Summons to and Agenda for a Meeting on

Thursday, 8th December, 2016

at **10.00 am**

DEMOCRATIC SERVICES
SESSIONS HOUSE
MAIDSTONE

Wednesday, 30 November 2016

To: All Members of the County Council

Please attend the meeting of the County Council in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 8 December 2016 at **10.00 am** to deal with the following business. **The meeting is scheduled to end by 4.30 pm.**

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.

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.

Voting at County Council Meetings

Before a vote is taken the Chairman will announce that a vote is to be taken and the division bell shall be rung for 60 seconds unless the Chairman is satisfied that all Members are present in the Chamber.

20 seconds are allowed for electronic voting to take place and the Chairman will announce that the vote has closed and the result.

A G E N D A

1. Apologies for Absence

2. Declarations of Disclosable Pecuniary Interests or Other Significant Interests in items on the agenda

3. Minutes of the meeting held on 20 October 2016 and, if in order, to be approved as a correct record **(Pages 7 - 16)**

4. Chairman's Announcements

5. Questions

6. Report by Leader of the Council (Oral)

7. Kent and Medway Safeguarding Adults Board Annual Report April 2015 - March 2016 **(Pages 17 - 72)**

8. Kent Health and Wellbeing Board Annual Report 2015-2016 **(Pages 73 - 92)**

9. Your Life, Your Well - Being - A vision and strategy for Adult Social Care 2016 - 2021 **(Pages 93 - 132)**

10. Appointment of External Auditors for the 2018/19 accounts and beyond **(Pages 133 - 144)**

11. Motion for Time Limited Debate

British Deaf Association's Charter of British Sign Language

To be proposed by Mr Burgess and seconded by Mr Baldock

"This Council fully supports the aspirations behind the British Deaf Association's Charter of British Sign Language (BSL), and agrees to sign up to the Charter and to implement their five pledges to improve access and rights for Deaf BSL users. Further, we request the appropriate Cabinet Members to submit a report to County Council in 12 months' time on progress made with implementing the pledges.

1. **Ensure access for Deaf people to information and services**

   Pledge: Deaf people will get the same quality of provision, information and standards and the same right to be consulted as everyone else.

2. **Promote learning and high quality teaching of British Sign Language (BSL)**

   Pledge: Family members, guardians and carers of deaf children and Deaf young people and local authority/public service employees will have access to BSL lessons from suitably qualified teachers.

3. **Support Deaf children and families**

   Pledge: At the point of diagnosis of deafness, health and education providers will offer parents genuinely informed choices, including a bilingual/bicultural approach.

4. **Ensure staff working with Deaf people can communicate effectively in BSL**

   Pledge: Customer-facing staff will have basic BSL skills. Specialist staff will have higher-level BSL skills so they can

deliver good services to Deaf people without needing interpreters.

5. Consult with the local Deaf community on a regular basis

Pledge: Deaf people should have the right to be consulted on services or changes to services that affect them and to have input into consultations alongside other forums and user groups."

John Lynch,
Head of Democratic Services
03000 410466

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KENT COUNTY COUNCIL

MINUTES of a meeting of the Kent County Council held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 20 October 2016.

PRESENT:
Mr T Gates (Chairman)
Mr D L Brazier (Vice-Chairman)

Mrs A D Allen, MBE, Mr M J Angell, Mr M Baldock, Mr M A C Balfour, Mr R H Bird, Mr H Birkby, Mr N J Bond, Mr A H T Bowles, Mrs P Brivio, Mr L Burgess, Mr C W Caller, Miss S J Carey, Mr P B Carter, CBE, Mr N J D Chard, Mr I S Chittenden, Mr B E Clark, Mrs P T Cole, Mr G Cooke, Mr G Cowan, Mrs M E Crabtree, Mr A D Crowther, Mrs V J Dagger, Mr D S Daley, Mr M C Dance, Mr J A Davies, Mrs T Dean, MBE, Dr M R Eddy, Mr J Elenor, Mrs M Elenor, Mr G K Gibbens, Mr R W Gough, Mr P M Harman, Mr M J Harrison, Mr M Heale, Mr P M Hill, OBE, Mr C P D Hoare, Mrs S V Hohler, Mr P J Homewood, Mr E E C Hotson, Mr M J Horwood, Mrs S Howes, Mr A J King, MBE, Mr J A Kite, MBE, Mr S J G Koowaree, Mr R A Latchford, OBE, Mr R L H Long, TD, Mr G Lymer, Mr B E MacDowall, Mr T A Maddison, Mr S C Manion, Mr R A Marsh, Ms D Marsh, Mr F McKenna, Mr B Neaves, Mr M J Northey, Mr P J Oakford, Mr J M Ozog, Mr C R Pearman, Mr L B Ridings, MBE, Mrs E D Rowbotham, Mr J E Scholes, Mr T L Shonk, Mr C Simkins, Mr J D Simmonds, MBE, Mr C P Smith, Mr D Smyth, Mrs P A V Stockell, Mr B J Sweetland, Mr A Terry, Mr N S Thandi, Mr R Truelove, Mr M J Vye, Mrs C J Waters, Mr J N Wedgbury, Mrs J Whittle, Mr M E Whybrow, Mr M A Wickham and Mrs Z Wiltshire

IN ATTENDANCE: Mr D Cockburn (Corporate Director Strategic & Corporate Services), Ms D Fitch (Democratic Services Manager (Council)) and Mr B Watts (General Counsel (Interim))

UNRESTRICTED ITEMS

24. Apologies for Absence

The General Counsel (Interim) reported apologies from Miss Harrison, Mr Holden and Mr Scobie.

25. Declarations of Disclosable Pecuniary Interests or Other Significant Interests in items on the agenda

Mr Cowan declared an interest in that both he and his wife were foster carers for Kent County Council.

26. Minutes of the meeting held on 14 July 2016 and, if in order, to be approved as a correct record

RESOLVED that the minutes of the meeting held on 14 July 2016 be approved as a correct record.

27. Chairman's Announcements

(a) Mr Robert Brookbank

(1) The Chairman stated that it was with regret that he had to inform Members of the death of Mr Brookbank on 2 August 2016. Mr Brookbank had been the County Councillor for Swanley since June 2009.

(2) Mr Brookbank's funeral had taken place on 25 August 2016.

(3) Mr Brazier, Mr Latchford, Mr Birkby, Dr Eddy, Mr Daley, Mr Gough and Mr Angell paid tribute to Mr Brookbank.

(b) Mr Alexander Perry

(4) The Chairman stated that it was with regret that he had to inform Members of the death of Mr Perry on 17 July 2016. Mr Perry was the Conservative Member for Folkestone South from 1977-1981.

(5) Mr Perry's funeral had taken place on 2 August 2016.

(6) Miss Carey paid tribute to Mr Perry.

(c) Mr Mike O'Brien

(7) The Chairman stated that it was with regret that he had to inform Members of the death of Mr O'Brien on 8 September 2016. Mr O'Brien was a former Conservative Councillor for Medway Council and a former KCC Member for the Gillingham No2 Division between1977-1980.

(8) Mr O'Brien's funeral took place on 23rd September 2016.

(9) Mr Hill paid tribute to Mr O'Brien.

(d) Dr Stuart James Cox JP

(10) The Chairman stated that it was with regret that he had to inform Members of the death of Dr Cox on Sunday 16 October 2016. Dr Cox was a former Conservative Member for Gillingham No 4 (South Central) between 1967 and 1997.

(11) Mr Harrison and Mrs Dean paid tribute to Dr Cox.

(12) At the end of the tributes all Members stood in silence in memory of Mr Brookbank, Mr Perry, Mr O'Brien and Dr Cox.

(13) After the one minute silence the Chairman moved and the Vice-Chairman seconded and it was resolved unanimously that :

(14) This Council desires to record the sense of loss it feels on the sad passing of Mr Brookbank, Mr Perry, Mr O'Brien and Dr Cox and extends to their families and friends heartfelt sympathy in their sad bereavements.

(e) Rio Sports Performers from Kent

(15) The Chairman stated that he was delighted to confirm that 26 performers with Kent connections were selected to represent Great Britain at the Olympic and Paralympic Games in Rio. At the Olympic Games, there were Gold medals for Rower, Tom Ransley from Ashford, and Hockey player Susannah Townsend from Canterbury. There were also four other women who play for Holcombe Hockey Club who were part of the gold medal winning team.

(16) The Chairman informed Members that in the Paralympic Games, table tennis player Will Bayley from Tunbridge Wells won a gold medal in men's singles and also won a bronze in the men's team event. Ross Wilson from Swale was also part of the Bronze medal winning table tennis team. A number of the athletes who participated in Rio had received grant aid from Kent County Council and a number had also competed through the Kent School Games programme. He expressed his congratulations to them all.

(f) RTPI Southeast - Excellence in Planning to Deliver Infrastructure Award 2016.

(17) The Chairman stated that he was pleased to report that the Kent and Medway Growth and Infrastructure Framework had won the RTPI Excellence in Planning to Deliver Infrastructure Award 2016. There had been a strong field for the category, and so was a great result. The Judging Panel had said that they were particularly impressed with the "boldness of the County" in its approach with the Framework and the actions it was now taking to tackle barriers to infrastructure.

(g) Petition - The Bridge Community Primary School, Dartford

(18) The Chairman invited Mr Maddison to present a petition requesting the expansion of The Bridge Community Primary School in Dartford

(19) The Chairman then invited Mr Gough, the Cabinet Member for Education and Health Reform, to collect the petition and to respond to it accordance with the Petition Scheme.

28. Questions

In accordance with Procedure Rule 1.17(4), 7 questions were asked and replies given. A record of all questions put and answers given at the meeting are available online with the papers for this meeting.

29. Autumn Budget Statement

(1) The Chairman reminded all Members that any Member of a Local Authority who was liable to pay Council Tax, and who had any unpaid Council Tax amount overdue for at least two months, even if there was an arrangement to pay off the arrears, must declare the fact that they were in arrears and must not cast their vote on anything related to KCC's Budget or Council Tax.

(2) Mr Baldock declared that he had unpaid Council Tax and withdrew from the meeting.

(3) The Chairman moved and the Vice-Chairman seconded that:

(a) Procedure Rule 1.28 be suspended in order that the Leader and the Deputy Leader be allowed to speak for a maximum of 12 minutes in total and the Leaders of the UKIP, Labour, Liberal Democrat and Independent Groups speak for 6, 5, 4 and 3 minutes respectively.

(b) Procedure Rule 1.35 be suspended in order to allow Members to speak more than once during the debate, at the discretion of the Chairman, and in particular the Deputy Leader as seconder of the motion to speak again at the end of the debate.

Agreed without a formal vote

(4) The Chairman then invited Mr Wood, Corporate Director Finance and Procurement, to give a brief presentation to provide a context for this item.

(5) Mr Carter proposed and Mr Simmonds seconded the following motion:

"The County Council is asked to:

(a) AUTHORISE Corporate Directors to make the necessary arrangements to be able to deliver savings once the final budget has been approved in February, and to develop further proposals to resolve the unidentified gap and resolve the uncertainties should these arise;
(c) AGREE the savings from a revised approach to the Minimum Revenue Provision policy (as detailed in paragraph 5.8);
(d) AGREE the additional income target for returns on our cash balances, as detailed in Appendix 3;
(e) RECOGNISE the excellent progress on eliminating the £52m gap that was included in the published MTFP for 2017-18, down to its current level of £5.2m."

(6) Mr Latchford, Mr Cowan, Mrs Dean and Mr Whybrow were given the opportunity to speak at the start of the debate on this item.

(7) Mr Smyth proposed and Mr Cowan seconded the following amendment:

(a) Authorise Corporate Directors to bring forward proposals to close the funding gap for Members' consideration at the budget meeting in February 2017.
(b) AGREE the savings from a revised approach to the Minimum Revenue Provision policy (as detailed in paragraph 5.8);
(c) AGREE the additional income target for returns on our cash balances, as detailed in Appendix 3;
(d) Note the hard work by Officers in eliminating the £52m funding gap that was included in the published MTFP for 2017 – 18 down to its current level of £5.2m and deplore the necessity to do so forced on us by Central Government."

(8) Following the debate the Chairman put the amendment set out in paragraph (7) above to the vote and the voting was as follows:

For (21)

Mr R Bird, Mrs P Brivio, Mr C Caller, Mr I Chittenden, Mr B Clark, Mr G Cowan, Mr D Daley, Mrs T Dean, Dr M Eddy, Mrs M Elenor, Mr C Hoare, Ms S Howes, Mr T Maddison, Mr F McKenna, Mr B MacDowall, Mrs E Rowbotham, Mr D Smyth, Mr N Thandi, Mr R Truelove, Mr M Vye, Mr M Whybrow

Against (52)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr H Birkby, Mr N Bond, Mr A Bowles, Mr D Brazier, Mr L Burgess, Miss S Carey, Mr P Carter, Mr N Chard, Mrs P Cole, Mr G Cooke, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr M Dance, Mr J Davies, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Heale, Mr M Hill, Mrs S Hohler, Mr P Homewood, Mr E Hotson, Mr M Horwood, Mr A King, Mr J Kite, Mr R Latchford, Mr R Long, Mr G Lymer, Mr S Manion, Mr A Marsh, Mrs D Marsh, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr J Ozog, Mr C Pearman, Mr L Ridings, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mr B Sweetland, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr A Wickham

Abstain (3)

Mr J Elenor, Mr T Gates, Mr A Terry.

Amendment lost

(9) After a debate on the motion as set out in paragraph (5) above the Chairman put each part of the motion to a formal vote and the voting was as follows:

> " (a) AUTHORISE Corporate Directors to make the necessary arrangements to be able to deliver savings once the final budget has been approved in February, and to develop further proposals to resolve the unidentified gap and resolve the uncertainties should these arise;

For (62)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr R Bird, Mr N Bond, Mr A Bowles, Mr D Brazier, Mr L Burgess, Miss S Carey, Mr P Carter, Mr N Chard, Mr I Chittenden, Mr B Clark, Mrs P Cole, Mr G Cooke, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr D Daley, Mr M Dance, Mr J Davies, Mrs T Dean, Mr J Elenor, Mrs M Elenor, Mr T Gates, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Heale, Mr M Hill, Mr C Hoare, Mrs S Hohler, Mr E Hotson, Mr M Horwood, Mr A King, Mr J Kite, Mr R Latchford, Mr R Long, Mr G Lymer, Mr B MacDowall, Mr A Marsh, Mrs D Marsh, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr J Ozog, Mr C Pearman, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mr B Sweetland, Mr A Terry, Mr M Vye, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr M Whybrow, Mr A Wickham, Mrs Z Wiltshire.

Against (11)

Mr H Birkby, Mr C Caller, Mr G Cowan, Dr M Eddy, Ms S Howes, Mr T Maddison, Mr F McKenna, Mrs E Rowbotham, Mr D Smyth, Mr N Thandi, Mr R Truelove.

Abstain (2)

Mrs P Brivio, Mr P Homewood.

Motion carried

"(b) AGREE the savings from a revised approach to the Minimum Revenue Provision policy (as detailed in paragraph 5.8);"

For (75)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr R Bird, Mr H Birkby, Mr N Bond, Mr A Bowles, Mr D Brazier, Mrs P Brivio, Mr L Burgess, Mr C Caller, Miss S Carey, Mr P Carter, Mr N Chard, Mr I Chittenden, Mr B Clark, Mrs P Cole, Mr G Cooke, Mr G Cowan, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr D Daley, Mr M Dance, Mr J Davies, Mrs T Dean, Dr M Eddy, Mr J Elenor, Mrs M Elenor, Mr T Gates, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Heale, Mr M Hill, Mr C Hoare, Mrs S Hohler, Mr P Homewood, Mr E Hotson, Mr M Horwood, Ms S Howes, Mr A King, Mr J Kite, Mr R Latchford, Mr R Long, Mr G Lymer, Mr B MacDowall, Mr T Maddison, Mr A Marsh, Mrs D Marsh, Mr F McKenna, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr J Ozog, Mr C Pearman, Mrs E Rowbotham, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mr D Smyth, Mr B Sweetland, Mr A Terry, Mr N Thandi, Mr R Truelove, Mr M Vye, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr M Whybrow, Mr A Wickham, Mrs Z Wiltshire

Against (0)

Abstain (0)

Motion carried

"(c) AGREE the additional income target for returns on our cash balances, as detailed in Appendix 3;"

For (74)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr R Bird, Mr H Birkby, Mr N Bond, Mr A Bowles, Mr D Brazier, Mrs P Brivio, Mr L Burgess, Mr C Caller, Miss S Carey, Mr P Carter, Mr N Chard, Mr I Chittenden, Mr B Clark, Mrs P Cole, Mr G Cooke, Mr G Cowan, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr D Daley, Mr M Dance, Mr J Davies, Mrs T Dean, Dr M Eddy, Mr J Elenor, Mrs M Elenor, Mr T Gates, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Heale, Mr M Hill, Mr C Hoare, Mrs S Hohler, Mr P Homewood, Mr E Hotson, Mr M Horwood, Ms S Howes, Mr A King, Mr J Kite, Mr R Latchford, Mr R Long, Mr G Lymer, Mr B MacDowall, Mr T Maddison, Mr A Marsh, Mrs D Marsh, Mr F McKenna, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr J Ozog, Mr C Pearman, Mrs E Rowbotham, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mr D Smyth, Mr B Sweetland, Mr A Terry, Mr N Thandi, Mr R Truelove, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr M Whybrow, Mr A Wickham, Mrs Z Wiltshire

Against (0)

Abstain (0)

Motion carried

"(d) RECOGNISE the excellent progress on eliminating the £52m gap that was included in the published MTFP for 2017-18, down to its current level of £5.2m."

For (56)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr R Bird, Mr H Birkby, Mr N Bond, Mr A Bowles, Mr D Brazier, Mr L Burgess, Miss S Carey, Mr P Carter, Mr N Chard, Mrs P Cole, Mr G Cooke, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr D Daley, Mr M Dance, Mr J Davies, Mrs T Dean, Mr J Elenor, Mrs M Elenor, Mr T Gates, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Heale, Mr M Hill, Mrs S Hohler, Mr P Homewood, Mr E Hotson, Mr M Horwood, Mr A King, Mr R Long, Mr G Lymer, Mr A Marsh, Mrs D Marsh, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr C Pearman, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mr B Sweetland, Mr A Terry, Mr M Vye, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr A Wickham, Mrs Z Wiltshire

Against (12)

Mrs P Brivio, Mr C Caller, Mr G Cowan, Dr M Eddy, Ms S Howes, Mr T Maddison, Mr B MacDowall, Mrs E Rowbotham, Mr D Smyth, Mr N Thandi, Mr R Truelove, Mr M Whybrow

Abstain (3)

Mr B Clark, Mr C Hoare, Mr F McKenna

Motion carried

(10) RESOLVED that;

(a) the Corporate Directors be authorised to make the necessary arrangements to be able to deliver savings once the final budget has been approved in February 2017, and to develop further proposals to resolve the unidentified gap and resolve the uncertainties should these arise;
(b) the savings from a revised approach to the Minimum Revenue Provision policy (as detailed in paragraph 5.8 of the report be agreed;
(c) the additional income target for returns on our cash balances, as detailed in Appendix 3 to the report be agreed;
(d) the excellent progress on eliminating the £52m gap that was included in the published MTFP for 2017-18, down to its current level of £5.2m be recognised."

30. Treasury Management Annual Review 2015-16

(1) Mr Simmonds moved and Mrs Crabtree seconded the following motion:

"Members are asked to note the report"

(2) The motion was agreed without a formal vote

(3) RESOLVED that the report be noted.

31. Revised Proportionality Calculations and Committee Membership

(1) The Chairman moved and the Vice-Chairman seconded the following motion

"The Council is invited to agree:

(a) that the Labour Group should lose a seat on each of the Regulation Committee and the Health Overview and Scrutiny Committee to the Conservative Group; and
(b) that the question of proportionality of membership of the Kent Fire and Rescue Committee be referred to Selection and Member Services Committee for further detailed consideration."

(2) The motion was agreed without a formal vote.

(3) RESOLVED that:

(a) the Labour Group lose a seat on each of the Regulation Committee and the Health Overview and Scrutiny Committee to the Conservative Group
(b) the question of proportionality of membership of the Kent Fire and Rescue Committee be referred to Selection and Member Services Committee for further detailed consideration.

32. Appointment of Independent Member Remuneration Panel from 1 November 2016

(1) Mr Cooke moved and Mrs Allen seconded the following motion:

"The County Council is invited to consider the recommendation of the Panel of Honorary Aldermen and appoint Mr Ghualam Khan, Ms Margaret Ryder and Mr Stephen Wiggett as the new members of the new Independent Remuneration Panel for a four year term, from 1 November 2016 to 31 October 2020."

(2) The motion was agreed without a formal vote.

(3) RESOLVED that Mr Ghualam Khan, Ms Margaret Ryder and Mr Stephen Wiggett be appointed as the new members of the new Independent Remuneration Panel for a four year term, from 1 November 2016 to 31 October 2020."

33. Kent Safeguarding Children Board - 2015/16 Annual Report

(1) Mr Oakford moved and Mr Lymer seconded the following motion:

"County Council is asked to:

(a) COMMENT on the progress and improvements made during 2015/16, as detailed in the Annual Report from Kent Safeguarding Children Board

(b) NOTE the 2015/16 Annual Report attached."

(2) Ms Gill Rigg, Independent Chairman of the Kent Safeguarding Children's Board, addressed the meeting and answered a number of questions from Members.

(3) Following further debate, the motion was agreed without a formal vote.

(4) RESOLVED that the 2015/16 Annual Report from Kent Safeguarding Children Board and the comments made by Members be noted.

34. "Increasing Opportunities, Improving Outcomes" - Strategic Statement Annual Report 2016

(1) Mr Carter moved and Mr Simmonds seconded the following motion:

"County Council is asked to approve the 'Increasing Opportunities, Improving Outcomes' Annual Report 2016 (Appendix 1)."

(2) Following a debate the Chairman put the motion as set out in paragraph (1) above to the vote and the voting was as follows:

For (49)

Mrs A Allen, Mr M Angell, Mr M Balfour, Mr H Birkby, Mr A Bowles, Mr D Brazier, Miss S Carey, Mr P Carter, Mr N Chard, Mrs P Cole, Mr G Cooke, Mrs M Crabtree, Mr A Crowther, Mrs V Dagger, Mr M Dance, Mr J Davies, Mrs M Elenor, Mr T Gates, Mr G Gibbens, Mr R Gough, Mr P Harman, Mr M Harrison, Mr M Hill, Mrs S Hohler, Mr P Homewood, Mr E Hotson, Mr M Horwood, Mr A King, Mr J Kite, Mr R Latchford, Mr R Long, Mr G Lymer, Mr A Marsh, Mr F McKenna, Mr B Neaves, Mr M Northey, Mr P Oakford, Mr J Ozog, Mr C Pearman, Mr J Scholes, Mr T Shonk, Mr C Simkins, Mr J Simmonds, Mr C Smith, Mrs C Waters, Mr J Wedgbury, Mrs J Whittle, Mr A Wickham, Mrs Z Wiltshire

Against (13)

Mrs P Brivio, Mr C Caller, Mr G Cowan, Dr M Eddy, Ms S Howes, Mr T Maddison, Mrs D Marsh, Mrs E Rowbotham, Mr D Smyth, Mr B Sweetland, Mr N Thandi, Mr R Truelove, Mr M Whybrow

Abstain (7)

Mr R Bird, Mr I Chittenden, Mrs T Dean, Mr J Elenor, Mr B MacDowall, Mr A Terry, Mr M Vye

Motion carried

(3) RESOLVED that the ‘Increasing Opportunities, Improving Outcomes’ Annual Report 2016 be approved.

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

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

Deborah Stuart-Angus – Independent Chair, Kent and Medway Safeguarding Adults Board

To: County Council – 8 December 2016

Subject: Kent and Medway Safeguarding Adults Board Annual Report April 2015 – March 2016

Classification: Unrestricted

Summary: This report introduces the Kent and Medway Safeguarding Adults Annual Report April 2015–March 2016, which details the work of the multi-agency partnership and how it managed safeguarding adults issues in 2015-2016. The report provides safeguarding activity information and also contains key statements from partner organisations regarding how they dealt with safeguarding issues in their respective agencies and outlines key priorities for the year ahead.

Recommendations: County Council is asked to **COMMENT** on the progress and improvements made during 2015-16, as detailed in the Annual Report from the Kent and Medway Safeguarding Adults Board and **ENDORSE** the 2015-16 Annual Report attached. Following this meeting, this document will be available for download on the KCC website.

1. Introduction

1.1 This report presents the 2015-2016 Annual Report produced by Deborah Stuart-Angus, the Independent Chair of the Kent and Medway Safeguarding Adults Board (KMSAB) and endorsed by members of that Board.

1.2 Following the Care Act 2014 Safeguarding Adults is now a statutory responsibility for all Agencies, with Local Authorities taking the lead. Safeguarding continues to be the major priority of the Social Care, Health and Wellbeing Directorate. In meeting this responsibility, it is essential that the Directorate plays a key role in the workings of the Kent and Medway Safeguarding Adults Board.

1.3 The Kent and Medway Safeguarding Adults Board works to make sure that all agencies are working together to help keep Kent and Medway's adults safe from harm and to protect the rights of citizens, in line with the Care Act 2014 and the Mental Capacity Act 2005.

1.4 The enactment and implementation of the Care Act 2014, placed Safeguarding Adults Boards on a statutory basis from April 2015. The Care Act (14.116) states that the following organisations **must** be represented on the Safeguarding Adults Board:

- Local Authority
- Clinical Commissioning Groups in the Local Authority's area
- Police

1.5 The Care Act (14.10) also requires that each Local Authority **must**:

- make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect , and if so, by whom
- set up a Safeguarding Adults Board
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them
- co-operate with each of its relevant partners (as set out in Section 6 of the Care Act) in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

1.6 In line with the Care Act 2014, the Kent and Medway Safeguarding Adults Board is required to publish an Annual Report each financial year.

1.7 The Kent and Medway Safeguarding Adults Board comprises of Senior Officers from the key agencies in Kent and Medway involved in safeguarding, including the Police, Health Service, Medway Council and Kent County Council. Following a rigorous recruitment campaign, Deborah Stuart-Angus was appointed to the position of Independent Chair, taking up the post in December 2015.

1.8 The Care Act 2014 states that once the report is published, it should be submitted to the Chief Executive (where one is in situ) and Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

2. Increasing Opportunities, Improving Outcomes

2.1 The work of the Kent and Medway Safeguarding Adults Board, which is detailed within the Annual Report, plays a key role in supporting KCC's Strategic Statement 2015-2020 'Increasing Opportunities, Improving Outcomes':

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

3. The 2015–2016 Annual Report

3.1 The report contains a wealth of information from each of the key agencies engaged in the Kent and Medway Safeguarding Adults Board.

3.2 Section 7 outlines the activity data for adult safeguarding in Kent and Medway. This includes referral data, the background data in regard to victims and the current trends in relation to adult safeguarding in Kent and Medway.

3.3 There has been a significant increase in safeguarding enquiries, especially in Kent. In 2014–2015 there were 3,273 safeguarding enquiries in Kent compared to 3,906 safeguarding enquiries in 2015-2016. This is a 19.3% increase. In Medway there was a 9.8% increase, from 244 safeguarding enquiries in 2014-2015 to 268 safeguarding enquiries in 2015–2016.

3.4 Section 8 identifies the key priorities for the Kent and Medway Safeguarding Adults Board for 2016-2017.

3.5 In her first six months as Independent Chair of KMSAB, Deborah Stuart-Angus has undertaken a partnership consultation, which will lead to a more robust approach to Board decision making, governance and structure, and partnership agreement, which in turn will lead to a new and strong Board Constitution.

3.6 A review of the course content for multi-agency training at Levels 3 (The Guide to Undertaking Safeguarding Enquiries) and 5 (Decision Making and Accountability in Safeguarding) was undertaken during 2015 - 2016 to ensure that the content was fit for purpose and reflective of current legislation and policy developments. KMSAB will be commissioning new training courses to be delivered from April 2017.

3.7 The Self Assessment Framework was revised and updated to ensure that it was fit for purpose in light of the Care Act 2014 and to align it to the themes identified in the Local Government Association's 'Adult Safeguarding Improvement Tool'. KMSAB requires agencies to complete the self-assessment framework to measure their progress against key standards. These are then peer reviewed by another agency and findings are presented to the Board. Any actions rated red or amber require regular update reports to the Quality Assurance Working Group and Board to ensure the required standards are achieved.

3.8 The Practice, Policy and Procedures Working Group developed a Protocol as a means of supporting professionals and communities in Kent and Medway to identify and respond appropriately to safeguard adults who are at risk of: being trafficked, sexually exploited or modern slavery. The Protocol contains hyperlinks to the relevant sections in the

main Policies, Protocols and Guidance document to support good safeguarding adults practice.

3.9 Adult Reviews. In September 2014, the Board commissioned a Safeguarding Adult Review (SAR) in respect of Mary Smith.[1] The overview report and recommendations were presented to the Board in June 2015. Agencies developed action plans to address the recommendations. These plans were reviewed after six months and a progress report was presented to the Board in March 2016 to assure the Board of progress. Other SARs are currently being undertaken in 2016 - 2017. The lessons from all of these and from other National SARs continue to influence the focus of KMSAB's multi-agency learning and development strategy and training programme.

4. Conclusion

4.1 During 2015 - 16, KMSAB and our partner agencies have built on the good work from the previous year. The Board has continued with its scrutiny and challenge role through stricter governance and lines of accountability.

5. Recommendations

5.1 County Council is asked to **COMMENT** on the progress and improvements made during 2015-16, as detailed in the Annual Report from the Kent and Medway Safeguarding Adults Board and **ENDORSE** the 2015-16 Annual Report attached. Following this meeting, this document will be available for download on the KCC website.

6. Background Documents

None

7. Contact Details

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[1] To protect the identity of the individual this is a fictitious name

Kent and Medway Safeguarding Adults Board

Annual Report
April 2015 – March 2016

Contents

Foreword from Deborah Stuart-Angus, Independent Chair, Kent and Medway Safeguarding Adults Board

Thank you for your interest in safeguarding adults at risk in Kent and Medway. As Independent Chair of the Kent and Medway Safeguarding Adults Board, it gives me great pleasure to introduce our 2015-16 Annual Report. This not only gives our partnership the opportunity to share their achievements with our communities, but also addresses the huge range of activity and continued endeavor, clearly demonstrated in combined efforts to keep residents of Kent and Medway safe.

In December 2015, I was honoured to take over this exacting role from the former Chair: Andrew Ireland, KCC Corporate Director for Social Care, Health and Wellbeing, and would like to take this opportunity to thank him for his hard work and continued contribution, in strengthening the Board, despite the significant challenges posed in 2014-15.

My intention has been, and will continue to be, to work closely and collaboratively, with our partnership, moving us forward to its next natural stage of development. A partnership consultation, held in Spring 2016, will lead to a more robust approach to Board decision making, governance and structure, and partnership agreement will lead to a new and strong Board Constitution. A robust approach to risk management has been adopted and a Safeguarding Adult Review Panel has been established - well lead and managed by our multi-agency partners. A Risk Register is in the making, setting priorities for mitigation and outlining our focus areas. A revised Multi Agency Training Plan has commenced, this will prioritise and target learning opportunities for the partnership, which the Board is managing to deliver despite financial constraints. Plans for the year ahead will be led by the review of 2014-15 Safeguarding Adult Strategy and I will look forward to reporting back on the outcomes that this achieves in 2016-17. A key focus of this revision will be to engage service users and carers in the work of the Board, so that a more defined approach to Making Safeguarding Personal can be molded and grown. The development of their input will keep us realistically focused on what makes a difference to people's health, safety and wellbeing.

My tenure is for three years and so far I have been more than impressed by the sheer dedication and commitment of Board Members; Board Sub Groups and their Chairs; the Safeguarding Adult Review Group and our Board Management Team. They have all faced significant challenges and austerity, yet have continued to deliver on a tremendous amount of work, which has been timely; been of high quality and been very well received. My personal thanks go to these people.

All statutory partners have made significant financial contributions to the Kent and Medway Safeguarding Adults Board budget and the difficulties of doing this in the current financial environment cannot be underestimated. My aim will be to deliver on measurable quality and value for this money.

Both Kent (19%) and Medway (nearly 10%) have seen increases in the numbers of Safeguarding Enquiries. This is believed to reflect greater awareness and more robust reporting following the implementation of the requirements of the Care Act 2014. Physical abuse remains the most prevalent, but percentages are slightly down from last year with a small increase in Enquiries for neglect.

We will be working with all agencies to minimise this. Figures show a continued four year decline in financial and material abuse, a testament to many combined prevention efforts across Kent and Medway.

I would particularly like to thank the Councillors in Kent and Medway, for their continued interest and encouragement and last but not least, thanks go out to the residents of Kent and Medway, and staff across organisations, for their vigilance and efforts in reporting abuse and trying to prevent it from being repeated

Deborah Stuart-Angus
Independent Chair of the Kent and Medway Safeguarding Adults Board

Section 1. Introduction

What is safeguarding?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." Care Act (2014).

The Care Act states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect

Abuse or neglect can take many forms. The Care Act lists the following types of abuse and neglect:

- Physical abuse
- Domestic violence
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglect and acts of omission
- Self-neglect

For a full definition of each category of abuse and neglect please see Appendix 2.
These are embodied in the Multi-Agency Safeguarding Adults Policies, Protocols and Guidance for Kent and Medway.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when an adult at risk is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person. Abuse can happen anywhere and take place in any context, for example, in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations. Adults at risk may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

The Care Act 2014 consolidates provisions from over a dozen different Acts into a single, framework for care and support. It is a fundamental reform of the way the law works. It places the wellbeing, needs and goals of people at the centre of the legislation, to create care and support which fits around the individual and works for them.

The Act also provides a framework for adult safeguarding. It sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area.

How do I report abuse or neglect?

If you think you or another person is at risk of harm, neglect or abuse, please contact:

If you live in Medway:
01634 334466
(Next Generation Text Service - 18001 01634 334466)

Or if you live in any other part of Kent:
03000 41 61 61
(Next Generation Text Service - 18001 03000 416161)

If you think someone is in immediate risk or danger, the best thing to do is call 999 for the emergency service

.

For further information go to: www.medway.gov.uk/abuse
www.kent.gov.uk/adultprotection

What is the role of the Kent and Medway Safeguarding Adults Board?

The Kent and Medway Safeguarding Adults Board (KMSAB) has a statutory function as set out within the Care Act 2014. In relation to deploying its lawful safeguarding duty, the KMSAB has three main functions:

1. Assurance
2. Accountability
3. Prevention

In order for these functions to work well, the KMSAB ensures that all member agencies work together to help keep Kent and Medway's adults safe from harm, to protect their right to live free from harm, abuse and neglect. From December 2015, KMSAB has been chaired by an Independent Chair (Deborah Stuart-Angus) and meets four times a year. Our vision is:

'to ensure that Kent and Medway is an increasingly safer place for adults at risk of abuse and neglect'

To achieve its vision, the KMSAB works with partners and local communities to:

- Prevent abuse and neglect from happening
- Identify and report abuse and neglect
- Respond to any abuse and neglect that is occurring
- Support people who have suffered abuse or neglect to recover and to regain trust, where possible, in those around them
- Raise awareness of safeguarding adults and the role everyone can play in responding to, and preventing, abuse and neglect

The KMSAB supports adults at risk to have choice and control over their lives by following and endorsing the six safeguarding principles outlined in the Care and Support Guidance:

- Empowerment - individuals will be asked what they want the outcomes from the safeguarding process to be and these outcomes will directly inform what happens wherever possible

- Prevention - individuals will get help and support to report abuse and neglect and get help to take part in the safeguarding process

- Proportionality - individuals will be confident that professionals will work for their best interests and that professionals will only get involved as much as needed

- Protection - individuals will receive clear information about what abuse and neglect is, how to recognise the signs and what they can do to seek help and support

- Partnership - individuals will be confident that professionals will work together to get the best outcomes for them. They will also be confident that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary

- Accountability - individuals will receive timely help they need from the person or agency best placed to provide it

The KMSAB used these principles to inform the Strategic Plan.

Key responsibilities of the KMSAB include:

- Providing strategic direction for the adults at risk agenda
- Developing and reviewing multi-agency policy, procedures and guidance for safeguarding adults at risk
- Monitoring and reviewing the implementation and impact of policy
- Promoting and deploying multi-agency training
- Undertaking Safeguarding Adult Reviews (replacing Serious Case Reviews)
- Holding partners to account and gaining assurance of the effectiveness of safeguarding arrangements

Section 2. National Context

Key documents which have influenced the safeguarding agenda include:

The Care Act 2014

The Care Act 2014 came into force on 1 April 2015, replacing and consolidating a number of previous laws and statutory guidance, to create a single, consistent approach to establishing entitlement to adult social care in England. It sets out new duties for local authorities and partner agencies and introduces the right to an assessment for anyone, including carers, in need of support. The Act promotes a preventative approach and aims to put individuals in control of their care and support.

Care Act 2014 Safeguarding Provisions

Clauses 42-48 of the Care Act provide the statutory framework for protecting adults from abuse and neglect. The safeguarding provisions include:

- New duty for local authorities to carry out enquiries (or cause others to) where it suspects an adult is at risk of abuse or neglect
- Local Safeguarding Adults Boards to carry out Safeguarding Adult Reviews into cases where someone, who experienced abuse or neglect, died, or was seriously harmed, and there are concerns about how authorities acted, to ensure lessons are learned
- New ability for Safeguarding Adults Boards to require information sharing from other partners to support reviews or other functions
- Abolition of the existing power (under section 47 of the National Assistance Act 1948) for local authorities to remove people from their homes
- Requirement for all areas to establish a Safeguarding Adults Board to bring together the local authority, NHS and Police to co-ordinate activity to protect adults from abuse and neglect
- Introduction of new categories of abuse, including: Self-Neglect and Modern Slavery

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Care Act Statutory Guidance 2014

The Care Act 2014 statutory guidance was published on 24 October 2014. In addition to providing a fundamental reform of the adult social care and support system, the Care Act also creates a legal framework for key organisations and individuals, with responsibility for adult safeguarding, to agree how they must work together and what roles they must play to keep adults at risk safe. Chapter 14 specifically relates to safeguarding (page 229).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

Adult Safeguarding Improvement Tool – March 2015

The Improvement Tool, based on the Adult Safeguarding Standards, was refreshed in March 2015. Developed by the Local Government Association, the document sets out key areas of focus, which have been used in numerous peer reviews and challenges and as a means of self-assessment. The characteristics of a well-performing and ambitious partnership are described, particularly in relation to the three key partners in safeguarding adults; the council, NHS and Police. The Kent and Medway Safeguarding Adults Board used this tool when revising its self-assessment document.

http://www.local.gov.uk/documents/10180/6869714/Adult+safeguarding+improvement+tool.pdf/dd2f25ff-8532-41c1-85ed-b0bcbb2c9cfa

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards (DoLS) came into force in England and Wales in April 2009, under an amendment to the Mental Capacity Act 2005. These safeguards are intended to protect individuals, who lack the capacity to consent to care or treatment, from being deprived of their liberty unless there is no other, less restrictive alternative, and a deprivation of liberty is assessed to be in their best interests to protect them from harm, or to provide treatment.

The definition of what constitutes a deprivation of liberty was amended following a Supreme Court Judgement in 2014, P v Cheshire West and Chester Council (2014), which created an 'acid test' for what constitutes a deprivation of liberty. The 'acid test' is fulfilled, and an individual is considered to be deprived of their liberty, if they:

- lack the capacity to consent to their care/treatment arrangements **and**
- are under continuous supervision and control **and**
- are not free to leave

The following are not relevant to the application of the test:

- the person's compliance or lack of objection
- the relative normality of the placement and the reason
- the purpose for the placement having been made

Statistics published by the Health and Social Care Information Centre (HSCIC) illustrate a significant increase in DoLS applications following the Supreme Court Judgement on 19 March 2014. "There were 137,540 DoLS applications received by councils between 1 April 2014 and 31 March 2015, the most since the safeguards were introduced in 2009. This is a tenfold increase from 2013-14 (13,700)."[1] It is expected that figures for 2015-16 will be published in October 2016.

Further details available at:
http://www.hscic.gov.uk/catalogue/PUB18577/dols-eng-1415-rep.pdf

The Department of Health has funded the Law Commission to review the DoLS legislation. An interim statement is available at:
www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

This interim statement is not a consultation document and should not be taken as necessarily representing the final position. The final report and draft legislation is due to be published before the end of 2016. The Government will determine how the recommendations will be taken forward.

Modern Slavery Act 2015

Trafficked adults are at increased risk of significant harm because they are largely invisible to the professionals and volunteers who would be in a position to assist them. The adults who traffic them take trouble to ensure that the adults do not come to the attention of the authorities, and either have no contact or disappear from contact with statutory services soon after arrival in the United Kingdom (UK), or in a new area within the UK.

The Modern Slavery Act 2015 consolidates slavery and trafficking offences and includes provisions to:

- consolidate and simplify existing offences into a single act
- ensure that perpetrators can receive suitably severe punishments for these appalling crimes – including life sentences

[1] Health and Social Care Information Centre (2015) Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England) Annual Report, 2014-15, Published 29 September

- introduce new orders to enhance the Court's ability to place restrictions on individuals where this is necessary to protect people from the harm caused by modern slavery offences
- create an independent Anti-Slavery Commissioner to improve and better coordinate the response to modern slavery
- introduce a defence for victims of slavery and trafficking
- place a duty on the Secretary of State to produce statutory guidance on victim identification and victim services
- enable the Secretary of State to make regulations relating to the identification of, and support for, victims
- make provision for Independent Child Trafficking Advocates
- introduce a new reparation order to encourage the Courts to compensate victims where assets are confiscated from perpetrators
- close gaps in the law to enable law enforcement to stop boats where slaves are suspected of being held or trafficked
- require businesses over a certain size threshold to disclose each year what action they have taken to ensure there is no modern slavery in their business or supply chains[2]

The Modern Slavery Act 2015 Section 52 places a duty on a range of public authorities to notify the Home Office about suspected victims of slavery or human trafficking

The Counter Terrorism and Security Act

The Counter Terrorism and Security Act 2015 aims to disrupt the ability to travel abroad to engage in terrorist activity and then return to the UK. It also places a duty on a range of organisations to prevent people from being drawn into terrorism. It places Channel, the Government's programme for people vulnerable to being drawn into terrorism, on a statutory footing.

Female Genital Mutilation (FGM) Act 2003 as amended by the Serious Crime Act 2015

The Female Genital Mutilation Act (2003) was amended by section 73 of the Serious Crime Act 2015 to include FGM Protection Orders. A FGM Protection Order is a civil measure which can be applied for through a family court. The FGM Protection Order offers the means of protecting actual or potential victims from FGM under the civil law. Breach of an FGM Protection Order is a criminal offence carrying a sentence of up to five years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of two years' imprisonment. (NSPCC).

Controlling or Coercive Behaviour in an Intimate or Family Relationship

This legislation allows the Crown Prosecution Service to prosecute specific offences of Domestic Abuse if there is evidence of repeated, or continuous, controlling or coercive behaviour. This type of abuse in an intimate or family relationship can include a pattern of threats, humiliation and intimidation, or behaviour such as stopping a partner socialising, controlling their social media accounts, surveillance through apps and dictating what they wear. The legislation states that to be defined as controlling or coercive, the behaviour must have had a 'serious effect' on the victim, meaning that it has caused the victim to fear violence will be used against them on 'at least two occasions', or it has had a 'substantial adverse effect on the victims' day to day activities.

[2] Home Office Modern Slavery Act Update https://www.gov.uk/government/collections/modern-slavery-bill

Section 3. Local Context

Governance and Membership Review

Kent and Medway Safeguarding Adults Board reviewed its governance and membership arrangements in 2015, in response to the Care Act statutory guidance which states: the SAB 'should assure themselves that the Board has the involvement of all partners necessary to effectively carry out its duties'. The Guidance suggests reviewing the links to other partnerships to maximise impact and minimise duplication, which would reflect the reality and interconnectivities of local partnerships. (Paragraph 14.118 and 14.119)

Following the review, membership to the Board was broadened. Membership includes representatives from: KCC, Medway Council, Kent Police, Acute Trusts, Clinical Commissioning Groups, Community Health Trusts, Kent and Medway NHS and Social Care Partnership Trust, NHS England, Care Quality Commission, Kent Probation, Kent Fire & Rescue Service, Prison Service, both Kent and Medway Community Safety Partnerships, Healthwatch, District Councils, Advocacy, housing providers, Elected Members from both KCC and Medway Council and representatives from independent provider organisations.

As part of the governance and membership review the Board agreed to appoint an Independent Chair. Deborah Stuart-Angus was appointed in November 2015, following a rigorous recruitment campaign. She took up post in December 2015.

Safeguarding Adult Reviews (SARs)

Kent and Medway Safeguarding Adult Board has a duty to carry out a Safeguarding Adult Review (SAR) when an adult at risk in Kent or Medway dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. KMSAB must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. KMSAB can also arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults, and can include exploring examples of good practice.

In September 2014, the Board commissioned a Safeguarding Adult Review (SAR) in respect of Mary Smith,[3] chaired by Paul Pearce. The overview report and recommendations were presented to the Board in June 2015. Agencies developed action plans to address the recommendations. These plans were reviewed after six months and a progress report was presented to the Board in March 2016 to assure the Board of progress. Paul Pearce also hosted multi-agency workshops to present his findings and disseminate the lessons learned.

Three further SAR applications were received between April 2015 and March 2016. Two of these have progressed to a Safeguarding Adult Review and are expected to conclude in 2016. The third case did not meet the criteria, but agencies involved are working together to review the case; addressing the lessons to be learned and developing practice improvements.

Deprivation of Liberty Safeguards

The national context is reflected in both Kent and Medway. Given the high number of referrals, both local authorities have robust triage processes in place, as recommended by ADASS, to prioritise applications. The current DoLS process puts significant pressure on the health and social care system. Since the Supreme Court Judgement in 2014, there has been a 17 fold increase in the number of applications locally.

[3] To protect the identity of the individual this is a fictitious name

Medway Safeguarding Adults Executive Group

Medway Safeguarding Adults Executive Group (MSAEG) has been established to bring together senior representatives from the key agencies responsible for the effective delivery of Adult Safeguarding in Medway. The MSAEG will work collaboratively to deliver the strategic priorities of the Kent and Medway Safeguarding Adults Board, strengthening delivery, oversight and governance.

Prevent and Channel

In September 2015, a Multi-Agency Prevent Duty Delivery Board was established to oversee the delivery of the Prevent Duty across Kent and Medway. The Board receives feedback from Channel, shares information regarding Prevent awareness raising and training activity within individual agencies and has agreed to the development of a Kent-wide action plan.

Channel is a voluntary early intervention mechanism used before a person engages or becomes involved in criminal terrorist activity. All agencies and members of the community can refer individuals to Channel by emailing the Kent Police Channel inbox (Channel@kent.pnn.police.uk). In September 2015 the 12 existing Channel Panels in Kent were replaced by one Channel Panel. This panel meets monthly to consider the cases of those who have been identified at risk of being drawn into terrorism and plans tailored support for them.

Medway has a Channel Panel separate to Kent's. This Panel meets every month and referrals are made using the Kent-wide referral form. Medway Council also has its own internal Prevent Board as well as a multi-agency Prevent Board to meet the guidance laid down in the Counter Terrorism and Security Act 2015.

Sub-group Activity

The Practice, Policy and Procedures Working Group (PPPWG)

Key achievements in 2015-2016:

- **Review of the KMSAB Multi-agency Safeguarding Adults Policy, Protocols and Guidance Document**

The PPP Working Group reviewed and updated the Kent and Medway multi-agency adult safeguarding policy, protocols and guidance document, in light of the Care Act 2014 and other relevant local and national developments. The updated document can be found at: http://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/multi-agency-safeguarding-adults-policies-protocols-and-guidance-kent-and-medway.pdf

- **Protocols for Kent and Medway to Safeguard Adults who are at Risk of Sexual Exploitation, Modern Slavery and Human Trafficking**

The PPP Working Group developed a Protocol as a means of supporting professionals and communities in Kent and Medway to identify and respond appropriately to safeguard adults who are at risk of: being trafficked, sexually exploited or modern slavery. The Protocol contains hyperlinks to the relevant sections in the main Policies, Protocols and Guidance document to support good safeguarding adults practice.

- **Self-Neglect Policy and Procedure Workshops**

Four multi-agency training workshops were hosted across the County to launch the revised Kent and Medway multi-agency Policy and Procedures to Support People who Self-Neglect. Over 360 members of staff from partner organisations attended the training. The workshops were well received and there was huge demand; feedback was that more such events would be beneficial as not all staff who wished to attend were able to secure a place.

- **Development of Easy Read Safeguarding Meeting Documentation**

In response to feedback from Safeguarding Co-ordinators that adults at risk often feel safeguarding meetings are daunting, the PPP Working Group developed 'Easy Read' safeguarding meeting documentation. This included easy read templates for the invite letter, agenda and minutes. The use of these documents supports the 'Making Safeguarding Personal' commitment "you will be given information in a way we hope you can understand".

The Quality Assurance Working Group (QAWG)

Key achievements in 2015-2016:

- **Performance Dashboard**

The QAWG developed a performance dashboard to provide KMSAB with a high level overview of key performance indicators. The dashboard is updated quarterly and considered at each Board meeting, to monitor progress against key performance indicators. The dashboard includes monitoring of DoLS performance and compliance with Prevent training.

- **Revised Self Assessment Framework**

The QAWG revised and updated the Self Assessment Framework to ensure that it was fit for purpose in light of the Care Act 2014 and to align it to the themes identified in the Local Government Association's 'Adult Safeguarding Improvement Tool'. KMSAB requires agencies to complete the self assessment framework to measure their progress against key standards. These are then peer reviewed by another agency and findings are presented to the Board. Any actions rated red or amber require regular update reports to the QAWG and Board to ensure the required standards are achieved.

- **Annual Plan 2016-17**

The QAWG developed, and will monitor, the Board's annual plan for 2016-17. The plan details how the Board will deliver the priorities set out in the Strategic plan.

- **Safeguarding Adult Reviews**

The QAWG monitors progress against Safeguarding Adult Reviews, ensuring that recommendations are actioned and presenting updates to the Board.

- **Development of Strategic Plan**

The QAWG leads on the strategic plan, which will be reviewed and revised in September 2016.

The Learning and Development Working Group (LDWG)

Key achievements in 2015-2016:

- **Review of Course Content**

A review of the course content for multi-agency training at Levels 3 (The Guide to Undertaking Safeguarding Enquiries) and 5 (Decision Making and Accountability in Safeguarding) was undertaken to ensure that the content was fit for purpose and reflective of current legislation and policy developments. The course content was also cross referenced against key competencies recommended by Research in Practice for Adults (RiPfA) and developed by the working group, and updated to address any gaps identified.

- **Delivery of Multi-agency Training Programme**

The Learning and Development Working Group maintains oversight of the delivery of multi-agency safeguarding training, monitoring demand and uptake of training. More details are provided in the next section of the plan.

- **Independent Management Report (IMR) Writing Training**

In response to feedback from agencies, a series of IMR training workshops were delivered in October 2015, to help prepare staff that may be required to complete an IMR on behalf of their agency, as part of a Safeguarding Adult Review. These were facilitated by Paul Pearce, an experienced Review Writer/Independent Chair of Review Panels. Training focused on the process and purpose of the SAR, and gave an overview of the forms/templates that need to be completed, as well as discussing the research required in order to write an IMR.

In addition, feedback workshops for multi-agency staff were held in November to disseminate the lessons learnt from a recent SAR.

- **Making Safeguarding Personal / Care Act Highlights / KASAF Workshops**

Multi-agency workshops for managers and senior safeguarding leads were delivered between June and September 2015. The workshops focused on key messages from the Care Act 2014, the implementation of Making Safeguarding Personal and use of the revised Kent Adult Safeguarding Alert Form (KASAF).

The Association of Directors of Adult Social Services has undertaken a 'stocktake' which included Making Safeguarding Personal. It is expected the report will be published in September 2016.

Section 4. Kent and Medway Multi-Agency Training

During 2015-2016 the multi-agency training programme has been supported by the Kent and Medway Safeguarding Adults Board.

The Kent and Medway multi-agency training structure comprises of six levels:

- Level 1 and Level 2 – Adult Safeguarding Awareness and Application of Law and Policy
- Level 3 – Guide to Undertaking Safeguarding Enquiries
- Level 4 – Public Protection Core Learning and Adults at Risk
- Level 5 – Decision Making and Accountability in Safeguarding
- Level 6 – Post Abuse Responsibilities

The training structure continues to be based on common tasks reflected in the Multi-agency Policy, Protocols and Guidance for Kent and Medway. It aims to ensure that staff build on their existing knowledge and skills by adopting a sequential learning approach. It is designed to reflect core and complimentary knowledge and skills within the multi-agency context of safeguarding work. Details of the current course aims and objectives are available on the website: http://www.kent.gov.uk/social-care-and-health/information-for-professionals/training-and-development

All agencies take responsibility for the delivery of Level 1 and Level 2 training to their staff. A training standards tool was introduced in August 2015, for partner agencies to record the quality of the content and delivery methods of Safeguarding Adults Level 1 and 2 training. The tool supports an evaluation of the training in line with the agreed KMSAB Competence Framework. Levels 1 and 2 training for staff in the private, voluntary and independent sectors has continued to be available through KCC's Learning and Development Team.

Levels 3, 5 and 6 of the multi-agency training programme are provided by external training consultants, funded by the KMSAB. In 2015-16 the KMSAB also funded twenty places for multi-agency partners to attend Level 4 training, which was provided in collaboration with specialist trainers within a partner agency.

A review of the course content for multi-agency training at Levels 3, 5 and 6 has been undertaken to ensure that the course content is fit for purpose and reflective of current legislation and policy developments. The course materials were updated in readiness for the new multi-agency training offer from April 2016.

The Board will be commissioning new training courses to be delivered from April 2017. It is anticipated that this will comprise a blended-learning approach, to include e-learning packages, as well as face to face workshops.

The table below outlines the level of multi-agency course provision and attendance during April 2015-March 2016. Please note figures only reflect places funded by the Board.

		Attendance by					
Course	**Total No of Persons Attending**	**Police**	**KCC**	**Medway Council**	**KMPT**	**Health - other**	**Other Agencies**
Level 3 (16 courses)	258	2	106	19	106	24	1
Level 4 (2 courses)	19	0	12	4	2	1	0
Level 5 (7 courses)	91	0	60	9	20	2	0
Level 6 (2 courses)	37	0	20	9	2	6	0

Section 5. Funding Arrangements

The Kent and Medway Safeguarding Adults Board is funded by five partner agencies including Kent County Council, Medway Council, Kent Police, Kent Fire & Rescue Service, Clinical Commissioning Groups and commissioned Health provider organisations. Each of these agencies made the following percentage contributions in 2015-16:

- KCC, Social Care Health and Wellbeing – 40.4%
- Medway Council – 8.2%
- Kent Police – 14%
- NHS Kent and Medway – 35.8%
- Kent Fire & Rescue Service – 1.7%

The multi-agency budget covers the salaries for the Independent Chair, Safeguarding Adults Board Co-ordinator and Administration Officer posts. It also covers the administration costs for the various multi-agency group meetings, Safeguarding Adult Reviews and the provision of multi-agency training.

The table below sets out the budget contributions for the past three years

	2013-2014 Actual contribution (£000's)	2014-2015 Actual contribution (£000's)	2015-2016 Actual contribution (£000's)
KCC	**50.5**	**61**	**72.8**
Medway Council	**12.6**	**12.6**	**14.8**
Local Health Commissioners and Providers	**54.8**	**54.8**	**64.5**
The Office of the Police and Crime Commissioner	**21.9**	**21.9**	**25.3**
Kent Fire & Rescue Service	**2.6**	**2.6**	**3**
Shortfall	**9.8**	**15.2**	**1.9**
Total	**152.2**	**168.1**	**182.3**

A decision was made by the Board to use reserves in order to reduce the contributions of partners, given the savings agencies needed to make in the financial year.

Section 6. Partner Highlights

Kent County Council, Social Care, Health and Wellbeing

Overview of 2015– 2016
Adult Safeguarding is managed in the Divisions of Older People and Physical Disability (OPPD), and Disabled Children, Adults Learning Disability and Mental Health (DCLDMH), including the Kent and Medway NHS and Social Care Partnership Trust. These Divisions are supported by Adult Safeguarding Co-ordinators. The strategic role of the Adult Safeguarding Unit is fully embedded with a focus on quality assurance and policy development. The Deprivation of Liberty Safeguards (DoLS) function sits within this Unit.

Key Achievements
The Safeguarding Adults documentation suite was reviewed and the Kent Adult Safeguarding Alert Form (KASAF) was implemented in October 2015. Feedback from staff across all client categories was that the KASAF was well received. The new safeguarding process was reviewed in February 2016 to look at changes requested, including Prevent issues being identified and the self-neglect referral process. A mandatory Prevent e-learning module was introduced for all KCC staff.

The new KCC Mental Health Adult Safeguarding Team commenced, managing safeguarding concerns from late February 2016 in two phases. The Team is managed centrally and staffed by eight Mental Health Safeguarding Co-ordinators working across Primary and Secondary Care Mental Health. This new Mental Health Model achieves S42 compliance.

A new Safeguarding Adults Capability Framework Portfolio has been developed for all KCC staff who work, or have contact, with adults, to help increase knowledge, skills and understanding of their roles and responsibilities within Adult Safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards. Initial staff feedback is positive.

The quarterly Learning Disability County Good Practice, Quality and Safeguarding Group is now fully embedded with senior representatives and Safeguarding Co-ordinators attending from each locality team. Lessons learned from complaints/Ombudsman findings and Safeguarding Adult Reviews are particularly welcomed by the group for discussion and sharing of good practice/lessons learned to the teams.

A Protocol for Kent and Medway to Safeguard Adults who are at Risk of Sexual Exploitation, Modern Slavery and Human Trafficking has been developed. The Protocol is a means of supporting professionals and communities to identify and respond appropriately to safeguard adults who are at risk of being trafficked, sexually exploited or modern slaves. The Protocol is electronically linked to the relevant sections in the main Policy, Protocols and Guidance document to support good safeguarding adults practice.

Key Challenges
- Obtaining Making Safeguarding Personal feedback from people who have been the subject of a Safeguarding Enquiry
- DoLS applications continue to rise significantly
- Safeguarding referrals are increasing, due to increased awareness of the service

Future Plans 2016-2017
- Continue to focus on the quality of safeguarding work across KCC, including ongoing programme of independent audits of practice, ensuring lessons learnt are embedded.
- Continue to support the Kent and Medway Safeguarding Adults Board in future developments
- Review the existing feedback mechanism for Making Safeguarding Personal

Medway Council

Overview of 2015– 2016

The number of Safeguarding Adult concerns received by Medway Council increased by 53% from 2014-15 to 2015-16. The Adult Social Care teams, namely the Over 25 Disability Team, the Mental Health Team, the 0-25 Disability Team, the Older People East Team and the Older People West Team, retain responsibility for screening and progressing Safeguarding Adult concerns received by Medway Council. A dedicated Deprivation of Liberty Safeguards Team manages and progresses all Deprivation of Liberty Safeguards (DoLS) activity.

Medway Council continues to strengthen collaborative working to prevent and raise awareness of abuse, ensuring a robust, timely and proportionate multi-agency response when abuse occurs.

Key Achievements

Local policies and procedures are Care Act 2014 compliant and have been revised in accordance with the six key principles of Safeguarding Adults.

Making Safeguarding Personal - a "Safeguarding and You" booklet, practitioner guidance and an end of Safeguarding questionnaire to capture the adult's views on the Safeguarding Enquiry have been embedded into practice. The data from the questionnaires will be used to continuously improve local Safeguarding Adults policy, procedures and practice.

To ensure the delivery of the KMSAB's strategic objectives, along with strategic objectives pertinent to Medway; improve multi agency collaborative working, enhance engagement with adults in Medway and alignment with other local strategic forums, a Medway Safeguarding Adults Executive Group has been established.

Key Challenges

- There was limited analysis of data as a result of not optimising the potential of the Council's IT system
- DoLS applications have increased by 43% from 2014-15 - the DoLS Team is applying the ADASS risk management guidance to prioritise cases
- The Care Quality Commission published Medway Foundation NHS Trust's Inspection Report, outlining the need for the Trust to review its Safeguarding Model and activity related to The Mental Capacity Act 2005 and DoLS
  Engagement between the Trust and executive leads in Medway has demonstrated a clear ambition to strengthen safeguarding arrangements - key partners continue to work together to achieve this

Future Plans 2016-2017

- Analysis of local qualitative and quantitative data, supported by a robust Quality Assurance Framework will shape the continual development of staff competencies, local policies and local operational procedures within a multi-agency framework
- Information sharing related to Quality in Care and Safeguarding concerns between key partners is being developed, to ensure appropriate preventative and responsive action is taken to optimise the quality of care provided and minimise the risk of Safeguarding concerns
- A Task and Finish Group is reviewing how the Council manages DoLS applications, to optimise efficiency

NHS Clinical Commissioning Groups across Kent and Medway

Overview of 2015 – 2016

Clinical Commissioning Groups were established under the Health and Social Care Act 2012 and are clinically led membership organisations. They are statutory bodies which have the function of commissioning services for the purposes of the health services in England. NHS England has a statutory duty to conduct a performance assessment of each CCG and it does this through the assurance process. Safeguarding Adults continues to be a high priority for the CCGs and has been embedded across all commissioning intentions.

Key achievements

- Mental Capacity Act project - this project has provided bespoke training for Primary Care partners by Capsticks Solicitors on The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The project has also developed a MCA Assurance Tool for Primary Care partners to use to benchmark and develop their knowledge and practice in accordance with the Mental Capacity Act.
- Safeguarding standards with Commissioned Providers - the CCGs and providers collaborated to develop and agree the 2015/16 safeguarding standards. The standards ensure that all commissioned health services effectively discharge their contribution to safeguarding. The standards monitor safeguarding expectations and responsibilities outlined in provider contracts.
- NHS England's assurance and alignment of policies - all eight CCGs achieved compliance with NHS England's accountability and assurance framework in May 2015. Safeguarding policy and strategy were aligned with relevant and emerging legislation.

Key Challenges

- Ensure that safeguarding is embedded in quality and safety visits within commissioned services.
- To continue to increase and embed awareness of domestic violence and abuse across all providers and primary care - embed National Institute of Clinical Excellence (NICE) Guidelines for Domestic Abuse
- Work with partners to prevent harm and improve the safety of residents in care homes - transfer of care issues, delayed discharge, sharing of soft intelligence with multi-agency partners

Future Plans

- Safeguarding training will be reviewed in line with the Intercollegiate Document for Safeguarding Adults. The training needs subsequently identified will need to be embedded across primary care in order to ensure compliance and promote better engagement in safeguarding
- The expanding agenda for safeguarding will have to be managed so that safeguarding adults and children are interlinked to include PREVENT, Domestic Violence and Abuse, Female Genital Mutilation and also the Mental Capacity Act.
- Developing a more robust system to measure how primary and secondary care services learn lessons from Safeguarding Adult Reviews and Domestic Homicide Reviews

Kent and Medway NHS and Social Care Partnership Trust (KMPT)

Overview of 2015-2016

The year has been a very impactful one for KMPT as we follow through from our external inspection by the Care Quality Commission (CQC). Although the CQC saw some very good practice, there was a lack of consistency across the organisation. Additional resource into the safeguarding team was welcomed to see through the actions of KMPT's response to the CQC inspection.

The drive to embed the principles and understanding of the Mental Capacity Act (MCA) and the requirements, where identified, for the deprivation of someone's liberty, has been a commitment throughout the organisation.

The Self-Neglect Policy has worked very well in practice with several cases being highlighted by practitioners and multi-agency meetings being convened to plan a way forward. All training was updated in line with the Care Act 2014, ensuring staff are aware of the broadening in categories of abuse such as Human Trafficking and Modern Slavery.

The year ended with the return to the Local Authority of the responsibility for overseeing of the adult protection processes. The team of Safeguarding Co-ordinators, managed by KCC, is now firmly in place.

Key achievements

- An overall assessment by the CQC of 'Outstanding' for the Forensic Services
- Partnership working between KCC and KMPT to create the designated team of Safeguarding Co-ordinators and to test this structure with a successful pilot
- Participation in the 'Making Safeguarding Personal' workshops across Kent and ensuring the roll out of the Kent Adult Safeguarding Alert Form KASAF within KMPT

Key challenges

- There are still a considerable number of older safeguarding cases that KMPT would have led on with the former delegated responsibility for safeguarding that require closure. The teams are working hard to close out these cases.
- The numbers of breached Deprivation of Liberty applications, although improving, remain a concern
- Inconsistencies in the understanding, application and compliance around the Mental Capacity Act

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Future plans 2016-2017

- Continue to build on the practical bespoke training in place to address gaps in knowledge and practice with MCA - audits will continue quarterly
- Additional work on Making Safeguarding Personal and completion of the Kent Adult Safeguarding Alert Form (KASAF) to demonstrate that staff have grasped the principles
- Ensure training meets the requirements of the Health Intercollegiate Document for Safeguarding Adults, as well as ensure it meets the standards and competences laid down by the Safeguarding Adults Board

Dartford and Gravesham NHS Trust

Overview of 2015 – 2016
During 2015-16 the Adult Safeguarding Team has seen some challenging times. The team has been through a period of transition following the retirement of the Safeguarding Lead. At the end of October 2015, a new Safeguarding Lead was appointed followed by the appointment in March 2016 of a Learning Disability Liaison Nurse; both posts are being supported by a part time clerical and administration assistant. The Safeguarding Lead continues to support staff throughout the Trust in all matters relating to safeguarding.

During the past year there has been thirty seven safeguarding referrals submitted by the Trust, thirteen referrals have been made during the first quarter of 2016. The increased presence by the Safeguarding Lead throughout the Trust aims to promote and enhance the awareness regarding the safeguarding process and mental capacity.

The Trust has provided a number of training sessions via Capsticks Solicitors and Kent County Council in relation to Deprivation of Liberty Safeguards (DoLS). The Trust has seen the numbers of DoLS applications rise in line with national trends.

The Safeguarding Lead continues to report to the Clinical Commissioning Group, Trusts Quality & Safety Committee and Safeguarding meeting so as to provide assurance.

Key Achievements

- Production of a quarterly Safeguarding Adults newsletter which is made available Trust wide via the Trust intranet. It highlights current safeguarding points, training dates and changes in services (i.e. IMCA services) and lessons learnt
- Workshop to raise awareness of PREVENT WRAP 3 Train the Trainer session has been delivered by the Police to a number of staff and providers who work within the Trust. This has enabled training dates to be released to all appropriate members of staff in a timely manner. Channel e-learning sessions are now a requirement for all new employees to the Trust within their first two weeks of commencing employment. All existing members of staff are also completing the training - from October 2015 – March 2016 approximately 672 staff have completed the Channel e-learning
- Promoting partnership working within the Trust and external agencies including Tissue Viability Team, Emergency Department and SECAmb

Key Challenges

- Investigation of historical safeguarding alerts with the Local Authority, some of which dated back to 2013
- Multi-agency working to support a patient whose care was being reviewed by the Court of Protection
- The balance between the amount of people attending the Emergency Department whose medical needs take priority and completion of paper work, i.e. KASAF and DoLS

Future Plans 2016-2017
To continue to raise the importance of safeguarding adults throughout the Trust, to include education, ward Links and a regular newsletter. The Trust will continue to develop good working relationships with external safeguarding teams, Local Authorities, to include South East Coast Ambulance Service and the London Ambulance Service

East Kent Hospitals University NHS Foundation Trust

Overview of 2015-2016

The People at Risk Team has been providing training and education for staff in all aspects of safeguarding, domestic abuse, Mental Capacity Act and Deprivation of Liberty Safeguards. There has been on-going work with the Tissue Viability team to reduce the risk of hospital acquired pressure ulcers. The team has also supported work experience for young people with learning disabilities at the Trust. Work continues with the staff and the Dementia team to manage people at risk with challenging behaviours in the acute health care setting.

Key achievements

- The Adult Safeguarding policy was renewed in December 2015
- Continued greater levels of involvement with medical teams, to support complex discharges for patients who lack mental capacity
- Participation in the Tap2Tag project - a research project to hold key health information, for high risk patients, on an electronic wrist band, accessible by professionals using a SMART phone
- The Quality Improvement and Innovation Hubs were set up to give staff a way to share learning, raise issues and innovate for frontline improvement on their site. The team has used the hubs to raising awareness about adult safeguarding, the Mental Capacity Act and domestic abuse

Key challenges

- Failure of the computer system which logs staff training, leading to lack of data to support teams achieving compliance with training requirements
- To continue to follow the DoLS processes, even though it is widely acknowledged that the system is not fit for purpose. Changing practice in record keeping to evidence adherence to the Mental Capacity Act

Future plans 2016-2017

- Improve training compliance across all staff groups to meet a target of 85%
- Create a public facing electronic adult safeguarding page
- Continue to embed identification of high risk patients within the acute setting and thus improve discharge planning
- Improve understanding of modern slavery and human trafficking

Medway Community Healthcare

Overview of 2015-2016

2015-16 has been a year of assimilation and embedding within Medway Community Healthcare (MCH) services in relation to safeguarding adults.

Services continue to successfully apply the Mental Capacity Act (MCA) 2005 to practice, as evidenced by our bi-annual audit of the quality of MCA assessments documented within our electronic patient notes system. Staff are using MCA appropriately in the majority of situations and the audit showed some excellent examples of Best Interest decision making. In relation to the Deprivation of Liberty Safeguards (DoLS,) our inpatient services made 126 applications to the Local Authority during the year, allowing our most vulnerable patients access to the safeguards provided by the legislation.

Services raised 79 concerns regarding potential adult abuse during this year, and we continue to build on our confidence and knowledge in this area working in partnership with local authorities. Services contacted our internal Safeguarding Adults Team on 527 occasions, accessing advice and support for situations with patients, which can be both complex and distressing to manage.

In addition, the Safeguarding Adults Team reviewed and updated the Trust's local policy in line with changes to legislation and contract requirements, and undertook the same piece of work with safeguarding adults training packages. This has included revamping corporate induction to provide a half day safeguarding session for all new starters covering Safeguarding Adults, Safeguarding Children, Domestic Abuse and PREVENT WRAP.

Key Achievements

- Further embedding of the Self-Neglect Policy in standard practice
- Revision of policy and training in line with legislation changes
- Continued implementation of the "acid test" for DoLS

Key Challenges

- Working with partner agencies at a time of Safeguarding personnel changes and reduced staffing
- Understanding thresholds for safeguarding vs quality concerns
- Lack of defined process for raising quality concerns externally and sharing such intelligence across agencies

Future plans 2016-2017

- Increase collaboration with internal Safeguarding Children and Quality Teams
- Evaluation of changes to training and supervision packages in line with Intercollegiate guidelines
- Continued partnership working with local agencies to safeguard adults at risk of harm

Kent Community Health NHS Foundation Trust (KCHFT)

Overview of 2015-2016

During 2015-16, a total of 308 Kent Adult Safeguarding Alert Form (KASAF) referrals were received, 223 were raised by KCHFT implicating others. 61 were raised implicating KCHFT - 37 were raised by KCHFT staff against KCHFT and 24 by other organisations against KCHFT. The highest area of abuse raised is Neglect. The Trust has had no cases to date in which abuse has been substantiated by KCC.

The Trust's Safeguarding Service provides a daily duty rota for provision of safeguarding advice to staff who may have a safeguarding concern.

Audit actions and audits for 2015-16 have been completed and have provided assurance and evidence of good practice and identified areas for further development.

Key Achievements

- Safeguarding practitioners have developed strong working relationships within the Community Hospitals, in conjunction with the Safeguarding champions who work closely with the Mental Capacity Act co-ordinator to disseminate safeguarding information
- Timely completion of multi-agency audits, Domestic Homicide Reviews (DHRs) and strong cross organisational working to complete external Self Assessment Frameworks
- The reduction of serious incidents of a safeguarding concern from 45 last year to 24 this year demonstrates improvement towards reducing avoidable harm to patients

Key Challenges

- To ensure services work collaboratively with internal and external partners to reduce patient harms
- To support staff with their understanding of the emerging areas of safeguarding including the PREVENT agenda
- Difficulties influencing change when gaps are identified within other agencies

Future Plans 2016-2017

- Continue to work with the KCHFT incidents team to support accurate and timely completion of the same information
- Continue to promote safeguarding within the Trust and support services to address identified gaps within their areas
- Develop an internal domestic abuse training framework which meets the training needs across the organisation
- Continue to develop processes that support embedding lessons learnt into practice, including the development of a robust process for reviewing of Serious Incident triangulation that will support and enhance lessons processes

Kent Police

Overview of 2015-2016

Following the Force's annual strategic assessment, the 4-year Control Strategy was created (2015-2018). Vulnerability is now the key theme of Kent Police's priorities and safeguarding adults plays a key part in addressing a number of areas of priority, which include sexual offences, domestic abuse, as well as potentially human trafficking and modern slavery.

Kent Police has developed a 3-day 'Protecting Vulnerable People (PVP)' training course ensuring that staff have the level of skill and knowledge around the 13 strands of vulnerability, focusing on domestic abuse, human trafficking and honour based abuse. This training is mandatory for every officer and the College is committed to a programme whereby every officer will be trained within three years. This hopefully demonstrates our commitment to address the need to continually improve all our staff's awareness and activity to safeguard adults at risk of harm.

Kent Police remains committed to engaging with multi-agency partners and has representation across the Board. As well as being proactive in supporting awareness around adult safeguarding, the Force has hosted two multi-agency conferences around exploitation and vulnerability and a conference on Female Genital Mutilation (FGM), within the last year, to raise awareness on these subjects. Officers have recently spoken at a domestic abuse conference at Christchurch University, as well as delivering bespoke training and presentations to specialist teams around domestic abuse supporting partner agencies with training delivery.

Kent Police has worked closely with partners in the development of the Protocol and Good Practice Model for Police and local authority disclosures in parallel proceedings.

The Force currently undertakes customer satisfaction surveys and this is in the process of being widened to include domestic abuse victims. The staff completing these surveys will be provided with specialist training. Domestic abuse will be a very significant focus for the Force this year, recognising the long term impact on victims and children if we do not work effectively and quickly in partnership to provide appropriate support and safety.

Key Achievements

- The implementation of the Mental Health Triage process across the Force
- Vulnerability being recognised as central to the control strategy of Kent Police
- The creation of the 'At risk of going missing' pack, designed to support families and carers in managing missing episodes

Key Challenges

- With a further restructure of Kent Police likely, the maintaining and improving of safeguarding services for victims of crime
- Developing a multi-agency approach to persistent and repeat referrals from adults at risk of harm (incorporating lessons learnt from recent Safeguarding Adult Reviews)

Future Plans 2016-2017

- Embedding the disclosure protocol in working practices
- Training civilian investigators within Public Protection Unit to provide a better service to victims and support to partner agencies

Adult Abuse Data Financial Year 2015/16

	Total Recorded Crimes	Total Secondary Incidents	No Crimed / Unvalidated	Total
Kent	449	530	31	1010
Medway	76	173	9	258
Force Total	**525**	**703**	**40**	**1268**
2014-15	676	1058	24	1758

Crime Type Breakdown
Notifiable

	Violence Against the Person	Sexual	Robbery	Burglary (Dwelling and OTD)	Criminal Damage	Vehicle Crime	Theft Other	Other Crime	Total Notifiable Offences
Kent	317	54	5	0	0	0	46	27	**449**
Medway	41	13	0	0	0	0	21	1	**76**
Total	**358**	**67**	**5**	**0**	**0**	**0**	**67**	**28**	**525**

Crime Type Breakdown
Secondary

	Secondary Incidents	No Crimed/Unvalidated	Total Incidents
Kent	530	31	**561**
Medway	173	9	**182**
Total	**703**	**40**	**743**

Definitions:

Notifiable – A Notifiable Offence is any offence under United Kingdom law where the police must inform the Home Office.

Secondary Incidents – This term is used when recording non crime incidents – for example a verbal altercation or an adult protection concern that would not constitute a crime, for example: an elderly person found wandering the street would lead to a referral being made.

No Crimed/Unvalidated – This term is used when an incident was recorded as a crime but it was subsequently established that no crime had been committed, or the details did not constitute recording as a crime. For example a person reports their purse has been stolen which is recorded as a theft. If they then make contact to advise that it was lost rather than stolen, it will then be reclassified as no crimed/unvalidated.

Medway NHS Foundation Trust

Overview of 2015-2016

A Care Quality Commission inspection carried out during August and September 2015, with the report published in January 2016, highlighted a number of concerns relating to safeguarding practices, including Medical Care: - practice did not always comply with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

A peer review of Medway NHS Foundation Trust's safeguarding processes and procedures took place in February 2016 by Guy's and St Thomas' NHS Foundation Trust. A report and recommendations was provided for the Trust Board to consider.

A formal contract performance notice was served by the CCG in relation to safeguarding concerns and performance in April 2016.

Key Achievements

- Appointment of new Safeguarding Lead for MCA/DoLS March 2016
- Review of DoLS process in March 2016
- Appointment of a Learning Disabilities Liaison Nurse

Key Challenges

- Under-resourced area of workforce
- Staff understanding and implementation of the MCA/DoLS process
- Timely responses to safeguarding concerns raised

Future Plans 2016-2017

- New Safeguarding Adult Team to be recruited with robust governance structure
- Training strategy to include training and education for staff including Prevent, Domestic Abuse, MCA/DoLS and Safeguarding Adults levels 1 and 2, to achieve 85% of all staff profiled, where their roles apply
- Medway NHS Foundation Trust to engage with partner organisations and multi-agency working on a regular basis, building strong working relationships

Maidstone and Tunbridge Wells NHS Trust

Overview of 2015-2016
The Executive Lead for Safeguarding Adults is the Chief Nurse and this agenda is supported by a Matron for Safeguarding Adults. The Trust has an established multi-agency Safeguarding Adults Committee which is chaired by the Deputy Chief Nurse.

The Trust's policies and procedures in relation to Safeguarding Adults at Risk of Harm and the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) have been reviewed this year. This, to bring them in line with national changes in legislation and local developments in relation to updated policies, procedures and guidance.

The way in which training is delivered changed in January 2015 in order that Level 2 Safeguarding, MCA awareness is delivered to clinical staff on their first day working in the Trust. Compliance with mandatory training Level 1 is 92.2%, and Level 2 is 64.9% - this is on an upwards trajectory and should reach our 85% target by August 2016. Level 3 Safeguarding Adults Training (non-mandatory); a one day course has been offered since May 2015. This enables staff to explore the subject matter in greater depth. Basic awareness in PREVENT is delivered to clinical staff and we are developing plans to deliver WRAP training to staff throughout the organisation.

There have been 43 Hospital alerts raised, either against our hospitals or by the hospital staff. Trust staff remain keen to learn from allegations of abuse and put in place remedial actions when investigations highlight any shortcomings in practice.

The Trust is effectively represented on the Kent and Medway Safeguarding Adults Board and sub-groups of the Board.

Key Achievements
- Development of a robust system to review investigation reports and agree outcomes of cases with the Safeguarding Co-ordinator allocated to work with our Trust and the CCG lead
- The Trust continues to be acknowledged by our multi-agency colleagues to be performing well within the area of Safeguarding Adults at Risk of Harm
- Ensuring that the new definition of Adult at Risk of Harm is understood by practitioners so that appropriate referrals, in line with the Care Act 2014, are forwarded to the Local Authority

Key Challenges
- Our ability to respond and develop good practice within the Trust for people with a learning disability is currently under review, to enable us to strengthen this area of work within the Trust
- The DoLS applications process and administration remains a challenge for Trust staff
- Applying the Mental Capacity Act consistently across the Trust

Future Plans 2016-2017
- To employ the services of a Hospital Learning Disability Liaison Nurse
- To work closely with the Trust Solicitor to ensure the message with regards to consent and Mental Capacity is understood by all practitioners
- To put the Supervision Policy for Safeguarding Adults into meaningful practice

South East Coast Ambulance Service NHS Foundation Trust

Overview of 2015-2016

South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to promoting and safeguarding the welfare of all vulnerable people; recognising that everybody has the right to be protected from harm, exploitation and neglect within the context of the law and personal civil liberties.

During 2015-16, the Trust has worked hard to implement the changes which the Care Act introduced. Referral rates have risen again over the year with overall activity across the whole Trust increasing by 22% from 2014-15. For Kent, this translates to 2380 concerns being shared with Kent Adult Social Care, from April 2015 to March 2016, and equates to 30% of all adult referrals. The most common primary concern staff identified was self-neglect, making up 28% of all referrals.

Key Achievements

- Increasing rates of safeguarding training to 90% across the Trust
- Implementing a Trust-wide on-line reporting process for concerns. - this has improved the quality and quantity of referrals being submitted
- Improved Domestic Abuse (DA) awareness and training across the Trust with an extended DA pilot

Key Challenges

- Capacity within the safeguarding team, with staff being seconded into posts and the increasing workload resulting from increased reporting activity
- Loss of the DA practitioner when the external pilot funding ended in December 2015 meaning that it was not possible to continue and expand on the work undertaken
- Implementation of the Care Act within the Trust

Future Plans 2016-2017

The improved data gathering will be used to better understand reporting patterns within the Trust.

We will also be piloting using this information within the appraisal process at a practitioner level, so that staff will be able to benchmark their activity within their own teams/station areas which will, in turn, help the Trust identify possible learning needs for a specific area or areas of good practice, which could be shared across the whole organisation.

Kent Fire & Rescue Service

Overview of 2015-2016

As part of an ongoing review of the Service's Community Safety Department, it was decided to expand the work it undertakes in visiting people in their homes to enable a more in-depth assessment of individual's needs, not just focussing on fire safety but to include some health and well-being issues. Officers will be given the flexibility to allow them to spend time with individuals to understand their motivations and behaviours, with a view to supporting them to make more informed choices.

Key Achievements

- Approval obtained to recruit staff to 11 new posts to enable the service to expand its home safety visit work
- Review of the Service's overall approach to safeguarding and introduction of an out of hours Duty Safeguarding Officer rota
- Commissioned the development of a new customer management tool to enable more effective and secure data collection

Key Challenges

- Identifying training to enable the teams to move from just giving advice to supporting behavioural change
- Understanding the changes to other organisations' structures and how the Service fits into the partnership landscape
- Raising awareness internally of a new out of hours safeguarding rota system and encouraging its use

Future Plans 2016-2017

- Development of an allegation handling process to better protect staff and the Service when working with vulnerable clients
- Launch the new customer management system
- Revamp the training for all staff involved in safeguarding and raise general awareness levels across the Service

Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)

Overview of 2015-2016

KSS CRC works with adult service users subject to community orders and licences. KSS CRC formed on 1st June 2014 following the government's reform of probation services. The ownership of the Community Rehabilitation Company transferred to Seetec, our parent company on 1 February 2015. One of the key priorities during the last year has been to build and consolidate the senior management team and embed the new delivery model. The CEO, who is a qualified and registered Social Worker with extensive experience in safeguarding, remains the designated lead.

Key Achievements

The KSS CRC delivery model has now been implemented with operational staff working within three functional teams: Assessment, Rehabilitation and Resettlement. My Solution Rehabilitation Programme (MSRP), a flexible tailor made programme through which the sentence of the court and rehabilitative services are delivered, is available as a practitioner toolkit and will be further developed during the coming year.

An overarching Safeguarding Policy has been updated, linked to separate Children and Adult Safeguarding policies. A Quality Strategy has been developed which outlines the purpose, principles, strategies and key deliverables for quality assurance within KSS CRC.

Key Challenges

- To improve levels of service user engagement and motivation
- To develop a Community Payback Placement Strategy, which meets the requirements of service users with identified needs and vulnerabilities
- To fully implement and embed the Quality Strategy

Future Plans 2016-2017

- In collaboration with the Service User Council, the CRC has recruited three Case Support Workers who have personal experience of the Criminal Justice System to work with the hardest to reach service users to support engagement. This will run as a pilot during the coming year to test the efficacy of the role
- We are introducing a peer mentor scheme, whereby current service users will be trained to provide support and assistance to individuals under our supervision
- The CRC Organisational Effectiveness Team will have responsibility for implementing the Quality Strategy and leading on quality assurance activities, including a safeguarding audit which will be conducted imminently

Advocacy for All

Overview of 2015-2016

- All staff undertake safeguarding - learning as part of induction
- All staff working in statutory and non-statutory advocacy, trained to level 2 or 3
- Safeguarding discussed during all supervision and appraisals using the Bournemouth criteria
- Written easy read 'Hate Crime' booklet
- Support self-advocacy group members and others with a learning disability and/or autism, with 1:1 advocacy support via our Kent Learning Disability Advocacy Project and Speaking up Groups for people with high functioning autism
- Involved in training of Making Safeguarding Personal
- Current IMCA providers – safeguarding support for those who lack capacity

Key Achievements

- Developed Care Act Advocacy Service in East Kent – promoting role within safeguarding
- Secured funding from Awards for All and successful winners of the 'People's Project' Big Lottery/ITV News competition to support our 'A Team', who are a group of people with a learning disability who are trained as trainers for other disabled young people and adults to ensure they are aware of, and can recognise, abuse. Free training to people with a disability and costed sessions for professionals. People have felt comfortable and confident enough to disclose situations that have happened to them. Keen to extend to Kent.

Key Challenges

- Ensuring people recognise the role of the advocate from the beginning of the safeguarding process
- Access to advocacy for people who live in Kent but funded by another local authority, when they are not covered by a statutory service

Future Plans 2016-2017

- To ensure people with a learning disability recognise abuse and how to report it
- To raise the awareness around Mate Crime

SEAP Advocacy – Support, Empower, Advocate, Promote

Key Achievements

- Implementation of a new contract and legal requirement
- Increased knowledge of the 'Inns of Court College of Advocacy' (ICCA) at Medway Council leading to an increased number of referrals each quarter
- Upskilling of SEAP Advocates via our own training arm, Advocacy Training, to ensure a high quality service was delivered from day 1.

Key Challenges

- Unknown demand made it difficult to determine staffing requirements
- Continuing to raise awareness of the requirement to refer to advocacy, in accordance with the Care Act 2014.
- Lack of referrals for carers and young people in transition

Future plans 2016/17

- To employ a full-time dedicated Medway ICAA Advocate
- To further increase awareness of ICAA at Medway Council and other professionals, especially to increase referrals for carers and young people in transition
- Having secured the independent mental capacity advocacy (IMCA)/DoLS/ Relevant Person's Representative (RPR) contract, to ensure a smooth transition from the outgoing provider.

Section 7. Safeguarding Activity

Background to data

The data for this report was extracted from the Kent County Council social care system (SWIFT) and Medway Council's Adult Social Care database (Framework i).

Data included in this report is consistent with the Department of Health (DH) statutory returns: Abuse of Vulnerable Adults (AVA) for 2012-13, the Safeguarding Adults Return (SAR) for 2013-14 and 2014-15, and the Safeguarding Adults Collection (SAC) for 2015-16.

Following the implementation of the Care Act 2014, terminology used within safeguarding has been amended to 'safeguarding concerns' and 'safeguarding enquiries'. This terminology has been used within this report.

The first part of this section of the report looks at new safeguarding adults enquiries. This is defined as the action taken, or instigated, by the Local Authority in response to a concern that abuse or neglect may be taking place. The second part of this section of the report summarises the outcome of safeguarding enquiries in Kent and Medway.

New safeguarding adults enquiries

Number of enquiries and rate of change

There were a total of 4174 new safeguarding adult enquiries in the period 2015-2016, which reflects an 18.7% increase on the previous year. Both Kent and Medway demonstrated increases in enquiry activity from 2014-15 to 2015-16, with Kent reflecting an increase of 19.3% and Medway increasing by 9.8%. Intelligence suggests that the increases seen in this period are reflective of greater awareness and reporting of potential safeguarding issues, as a result of the implementation of the Care Act 2014.

Area	12-13	13-14	14-15	15-16	% change between 14-15 and 15-16	% of total in 15-16
Kent	2863	3176	3273	3906	19.3%	93.6%
Medway	313	315	244	268	9.8%	6.4%
Total	**3176**	**3491**	**3517**	**4174**	**18.7%**	**100%**

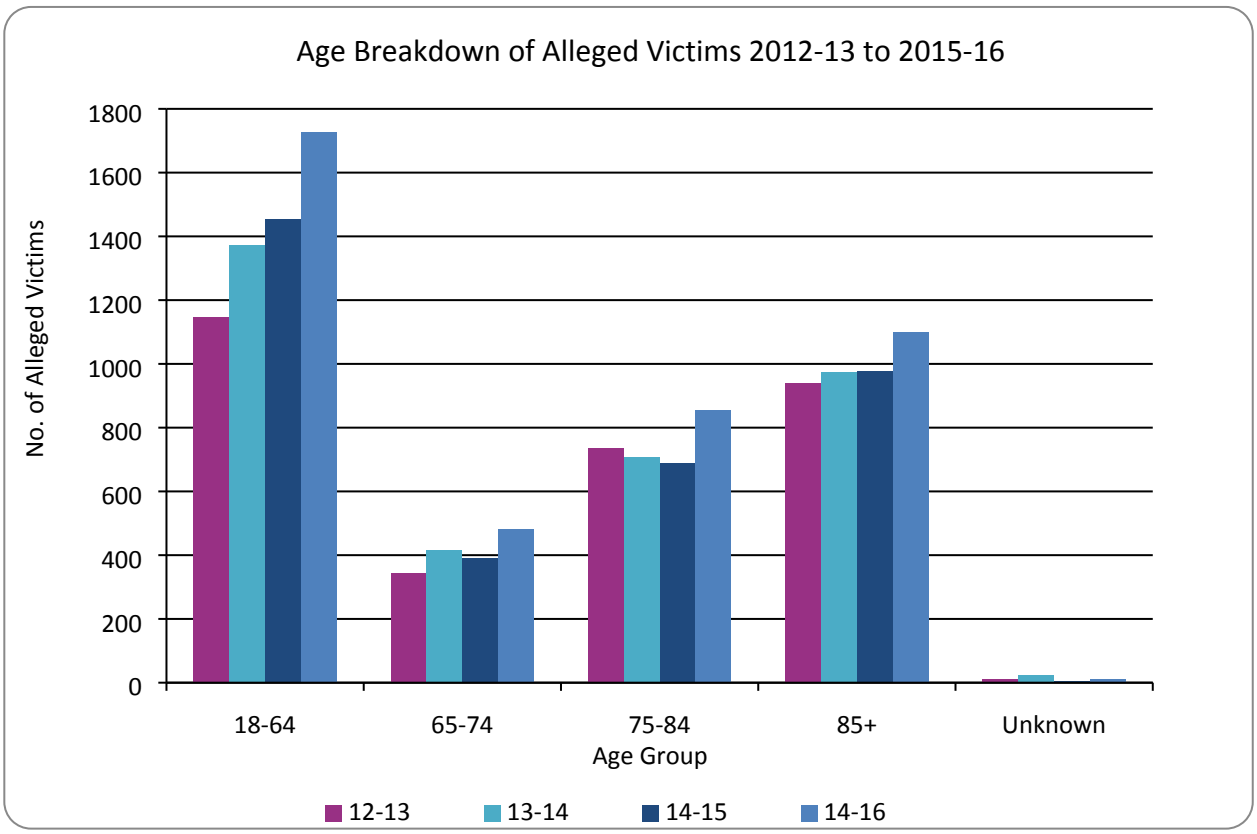
Table 7.1: Number of enquiries year on year and rate of change 12-13 to 15-16

Age of alleged victims

In the period 2015 to 2016, the majority of all enquiries, 41.4%, related to the 18-64 age group. The second most prevalent group is the 85+ age group, representing 26.4%. There has been no significant variation in the proportions of enquiries across the age groups over the past four years.

Age group	12-13		13-14		14-15		15-16	
	Number	%	Number	%	Number	%	Number	%
18-64	1145	36.1%	1372	39.3%	1454	41.3%	1726	41.4%
65-74	344	10.8%	416	11.9%	391	11.1%	483	11.6%
75-84	737	23.2%	707	20.3%	690	19.6%	855	20.5%
85+	939	29.6%	974	27.9%	976	27.8%	1100	26.4%
Unknown	11	0.3%	22	0.6%	6	0.2%	10	0.2%
Total	**3176**	**100%**	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**

Table 7.2: Age breakdown of alleged victims for the periods 2012-13 to 2015-16

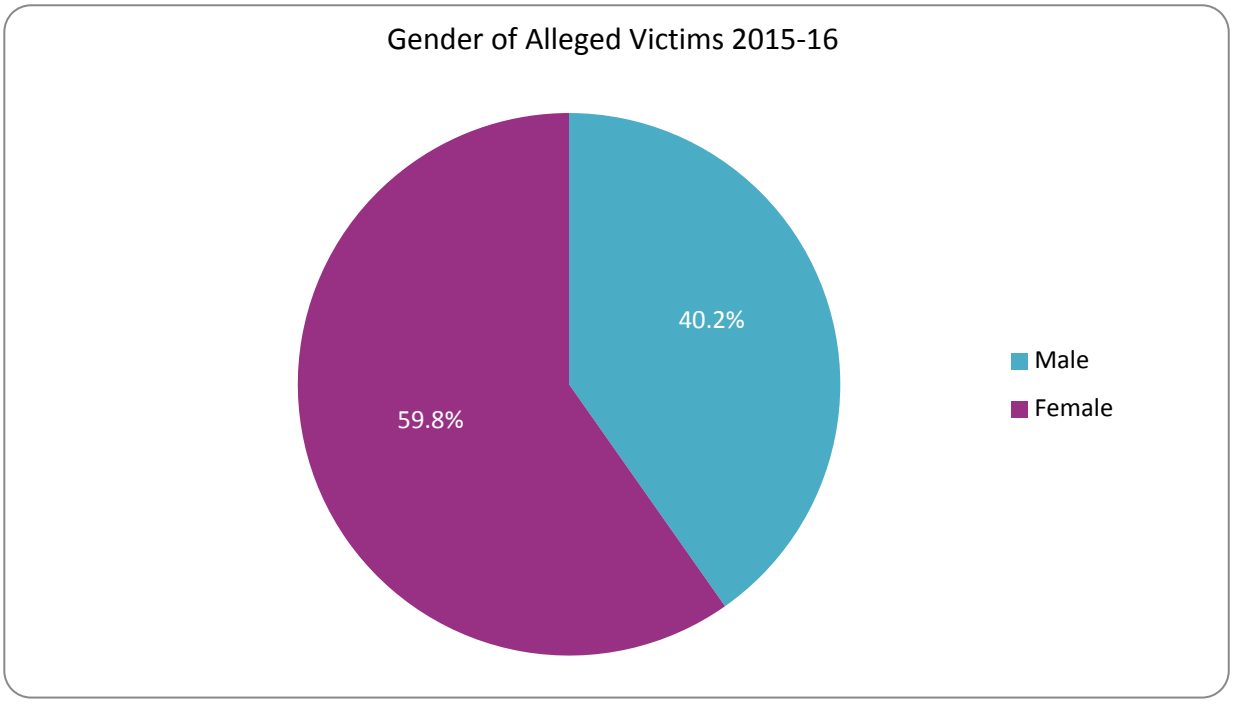


Gender of alleged victims

In 2015-16, the highest proportion of alleged victims were female at 59.8%, which reflects a marginal decrease compared with the 2014-15 figures.

Gender	12-13		13-14		14-15		15-16	
	Number	%	Number	%	Number	%	Number	%
Male	1193	37.6%	1375	39.4%	1366	38.8%	1680	40.2%
Female	1983	62.4%	2116	60.6%	2151	61.2%	2494	59.8%
Total	**3176**	**100%**	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**

Table 7.3a: Gender of alleged victims over the periods 2012-13 to 2015-16



For comparison purposes, based on the 2015 mid-year population estimates, the following table presents the total population, by gender, for Kent and Medway.

Gender	Kent		Medway		Kent and Medway combined	
	Number	%	Number	%	Number	%
Male	747,400	49.0%	137,300	49.7%	884,700	49.1%
Female	777,300	51.0%	139,200	50.3%	916,500	50.9%
Total Persons	1,524,700	100%	276,500	100%	1,801,200	100%

Table 7.3b: Population estimates by Gender
Source: Population Estimates Unit, ONS (Crown Copyright).
Data released on 23 June 2016 by the Office for National Statistics.

Ethnicity of alleged victims

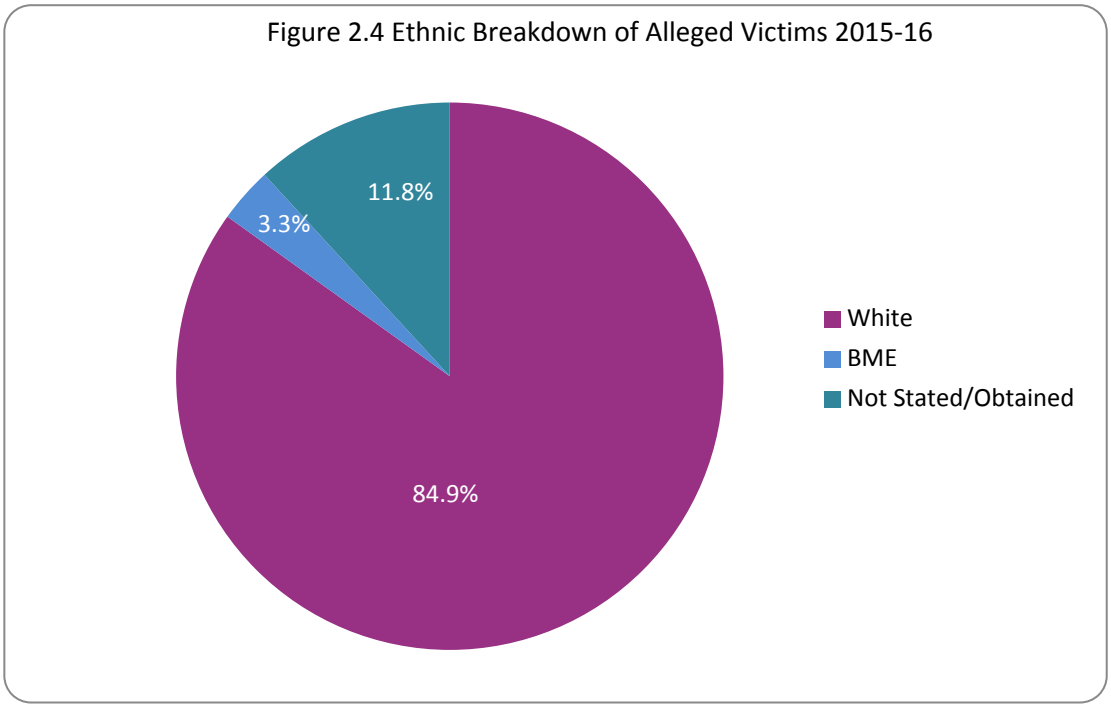
Between the periods of 2014-15 and 2015-16, the percentage of enquiries relating to alleged victims from a white background decreased from 87.1% to 84.9%. The percentage of alleged victims from a black or ethnic minority background has decreased by 0.1%, from 3.4% to 3.3%.

In contrast, there has been an increase in the number of cases where the ethnicity was not stated/not obtained, which has risen to 11.8%, a rise of 2.2 percentage points.

Ethnic Group	12-13		13-14		14-15		15-16	
	Number	%	Number	%	Number	%	Number	%
White*	2713	85.5%	3077	88.1%	3062	87.1%	3544	84.9%
BME **	113	3.6%	106	3.0%	118	3.4%	136	3.3%
Not stated/ obtained	348	11.0%	308	8.8%	337	9.6%	494	11.8%
Total	**3174**	**100%**	**3491**	**100%**	**3517**	**100%**	**4174**	**100%**

Table 7.4a: Breakdown of Ethnic Group for the periods 2012-13 to 2015-16

**' White' contains the DH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background*
*** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups*



For comparison purposes, based on the 2011 census, the following table presents the total population, by ethnic group, for Kent and Medway.

Ethnic Group	Kent		Medway		Kent and Medway combined	
	Number	%	Number	%	Number	%
White	1,371,102	93.7%	236,579	89.6%	1,607,681	93.1%
BME	92,638	6.3%	27,346	10.4%	119,984	6.9%
All usual residents	1,463,740	100%	263,925	100%	1,727,665	100%

Table 7.4b: Kent Population by Ethnic Group
Source: 2011 Census: Key Statistics Table 201, Office for National Statistics (ONS) © Crown Copyright

Primary Support Reason of alleged victims

The table below shows the number and proportions of individuals according to the Primary Support Reason.

In both Kent and Medway, the most prevalent support reason was Physical Support. This is then followed by no support reason at the time of the alleged incident, with Kent and Medway reflecting 18.9% and 24.3% of cases respectively having no support reason. This is to be expected, as individuals subject to a safeguarding referral will not always be receiving support from the Local Authority.

Primary Support Reason	Kent	Medway
Physical Support	36.3%	45.1%
Sensory Support	<5%	<5%
Support with Memory and Cognition	11.8%	<5%
Learning Disability Support	15.3%	<5%
Mental Health Support	15.4%	13.4%
Social Support	<5%	7.5%
No Support Reason	18.9%	24.3%

Table 7.5: Breakdown of Primary Support Reason (PSR) for the period 2015-16

Location of alleged abuse

In 2015 to 2016 the main location for incidences of alleged abuse was within care homes, with 42% of incidents occurring in such settings. This represents a 3.4% increase from 2014-15. 34.7% of incidences were reported to be in the alleged victims own home, this represents a 3.3 percentage point increase from 2014-15.

Due to the Care Act changes and changes within statutory reporting, from 2015-16 the location of alleged abuse is reported on by own home, community service, care home, hospital and other. The location of other has reflected an increase, but this location will include cases where the alleged abuse took place in public or where the location of abuse was not known.

Please note, from 2015-16 the method of calculating the location of alleged abuse is now based on closed enquiries in the reporting year. Therefore, the total number of enquiries will not correlate with earlier sections of the report which detail number of enquiries received within the reporting period.

Location	12-13		13-14		14-15		15-16	
	Number	%	Number	%	Number	%	Number	%
Own Home	1161	36.6%	1215	34.8%	1209	34.4%	1262	34.7%
Community Service	131	4.1%	109	3.1%	116	3.3%	111	3.1%
Care Home*	1270	40.0%	1415	40.5%	1359	38.6%	1528	42.0%
Hospital**	125	3.9%	191	5.5%	150	4.3%	171	4.7%
Mental Health Inpatient Setting	~	~	~	~	112	3.2%	~	~
Public Place	89	2.8%	71	2.0%	70	2.0%	~	~
Other	143	4.5%	130	3.7%	156	4.4%	563	15.5%
Not Known	257	8.1%	360	10.3%	345	9.8%	~	~

Table 7.6: Location of alleged abuse for the periods 2012-13 to 2015-16

** All care home settings, including nursing care, permanent and temporary*
*** Acute, community hospitals and other health settings*

Types of alleged abuse

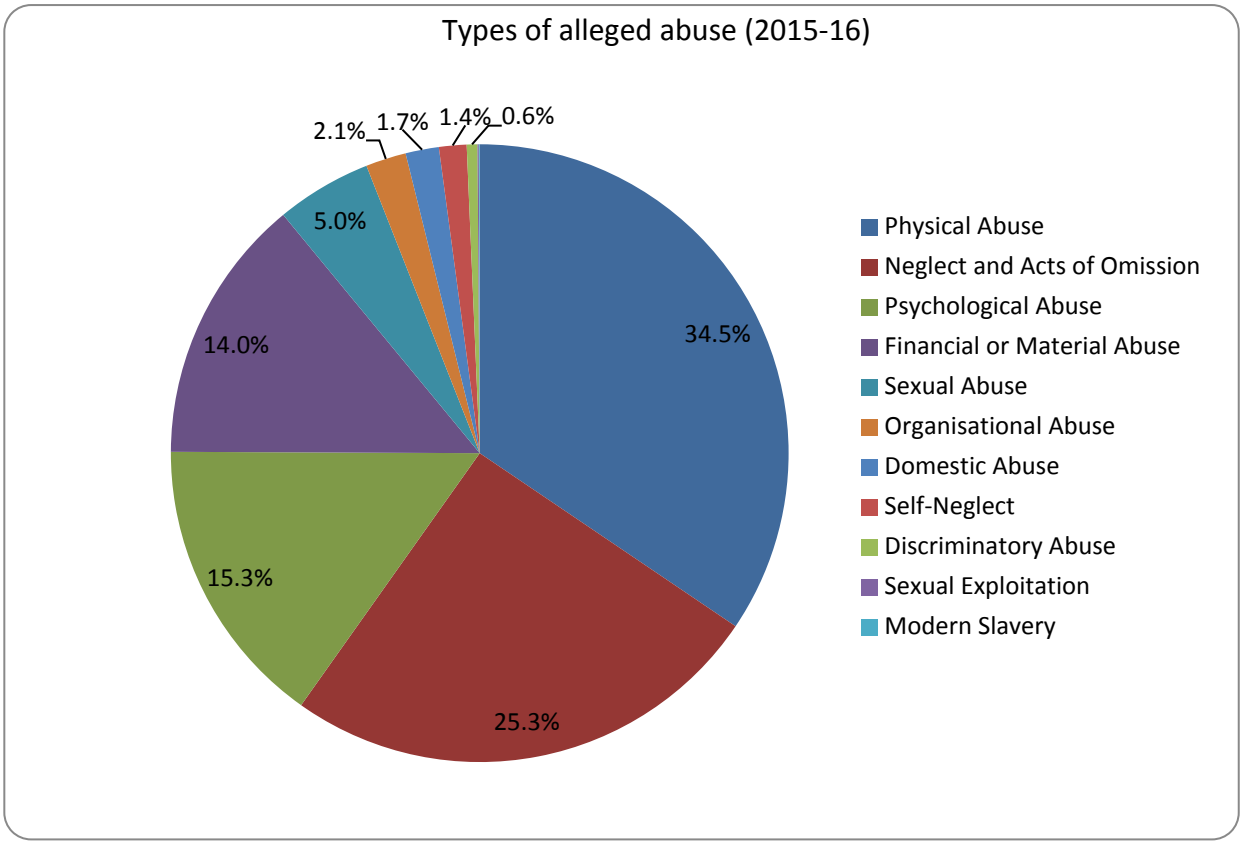
Following the Care Act 2014, additional categories of abuse relating to Domestic Abuse, Modern Slavery, Self-Neglect and Sexual Exploitation were introduced. These are now included in the table below.

Categories of alleged abuse	2012-13		2013-14		2014-15		2015-16	
	Number	%	Number	%	Number	%	Number	%
Physical Abuse	1231	30.7%	1407	33.6%	1100	36.0%	1482	34.5%
Neglect and Acts of Omission	931	23.2%	1054	25.2%	750	23.5%	1090	25.3%
Psychological Abuse	765	19.1%	691	16.5%	366	17.0%	656	15.3%
Financial or Material Abuse	707	17.6%	688	16.4%	572	14.7%	600	14.0%
Sexual Abuse	183	4.6%	206	4.9%	146	5.8%	215	5.0%
Organisational Abuse	167	4.2%	98	2.3%	65	2.4%	91	2.1%
Domestic Abuse	-	-	-	-	-	-	75	1.7%
Self-Neglect	-	-	-	-	-	-	62	1.4%
Discriminatory Abuse	28	0.7%	39	0.9%	9	0.6%	24	0.6%
Sexual Exploitation	-	-	-	-	-	-	5 or less	<1%
Modern Slavery	-	-	-	-	-	-	5 or less	<1%

Table 7.7: Type of alleged abuse (an enquiry may have multiple types of abuse recorded – the percentage figures relate to the proportion of all enquiry where each type of abuse was apparent)

Physical Abuse has remained the most prevalent category over the past four years. The proportion of incidents where Neglect and Acts of Omission was a factor has increased over the last year by 1.8 percentage points.

Incidents where Psychological Abuse was a factor have decreased over the past four years by 3.8 percentage points between 2012-13 and 2015-16. Notably, incidents where Financial or Material Abuse was apparent continued to decrease over each of the last four years, falling from 17.6% in 2012-13 to 14% in 2015-16.


Types of alleged abuse (2015-16)
34.5%
25.3%
15.3%
14.0%
5.0%
2.1%
1.7%
1.4%
0.6%
Physical Abuse
Neglect and Acts of Omission
Psychological Abuse
Financial or Material Abuse
Sexual Abuse
Organisational Abuse
Domestic Abuse
Self-Neglect
Discriminatory Abuse
Sexual Exploitation
Modern Slavery

Source of safeguarding concern leading to safeguarding enquiry

The table below shows the comparison of the sources of safeguarding concerns leading to safeguarding enquiries over the past four years. The majority of enquiries continue to initiate from social care staff - however; there has been a 2.1 percentage point decrease from 2014-15 to 2015-16. In comparison, referrals from health care staff have seen an increase of 2.9 percentage points to 26.4% between the same period, and other sources has increased by 3.2 percentage points over the same period.

The 'Other' category includes carers, voluntary agencies/independent sector, anonymous, legal, other Local Authorities, Benefits Agency, Probation Service and strangers. Both Kent and Medway have safeguarding websites and leaflets accessible by members of the public. Safeguarding Awareness Week is key to increasing safeguarding awareness amongst members of the public. The source of 'Other' has seen an increase of 3.2 percentage points between 2014-15 and 2015-16.

Please note the 2015-16 information does not include Medway data as this data was not collated. Prior to a review of Medway Council's computer system in Spring 2016, the data relating to referral source was manually input into the computer system and was difficult to report on. Following a review of the safeguarding adults computer system, this data can now be collected and Medway will run a report and analyse this data on a quarterly basis, to determine high level of referrals and areas where referral numbers are low or non-existent. This will focus local awareness raising activity.

Source of Safeguarding Concern leading to Enquiry	12-13		13-14		14-15		15-16		% point change 14-15 and 15-16
	Number	%	Number	%	Number	%	Number	%	
Social Care staff	1325	41.7%	1689	48.4%	1602	45.6%	1701	43.5%	-2.1
Health Staff	754	23.7%	718	20.6%	827	23.5%	1032	26.4%	2.9
Other	379	11.9%	298	8.5%	386	11.0%	553	14.2%	3.2
Police	163	5.1%	152	4.4%	132	3.8%	158	4.0%	0.2
Family member	273	8.6%	271	7.8%	202	5.7%	135	3.5%	-2.2
Care Quality Commission	63	2.0%	115	3.3%	132	3.8%	125	3.2%	-0.6
Self Referral	97	3.1%	129	3.7%	122	3.5%	105	2.7%	-0.8
Housing	64	2.0%	45	1.3%	60	1.7%	66	1.7%	0.0
Friend/Neighbour	37	1.2%	49	1.4%	25	0.7%	23	0.6%	-0.1
Education/Training Workplace	18	0.6%	10	0.3%	22	0.6%	6	0.2%	-0.4
Other service user	5 or less	<1%	8	0.2%	7	0.2%	5 or less	<1%	~
Unknown	5 or less	<1%	7	0.2%	0	0.0%	5 or less	<1%	~
Overall Total	**3176**	**100%**	**3491**	**100%**	**3517**	**100%**	**3906**	**100%**	~

Table 7.8: Source of safeguarding for the periods 2012-13 to 2015-16

Closed referrals

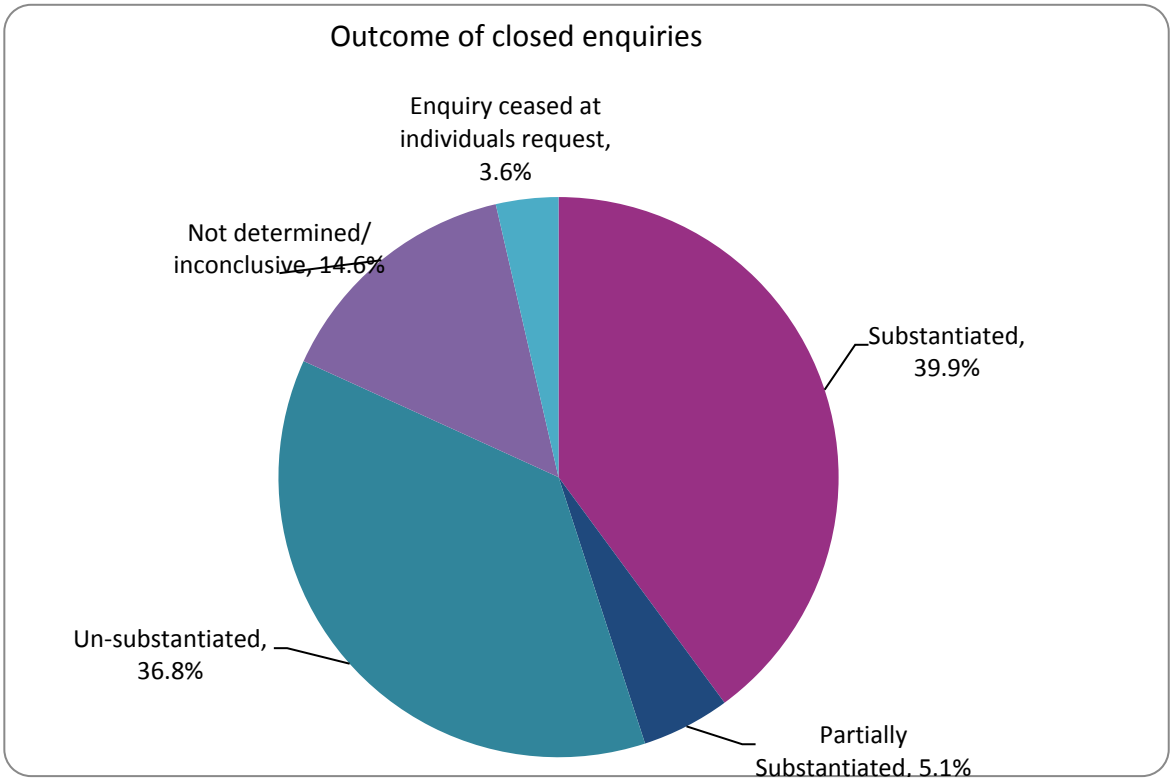
Outcome of closed enquiries

In Kent, the highest proportion of cases was substantiated (41.1%) whereas in Medway the highest proportion of cases was unsubstantiated (31%). Medway had a higher proportion of cases where outcomes were not determined/inconclusive and partially substantiated.

Across both Kent and Medway, the highest proportion of cases was substantiated and the lowest proportion resulted in the investigation ceasing at the individuals request.

Area	Substantiated		Partly substantiated		Un-substantiated		Not determined/ inconclusive		Investigation ceased at request of individual	
	No.	%	No.	%	No.	%	No.	%	No.	%
Kent	1384	41.1%	146	4.3%	1255	37.3%	475	14.1%	104	3.1%
Medway	65	24.0%	41	15.1%	84	31.0%	56	20.7%	25	9.2%
Total	**1449**	**39.9%**	**187**	**5.1%**	**1339**	**36.8%**	**531**	**14.6%**	**129**	**3.6%**

Table 7.9: Outcome of closed referrals in Kent and Medway 2014-15



Action resulting from closed enquiries

In 2015-16, the highest proportion of cases in Kent related to action taken and the risk being reduced. In Medway, the highest proportion of cases related to action being taken and the risk removed. The percentage of cases where the risk remains has reflected marginal decreases across both Kent and Medway.

In contrast, both Kent and Medway have seen significant changes between 2014-15 and 2015-16 for cases where the risk reduced. For cases where the risk was reduced, Kent increased from 27.3% to 81.5%, and Medway increased from 23.6% to 34.7%. In Kent, changes to processes and systems were implemented as a result of the Care Act 2014. This has allowed for improvement in recording of the data and greater accuracy in reporting.

For Kent, in the 2014-15 year it is not representative that no action was taken on cases in the first section of the table below. For those cases recorded as 'no action taken', the cases may have been inappropriate and therefore passed on to the relevant teams. It should also be noted that, for the 2015-16 period, clarification was made by the Health and Social Care Information Centre in relation to the categorisation of no action taken.

Area	No Action Taken		Action Taken and Risk Remains		Action Taken and Risk Reduced		Action Taken and Risk Removed	
	14-15	15-16	14-15	15-16	14-15	15-16	14-15	15-16
Kent	54.8%	0.4%	6.4%	5.8%	27.3%	81.5%	11.5%	12.3%
Medway	0.0%	11.4%	16.8%	16.6%	23.6%	34.7%	59.5%	37.3%

Table 7.10: Actions resulting from closed safeguarding referrals 2014-15 and 2015-16

Section 8. Priorities for 2016-2017

A number of priorities have been identified for 2016–2017

- Engage with service users and carers, and empower and enable them to contribute to safeguarding in Kent and Medway, and to the work of the Board
- Increase public engagement and awareness
- Progress SARs, ensuring lessons learnt lead to practice improvements
- Complete the review of the Kent and Medway multi-agency training programme and commission training providers
- Prepare a new strategic plan for the Kent and Medway Safeguarding Adults Board
- Further develop and implement the Board Constitution
- Review the Board structure and ensure governance arrangements are robust
- Develop and implement a risk register
- Continuously review the multi-agency Policy, Protocols and Guidance document in accordance with national and local safeguarding developments
- Build on current quality assurance mechanisms to ensure safeguarding work is of a good or excellent quality
- Seek to continuously collaborate and work closely with partners to ensure a variety of safeguarding contribution
- Work more closely with Medway to ensure dovetailing and governance consistency

Appendices

Appendix 1 : Kent and Medway Safeguarding Adults Board Principles and Values

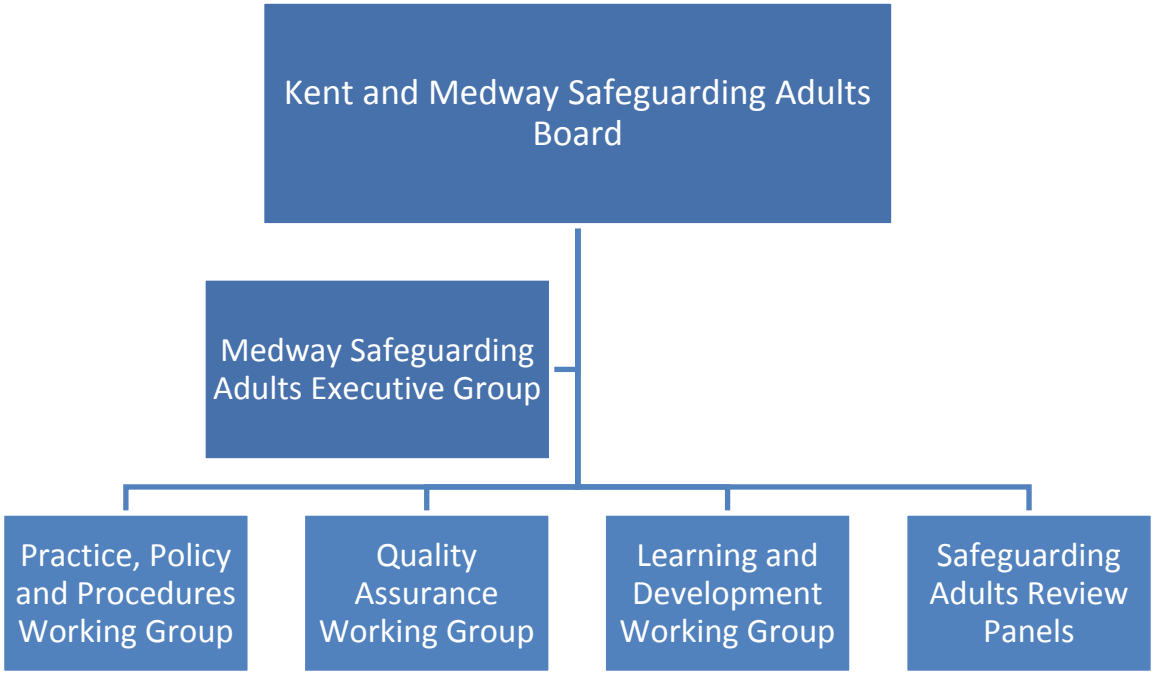
The Kent and Medway Safeguarding Adults Board is underpinned by the following principles and values:

- It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity
- All agencies and services should ensure that their own policies and procedures make it clear that they have a zero tolerance of abuse
- Priority will be given to the prevention of abuse, by raising the awareness of adult safeguarding issues and by fostering a culture of good practice through support and care provision, commissioning and contracting
- Adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services
- These principles are applicable to all adults whether living in a domestic setting, care home, social services or health setting, or any community setting
- Protection of adults experiencing, or at risk of, abuse or neglect, is a multi-agency responsibility and all agencies and services should actively work together to address the abuse of adults
- Interventions should be based on the concept of empowerment and participation of the individual at risk
- These principles should constitute an integral part of the philosophy and working practices of all agencies involved with adults experiencing, or at risk of, abuse or neglect, and should not be seen in isolation
- It is the responsibility of all agencies to take steps to ensure that adults experiencing, or at risk of, abuse or neglect, are discharged from their care to a safe and appropriate setting
- The need to provide support for carers must be taken into account when planning services for adults experiencing, or at risk of, abuse or neglect, and a carer's assessment should be offered
- These principles are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation

Appendix 2 : The Main Forms of Abuse

- **Physical abuse**, including assault, hitting, slapping, pushing, misuse of medication, restraint, or inappropriate physical sanctions
- **Domestic Abuse**, including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence
- **Sexual abuse**, including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or acts to which the adult has not consented, or was pressured into consenting
- **Psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks
- **Financial or material abuse**, including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- **Modern slavery** encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment
- **Discriminatory abuse**, including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
- **Organisational abuse**, including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation
- **Neglect and acts of omission**, including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- **Self-neglect** covers a wide range of behavior neglecting to care for one's personal hygiene, health or surroundings, and includes behaviour such as hoarding
- **Forced Marriage** is a marriage in which one or both of the parties is married without his or her consent or against his or her will
- **Honour Based Violence** is a term used to describe violence committed within the context of the extended family which is motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim
- **Hate Crime** is any crime that is targeted at a person because of hostility or prejudice towards that person's: disability, race or ethnicity, religion or belief or sexual orientation
- **Mate Crime** is a form of crime in which a perpetrator befriends a vulnerable person with the intention of then exploiting the person financially, physically or sexually

Appendix 3 : Kent and Medway Safeguarding Adults Board Governance Structure



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Kent and Medway Safeguarding Adults Board

Annual Report 2015-2016

Please visit our website: www.kent.gov.uk/about-the-council/partnerships/kent-and-medway-safeguarding-adults-board

From:	Roger Gough – Cabinet Member for Education and Health Reform
To:	County Council 8 December 2016
Subject:	Kent Health and Wellbeing Board Annual Report 2015-2016
Past Pathway of Paper:	21 September 2016 Kent Health and Wellbeing Board 7 October 2016 Health Overview and Scrutiny Committee

Summary: The Kent Health and Wellbeing Board is required to report annually to Kent County Council summarising how it has discharged its statutory duties and associated functions.

Recommendation – That the County Council is asked to agree that the Kent Health and Wellbeing Board has fulfilled its responsibilities under its Terms of Reference.

1. Background

1.1 The Kent Health and Wellbeing Board was established following the enactment of the Health and Social Care Act 2012. From 1 April 2013 it became a committee of Kent County Council although from September 2011 the Health and Wellbeing Board operated in shadow form as part of the Government's Early Adopter programme.

1.2 Under the terms of reference for the Board it is required to submit an annual report to the County Council detailing how it has met its statutory obligations and performed other important functions that fall within its terms of reference. The report is not intended to be a comprehensive review of the Health and Social Care system in Kent but focusses on the work of the Board itself.

2. The Report

2.1 The attached report details the activity of the Board during the period April 2015 to March 2016.

2.2 Appendices to the report give detail on the agenda items considered, the terms of reference the Board operates within, and the structure of the Board and its subgroups and committees. Other sections of the report describe initiatives that have been developed with the involvement of the Board during the year and commentary on how some of the issues are being progressed in the current year.

3. Recommendation

3.1 That the County Council is asked to agree that the Kent Health and Wellbeing Board has fulfilled its responsibilities under its Terms of Reference.

Report Authors

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Background documents - none

Kent Health and Wellbeing Board Annual Report 2015-16

1. Introduction

This is the annual report for the Kent Health and Wellbeing Board for 2015/16. During this time the health and social care system experienced serious challenges including continued rising demand and limited resources. These challenges have fueled the necessity for finding alternative ways to provide the services and care people need whilst increasing the quality of care they experience. Government policy has also driven the requirement to integrate the services we jointly provide and the ways in which they are commissioned. Major initiatives from NHS England have been previously launched to find ways to meet these challenges such as the Health and Social Care Integration Pioneer Programme, the Better Care Fund and the Five Year Forward View and all have come within the scope of the Kent Health and Wellbeing Board.

Most recently, in December 2015 the Government tasked local health and social care systems to produce Sustainability and Transformation Plans (STP) that will deliver the Five Year Forward View and the Kent Health and Wellbeing Board is at the forefront of this development.

2. The structure of the Kent Board and its membership

The Kent Health and Wellbeing Board is a statutory body established by the Health and Social Care Act 2012 as a formal committee of the County Council. However it does function in practice and in membership as a partnership board. The Kent Board is composed of all the organisations that are responsible for the planning and commissioning of health and social care services in the county. The Act specified a minimum membership that in Kent has been extended to include representatives of district councils, recognising we operate in a two tier authority area where district colleagues are critical partners. Membership, governance arrangements and terms of reference are attached to this report in Appendix 1.

The Kent Health and Wellbeing Board is chaired by KCC Cabinet Member for Education and Health Reform, Cllr Roger Gough, and meets every two months. It met 6 times between April 2015 and March 2016. A full list of agenda items considered at each meeting can be found at Appendix 2. The Board does not have any dedicated resources and is administered as a Committee of Kent County Council by Democratic Services, a Secretariat of KCC.

3. Substructures

In a county the size and complexity of Kent it is not possible for the Board to fulfil its responsibilities without a supporting structure where a lot of its work is conducted. In Kent a district based health and wellbeing board in Dover and Folkestone was established by the Department of Health in the period prior to the formal introduction of health and wellbeing boards as part of the "pathfinders" programme. To facilitate the work of the County level board Kent, uniquely, decided to expand this model and there are now seven local health and wellbeing boards that are formal subcommittees of the Kent Board. They are based on CCG geography and have full representation from all relevant district councils.

Other subgroups have been established to assist the Kent Board for specific purposes.

- The Kent Children's Health and Wellbeing Board focusses on issues relevant to our children and young people
- The Kent Health and Social Care Integration Pioneer Steering Group is responsible for delivering the NHS England Integration Pioneer Programme of which Kent was a founder member

- The Better Care Fund Assurance Group monitors the progress of the Better Care Fund plans developed to promote integration
- The Multi-Agency Data and Information Group brings together the relevant data, information and intelligence from a variety of organisations to inform the business of the Board
- Task and Finish groups are established as required. For example a group looking at workforce issues came together in 15/16.

4. Statutory Responsibilities of the Board

Under the Health and Social Care Act 2012 the Kent Board has five responsibilities and in 2015/16 has successfully fulfilled its statutory requirements as described below:

4.1 To ensure that a Joint Strategic Needs Assessment that identifies the health priorities for the population is produced

Kent's JSNA is available here:
http://www.kpho.org.uk/joint-strategic-needs-assessment .

Regular reports concerning the JSNA were received by the Board:

- An exception report was considered by the Board on 20th May 2015 highlighting key changes from the 2014-15 refresh of the JSNA
- A report came to the Board on 16 September 2015 outlining key recommendations from the Kent JSNA that may be considered by CCGs and other commissioners for 2016/17 commissioning plans.

The revision of the JSNA was the focus of an event held in September 2015. A key challenge from Commissioners was that although the JSNA provided useful information it was less helpful in analysing the implications of the data to inform their decisions on investment, and disinvestment, in services. In Kent we are moving beyond the original concept of the JSNA and a working group is now looking at how a "JSNA Plus" can be developed that will include trend analysis, predictive modelling and value for money tools.

4.2 To ensure that a Joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment is produced.

The updated strategy was published in 2014 and runs until 2017. It is available here:
http://www.kent.gov.uk/social-care-and-health/health/health-and-public-health-policies/joint-health-and-wellbeing-strategy

The Board has continued to oversee the implementation of the strategy which has five outcomes:

- Every child has the best start in life
- Effective prevention of ill health by people taking greater responsibility for their health and wellbeing
- The quality of life for people with long term conditions is enhanced and they have access to good quality care and support
- People with mental health issues are supported to 'live well'
- People with dementia are assessed and treated earlier, and are supported to live well.

The Board monitors progress and performance against key indicators for each of the five outcomes through t**he Kent Assurance Framework.** The Board has developed an Assurance Framework that reports regularly on a suite of indicators designed to highlight when stresses may be appearing across the system, the indicators from the Joint Health and Wellbeing Strategy, and those relating to the Better Care Fund. In this way the Board is kept up to date with how the system is responding to the demands being placed upon it and progress towards the outcomes of the Health and Wellbeing Strategy. The Board has also commissioned Healthwatch Kent to identify and explore ways to address the key issues in the health and care system that may affect the quality of service that people experience

A major event was held in June 2015 to consider how useful stakeholders were finding the Joint Health and Wellbeing Strategy. The feedback was that the strategy was broadly on track but that there were some changes in emphasis that would be helpful going forward.

It was agreed that the County Board and Local Boards would develop work programmes focussed on achieving the outcomes of the strategy and built on the findings of the JSNA.

The Board has received reports and presentations on key issues relating to the strategy throughout the year including health inequalities, learning disability, mental health and children and young people. Examples include:

- **Kent & Medway Mental Health Crisis Care Concordat** brings together organisations such as Police, Health, Social Care and Public Health to improve outcomes for people experiencing a mental health crisis. The Concordat's purpose is to improve communication with and training for police officers and to put systems in place with partners that will reduce the number of detentions under Section 136 of the Mental Health Act 1983.
- **Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults 0-25 (CAMHS)** articulates a new model for the development of children's mental health services with a single point of access and seamless pathways ranging from universal early help through to highly specialist care with better transition between services. The development of this strategy was prompted by concerns expressed by the Board about the CAMHS service and has developed into a wider solution including early intervention and prevention.
- **Kent Safeguarding Children's Board Annual Report** highlighted the Strategic Priorities for 2015-18 as Early Help, children who go missing, On-Line safety and Female Genital Mutilation, child sexual exploitation, radicalisation, domestic abuse and working with parents with mental health and/or substance misuse issues. The Board noted the development of expertise and knowledge in relation to child sexual exploitation and to the issue of unaccompanied asylum seeking minors.
- **Learning Disability- Joint Health and Social Care Self-assessment Framework and update on Transforming Care (Winterbourne).** The Self-assessment Framework identifies areas of weakness in health and social care services delivered to people with a learning disability. Transforming Care is the national response to the failings at Winterbourne View Hospital. The Board agreed

    a) to support development of integrated commissioning arrangements between the Clinical Commissioning Groups and KCC to ensure all agencies continue to work together to improve the lives of people with learning difficulties;
    b) The future Joint Commissioning Plan for learning disability in 2016 should address the areas where Kent had scored a red rating (i.e. long term health conditions, breast cancer screening and bowel cancer screening);

c) The development of a Transforming Care Partnership for Kent and Medway to take forward the Transforming Care strategic plans for reducing the number of specialist in-patient beds and improving community support.

4.3 To ensure that the commissioning plans of the CCGs and Kent County Council (social care and public health) properly reflect the needs identified in the Joint Strategic Needs Assessment and the priorities within the Joint Health and Wellbeing Strategy

Commissioning plans for the year of 2015-2016 for Children's Services, Adult Social Care and NHS England were considered and agreed at the meeting of 20th May 2015 and can be found here:
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5833&Ver=4

Public Health Transformation and Commissioning plans were agreed by the Board at the meeting of 18th November 2015.
https://democracy.kent.gov.uk/documents/s60767/Item%207%20PH%20Nov%20HWBB%20report%20-%20v6.pdf

The latest commissioning plans of the seven Clinical Commissioning Groups in Kent were presented to the Board and agreed at its meeting of 16th March 2016.
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

4.4 To ensure that a Pharmaceutical Needs Assessment is produced

The main aim of the Kent Pharmaceutical Needs Assessment is to describe the current pharmaceutical services in Kent, systematically identify any gaps/unmet needs and in consultation with stakeholders make recommendations on future development.

The Board approved the Kent's Pharmaceutical Needs Assessment on 20th May 2015 and it is available here:

http://www.kpho.org.uk/health-intelligence/service-provision/pharmacy/pharmaceutical-needs-assessments

The Board has involved itself in consultation concerning the future of community pharmacies following the announcement by the Department of Health and NHS England in December 2015, that funding to community pharmacies would be reduced and there would be a reconfiguration of pharmacy services. This was shown to have a serious effect on smaller, independent pharmacies, typically those in villages such as Lyminge and Lenham. An announcement was made by Government in September 2016 that due to national response to the consultation the proposed changes would not be implemented as planned in October 2016.

4.5 To promote the integration of health and social care

a) Sustainability and Transformation Plan (STP)

Background to the STP: In December 2015 Government issued planning guidance outlining a new approach to help ensure that health and care services are built around the needs of local populations.

To do this, every health and care system in England was tasked with producing a multi-year Sustainability and Transformation Plan showing how local services will evolve and become sustainable over the next five years and ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

Local health and care systems came together in January 2016 to form 44 STP 'footprints' that would deliver plans that are based on the needs of local populations. The health and care organisations within these geographic footprints have been working together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term. NHS England has defined the footprint for our region which brings together Kent and Medway and appointed Glenn Douglas, Chief Executive of Maidstone & Tunbridge Wells NHS Trust, as the Senior Responsible Officer.

STPs must demonstrate how new models of care will be developed and full integration of health and social care achieved by 2020. The Kent and Medway plan is being developed to address the significant challenges in our footprint to provide a sustainable health and social care system, with many of the current providers in special measures and a significant financial deficit by 2021 if we do nothing. The plan must also consider how we will work with neighbouring footprints and communities with regard to those people who may cross boundaries to use local health services, for example people from Southeast London who are served by Darent Valley Hospital and people from Kent who may use services at the Conquest Hospital in Hastings.

The Health and Wellbeing Board has been involved in the development of the STP and the chair of the Board is a member of the Kent and Medway STP steering group, as is the Chair of the Medway Health and Wellbeing Board alongside NHS providers and commissioners.

These new planning arrangements, changes to the Better Care Fund and financial settlement for the NHS announced in the autumn statement were explored at the Board meeting 16th March 2016.
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

b) Better Care Fund

The Better Care Fund is a driver for integration as it promotes the pooling of budgets and the development of joint initiatives by health and social care organisations designed to reduce demand for hospital services. There has not been any additional investment but implementation has required establishing statutory s75 agreements (pooled budget arrangements) with each of the seven CCGs in Kent that have brought £101 million of existing CCG budgets together. The Kent approach has been commended at a national level. In the autumn statement the government announced that it intends to continue with an expanded BCF and that the BCF will be an integral part of the progress towards the requirement of full integration of health and social care by 2020. Together with the Sustainability and Transformation Plans the BCF going forward must be able to demonstrate how this will be achieved.

The Board regularly monitors implementation of the BCF plan. Papers were received on 16 September 2015: https://democracy.kent.gov.uk/documents/s59610/Item%2011%201.pdf

27 January 2016:
https://democracy.kent.gov.uk/documents/s61863/Item%206%20BCF%20and%20planning%20paper%20final%20final%20final.pdf

16 March 2016:
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=6180&Ver=4

c) Pioneer Programme

The national Integrated Care and Support Pioneer Programme was launched in November 2013 to assist selected authorities to progress with their health and social care integration plans at pace and scale. As one of the original Integration Pioneer sites Kent established an Integration Pioneer Steering Group (IPSG) as a sub-group of the Health and Wellbeing Board to coordinate the delivery of the objectives identified in the Kent Pioneer bid.
The Integration Pioneer Programme and team continue to support the diverse and expanding range of new models of care that are significant in the development of the STP.

The Board receives regular reports concerning these developments and papers have included progress reports relating to:

- **Encompass Vanguard Site:** The Kent Integration Pioneer is supporting the development of the Vanguard site which is providing a wide range of primary care and community services. Several members of the IPSG are members of the Vanguard Steering Group working in collaboration and supporting the establishment of the Vanguard.

The Vanguard: In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services. In March 2015 the first group of Vanguard sites were chosen.

Encompass is a group of 16 GP practices in Whitstable, Faversham, Canterbury, Ash and Sandwich which are working together to provide more local services. This will mean that patients can receive more of their care from their local surgery, without the need to travel to hospital. Locally provided care includes minor injuries unit, diagnostics and screening, consultants conducting outpatients' clinics in the community and there are plans to extend into nursing care. The population size covered by these arrangements is now 170,000 people.

- **Formation of an Integrated Care Organisation:** South Kent Coast and Thanet CCGs are leading in developing new local models for health and care services coordinated by the GP. The CCG's membership is working with more than 200 clinicians, professionals and local people to finalise the design of services that each community needs.
- **Integrated Discharge Teams** at Darent Valley consist of social care case managers, case officers and discharge coordinators providing an extended service outside of office hours to support people to leave hospital when they are well enough.
- **The Care Plan Management System** went live in West Kent in June 2016. This means moving care planning from GP systems to provide access to all of a person's care team for 2,250 people. The system was presented as good practice at a national conference hosted by NHS England.
- **Year of Care Programme** has provided a whole-system intelligence dashboard which delivers information on cost and activity across the health and social care economy. The

dashboard has been instrumental in evaluating the integration projects being delivered across the county and in supporting systems modelling for the STP.

- **International and European Work Stream**: Kent Integration Pioneers are taking the lead on behalf of the NHS and social care locally, nationally and internationally. Along with strong relationships with European partners, Pioneers have also worked with partners in New Zealand and Japan. The aim is to share transferable knowledge and learning on an international level. The impact of the UK leaving the EU is not yet known.
- **Kent Design and Learning Centre for Clinical and Social Innovation** opened in June 2016 to investigate, test and develop new technologies that can support people to remain independent for as long as possible.

d) In order to fulfil its duty relating to supporting the integration of health and social care the Board has also considered:

- **One Public Estate** (OPE) programme is designed to facilitate and enable public sector bodies to work collaboratively on property and land matters. The Board considered how the Department of Health's Local Estate Strategy and the requirement to establish local estates forums might fit with wider collaboration and integration of service commissioning and possible links with the local health and wellbeing boards and the Health and Wellbeing Strategy. A substantial amount of practical work in different localities has followed on from this.
- **Local Digital Roadmaps** are the plans for how local health and care economies will achieve their aim of being paper-free by 2020. It was agreed on 18th November 2015 that the roadmaps will be signed off by the Health and Wellbeing Board and regular progress updates will be reported to the Board
- **Workforce:** On 20 May 2015, the Board agreed to establish a task and finish group and work closely with Health Education England to look specifically at strategic workforce issues across the County. Workforce had been identified by the Board as one of the main barriers to implementing the necessary changes to the health and care system to make it both sustainable and deliver improvements to the quality and effectiveness of care. It was recognised that if the right actions could be identified, workforce would be a major enabler to deliver new models of care and the Five Year Forward View. The Group met 6 times between May and December 2015 and identified the following priority areas which were pursued in depth:

    - existing and emerging gaps
    - new models of care
    - productivity
    - recruitment and retention
    - cross-cutting – 'the Brand of Kent';

The Board agreed that joint work would continue around the issue of workforce. This aligned with the requirement to establish a Local Workforce Action Board to coordinate and support the workforce requirements of each STP. The Kent and Medway Workforce Action Board is currently under development and is building on the work of the Task and Finish Group.

5. Endorsement, consideration and support

A number of issues that either have implications for the health and wellbeing of the population or are likely to impact on the health and social care system have been presented to the Board for their consideration and endorsement. In 2015/16 these have included:

- Kent and Medway Growth and Infrastructure Framework which highlighted that within Kent and Medway approximately 160,000 new houses are planned. Medway, Dartford, Maidstone and Canterbury are highlighted as areas of significant growth with a projected increase of 304,500 people, equivalent to an 18% increase, in the population across the whole County (255,300 for Kent only). The Board was involved in shaping the development of the framework to take account of health and social care service delivery.
- Healthy New Towns scheme, which has recently started (2016) in Dartford, Gravesham and Swanley in relation to the Ebbsfleet Garden City development focused on working across capital developers, councils, social care and health to provide a healthy living space supported by innovative models of care delivery. This scheme is supported by the work of the One Public Estate programme.
- Winter preparedness: 16 Sept 2015 preparations for winter 2015-16 presented by NHS England South (South East) and 27 January 2016 review of arrangements for winter preparedness and resilience within the system with lessons learnt.
- Protocol on the working arrangements between the Kent Health and Wellbeing Board, Kent Children's Wellbeing Board and Kent Safeguarding Children Board which aims to support all three partnerships to operate effectively, being clear about their respective functions, inter-relationships and the roles and responsibilities of all those involved in promoting and maintaining the health and wellbeing of children and in keeping children safe. This is essential in order to maximise the safeguarding of children and young people, to avoid duplication and to ensure there are no preventable strategic or operational gaps in safeguarding policies, services or practice.

6. The Future: 2016-17

6.1 Sustainability and Transformation Plans- Integration at pace and scale

Health and Wellbeing Boards are increasingly seen as part of the internal governance and accountability arrangements for local health and care systems with an expectation that they will be involved in the development and sign-off of policies and strategies across a wide range of areas and of different scale and scope.
The STP is designed to have a significant impact on the progress of integration and will influence all aspects of health and social care. It provides the current framework for health and social care policy discussion. The Health and Wellbeing Board will continue to have the same statutory responsibilities that it currently has. The challenge for the Board as it goes forward will be to continue to fulfil its statutory duties and help ensure delivery of the STP.

The STP also provides the Board with an opportunity to use the innovative approaches that Kent is leading on through its Pioneer status and the progress it has made through the Better Care Fund to increase the pace and scale of integration.

6.2 The Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA and JHWS)

The introduction of the STP as the guiding vision for the future of the health and social care system will impact on the production of the Joint Health and Wellbeing Strategy for 2017 onwards and the Joint Strategic Needs Assessment. These documents should reflect challenges and innovation in the system that are necessary to articulate the case for change, focus change on improving local outcomes for the population and provide the means to measure and evaluate effectiveness. This opportunity to provide a golden thread from the needs identified in the JSNA, into the new JHWS and through the STP into whole system planning will be explored by the Board during 2016/17 with a focus on agreeing a new approach to the JSNA and the Health and Wellbeing Strategy. The potential to translate

those high level intentions into local actions will also be considered as part of the Board's work for 2016/17.

6.3 The Work of the Board

In July 2016 the Board agreed to adopt a work programme that will ensure it remains focussed on its primary objectives and this will direct the work of the Board for the next year.

(a) Area 1- Assuring Outcomes for Kent

- The practice of devoting part of a meeting to reviewing progress against one of the 5 outcomes of the Joint Health and Wellbeing Strategy has been viewed as one worth continuing. This will be supported by the assurance framework report being focused on producing data to help the Board understand progress against the outcome.
- Review of commissioning plans.
- Winter planning and resilience.
- Quality

(b) Area 2 – Core Documents

- JSNA refresh (underway).
- JHWS revision (from late 2016 onwards)
- PNA (next revision due 2018)

(c) Area 3 – Promotion of Integration

- Progress of the Five Year Forward View and Sustainability and Transformation Plans
- Strategic barriers and enablers – workforce, sustainability, technology and systems
- Integration Pioneer reports and Better Care Fund
- Relationship with providers and VCS

(d) Area 4 – Notifications

- Other important issues or policy documents which the HWB will wish to become informed about and respond to. More for short and medium term planning. Recent examples, Local Digital Roadmaps, One Public Estate Initiative.

(e) Area 5 – Reports to the Board

- Health Watch Annual Report
- HWB Annual Report
- Mental Health Concordat.
- Local commissioning/policy developments, e.g. Emotional Wellbeing Strategy for Children, Young People and Young Adults, Accommodation Strategy, Growth and Infrastructure Framework.
- Local Board Minutes.
- Children's Health and Wellbeing Board minutes
- Annual report of the Kent Safeguarding Children's Board.

Appendix 1

The Governance Arrangements of the Board

Role

The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

- secure better health and wellbeing outcomes in Kent
- reduce health inequalities and
- ensure better quality of care for all patients and care users.

The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner.

The HWB also aims to increase the role of elected representatives in health and provide a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

The HWB:

1. Commissions and endorses the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

2. Commissions and endorses the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

3. Commissions and endorses the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

4. Reviews the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if it considers that they do not.

5. Has oversight of the activity of its subcommittees (referred to as Clinical Commissioning Group level Health and Wellbeing Boards), focussing on their role in developing integrated local commissioning strategies and plans.

6. Works alongside the Health Overview and Scrutiny Committee (HOSC) to ensure that substantial variations in service provision by health care providers are appropriately scrutinised. The HWB itself will be subject to scrutiny by the HOSC.

7. Considers the totality of the resources in Kent for health and wellbeing and considers how and where investment in health improvement and prevention services could improve the overall health and wellbeing of Kent's residents.

8. Discharges its duty to encourage integrated working with relevant partners within Kent, which includes:

- endorsing and securing joint arrangements, including integrated commissioning where agreed and appropriate;
- use of pooled budgets for joint commissioning (s75);
- the development of appropriate partnership agreements for service integration, including the associated financial protocols and monitoring arrangements;
- making full use of the powers identified in all relevant NHS and local government legislation.

9. Works with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

10. Considers and advises Care Quality Commission (CQC) and NHS Commissioning Board; monitors providers in health and social care with regard to service reconfiguration.

11. Works with the HOSC and/or provides advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

12. Is the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

13. Reports to the full County Council on an annual basis on its activity and progress against the milestones set out in the Key Deliverables Plan.

14. Develops and implements a communication and engagement strategy for the work of the HWB; outlining how the work of the HWB will:

    - reflect stakeholders' views
    - discharge its specific consultation and engagement duties
    - work closely with Local HealthWatch.

15. Represents Kent in relation to health and wellbeing issues in local areas as well as nationally and internationally.

16. May delegate those of its functions it considers appropriate to another committee established by one or more of the principal councils in Kent to carry out specified functions on its behalf for a specified period of time (subject to prior agreement and meeting the HWB's agreed criteria).

Membership

The Chairman is elected by the HWB.

1. Kent County Council:

    - The Leader of Kent County Council and/or their nominee*
    - Cabinet Member for Education and Health Reform
    - Cabinet Member for Adult Social Care & Public Health
    - Cabinet Member for Specialist Children's Services
    - Corporate Director - Social Care, Health and Wellbeing*

- Director of Public Health*
- Any other County Council Member necessary for the effective discharge of HWB functions

2. Clinical Commissioning Group: up to a maximum of two representatives from each consortium (e.g. Chair of the CCG Board and Accountable Officer)*

3. A representative of the Local HealthWatch* organisation for the area of the local authority.

4. A representative of the NHS Commissioning Board Local Area Team*

5. Three elected Members representing the Kent District/Borough/City councils (nominated through the Kent Council Leaders)

   *denotes statutory member.

Procedure Rules

1. **Conduct.** Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g. GPs and officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

2. **Declaration of Disclosable Pecuniary Interests.** Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any subcommittee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared.

3. **Frequency of Meetings**. The HWB meets at least quarterly. The date, time and venue of meetings are fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

4. **Meeting Administration.**
   - HWB meetings are advertised and held in public and administered by the County Council.
   - The HWB may consider matters submitted to it by local partners.
   - The County Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.
   - Papers for each HWB meeting are sent out at least five clear working days in advance.
   - Late papers may be sent out or tabled only in exceptional circumstances.
   - The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.
   - The HWB meetings will be web cast where the facilities are in place.
   - The Chairman's decision on all procedural matters is final.

5. **Meeting Administration of Sub Committees**. HWB sub-committees are administered by a principal local authority, in the case of the Clinical Commissioning Group level HWBs, by a District Council in that area. They will be subject to the provisions stated in these Procedure Rules.
6. **Special Meetings.** The Chairman may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state

the particular business to be transacted and no other business will be transacted at such meeting.

The Chairman is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

7. **Minutes.** Minutes of all HWB meetings are prepared recording:

   - the names of all members present at a meeting and of those in attendance
   - apologies
   - details of all proceedings, decisions and resolutions of the meeting

   Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chairman.

8. **Agenda.** The agenda for each meeting normally includes:

   - Minutes of the previous meeting for approval and signing
   - Reports seeking a decision from the HWB
   - Any item which a member of the HWB wishes included on the agenda provided it is relevant to the terms of reference of the HWB and notice has been given to the Clerk at least nine working days before the meeting.

   The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. He must state these reasons at the meeting and the Clerk shall record them in the minutes.

9. **Chairman and Vice Chairman's Term of Office.** The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

10. **Absence of Members and of the Chairman.** If a member is unable to attend a meeting, then they may provide an appropriate alternate member to attend in their place, subject to them being of sufficient seniority to agree and discharge decisions of the Board within and for their own organisation. The Clerk of the meeting should be notified of any absence and/or substitution at least five working days prior to the meeting. The Chairman presides at HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the HWB appoints from amongst its members an Acting Chairman for the meeting in question.

11. **Voting.** The HWB operates on a consensus basis. Where consensus cannot be achieved the subject (or meeting) is adjourned and the matter is reconsidered at a later time. If, at that point, a consensus still cannot be reached, the matter is put to a vote. The HWB decides all such matters by a simple majority of the members present. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman. For clarity, each Clinical Commissioning Group has one vote, irrespective of whether both the Clinical Lead and Accountable Officer for that Clinical Commissioning Group attend the HWB.

12. **Quorum.** A third of members form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

13. **Adjournments.** By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

14. **Order at Meetings.** At all meetings of the HWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

15. **Suspension/disqualification of Members.** At the discretion of the Chairman, any body with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman, or if they breach the Kent Code of Conduct for Members.

APPENDIX 2

Substantive agenda items taken by the Kent Health and Wellbeing Board in 2015/16

20th May 2015

Workforce
Kent and Medway Growth and Infrastructure Framework
Commissioning Plans: NHS England, Children's services and Adult Social Care
Assurance Framework
JSNA Exception Report
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

15th July 2015

One Public Estate Initiative
Kent and Medway Mental Health Crisis Care Concordat
Quality and the Health and Wellbeing Board
Local Health and Wellbeing Board minutes

16th September 2015
Healthwatch Annual Report
JSNA Recommendations Report
NHS England- Preparations for winter 2015/16
Kent Emotional Wellbeing Strategy for Children, Young People and Young Adults (0-25) – (CAMHS)
Kent Health and Wellbeing Board and Local Health and Wellbeing Boards Relationship and Future Options Paper
Developing the Relationship between Kent's Health and Wellbeing Board and the Voluntary Sector that recognises the important role the voluntary sector plays in the health and wellbeing of local communities and explore how that local intelligence and knowledge can be shared with Local Boards and County Board to inform commissioning
Health and Social Care Integration
Local Health and Wellbeing Board minutes

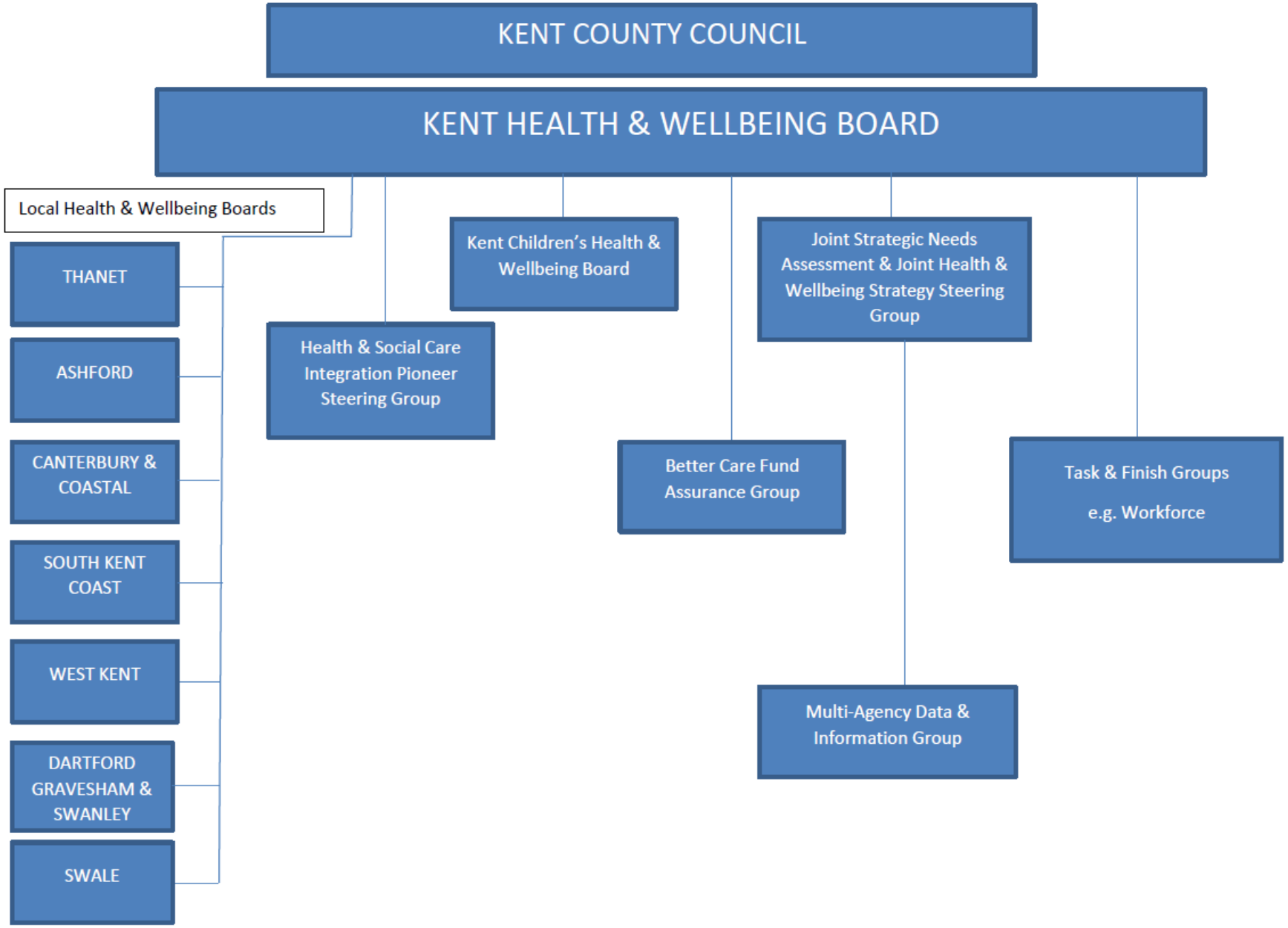
18th November 2015
Joint Health and Social Care Self-Assessment – Learning Disability
Growth and Infrastructure Framework
Public Health Services Transformation and Commissioning Plans
Assurance Framework
Kent Health and Wellbeing Board Annual report
Local Digital Road Maps
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

27th January 2016
NHS Preparations for and response to Winter 2015/16
The New Planning arrangements for Health and Social Care
New Models of Care progress report
Draft Kent Health and Wellbeing Board Work Programme
Kent Safeguarding Children's Board Annual Report
Children's Health and Wellbeing Board minutes
Local Health and Wellbeing Board minutes

16th March 2016
CCG Commissioning, Operational and Transformation Plans with regard to STP
Better Care Fund
Joint Strategic Needs Assessment – outcomes of JSNA workshop
Kent Health and Wellbeing Board Work Programme- Finalised
Local Health and Wellbeing Board minutes

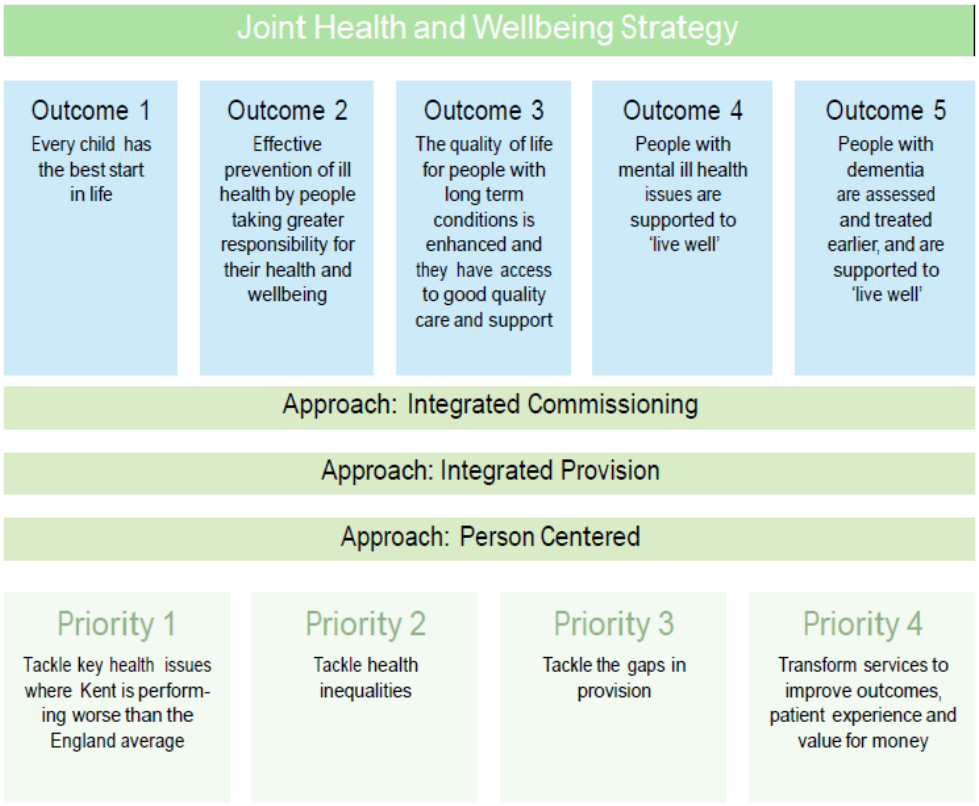
Appendix 3

THE KENT HEALTH & WELLBEING BOARD STRUCTURE



Appendix 4

The outcomes will be delivered by focusing on our priorities within each of the outcome areas, whilst ensuring that any intervention is informed by the three approaches, i.e. that it is centred around the person), that it is provided in a joined up way, and where appropriate it is jointly commissioned.



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

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

To: County Council – 8 December 2016

Subject: **YOUR LIFE, YOUR WELL - BEING – A VISION AND STRATEGY FOR ADULT SOCIAL CARE 2016 - 2021**

Classification: Unrestricted

Electoral Division: All

Summary: 'Your life, your well-being' is the new five year Vision and Strategy for adult social care in Kent.

Recommendation: County Council is asked to **ENDORSE** Your Life, Your Well-Being - A vision and Strategy for Adult Social Care 2016 -2021

1. Introduction

1.1 The 'Blueprint and Preparation Plan' which laid the foundation for the transformation programme in adult social care was endorsed by the County Council in 2012. A great deal of work has been accomplished since that endorsement against the backdrop of significant reduction of funding to local government since 2010. The new 'Your Life, Your Well-Being - A Vision and Strategy for Adult Social Care 2016 -2021 (Attached as Appendix 1), is in line with and supports Kent County Council's 'Strategic Statement' and the 'Commissioning Framework' outcomes and objectives. This new Strategy replaces the previous 'Active lives' Strategy. The Easy Read version of the Strategy and the Equality Impact Assessment are also available.

1.2 The new Strategy is based on the Care Act 2014. County Council will be aware that the Care Act has broadened the role of councils with adult social care responsibilities to promote the wellbeing of all adults with care and support needs living in their area. The new overarching Strategy for adult social care sits between relevant council-wide strategies as mentioned above and other specific social care group strategies.

1.3 This is a Strategy that builds on our past successes but firmly points to the future in how we intend to work with our partners - people who use our services, carers, providers, voluntary sector, health services, schools and colleges, district councils and other public services - to meet the challenges that we face. This Strategy sets out the overall direction that we intend to follow in the coming years, amidst the financial challenges and the ever increasing demand for services that we know are influenced by the changing demographic needs of the area.

2. Financial Implications

2.1 The financial implications associated with the implementation of the Strategy are generally outlined in the Medium Term and Financial Plan 2016-19 and the specific allocation for the adult social care portion out of the Social Care, Health and Wellbeing Directorate budget.

3. KCC Strategic Statement

3.1 Two out of the three strategic outcomes and supporting outcomes in KCC's Strategic Statement are key drivers for the Strategy. The first is the strategic outcome – 'Older and vulnerable residents are safe and supported with choices to live independently'. The second is the strategic outcome – 'Kent communities feel the benefits of economic growth by being in-work, healthy and enjoying a good quality of life'.

4. Consultation

4.1 A draft version of the Strategy was published for public consultation between 30 September and 4 November 2016. The primary aims of consulting on the Strategy were to raise awareness about the new Strategy, gather feedback from stakeholders to inform the final draft, check that people could understand the draft and to find out if anything important was missing. The final draft document was considered by the Adult Social Care and Health Cabinet Committee at its meeting on 6 December.

5. The Report – 'Your Life Your Wellbeing A Vision and Strategy for Adult Social Care 2016-2021'

5.1 The vision of the service "is to help people to improve or maintain their wellbeing and to live as independently as possible". The Strategy for adult social care over the next five years breaks down our approach into three themes, supported by four building blocks. The three themes cover the whole range of services provided for people with all kinds of social care and support needs and their carers throughout their adult lives.

5.2. The three themes are:

(1) 'Promoting Wellbeing' which is delivered through services which aim to prevent, delay or avoid people entering into formal social care or health systems, by enabling people to manage their own health and wellbeing;
(2) 'Promoting Independence' which is about provision of short-term support that aims to prevent or delay people's entry to the formal care system, and provide the best long-term outcome for individuals. People will be empowered to have greater choice and control to lead healthier lives;
(3) 'Supporting Independence' which is delivered through services for people who need ongoing support and aim to maintain individual wellbeing and self-sufficiency, keep people safe and enable them to live in their own homes, stay connected to their communities and avoid unnecessary admissions to hospitals or care homes lives.

5.3 The four 'building blocks' of the vision and Strategy which must be in place to deliver the vision are:

1. safeguarding;
2. workforce;
3. commissioning;
4. integration/partnership.

5.4 The Strategy recognises the huge contribution that carers make to the lives of their relatives and friends. Ensuring those carers are supported in their role is a critically important part of this Strategy, as supporting carers is the most effective way of achieving our overall vision – to enable people to improve or maintain their wellbeing and to live as independently as possible. The skills, knowledge and commitment of carers of people who need ongoing care will be respected and valued by the team of professionals involved in providing care.

6. Conclusions

6.1 The document is presented to County Council because it serves as the next five year forward Strategy for adult social care and it sets out the overall direction of the service in the coming years, amidst the financial, demographic and operational challenges.

6.2 The Strategy will be considered by the Adult Social Care and Health Cabinet Committee at its meeting on 6 December 2016 and the Cabinet Member for Adult Social and Public Health will take a key decision to approve the Strategy.

6.3 Delivery of the Strategy will be through the next phase of the ongoing Adults Transformation Programme. An implementation plan is currently being developed and the details of which will be reported to Members in due course.

7. Recommendation

7.1 Recommendation: County Council is asked to **ENDORSE** Your Life, Your Well-Being - A vision and Strategy for Adult Social Care 2016 -2021.

8. Contact details

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Background documents - none

Your life, your well-being

A vision and strategy for adult social care 2016 - 2021

Crystal Mark 22163
Clarity approved by Plain English Campaign

Kent County Council
kent.gov.uk

Contents

This document is aimed at members of the county council, our staff, people who use our service, carers, the wider public, providers, the voluntary sector, health services, schools and colleges, district councils and other public services.

This document is available in alternative formats and languages. Please call: 03000 421553 Text relay: 18001 03000 421553 for details or email alternativeformats@kent.gov.uk

Images Kent County Council, NHS photo library page 13,16,19,20,23,26, 29.

1. Foreword

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Andrew Ireland, Corporate Director for Social Care, Health and Well-being.

Graham Gibbens Andrew Ireland

It is well known that as a society we are living longer and, as a result, an increasing number of people have complex needs and require the support of the health and social care system. This includes increasing numbers of young people with learning and physical disabilities who are moving from Children's to Adult Services and often need high levels of support. These developments are happening at the same time as a dramatic reduction in funding since 2010. All the available information shows that this is likely to continue.

This document sets out how we are going to respond to the changing environment with a new vision and strategy for adult social care. It is a vision and strategy that builds on our past successes but firmly points to the future in how we plan to work with our partners to meet the challenges ahead.

Our vision, to put it simply, is to 'help people to improve or maintain their well-being and to live as independently as possible'. Our strategy sets out the overall direction that we aim to follow in the coming years to achieve this vision. It does not include detailed descriptions of current or proposed new services but forms the basis on which detailed plans will be made from now on.

The measure of our success will be if we are able to deliver more person-centred care and support, keep people safe, help people to have choice and control, make sure that there are enough care and support services available, work in partnership and make better use of our resources.

The new vision and strategy is based on the Care Act 2014. Under this Act we not only have responsibilities towards adults with care and support needs and their carers, but also a broader responsibility to promote the well-being of adults living in the area. This should help prevent some needs arising in the first place and delay their development.

We are already working with our partners in developing new ways of doing things, with the aim of breaking down the barriers between organisations when they get in the way of better care and support. This includes the NHS, and our vision and strategy is part of the broader process of joining up health and social care under the NHS Five Year Forward View work programme.

Working much more closely with the NHS will help to reduce unnecessary admissions to hospital and mean those already in hospital should be able to go back home as soon as they are ready. People will also be able to receive their health and social care from one community place linked to their GP surgery. People with more intense and complicated ongoing needs will have one professional who will lead on co-ordinating their care and build a team of support for the person. This support will include a single assessment (rather than several from different professionals) and enablement which helps people to become more independent by gaining the ability to move around and do everyday tasks.

Finally, in developing our detailed plans we will make the best use of 21st century technology, including digital systems, to share appropriate information between partners and tools such as telecare and telehealth to support those receiving health and social care.

The next five years are going to be very challenging but we are committed to doing all we can to provide the right level of care and support to those who need it.

2. Strategy at a glance

Purpose	Adult social care is there to support people (adults, young people and carers) who need help with daily living so they can live as independently as possible in the place of their choice.
Context	• Efficiency and finance • Quality of care • Outcomes and well-being.
Strategic outcomes from our Strategic Statement	Strategic outcome 3: Older and vulnerable residents are safe and supported with choices to live independently.
Our vision for adult social care	To help people to improve or maintain their well-being and live as independently as possible.
Achieving our vision through three themes	• Promoting well-being • Promoting independence • Supporting independence.
What will make it happen?	• Protection (Safeguarding) • Workforce • Commissioning • Integration and partnerships.
Our values and principles	• Person-centred care and support • Supporting people to be safe • Shared responsibility • Prevention • Quality of care • Integration • Answering for what we do • Best use of resources.

3. Introduction

Over the last 10 years we have been transforming adult social care in Kent, as can be seen from the timeline (on the following page). This strategy replaces the previous 'Active Lives' strategy. Its development took into account the views of service users, providers and partners that had been gathered through our ongoing discussions with these groups. The vision and aims set out in this document strongly link with and support 'Increasing Opportunities, Improving Outcomes: Kent County Council's Strategic Statement 2015-2020' and the principles described in the 'Commissioning Framework for Kent County Council'. It is important to understand that this strategy sits between the council-wide strategies and other specific social-care group strategies such as the Learning Disability Joint Commissioning Strategy, the Strategy for Adults with Autism in Kent and Live Well Kent Principles for Mental Health.

What is the purpose of adult social care?

Adult social care is there to support people who need help with daily living so they can live as independently as possible in the place of their choice. The care and support that adult social care commissions (arranges or provides) is based on needs assessments of adults (including carers and young people during transition) who are supported using public money or pay for their own services. By transition we mean the process where young people with health- or social-care needs move from children's services to adult services.

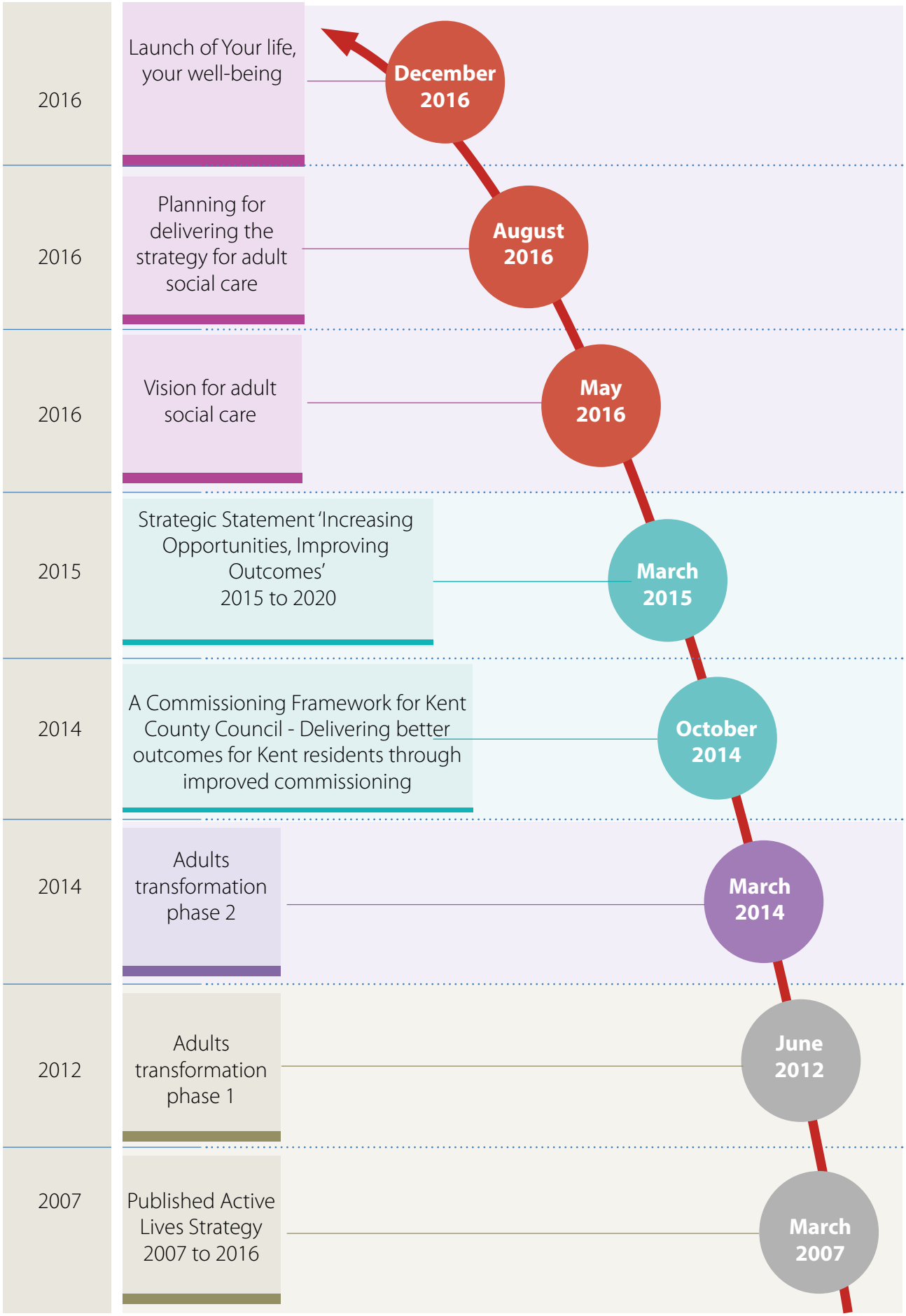
Keeping people safe is an important part of the legal obligations we must meet, and we take this very seriously.

The main responsibilities of adult social care are set out in three main pieces of legislation - the Care Act 2014, the Mental Health Act 1983 and the Mental Capacity Act 2005. As the overarching piece of legislation, the Care Act 2014 lays down new responsibilities and extends existing responsibilities, including:

- promoting well-being;
- protecting (safeguarding) adults at risk of abuse or neglect;
- preventing the need for care and support;
- promoting integration of care and support with health services;
- providing information and advice; and
- promoting diversity and quality in providing services.

Keeping people safe is an important part of the legal obligations we must meet, and we take this very seriously.

Timeline


2016
Launch of Your life, your well-being
December 2016
2016
Planning for delivering the strategy for adult social care
August 2016
2016
Vision for adult social care
May 2016
2015
Strategic Statement 'Increasing Opportunities, Improving Outcomes' 2015 to 2020
March 2015
2014
A Commissioning Framework for Kent County Council - Delivering better outcomes for Kent residents through improved commissioning
October 2014
2014
Adults transformation phase 2
March 2014
2012
Adults transformation phase 1
June 2012
2007
Published Active Lives Strategy 2007 to 2016
March 2007

4. Our vision and strategic approach to adult social care

While we are proud of our past successes, we believe that we must continue to do more to promote people's ability to improve and maintain their health and well-being, live independently, and cope well with deteriorating conditions. We will carry on putting the person at the centre of everything we do, offering a timely and integrated approach to care and support. In short, this is based on the central idea of focusing on 'a life not a service'. We have decided to use this approach based on consistent feedback that current models of support fit people into a narrow band of available services, whereas future support needs to be more personalised so people can achieve the outcomes that matter to them.

Our vision is 'to help people to improve or maintain their well-being and to live as independently as possible'.

This vision supports the delivery of some of our overall outcomes, set out in our Strategic Statement. In particular, it supports the following:

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

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
- More people receive quality care at home avoiding unnecessary admissions to hospital and care homes
- The health and social care system works together to deliver high quality community services
- Residents have greater choice and control over the health and social care services they receive

Strategic outcome – Kent communities feel the benefits of economic growth by being in work, healthy and enjoying a good quality of life.

Supporting outcome:

- Physical and mental health is improved by supporting people to take responsibility for their own health and well-being.

As well as supporting our wider outcomes, the delivery of the vision and strategy will link with the aims of our public-sector partners, including district and borough councils. We will continue to work closely with these partners to deliver our common aims to achieve the best outcomes for the people of Kent. Our strategy for adult social care over the next five years breaks our approach down into three themes, supported by four building blocks, as shown in the image over the page. The three themes cover the whole range of services provided for people with all kinds of social-care and support needs, and their carers, throughout their adult lives. Chapters 6, 7 and 8 explain our plans over the next five years for each of the themes, and Chapter 10 describes the building blocks.

Promoting well-being

This is delivered through services which aim to prevent, delay or reduce people's need for social-care or health support, by helping people to manage their own health and well-being.

- We will promote and build on people's strengths to help them look after themselves, stay independent and live a full life within their community.
- People will be able to make the best use of available resources such as information and advice and local support.

Promoting independence

This involves providing targeted support that aims to make the most of what people are able to do for themselves to reduce or delay their need for care, and provide the best long-term outcome for people.

They will have greater choice and control to lead healthier lives.

- We will promote independence by providing targeted support and adaptations such as community equipment, enablement and other assisted living technology, which are products designed to help people live independently in their own homes.
- Our aim will always be to achieve the best long-term solution for the person.

Supporting independence

This is delivered through services for people who need ongoing support and aims to maintain well-being and help people do as much as they can for themselves. The aim is to meet people's needs, keep them safe and help them to live in their own homes, stay connected to their communities and avoid unnecessary stays in hospitals or care homes.

- More people will receive care at home and stay connected in their community, avoiding unnecessary stays in hospital and care homes.
- We will change the way our services are commissioned and delivered to be more focused on achieving better outcomes for people.

We use case studies to help explain the three themes. These show how people's needs could be met through better use of existing support arrangements and new ways of doing things.

Four building blocks

To deliver the vision and strategy there are important building blocks that must be in place. They are:

- Making sure we provide effective management (with partners) to protect adults at risk of neglect or abuse and making sure staff are well trained and confident to carry out their duties.
- Developing a flexible workforce with the right skills to work across organisational boundaries, including having in place suitable and smooth care pathways (see below) for people.
- Commissioning and providing a range of flexible care and support services based on a strong understanding about what people need and what matters to them, setting the outcomes that need to be delivered, and deciding which organisation is best placed to deliver them.
- Improving the way we work with the NHS through integrated commissioning and provision to promote the well-being of adults with care and support needs, including carers to deliver the ambition of effective and efficient co-commissioning.

Care pathways
By this we mean an agreed plan for caring for and supporting people with a particular health condition so they can move smoothly between services. It is based on evidence about what works to treat and manage particular conditions.

Through these models of care and support, our aim is to:

- improve people's experience and promote their health and well-being;
- end the current crisis-driven model of care (a model of care is a way of providing care based on a set of beliefs and principles about what is right and works best);
- create a value-driven and outcome-focused culture that nurtures creativity and find new ways to meet people's needs;
- support people to access good-quality advice and information that allows them to look after themselves;
- create the right conditions which allow people to find solutions that support their well-being outside of traditional medical- or service-driven models of care and support;
- encourage community development and increase volunteering, befriending and good-neighbour schemes;
- support carers in their vital role by providing advice and individually tailored support;
- provide flexible and responsive models of care and support, including long-term care, that can increase and reduce in size as needed;
- free professionals up from rules and bureaucracy so they can 'do the right thing' and provide person-centred support that promotes well-being; and
- bring services together to make sure there is better communication and effective use of resources which will create a comfortable experience for people.

Prevention, support and managing the move for young people into adulthood

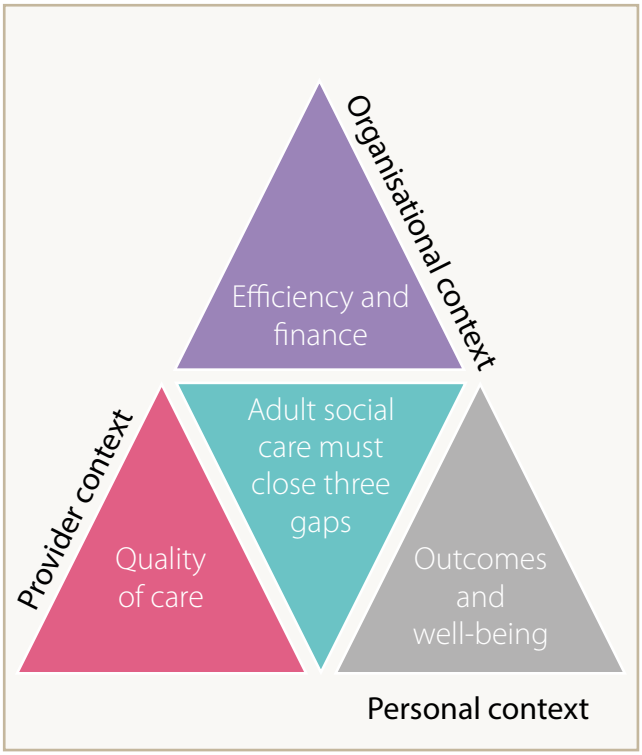
By prevention we mean any act that prevents or delays the need for people to receive care and support by keeping them well.

We recognise the importance of managing the move to adulthood for disabled young people receiving care and support. This can apply up to the age of 25. Our strategic outcome for children and young people is to make sure that they get the best start in life. So, it is vital

that we work with services for young people to make sure that they can have access to the appropriate preventative services as well as having the right links with health, education and housing. Getting this right should mean that we will be able to help young people to be with their families, until they can live independently (which will depend on their development needs).

Background

Like all councils, we are working within severe financial restrictions as well as seeing increased demand for services brought about in part by changes to the population. We know that this will continue for at least the next five years. We will measure our success by how well we manage to close three important gaps that are central to everything that we do. These are shown in the image below.



Organisational background (efficiency and finance gap)

It is great news that people are now living longer than ever. Nationally the number of people aged over 60 is expected to pass the 20 million mark by 2030 and within Kent, by 2026, the number of people who are 65 or over is expected to increase by 43.4%. Improved medical care and higher survival rates following illnesses and accidents also mean that we are seeing significant increases in the numbers of people with complex needs, including the number of younger people with long-term support needs. All of these changes are putting huge pressure on the adult social-care system.

National funding has not kept up with these increases in demand, with significant reductions in spending across services. In the last five years (since 2010) we have delivered over £433million of savings, around £80 to £90million each year, so the percentage of our total budget which is going on adult social care is rising. Where possible, we have made savings by redesigning services and passing funding to front-line services (staff or services who have direct contact with people who need care and support).

So that we can keep providing the services that people need, with reduced funding and increasing demand, we are becoming a commissioning authority. This means examining and reviewing the way we deliver services in partnership with the NHS, district councils and the private and voluntary sector, and looking at new ways of working to make sure that we develop the best services we can. This new approach involves working in a more joined-up way with our partners, including the NHS and providers of services. We will work with the people who use our services and their carers to produce changes in what is provided, where possible. The health and social-care workforce will increasingly work in a flexible way across organisational boundaries to deliver smoother care and support.

Provider background (quality of care gap)

Over 80% of our budget for adult social care is spent through the Kent care market, which is made up of around 500 providers of services in the public, private and voluntary sectors, employing over 40,000 people. We have significant buying power and this can help the economy in Kent to grow. However, the pressures on finances and demand are causing significant challenges for providers with many reporting that they are struggling to maintain their business, recruit staff with the right skills and maintain high-quality services.

As we move into delivering this strategy, we will need to look at our relationship with our main partners to see how together we can deliver what is needed in the most cost-effective way including using new models of care that are clearly based on outcomes. Like all local authorities, we have a duty under the Care Act to shape the local care market. As more people have control over their own care and support by being self-funders or through personal budgets, our role is increasingly focused on supporting providers to understand supply and meet demand.

Our relationship with the voluntary and community sector is changing, as reflected in our new Voluntary and Community Sector Policy. We will work with providers to help them become more sustainable, including by moving long-standing grants to contracts.

Personal background (outcomes and well-being gap)

The Care Act makes very clear adult social care's responsibilities for promoting the well-being of people with care and support needs in the local area. This includes those who pay for their own care. Our commitment to promoting the well-being of people in Kent is reflected in our Strategic Statement and Commissioning Framework. At the moment we know that we do not always make the best use of information

about the benefits our services are bringing to all the people who use them so that we can shape how services could be improved.

Well-being is defined very broadly in the Act and includes personal dignity, physical, mental and emotional well-being, protection from abuse and neglect and control over day-to-day life. We will continue to put the well-being of the person at the centre of everything we do. This means that we will listen and respond to the views and issues that are important to the person when working with them and use information more intelligently, such as identifying people at most risk.

We will also work with people who use our services to design them so that they meet their needs. This is known as co-production, We see a person's care and support as a shared responsibility between the person (and their carers and families) and public services and we will support people to take this responsibility as far as they are able to.

Outcomes for people are influenced by a number of factors including housing, education and lifestyle choices, some of which fall within our responsibilities in terms of public health. This is an area where we believe more needs to be done working with our health partners, district councils and local communities, to reduce health inequalities. By this we mean the differences in health between different population groups, for example, people from less well-off backgrounds tend to suffer from health problems more.

The carers of people with care and support needs (who might be family, friends or neighbours), play an essential role in the well-being of the people they care for and we recognise the important contribution that they make to society. We know that carers can experience significant negative effects on their finances, health (physical, mental and emotional) and employment prospects as a result of their caring role. As part of this strategy we will work with our partners to improve the lives of carers, as set out in Chapter 9.

How the strategy will be put into practice

This strategy explains our vision for adult social care over the next five years. We will deliver it through a wide-reaching programme which works across adult social care. The details of how we will deliver it will be set out in an implementation plan which we are developing for this strategy. In summary, this will include activity over the next 18 months around the following:

Scoping - in other words, defining the issues we are trying to tackle by identifying the span of the project, the resources and costs needed and producing a timeline

Assessment - this involves investigating the current delivery model and assessing against the proposed alternatives, supported by best practice. It means confirming the expected financial benefits and the changes needed to achieve the benefits . It also involves developing options to inform the next stage

Design - this means testing changes in specific areas and refining the expected financial benefits and, after changing the benefits, getting ready for putting into practice.

Implementation - this means putting changes into practice across Kent and monitoring the benefits and making sure that performance is consistent

Sustain - this involves closing the project and making sure that the changes continue as part of day-to-day work in adult social care.

5. Our values and principles

These values and principles guide everything we do to provide care and support to adults and their carers.

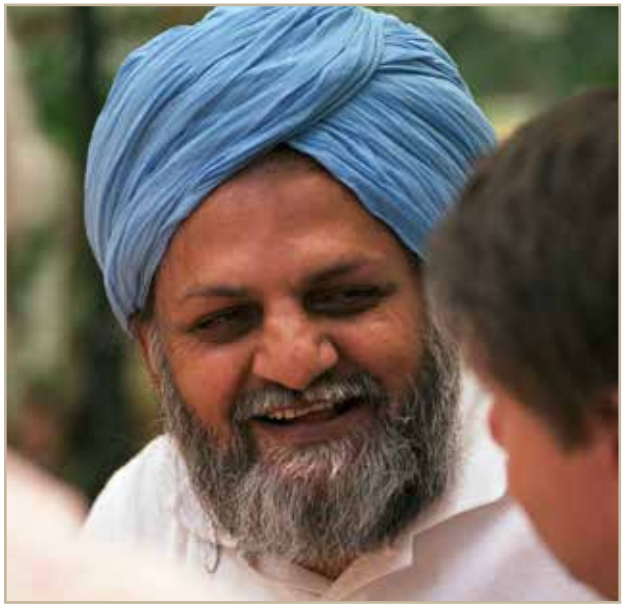
- **Person-centred care and support**
  We provide care and support that is tailored to the person so that they can achieve the things that matter most to them. This means putting the person at the centre of everything we do, supporting them to choose and control what care and support they receive. We will treat every person with respect and dignity.

- **Supporting people to be safe**
  Working with people to help them stay safe, including managing the risks of harm, abuse or neglect. This is central in everything we do.

- **Shared responsibility**
  Throughout a person's care journey we work with them and their carers to jointly design their care and support in a way that encourages them to do as much for themselves as possible, including taking responsibility for their own health and well-being and working with family members and carers.

- **Prevention**
  We work with our partners to provide advice and support to prevent problems getting worse. We aim to prevent, delay or reduce people's need for social care by helping them to maintain or improve their well-being and independence, or to cope better with conditions which are gradually getting worse.

- **Quality of care**
  We maintain and improve the quality of the care and support that people receive, no matter which organisation provides it, so that people receive the right support at the right time in the right place. We constantly look for opportunities to make improvements to the ways that people access our services and the ways we design and provide care and support, using information and feedback about people's experiences.



- **Integration**
  We aim to provide care that is 'joined-up' across organisations so that people do not experience duplication of services or delays in accessing support or fall between the gaps. We are open to new ways of doing things and we make the most of the strengths of all our partner organisations – from the public, private, voluntary and community sectors.

- **Answering for what we do**
  We answer to the people we provide care and support to, their carers and the whole community. We communicate clearly about our responsibilities and policies and we are honest and open about our performance.

- **Best use of resources**
  We make the most of the resources (money and our staff) we have available to promote people's well-being by focusing on the outcomes they want to achieve, including by influencing other organisations and the community. We use information intelligently to plan services that achieve outcomes in the most cost-effective way.

6. Promoting well-being

Providing the right response so people can manage their own need for care and support within their communities.

Many older and vulnerable adults are able to manage their care and support needs themselves and continue to live in their own homes and communities. However, to do this, they may need information and advice about the help that is available. This could include information on benefits, facilities available in the community, aids they can buy to use at home and outside, and advice on how to maintain or achieve a healthy lifestyle (what we can call 'well-being' services).

This type of early intervention aims to prevent or delay people from entering the formal social-care and health system, by helping them to manage their own health and well-being. Well-being services are based in local communities and use local resources. They help to prevent the issues that lead to people needing formal care and support, such as social isolation, falls and where the person's carer is not able to cope. Access to good-quality information and advice will be the cornerstone of our well-being services, helping people to identify and access the support that they want so they can keep on living fulfilled lives in their own homes.

At the same time as helping people to take more responsibility for their own health and well-being, we need to strengthen communities to support the vulnerable adults living in them. We need to support communities so they can better use their own assets and help each other.

How things are today

- Although there are various sources of support for people outside of the formal care system, it is not always easy to find out what is available locally and how to access it. Even GPs and other health and social-care professionals find it difficult keeping on top of all that is available in the community to support people's well-being.
- As a local authority we provide a range of useful information and advice in a number of places. But currently the system is broken up and it is not easy to access all of the information that a person may want or need. This is based on feedback from people stating that they have not always been told about support that exists in their communities.

How we want things to be in the future

By 2021 we want to have developed, with our partners, a wide-ranging information and advice system so that people can access all the information they need from wherever they ask for support. We also want to have significantly developed the community and voluntary sector to make best use of community resources and improve the range of support offered. We talk more about this in the integration and partnerships section of the Building blocks chapter in this strategy.

We will continue to make information and advice an important part of the 'community hubs' we plan to have across Kent. People will be able to get information about all the health and care services and activities in their local area and advice about living healthily and planning for future care needs.

Community hubs are a way of delivering health and care services locally. They are at the heart of our future strategy. The hubs will be a cluster of GP surgeries working together as one to provide quick, co-ordinated access to a wide range of services including therapies close to or at home.

We expect these hubs will be developed locally to reflect the needs in different areas of the county. The exact number of hubs is still to be decided. The aim is to improve the access and quality of care, reduce avoidable demand on hospitals (for example A&E departments) and provide better support in care homes. As a result they will help to reduce avoidable hospital admissions and care home placements in the longer term. They will be made up of the following typical services.

- GPs and paramedic practitioner services, which will support home visiting for those not able to go out.
- Integrated nursing and social-care services including home care, community and specialist nursing, occupational therapy, mental-health services, crisis care and palliative (end-of-life) care and support.
- Out-of-hospital services such as diagnostics and same-day treatment for minor illnesses and injuries.
- Prescribing medicines.
- Information and advice services to help with preventing health problems getting worse and promote good health.
- Support for carers in tackling their different needs.
- Access to voluntary and other community services including through social prescribing (see the definition on page 15).

We will make sure information and advice can be accessed through a variety of channels and formats, including, for example, advice lines, drop-in services, websites and health professionals.

We will make sure that when people ask for information or support services, all agencies either hold the information needed or know how to get hold of it.

We will greatly improve the information available to people who pay for their own care (self-funders) so that they are fully aware of all the options available to them and know which support is provided free of charge. This support includes assessment, enablement (helping people become more independent by gaining the ability to move around and do everyday tasks), and some equipment. It also includes information on what level of support people are likely to receive if it was arranged by us.

We will expand the use of 'care navigators', or other forms of community worker that we arrange using voluntary organisations. Care navigators give advice and information about what services are available in a person's area so that the person can choose to arrange the care and support that best meet their needs. Their role is to help people manage their own health and well-being by accessing local community-based services, aids and equipment, benefits and other sources of support.

We will continue to expand the role of 'trusted assessor'. These are people who have been trained to assess whether a person could benefit from simple aids and equipment or adaptations and take full advantage of new technology, to support qualified occupational therapists. We recognise that getting the right aids, equipment and technology can make a huge difference to a person's ability to stay independent and safe.

We will be looking at how medical and social-care professionals can use social-prescribing models more widely. An example of social

prescribing could be GPs prescribing a course of exercise classes rather than, or as well as, medication for someone with mild depression or anxiety.

Promoting well-being is also about encouraging and supporting people to live healthy lives, which has benefits for the person in the short term and can prevent a range of health problems in the longer term. Working with our partners, we will continue to promote public-health campaigns and programmes that encourage people to change their behaviour, such as taking more exercise, stopping smoking and attending health screenings that are offered. Well-being is also influenced by wider issues including housing, employment and education, and we will continue to work with partners to make improvements in these areas that will promote well-being.

Social isolation and loneliness can lead to ill health and we will be developing schemes which help people get together for mutual support, activity and fun. Keeping people connected helps to keep them well. We will work with the community and voluntary sector to make best use of our combined resources, encourage volunteering, befriending and good-neighbour schemes. Our focus will be on strengthening communities, making use of other social support networks where necessary to improve the range of support offered.

Case Study

George's story:
Promoting well-being in the future

George is 87 and, since his wife died two years ago, has been living on his own in the house he had shared with her for the previous 40 years.

Over the last year he has started to put on weight as a result of not walking as much as he used to when his wife was alive. This has also been due to the arthritis in his hips which has been slowly getting worse (but is not yet bad enough to need a hip replacement).

George generally manages to look after himself, but getting in and out of the bath can sometimes be painful and he often feels lonely and isolated. He has a daughter and son but they both live over 100 miles away and so only visit occasionally. His daughter worries that her father is becoming depressed. He doesn't want to move from his home or the area as he knows it very well, it is within walking distance of several shops and he does have some friends in the area that he sees occasionally.

George belongs to his local Neighbourhood Watch as do most people in his area. Recently they have decided to add to what they do by looking out for their more vulnerable members, including older people, like George, who live alone.

The local council provided some training for them and other local groups in recognising signs of social isolation, dementia and other problems among older people and also where to go for information and advice to help with these things. As a result, one of George's neighbours invites him for tea and suggests that he goes to or phones his GP practice which is now part of a community hub and can provide information, guidance and support to help people stay healthy and look after their own well-being.

As a result, George is given information on joining a befriending group organised by Age UK as well as information on joining his local University of the Third Age. This is a self-help organisation for retired and semi-retired people providing leisure, educational and creative activities which holds all sorts of regular group activities, including teaching people about using information technology to keep in touch with relatives. George also gains information on arranging for the appropriate equipment to be installed in his bathroom, which helps him to keep clean and manage his other personal needs. He also gets information on a scheme where a volunteer driver will take him, once a week, to see a friend who lives about five miles away.

George is encouraged to see his GP who advises him to go on a diet to lose weight. He also talks to the GP about his feelings of isolation and it is agreed he should return to see him after two months of taking part in the above activities to see if he has improved. The GP is concerned that George may be becoming depressed but decides to wait to see how the various activities help before deciding what to do next.

7. Promoting independence

Providing the right targeted action when it is needed and the right environment so people can care for themselves.

Not everyone who needs support needs it all the time. Some people only need help for a short period, either once or sometimes more often. This could be to help them get back on their feet after an illness or operation, to help them recover from a period of illness (physical or mental) or, if they have a carer, to give that person a break from caring.

Some people may need adaptations to help them manage without the need for formal support. This could include grab rails in the bathroom or the more sophisticated telecare services, for example to sense if someone has left the gas on or someone with dementia has gone missing from home.

People with long-term conditions (mental or physical) or disabilities may need training to help them be as independent as possible so they do not have to rely on formal care systems.

Our aim in promoting independence is to increase the availability of this type of support and to target it more effectively, at the right time, before a person's condition gets to the point that they need ongoing, long-term support.

How things are today

- There are already services in place to provide some of the short-term support needed and to promote independence in the home. This includes enablement services (both for those who have physical needs and those with a mental-health problem), which we currently provide to some people. However, we need to significantly expand this type of support.

Enablement services are provided to respond intensively for a short period of time to help a person get back their independence or to make significant steps towards being as independent as possible. They can help with physical problems, such as after an accident or illness when a person might need help getting out of bed, washing, dressing and so on. They can also help people suffering from mental-health problems who need an intensive period of support to help them regain their confidence or ability to interact with people and continue with what matters most to them such as work, study or family life. Help could also include aids, equipment and telecare. These services are available for a specific period of time, which can vary from a few days to a number of weeks.

- For several years we have provided telecare services to people we believe could benefit from them. For most people this involves using personal alarms that are triggered when help is needed (for example, after a fall, the bath being overfilled or the gas being left on). Telecare is an area of continual innovation and we need to do more to make sure we are making best use of the new technology becoming available.
- We have also tried to improve our referral, assessment and review practice to increase opportunities to make the most of a person's independence at every stage that we have contact with them. Rather than expecting a person to go on needing the same level of support for the rest of their lives, we are encouraging our staff to consider ways to reduce people's reliance on formal care and support. However, there is much more that we want to do.

How we want things to be in the future

By 2021 we want to have the systems and culture in place so that everyone we come into contact with is helped to be as independent as possible and this will be an ongoing process.

The starting point for all assessments will be to consider, with the person and any carers, what their specific goals are, what is important to them and what they would like to be doing that they cannot do at the moment. The above approach is supported by the Care Act which puts a person's well-being at the heart of the assessment. We will encourage people to make the best use of support from their own community, including voluntary organisations, as explained in the chapter on Promoting well-being.

Having considered what is important to someone, we will work with them to help them be as independent as possible and reduce, where we are able, the need to rely on the formal care sector. Clearly there will be some people who do need ongoing support and we will provide this when needed (see the section on Supporting independence), but we will provide much more targeted support for people at the crucial points when this is needed in the future.

Care and support, whether it is only short term or ongoing, will be co-ordinated from the community hub (see box on page 15). The hubs will provide access to equipment and assistive technology. We will look to combine occupational therapy services we and the NHS provide to improve access and remove the risk of duplication and variation in assessments and services. We will continue to develop the use of more sophisticated telecare and other technology and will work with professional organisations to increase the range of equipment on offer.

We will work on the basis that 'your own bed is best', and that in most cases people are more comfortable in their own homes and so recover and get their independence back more quickly if they can receive good-quality therapeutic support at home. If we get this right, it will reduce unnecessary stays in hospital and allow people to leave hospital as soon as they are medically fit to do so.

We will try to increase independence when we first make contact with a person and then continue to do this throughout the care journey. At every opportunity we will see if there is more that we can do to help people be independent. This will be done through assessing needs and responding to change. While continuing to review the support we provide in this way, we will also be sensitive to the fact that people need some certainty about the help they will be given. Because of this, we will make it clear that, while the aim of any support is to encourage independence and that some support might be short term, it can also be increased when needed.

Case Study

Ben's story:
Promoting independence in the future

Ben is 23 and lives with his parents who are in their 60s. He has always lived with them and has not had any experience of living alone.

Ben has fragile x syndrome (a genetic disorder linked to the x chromosome – one of the most common forms of inherited learning disability). He also has epilepsy, which is fairly well controlled with medication. Fragile x syndrome affects Ben in several ways.

Ben has attention deficit disorder and this and his hyperactivity have affected his ability to learn and hold on to information. While Ben can make himself understood, he gets very irritable quickly and this sometimes leads to aggressive and inappropriate behaviour. He can travel on his own on some simple routes but easily gets lost if he doesn't know the route well, or if the route changes.

Ben went to a special school until he was 19 and later a local college until age 21 where he was well-supported by the Additional Needs Unit in the college. He managed to get a certificate in basic computing and also gardening which is something he really enjoys.

He went to college for three days a week, and on the other two days he used some of his personal budget to pay for a support worker to go with him to a local garden centre where he carried out work experience. For the last six months of his college course he walked to the garden centre himself and stayed there on his own without his support worker. He was helped to do this by having a GPS locater on his wrist which would alert certain people if he got lost on the journey to and from the garden centre.

Towards the end of his time at college several meetings were held with Ben, his family and the main professionals involved in his care. Ben got a part-time paid job at the garden centre. He used his personal budget for short-term support from a support worker, who also helped him when he had to learn new tasks and went with him to a local club for all abilities on Saturdays. He has made friends at work and now calls on his support worker less and less.

Ben has recently said he would like to live with friends in his own flat. He and his parents are also keen that he moves into his own place. Jane, Ben's mother and carer, is finding it increasingly tiring supporting Ben and she doesn't like to leave him alone in the house for more than about an hour.

Ben and his family have started to look at options for independent living, including living in a shared house with other people with learning disabilities and on-site support if needed. He is spending short periods in one of these units to see how he gets on, which gives his parents a break. He has also gained new skills through support from the Kent Pathways Service.

As a result of the support being offered to Ben, his mum's situation as a carer has been helped. Jane has been given a personal budget and can use this in a way which best meets her needs to ease the stress of caring. She has also joined a local carers' support group.

8. Supporting independence

Providing effective ongoing support

Supporting independence is the final part of our strategic approach to adult social care and is aimed at those who need ongoing care, whether at home or in a residential setting. It aims to meet people's needs while allowing them to live in their own homes where possible, stay connected to their communities and avoid unnecessary stays in hospitals or care homes. Supporting independence is delivered though services that aim to maintain individual well-being and keep people safe, help people do as much as they can for themselves and allow people to live and be treated with dignity.

How things are today

We have a health and care system that is not responsive enough. This can unintentionally lead to people becoming more dependent on services than they need to be, which does not always lead to the best outcomes for them.

- The system is not always flexible enough to respond to changing needs, which can result in providing too much or not enough care.
- In spite of the progress on joining up health and social-care services across Kent, there are still areas where duplication of services could be avoided, more information could be shared and services could be better designed to provide more effective care.
- We need greater choice and availability of other accommodation options rather than long-term residential and nursing care. We need to work with partners to develop other options such as Extra Care housing and specialist accommodation for people who have dementia.
- Young people with disabilities and ongoing care needs can experience a lack of connection between children's and adults' services as they grow up. We have started to manage this by bringing together our services for disabled children and adults, but there is more to do.

We are developing new models to provide more independent living options in the community, including **Your Life Your Home** which aims to move adults with learning disabilities out of residential care, and **Shared Lives** which provides supported placements for adults with care and support needs within a family home. At the moment these new models are helping a small number of people with ongoing care needs.

- Currently we spend about £7million a year jointly with the NHS to provide support for carers whose health and well-being is affected by their caring responsibilities. The assessments and services provided are good quality but there are long waiting lists for some support such as sitting services to provide respite (a break from caring).

How we want things to be in the future

We will always make sure that people who need ongoing care and support receive it, while at the same time working with people to help them do as much as they can for themselves. By joining together health and social-care services in Kent, people who need ongoing care will receive personalised care and support that is focused on helping them achieve the outcomes that are important to them. More people will receive care in their communities or, wherever possible, in their own homes.

People who need the most intense and specialist care will be admitted to hospital or residential care, and the emphasis will be on moving people back to the community if they are able. For those people who do need to live in residential accommodation (which includes group homes, care homes, Extra Care housing and other types of residential accommodation), ongoing care will be designed, paid for and delivered to keep them as independent as possible.

Working with the person and their carer, all the professionals who are involved in providing care to the person will assess their needs and share their records meaning there will be no duplication or gaps and the person's mental capacity will be taken into account (following the Mental Capacity Act). (Mental capacity deals with a person's ability to make decisions for themselves. The law says that a person may lose their right to make decisions if this is in their best interests).

People with more intense and complicated ongoing needs will have one professional who will lead on coordinating their care and build a team of support for the person. They will be the first point of contact for them and their carers. Information, advice and guidance will be available at the right time for everyone to support people in making decisions about their care.

The services provided in the community hub will be flexible enough to adapt to a person's changing needs immediately and step up or step down the intensity of care they are receiving. Services will also be able to work together to identify people who might be at risk of becoming more unwell and offer support before a problem happens. All the organisations involved in providing care and support will be spending their money with the aim of achieving the same outcomes, improving the care we are able to provide to people with ongoing needs.

Bringing health and social care together will mean that people will be able to access a joint health and social-care personal budget where appropriate, giving them choice and control over all of their care. People will be supported to get the best use from their personal budgets to meet their needs. There will be a wide range of quality care and support services for people to choose from.

For young people with ongoing care and support needs, services will be as smooth as possible as the person moves from being a child to an adult, so there will be no need for specific support over that period. For example, throughout their life, people with autism and attention deficit hyperactivity disorder (ADHD) will be cared for and supported along the right pathway that is understood and followed by all the services involved. This will bring together psychological, social and medical assessment and support so the person receives care that meets all of their needs and is consistent as they move from childhood to adulthood.

If people need care at home to help them with daily living, this will be focused around supporting the person to achieve the outcomes that are important to them, rather than being based on specific tasks. Over the next five years we will develop more home care that is nurse-led. This will bring together nurses from the NHS with the home-care providers we pay to provide services. This means that people will receive homecare that responds to their needs for social care and health care and can provide specialist care at home.

We will routinely use technology to help keep people safe and maintain their health and well-being at home. We will continue to work with our providers to identify and, where helpful, put into place cutting-edge assistive technology. We will also make better use of technology to help people keep in touch with loved ones and stay connected with their community and the things that matter to them.

The aim is for fewer people to live in residential or nursing homes because there will be an improved choice of accommodation options that allows people with ongoing care needs to have their own homes. We will work with our partners, including district councils, to arrange accommodation in the right areas. There will be specially designed housing to meet the needs of people with ongoing care including people with mental-health problems, learning disabilities, physical disabilities and autism. Housing options will be available for young people to support them through the move into adult life and independence. We also hope to increase the amount of Extra Care housing available. Accommodation will have assistive technology built in, which uses telehealth and telecare. Options like Shared Lives will continue to be developed and will be available across the county where this best meets the needs of the person.

More people with ongoing care and support needs will stay in or enter education, training and employment. This is important to people's well-being and can help people keep or regain their confidence and independence and improve their health. The support we provide will be tailored according to the person's goals, strengths and situation. For people with ongoing mental-health problems, supported employment or education will be linked to their clinical treatment to support their recovery.

People with ongoing care needs will be able to access a range of activities in their local community to keep them active and doing things they enjoy. We will have a new model for day-care services that provides activities and opportunities that people with ongoing care needs want and that is of consistent quality across the county. We will work with providers, including in the voluntary and community sector, to build and maintain the market so people can access the day activities they want, when and where they want them.

For people who need to be in residential care, services from the community will go into care and nursing homes to provide specialist support to residents and to help staff develop skills and confidence. This will include enablement and rehabilitative care services and nurse-led home-care services coming into care homes and using assistive technology. The community hubs will also aim to promote activity that involves care-home residents in their local communities.

Extra Care housing is designed for people who need care and support to help them live their daily lives. People who live in Extra Care housing have their own homes with their own front doors. Homes are usually provided as a block of flats or houses built together. Support such as personal care and help around the home is available from on-site staff. Extra Care housing usually includes facilities for people who live there, for example, a restaurant and health and fitness facilities.

Case Study

Anita's story:
Supporting independence in the future

Anita is 59 with a degree in French. She was born with cerebral palsy and uses a walking frame to get around but this is becoming more difficult. Later in life she has developed diabetes, and due to problems with her eyesight brought on by this condition, over the last year has had to stay in hospital frequently. Anita needs support with daily living, including her personal care, cooking and help around the house. Up until recently she has been able to manage living on her own, in her own home, with visits from a home-care worker every other day. However, she has started to struggle to cope being on her own in the house between home-care visits and is in need of some further adaptations to her house. She also now needs support a couple of times a day to help manage her medication and monitor her blood-sugar levels.

As Anita has complex ongoing conditions, she has been allocated a care co-ordinator from her local community hub. This is the person leading the planning of Anita's care and support. Anita's care co-ordinator, James, meets with Anita to understand what is important to her, how she would like to live her life and the goals she would like to achieve. James has access to all of the assessments and records that the different health, and social-care professionals who have been involved in Anita's care and support have made. Based on this and what Anita has told him about her goals, James brings together a team of health and social-care professionals with the right skills to support Anita, including her GP, her community nurse with diabetes specialism, home-care worker and occupational therapist. Together they create a plan for Anita's care and support.

It is important to Anita that she has her own home with her own front door that she can stay in for the foreseeable future, but she also now needs a higher level of support. She is offered a home in a new Extra Care housing development that has just been built in her town. The on-site staff have caring and basic nursing skills and so can help Anita with her medication. Her new flat is completely accessible for her walking frame and a wheelchair. Telecare sensors are already installed that help to keep Anita safe while she is on her own in the flat, and she wears an alarm that she can press to call the on-site staff for help in an emergency. The flat also comes with telehealth technology, which Anita uses to monitor her weight and blood sugar and send this information to her nurse and GP so they can help her manage her blood sugar levels and act quickly if there are any signs that problems may be developing.

James and the team of professionals continue to monitor Anita and adapt her care and support plan as needed. If Anita needs some medical treatment, this is planned and all of the team know so they can arrange any extra support she might need afterwards. Anita now feels that she has regained her sense of independence and feels confident that she has the support she needs to keep safe and well. Since moving to her new home and the start of her new care and support plan, Anita has only had to stay in hospital in an emergency once, which is a huge improvement.

9. Supporting carers

We recognise that the vast majority of care is provided by relatives and friends. Making sure those carers are supported in their role is a critically important part of this strategy as supporting carers is one of the most effective way of achieving our overall vision – so people can improve or maintain their well-being and live as independently as possible.

We will continue to work with carers' organisations in Kent to help identify and assess carers who could benefit from support. The age profiles of carers show that they are getting older and the overall number of carers is increasing. Many carers may be reaching the point where their needs may change so they may not be able to carry on. We recognise that this may lead to an increase in demand for services that support carers.

Over the next five years we will work with carers to develop a new set of services and support for them. The new services will provide support for carers in all areas of their life that are affected by their caring responsibilities, helping them to achieve the things that are important to them.

This should allow them to continue their caring role and also protect their own health and well-being, something which the Care Act puts at the very centre of care and support . This will also apply to carers who care for someone who is not receiving formal care and support.

We will continue to expand the use of personal budgets for carers of people with ongoing support needs. This will allow carers to choose and control the support they receive to best meet their needs and preferences.

We will also help carers by providing the right sort of support for the person or people they care for. Support for carers will be part of the community hub model described earlier, meaning that they are fully joined up with all of the care and support that the person they care for is receiving. This will allow information to be shared and support managed together for the person with ongoing care needs and their carer, leading to better care for both.

The team of professionals involved in providing care will respect and value the skills, knowledge and commitment of carers of people who need ongoing care.

10. Building blocks

To deliver the vision and strategy there are important building blocks that must be in place. These are shown below.

- Protection (safeguarding)
- Workforce
- Commissioning
- Integration and partnership

Protection (safeguarding) - 'keeping you safe'
We have no greater duty than to help people exercise their right to live safely and we take our legal responsibilities in this area seriously. In carrying out our safeguarding duties, we aim to stop abuse or neglect wherever possible; prevent harm and reduce risk of it happening and allow adults at risk to have choice and control in how they live their lives. We recognise that adults may need protecting from many forms of danger that can affect their safety. It is part of our main business to work with other partners to take necessary action to protect adults who may be at risk of abuse or neglect, whether they live in their own homes or in care homes. We consider our protection and mental capacity responsibilities as one of the building blocks or foundations which form the backbone of our vision and the strategy.

It is important that our protection work puts the outcomes a person wants at the centre of our action and, where possible, we take action before a vulnerable person is harmed. This approach is in line with the principles of the national guidance on 'making safeguarding personal'. We know that taking effective action works best where we work with communities in helping to prevent or report incidents of abuse or neglect.

As a member organisation of the Safeguarding Adults Board, we will continue to promote the principles that rightly govern how protection should be treated and carried out.

- It is every adult's right to live free from abuse in line with the principles of respect, dignity, autonomy (being able to control their own actions), privacy and equity (fairness).

- All agencies and services should make sure that their own policies and procedures make it clear that they have zero tolerance of abuse. In other words, they will not put up with it at all.
- We will give priority to preventing abuse by raising the awareness of adult-protection issues and by fostering a culture of good practice by providing support and care, commissioning and contracting.
- Adults who are vulnerable or subjected to abuse or mistreatment will receive the highest priority for assessment and support services.

To continue to do this work well, we need to have competent and confident social-work staff who have the necessary skills and tools to do their jobs. Importantly, it will be expected that staff use an 'asset-based' approach, which is focused on what people can do, to identify the person's strengths and use meaningful community networks that can help them and their family in making difficult decisions and managing complicated situations.

We also recognise that we share these protection responsibilities with other partners and providers, the NHS, the police and the

community in general. To this end we will work to make sure that the collective roles and responsibilities are clear and continue to build on the already strong multi-agency framework in place for protecting vulnerable people. This means not only promoting strong multi-agency partnership working but also making sure we provide a supportive learning environment. By doing so we aim to break down cultures that are afraid of risk and clarify how we will tackle responses to protection concerns from poor-quality care or inadequacy of services and issues of safety of the person.

Workforce - 'getting the people right'

Without the right health and social-care workforce, we cannot deliver anything in this strategy. The Kent social-care market employs over 40,000 staff, most of whom are employed by private, voluntary and independent sector providers. The workforce needs to be appropriately skilled and competent to meet local needs, be sustainable and flexible. Staff will need to put outcomes for people first, and their performance will be assessed against this rather than a task-based approach. When we refer to 'workforce' in this document, we mean all staff who work in and deliver care and support services in the public, private, community and voluntary sectors.

Delivering tailored care that focuses on supporting people to achieve their outcomes will involve some changes to the skills, working practices and culture of the social-care workforce. We will make sure our staff and staff in partner organisations have the skills and knowledge needed so that people can have as much choice and control as possible. The emphasis will be on what works best to meet a person's outcomes, rather than what services are available that we can fit a person into. So we will encourage staff to be imaginative in the solutions they develop. People who provide care will take a new and creative approach in supporting people to maintain their independence. This will include the ability to design services alongside those receiving them and others involved in providing services.

It also involves a sophisticated understanding of people's right to choose to take risks so they can lead the lives they want.

Currently, the social-care sector is experiencing many challenges – one in five social-care workers is aged 55 or over, each year there is a high turnover of staff in some roles and recruitment and retention can be difficult particularly in some areas of Kent. Given this pressure, levels of training, skills and status are falling compared with other professions. We need to give more attention to the kind of job roles available and how career pathways are designed to meet the changing needs of the service, and the people it will help and serve.

Social care and health will increasingly work together so staff will need to work across organisational boundaries, which will help reduce current duplication in assessments and other activities. We will need to support changes in culture so we can achieve this and support staff to make the best use of digital technology to share information appropriately between partners and as a tool for those receiving social care. If the team is to work as one, the planning and management of the workforce needs to take a whole-system

approach. We are working with the NHS on developing our workforce to be ready for the future, and some of our agreed priorities include the following:

- Existing and emerging gaps – identifying where we currently have a shortfall in the workforce we need and where we are likely to have a shortfall in the future, including succession planning (finding and developing people with potential to move into important roles in organisations)
- New models of care – making sure that, as new ways of delivering services are developed, the right workforce will be available to deliver them
- Recruitment and retention – making sure that Kent can recruit the people it needs and, once it has done so, keep hold of them
- All this will need a shift towards focusing on the skills needed by a given workforce rather than how many of a particular staff group are needed. Care and health professionals will work as a team with colleagues from a range of other organisations and sectors as equals. Where appropriate they will take a co-ordinating role, managing the contributions of a range of professionals to meet a person's needs. We will develop specialist roles where needed and they will play an important part in the care and support team for people with complex ongoing needs.

To achieve this, we must treat the health and care workforce as one. We have already begun this process and examples include integrated discharge teams in all Kent and Medway hospitals to support roles that bring together health-and-social-care skills, joined-up working and a better career path. We have also introduced nurse-led outcome-based domiciliary care in a group of GP practices in Whitstable (Vanguard). These practices use new models of care which offer a more attractive career path for domiciliary care workers and blended roles with health-care assistants. This will also provide opportunities to train professionals who have traditionally worked in either social care or health so that they can meet all of the ongoing social-care and health needs of the people they care for in their own homes. This could include training home-care workers and carers to carry out medical procedures such as giving insulin injections to people who would otherwise also need a daily visit from a nurse.

We are using analysis of long-term hard-to-recruit professions to help us plan future care so that we move away from relying on locums or overstretching the current workforce. We are currently developing a strategic workforce action plan for health and social care together.

Commissioning - 'arranging services'

Driving our strategy forward is a new approach to commissioning – in other words, deciding what kinds of services should be provided to local populations, who should provide them and how they should be paid for. Traditional commissioning often involved paying for certain activities to be carried out by a provider and this left little room for the specific needs of an individual to be taken into account. An outcome-based approach identifies what outcomes matter most, and payment to providers depends on achieving the outcomes and is not simply based on activities. Under this model, there is an incentive for different providers across health and social care to work together to achieve outcomes. Prevention activities are also given a clearer priority than is currently the case.

As we move towards becoming a commissioning authority, we will be in a good position to adopt this model, and will do so by working with the NHS. Clinical commissioning groups and NHS England are also shifting their approach to commissioning to an outcome-based approach. When this is done jointly, the entire assets of a community or neighbourhood can be considered and made best use of. Where a good community network or organisation exists and can contribute to achieving the outcomes of this vision, it will be able to play its part and benefit from this approach. This

could be from the voluntary or community sector, or from a wider range of providers and public-sector organisations than currently delivers services for health and care. We recognise that making the shift from the current way of working to the future outcome-based commissioning approach will be a challenge for commissioners and all providers. It will also involve having appropriate IT systems in place, capturing and analysing information and tracking and monitoring quality.

In many cases, as direct payments and personal health budgets continue to develop, the person will be able to choose which services are provided.

Focusing on outcomes means that we, as commissioners, will have better information as to what does and doesn't work. This will mean that services improve steadily over time as further investment is directed to those services that work and away from those that do not contribute to the outcomes. Our role as commissioners will be to see how the market is delivering and decide how best to tackle any gaps in quality. This will support us in fulfilling our market-shaping responsibilities under the Care Act. Market-shaping responsibilities are where we look at what care and support needs people have in the local area and consider what services are available – working out where there are any gaps and how they can be filled.

The changes planned mean that we will need to develop new and effective ways of monitoring and managing contracts to achieve the best value for money from the resources we have available. The changes may include looking at new commissioning arrangements across both health and social care.

Increasingly our commissioning will be led by 'care pathways' for defined groups of users with similar characteristics and needs, for example young adults with long-term care needs or older people with dementia. We will be clear on our overall commissioning responsibilities

and approaches, which consider the needs of the whole population, and which are different from place-based commissioning to meet local needs.

Integration and partnerships - 'working together'

Kent has a good track record of health and care working together in partnership. It was one of the original 14 Integration Pioneers named in 2013 and this has continued through the Better Care Fund and the current Sustainability and Transformation Plans (STPs) which are to be the plans for delivering the NHS Five Year Forward View. The Five Year Forward View and the STPs give a name and framework to what Kent had already been moving towards. This involves approaching the health and care of the population as a whole system and breaking down barriers between sectors and organisations where they get in the way of better care and support.

This shift is necessary both to deliver the quality of care we want to see the people of Kent receive, but also to make sure that the finances of health and social care are secure. In spite of this strong track record of partnership working, there are some barriers that we must work hard to overcome, such as a lack of common

language, different culture of practice and shared priorities, multiple IT systems, different performance frameworks and budget cycles. These all combine to make what we want to achieve more difficult at the current time. Our vision for adult social care is built on existing work with social-care professionals, clinicians, carers, the public, and other partners in developing possible new models of care for the future. As a result, our visions is part of the broader process of joining up health and social care.

The new approach to commissioning is helping to develop a number of new models of care in Kent as set out in the Five Year Forward View. Particularly relevant to this vision for social care is the development of multi-specialty community providers (MCPs). These MCPs bring together GPs, nurses, other community-health staff, social-care, mental-health and acute hospital staff and services together to create fully integrated out-of-hospital care. At the heart of this are the 'community hubs' already discussed.

To deliver our ambition to work more with NHS services to provide smooth care and support will mean we need to overcome some substantial challenges including:

- finding the money to invest in the changes, including creating the 'community hubs';
- sharing information, which is vital for high-quality, integrated care, but must be carefully managed in ways that keep to the Data Protection Act 1998 and various other laws;
- finding incentives and targets that work across health and social care, given the different audit systems and payment models which can result in conflicting interests, and problems in agreeing how evaluation will be measured; and
- differing workforce practices. These range from different employment terms and conditions through to different organisational cultures and attitudes.

We will work through these challenges with our NHS colleagues and we will work together on effectively planning for and managing our buildings (including through One Public Estate). For example, delivering services out of hospital that would have previously been delivered in hospital will need access to digital technology to support remote consultation, diagnostics and virtual multi-disciplinary teams (remote consultation is when professionals give advice about a person's care and treatment without the need for a face-to-face visit. A virtual multi-disciplinary team is a group of staff who are members of different professions work from different locations and who each provide specific services to the person.)

Private and voluntary-sector organisations that provide social care and support will need to work more flexibly in future, putting the needs and outcomes of the people they support at the centre of their services. To support this approach, our contracts with providers of care will be focused on outcomes. We will ask providers of services, including homecare, to show how they are helping to achieve outcomes for the people they care for (for example, to help a person regain their independence following an operation, or to reduce social isolation), and we will reward them as a result. This is in contrast to many

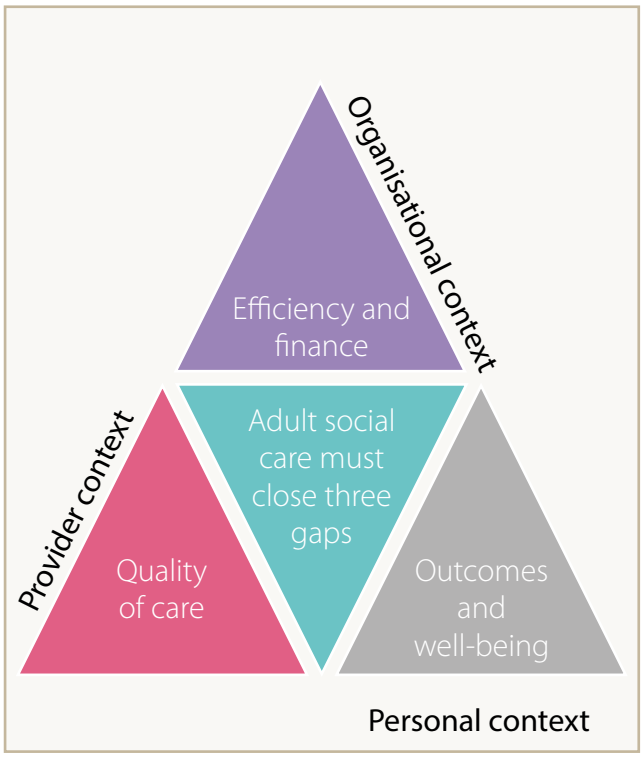
current contracts that reward providers according to the time spent with a person and the tasks carried out. As a result, partners will need to be flexible and responsive enough to meet the challenge of working with commissioners, and being commissioned on an outcomes-focused basis.

We will work with providers to increase and maintain the market in areas where we need greater choice and availability of services for people with ongoing care needs. This will include community activities and opportunities to help people keep active and involved in things they care about and enjoy. Working with providers, there will be an improved range of accommodation options to allow people to continue to live in the community including Extra Care and supported housing to meet specialist needs.

We will continue to work with the voluntary and community sector (VCS) who will play an even more significant role in supporting people's independence and well-being. We will continue to support the sector so it can cope with the changing and increasing demands for care and support in the communities that it works with. The way in which we want to work with the VCS in the future is set out in our Voluntary and Community Sector Policy. This sets out our commitments to support the VCS both to respond to communities' needs and as a key partner in delivering services on our behalf. To achieve this, we want to continue to build an ongoing, two-way dialogue with the sector, provide infrastructure support that is flexible and responds to the sector's needs, and be clearer about funding. Some of the more specific things we want to do to support the proposals in this strategy include encouraging new enterprises (for example, befriending schemes) and working with existing organisations to help them expand to new areas (for example, Neighbourhood Watch schemes, allotment societies and so on).

11. Monitoring our performance

As explained in the Introduction, this strategy explains our vision for adult social care over the next five years and we will set out the full details of how it will be delivered in an implementation plan which we are developing for this strategy. It is important that we understand the difference that we are making through delivering the vision and strategy. Our success will be measured by how well we manage to close the three important gaps that are central to everything that we do.



We will monitor performance by looking at outcomes. This will include existing methods for monitoring performance plus the experience of people who use our services, including using the following:

- Measures of success – a one-page activity, finance and performance information report used by adult social-care managers on a monthly basis to keep track of progress
- Progress on our transformation programme – a report produced for the Adults Portfolio Board and our members to account for progress against the priorities in the transformation implementation plan already mentioned
- Local Account – an annual public report of how well adult social care is doing, produced with people who use our services and their carers, main partners and staff
- Corporate & Directorate performance management – a wide-ranging report for our members and senior management produced on a regular basis which the public have access to
- User surveys – surveys of people who use our services, and their carers, on their views on outcomes and experience of services
- Deep dives – an in-depth examination of the main service areas with the aim of improving service delivery
- CQC – service quality and other information put together by the Care Quality Commission, the independent regulator of health and social-care services
- KCC Strategic Statement Annual Report – an annual report on adult social care's contribution to achieving our strategic objectives which is produced with input from our partners
- Health and Well-being Board – a report on adult social care's contribution to the progress on outcomes in the Joint Kent Health and Well-being Strategy and this strategy
- Health Watch - through independent monitoring of how well health and social care services are being provided.

Kent County Council
Social Care, Health and Well-being
Invicta House
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Maidstone
Kent
ME14 1XX

From: John Simmonds, Cabinet Member for Finance & Procurement and Deputy Leader

To: County Council – 8th December 2016

Subject: Appointment of External Auditors for the 2018/19 accounts and beyond

Classification: Unrestricted

Summary: Following the abolition of the Audit Commission the Council will need to adopt a process for appointing an external auditor for the 2018/19 accounts and beyond. The Local Audit and Accountability Act 2014 (the Act) provides for 3 options for this appointment process and they are summarised below:

1. The Council establishes its own independent auditor panel.
2. The Council establishes a joint independent auditor panel with other Local Authorities.
3. The Council resolves to become an opted-in authority, allowing a sector led body or appointing person to appoint an external auditor on behalf of the Council and other opted-in authorities.

The Governance and Audit Committee has reviewed these options and has resolved to recommend to the Council that a sector wide procurement be pursued by an appointed sector led body. This body is Public Sector Audit Appointments Ltd (PSAA) operated by the Local Government Association (LGA).

The Act requires the decision to become an opted-in authority with a sector led body to be taken by the full Council.

Recommendations:

County Council is asked to:

a) NOTE the changes in the external auditor appointment process following the Local Audit and Accountability Act 2014.

b) NOTE the options available to the Council for the appointment of an external auditor for the 2018/19 accounts and beyond.

c) RESOLVE that the Council opts-in to a sector led body (PSAA Ltd) to appoint external auditors for five financial years commencing 1st April 2018.

1. Background

- The Local Audit and Accountability Act 2014 (the Act) brought the Audit Commission to a close, which was previously responsible for the appointment of external auditors for all local public bodies.

- Transitional arrangements introduced by the Act allowed auditors and Local Authorities to continue the contracts originally let by the Audit Commission, with external auditor appointments being made instead by Public Sector Audit Appointments Ltd (PSAA), an independent, not-for-profit company established by the Local Government Association (LGA).

- Transitional arrangements introduced by the Act will come to an end on 31st March 2018, and public bodies are required by legislation to have appointed new external auditors for the financial year beginning 1st April 2018 by the 31st December 2017.

- The Council's current external auditor is Grant Thornton, with audit fees of £155,925 per annum. There is a risk that fee levels could increase when the current contract ends in 2018.

2. Options for local appointment of external auditors

- The Act set out the arrangements for the appointment of external auditors for the 2018/19 accounts and subsequent years, with the opportunity for authorities to make their own decisions about how and by whom their auditors are appointed.

- There are three broad options open to the Council under the Act and these are detailed below:

Stand-alone appointment

- In order to make a stand-alone appointment the Council will need to set up an Auditor Panel. The members of the panel must be wholly or a majority independent members as defined by the Act. Independent members for this purpose are independent appointees, and excludes current and former elected members (or officers) and their close families and friends. This means that elected members will not have a majority input to assessing bids and choosing which firm of accountants to award a contract for the Council's external audit. A new independent auditor panel established by the Council will be responsible for selecting the auditor.

- The principal benefits or advantages from such an approach are:

    - Setting up an auditor panel allows the Council to take maximum advantage of the new local appointment regime and have local input to the decision.

- The principal risks or disadvantages from such an approach are:
    - Recruiting to and maintaining the Auditor Panel, running the bidding exercise and negotiating the contract is likely to be resource intensive.
    - It is not evident whether there would be sufficient availability of suitable local independent members to form an effective independent Auditor Panel.
    - The Council will not be able to take advantage of reduced fees that may be available through joint or national procurement contracts.
    - While this option maximises local input, elected members or Council officers will not have a majority input in the appointment process.

Joint auditor panel appointment

- The Act enables the Council to join with other authorities to establish a joint auditor panel, which will also need to consist of a majority of independent members (or wholly of independent members), and must be chaired by an independent member.
- The principal benefits or advantages from such an approach are:
    - Setting up a joint auditor panel will allow the Council to have local input to the appointment decision.
    - The costs of setting up the panel, running the bidding exercise and negotiating the contract will be shared across a number of authorities.
    - There is greater opportunity for negotiating some economies of scale by being able to offer a larger combined contract value to external audit firms.
    - A larger procurement arrangement also reduces the risk of a lack of competition in the procurement process.
- The principal risks or disadvantages from such an approach are:
    - Further legal advice will be required on the exact constitution of such a panel having regard to the obligations of each Council under the Act.
    - This option is dependent upon the co-operation and partnership of a number of local authorities, and there may not be an appetite from other local authorities in adopting this approach.

- While this option still allows for local input into the appointing decision, this local input will be completely independent of the Council and will be influenced by panel members from other authorities.

Opt-in to a sector led body

- Regulations made under the Act allow authorities to 'opt in' for their auditor to be appointed by an 'appointing person', also known as a sector led body. A sector led body would have the ability to negotiate contracts with external audit firms nationally, maximising the opportunities for the most economic and efficient approach to procurement on behalf of the whole sector.

- Under the legislation this route can only be adopted if approved by the County Council.

- In July 2016 PSAA were specified by the Secretary of State as an appointing person under regulation 3 of the Local Audit (Appointing Person) Regulations 2015.

- As at July 2016, the LGA had received informal expressions of interest from over 200 authorities in favour of opting into a sector led body, which included all of the local authorities in Kent.

- The principal benefits or advantages from such an approach are:

  - The audit costs are likely to be lower than if the Council sought to appoint locally, as national large-scale contracts would benefit from economies of scale.

  - The overall procurement costs would be lower than individual or smaller scale procurement exercises.

  - The overhead costs for managing the contracts will be minimised though a smaller number of large contracts across the sector

  - The practical difficulties in establishing and maintaining an independent auditor panel or joint auditor panel with other local authorities would be by-passed.

  - PSAA will ensure the appointment of a suitably qualified and registered auditor and will monitor contract delivery and ensure compliance with contractual, audit quality and independence requirements.

- The principal risks or disadvantages from such an approach are:

  - Individual elected members would have less opportunity for direct involvement in the appointment process other than through the LGA and/or stakeholder representative groups.

- Final contract prices will be unknown at the point of the decision to become an opted-in authority with the PSAA.

3. Additional information

- The scope of the external audit undertaken each year will still be specified nationally by the National Audit Office (NAO), which is responsible for writing the Code of Audit Practice which all local authority external audit firms must follow.

- Not all audit firms will be eligible to compete for the work. Only those that can demonstrate that they have the required skills and experience and be registered with a Registered Supervising Body approved by the Financial Reporting Council will be eligible for appointment. This means that procurement exercises undertaken from each of the aforementioned options would seek tenders from the same pool of firms, subject to the need to manage any local independence issues. The below firms are currently eligible for appointment:

    - BDO LLP
    - Deloitte LLP
    - Mazars LLP
    - Ernst & Young LLP
    - PricewaterhouseCoopers LLP
    - KPMG LLP
    - Grant Thornton UK LLP
    - Scott Moncrieff
    - Moore Stephens LLP
    - Cardens Accountants LLP

4. Governance and Audit Committee recommendation

- On the 27th January 2016 and 21st July 2016 the Governance and Audit Committee reviewed the options available to the Council in appointing an external auditor for the 2018/19 accounts and beyond, and resolved to recommend to the Council that the preferred option of opting in to a sector led body be approved.

5. Next steps

- PSAA has now formally invited the Council to opt in, and details relating to PSAA's invitation are provided in an Appendix to this Report (see Appendix 1).

- In summary the national opt-in scheme provides the following:
  - The appointment of a suitably qualified audit firm for each of the five financial years commencing 1 April 2018;

  - Appointing the same auditor to other opted in bodies that are involved in formal collaboration or joint working initiatives to the extent this is possible with other constraints;

  - Managing the procurement process to ensure both quality and price criteria are satisfied. PSAA will seek views from the sector to help inform its detailed procurement strategy;

  - Ensuring suitable independence of the auditors from the bodies they audit and managing any potential conflicts as they arise;

  - Minimising the scheme management costs and returning any surpluses to scheme members;

  - Consulting with authorities on auditor appointments, giving the Council/Authority the opportunity to influence which auditor is appointed;

  - Consulting with authorities on the scale of audit fees and ensuring these reflect scale, complexity and audit risk; and

  - Ongoing contract and performance management of the contracts once these have been let.

- Regulation 19 of the Local Audit (Appointing Person) Regulations 2015 requires that a decision to opt in must be made by a meeting of the Council. The Council then needs to formally respond to PSAA's invitation in the form specified by PSAA by the 9th March 2017.

- PSAA will commence the formal procurement process after this date. It expects to award contracts in summer 2017 and consult with authorities on the appointment of auditors so that it can make an appointment by the statutory deadline of December 2017.

6. Conclusion

- There is a risk that current external fees levels could increase when the current contracts end in 2018.

- Opting-in to a national scheme provides maximum opportunity to ensure fees are as low as possible, whilst ensuring the quality of audit is maintained by entering in to a large scale collective procurement arrangement.

- If the national scheme is not used some additional resource may be needed to

establish an auditor panel and conduct a local procurement.

7. Recommendations

The County Council is asked to:

a) NOTE the changes in the external auditor appointment process following the Local Audit and Accountability Act 2014.

b) NOTE the options available to the Council for the appointment of an external auditor for the 2018/19 accounts and beyond.

c) RESOLVE that the preferred external audit procurement route is via a sector led body (PSAA Ltd).

8. Appendices

Appendix 1 – Opt in invitation from PSAA Ltd

9. Background Documents

Local Audit and Accountability Act 2014
http://www.legislation.gov.uk/ukpga/2014/2/contents/enacted

Governance and Audit Committee meeting minutes – 21st July 2016
https://democracy.kent.gov.uk/documents/g6091/Printed%20minutes%2021st-Jul-2016%2010.00%20Governance%20and%20Audit%20Committee.pdf?T=1

Governance and Audit Committee meeting report pack – 21st July 2016 (pages 429-432)
https://democracy.kent.gov.uk/documents/g6091/Public%20reports%20pack%2021st-Jul-2016%2010.00%20Governance%20and%20Audit%20Committee.pdf?T=10

Governance and Audit Committee meeting minutes – 27th January 2016
https://democracy.kent.gov.uk/documents/g6089/Public%20minutes%2027th-Jan-2016%2010.30%20Governance%20and%20Audit%20Committee.pdf?T=11

Governance and Audit Committee meeting report pack – 27th January 2016 (pages 141-160)
https://democracy.kent.gov.uk/documents/g5760/Public%20reports%20pack%2029th-Jan-2015%2010.30%20Governance%20and%20Audit%20Committee.pdf?T=10

10. Contact details

Bob Patterson Head of Internal Audit – Finance and Procurement Robert.Patterson@kent.gov.uk 03000 416554	Relevant Corporate Director: Andy Wood, Corporate Director Finance & Procurement Andy.Wood@kent.gov.uk 03000 416854

Appendix 1

27 October 2016 **Email:** appointingperson@psaa.co.uk

David Cockburn
Kent County Council
Sessions House
County Hall Maidstone
Kent ME14 1XQ

Copied to: Andy Wood, Director of Finance, Kent County Council
James Pigott, Head of Law, Kent County Council

Dear Mr Cockburn

Invitation to opt into the national scheme for auditor appointments

As you know the external auditor for the audit of the accounts for 2018/19 has to be appointed before the end of 2017. That may seem a long way away, but as there is now a choice about how to make that appointment, a decision on your authority's approach will be needed soon.

We are pleased that the Secretary of State has expressed his confidence in us by giving us the role of appointing local auditors under a national scheme. This is one choice open to your authority. We issued a prospectus about the scheme in July 2016, available to download on the appointing person page of our website, with other information you may find helpful.

The timetable we have outlined for appointing auditors under the scheme means we now need to issue a formal invitation to opt into these arrangements. The covering email provides the formal invitation, along with a form of acceptance of our invitation for you to use if your authority decides to join the national scheme. We believe the case for doing so is compelling. To help with your decision we have prepared the additional information attached to this letter.

I need to highlight two things:

- we need to receive your formal acceptance of this invitation by 9 March 2017; and
- the relevant regulations require that, except for a body that is a corporation sole (a police and crime commissioner), the decision to accept the invitation and to opt in needs to be made by the members of the authority meeting as a whole. We appreciate this will need to be built into your decision making timetable.

If you have any other questions not covered by our information, do not hesitate to contact us by email at appointingperson@psaa.co.uk.

Yours sincerely

Jon Hayes, Chief Officer

Appointing an external auditor

Information on the national scheme

Public Sector Audit Appointments Limited (PSAA)

We are a not-for-profit company established by the Local Government Association (LGA). We administer the current audit contracts, let by the Audit Commission before it closed.

We have the support of the LGA, which has worked to secure the option for principal local government and police bodies to appoint auditors through a dedicated sector-led national procurement body. We have established an advisory panel, drawn from representative groups of local government and police bodies, to give access to your views on the design and operation of the scheme.

The national scheme for appointing local auditors

We have been specified by the Secretary of State for Communities and Local Government as the appointing person for principal local government bodies. This means that we will make auditor appointments to principal local government bodies that choose to opt into the national appointment arrangements we will operate for audits of the accounts from 2018/19. These arrangements are sometimes described as the 'sector-led body' option, and our thinking for this scheme was set out in a prospectus circulated to you in July. The prospectus is available on the appointing person page of our website.

We will appoint an auditor for all opted-in authorities for each of the five financial years beginning from 1 April 2018, unless the Secretary of State chooses to terminate our role as the appointing person beforehand. He or she may only do so after first consulting opted-in authorities and the LGA.

What the appointing person scheme will offer

We are committed to making sure the national scheme will be an excellent option for auditor appointments for you.

We intend to run the scheme in a way that will save time and resources for local government bodies. We think that a collective procurement, which we will carry out on behalf of all opted-in authorities, will enable us to secure the best prices, keeping the cost of audit as low as possible for the bodies that choose to opt in, without compromising on audit quality.

Our current role means we have a unique experience and understanding of auditor procurement and the local public audit market.

Using the scheme will avoid the need for you to:

- establish an audit panel with independent members;
- manage your own auditor procurement and cover its costs;
- monitor the independence of your appointed auditor for the duration of the appointment;
- deal with the replacement of any auditor if required; and
- manage the contract with your auditor.

Our scheme will endeavour to appoint the same auditors to other opted-in bodies that are involved in formal collaboration or joint working initiatives, if you consider that a common auditor will enhance efficiency and value for money.

We will also try to be flexible about changing your auditor during the five-year appointing period if there is good reason, for example where new joint working arrangements are put in place.

Securing a high level of acceptances to the opt-in invitation will provide the best opportunity for us to achieve the most competitive prices from audit firms. The LGA has previously sought expressions of interest in the appointing person arrangements, and received positive responses from over 270 relevant authorities. We ultimately hope to achieve participation from the vast majority of eligible authorities.

High quality audits

The Local Audit and Accountability Act 2014 requires audit firms to be registered as local public auditors with one of the chartered accountancy institutes acting in the capacity of a Recognised Supervisory Body (RSB). The quality of registered firms' work will be subject to scrutiny by both the RSB and the Financial Reporting Council (FRC), under arrangements set out in the Act.

We will:

- only contract with audit firms that have a proven track record in undertaking public audit work;
- include obligations in relation to maintaining and continuously improving quality in our contract terms and in the quality criteria in our tender evaluation;
- ensure that firms maintain the appropriate registration and will liaise closely with RSBs and the FRC to ensure that any quality concerns are detected at an early stage; and
- take a close interest in your feedback and in the rigour and effectiveness of firms' own quality assurance arrangements.

We will also liaise with the National Audit Office to help ensure that guidance to auditors is updated as necessary.

Procurement strategy

In developing our procurement strategy for the contracts with audit firms, we will have input from the advisory panel we have established. The panel will assist PSAA in developing arrangements for the national scheme, provide feedback to us on proposals as they develop, and help us maintain effective channels of communication. We think it is particularly important to understand your preferences and priorities, to ensure we develop a strategy that reflects your needs within the constraints set out in legislation and in professional requirements.

In order to secure the best prices we are minded to let audit contracts:

- for 5 years;
- in 2 large contract areas nationally, with 3 or 4 contract lots per area, depending on the number of bodies that opt in;
- to a number of firms in each contract area, in order to help us manage independence issues.

The value of each contract will depend on the prices bid, with the firms offering the best value being awarded larger amounts of work. By having contracts with a number of firms, we will be able to manage issues of independence and avoid dominance of the market by one or two firms. Limiting the national volume of work available to any one firm will encourage competition and ensure the plurality of provision.

Auditor appointments and independence

Auditors must be independent of the bodies they audit, to enable them to carry out their work with objectivity and credibility, and in a way that commands public confidence.

We plan to take great care to ensure that every auditor appointment passes this test. We will also monitor significant proposals for auditors to carry out consultancy or other non-audit work, to protect the independence of auditor appointments.

We will consult you on the appointment of your auditor, most likely from September 2017. To make the most effective allocation of appointments, it will help us to know about:

- any potential constraints on the appointment of your auditor because of a lack of independence, for example as a result of consultancy work awarded to a particular firm;
- any joint working or collaboration arrangements that you think should influence the appointment; and
- other local factors you think are relevant to making the appointment.

We will ask you for this information after you have opted in.

Auditor appointments for the audit of the accounts of the 2018/19 financial year must be made by 31 December 2017.

Fee scales

We will ensure that fee levels are carefully managed by securing competitive prices from firms and by minimising our own costs. Any surplus funds will be returned to scheme members under our articles of association and our memorandum of understanding with the Department for Communities and Local Government and the LGA.

Our costs for setting up and managing the scheme will need to be covered by audit fees. We expect our annual operating costs will be lower than our current costs because we expect to employ a smaller team to manage the scheme. We are intending to fund an element of the costs of establishing the scheme, including the costs of procuring audit contracts, from local government's share of our current deferred income. We think this is appropriate because the new scheme will be available to all relevant principal local government bodies.

PSAA will pool scheme costs and charge fees to audited bodies in accordance with a fair scale of fees, which has regard to size, complexity and audit risk, most likely as evidenced by audit fees for 2016/17. Pooling means that everyone in the scheme will benefit from the most competitive prices. Fees will reflect the number of scheme participants – the greater the level of participation, the better the value represented by our scale fees.

Scale fees will be determined by the prices achieved in the auditor procurement that PSAA will need to undertake during the early part of 2017. Contracts are likely to be awarded at the end of June 2017, and at this point the overall cost and therefore the level of fees required will be clear. We expect to consult on the proposed scale of fees in autumn 2017 and to publish the fees applicable for 2018/19 in March 2018.

Opting in

The closing date for opting in is 9 March 2017. We have allowed more than the minimum eight week notice period required, because the formal approval process for most eligible bodies, except police and crime commissioners, is a decision made by the members of an authority meeting as a whole.

We will confirm receipt of all opt-in notices. A full list of authorities who opt in will be published on our website. Once we have received an opt-in notice, we will write to you to request information on any joint working arrangements relevant to your auditor appointment, and any potential independence matters that would prevent us appointing a particular firm.

If you decide not to accept the invitation to opt in by the closing date, you may subsequently make a request to opt in, but only after 1 April 2018. The earliest an auditor appointment can be made for authorities that opt in after the closing date is therefore for the audit of the accounts for 2019/20. We are required to consider such requests, and agree to them unless there are reasonable grounds for their refusal.

Timetable

In summary, we expect the timetable for the new arrangements to be:

- Invitation to opt in issued — 27 October 2016
- Closing Date for receipt of notices to opt in — 9 March 2017
- Contract Notice Published — 20 February 2017
- Award audit contracts — By end of June 2017
- Consult and make auditor appointments — By end of December 2017
- Consult and publish scales fees — By end of March 2018

Enquiries

We publish frequently asked questions on our website. We are keen to receive feedback from local bodies on our plans. Please email your feedback or questions to: appointingperson@psaa.co.uk.

If you would like to discuss a particular issue with us, please send an email to the above address, and we will make arrangements either to telephone or meet you.