	1	10
Assessment	49	43
Autistic Spectrum Condition	2	0
Benefits Team	0	1
Best Interests Assessments/MCA	6	5
Blue Badges	6	15
Carers Assessment	7	2
Case/care management	123	38
CFAO	3	2
Charging	76	18
Continuing Health Care	4	7
Debt Recovery	5	0
Direct Payments	43	12
Eligibility	5	9
Equipment and Adaptations	26	30
External Providers	94	74
Financial Assessment	32	19
Hospital Discharge	11	11
Housing	4	9
In House Day Care	6	7
In House Residential	6	2
Information, Advice ,Guidance	5	22
Integrated Care Centre	14	2
Kent Enablement at Home	9	4
Payments (to providers)	8	4
Policy	2	3
Respite Care	9	9
Review	5	4
Safeguarding	15	12
Central Purchasing Team (DPS)	4	0
Sensory/KAB/Hi Kent	2	0
Supported Living	5	5
Supporting People	0	4
Telecare	4	3
Tendering	34	27
Transition	5	3
Transport	5	0
Total	**650**	**435**

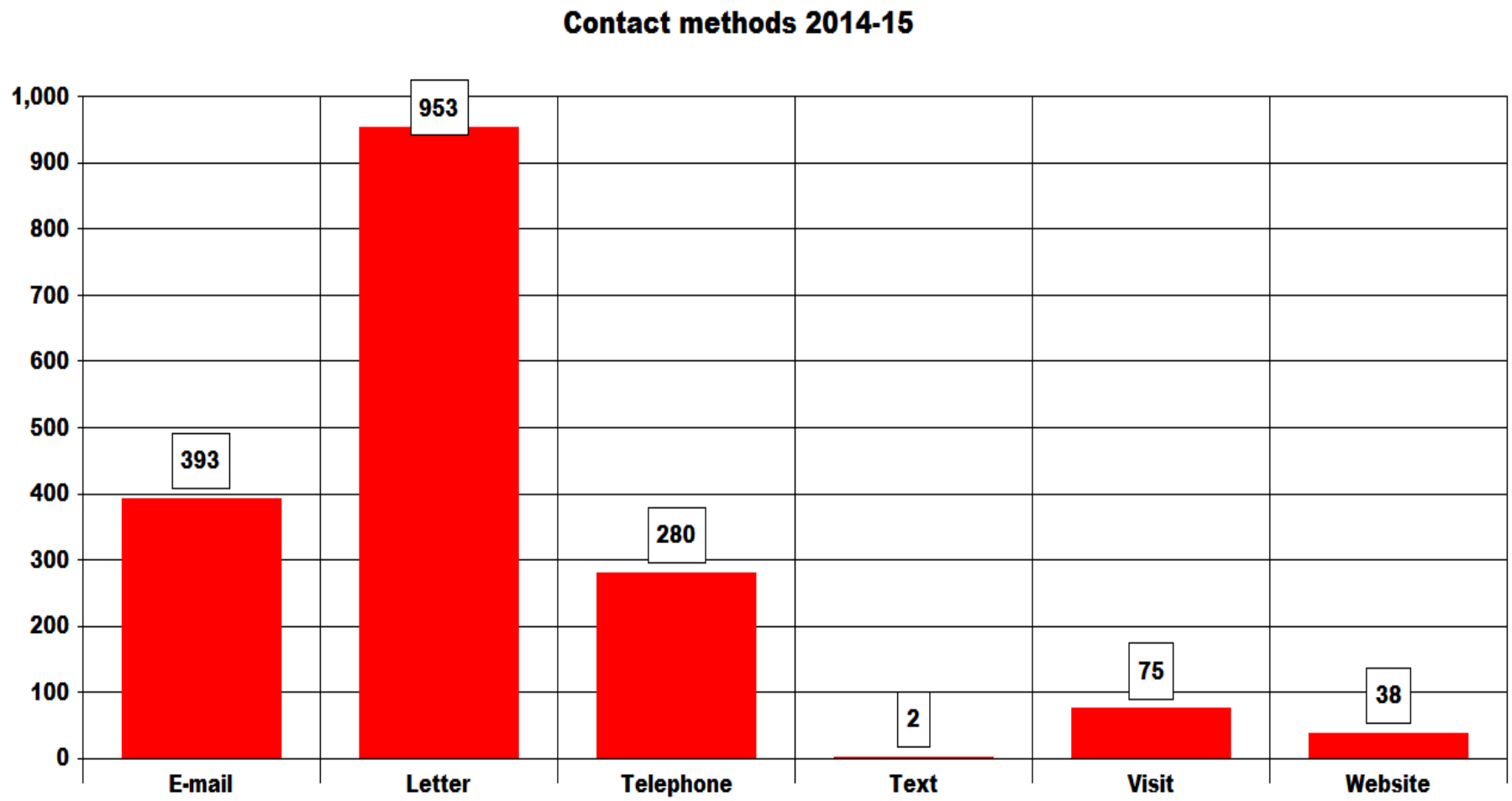

Complaints and Enquiries by Division 2014-15
800
600
400
200
0
3
1
47
92
680
40
82
CDT/OOH
Corporate Policy
Finance
Learning Disability & Mental Health
Older People & Physical Disability
Operational Support Unit
Strategic Commissioning Unit

Complaints final outcome 2014-15




Enquiry trend 2014-15
45
40
35
30
25
20
15
10
5
0
24
35
38
37
25
37
32
31
37
30
39
42
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Mar 2015


Complaints trend 2014-15
60
50
40
30
20
10
0
52
48
51
54
37
41
47
52
36
44
36
40
Apr 2014
May 2014
Jun 2014
Jul 2014
Aug 2014
Sep 2014
Oct 2014
Nov 2014
Dec 2014
Jan 2015
Feb 2015
Mar 2015


Contact methods 2014-15
1,000
900
800
700
600
500
400
300
200
100
0
393
953
280
2
75
38
E-mail
Letter
Telephone
Text
Visit
Website

Appendix Two

Complaints to the Local Government Ombudsman in 2014/15 where the LGO found the Local Authority to be at fault with injustice.

- In one case a service user was in receipt of home care from a private agency. The agency failed to inform the Council when the service user refused personal care. Also the agency did not seek medical help for the client when his health deteriorated.

- A complaint related to a self–funder in a residential care home. The person's daughter contacted the Council to say her mother's needs had changed and requested an assessment. There was considerable delay in responding and the Council was criticised for not addressing the concerns about the person's declining condition.

- In another case a care worker from an agency did not seek advice from a manager, or get medical attention for a service user. In addition to criticising the agency, the LGO was critical of the Local Authority for poor communication with the family in the safeguarding investigation that ensued.

- A complaint was received that the Council failed to address a person's care needs properly. The service user had a number of care needs. A review of her care took place and as a result the level of care and support was reduced. However, in reviewing her care, not all her assessed needs that had previously been identified were taken into account. The level of care and support was subsequently adjusted to reflect all her care needs.

- There was a complaint that the Council had used a person's Personal Expenditure Allowance to reduce the level of debt he owed to the council. The person, who did not have capacity, was resident in a care home and did not spend all their Personal Expenditure Allowance so it accumulated into his capital savings. The Council accessed the savings to pay off some of the debt. The LGO criticised the Council in the way it handled the person's finances and took the view that it was contrary to guidance to use the person's Personal Expenditure Allowance.

- A complaint related to the possessions of someone who moved from one care home to another. The person was a resident in one care home but the Council terminated the contract with the home and the person had to transfer to another care home. There was less space in the care home he moved to and so he could not take all his possessions with him. As a result his possessions were placed in bags and stored for him. However in due course the possessions were lost and the Council reimbursed the service user.

This page is intentionally left blank

From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 10 July 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, paragraphs 21 to 23, 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 1 May 2015, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion to the agenda of future meetings.

3.3 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 2015/16.

6. **Background Documents**
None.

7. **Contact details**

Report Author:
Theresa Grayell
Democratic Services Officer
03000 416172
theresa.grayell@kent.gov.uk

Lead Officer:
Peter Sass
Head of Democratic Services
03000 416647
peter.sass@kent.gov.uk

This page is intentionally left blank

Last updated on: 1 July 2015

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

Agenda Section	Items
11 SEPTEMBER 2015	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS AND MONITORING OF PAST DECISIONS	• ~~**Learning disability commissioning project** - key decision will be in Jan/Feb~~ *is this the same thing that went on 10 July?* • **Lead in to/consultation on Active Transport Strategy** (joint Strategy Public Health and Growth, Envt and Transport (will be a Cabinet decision in ?April 2016) • **KCC/KMPT Partnership** (arose at HWB agenda setting on 4/6/15) • **Kent Drug and Alcohol Services commissioning proposals** – update following 10 July mtg. Will the situation re East Kent contract extension be clear by then? • **Update on Public Health Transformation programme**
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly* • **Live it Well Strategy refresh** • **'Mind the Gap' strategy refresh** – advance discussion in September, decision in December
D – Monitoring	• **Local Account Annual report** • **Mid-year business plan Monitoring** • **Safeguarding Vulnerable Adults annual report** • **Equality and Diversity 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	• **'Mind the Gap' strategy refresh** – decision • Lead in to/consultation on **Active Transport Strategy** (joint Strategy Public Health and Growth, Envt and Transport (will be a Cabinet decision in ?April 2016) • **Adult Advocacy contract re-let**
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	• Lead in to/consultation on **Active Transport Strategy** (joint Strategy Public Health and Growth, Envt and Transport (will be a Cabinet decision in ?April 2016)

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** • **Update on Care Act implementation** – 6 monthly
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)* • **Tobacco Control** – 'one year on' update
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	

Last updated on: 1 July 2015

LATE 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	• **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	

This page is intentionally left blank

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

Document is Restricted

This page is intentionally left blank