ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Tuesday, 12 July, 2016

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

Tuesday, 12 July 2016 at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

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

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

Membership (13)

Conservative (8):	Mr C P Smith (Chairman), Mr G Lymer (Vice-Chairman), Mrs A D Allen, MBE, Mr R E Brookbank, Mrs P T Cole, Mrs V J Dagger, Mr P J Homewood and Mrs C J Waters
UKIP (2)	Mr H Birkby and Mr A D Crowther
Labour (2)	Mrs P Brivio, Mrs S Howes and Ms A Harrison
Liberal Democrat (1):	Mr R H Bird and Mr S J G Koowaree

Webcasting Notice

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

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

UNRESTRICTED ITEMS

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

A - Committee Business

A1 Introduction/Webcast announcement

A2 Membership - to note that Ms A Harrison has joined the committee in place of Mr T Maddison

A3 Apologies and Substitutes

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

A4 Declarations of Interest by Members in items on the Agenda

To receive any declarations of interest made by Members in relation to any

matter on the agenda. Members are reminded to specify the agenda item number to which it refers and the nature of the interest being declared.

A5 Minutes of the meeting held on 10 May 2016 (Pages 7 - 12)

To consider and approve the minutes as a correct record.

A6 Verbal updates by the Cabinet Member and Directors (Pages 13 - 14)

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

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

B1 Re-commissioning of Infrastructure Support to the Voluntary and Community Sector (16/00051) (Pages 15 - 22)

To receive a report from the Leader of the Council and the Corporate Director of Social Care, Health and Wellbeing, and to consider and endorse or make recommendations to the Leader on the proposed decision on arrangements for re-commissioning.

B2 Chlamydia Testing Service Contract Extension (16/00062) (Pages 23 - 28)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, and to consider and endorse or make recommendations to the Cabinet Member on the proposed decision to extend the existing contract for the chlamydia testing service to 31 July 2017.

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

C1 'Mind the Gap' - Health Inequalities Action Plan for Kent, 2016 (Pages 29 - 36)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, and to consider, comment on and endorse the analysis and progress in developing the next Mind the Gap strategy for Kent.

C2 Update on Health Improvement Services Transformation Programme (Pages 37 - 42)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, to consider, comment on and endorse progress on re-commissioning and support the competitive tendering of a new model, based on the key points set out in the report.

C3 Proposed Kent Drug and Alcohol Strategy, 2017-2022 (Pages 43 - 54)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, to consider and comment on the proposed Kent Drug and Alcohol Strategy, its main themes and timeline, and either endorse the approach set out or make alternative suggestions to the

Cabinet Member.

D - Monitoring

D1 Adult Social Care Performance Dashboard (Pages 55 - 72)

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

D2 Public Health Performance - Adults (Pages 73 - 80)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, outlining current performance and actions taken by Public Health, to note the performance outlined and agree the changes proposed to be made to the way in which chlamydia detection and substance misuse are measured.

D3 Public Health Communications and Campaigns Update (Pages 81 - 108)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Director of Public Health, to consider and comment on the progress and impact of public health campaigns and endorse the key developments planned for 2016/2017.

D4 Adult Social Care Annual Complaints Report (2015 - 2016) (Pages 109 - 128)

To receive a report from the Cabinet Member for Adult Social Care and Public Health and the Corporate Director of Social Care, Health and Wellbeing, outlining the operation of the complains and representations procedure between 1 April 2015 and 31 March 2016.

D5 Business Plan/Contract Management - new standing item

D6 Work Programme 2016/17 (Pages 129 - 134)

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

EXEMPT ITEMS

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

Peter Sass
Head of Democratic Services
03000 416647

Monday, 4 July 2016

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

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 10 May 2016.

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

ALSO PRESENT: Mr G K Gibbens

IN ATTENDANCE: Mr A Ireland (Corporate Director Social Care, Health and Wellbeing), Mr A Scott-Clark (Director of Public Health), Mr M Lobban (Director of Commissioning), Ms P Southern (Director, Learning Disability and Mental Health), Mrs A Tidmarsh (Director, Older People and Physical Disability), Dr F Khan (Deputy Director of Public Health), Mr M Gilbert (Performance and Contracts Manager), Mr W Gough (Business Planning and Strategy Manager, Pubic Health) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

1. Apologies and Substitutes
(Item A2)

Apologies had been received from Mr R E Brookbank, Mrs V J Dagger, Mr P J Homewood and Mrs C J Waters.

Mr S Manion was present as a substitute for Mrs Dagger.

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

There were no declarations of interest.

3. Minutes of the meeting held on 10 March 2016
(Item A4)

RESOLVED that the minutes of the meeting held on 10 March 2016 are correctly recorded and they be signed by the Chairman. There were no matters arising.

4. Verbal updates by the Cabinet Member and Directors
(Item A5)

1. Mr Gibbens gave a verbal update on the following adult social care issues:

Community Health and Wellbeing Service – he summarised recent developments, including the end of grant payments and their replacement by a tender process, culminating in contract awards to Porchlight and the Shaw Trust in January 2016,

and set out how the new service would be monitored. A report on the performance of the new service would be made to this committee at its 11 October meeting. Committee Members were each given a copy of a pack for 'Live Well Kent', which would be launched on 17 May. In response to questions, Mr Gibbens clarified that Porchlight and the Shaw Trust were the County Council's strategic partners and explained that other, smaller organisations may be contracted by these two to provide some services, and Ms Southern undertook to look into and advise a speaker outside the meeting on the involvement of specific clinical commissioning groups in this service delivery.

21 April - Visit to West Kent Mind in Sevenoaks
21 April – Visit to Age UK Sevenoaks
21 April – Visit to Age UK Tunbridge Wells

2. Mr Ireland then gave an oral update on the following issues:

Sustainability and Transformation Plans – these would be published shortly, although the content of them was not yet known. In response to a question, he referred to the general difficulties in recruiting social workers and managers, which had been well documented in recent years, but said that difficulties in recruiting adult social care staff would hopefully soon be resolved.
Delayed Transfers of Care review – although formalised data would take a while to be published, current live data was showing a significant improvement in the number of delayed transfers.

3. Mr Gibbens gave an verbal update on the following adult public health issues:

Community Pharmacy Consultation – he outlined a number of issues arising from the consultation and reported his intention to respond jointly to the consultation with the Chairman of the Health and Wellbeing Board, Mr R Gough. Key concerns were the potential impact of the loss of community pharmacies in rural and suburban areas and the impact of centralised dispensing on those less able to access and use IT facilities. His approach, and proposal to respond jointly with the Health and Wellbeing Board, was endorsed.
26 April – Visit to Folkestone Men's Sheds – this was a very inspiring project which had produced success stories for participants. Committee Members added that most local shed schemes were now accessible to both men and women, and some local variations on the scheme had developed, eg 'Men in Boats' in Dover. A view was expressed that Community Shed schemes would be more easily accessible to transgender people.

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

Suicide Prevention Campaign for men under 45: 'Release the Pressure' – this was being publicised by the County Council public health team by a range of media and outlets, including leaflets, billboards, on beermats and at petrol stations. The response so far had been good, with an online media clip having been viewed 65,000 times and the website having had 20,000 hits. The helpline had reported a 16% increase in calls overall and a 20% increase in male callers. Other organisations, for example, Gillingham Football Club, had also undertaken their own campaigns. In response to a question, Mr Scott-Clark explained that it would take about a year for the male suicide figures to show any reduction as a result of the success of the campaign.

5. RESOLVED that the verbal updates be noted.

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

1. Mr Lobban introduced the report and explained that, although the contract with Newton Europe would end shortly, the work which had been started with them as the County Council's Efficiency Partner would continue. Newton Europe staff were currently in the process of handing over work streams to County Council staff. Ms Southern, Mr Lobban and Mrs Tidmarsh responded to comments and questions from Members, as follows:-

a) although there had been 45 applications for the Shared Lives programme awaiting approval at the time of writing the report, this did not indicate a lack of capacity in the service. The committee was assured that all applications were considered very carefully, and much effort was put into matching applicants to suitable hosts, and this inevitably took time. It was important also that hosts had been carefully assessed and had received appropriate training before being matched to an applicant. The training and matching requirements for this service were similar to those of the adoption service;

b) the County Council had approached bus companies to explore the possibility of allowing travel with a bus pass earlier in the day, to give service users more scope to access training and employment, but had been advised that the costs of a blanket change to times would be prohibitive. It may be possible, however, to establish a targeted scheme whereby those wishing to travel to training or work could be given a different concession from those wishing to travel for leisure; and

c) the acute hospital optimisation initiative, to promote independence for people leaving acute hospitals, highlighted the need for a strategic approach to service provision, so that a range of options was available, from which the most suitable choice could be made for each individual. The decision process by which an individual would be placed in a care setting and the care setting itself were of equal importance. It was important also that people should be able to express a preference of care option, for example, a wish to return home, and for that option to be tried.

2. RESOLVED that progress on the adult transformation programme be endorsed, and Members' comments on it, set out above, be noted.

6. Public Health Quality report
(Item C2)

1. Dr Khan introduced the report and, with Mr Gilbert and Mr Scott-Clark, responded to comments and questions from Members, as follows:

a) Patient Group Direction referred to a group which consisted of professionals such as nurses and medical directors who were permitted under the Medicines Act 1968, in very specific and controlled circumstances, to issue prescription drugs;

b) Dover had been chosen to pilot a community weight management programme as the East Kent Healthy Weight service was based there. The timescale of the pilot was open-ended but it was expected that it would continue;

c) an additional staffing resource, allocated for six months, would be used to establish a dashboard for each service, to record performance against quality indicators. Work would also be undertaken with providers to incorporate quality indicators into service provision; and

d) a challenge to be addressed was the way in which information gathered by Health Visitors could be used to identify families living in poverty. Health Visitors were well placed to observe indicators of poverty but were under an obligation to protect the privacy of the families they worked with. Information sharing among multi-disciplinary teams of professionals was an important part of their role but was also very closely prescribed. Any local authority wishing to establish a child poverty strategy would need to ensure that such a strategy included a very clear definition of poverty.

2. The Cabinet Member, Mr Gibbens, suggested that an update report on quality on public health be made to this committee annually.

3. RESOLVED that the measures being put in place to improve the quality of public health programmes, and the direction of travel, be noted, and Members' comments, set out above, be taken into account when developing future programmes.

7. Public Health Risk Management
(Item D1)

1. Mr Gough introduced the report and Mr Gilbert responded to a question by explaining that the risk rating for 'managing and working within the market' was currently quite high at level 9, although the aim was to reduce this to level 6. This high rating was due to some public health services being new to the market and needing more proactive market development. Work was needed to identify the market approach which would best contribute to minimising the level of risk.

2. RESOLVED that the risk management arrangements for public health, outlined in the report, be noted.

8. Work Programme 2016/17
(Item D2)

RESOLVED that the committee's work programme for 2016/17 be agreed.

9. INFORMATION ITEM - Financial arrangement to place a legal charge on a property of a service user accessing domiciliary care (decision number 16/00039)
(Item E1)

RESOLVED that the non-key decision, taken by the Cabinet Member for Adult Social Care and Public Health, in accordance with the decision-making process set out in

Appendix 4 Part 6 of the Constitution, and on advice from Democratic Services, be noted.

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

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

Mr A Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

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

Classification: Unrestricted

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

Adult Social Care

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

1. 17 May Spoke at Live Well Kent Launch Event at Canterbury Christchurch University
2. 19 May Attended Kent Integrated Care Alliance Conference at Ashford International Hotel
3. 25 May Attended South East England Councils and South East Strategic Leader joint Health & Social Care Integration Workshop at King's College, London
4. Short Breaks Consultation

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

1. Update on Adults Transformation and the start of Phase 3
2. Blackburn Lodge's recent "Good" CQC Inspection
3. Meeting with Helen Greatorex, new Chief Executive of KMPT
4. Update on CQC Strategy

Adult Public Health

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

1. Community Pharmacies
2. 29 June Spoke at Perinatal Mental Health Conference at Canterbury Christ Church University
3. 29 June Visited Turning Point (substance misuse services) in Canterbury

Director of Public Health – Mr A Scott-Clark

1. Community Pharmacy funding
2. NHS Sustainability and Transformation Plans: Prevention
3. Town and Country Planning Association
4. Healthy New Towns/Ebbsfleet

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From:	Paul Carter, Leader of the Council and Cabinet Member for Business Strategy, Audit and Transformation and Commercial and Traded Services Andrew Ireland, Corporate Director, Social Care, Health and Wellbeing
To:	Adult Social Care and Health Cabinet Committee – 12 July 2016
Decision No:	**16/00051**
Subject:	Re-commissioning of Infrastructure Support to the Voluntary and Community Sector
Classification:	Unrestricted
Past Pathway:	Social Care Health and Wellbeing Directorate Management Team Meeting – 6 April 2016 Corporate Management Team – 25 April 2016 Commissioning Advisory Board – 6 July 2016
Future Pathway:	Cabinet Member decision
Electoral Division:	All

Summary: This report proposes to re-commission infrastructure support to the voluntary and community sector (VCS) to ensure that it responds to the sector's needs, delivers the aspirations of the VSC policy and is sustainable in the longer term, whilst building collaboration across the sector.

Recommendations: The Adult Social Care and Health Cabinet Committee is asked to consider and endorse or make a recommendation to the Leader and Cabinet Member for Business Strategy, Audit and Transformation and Commercial and Traded Services on the proposed decision to:

1) Confirm that the current grant funding arrangements to Local Infrastructure Organisations will end;

2) Procure and award a new contract that meets the outcomes identified in section 4.2 of this report and commences from January 2017; and

3) Delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement this decision.

1. Background

1.1 There are approximately 3,300 voluntary and community sector (VCS) organisations in Kent. Of these, the majority are small organisations with an annual income of less than £500k.

1.2 Kent County Council's VCS Policy commits the Council to supporting the VCS in Kent. It sets out the principles which will underpin future support to the sector, but recognises the need to review the current model of support.

2. Current Support to the Sector

2.1 Current infrastructure support to the sector is delivered through Local Infrastructure Organisations (LIOs). These are voluntary sector organisations whose purpose is to provide guidance, training and support to VCS organisations.

2.2 In Kent, LIOs consist of 10 volunteer centres (VC), five Councils for Voluntary Services (CVS) and a handful of independent organisations such as KentCAN, Action for Communities in Rural Kent and Funding for All.

2.3 Identified issues with the current model of support are:

- Consultation with the sector indicates that they need support with a range of issues, including networking, identifying and bidding for funding and developing plans for longer-term sustainability, as well as support with more pragmatic issues such as DBS checks for volunteers, and recruiting trustees.
- CVS support mainly small organisations but there is a lack of consistency to the type or quality of support offered across the county.
- Volunteer centres are not consistently meeting the needs of all groups of people who want to volunteer, either formally or informally, in their communities.
- The majority of LIOs are also providers of direct services and, as such, are perceived as competition by the organisations they are there to support.
- The sector values opportunities to network with other organisations, and this is not available consistently or regularly across the county.
- Funding to LIOs is awarded on an annual basis and longer-term funding would enable organisations to plan their business better and invest in service development.

3. Financial Implications

3.1 The Adult Social Care and Public Health current investment (2016-17) in annual grants to volunteer centres and CVS for their core infrastructure function is £615,291. These would end in order to finance the new contract.

3.2 The overall value of the proposed contract would be £1,500,695 for the first three years, with projected savings over the life of the contract of £166,744.

3.3 The contract will diminish in value by 10% each year, to support the sector move towards a self-sustaining model.

4. Delivering Outcomes

4.1 A cross directorate group of officers has noted the issues identified with the current offer of support, and the findings of the VCS policy consultation, and has considered other local authority models to identify a proposal for the future of infrastructure support to the VCS.

4.2 Three primary outcomes, which are in line with the outcomes of the policy, have been developed through a co-design process with the current market. These are:

- Business Support Outcomes: Kent's voluntary sector is supported to grow and develop, enabling local residents to enjoy a good quality of life, and more people to benefit from greater social, cultural and sporting opportunities.
- Volunteering and Social Action Outcomes: Volunteering is regarded as a valuable opportunity for individuals to contribute to their community and is accessible to all, regardless of their skills or time capacity.
- Strategic Outcomes: Voluntary sector organisations are well informed and understand the priorities of Kent County Council, as set out in the Strategic Statement.

4.3 It is clear from the policy consultation that the current model of annual grant awards is unsustainable, not delivering what the market needs and is not in a position to meet the above outcomes.

4.4 The proposal is to re-commission this support to provide a consistent offer of infrastructure support to the VCS sector across the county.

4.5 Infrastructure providers have welcomed this proposed change.

5. Contracting Model

5.1 Review of the market indicates that a single organisation would be unlikely to be able to deliver a countywide contract without entering into a partnership arrangement with other providers. (The current infrastructure market consists of organisations of varying size, geographical focus and a history of partnership working.)

5.2 In order to encourage partnerships between organisations that can deliver all of the outcomes in a collaborative way, three contracting types have been discussed with potential providers. These are:

- Option 1: Key Strategic Partner (KSP): The KSP is the contract holder and works with a countywide delivery network to provide services which meet the outcomes identified. The KSP would take management costs and, given the low value of the contract, this would mean money being diverted away from direct support to VCS organisations.
- Option 2: Framework: This model would set up a framework contract for all providers wanting to deliver services that meet the outcomes. This model allows beneficiary organisations to receive bespoke support, but reduces the overall number of organisations that can benefit from the support.
- Option 3: A contract-based on Alliance contracting principles: The model invites tenders from providers, who work together based on alliance contracting principles in which each partner is equal and there is one performance framework, aligned objectives, shared risks and success, judged on performance, and a collective overall accountability to deliver outcomes. Sub-contracting would be encouraged in order to meet outcomes.

5.3 These models have been shared with the current market as part of market engagement. There were mixed views about which model was best, with

most organisations preferring an Alliance or Strategic Partner model, and recognition that subcontracting would still be important.

5.4 However, all organisations were in agreement that the model of support commissioned must be the model which offers the best opportunity to deliver the outcomes for the benefit of recipient voluntary sector organisations, not a model that is designed to sustain current providers.

5.5 Analysis of the feedback by the County Council saw greatest strengths in the Alliance model. Based on this the preferred option is option 3.

6. Proposal Model of Infrastructure Support to the VCS Sector

6.1 The proposal is that a new contract is tendered that meets the outcomes and upholds thr County Council commitment of support to the VCS, identified within the VCS policy.

- The model will be based on Alliance contracting principles
- The contract will be for a countywide service (one lot) and the contract will be for three years (plus two, optional, one-year extensions) at a diminishing value of 10% per year of the contract.
- Beneficiaries of the service will include voluntary and charity sector providers within Kent. However, the contract will focus on subsidising support for organisations with an income of under £500k.
- The contract will retain an emphasis on local knowledge and presence, including a focus on volunteering more generally as a mechanism to promote and enable social action and community development.
- The new contract will be called Strengthening Community Organisations in Kent. This avoids ambiguity around the meaning of Infrastructure.
- It is proposed that the procurement process begins on 1 August 2016, and that contracts are awarded mid-October 2016. The contract will start on 1 January 2017.

7. Equality Implications

7.1 An Equality Impact Assessment has been completed to consider the impact of this on individuals with protected characteristics. It has concluded that any negative impact on individuals with protected characteristics will be minimal as this funding is not used to deliver services directly to individuals, but rather to provide support to organisations that may provide support directly to people. Conversely, improvements in the type and quality of support provided to VCS organisations through the proposed contract may have an indirect positive impact on people using the support the recipient organisations provide.

8. Conclusions

8.1 Support to VCS organisations is currently provided by disparate local CVS and volunteer centres that are partly funded by Public Health and Adult Social Care. The current funding does not support the longer-term sustainability of the recipient organisations and the type and quality of support provided varies across the county.

8.2 The proposal in this report will provide organisations with a clear commitment from the County Council over three (possibly five) years,

enabling providers to develop their business model and leverage additional funding. An alliance type contract will help to foster collaboration, support the County Council's strategic relationship with the sector and ensure a consistent offer of support to VCS organisations across the county.

9. Recommendation(s)

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to to consider and endorse or make a recommendation to the Leader and Cabinet Member for Business Strategy, Audit and Transformation and Commercial and Traded Services on the proposed decision to:

1) Confirm that the current grant funding arrangements to Local Infrastructure Organisations will end;

2) Procure and award a new contract that meets the outcomes identified in section 4.2 of this report and commences from January 2017; and

3) Delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement this decision.

10. Background Documents

none

11. Contact details

Report Authors

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Andrew Scott-Clark, Director of Public Health
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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Paul Carter Leader of Kent County Council and Cabinet Member for Business Strategy, Audit and Transformation and Commercial and Traded Services	16/00051

For publication

Key decision Affects more than two electoral divisions and expenditure of over £1m

Subject: Recommissioning of Infrastructure Support to the Voluntary and Community Sector

Decision: As Leader of the Council and Cabinet Member for Business Strategy, Audit and Transformation and Commercial and Traded Services, I propose to:

1) Confirm that the current grant funding arrangements to Local Infrastructure Organisations will end.
2) Procure and award a new contract that meets the outcomes identified in section 4.2 of the recommendation report and commences from January 2017.
3) Delegate authority to the Corporate Director of Social Care, Health and Wellbeing, or other nominated officer, to undertake the necessary actions to implement this decision.

Reason(s) for decision: Re-commissioning infrastructure support to the voluntary and community sector (VCS) will ensure that it responds to the sector's needs, delivers the aspirations of the VSC policy and is sustainable in the longer term, whilst building collaboration across the sector.

Financial Implications: The value of the proposed contract is between £1.5m (for three years) and £2.3m (for five years).

Legal Implications: None

Equality Implications: An Equality Impact Assessment has been completed to consider the impact of this on individuals with protected characteristics. It has concluded that any negative impact on individuals with protected characteristics will be minimal as this funding is not used to deliver services directly to individuals, but rather to provide support to organisations that may provide support directly to people

Cabinet Committee recommendations and other consultation:
The proposed decision will be discussed at the Adult Social Care and Health Cabinet Committee Meeting on 12 July and the outcome included in the decision paperwork which the Leader will be asked to sign.

Any alternatives considered: The alternative is to maintain current arrangements.

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

....
signed date

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee - 12 July 2016

Subject: Chlamydia Testing Service Contract extension (16/00062)

Classification: Unrestricted

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

Future Pathway: Cabinet Member decision

Electoral Division: All

Summary: This report seeks the committee's endorsement of a proposal for a one-year extension to the County Council contract for the chlamydia testing service. The service has performed well since being competitively tendered in 2013 and provides good value for money. The one-year extension will cost a maximum of £344k and is included in the Public Health budget.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and either **ENDORSE** or make a recommendation to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the existing contract for the chlamydia testing service to 31 July 2017.

1. Introduction

1.1. The purpose of this paper is to seek the committee's endorsement of a proposed decision to extend the existing contract for chlamydia testing until 31 July 2017.

1.2. Kent County Council has a statutory obligation to ensure provision of open access sexual health services. At its March meeting, the committee noted and welcomed the range of sexual health services commissioned across the county.

2. Background

2.1. The National Chlamydia Screening Programme (NCSP) is a surveillance and prevention programme targeted at young people aged 15 to 24 years of age. Chlamydia is the most common bacterial sexually transmitted infection (STI) in the UK, affecting both males and females.

2.2. As part of its statutory responsibility for the prevention and treatment of STIs, the County Council commissioned a chlamydia pathology and testing service

through a competitive tender process in 2013. The contract was awarded to Source Bioscience. The initial three-year term of the contract is now due to end but there is provision in the contract for a one-year extension.

3. Contract Performance

3.1. Source Bioscience have successfully and efficiently implemented and delivered the requirements of the contract over the past three years. The scope of the service has evolved in order to meet changes in demand and the new landscape of community sexual health services.

3.2. The contract now includes provision for online ordering of Chlamydia test kits, which encourages more people to take up the opportunity of a test. This new arrangements started in January 2016 and is accessed directly from the Kent County Council's sexual health website www.kent.gov.uk/sexualhealth

3.3. The use of the internet to access chlamydia testing kits has grown considerably in recent months and is a cost-effective way to identify infections as there is a significant number of people who have internet access but do not tend to visit face to face services. This has been evidenced over the past five months as there have been more than 400 online requests for chlamydia testing kits.

3.4. The positivity rates for internet tests from January to May 2016 was 11%; this exceeds the national targets for positivity rates and supports the case for continued investment and availability of tests online.

3.5. Further efficiencies and enhancements to the service were introduced in April 2015 with the introduction of a system which enables all laboratory test results from the Source Bioscience contract to notify the patient with their negative test results via text message or email. This is a much more cost effective way of managing patient notification as this reduces the administrative time and task of uploading data and contacting patients.

4. Proposed Extension

4.1. The original contract, awarded in 2013, allowed for a one-year extension. Extending the contract until July 2017 will allow the current service to continue to support improved performance in chlamydia testing rates.

4.2. The additional 12 months will also allow for further developments and efficiencies through integrating the programme into a wider digital service offer for promoting improved sexual health in line with the County Council's statutory responsibilities.

5. Financial Implications

5.1. The payment mechanism for the Chlamydia Testing Service contract is entirely activity-based, which means that the County Council only pays for the tests which are actually requested and issued. There are no minimum or block payments.

5.2. The competitive tender process undertaken in 2013 also ensured that the contract provides best value for money. The basic unit charges have also remained fixed at the original 2013 values and have not risen with inflation. These fixed rates will also be maintained for the duration of the one-year extension.

5.3. The maximum cost of the one-year extension will be £344,000. The actual payments will be dependent on the number of chlamydia tests issued.

6. Conclusion

6.1. The County Council's Public Health team is proposing to extend the existing contract for chlamydia testing and pathology by one year to 31July 2017. The contract has performed well over the past three years, delivered efficiencies and provided good value for money for the County Council.

6.2. The scope of the contract has evolved over the past two years to respond to the changing demand for the service. The additional year will enable this performance to continue and will continue to help the County Council to fulfil its statutory obligation to ensure provision of effective sexual health services.

6.3. The one-year extension to the contract will cost a maximum of £344,000 and is included in the Public Health budget.

7. **Recommendation:** The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and either **ENDORSE** or make a recommendation to the Cabinet Member for Adult Social Care and Public Health on the proposed decision to extend the existing contract for the chlamydia testing service to 31 July 2017.

Background Documents:

None

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	16/00062

For publication

Subject: Chlamydia Testing Service Contract

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to authorise an extension to the contract with Source Bioscience for the provision of the Chlamydia Testing Service until 31July 2017.

Reason(s) for decision:

Financial

Cabinet Committee recommendations and other consultation:

The Adult Social Care and Health Cabinet Committee will discuss the matter at its meeting on 12 July 2016 and the outcome of this will be included in the paperwork which the Cabinet Member will be asked to sign when taking the decision.

Any alternatives considered:
N/A

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

..... signed

..... date

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Mind the Gap - Health Inequalities Action Plan for Kent 2016

Decision Non-Key

Classification: Unrestricted

Past Pathway of Paper: This is the first committee

Future Pathway of Paper: A summary will be shared at the July Kent Health and Wellbeing Board.

Electoral Division: All

Summary: This report updates the committee on analysis and progress on developing the next Mind the Gap Reducing Health Inequalities Action plan for the county. The health inequalities gap has not narrowed since 2006. This report identifies the populations across Kent who shows the worst health outcomes and describes the mapping analysis and actions required at local level in order to reduce health inequalities in the future. This work continues to supported by Professor Chris Bentley (former national lead for the Health Inequalities National Service Team).

Recommendation(s):

The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER**, **COMMENT ON** and **ENDORSE** the analysis and progress in developing the next 'Mind the Gap' for Kent.

1. Introduction

1.1 Health Inequalities are differences in health outcomes between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

1.2 The Adult Social Care and Health Cabinet Committee in September last year considered the future direction for "Mind the Gap: Reducing Health Inequalities in Kent" and endorsed the proposed direction for development of a new Kent Inequalities Action Plan.

1.3 This report provides an update on the public health analysis carried out following publication of the new national Index of Multiple Deprivation (2015) and sets out a proposed action plan.

2. Findings

2.1 Whilst mortality rates in Kent have been falling over the last decade for all populations in Kent, the gap in all-age, all-cause mortality rates between the most and least deprived communities has remained constant. This gap is also consistent nationally where the Office of National Statistics recently reported a persistent fixed gap in life expectancy across England as a whole.

2.2 Our findings show that the most deprived populations have disproportionately worse life expectancy and the highest premature mortality rates, signalling that, if we are to begin to narrow the health inequalities gap, we need to understand exactly where and who these populations are.

2.3 Analysis of the causes of premature deaths in the most deprived population's show that cancers, cardiovascular, respiratory and gastro-intestinal diseases account for the majority of the cause.

2.4 The populations that show the highest rates of all-age, all-cause mortality and premature mortality are identified by segmenting Kent's population based on Lower Layer Super Outputs Areas (LSOAs). LSOAs are typically a population of about 1,500 people, and no smaller than 1000 people. LSOAs allow the reporting of small area statistics. Kent is made up of 880 LSOAs and thus the bottom decile is made up of 88 LSOAs

2.5 The geographical spreads of these 88 LSOAs is as follows:

2.5.1	Ashford District:	4
2.5.2	Canterbury District	7
2.5.3	Dartford District	4
2.5.4	Dover District	11
2.5.5	Gravesham District	7
2.5.6	Maidstone District	5
2.5.7	Sevenoaks District	2
2.5.8	Shepway District	8
2.5.9	Swale District	16
2.5.10	Thanet District	24

2.6 Further analysis of the 88 LSOAs and applying a segmentation tool known as MOSAIC shows that these populations have very different social characteristics and thus demonstrates that there will need to be multiple and differing approaches to improving life expectancy and reducing premature mortality.

2.7 However, a number of common themes are also evident in the analysis, as follows:

2.7.1 *Young people*: In general, the most deprived areas in Kent feature a high proportion of young adults. This is significant as evidence shows that early choices and behaviours have lasting effects on life chances, and the health impacts of deprivation

accumulate in individuals throughout their lives.

2.7.2 *Children*: There should be a focus on child health and education, to provide opportunities to these children to break the cycle of deprivation. Even by the age of 3, there is a marked inequality gradient in childhood development, which will impact on outcomes throughout life.

2.7.3 *Education/Employment/Housing:* The big challenges in many of these communities are not health problems, but rather socio-economic problems: education, employment, and housing. Any long-term strategy to address health inequalities must address these issues. Housing in particular is a defining issue for some local areas.

2.7.4 *Churn:* A number of areas are subject to high levels of 'transiency' i.e. people moving in and out of the area (churn). What this suggests is that efforts to tackle deprivation should not focus solely on individuals or households because those who do graduate through such programmes are likely to move away from the area and be replaced by other young, struggling, individuals. Rather, there should be concurrent efforts to regenerate local communities themselves as physical, social and cultural spaces. This area-based approach will have an enduring impact on the health and wellbeing of local populations, however transiently they may live there.

2.8 Analysis of other social indicators such as school readiness, GCSE Attainment, crime rates, overcrowded accommodation and living environment shows exactly the same pattern of inequality, in fact some of the gradients are not linear, but rather curved, which shows a disproportionate effect in the most deprived deciles. For example, alcohol-related premature mortality is six times higher in the most deprived decile than it is in the most affluent decile.

3. Action Plans

3.1 Reducing health inequalities requires a much more systematic, place-based and disproportionate approach with a focus on those LSOAs identified above.

3.2 It will also require a range of interventions and programmes that aim to deliver improved outcomes in the short, medium and long term. For example, improving detection and optimising treatment for disease, particularly those diseases associated with premature mortality, will provide short term (0-5year) outcomes, whereas lifestyle interventions such as stop smoking have medium term (0-10year) outcomes and modifying social determinants of health may well have longer term (0-15year) outcomes.

3.3 Plans also require buy-in and action across a wide range of local stakeholders and can be split into three approaches, as follows:

3.3.1 Population approaches, which describes the action by policy makers in addressing the wider determinants of health through,

for example, policy, legislation and regulation and local strategies of “Health in all Policies”.

3.3.2 Service approaches, which describes action by service providers relating to health, for example general practice, acute services.

3.3.3 Community development approaches, which describes actions by community groups and local community leaders to build resilience and improve community wellbeing.

3.4 Traditional methods for community development have tended to focus upon prescribing top-down solutions to the needs and deficiencies of deprived areas, with poor buy-in and engagement of local communities. We are advocating for an asset-based community development approach. This approach recognises the inherent assets, skills and capabilities of residents, citizen associations and local institutions and builds upon these in a co-productive way that creates sustainable long term change.

3.5 Community development can be carried out systematically in the deprived areas identified in this report. A methodology for systematically engaging communities is found in Chris Bentley’s Ten Point Plan of ‘System and Scale into Community Empowerment’:-

3.5.1 *Prioritisation of areas* : This has already been done by focussing on the most deprived decile LSOAs in Kent.

3.5.2 *Defining communities*: The next step is to define how communities define themselves, geographically and in a socio-cultural sense.

3.5.3 *Asset mapping*: We then need to produce a stocktake of the positive resources in place in each community.

3.5.4 *Behaviour of partners*: A multi-agency response requires co-ordination, such as agreed common ways of working and the sharing of intelligence.

3.5.5 *Community profiles*: Local profiles involve collating the top-down analysis already conducted with bottom-up views from the ground to construct a recognisable story of place and culture.

3.5.6 *Community Based Research (CBR):* Local residents can be trained to be involved in assessing needs, barriers and aspirations, and exploring ideas for action. This develops skills, and raises self-esteem, in residents who can go on to become community champions.

3.5.7 *Neighbourhood Action Plans (NAPS):* Plans for action should be community-owned, but could also form the building blocks on which to base Health and Wellbeing Strategies.

3.5.8 *Outreach models*: Community empowerment should allow locals to have a say in how and where they receive services from a range of statutory sector and community venues.

3.5.9 *Community Links Strategy:* There need to be ongoing mechanisms to involve all sections of the community in what services are provided and how they are provided. Solutions should not involve rigid structures but mechanisms for ongoing,structured gathering and collation of local intelligence of community infrastructures.

3.5.10 *Transfer of Service Ownership:* Change will be more sustainable if we transfer power and resources to genuinely empower communities to take more control of things that affect them e.g. through social enterprise.

3.6 Public Health are currently working with local partners in each district highlighted above as having LSOAs in the most deprived decile in order to ensure we have accurately defined local communities and have mapped local assets.

3.7 Our aim is to develop a number of local plans (based on natural local communities) which aim to improve place-based health through population, service and community-based approaches.

4. Legal implications

4.1 None identified.

5. Equalities implications

5.1 This action plan is designed to reduce inequalities within and between communities. It is expected the equality impact assessments will be carried out on each local plan.

6. Other corporate implications

6.1 As described above, the wider determinants of health impact on other services and areas of the County Council, and importantly of public, private and local voluntary sectors

7. Governance

7.1 As this is primarily about health inequalities, and a place-based approach, the oversight of local plans should be managed through local Health and Wellbeing Boards and Local Children's Partnership Groups.

7.2 Oversight at a Kent strategic level will be managed at the Kent Health and Wellbeing Board; reducing health inequalities remains part of the Kent Joint

Health and Wellbeing Strategy.

8. Conclusions

8.1 Health Inequalities result from a wide variety of determinants: the conditions in which we are born, grow, live, work and age. Addressing these health inequalities is a key policy focus at the local, national and global level.

8.2 Since Kent's 2012 Strategy 'Mind the Gap', Kent has shown progress in some health outcomes, and Kent as a whole scores above the England average on a number of indicators. However, inequalities continue to exist within and between Kent communities, and there is a persistent gap in mortality rates between the most and least deprived.

8.3 Steep gradients exist across a range of health and social indicators in Kent, and the very worst outcomes are found in the most deprived decile. These inequalities carry through to life expectancy and premature mortality, with steeper gradients in men than in women.

8.4 The most significant causes of death (in both men and women) that are driving these inequalities are cardiovascular disease, respiratory disease and gastro-intestinal disease. In the main these diseases are preventable through earlier detection, behavioural modification and optimal risk management.

8.5 There are four different 'types' of deprivation within the most deprived decile. These populations have been mapped geographically in Kent. Granular analysis over small areas provides insights into the challenges facing local communities.

8.6 Moving forward, the priorities to tackle health inequalities in Kent should be to focus on these most deprived decile areas. Preventative interventions should focus on early identification and management of health risks in these traditionally hard-to-reach populations.

8.7 The health system is moving towards a place-based approach to improving health outcomes through the NHS five year forward view and local Sustainability and Transformation plans. Recognising area inequalities is a key part of this. Community initiatives (often already existing in some form) present opportunities to engage, though this is not currently systematic or at-scale. The Chris Bentley ten-step plan helps us to work towards this aim.

8.8 Public Health are currently working with local partners in each district highlighted above (para 2.5) as having LSOAs in the most deprived decile in order to ensure we have accurately defined local communities and have mapped local assets.

9. Next steps

9.1 Local plans (based on natural local communities) will be developed which aim to improve place-based health through population, service and community-based approaches.

9.2 These plans will be reported back to this committee by January 2017.

10. Recommendation:

10.1 The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER**, **COMMENT ON** and **ENDORSE** the analysis and progress in developing the next 'Mind the Gap' for Kent.

11 Background Documents

11.1 Kent Public Health Annual Report 2015
http://www.kpho.org.uk/__data/assets/pdf_file/0005/57407/Final-Public-Health-Annual-Report-2015.pdf

11.2 Future Direction for "Mind The Gap: Reducing health inequalities in Kent Report to the September 2015 Adult Social Care and Health Cabinet Committee.
"https://democracy.kent.gov.uk/documents/s59510/C2%20-%20Mind%20the%20Gap%20final.pdf

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Update on Health Improvement Services Transformation Programme.

Classification: Unrestricted

Past Pathway of Paper: Adult Social Care and Health Cabinet Committee, 1 May 2015, 10 July 2015, 14 January 2016, 10 March 2016

Future Pathway of Paper: Cabinet Member decision

Electoral Division: All

Summary:

This report provides an update to the Adult Social Care and Health Cabinet Committee on the commissioning transformation programme for adult health improvement services and follows previous reports, which have been shared with the committee, to shape the emerging model.

The Public Health team has continued engagement with a range of stakeholders, including Kent residents, which highlighted a number of opportunities to align and/or integrate the new adult health improvement model.

This Committee is asked to endorse the direction of travel and support the procurement of a new integrated service following final engagement over the summer 2016 to enable effective integration.

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

1. **COMMENT** on progress with partners on the re-commissioning of adult health improvement services and **ENDORSE** the direction of travel; and
2. **SUPPORT** a competitive tendering of a new model, based on the key points identified in the paper

1. Introduction

1.1. This paper provides an update to the Adult Social Care and Health Cabinet Committee on the work to develop a new model for integrated healthy lifestyle services and proposal to start the procurement process in autumn 2016. The committee has been invited to shape the emerging model alongside stakeholders, public residents and the market to ensure the final solution will address key drivers for this work.

1.2. The scope of the review looked beyond commissioned services to ensure that the County Council secures the best possible value from the total resource

available and takes into account the wider determinates of health, emerging health structures and interdependencies with district councils.

1.3. This report outlines some of the key findings from the work to date and emerging opportunities for integration and sets out the new service model for integrated lifestyle services in Kent.

2. Summary of findings

2.1. There are still 827,470 adults in Kent with two or more unhealthy behaviours and those from deprived communities have an increased risk of having all four risk behaviours[1]. Forty per cent of all deaths in England are related to people's behaviours and correlate closely to a number of long term-conditions (such as type 2 diabetes, cancer, heart disease and dementia); a widening gap in health inequalities and early death amongst deprived populations.

2.2. Findings from this work have demonstrated that a more integrated and targeted approach would be the most effective way of delivering the outcomes, making greater use of the resources available and a more simplistic and tailored user experience.

2.3. There is support from Kent residents, with 75% of respondents agreeing with the proposed model, and only 9% disagreeing. Insight work also highlighted the need to support people in a holistic way, as unhealthy behaviours commonly cluster, are interchangeable and substitute for one another. For example, individuals who quit smoking commonly report putting on weight as they may eat more instead.

2.4. There is also a clear consensus for change and support for the approach from key stakeholder and potential providers. Ongoing discussions with CCGs and district councils has highlighted the need to align with emerging structures in health and the work of district councils to deliver maximum improvements in the health and wellbeing of the residents of Kent.

2.5. There is an opportunity to make better use of behavioural science to promote healthy lifestyles, positively influence lifestyle choices at key life stages and the need to make better use of community assets to reduce demand on services.

3. Opportunities for integration

3.1. Discussions with stakeholders and partners across the system have highlighted a number of opportunities for integration and the need for the new model to integrate with emerging health structures, the devolution agenda and the Sustainability Transformation Plans. Developments are expected in each of these areas during 2016/17. The current position is summarised below.

3.2. **Partnership working:** The CCGs and other local NHS and social care partners recognise that the current pattern of health and social care locally cannot continue in its current form. The vision is to provide a more coherent and

[1]Buck and Rossini (2012).

sustainable service model, designed and delivered around patients rather than the needs of patients being forced to fit around the services already available. These changes are expected to include establishment of Integrated Care Organisations (ICOs), Multi-speciality Community Providers (MCPs) and/or GP federations in a number of areas of the county. CCGs are taking an incremental planned approach to integration and the provider of integrated lifestyle services will need to work with the CCGs and other partners to align to Integrated Care Organisations (ICO), work collaboratively to provide a proactive, coordinated and responsive, person-centred care, consistent with the agreed model and develop locality-based working where the GP is the co-ordinator of care.

Work with Districts: District Councils play a significant role in delivering core public health outcomes and understand local communities' needs. Work is being developed across the County and there is a specific programme of work in West Kent to re-model our approach with stronger working and better utilisation of resource across the County Council and 3 District Councils. This closer collaborative working will make better use of the diminishing preventative resources collectively and inform the development of the model more widely across the County.

3.3. **The Sustainability and Transformation Plans** (STP) will help deliver the aspirations of the Five Year Forward Plan and are currently being developed on a Kent footprint to show how local services will evolve and become sustainable over the next five years. The new contract will need to be flexible enough to align to the STP, and will support the prevention strand of the plan.

4. Future model

4.1. The proposed model will integrate the current lifestyle services including healthy weight, smoking cessation, physical activity, health trainers and outreach health checks. There will be simple access and referral pathways to support residents to access support quickly, reducing the need to visit multiple services.

4.2. NHS Health Checks core programme will also be re-procured and be used as a way to support behavioural change. This is a mandated programme that provided 89,787 Health Checks in 2015/16 to the eligible population of 40 to 74 year olds in Kent.

4.3. The model will see a greater integration of health improvement practitioners (who currently deliver Health Trainers, smoking and weight management) into a joint role which is similar to that of a Health Trainer (in other areas these are referred to as Wellness Advisors or Lifestyle coaches). These community practitioners will be targeted to Kent residents who are more likely to have multiple unhealthy lifestyle behaviours, at-risk groups and individuals from deprived areas.

4.4. Feedback from the review has highlighted the importance of retaining specialist expertise within a skill mixed workforce for each health outcome. This will be an important part of the final delivery model to ensure expert advice is given.

There is no dilution of expertise however services can be delivered at an increased scale and in a more targeted way.

4.5. The service will support individuals to overcome the barriers preventing them from adapting healthy behaviours, working with them in a tailored way and use motivation interviewing techniques to increase motivation and readiness to change. The service will take an evidence-based approach by delivering interventions that have been proven to help people quit smoking, lose weight, take more exercise, reduce their drinking and keep them feeling mentally well, and make it possible for people to tackle more than one behaviour, should they wish. The service will work closely with specialist services such as mental health, alcohol, drugs, housing and domestic abuse services to ensure onward referral where appropriate. A particular emphasis will be placed in the health promotion and lifestyle advice to people with diagnosed mental health problems ensuring parity of esteem.

4.6. There will be a greater emphasis placed on utilisation and signposting to the vast range of activities available to those living in Kent. By motivating people to access opportunities within their existing communities and build on the assets available, demand on services can be reduced and people will be better equipped to sustain behavioural changes. It will also see a greater role for volunteers, advocates and peer led help to support individuals achieve their personal lifestyle goals.

4.7. The recommissioning will look to increase choice of services by increasing the range of places where people can access support. This will include GP surgeries, pharmacies, leisure centres and other qualified community providers.

4.8. The brand identity will align with the national behaviour change campaign for adults called “One You” (www.nhs.uk/oneyou) to ensure it is clear for Kent residents where they can go to access support. The service will utilise national resources including apps and campaign materials and support Public Health led campaigns.

4.9. The innovative model will use a number of robust measures for tracking outcomes to help build the evidence base of what works and link to the Kent Integrated Dataset.

5. Financial implications

5.1. As indicated in the report to this committee in March 2016, the contracts for the health improvement services currently have a total annual value of approximately £5.3m. However, ongoing budget pressures and reductions each year will mean the contract will see a reduction in budget year on year.

5.2. The successful provider will need to work with the County Council to drive efficiencies and meet savings targets across the life of the contract, which will include a greater use of online and digital innovations.

6. Next steps

6.1. The work to date will enable Public Health to develop an outcome-based service specification for an integrated Healthy Lifestyle service that will deliver the needs identified, but be flexible enough to adapt to emerging needs and priorities over the life of the contract.

6.2. There will be continued engagement over the summer of 2016 with Kent residents, CCGs, district councils and the market to refine the model, prior to a competitive tender process in the autumn.

6.3. Following a competitive tender process, the committee will receive a further report later this year prior to a key decision being taken to award the contract. New contracts will be in place by April 2017, following a mobilisation period.

7. Conclusions

7.1. Living healthily in middle age can increase life expectancy and double the chances of being healthy at 70. It is therefore important to take a preventive approach by supporting adults to make lifestyle changes today, which will have a positive impact on their health, and reduce demand on social care and health services in later life.

7.2. Many other local authority areas such as Birmingham, Dorset and Portsmouth have already moved to an integrated model of provision. There is momentum towards local authorities commissioning integrated health and wellbeing services across the UK and Kent is working with other areas to share learning of what works.

7.3. There is clear scope for partners (including health commissioners and district / borough councils) to work in partnership to drive better integration of services that contribute to improving Public Health outcomes. This transformation and re-commissioning will support this work to improve the health of Kent residents and reduce health inequalities.

8. Recommendation(s)

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

1.1 **COMMENT** on progress with partners on the re-commissioning of adult health improvement services and **ENDORSE** the direction of travel; and

1.2 **SUPPORT** a competitive tendering of a new model based on the key points identified in the paper

Background Documents

Five Year Forward View. (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf.

Buck and Rossini (2012). Clustering of unhealthy behaviours over time. The Kings Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Proposed Kent Drug and Alcohol Strategy 2017-2022

Classification: Unrestricted

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

Future Pathway of Paper: Kent Drug and Alcohol Partnership

Electoral Division: All

Summary:

The current Kent Alcohol Strategy ends in 2016. It is proposed that a five-year combined drug and alcohol strategy will replace this from 2017-22, jointly produced by Kent Police and Public Health on behalf of the Kent Drug and Alcohol Partnership.

This paper outlines the themes of the new strategy, which are: Resilience, Identification, Early Help and Harm Reduction, Recovery and Supply. A new strategy is required, as the complexity of drug use has increased. The paper proposes that the next steps are to draft a strategy, consult with our partners and the public in order to develop and implement the Kent Drug and Alcohol Strategy 2017-2022.

All partners will need to be more involved – particularly the NHS.

Recommendation:

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

COMMENT upon the proposal for the Kent Drug and Alcohol Strategy (2017-2022), specifically the main themes of the strategy and the timeline;

ENDORSE this approach and/or make alternative suggestions to the Cabinet Member for Adult Social Care and Public Health.

1. Introduction

This report presents an overview of the proposed Kent drug and alcohol strategy (2017-2022). This strategy will be a joined strategy led by Kent Police and Public Health on behalf of the Kent Drug and Alcohol Partnership, allied community groups and the public. The strategy will be developed throughout 2016-17 for launch in April 2017**.**

2. Rationale

2.1 Until recent years there was a clear picture of the types of drugs being misused and their associated harms. This is no longer the case. There are newer harms resulting from a range of drugs previously not seen by services, including steroids, psychoactive substances and prescription drugs – both legal and illicit.

2.2 This challenging landscape requires an integrated and co-ordinated approach by all partners. We require all agencies to be active participants in prevention in order to facilitate cultural and behaviour change towards alcohol and drug misuse.

2.3 There are early indications that young people have responded to preventative messages. There are now higher reported national rates of alcohol abstinence and fewer alcohol-related hospital admissions in Kent. The new strategic challenge is to see a change in the adult population. The combination of public sector austerity and increasingly complex drug and alcohol challenges mean that a new approach is needed that is shared with all partners – including the NHS.

2.4 All partners need to be part of tackling the growing complexities in drug and alcohol misuse, e.g. housing and employment are crucial to maintaining recovery. The NHS are needed to play their part in helping individuals manage their drug and alcohol issues as long-term conditions – just as diabetes and high blood pressure are managed.

2.5 There have been notable successes of alcohol strategy that we are keen to maintain. Each district in Kent has a collaborative local alcohol action plan. The progress on the current Alcohol Strategy for Kent is displayed in appendix 2 to this report.

2.6 The new Drug and Alcohol Strategy will build on this and also ensure treatment services become more focused on those with complex drug and alcohol issues. The recommissioning of the current treatment service in East Kent is to begin in autumn 2016**.**

2.7 The new strategy will tackle health inequalities and inequities. The recent needs assessments for drugs and alcohol have shown that there are higher alcohol-related harm rates in East Kent, particularly in Canterbury, Swale and Thanet. There are also higher rates of drug-related deaths in Swale, Canterbury and Maidstone. The needs assessment highlights issues of the offender population, homeless and leaving care population as the most vulnerable. The strategic themes in the strategy will tackle these issues in partnership.

3. Governance

3.1 The current Kent Alcohol Strategy reports to the Kent Drug and Alcohol Partnership Group. This strategy ends at the end of 2016. The new Kent Drug and Alcohol Strategy will report to the Kent Drug and Alcohol Partnership and also to the Health and Wellbeing Board and the Crime Partnership Board.

4. Themes

4.1 The priority areas and key themes forming the basis of the strategy are displayed in Table 1. These are applicable to both adults and children and are aligned to national evidence and locally-identified priorities.

Table 1 Drug and alcohol strategy themes

Theme	Main tasks – *example activity*
Resilience	• Maintain focus upon building resilience in individuals
Identification	• Increase workforce training and screening capacity in both statutory and non-statutory organisations • Public information and education
Early Help & Harm Reduction	• Drug and alcohol pathways • Increasing and earlier referrals to treatment services, especially for at-risk groups • Reduce preventable mortality and morbidity
Recovery	• Move from an acute (episodic) model of care to a sustained recovery model. • Improve support for sustained recovery
Supply	• Disrupt related criminal activities • Public health data contributing to the licensing process

4.2 There are no financial implications to the development of this strategy other than to make best use of available commissioning resources across the health and social care economy.

5 Next steps

5.1 A strategy development timeline, inclusive of a public consultation, has been issued (appendix 4). A working group drawn from partner organisations will facilitate and coordinate this work. The anticipated partners and allied interest organisations who will be involved are listed in appendix 3. The public consultation will take place over the summer and we will be seeking views on the strategy and proposed actions. We will also seek opinion on the evaluation criteria e.g. relevance, coherence, effectiveness, efficiency and value.

6. Recommendation

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

COMMENT upon the proposal for the Kent Drug and Alcohol Strategy (2017-2022), specifically the main themes of the strategy and the timeline;

ENDORSE this approach and/or make alternative suggestions to the Cabinet Member for Adult Social Care and Public Health.

7. Background Documents

7.1 None

8. Appendices

8.1 Appendix 1 Summary of Drug Misuse Needs Assessment for Kent

8.2 Appendix 2 Update of progress of Alcohol Strategy 2014-2016

8.3 Appendix 3 Briefing on Cannabis use in Kent

8.4 Appendix 4 list of Participants and Stakeholders

8.5 Appendix 5 Timeline: drug and alcohol strategy development

9. Contact details

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Appendix 1

Key Facts from Adults Drug Misuse Needs Assessment by Kent Public Health Team.

National

- Drug use is decreasing: Drug use is at its lowest since measurement began in 1996 with the use of any drug in the last year among 16 to 59 year olds falling from 8.9% in 2011/12 to 8.2% in 2012/13. Among young people aged 11 to 15, 12% reported having taken any drug in the last year in 2012, the latest drop in a downward trend from 20% in 2001
- Pattern of drug use is changing: Fewer Opiate and Crack and greater poly drug use, NPS (Legal Highs), prescribed drug misuse and dependent drinking.
- Attitudes to drugs are negative: The majority of adults think that drug-taking is unsafe: 98% of adults thought heroin was very unsafe; 97% view cocaine and ecstasy as unsafe (very or a bit unsafe); 79% of adults thought taking cannabis was unsafe compared with 3% who thought it was very safe; and 75% of adults viewed getting drunk as unsafe.
- Supply may be decreasing: In 2012/13, over 109 tonnes of Class A drugs were seized at home and abroad as a result of Serious Organised Crime Agency (SOCA) activity. The police and the UK Border Force made 193,980 drug seizures in England and Wales in 2012/13, an 8% decrease from 2011/12
- Treatment is getting more effective: Record numbers of people in England are completing their treatment free of dependence. The overall number of people who have successfully completed their treatment for any drug has gone up from around 11,000 in 2005/06 to just under 30,000 in 2011/12; and nearly one third of users in this period successfully completed their treatment and did not return, which compares favourably to international recovery rates
- Fewer Heroin and Crack Users. The number of heroin and crack cocaine users in England has fallen below 300,000 for the first time. The latest estimates show the number of heroin and crack users fell to 298,752 in 2010/11, from a peak of 332,090 in 2005/06

Local

- Treatment Providers may not be treating the most needy or vulnerable people Recent needs assessment on treatment data shows that while services are getting good outcomes for lower level substance misusers, there are far fewer clients in the most vulnerable category and vulnerable people are less likely to be recovering.

- Estimated number of 4616 Heroin and Crack Users in Kent (Glasgow Estimate).
- The data indicates that there is a significantly larger difference in treatment penetration between crack and opiate users in Kent. There are hypotheses as to the reason for this difference. It has been noted that treatment has historically been overwhelmingly focused on opiate users, with little attention paid to the growing numbers of crack and poly-drug users (Audit Commission, 2002)

- Vulnerable Groups: Prevalence statistics indicate that substance misuse among the LGB community is nearly 4 times greater than that of the overall population. Kent treatment data shows that LGB individuals were less likely to be in structured treatment in 2012/13 (0.1%) than the Kent population overall (0.3%).
- Drug Treatment is value for money. Using the PHE value for Money Tool it can be argued that in Kent, for every £1 spent on drug treatment, nearly £6 is gained in benefits.
- There are links between injecting drug use (including steroids) and HIV and Hep B & C.
- Lower rates in Kent for Drug related deaths but lots of variation. The 2012 figure was 2.5 in comparison to an average over the period of 2.7. There is notable variation between rates in districts. The highest rates are found in Thanet, Swale and Gravesham. The lowest rates are found in Ashford, Sevenoaks and Tonbridge & Malling. Dover has also had a very high rate over the period that has reduced in recent years.
- There has been an increase in mental health related drug hospital admissions in England and Kent. There were a total of 1157 admissions for drug-related mental health and behavioural disorders in Kent in 2012/13.
- Decrease in emergency detox in hospitals.
- Fewer people in structured treatment in Kent. 13% decrease from 2009. Mainly people are accessing for opiate and crack and 24% decrease in ‘other drug use’.

Alcohol (Adults): Progress on Current Alcohol Strategy

Pledge area	Aim	Achievement	Status/ DoT
1. Improve prevention and Identification	Screen 9% of the Kent population (18+) Target 106,389	11% of the target population; 128,542 (121%) .	Green 
2. Improve the Quality of Treatment	Increase number of referrals into treatment services by 15% by 2016[1].	Trend increasing.	Green 
3 Co-ordinate Enforcement and Responsibility *These elements of the plans are largely taken from the work of Kent Community Safety Partnerships.*	12 police operations per year will be completed e.g. CSP targeted activity within localities Support the work the development of Kent CAPs	Achieved in 2015. Ongoing in 2016. Achieved and ongoing	Green 
4 Tailor the plan to the local community	Each District will develop a local alcohol action plan.	Achieved	Green 
5. Target Vulnerable groups and Tackle Health Inequalities	Contained in District plans as locally identified priorities.	Ongoing. Evaluation at the end of the strategy	Green 
6 Protect Children and Young People	Reduce alcohol related hospital admissions for those aged under 18 years	The number of admissions is decreasing. Kent is better than the national and South East region	Green 

[1] Successful completions are a good indication of quality. Service Quality Assured by service monitoring of national reports on a range of service indicators and via quarterly KDAAP reports Service information available at: https://www.ndtms.net/default.aspx

Cannabis use in Kent

Summary

Data is limited due to the illegal nature of the drug. Data is presented from national surveys and Kent treatment services.

Cannabis is a Class B drug. It is the most commonly used illicit drug in UK and in Kent, with 29% of people claiming to have used the drug at least once in their lifetime. There is some evidence that there is more cannabis users in structured treatment in Kent then might be expected given national prevalence. However this does not mean that there are a higher proportion of drug users in Kent only that more people are referred and/or seek treatment. There is national evidence that the strength of Cannabis is increasing which may pose risks to user's mental and emotional health.

1.1 What is Cannabis?

Three products of the plant *Cannabis sativa* (also known as hemp) are commonly available in the UK[2]:

a) **Cannabis resin (hash),** which is prepared from the flowering and other parts of the cannabis plant that contain many glandular trichomes. The material is processed and compressed into hard blocks before importation into the UK, mainly from North Africa.

b) **Traditional herbal cannabis (marijuana),** which is a dried plant preparation of floral and folia material imported from the Caribbean, Africa or Asia. Like resin, it is either rolled with tobacco and smoked as a "joint" or vaporised in a smoking device.

c) **Sinsemilla (including skunk),** which is composed of the flowering tops of unfertilised female cannabis plants produced by intensive indoor cultivation methods. Although some is imported, much is now grown in the UK. As with other forms of cannabis, it is either rolled with tobacco or vaporised in a smoking device *(ACMD, 2008).*

- A study by the Home Office (2008) on cannabis potency found that the majority of cannabis seized across the UK was Sinsemilla.
- The potency of cannabis is measured according to its concentration of THC. THC (r9-tetrahydrocannabinol) is the dominant chemical component found in cannabis which stimulates cannaboid receptors in the brain to manipulate mood and cognition and give users a 'high'.
- Increasingly sophisticated cultivation of Sinsemilla has made cannabis stronger over the last 30 years
- Data from the Home Office study (2008) showed the percentage of THC in Sinsemilla ranged from 4.1% to 46.0%
- This study showed an increase in THC content from 5.8% in 1995 to 10.4% in 2007 and 16.1% in 2008, showing that more potent forms of cannabis are becoming more prevalent in the UK.
- Cannabis retains its Class B drug status due to a moderate risk and association with schizophrenia and psychosis.

[2] This is not to be confused with 'synthetic cannabis', a psychoactive mix of herbs and chemicals commonly known as 'spice'.

1.2 Classification and Penalties

- Cannabis is controlled under Class B of the Misuse of Drugs Act (1971). In 2008, the Advisory Council on the Misuse of Drugs (ACMD) recommended in their report that cannabis remain a Class C drug, as a result of a review of the evidence on the harms posed by cannabis. However this was not accepted by the Government and it was upgraded to Class B., which has a number of implications for the way that police will deal with offences involving the drug (Drugscope, 2013)

- For possession of the drug: Up to 5 years prison, unlimited fine or both. For Supply Up to 14 years in prison, an unlimited fine or both.

- A person under 18: is found to be in possession of cannabis, they will be arrested and taken to a police station where they can receive a reprimand (first time), final warning (second time) or charge depending on the seriousness of the offence. This must be administered in the presence of an appropriate adult. After a final warning, the young offender must be referred to a Youth Offending Team to arrange a rehabilitation programme.

2. Nature and Extent of Use in UK:

Cannabis is by far the most commonly used drug according to the Crime Survey for England and Wales in 2015 (CSEW). In 2015 29% of people surveyed said they had used Cannabis sometime in their lives (Table 1).

Table 1 Reported drug use ever

Drug	Proportion
cannabis	29.2%
class A drug use	15.5%
amphetamines	10.3%
powder cocaine	9.7%
ecstasy	9.2%
amyl nitrite	8.5%

CSEW, 2015

Findings from the CSEW (2015) show that around 1 in 12 (8.2%) adults had taken an illicit drug (excluding mephedrone) *in the last year*, with cannabis being the most commonly used by **6.4%.** This is the lowest proportion since measurements began in 1996.

Cannabis was also the most commonly used drug amongst young people, with **13.5%** aged 16 to 24 *using it last year*. This is a decrease since 2011/12 (15.7%) and again is the lowest proportion since measurement began in 1996.

Data from the *Smoking, drinking and drug use amongst young people in England* survey (Fuller, 2012) shows that cannabis remains the most widely used drug among 11-15 year olds with **7.5%** of pupils reporting taking the drug in the last year.

Of those using Cannabis in the last year – around 40% report being regular users of Cannabis.

2.1. UK Treatment of Cannabis

Despite figures showing that the use of cannabis has declined since 2003, the number of treatment presentations for cannabis use nationally has substantially increased. However the increase in treatment presentations, which is mainly amongst young people aged under 20 years old, is likely to reflect the expansion of young people's treatment services (United Kingdom Drug Situation 2011). Data from the National Drug Treatment and Monitoring Service (NDTMS) showed that nationally, cannabis was the primary drug for **8%** of all clients receiving treatment.

National evidence points to the most effective treatment being any behavioural intervention (including cognitive behavioural therapy (CBT), motivational interviewing (MI) and contingency management) can help to reduce use and improve psychosocial functioning, both in adults and adolescents, at least in the short-term
Multidimensional family therapy helps reduce use and keep patients in treatment, especially in high-severity young patients.

2.2 Cannabis Use in Kent

The most recent needs assessment data in Kent shows that for 12% of people in Drug Treatment in Kent in 2014 had Cannabis as their primary drug. This is higher than the national average (Table 2).

More recent data from the local drug treatment services show that in 2015-2016, 21% of East Kent's clients accessing structured treatment cited Cannabis as either a primary, secondary or tertiary problem and in West Kent the proportion was 19%. However this data is not verified by the National data base so must be seen as indicative only at this stage. However data indicates a slight increase.

Overall treatment outcomes in Kent are good compared to National – with 54% of patients remaining abstinent 1 year after treatment.

Table 2 Treatment services: use by substance 2014

Drug	1st drug		2nd drug		3rd drug		Total
	n	%	n	%	n	%	n
Heroin	1813	68%	108	6%	18	2%	1939
Cannabis	*308*	*12%*	*461*	*25%*	*238*	*29%*	*1007*
Crack Cocaine	44	2%	534	29%	122	15%	700
Cocaine	111	4%	195	10%	58	7%	364
Other Opiates	144	5%	109	6%	52	6%	305
Methadone	69	3%	159	9%	69	8%	297
Benzodiazepines	28	1%	123	7%	113	14%	264
Amphetamines	66	2%	86	5%	53	6%	205
Prescription Drugs	37	1%	23	1%	26	3%	86
Other Drugs	14	1%	32	2%	28	3%	74
Ecstasy	7	0%	15	1%	21	3%	43
Hallucinogens	8	0%	14	1%	20	2%	42
NPS	4	0%	2	0%	4	0%	10
Solvents	1	0%	2	0%	2	0%	5

Source: KDAAT/NDTMS, 2014

Appendix 4

Strategy development: participants and Stakeholders

This list is not exhaustive and is subject to amendment.

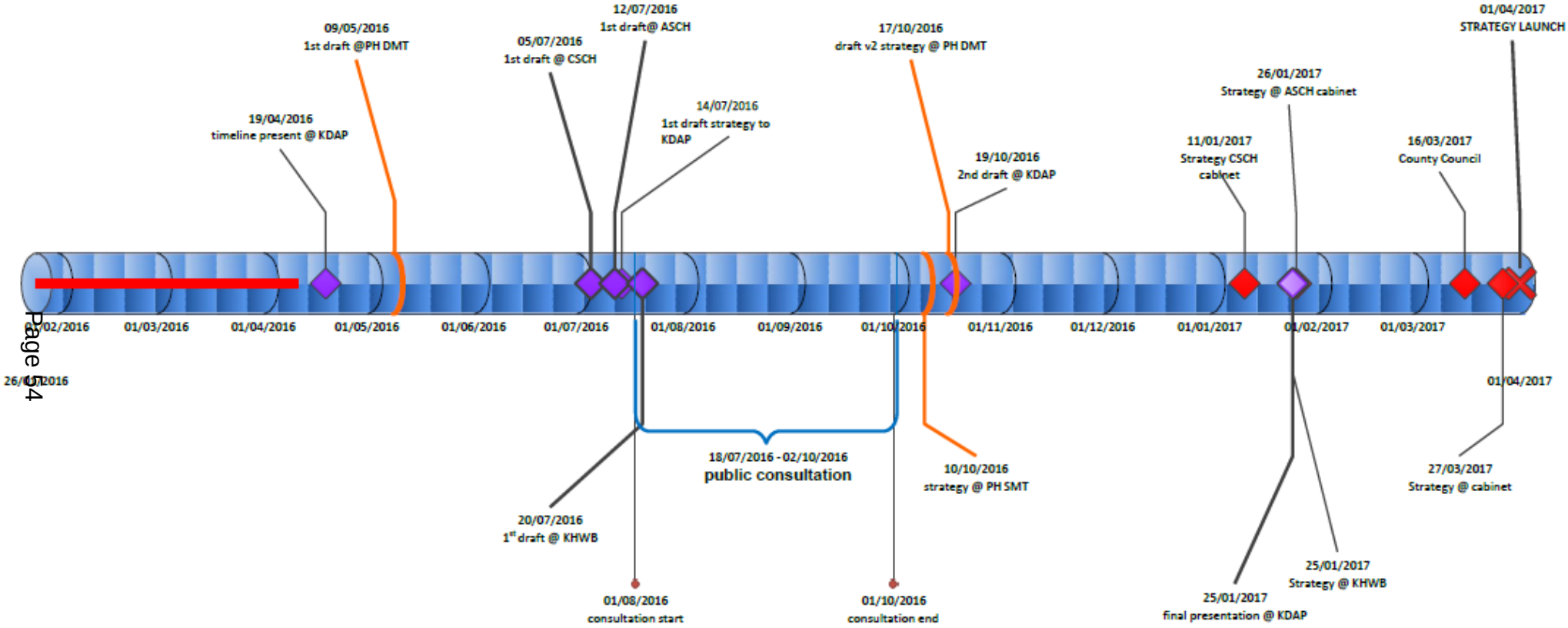
- Kent Police
- Community Safety Partnerships
- National Probation Service
- Community Rehabilitation Company (CRC)
- SEETEC
- Office of the Police and Crime Commissioner
- Coroner's office

Kent County Council: public health, housing, early help/preventative services
District Councils

- Kent and Medway NHS and Social Care Partnership Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Kent NHS Hospitals:
    - William Harvey
    - Queen Elizabeth the Queen Mother
    - Kent and Canterbury
    - Maidstone
    - Tunbridge Wells
    - Medway Maritime
    - Darent Valley
- NHS England
- NHS Clinical Commissioning Groups
- NHS England Local Area Team Head of Health and Justice
- Kent Local Pharmaceutical Committee

- Kent and Medway Licensing Steering Group
- KCA
- Health watch
- Change, Grow, Live
- Turning Point
- RAPT
- Addaction
- Consultant / Specialist: drugs and alcohol (Chair)
- Head of Quality (Vice Chair)
- Commissioner: drugs and alcohol services
- Regional drug and alcohol representative
- Job Centre Plus
- Service user representation
- Kent Drug and Alcohol Partnership organisations
- Shelter
- Community, Voluntary an allied interest groups (TBA)

Appendix 5 Timeline: drug and alcohol strategy development



[End]

From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director - Social Care, Health and Wellbeing
To:	Adult Social Care and Health Cabinet Committee – 12 July 2016
Subject:	ADULT SOCIAL CARE PERFORMANCE DASHBOARD
Classification:	Unrestricted
Previous Pathway:	Social Care, Health and Wellbeing DMT
Future Pathway:	None
Electoral Division:	All

Summary: The performance dashboard provides Members with progress against targets set for key performance and activity indicators for April 2016 for Adult Social Care.

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** the Adult Social Care performance dashboard

1. Introduction

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

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

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

2. Performance Report

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

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

2.3 The latest report contains the most up to date indicators with revised targets, based on the delivery of our transformation programme (Phase 1 and Phase 2). This includes ensuring that the interdependencies between services are understood and that the targets reflect these. For example, a reduction in nursing care may mean an increase in residential care.

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

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

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

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

Green: Current target achieved or exceeded

Red: Performance is below a pre-defined minimum standard

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

3. Recommendations

3.1 Recommendation: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** the Adult Social Care performance dashboard.

4. Background Documents

None

5. Report Author

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Adult Social Care Dashboard

April 2016

Key to RAG (Red/ Amber/ Green) ratings applied to KPIs	
GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
→	Performance has stayed the same
↓	Performance has worsened relative to targets set

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

Adult Social Care Indicators

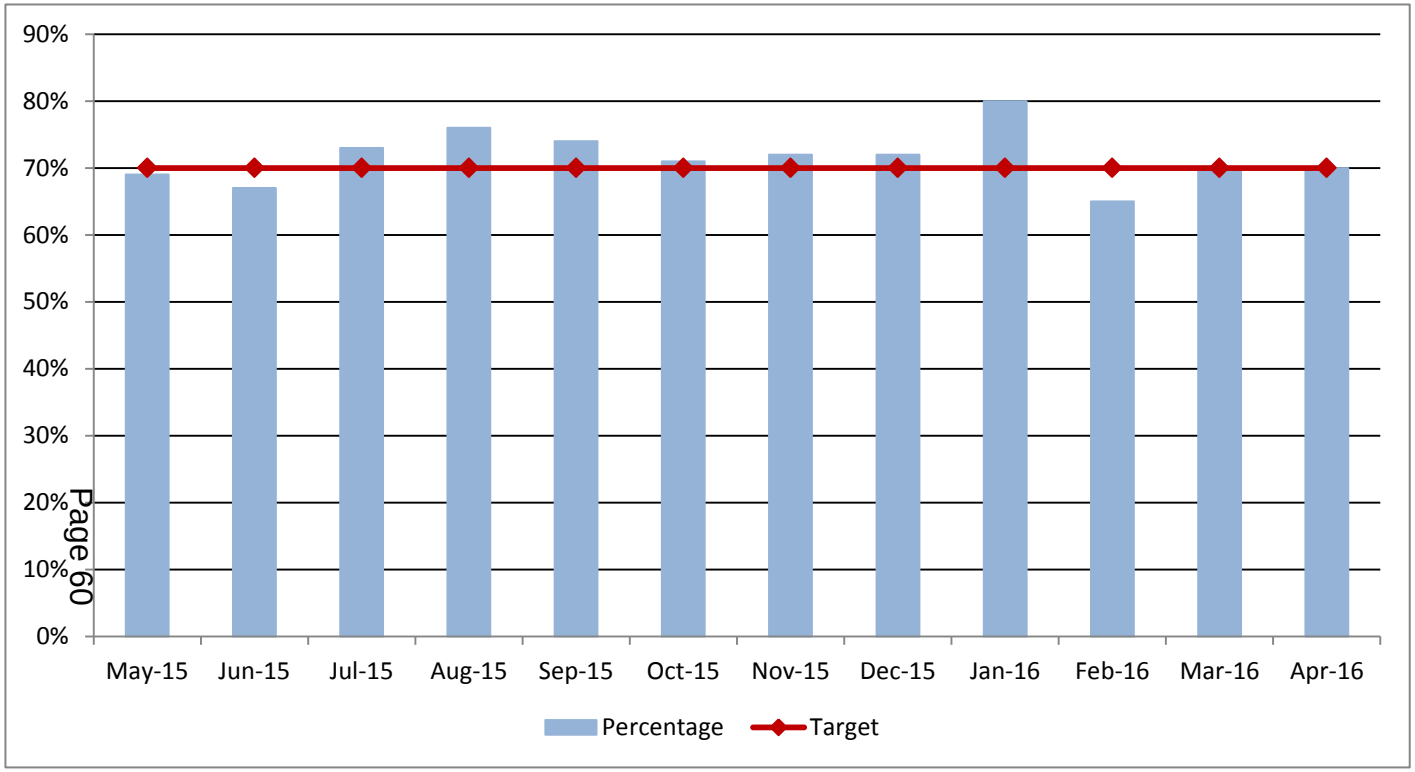
The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet. This is clearly labelled on the summary and in the detail.

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

All information is as at the latest month wherever possible.

Indicator Description		MoS	SCHW SPS	QPR	2015-16 Outturn	Current 2016-17 Target	Current Position	Data Period	RAG	Direction
1)	Percentage of contacts resolved at source (ASC01)	Y	Y	Y	72%	70%	**70%**	Month	GREEN	→
2)	Number of adult social care clients receiving a Telecare service (ASC02)		Y	Y	5,792	5,708	**5,998**	Cumulative	GREEN	↑
3)	Referrals to Enablement (ASC03)	Y	Y	Y	770	940	**875**	Month	AMBER	↑
4)	Delayed Transfers of Care				26.8% full year effect	30%	**23.3%**	12M	GREEN	↓
5)	Admissions to permanent residential or nursing care for people aged 65+	Y		Y	121	139	**121**	Month	GREEN	→
6)	Number of people aged 65+ in permanent residential care (AS01)	Y	Y	Y	2,423	2,386	**2,368**	Snapshot	GREEN	↓
7)	Number of people aged 65+ in permanent nursing care (AS02)	Y	Y	Y	1,251	1,214	**1,194**	Snapshot	GREEN	↓
8)	Number of people receiving domiciliary care (AS03)	Y	Y	Y	4,534	4,676	**4,497**	Snapshot	GREEN	↓
9)	Number of people receiving direct payments	Y			2,405	2,404	**2,384**	Snapshot	GREEN	↓
10)	Number of people with a learning disability in residential care (AS04)		Y	Y	1,210	1,219	**1,206**	Snapshot	GREEN	↓
11)	Number of people with a learning disability receiving a community service				1,936	1,568	**1,759**	Snapshot	GREEN	↓
12)	Percentage of adults in contact with secondary mental health in settled accommodation				83.5%	75%	**83.1%**	Month	GREEN	↓
13)	Percentage of adults with mental health needs in employment				13.9%	13%	**13.7%**	Month	GREEN	↓

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



Data Notes

Data Source: Measures of Success - MoS 1

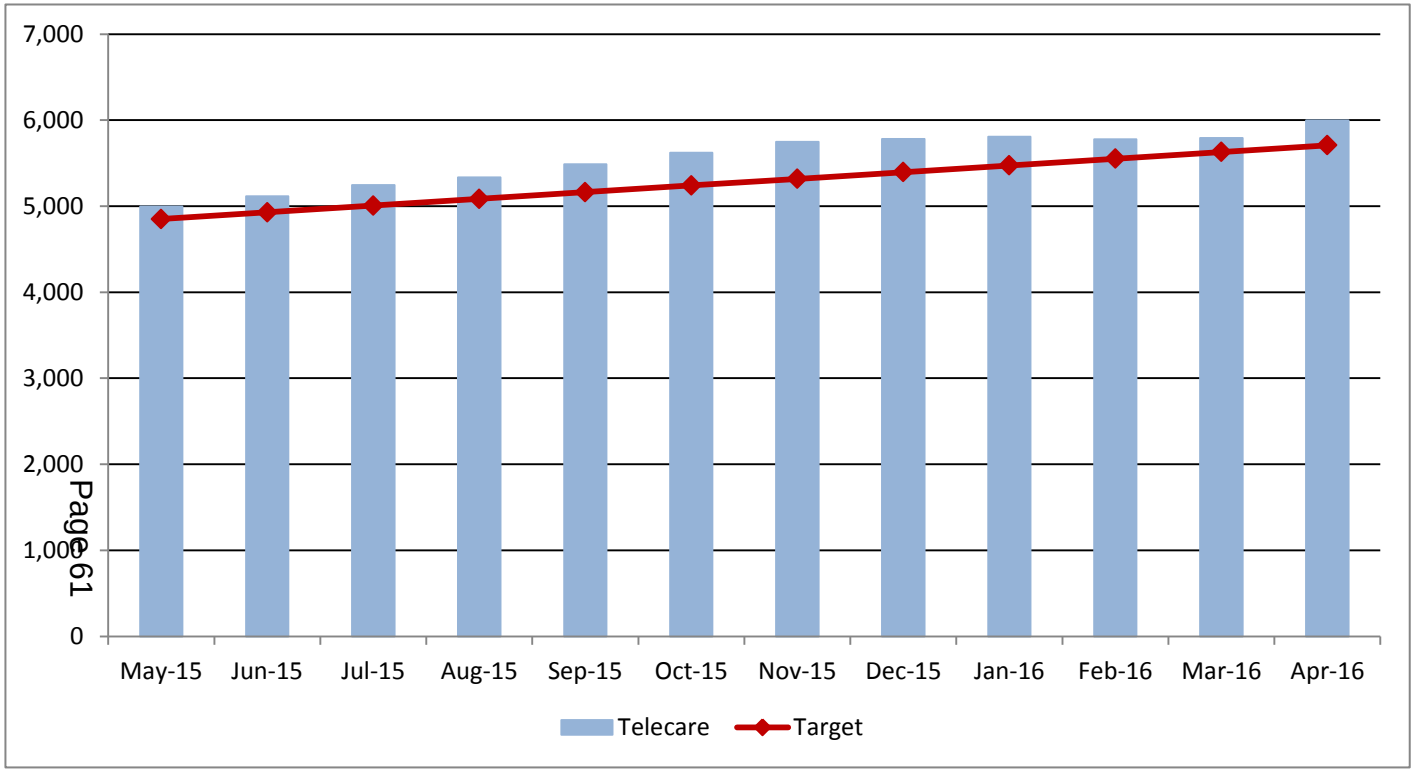
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**	**70%**
Percentage	69%	67%	73%	76%	74%	71%	72%	72%	80%	65%	70%	70%
RAG Rating	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN

Commentary

A key priority for Adult Social Care is to respond to more people's needs at the point of contact, through better information, advice and guidance, or provision of equipment where appropriate. Performance in April was on target.

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



Data Notes

Unit of Measure: Snapshot with Telecare as at the end of each month

Data Source: Adult Social Care SWIFT client system

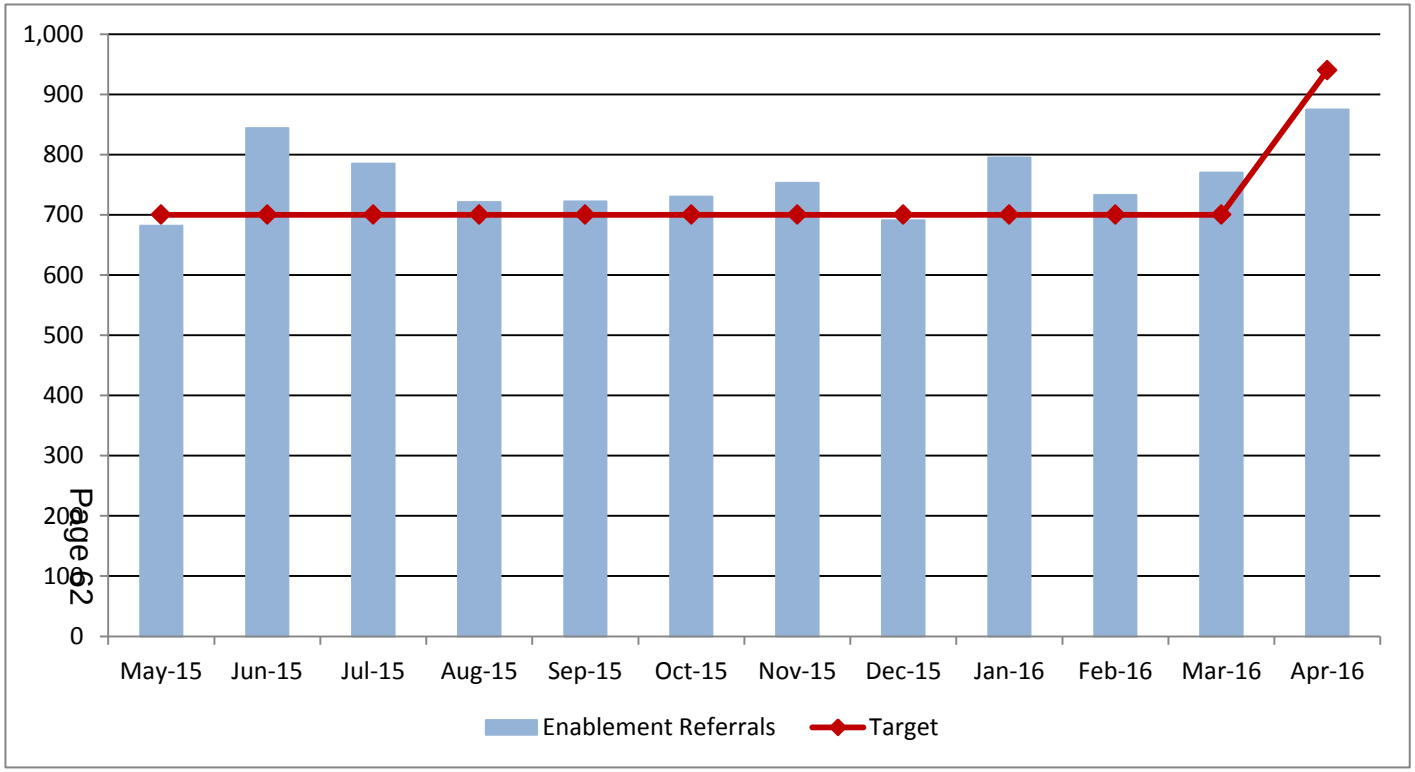
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**4,850**	**4,928**	**5,006**	**5,084**	**5,162**	**5,240**	**5,318**	**5,396**	**5,474**	**5,552**	**5,630**	**5,708**
Telecare	4,996	5,116	5,246	5,336	5,489	5,623	5,746	5,781	5,809	5,779	5,792	5,998
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

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

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



Data Notes

Unit of Measure: Number of people who had a referral that led to an Enablement service

Data Source: Measures of Success - MoS 4

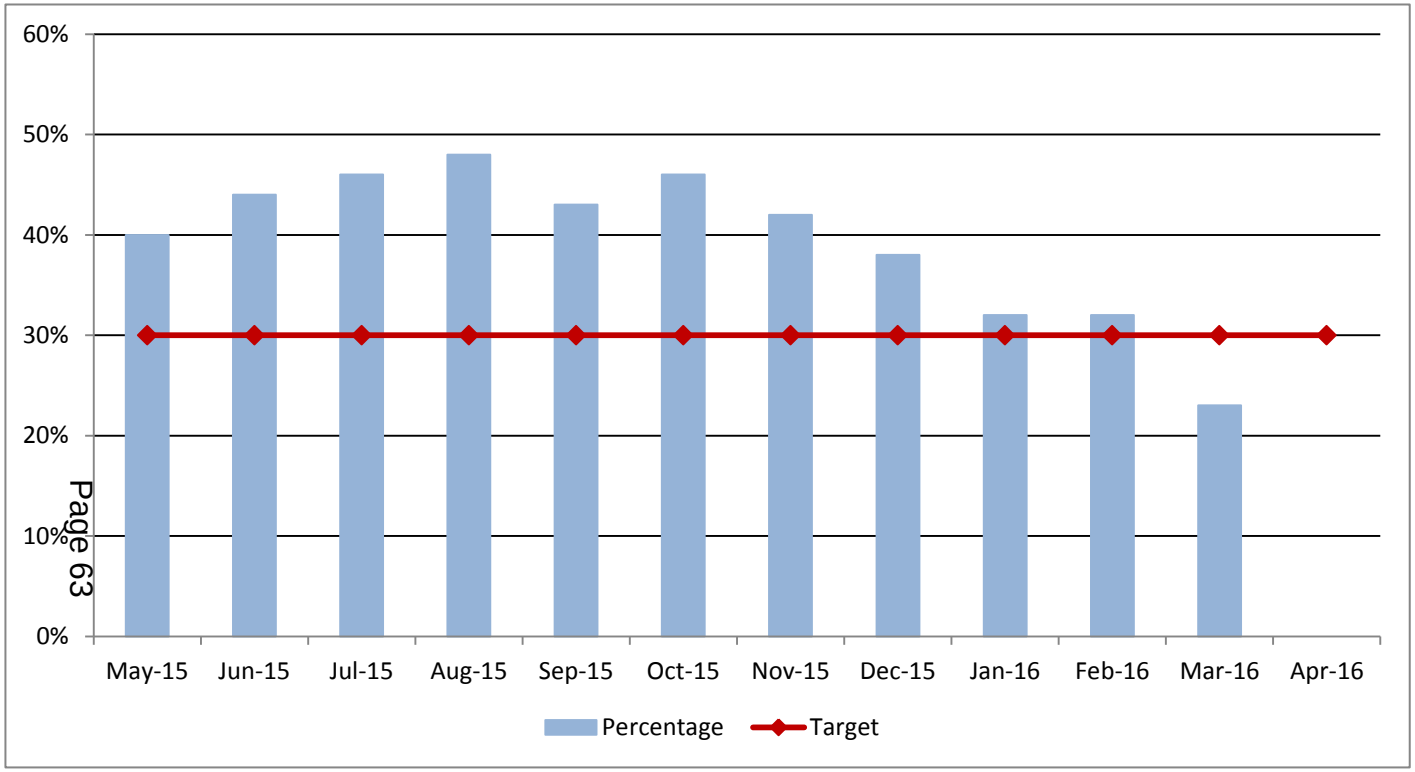
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**700**	**940**
Enablement Referrals	682	844	785	721	722	730	753	691	795	733	770	875
RAG Rating	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN	GREEN	AMBER

Commentary

Additional capacity in KEAH Enablement service has been created which has led to an increase in the target (217 per week). This will result in more people utilising the enablement service to aid clients to achieve independence and/ or a lesser care package following enablement.

4) Delayed Transfers of Care			GREEN ↓
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes

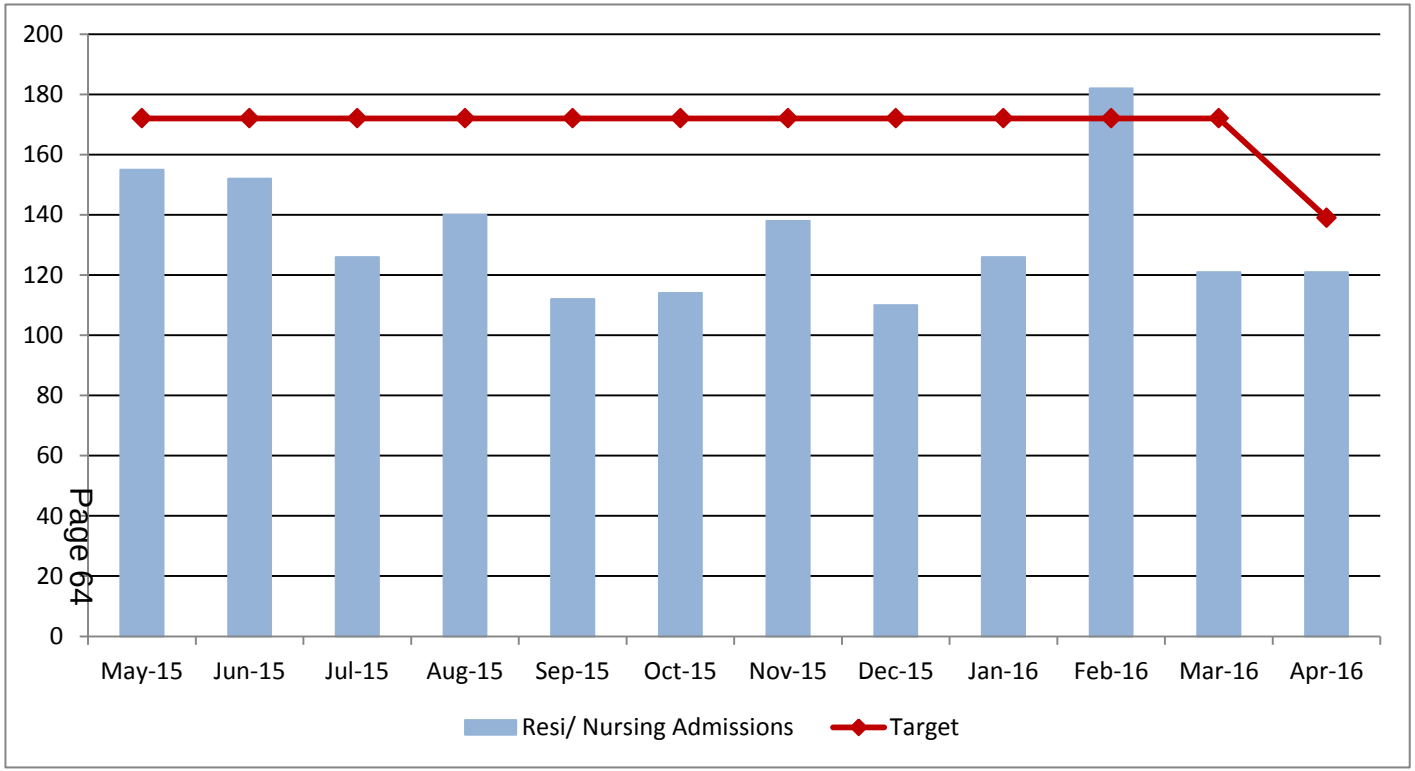
This indicator represents the percentage of delays attributable to Social Care.

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**	**30%**
Percentage	40%	44%	46%	48%	43%	46%	42%	38%	32%	32%	23%	N/A
RAG Rating	AMBER	RED	RED	RED	RED	RED	RED	AMBER	AMBER	AMBER	GREEN	

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently 23.3% of delays are attributable to Adult Social Care; this reflects a further reduction in Q4 of 2015-16 and is now below the 30% target. The top three reasons for delays are: awaiting further NHS non-acute care, patient choice, and awaiting Nursing Home placement availability.

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



Data Notes

Unit of Measure: Older people placed into Permanent Residential and Nursing Care per month

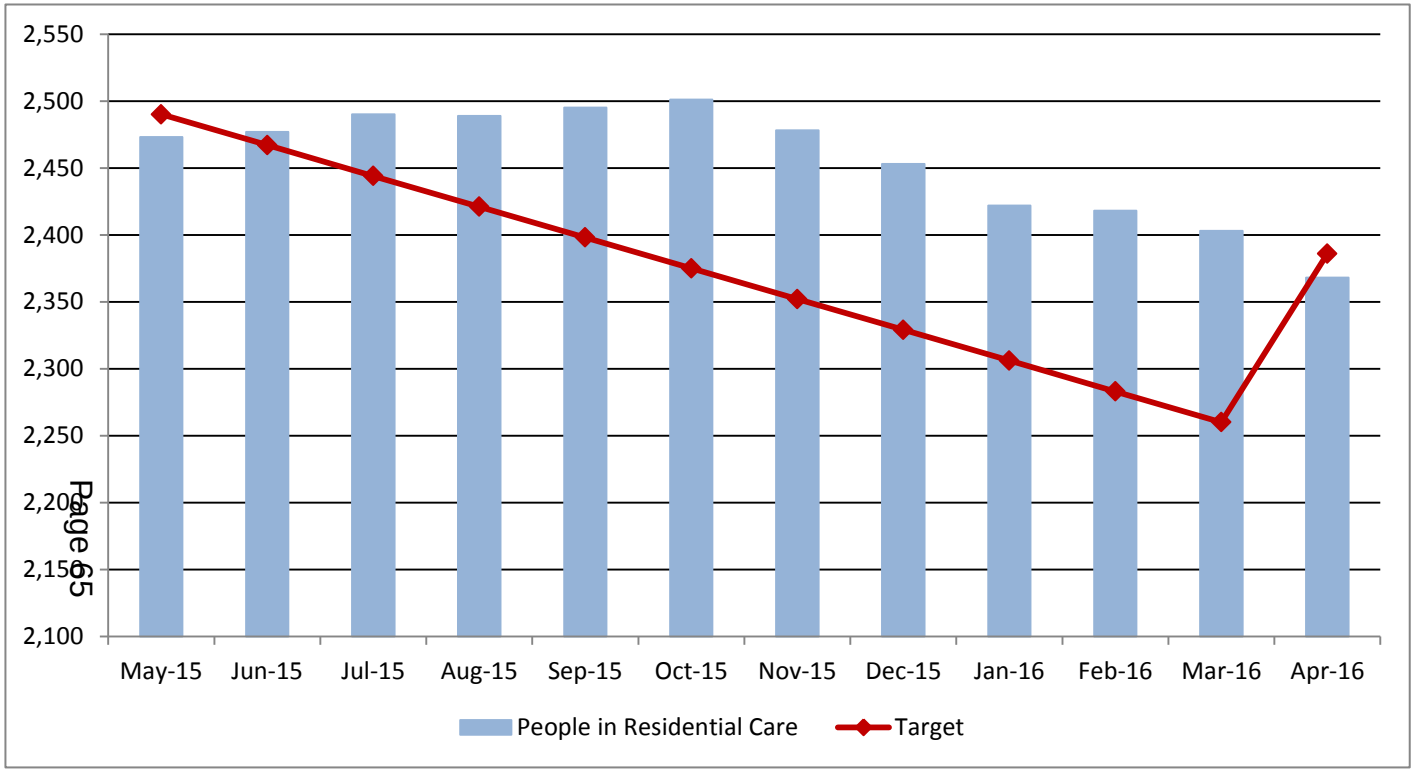
Data Source: Measures of Success - MoS 6 and MoS 8

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**172**	**172**	**172**	**172**	**172**	**172**	**172**	**172**	**172**	**172**	**172**	**139**
Resi/ Nursing Admissions	155	152	126	140	112	114	138	110	126	182	121	121
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	GREEN	GREEN

Commentary

Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. As part of the monthly budget and activity monitoring process, admissions are examined, to understand exactly why they have happened. The objectives of the transformation programme will be to ensure that the right services are in place to ensure that people can self manage with these conditions, and ensure that a falls prevention strategy and support is in place to reduce the need for admission. In the meantime, there are clear targets set for the teams which are monitored on a bi weekly basis through Measures of Success. The monthly target is for no more than 32.12 permanent admissions per week for the over 65's to Residential or Nursing Care.

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



Data Notes

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

Data Source: Measures of Success - MoS 6

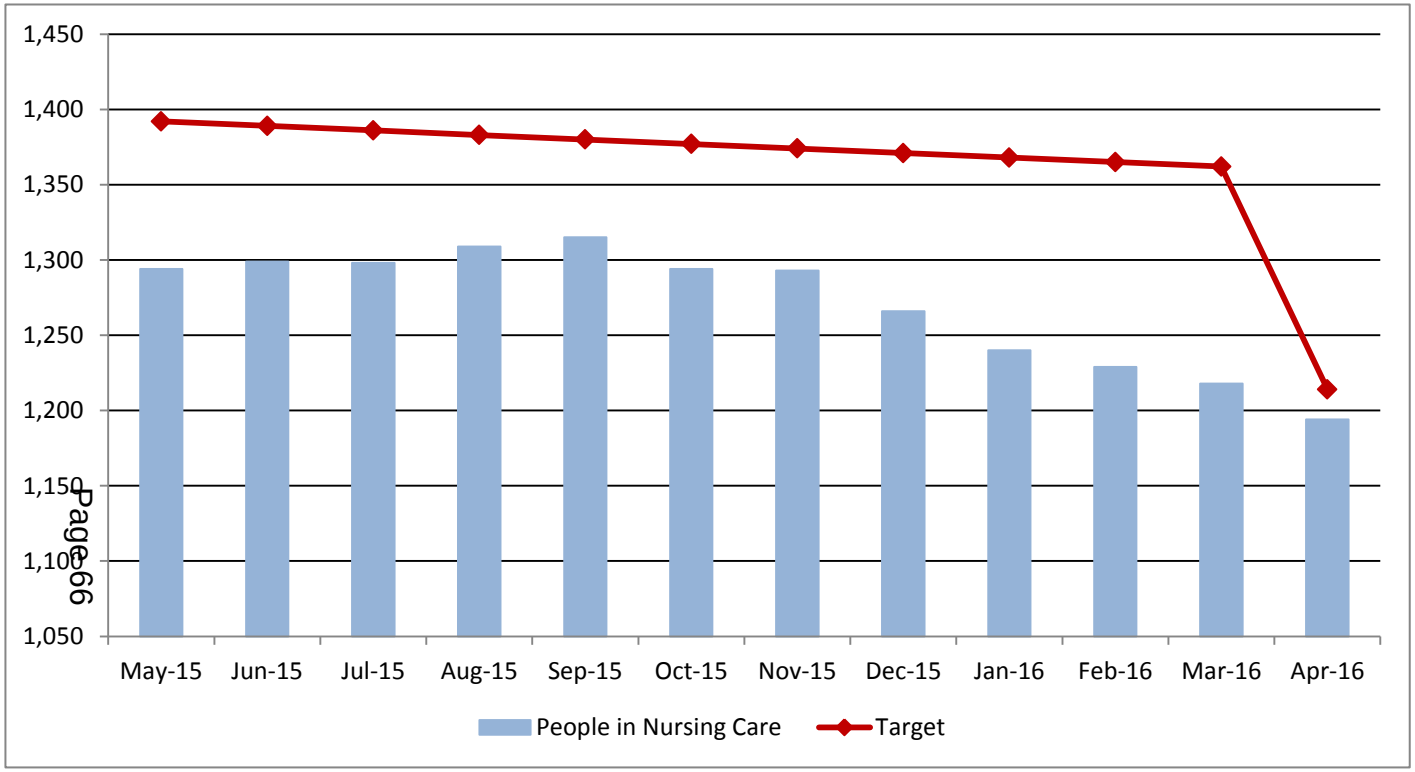
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**2,490**	**2,467**	**2,444**	**2,421**	**2,398**	**2,375**	**2,352**	**2,329**	**2,306**	**2,283**	**2,260**	**2,386**
People in Residential Care	2,473	2,477	2,490	2,489	2,495	2,501	2,478	2,453	2,422	2,418	2,403	2,368
RAG Rating	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	GREEN

Commentary

The number of people aged 65+ in permanent residential care is currently above the target level by 18 this month. There is an end of year target of 2,028 people or less to be in permanent residential care by 31st March 2017.

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



Data Notes

Unit of Measure: End of month snapshot of the number of people aged 65+ in permanent nursing care

Data Source: Measures of Success - MoS 8

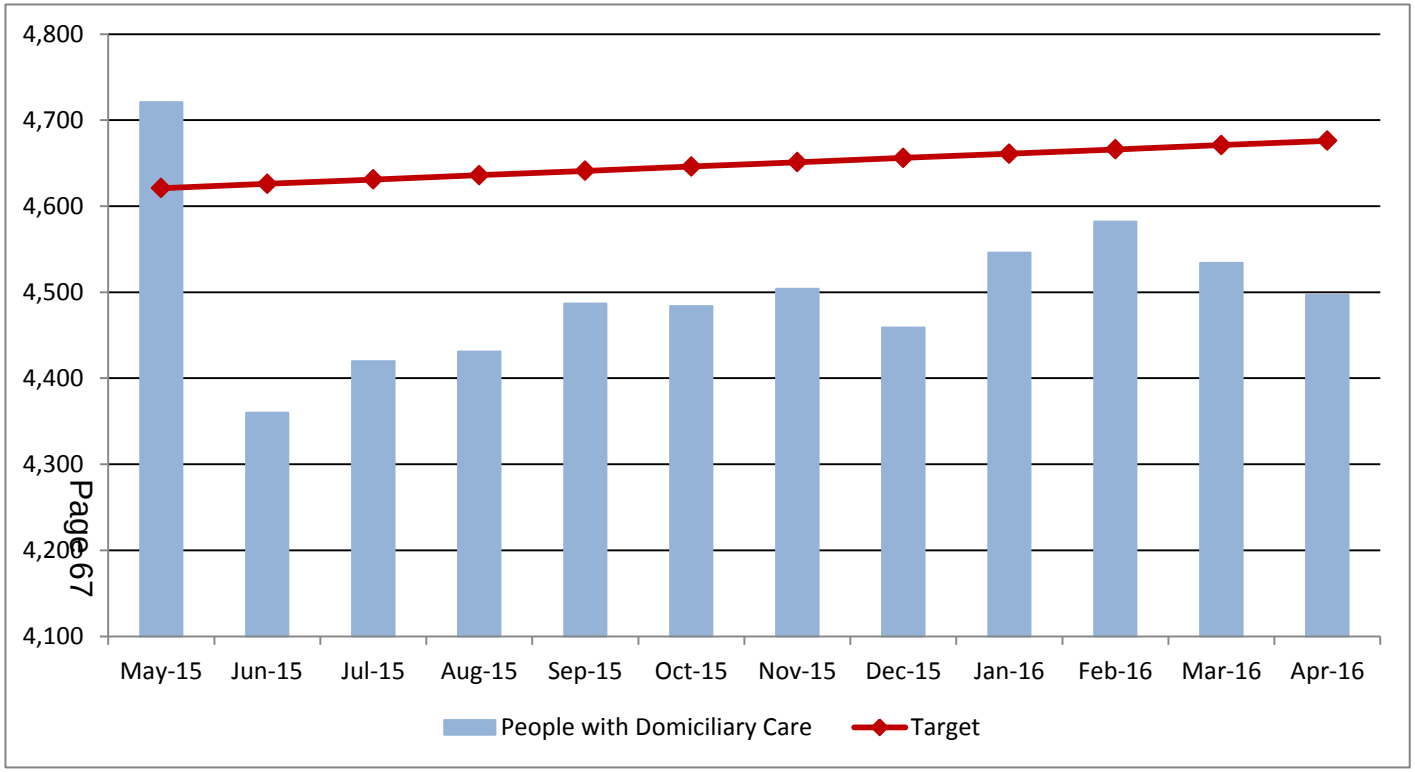
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**1,392**	**1,389**	**1,386**	**1,383**	**1,380**	**1,377**	**1,374**	**1,371**	**1,368**	**1,365**	**1,362**	**1,214**
People in Nursing Care	1,294	1,299	1,298	1,309	1,315	1,294	1,293	1,266	1,240	1,229	1,218	1,194
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

The number of people aged 65+ in permanent Nursing Care had been decreasing across Kent. The number of new starters for Nursing care is significantly higher in West Kent with an average of 6.2 starts per week compared to an average of 2.3 starts in the other areas. Despite this, performance remains significantly less than the target by 20.

8) Number of people receiving domiciliary care (AS03)			GREEN ↓
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes

Unit of Measure: End of month snapshot of the number of people receiving domiciliary care

Data Source: Measures of Success - MoS 10

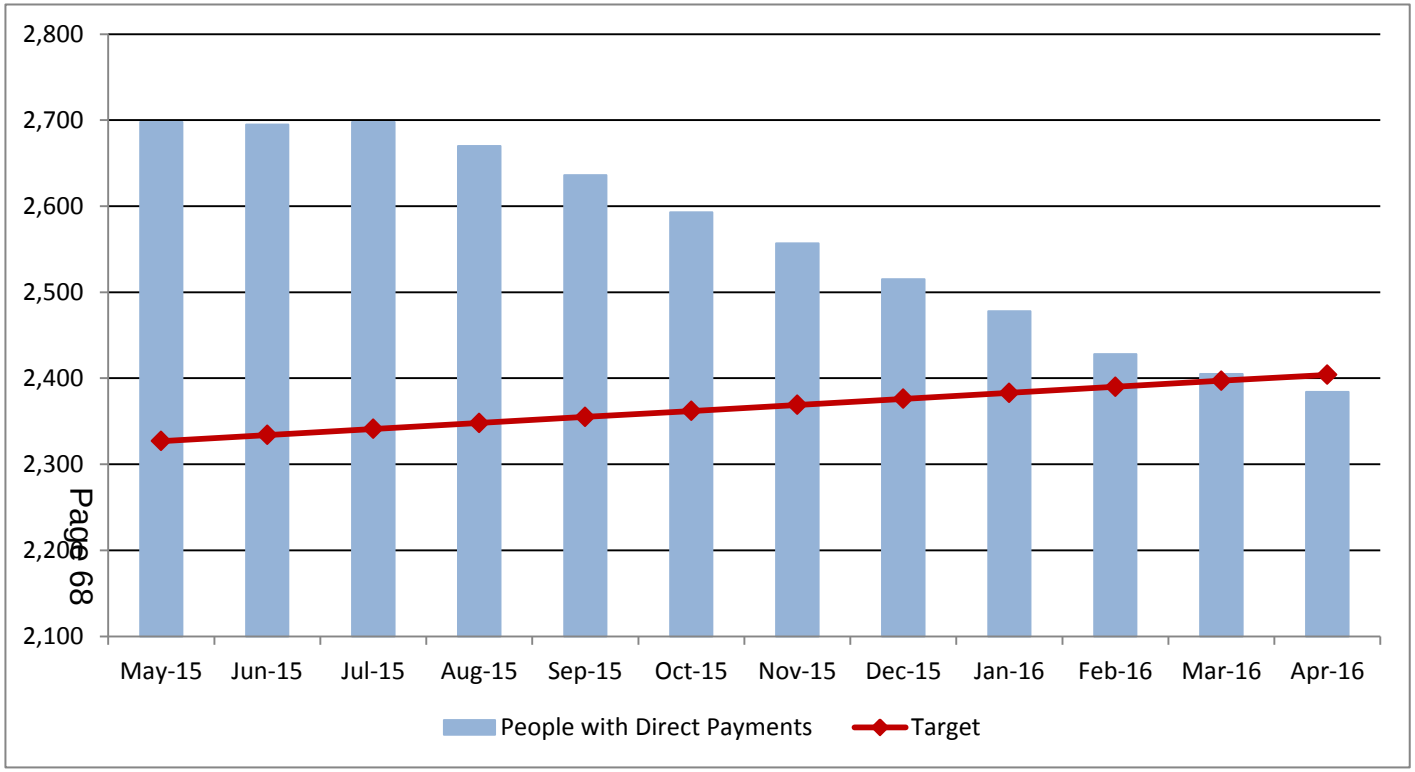
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**4,621**	**4,626**	**4,631**	**4,636**	**4,641**	**4,646**	**4,651**	**4,656**	**4,661**	**4,666**	**4,671**	**4,676**
People with Domiciliary Care	4,721	4,360	4,420	4,431	4,487	4,484	4,504	4,459	4,546	4,582	4,534	4,497
RAG Rating	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

The total number of people receiving domiciliary care has remained fairly stable but remains significantly below target.

9) Number of people receiving direct payments			GREEN ↓
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Social Care, Health and Wellbeing - Adults	**Division**	Older People and Physical Disability



Data Notes

Unit of Measure: End of month snapshot of the number of people receiving direct payments

Data Source: Measures of Success - MoS 12

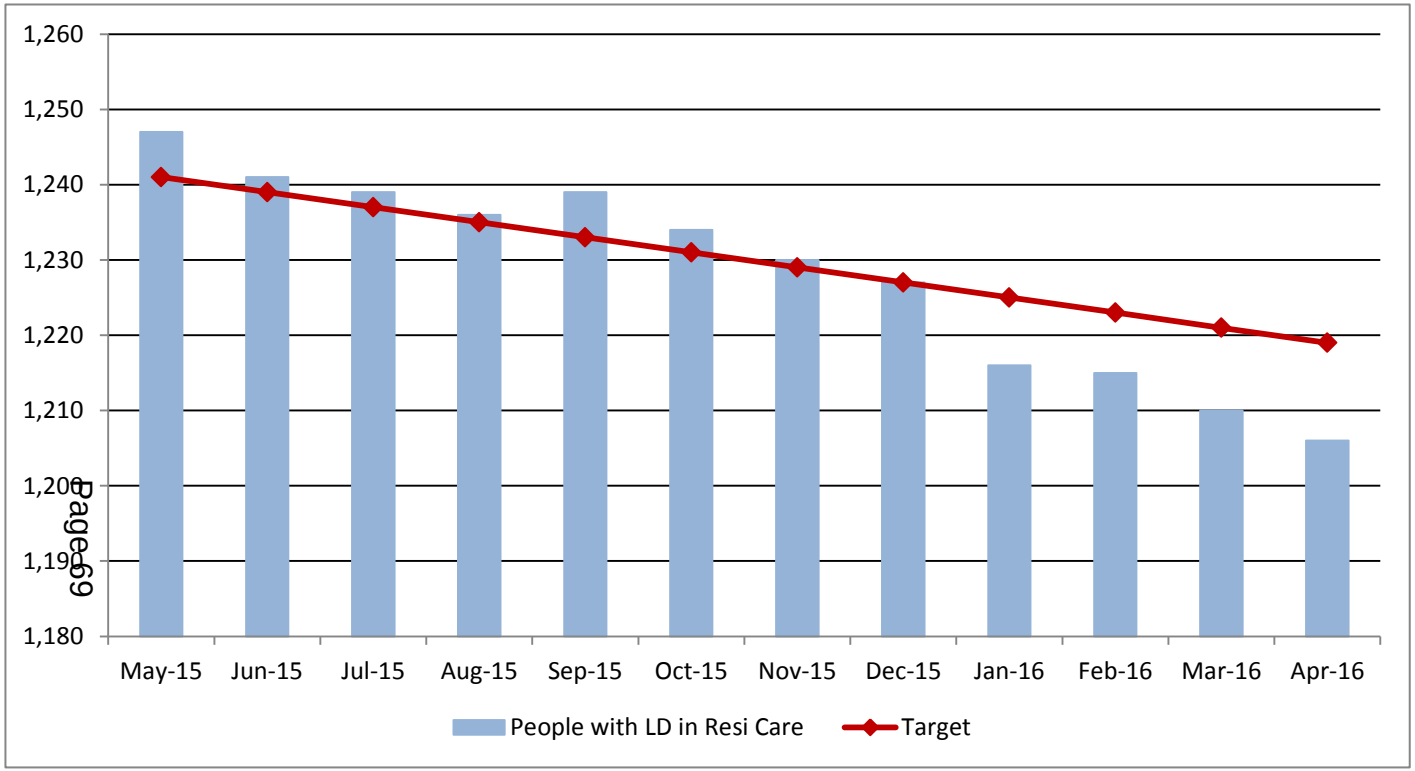
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**2,327**	**2,334**	**2,341**	**2,348**	**2,355**	**2,362**	**2,369**	**2,376**	**2,383**	**2,390**	**2,397**	**2,404**
People with Direct Payments	2,698	2,695	2,698	2,670	2,636	2,593	2,557	2,515	2,478	2,428	2,405	2,384
RAG Rating	**RED**	**RED**	**RED**	**RED**	**RED**	**RED**	**AMBER**	**AMBER**	**AMBER**	**AMBER**	**GREEN**	**GREEN**

Commentary

The total number of people receiving direct payments has been reducing since the home care mobilisation exercise in July 2014.

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



Data Notes

Unit of Measure: Number of people with a learning disability in permanent residential care as at month end.

Data Source: MCR Summary

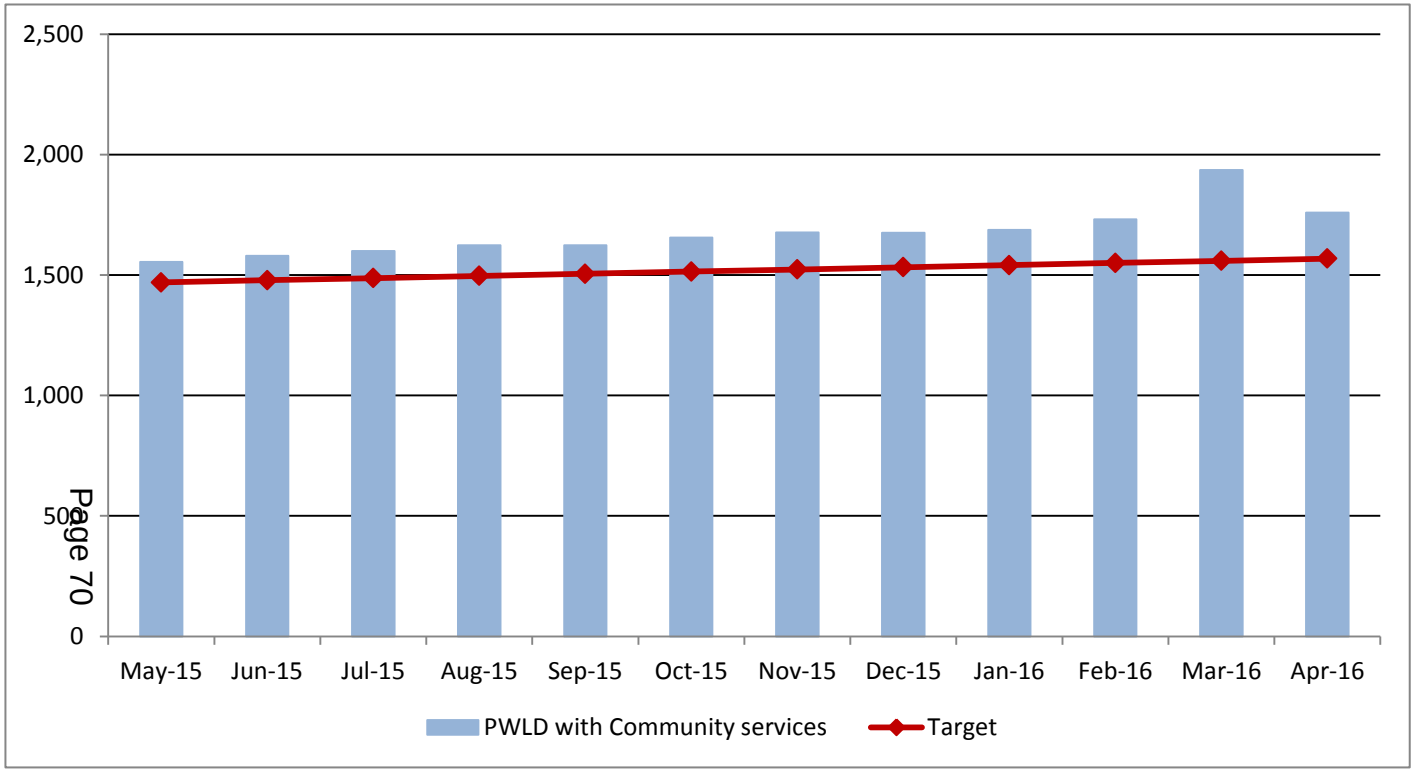
Quarterly Performance Report Indicator

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**1,241**	**1,239**	**1,237**	**1,235**	**1,233**	**1,231**	**1,229**	**1,227**	**1,225**	**1,223**	**1,221**	**1,219**
People with LD in Resi Care	1,247	1,241	1,239	1,236	1,239	1,234	1,230	1,227	1,216	1,215	1,210	1,206
RAG Rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

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

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



Data Notes

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

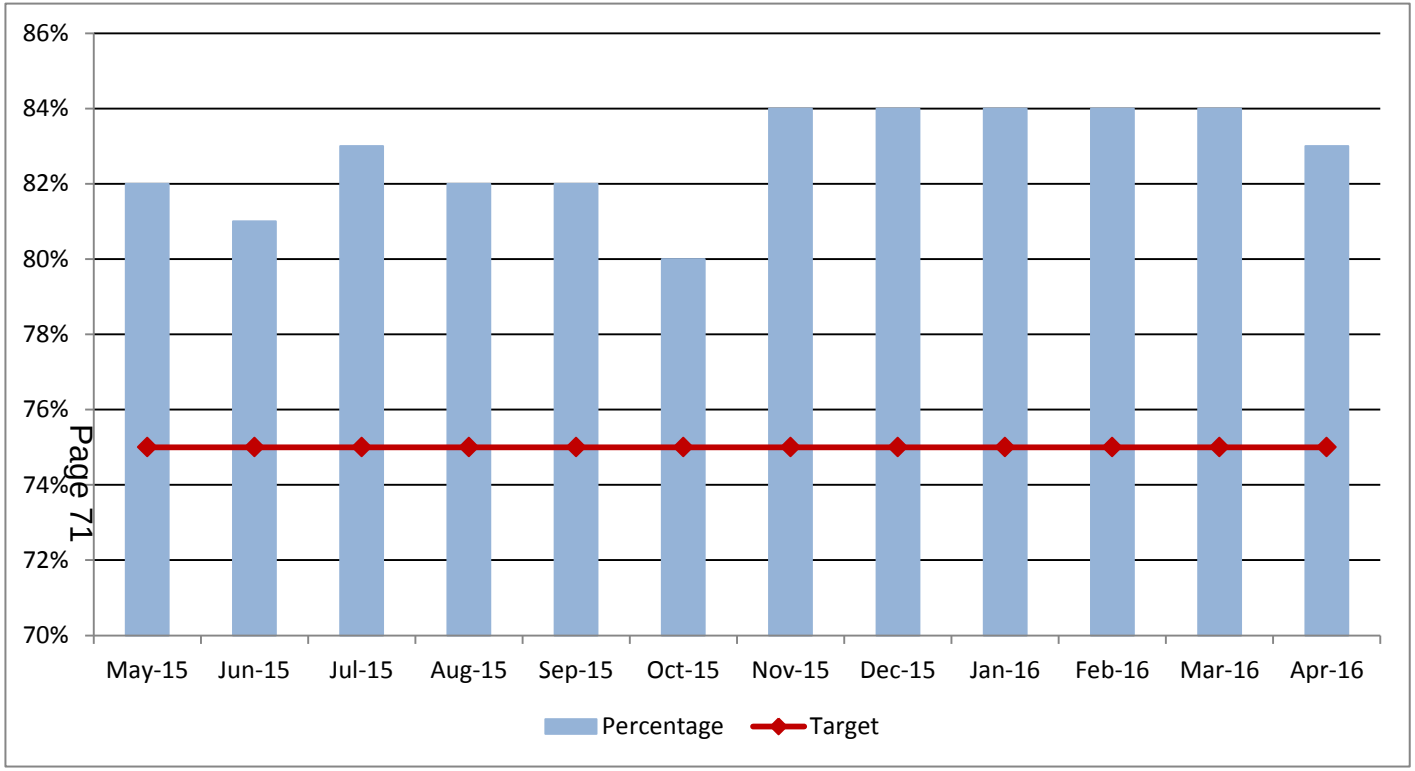
Data Source: MCR Summary

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**1,469**	**1,478**	**1,487**	**1,496**	**1,505**	**1,514**	**1,523**	**1,532**	**1,541**	**1,550**	**1,559**	**1,568**
PWLD with Community services	1,555	1,579	1,599	1,624	1,623	1,656	1,677	1,675	1,687	1,731	1,936	1,759
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

The figure for April 2016 has normalised following the Campus Re-provision, when a high number of Supported Living services were migrated to new SIS services on 28/03/16 and were therefore effectively counted twice in that reporting month, explaining the sudden apparent spike in March. The net number of people with a learning disability receiving a community service (shared lives, supported living and Supporting Independence Service) remains stable and April's figure is more consistent with the average for 2015-16.

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



Data Notes

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

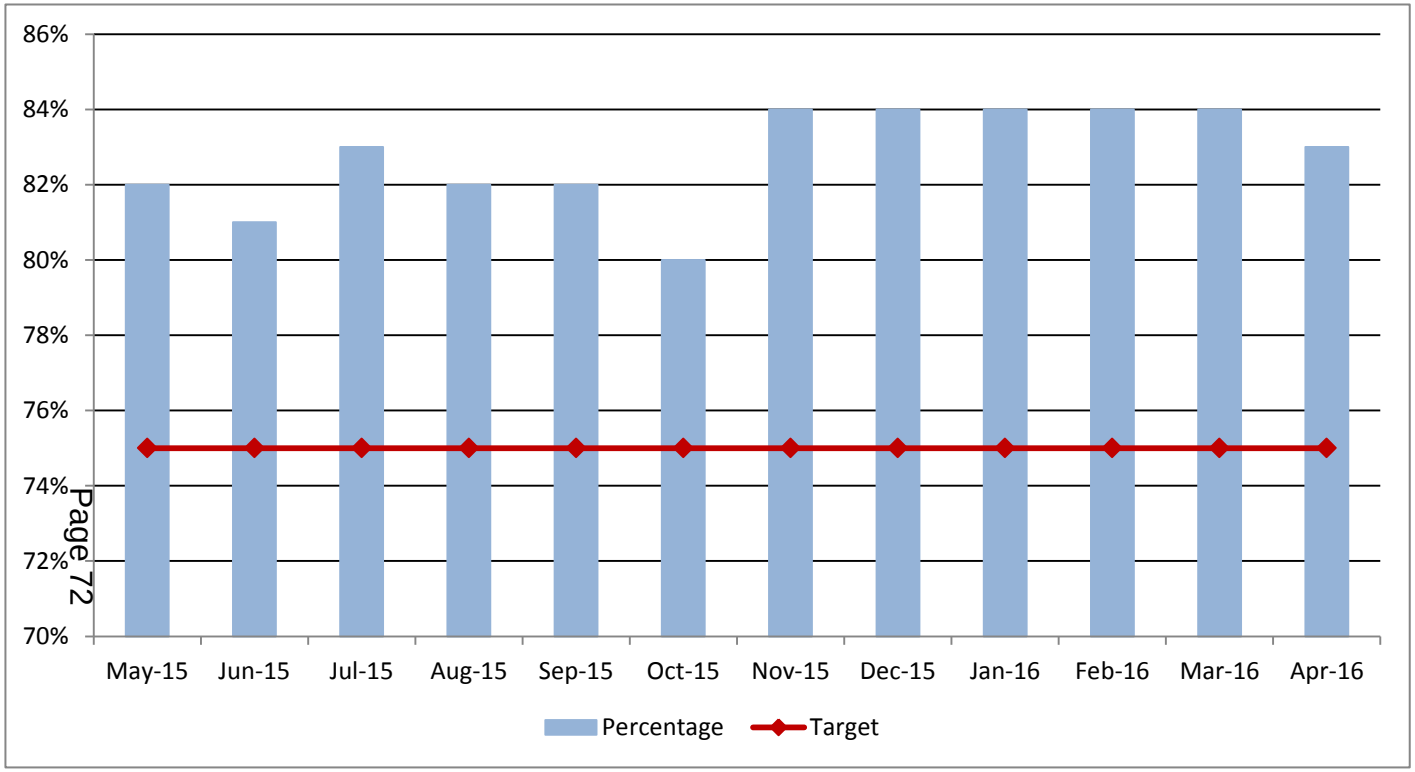
Data Source: KMPT – quarterly

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
Percentage	82%	81%	83%	82%	82%	80%	84%	84%	84%	84%	84%	83%
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This data is provided directly from KMPT and remains above target.

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



Data Notes

Units of Measure: Percentage of people with mental health needs in employment

Data Source: KMPT – quarterly

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Target	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**	**13%**
Percentage	12.1%	12.2%	12.9%	13.0%	12.8%	12.4%	12.7%	13.5%	13.7%	13.8%	13.8%	13.7%
RAG Rating	AMBER	AMBER	AMBER	GREEN	AMBER	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This data is provided directly from KMPT and remains above target.

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee

12 July 2016

Subject: Public Health Performance - Adults

Classification: Unrestricted

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

Future Pathway: None

Electoral Division: All

Summary: This report provides an overview of key performance indicators for Public Health commissioned services relating to adults, and also for a range of Public Health Outcome Framework indicators. Most performance is good and retains the green or amber status.

Where there is a decline, in particular in substance misuse and health checks, Public Health are working with the providers to agree the actions to improve delivery, as well as ensuring that payment reflects performance.

Access to community sexual health services continues to be open and accessible to those who need it, and the Health Trainer service remains focused on targeting and engaging those in the most deprived areas across Kent. The smoking cessation service not only increased the numbers of Kent residents quitting smoking in the quarter, but also worked with higher numbers of residents who were unemployed or have never worked, who were sick/disabled or unable to work, home carers and those in routine and manual occupations to set a quit date.

This report will now include an exception reporting section on quality assurance as requested by the Cabinet Committee in May 2016.

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

i) **COMMENT** on the performance outlined in this report;

ii) **AGREE** that the chlamydia detection metric be temporarily removed whilst system-wide concerns on recording and reporting are resolved, and Public Health calculate a robust alternative; and

ii) **AGREE** to replace the substance misuse measure from opiate-only re-presentation to all clients planned exits.

1. Introduction

1.1. This report provides an overview of the key performance indicators for Kent Public Health which relate to services for adults; the report includes a range of national and local performance indicators.

1.2. There is a wide range of indicators for Public Health, including some from the Public Health Outcomes Framework (PHOF). This report will focus on the indicators which are presented to Kent County Council Cabinet and which are relevant to this Committee.

2. Performance Indicators of Commissioned Services

2.1. The table below sets out the performance indicators for the key public health commissioned services which deliver services primarily for adults. The RAG status relates to the target.

Table 1: Commissioned services quarterly performance, RAG against target

Indicator Description	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
% of annual target population with completed NHS Health Check (rolling 12 month basis)	46 (a)	51 (g)	51 (g)	52 (g)	48 (a)	45 (a)	43 (a)
% of clients accessing community sexual health services offered an appointment to be seen within 48 hrs	100 (g)	100 (g)	100 (g)	100 (g)	100 (g)	100 (g)	100 (g)
Chlamydia positivity detection rate per 100,000 for 15-24 year olds	1,672 (r)	1,635 (r)	1,335 (r)	1,099 (r)	951 (r)	Delayed by CTAD to after July 2016	
% of smokers successfully quitting, having set a quit date	52 (g)	54 (g)	57 (g)	55 (g)	57 (g)	54 (g)	54 (g)
% of opiate users completing treatment successfully who do not return to treatment within 6 months, of all in treatment. (rolling 12 month basis)	9.7 (g)	9.6 (g)	9.4 (g)	9.3 (g)	9.7 (g)	8.9 (a)	8.7 (a)
Local Indicator							
% of new clients seen by the Health Trainer Service from the two most deprived quintiles (and NFA)	53 (r)	57 (a)	51 (r)	53 (r)	56 (a)	55 (r)	56 (a)
% of adult drug and alcohol treatment population that successfully completed treatment (NEW)	25	27	29	29	31	34	33

NHS Health Checks

2.2. Kent County Council took on the commissioning responsibility for the NHS Health Check programme from April 2013. Since this time, over 115,000 checks

have been delivered, whilst over 280,000 of the eligible Kent population have been invited to have an NHS Health Check.

2.3. The programme has a target for at least 50% of those eligible for a health check to receive it within a twelve month period. The performance against this target fell to 43% in the twelve months to the end of March 2016.

2.4. Performance on overall uptake of checks, as a proportion of invites issued, has remained constant over the past two years at 42%. The decline in the actual number of checks completed is therefore likely to be the result of fewer invites needing to be issued in 2016/17 and the increasing capacity constraints in primary care. The provider is aiming in 2016/17 to increase its work with primary care by offering practices assistance with delivery to their patients and increase the work with pharmacies across Kent. The contract payments for the health checks are also based upon actual activity so the fall in the numbers of checks based payments has resulted in a saving for the County Council and has not resulted in any reduction in value for money.

2.5. Public Health will be conducting an equity audit to unpick equity gradients in access and performance across Kent. The audit which will follow an agreed methodology developed by Public Health England will help guide and inform a more targeted approach to Health Checks delivery and will also inform the wider Public Health strategy with regard to tackling inequalities in health

Sexual Health

2.6. Community sexual health clinics in Kent have continued to exceed the waiting times target of offering an appointment within 48 hours, where requested. Community sexual health services are available across Kent and provide sexual health testing and treatment, contraception and HIV outpatient services. Most clinics offer walk-in clinics as well as appointment-based systems.

2.7. There are ongoing concerns about the reporting of the chlamydia detection rate for Kent; Public Health Commissioners have investigated discrepancies between local information and national reporting and found multiple causes across the system, from completion of the forms by providers, the labs processing and Chlamydia Testing Activity Database (CTAD) reporting. Public Health are in the process of addressing the causes at provider and laboratory level and will be meeting with Public Health England who oversee CTAD in June.

2.8. This report is asking the committee to agree that the chlamydia metric be removed temporarily whilst these problems are being addressed to allow action by the relevant agencies to show an accurate detection rate; as these measures will not be in place in time to affect the CTAD figures presented within the next

financial year, Public Health will be working towards a robust local measure to provide an alternative detection rate during this time period.

Smoking

2.9. The latest available data for the Stop Smoking Service shows that in Q4 2015/16 the service exceeded the 'quit-rate' target of 52% with a rate of 54%. 1,001 Kent residents were recorded as having quit smoking through the programme during this time period; for 2015/16, 3,417 Kent residents quit smoking via the service, leading to an overall 'quit-rate' of 55%.

2.10. The 1,849 residents setting a quit date during Q4 included 34 pregnant women, 200 who had never worked or been unemployed for over 1 year, 138 sick/disabled and unable to return to work, 104 home carers (unpaid) and 464 in routine and manual occupations.

Health Trainers

2.11. The Health Trainer service engaged with 901 new clients during Q3 and exceeded the target of 2,750 by engaging 3,689 new clients during 2015/16.

2.12. 56% of new clients are from the two most deprived quintiles in Kent. The target set for 2015/16 was for 62% of new clients to be from quintiles 1 and 2 in order to help address health inequalities. This was a challenging target for the provider and performance has increased in comparison to the previous time frame.

2.13. The Health Trainer Service clients reported that 89% of goals were either achieved or part-achieved. Common goals related to diet, exercise and emotional wellbeing.

Substance Misuse

2.14. The Q4 data on adult community drug and alcohol services show that 200 adult opiate clients completed treatment successfully in the twelve months to the end of March 2016 and did not return within the following six months.

2.15. This was 8.7% of all opiate clients in treatment, which misses the target of 9%. However, Kent's performance on this indicator remains well above the national average of 6.9%. The decline in Kent reflects the national trend which is likely to be due to the complexity of opiate clients who require on-going drug treatment.

2.16. Whilst this can be a useful performance indicator, it does not reflect the outcomes for non-opiate or alcohol clients who access treatment. Public Health are therefore proposing a new performance indicator which shows the proportion

of the whole treatment population who successfully completed treatment; this measure includes all clients accessing structured treatment regardless of their substance status. It is the first time that Public Health has been able to present alcohol clients alongside opiate and non-opiate clients. The opiate non-representation measure will still be presented in the PHOF section below.

3. Annual Public Health Outcomes Framework (PHOF) Indicator

3.1. The table below presents the most recent nationally-verified and published data; the RAG is the published PHOF RAG and is in relation to National figures.

Table 2: Public Health Outcomes Framework Metrics

	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14
U75 mortality rate Cardiovascular diseases per 100,000	59.8 (g)	57.4 (g)	55.9 (a)	52.3 (a)	49.3 (a)	46.0 (g)
U75 mortality rate Cancer per 100,000	85.4 (g)	84.8 (g)	83.6 (g)	81.5 (g)	79.3 (g)	78.4 (g)
U75 mortality rate Liver disease per 100,000	12.4 (g)	12.1 (g)	12.0 (g)	12.4 (g)	13.2 (g)	13.7 (g)
U75 mortality rate Respiratory disease per 100,000	17.4 (a)	17.4 (a)	17.6 (a)	16.6 (a)	16.7 (a)	16.5 (a)
Suicide rate (all ages) per 100,000	8.4 (a)	7.7 (a)	8.4 (a)	8.1 (a)	9.2 (a)	10.2 (r)
Proportion of people presenting with HIV at a late stage of infection (%)	Not available		49.5 (a)	46.7 (a)	51.0 (a)	52.8 (r)
Adults classified as overweight or obese (%)	Not available					65.1 (a)
		2010	2011	2012	2013	2014
Prevalence of smoking among persons aged 18 years and over (%)		21.7 (a)	20.7 (a)	20.9 (a)	19.0 (a)	19.1 (a)
Opiate drug users successfully leaving treatment and not re-presenting within 6 months (%)		14.6 (g)	14.7 (g)	10.9 (g)	10.3 (g)	9.3 (g)
		2010/11	2011/12	2012/13	2013/14	2014/15
Alcohol-related admissions to hospital per 100,000. All ages		574 (g)	557 (g)	565 (g)	551 (g)	526 (g)
Proportion of adult patients diagnosed with depression (% - QOF Register)		Not available due to methodology changes		5.6	6.4	7.3

3.2. All mortality rates considered preventable presented here have continued to decrease, with the exception of liver disease, which experienced an increase. However, it does remain better than national.

3.3. The report taken to the committee in December 2015 reported on the partnership work undertaken to address the increasing suicide rate in Kent. This increase is being driven by middle-aged men who were not known to secondary mental

health services. A particular focus of the partnership work since December has been a social marketing campaign targeting this group of men. An update of the impact of this campaign is presented in the next item on this agenda.

3.4. Kent County Council continues to monitor commissioned sexual health services and their ability to engage those in the population who are particularly at risk of sexually transmitted diseases including HIV.

4. Quality Issues

4.1. A detailed Quality report on Public Health Services was presented to the Adult Social Care and Health Cabinet Committee in May. It was agreed that quality assurance issues would be reported by exception as part of the performance reports to the Adults and the Children's Social Care and Health Cabinet Committees. The Head of Quality reports that there are no quality exception items to report for Q4.

5. Conclusions

5.1. Performance has varied across the commissioned services with decreases in delivery of NHS Health Checks and completion of drug treatment for opiate misuse; Public Health are working with the provider of both services to look at factors which have affected performance and look to make improvements into 2016/17.

5.2. Access to community sexual health services has been maintained whilst new services have been implemented and the Health Trainer service continues the challenging aim to engage those in the most deprived areas. In Q4 the smoking cessation service assisted 1,001 Kent residents to quit smoking.

5.3. An update of the recent campaign targeting male suicides in Kent has been included in the next item on this agenda; this was a social marketing campaign targeting men under the age of 50, following the increase in male suicides driven by those who were not known to secondary mental health services.

6. Recommendations

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

i) **COMMENT** on the performance outlined in this report;

ii) **AGREE** that the chlamydia detection metric be temporarily removed whilst system-wide concerns on recording and reporting are resolved, and Public Health calculate a robust alternative; and

iii) **AGREE** to replace the substance misuse measure from opiate-only re-presentation to all clients' planned exits

7. Background Documents

7.1. None

8. Appendices

8.1. Appendix 1 – Key to KPI rating used

9. Contact Details

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Relevant Director:

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

Appendix 1

Key to KPI Ratings used:

(g) GREEN	Target has been achieved or exceeded; or is better than national
(a) AMBER	Performance at acceptable level, below target but above floor; or
(r) RED	Performance is below a pre-defined floor standard; or lower than
⇧	Performance has improved
⇩	Performance has worsened
⇔	Performance has remained the same

Data quality note: Data included in this report is provisional and subject to later change. This data is categorised as management information.

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

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee - 12 July 2016

Subject: Public Health Communications and Campaigns Update

Classification: Unrestricted

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

Future pathway: N/A

Electoral Divisions: All

Summary

Marketing and communications is a key element in delivering successful public health interventions. This paper reports on the recent campaigns delivered through the County Council public health team and our plans for the coming year.

Delivering effective campaigns and communication to the residents of Kent is one of the key priorities agreed for public health this year, with the core aim of driving behaviour change particularly in the communities with highest need.

Recommendation:

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

i) **COMMENT** on the progress and impact of Public Health campaigns in 2015/16; and

ii) **COMMENT** on and **ENDORSE** the key developments planned for 2016/17

1. Introduction

1.1 Marketing and Communications is a key element of the public health strategy to support Kent residents to improve both their physical and mental health.

1.1. During 2015/16, the County Council Public Health department delivered a series of campaigns aimed at increasing awareness of public health issues, and directing people to sources of support

1.2. The Public Health department has recognised that there is a great opportunity for further development in this area, particularly through working with local partners, and has identified the following as one of the Division's strategic priorities for action in 2016/17.

> "Ensuring a co-ordinated and effective programme of Health Improvement Campaigns across the health and care sector, delivering consistent health improvement messages to the public. Raising awareness of key public health challenges both through proactive public relations and through a series of campaigns, with the aim of educating and supporting people to take more responsibility for their own health and wellbeing."

1.3. This paper will cover some of the recent campaigns, the coverage received and the evidence of impact, before looking at the key developments planned in the coming year.

2. Campaigns and Press in 2016/17

2.1. When developing campaigns it is obviously key to identify the problem, understand the behaviour change needed, the core audience to be reached, and what channels can be used to get the message across most effectively.

2.2. Wherever possible, national campaigns are supported, and their reach extended where needed, rather than trying to create something new, and therefore competing against national campaigns and brands such as Change 4 Life. The Public Health team work with partners, and our suppliers, wherever possible, to ensure a co-ordinated approach to communicating messages to the public.

2.3. During 2015/16 a series of campaigns was delivered, alongside targeted press releases that resulted in increased awareness of the role of the County Council in delivering public health interventions, and the options available to improve their healthy behaviours.

2.4. The key campaigns delivered during the year were:

- Know Your Score – Alcohol Awareness
- Release the Pressure – Suicide Prevention
- Sugar Smart Campaign Extension
- Smokefree – Campaign Extension

These campaigns are covered in more detail in appendices 1-4 of this document.

3. Press coverage during 2015/16

3.1 In addition to the planned campaigns during the year, the County Council Public Health team has been keen to utilise the press to promote health messages, and to take advantage of opportunities as they arise throughout the year.

3.2 There has been clear interest from the press in public health-themed stories and over the past year, there have been:

- 57 countywide and localised press releases
- 32 reactive statements
- 36 television and radio interviews
- 175 articles in regional newspapers
- 52 online articles

3.3 More detail on the press coverage during 2015/16 can be found in Appendix 5.

4. Key Developments for 2016/17

4.1 In line with the changing approach by the County Council's Corporate Communications department, Public Health will be commissioning future work from the Creative Services Framework.

4.2 Two key areas of focus will be to extend the two key Public Health England branded campaigns further in Kent, with a focus on targeting areas of high health inequalities. Public Health will be using the Creative Service Framework to bring on board an agency to deliver a programme of Change 4 Life promotions from July – March, and an agency to deliver a programme of work aimed at promoting healthier lifestyles for adults, utilising the PHE One You brand (which encompasses smoking, drinking, healthy eating and physical activity).

4.3 Work will be undertaken to redevelop the Public Health web pages to ensure that there is a smooth customer journey that is able to provide support to Kent residents to enable them to develop healthier lifestyle behaviours. In a similar way to the process described above for the Smokefree campaign, for residents who just need a tool such as an app or a quit kit, the website will support them to find the resources they need. For those that will require the more intensive support provided by a service, the website will be designed make it easy for them to access this.

4.4 The Kent Public Health team has developed a strong working relationship with the PHE Communications team over the past twelve months, and has been selected as one of five authorities to be involved in a pilot project called the Local Authority Marketing Measurement Framework. This will provide real-time data on response to national campaigns in local areas. The aim is to provide local authorities with data such as response to online ads in a certain location (e.g. at ward level). This will then allow us to extend campaigns in a much more effective way, utilising the kind of targeting detailed above, but in a much more timely manner.

4.5 There will be further investment in promoting the Release the Pressure campaign, utilising the intelligence gathered from the work in March and April to target even more effectively.

4.6 A campaign to promote condom use is planned for later in the year, and will be built upon the results of research that is currently being undertaken by the Health Protection team.

5. Conclusion

5.1 Well-planned, targeted campaigns can have a positive impact on people's behaviour. The campaigns that the County Council Public Health team have undertaken during

2015/16, as well as delivering strong results, have also provided excellent learning on the best methods to target groups, and on the benefits of utilising social media.

5.2 Close working with PHE during the coming months will bring about even more effective targeting, and will help the County Council Public Health team to provide Kent residents with access to the tools they need to improve their health.

5.3 However, it is important to recognise that long-term change requires long-term, consistent messaging, and it will be important to work ever closer with local partners and to provide them with the leadership and resources to support strong social marketing in their area.

6 Recommendation

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

i) **COMMENT** on the progress and impact of Public Health campaigns in 2015/16; and

ii) **COMMENT** on and **ENDORSE** the key developments planned for 2016/17.

Background Documents
None

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Appendix 1

Know Your Score – Alcohol Awareness Campaign

1. Introduction

1.1. After publication of the KCC Director of Public Health's Annual report in 2015, on the challenges Kent faces around alcohol, KCC and partners across health, social care and supporting services, set themselves the challenge of offering Identification and Brief Advice (IBA) to nine percent of the Kent population.

1.2. To support this effort the Public Health team created a new online "Know Your Score" quiz, based on the Audit – C test. This was created on the KCC website, with a unique addition to make it more engaging, of experts providing video messages to people who complete the test, with the message varying depending on the level of drinking.

2. Early Implementation

2.1. The online test was launched in November as part of Alcohol Awareness Week. Which resulted in:

- TV and radio packages on BBC South East Today, KMFM and Heart FM plus a special alcohol awareness programme on BBC Radio Kent.
- 11 print articles across all Kent newspaper groups.
- Online articles on approx. 20 Kent news sites and partner organisations' websites.

2.2. The story was widely debated and shared on social media, including:

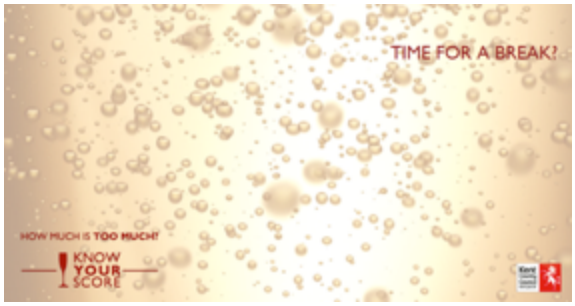
- 12,527 impressions of KCC Twitter feed and 180 engagements
- Facebook posts on BBC South East Today and BBC Radio Kent pages (68,000 followers and 9,000 followers respectively).

2.3. The KCC website www.kent.gov.uk/knowyourscore received 2523 unique page views and 1770 tests were completed during the launch week. There were 1440 page views on Friday 20 November after BBC television and radio broadcasts.

3. Online Campaign

3.1 However following this initial period, it was recognised that there was a need to promote the tool more widely, and an agency were engaged to develop an online only campaign to drive people onto the web tool.

3.2 A campaign was developed featuring a series of images, with the strapline – "How much is too much, Know Your Score."



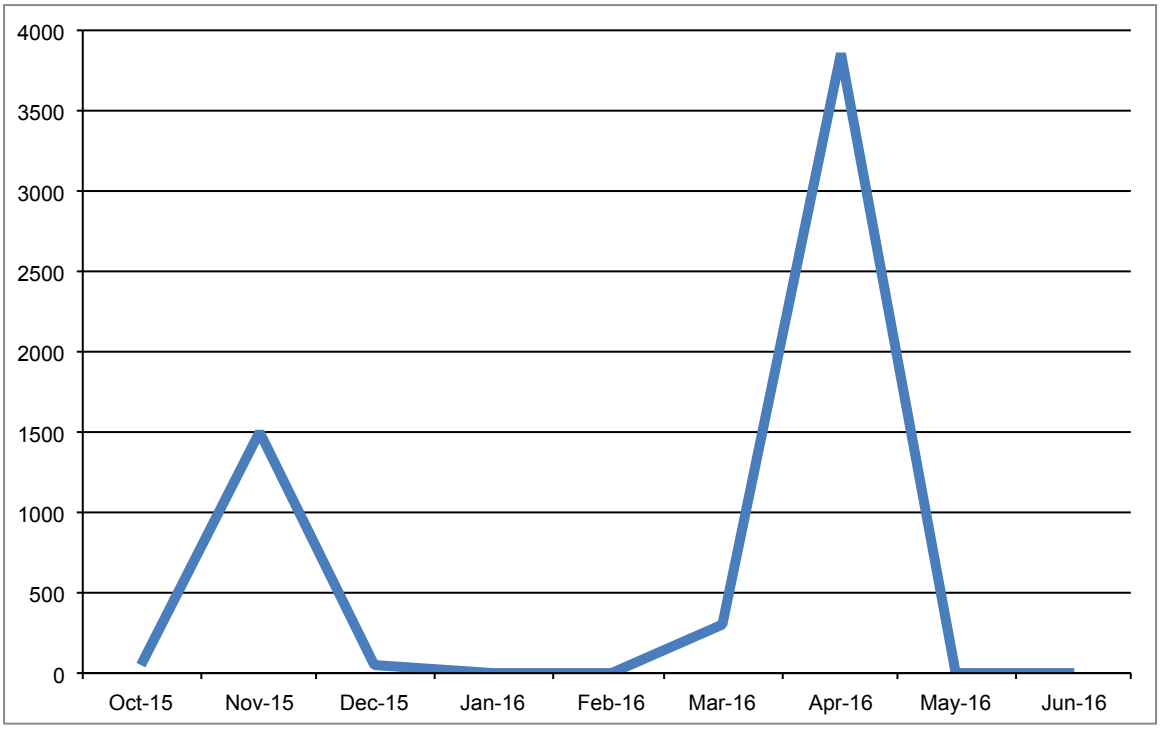
These adverts were placed on various digital platforms (e.g. Facebook, google adwords). The three planer images above proved particularly popular, with click through rates (the number of times someone clicked on the ad, as opposed to the number of people who viewed them) of 4.03%, 2.93% and 2.92%. The industry standard for an effective ad is 0.5%.

3.3 Some of the key results of the campaign show the advantage of digital advertising in gathering robust evaluation data. During the three weeks of the online campaign:

- the adverts were shown to Kent people 7,658,988 times, with
- 31,743 people clicking through to www.Kent.gov.uk/knowyourscore to find out more about their drinking levels,
- 3,862 people completing the online test and receiving their video briefing from an expert.

4. Evaluation

3.8 The graph below shows the total usage of the Know Your Score tool since launch in November, and the necessity of effective promotion.



3.9 The learning from this short run campaign will be used to run a further campaign later in the year, utilising the ads with the best response rates, and on the sites that were most effective.

3.10 The results for the people who have completed the online test show that of the respondents a significant number are drinking at concerning levels. Evidence suggests that 1 in 8 people who take an Audit C test will reduce their drinking to a safer level.

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Score	Grand Total	% of Total
0	213	3.5%
01-7	2,272	37.3%
08-15	2,345	38.5%
16-19	574	9.4%
20-40	690	11.3%
Grand Total	6,094	

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Release the Pressure – Briefing

1. Background

1.1 Suicide rates in Kent are at their highest level since 2002 and suicide is the leading killer of men under 45. In 2014, there were 163 suicides in the county - nearly 80% were men. The effect of someone committing suicide is devastating for families and friends of the individual concerned. The impact can be felt across the whole community. It should be noted that in 2011, the Department of Health estimated that the average cost per suicide in England is £1.7 million.

1.2 A campaign need was identified to address this growing issue in Kent among men aged 30 to 60-years-old who live in Kent and who are feeling stressed, anxious, low in mood or depressed.

1.3 Specific communications objectives:

- Increase awareness among the target audience of the help available and how to access it
- Increase discussion and debate around the issue of mental health issues
- Increase uptake of dedicated support services by men – including a free phone helpline with trained staff available 24 hours a day, seven days a week, commissioned by KCC and provided by the charity Mental Health Matters.

2. Research and planning

2.1 “Release the Pressure” was developed by KCC in partnership with behaviour change and social marketing agency Good Business. The campaign drew on the principles of social marketing and behaviour change theory and was developed by:

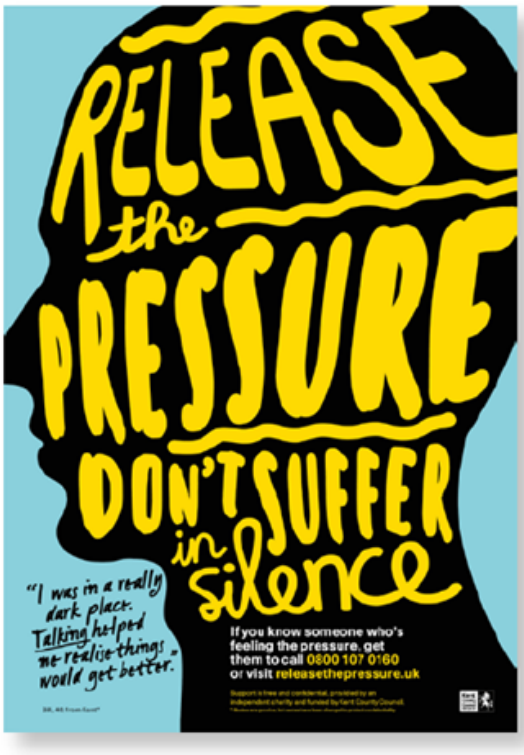
- Examining local and national statistics and research
- Analysing existing mental health campaigns targeted at men
- Focus groups with Kent men
- Testing early versions of the campaign materials with mental health professionals and members of the public

2.2 The challenge for the campaign was that mental health and suicide are areas that the target audience do not necessarily identify with. This meant that the final creative needed to avoid direct mention of both areas, while showing that people do care and that there are services that can provide an outlet to release the pressure created by many of the social triggers (e.g. divorce, financial concerns, alcohol etc.) related to suicide.

2.3 The campaign also used a decoy approach of directing communications to a “friend” rather than directly singling out those most in need or who might not identify themselves as being in need.

2.4 The final campaign creative used images of male heads filled with words - the quotes of real men in Kent - to communicate that this pressure is understandable and talking can help.

3. **Strategy and tactics**



3.1 The fresh and impactful creative established a new opportunity for media coverage and social media interest.The highly visual images were displayed at key sites across the county through marketing activity and promoted on social media.

3.2 The website www.releasethepressure.uk was created for people wanting more details, featuring anonymised case studies of Kent men who have turned their lives around after attempting suicide.
PR tactics included:

- A series of editorial features with the Kent Messenger newspaper group
- A special editorial programme by local radio station, KMFM
- A campaign launch for all Kent news media with supporting information, case studies and headline statistics.
- Images, quotes and figures for KCC's social media platforms
- Retweets/sharing of partner messages including service providers and opinion leaders.
- Sharing a PR/media toolkit with partners (including health organisations, district councils and emergency services) for promotion within their own internal/external communications channels.
- Guidance for newsdesks reporting suicides and use of sensitive photographs

4. Implementation

4.1 The PR campaign was launched in March 2016 as research showed a spike in suicides during the March/April period.

4.2 A marketing and editorial pack of material was created for partners and key stakeholders to share through their own internal communications channels – this also helped strengthen local partnerships.

4.3 A number of media interviewees - including health experts and individuals affected by suicide - were identified, briefed and offered at regular points during the campaign to ensure coverage of the launch and further editorial opportunities to keep the campaign in the public eye.

4.4 The campaign received further support from Gillingham Football Club with articles in match day programmes, on its website and stadium hoardings. Gills Manager Justin Edinburgh (whose former player had died by suicide) featured in further editorial coverage.

4.5 The family of a man who committed suicide also came forward to support the campaign, creating huge coverage in media and social media.

4.6 Social media played a key role throughout with messages from the KCC Twitter and Facebook accounts and cross-promotion of content by stakeholders, partners and other media.

4.7 A multi-channel approach was used to advertise the campaign consisting of:

- **Outdoor advertising**
  - Bar packs

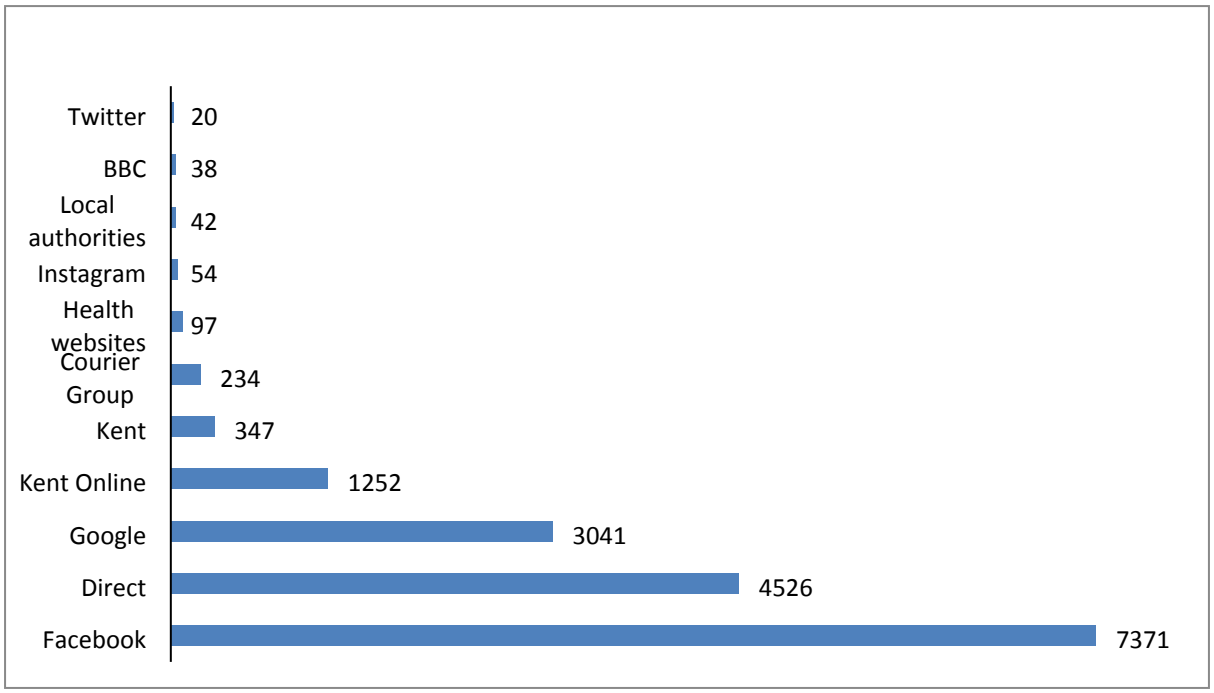
    - 6/48 sheet outdoor
    - Petrol ad nozzles
    - Bus advertisements
    - Leaflets
- **Digital advertising**
    - KM display advertising
    - Trinity digital advertising
    - Google advertising
    - Facebook advertising
    - KM native content pieces
    - Hospital screens
- **Newspaper advertising**
    - Trinity Mirror print ads
    - KM Media print ads
- **Radio advertising**
    - Heart radio ads
    - KM Fillers
    - KM Special Programme
    - DAX digital radio

5. Measurement and evaluation

5.1 A suspected suicide can only be confirmed as such by a coroner and this can take over a year. Therefore the impact of the campaign on overall suicide numbers won't be known until 2017. However, the campaign was evaluated in a number of ways including:

- 20% increase in male callers during campaign period
    - **Helpline calls – Average calls per month last year - 1,171**
    - **Calls in first month of the campaign - 1507**
    - **Following the campaign calls to the helpline have increased by:**
        - **15% overall**
        - **20% amongst men**
- 20,000 unique visits to the website
- 515 people clicked on web chat option from the website
- 19 million impacts with men through all channels

5.2 Of the unique visits to the website, by far the most effective in driving traffic to the site were the Facebook adverts, however the number of people going directly to the site by typing in Releasethepressure.uk was also high, with 4,526 during the campaign period. The most popular time that male targeted ads were interacted with was from 5pm – 11pm. Even after the end of the advertising campaign, there are still approximately 100 visitors per week to the site, as a result of campaign literature being distributed to key stakeholders.



5.3 Caller Testimonials

The helpline provided some feedback from callers who responded to the campaign:

- “Release the Pressure really spoke to me."
- "I was panicking but I feel so much better now, thank you."
- "Getting your number was the best thing that has happened to me.“
- "Thank goodness the help line is there for me”
- "Thank you for your help I feel I have a good plan in place and I can settle now."

5.4 Media coverage included:

- **TV and radio** packages on BBC South East Today, BBC Radio Kent and Heart FM plus a special suicide awareness programme on KMFM.
- **30 print articles** across Kent’s newspaper groups including KM, Kent Regional News, Kent on Sunday series and News Shopper titles.
- **Online articles** on 20 Kent news sites and partner organisations’ websites.

5.5 The story was widely debated and shared on social media, including:

- BBC Facebook posts (79,000 followers) with over 60,000 views of South East Today’s video.

5.6 “Release the Pressure” has since been publicised as part of Mental Health Awareness Week and continues to feature in communications work around suicide prevention. The Campaign received significant national interest and has been presented to both the Local Government Association Public Health Conference and the Faculty of Public Health annual conference this year. As a result of the campaign, Public Health England has invited the Tim Woodhouse, the responsible Programme Manager, to be part of a national panel of experts

overseeing the development of new suicide prevention guidance for local authorities.

Appendix 3

Sugar Smart Campaign Extension

1. Introduction

1.1 Change4Life has become one of the most instantly recognisable brands in health improvement. It enjoys high levels of trust and involvement from both the public and private sectors.

1.2 The Change4Life Sugar Smart campaign aims to encourage and support families to reduce the amount of sugar they consume. It was launched in early January 2016, and ran throughout the month.

1.3 The campaign aims to raise awareness of the high level of sugar consumed and its influence on health, by providing families with the knowledge and tools to understand the amount of sugar in foods and find healthier alternatives to reduce sugar intakes.

1.4 The Change4Life Sugar Smart app was launched, with media and advertising to promote the campaign. The Change4Life website also provides support for both families and teachers.

2. Kent County Council Campaign Extension

2.1 It was felt that there would be a benefit to extending this campaign further in Kent, during the months of February and March, with a particular focus on areas with higher rates of children with excess weight.

2.2 A programme of press advertising, out of home (billboards, mobile ad van, buses etc) and social media work was delivered. This was supported by targeted materials to the three schools in each District with the highest levels of excess weight according to the National Childhood Measurement Programme (NCMP) results, and also by a letter from Andrew Scott-Clark to each GP with a supply of posters, as well as business cards that they could hand to patients, at their discretion.

2.3 Every Children's Centre in Kent received a supply of Sugar Smart materials. All 277 pharmacies in Kent were provided with a poster, and the 100 in the target areas also received a sugar swaps pack.

3. Campaign Evaluation

3.1 PHE provided us with a unique web url so that we can track the benefits of our work. The agency which delivered the campaign extension for us, ThinkZest, also conducted post campaign research which showed that from a sample of 242 parents:

- 58% of respondents recalled the campaign, with this raising to 70% when prompted by a campaign poster
- Individuals were more likely to have been in contact with campaign materials in schools (38%) and GP surgeries (45%)
- They felt that schools and GP surgeries were the most effective channels for getting across health messages
- Compared to a year ago, 74% are more aware of the dangers of excessive sugar consumption
- The campaign made 81% think more about the amount of sugar they give their children, with 73% acting upon the message and reducing the amount of sugar they gave their child.

Clearly some of the respondents may have recalled the campaign promotion as a result of the national campaign; however the KCC extension was the only element to feature in GP surgeries or in school packs.

3.2 PHE also issued a postcode based report on the results of the January campaign, which showed that Kent had 1788 registrations to the Change 4 Life site during January. They have also recently provided a report on the subsequent sign ups during February and March, as a result of our promotion, when a further 1,660 Kent parents registered for support from the Change 4 Life programme.

3.3 The original data release from PHE (on the January element), has been analysed by the Public Health Observatory and shows that registrations were divided by district as follows:

	Registrations
Ashford	159
Canterbury	186
Dartford	110
Dover	153
Gravesham	98
Maidstone	194
Sevenoaks	127

Shepway	139
Swale	188
Thanet	171
Tonbridge and Malling	144
Tunbridge Wells	119
Kent	**1,788**

3.4 Further analysis highlights the following wards as having high overweight and obesity prevalence but low levels of uptake of Sugar Smart, whereas in all other areas sign up was in line with expectation;

- Within Gravesend; Central, Chalk, Riverview and Northfleet South.
- Within Dartford; Castle, Sutton at Hone & Hawley, Stone and Swanscombe.
- Within Swale; Grove.
- Within Ashford; Charing, Great Chart with Singleton North and Victoria.
- Within Dover; Tower Hamlets.
- Within Tonbridge & Malling; Aylesford.
- Within Tunbridge Wells; Paddock Wood East.

3.5 This analysis will be repeated, with the recently received data from PHE, and will be used to target increased coverage at these areas in future campaign work.

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1 Smokefree Kent Campaign Briefing

1.1 This campaign, in a similar way to the Sugar Smart extension, is based around the core branding provided by PHE. An agency called Social Change have been engaged to deliver a promotional campaign, and associated materials to promote the various options that smokers in Kent have to help then to stop smoking**.**

1.2 The target is to reach 100,000 smokers in Kent, and help them to understand how to access help. The core message is to visit www.kent.gov.uk/smokefree , where the range of options is laid out.

- Sign up for a quit kit
- Get online support (from PHE app or e-mail support
- Sign up for a quit club or 1-1 support
- From your pharmacist
- From your GP

1.3 The decision to replicate the PHE options on the KCC site allows us to offer more localised support to Kent residents. For example, if someone requests a quit kit, we ask them if they would like a follow up call from our Stop Smoking provider service to see how they are progressing after a few days. This allows us to support the customer journey in a much more integrated way, and has allowed us to test close KCC communication/ commissioned provider working in anticipation of a move to an integrated model (as discussed in the Adult Health Improvement paper to this committee).

1.4 A series of case studies have been produced which feature people who have been supported to quit smoking, and the effect it has had on their lives. The website also features some short videos from experts in Kent explaining the effect that smoking has on various aspects of peoples' lives, and include a vet, a beautician, and a hairdresser, amongst more traditional healthcare professionals such as a pharmacist or a health visitor. The case studies and clips from the videos are then used in social media adverts to attract people to click on the site.

1.5 To enable partners to support this campaign, a resources page has been created at www.kent.gov.uk/smokefreeresources where partners can download a campaign guide, alongside printable versions of posters, or even graphics that can be uploaded onto screens in waiting areas, for example for GPs. Posters, and table top displays have also been distributed to GPs, pharmacists ,and Children's centres.

1.6 This campaign will be running until the end of July, with a big push from 27th June, however by 14th June, 11,108 people have visited the website, with 504 people signing up for further support.

1.7 In a similar way to the data provided by PHE around Sugar Smart, PHE have also provided data from last year's Stoptober Campaign which has been used to target this Smokefree campaign. The Stoptober analysis showed the following sign ups by area:

	Registrations	Pack requests	Text	App
Ashford	467	399	123	335
Canterbury	555	463	122	406
Dartford	432	382	95	324
Dover	502	428	116	369
Gravesham	398	341	87	299
Maidstone	635	539	157	460
Sevenoaks	340	283	91	237
Shepway	498	426	102	380
Swale	627	543	145	461
Thanet	647	564	141	486
Tonbridge and Malling	515	448	115	391
Tunbridge Wells	390	314	103	272
Kent	6,006	5,130	1,397	4,420

1.8 Analysis of sign-up versus prevalence rates at ward level indicated that the following wards should be targeted more heavily in future work.

- Ashford; Stanhope.
- Dover; Aylesham and Castle.
- Thanet; Cliftonville West.
- Dartford; Princes and Town.
- Gravesend; Northfleet North and Pelham

April 2015 to March 2016 Media coverage report

The following list of media coverage has been divided into key areas:

1. Smoking
2. Mental Health and Wellbeing
3. Alcohol
4. Obesity/healthy living (including Healthy Business Awards)
5. Sexual health
6. Breastfeeding
7. Flu & winter health
8. Heatwave & Op Stack crisis communications
9. Other

Major media Public Health coverage from the past year includes:

- Release the Pressure suicide campaign
- Know Your Score campaign
- Smoke-free parks (Ashford and Canterbury)
- Kent Sheds launch
- Changes to sexual health services
- NCMP and PHE childhood obesity figures
- Flu and winter safety advice (plus partnership with Kent Fire & Rescue Service)
- Heatwave and Operation Stack major incident.

Over the past year, there have been:

- 57 countywide and localised press releases
- 32 reactive statements
- 36 television and radio interviews
- 175 articles in regional newspapers
- 52 online articles
- Coverage on Kent FA website, Gillingham FC website and in KCHFT magazine.

It should be noted that the coverage figures are not necessarily a fully comprehensive list as some coverage can be missed by media monitoring. Also, articles are often repeated in a range of local newspaper editions ie the Kent Messenger's Kentish Express newspaper has different editions for communities in Tenterden, Hythe & Romney Marsh and Ashford. The information below is a list of coverage from main media outlets across Kent and details the main areas of newsdesk interest over the past year.

The majority of coverage has followed proactive media work – press releases, photocalls and interview opportunities – and approximately 98 per cent is positive and neutral coverage of KCC public health services, activities and issues.

Approximately 25-30 per cent of the coverage is from a reactive response to a media inquiry where a statement, quote or background quotes have been supplied to a specific request. Statements have also been drafted for more contentious issues but some have simply been held for potential reactive inquiries which subsequently haven't arisen.

The most successful media events, in terms of widespread and positive coverage, are those when the media can be offered a *local* case studies and service users, interviews with a range of spokespeople and audio/visual opportunities, supported by Kent data and details of local services (*see, for example, Release the Pressure Suicide campaign coverage*). Where possible, the use of traditional PR / media channels is supported by social media work on KCC's Twitter and Facebook sites, sharing messages and communications toolkits with appropriate partners. This offers a more direct public relations channel and can generate further media interest (*see Know Your Score campaign*).

SMOKING:

Smoking in pregnancy:

- Kent on Sunday
- BBC Radio Kent
- Kent & Sussex Courier
- Canterbury Times

Stoptober:

- Hawkinge Gazette
- Isle of Thanet Gazette
- Kent on Sunday, Kent News Online and Your….series
- Hawkinge Gazette follow-up
- Kent on Sunday
- Community Health KCHFT magazine

Smoking in cars ban:

- BBC Radio Kent
- Kent on Sunday, Kent News Online and Your….series
- Hawkinge Gazette
- Kent & Sussex Courier
- AHBS radio online

Ashford and Canterbury smoke-free parks:

- BBC Radio Kent
- BBC SE Today
- AHBS Community Radio
- Kentish Express (Tenterden, Hythe & Romney Marsh and Ashford editions)
- Kent Online
- Ashford Extra
- Taking Liberties blog
- Hawkinge Gazette
- East Kent Hospitals website

MENTAL HEALTH AND WELLBEING:

Kent Sheds launch event:

- Hawkinge Gazette
- KMFM
- News Shopper
- News Shopper follow-up
- Gravesend Reporter
- Gravesend Messenger and Dartford Messenger
- Gravesend Messenger and Dartford Messenger follow-up
- Kent on Sunday
- Dover Express
- Dover Mercury
- AHBS community radio online

Mental Health/suicide strategy:

- BBC Radio Kent
- Kent & Sussex Courier
- News Shopper
- Kent & Sussex Courier
- Gravesend Reporter

World Suicide Prevention Day/Partnership with KCFL:

- KMFM

- BBC Radio Kent
- BBC Online
- Kent News online
- Kent on Sunday and Your…. Newspaper series
- Kent & Sussex Courier (various local editions)
- Hawkinge Gazette
- Kent Sport News
- Kent FA website
- Sevenoaks Forum online
- Kentish Football online
- LocalGov online
- Dartford News Shopper

Kent on Sunday re mental health issue among teenagers

Release the Pressure Suicide Prevention Campaign launch:

- BBC South East Today
- BBC Radio Kent
- BBC Online
- KMFM
- KMFM special programme
- Kent Online
- Kentish Gazette
- Folkestone & Hythe Express
- Sheerness Times Guardian
- Sheerness Times Guardian follow-up
- Sittingbourne News Extra
- Sittingbourne News Extra follow-up
- East Kent Mercury
- East Kent Mercury follow-up
- Kent Messenger (Maidstone, Weald and Malling editions)
- Kentish Express
- Folkestone and Hythe Express follow-up
- KM Maidstone follow-up
- Kent Extra follow-up
- Kent on Sunday
- Gravesend Reporter
- Gravesend Reporter follow-up
- Gravesend Messenger follow-up
- Dartford Messenger follow-up
- Hawkinge Gazette
- Isle of Thanet Gazette
- Kent FA website
- Gills website
- Kent Online follow-up
- East Kent Mercury follow-up
- KM Maidstone follow-up
- Kent & Sussex Courier
- Kent News follow-up

ALCOHOL:

"Know Your Score" campaign? & Alcohol Awareness Week:

- BBC South East Today
- KMFM
- BBC Radio Kent Heart FM
- Kent on Sunday series
- Kent News online
- Isle of Thanet Gazette
- Hawkinge Gazette
- Folkestone Herald
- Kent & Sussex Courier
- Sevenoaks Chronicle
- Canterbury Times
- Ashford Herald
- Maidstone & Medway News

Dry January:

- Kent on Sunday series
- Kent on Sunday/Kent News
- Kent & Sussex Courier
- BBC Radio Kent
- Kent on Sunday/Kent News

- **Alcohol strategy** interview with Andrew Scott-Clark on **BBC Radio Kent**
- Statement to **Kent & Sussex Courier** re support for children of **dependant drinkers**.
- **Teen alcohol abuse** statement to Canterbury Times

OBESITY & HEALTHY LIFESTYLE

Shake it Up, 'Ready Steady Go' and Sky Ride:

- Kent Online
- BBC South East Politics Show
- Kent Online/KM
- Kent on Sunday
- InsideKent
- Folkestone Herald and Ashford Herald
- Kent on Sunday series
- KM Ashford
- Kentish Gazette

NCMP and PHE childhood obesity figures:

- BBC Radio Kent
- The Sun on Sunday
- Dover Express

SugarSmart

- Sevenoaks Chronicle
- Kent & Sussex Courier

Kent Healthy Business award:

- Kent & Sussex Courier
- Kentish Express
- Sheerness Times Guardian

SEXUAL HEALTH

- Times of Tunbridge Wells
- KMFM
- Gravesend Messenger
- Dartford Messenger
- Kent Messenger
- Dover Mercury
- Maidstone Messenger
- Kent Messenger (Malling)
- Kent Messenger (Weald)
- Statement to East Kent Mercury re sexual health services consultation
- Statement and quote to Kent on Sunday series re HIV campaign
- Pulse News online

Teen pregnancies:

- Kentish Express
- Sheerness Times Guardian
- KMFM interview clips with Faiza Khan

BREASTFEEDING:

Best Beginning **Breastfeeding** launch

- Kent News/ Kent on Sunday
- KMFM
- Sheerness Times Guardian
- SFM
- Heart FM online
- BBC Radio Kent
- ITV Meridian
- Isle of Thanet Gazette
- Hawkinge Gazette
- Gravesend Messenger
- Dartford Messenger

FLU & WINTER HEALTH

Flu:

- ITV Meridian online
- ITV Meridian online follow-up
- BBC Radio Kent
- KMFM
- Sevenoaks Chronicle
- Kent & Sussex Courier
- Canterbury Times
- Kentish Express (Ashford and Tenterden)
- Community Health KCHFT magazine
- Dartford Messenger and Gravesend Messenger
- Thanet Extra
- Kent News

Winter health & home safety:

- AHBS radio online
- KMFM
- Kent News
- Kent on Sunday

- E-watch online

Norovirus:

- Kent & Sussex Courier
- Kent News/Kent on Sunday
- Sheerness Times Guardian
- KM Sittingbourne

Cold Weather alert & PH advice:

- Heart FM and KMFM
- Canterbury Times online
- Canterbury Times
- Kent Online/Kent Messenger
- Kent News/Kent on Sunday
- Kent & Sussex Courier
- Hawinge Gazette
- Sevenoaks Chronicle
- Isle of Thanet Gazette
- East Kent Hospitals University NHS
- Kent Online/KM follow-up

HEATWAVE and Op Stack:

- Meridian ITV
- Meridian ITV online
- KMFM
- Kent & Sussex Courier
- Kent Online
- Dover Express
- Isle of Thanet Gazette
- Folkestone Herald
- AHBS Community radio
- The Times
- The Guardian
- Canterbury Times

Operation Stack and Public Health messaging:

- BBC SE Today
- BBC Radio Kent
- BBC 5Live
- KMFM
- Heart FM
- Meridian
- Kent online/Kent TV
- Kent News
- The Guardian
- BBC online
- ITV Meridian online
- The Times
- Dover Express
- Dover Express
- Canterbury Times
- Hawkinge Gazette

OTHER:

Air pollution:

- KMFM
- Kent Online
- Maidstone KM

Public Health budget cuts:

- BBC Radio Kent
- Kent on Sunday
- BBC Radio Kent follow-up
- KM

Deaf card:

- Kent & Sussex Courier
- East Kent Hospitals University
- AHBS community radio online
- Hearing Times
- Downs Mail

Health Checks:

- Meridian ITV coverage
- ITV online
- BBC South East Today
- KMFM
- Thanet Gazette

HSJ Healthcare award:

- Kent on Sunday
- Times of Tunbridge Wells

Dental:

- Kent on Sunday series coverage of children's dental care

Public Health Improvement Services Consultation:

- Kent & Sussex Courier
- Kent on Sunday
- Kent News online

Community Health funding:

- Kent Messenger Maidstone
- Hawkinge Gazette
- Kent Messenger
- Sevenoaks Chronicle
- Kent & Sussex Courier
- Kentish Gazette
- Kent on Sunday
- Kentish Gazette follow-up

- Andrew Scott-Clark New Year's message article for **Kent on Sunday**

- Statement to **Kent & Sussex Courier** re immigration and public health in Sevenoaks area

- Ashford inequalities statement to **Kentish Express**

From:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director of Social Care, Health and Wellbeing
To:	Adult Social Care and Health Cabinet Committee – 12 July 2016
Subject:	ADULT SOCIAL CARE ANNUAL COMPLAINTS REPORT (2015-2016)
Classification:	Unrestricted
Previous Pathway:	Social Care, Health and Wellbeing DMT
Future Pathway:	None
Electoral Division:	All

Summary:	This report provides Members with information about the operation of the Adult Social Care complaints and representations procedure between 1 April 2015 and 31 March 2016.
Recommendation	The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and **COMMENT ON** the content of this report.

1. Introduction

1.1 Local Authorities have a statutory duty to have in place a complaints and representations procedure for Adult Social Care services. Furthermore, each local authority that has a responsibility to provide social services is required to publish an annual report relating to the operation of its complaints and representations procedure.

1.2 This report provides an overview of the operation of the complaints procedure for Adult Social Care services. It includes summary data on complaints and enquiries received during the year. It also provides Members with examples of the lessons learned from complaints which are used to inform and improve future service delivery.

2. Policy Context and Procedures

2.1 The NHS and Community Care Act 1990 placed statutory requirements on local authority social service departments to have a complaints procedure in place. The legislation and associated statutory guidance was prescriptive about how the procedures should operate in practice.

2.2 For Adult Social Care, there was a significant change to the complaints procedure in 2009 with the introduction of Regulations with the objective of delivering a consistent approach to complaints handling for both Health and Social Care.

2.3 The key principles of the procedure are **Listening** – establishing the facts and the required outcome; **Responding** – investigate and make a reasoned decision based on the facts/information and **Improving** – using complaints data to improve services and influence/inform the commissioning and business planning process.

2.4 Wherever possible, complaints that involve health and social care are dealt with via a single co-ordinated response. To facilitate this, a joint protocol was developed by the Health and Social Care Complaints Managers in Kent and Medway.

2.5 For Adult Social Care the complaint response needs to be proportionate to the issues raised. The only timescale in the process relates to the acknowledgment of the complaint, which must be done within three days of receipt. Thereafter, the response time is agreed with the complainant and reflects the circumstances and complexity of the complaint. When appropriate, an independent investigator will complete an investigation into the complaint.

3. Total Representations received by Adult Social Care

3.1 Appendix 1 contains information about the number and type of complaints received.

3.2 The figures show an increase in the number of complaints received in 2015/16 compared with previous years (659 statutory complaints in 2015/16 compared with 538 in 2014/15). This reflects the increased demand and pressures on services during a time of transformation and change and a time of financial constraint. There was a slight decrease in the number of enquiries (the enquiries include letters from MPs on behalf of constituents). In 2015/16, there were 403 enquiries compared with 408 the previous year.

3.3 The number of statutory complaints received (659), is relatively small when put in the context that there were 31,012 open adult social care cases at the start of 2015-16 and a further 19,156 referrals were received during the course of the year.

3.4 In 2015/16, 523 compliments (or merits) were logged. The compliments provide useful feedback where people had written to Adult Social Care with positive comments about their experience of using the service. There was a decrease in the number of compliments received in the previous year (778) but this is partly accounted for by the compliments about financial services now being logged separately.

4. Performance against timeframes

4.1 The average response time for statutory complaints is set within a complaint plan timeframe of 20 working days. Complex cases that require either an off-line or

external investigation or a joint response with health services are identified at the commencement of the complaint and a longer timeframe is negotiated.

4.2 Approximately 70% of complaints were responded to within the 20 day timescale agreed with the complainant and 92% of complaints were acknowledged within the statutory timescale of three working days. For enquiries, 89% were acknowledged in 3 working days and 63% were responded to in 20 working days.

5. Themes identified arising from complaints

5.1 It has been another challenging year in terms of the number of complaints and enquiries received. The budgetary pressures have led to pressures on Adult Social Care Services and the wider social care market. However, the increase in complaints is a general increase rather than being attributable to any one factor and reflects the increased complexity of case management.

5.2 Communication is a theme that crops up in many complaints. A particular issue towards the start of 2015-16 was that some members of the public experienced problems when trying to contact a case or care manager by telephone. A factor was the switch to the Unified Communication telephone system used in the County Council and a lack of familiarity amongst practitioners with the new system. (This was addressed by providing workshops and information for staff).

5.3 There was an increase in the number of complaints received as a result of disputed decisions (281 in 2015/16 compared to 185 in 2014/15). Examples include where people consider they require more support than has been agreed or where the support has been decreased following a review of needs or where someone is unhappy about the level of charging. There was also a significant increase in the number of complaints where there were disputes about charges compared with the previous year (114 in 2015/16 compared with 45 in 2014/15).

5.4 Delay was a factor mentioned in approximately 181 complaints. Examples included delays in adaptations to property being completed and delays in services being arranged.

5.5 Some people complained about the lack of availability of residential placements. In some cases this related to a lack of placements for people with specific types of needs and other cases it related to a lack of choice of provision in particular localities.

5.6 The Local Authority also logs complaints about contracted providers. These are investigated by the case/care manager and also brought to the attention of the Strategic Commissioning service as part of the intelligence for contract monitoring.

6. The Outcome of Complaints

6.1 The Local Authority is required to report on the number of complaints received that are considered to be “well-founded”, in Kent these are logged as “upheld

complaints". This is not always clear as the nature and contents of complaints can vary considerably and many responses provide an explanation where there might be a misunderstanding or a lack of clarity. Nevertheless 222 complaints were upheld; 151 were partially upheld and 198 were not upheld.

7. Learning the Lessons

7.1 Receiving a complaint provides an opportunity to resolve an issue where the service might not have been to the standard required or expected. In addition complaints and enquiries, along with other customer feedback provide valuable insights that can be used to improve service performance. A complaints procedure is only as good as the culture in which it operates so it is important to maintain an open and learning culture that is receptive to feedback from customers.

7.2 Complaints reports are regularly presented to the Divisional Management Teams. The Quality and Good Practice Group meetings are also used to reflect on issues arising from complaints and an opportunity to identify lessons to be learnt. Operational teams identify a representative for the group who then takes a lead role within their teams for good practice and sharing lessons.

7.3 Some of the lessons/issues arising in 2015/16 and discussed at the Quality and Practice Group included:

- It was evident from some complaints that relatives/family members sometimes felt they were not communicated with regarding decisions or changes in circumstances. (Although the client's right to confidentiality also has to be recognised). There were a number of complaints relating to safeguarding where families did not feel they were kept sufficiently informed. The Making Safeguarding Personal initiative has helped to address this
- The need to ensure that the assessment is "joined up" where more than one service is involved. This became apparent where an individual was in contact with Older People Physical Disability, Mental Health and Sensory Services. The lack of an agreed assessment led to different views about what should be in the person's Care and Support Plan
- One complaint highlighted a problem where there was a delay in responding to a case where a person had suffered a fall and the family were requesting an urgent respite placement. In the locality where the complaint occurred a guidance document was produced for the practitioners about "on call" arrangements
- Another issue that was identified through complaints was a gap in service when staff go on leave or unexpectedly have to take time off. It was apparent in some cases that the public found it difficult to know who to contact in such circumstances and decisions were being delayed. In Learning Disability Services each team has been asked to put arrangements in place to cover such eventualities
- In one case the tenancy agreement for someone in sheltered living was terminated and it took some time for alternative arrangements to

be set up. Following this case a Good Practice note was issued to practitioners

- In the Good Practice meetings there has been a reminder of the need to ensure information is entered onto the systems in a timely way following assessments and financial assessments. Where this has not occurred it can lead to a delay in invoices being issued (leading to a sizeable Bill being sent when it is issued) and delays to providers being paid. The introduction of a placements services should help to address this issue and ensure service users and /or their representative is provided with information about charging
- Complaints provided a reminder that good record keeping should be maintained, particularly where decisions are made or a significant change takes place for the service user.

7.4 Lessons are also learned from the investigation of complaints. Following independent or "off line" investigations, there are adjudication meetings where actions are agreed and the outcomes and any lessons from the complaints are shared more widely as appropriate.

7.5 The outcomes from complaints can also lead to training or specific actions for individuals or teams.

8. External investigations

8.1 There were 5 off line investigations carried out during the year. The responses to complaints need to be proportionate and an external, independent investigator is usually appointed when the complaint issues are particularly complex or where communication has broken down or confidence in the organisation has been lost. In these cases, the complainant has felt their complaints have been taken seriously and an independent view has been obtained.

9. Financial

9.1 In 2015/16, £20,122 has been paid in financial settlements – including cases where the Local Government Ombudsman made a recommendation for a financial settlement. A financial settlement is when an amount of money is offered to provide redress or as a gesture of goodwill to recognise the anxiety and time and trouble to pursue a complaint.

9.2 During the same time frame £89,912 of financial adjustments has been made to accounts. An example of a financial adjustment is when an error has occurred with the charging process and has been rectified or where part of a debt has been written off as part of a complaint resolution.

10. Complaints via the Local Government Ombudsman (LGO)

10.1 There were a total of 45 referrals about County Council Adult Social Care made to the LGO during the year. Additional cases were carried forward from

the previous year and settled during the reporting year (these are not included in the figures). This is a slight increase from the previous year when 38 new referrals were made.

10.2 Of those complaints, where a final decision was received the outcome was:-

- 4 cases where the LGO closed the case after initial enquires and there was no further action
- 9 cases that were not upheld
- 1 case upheld but not further action
- 8 cases where the complaint was considered premature
- 4 cases where there was maladministration but no injustice
- 9 cases where there was maladministration and injustice
- 10 cases which are currently with the LGO

10.3 A summary of the cases where the Local Government Ombudsman found fault with injustice, is provided in the appendices.

11. Compliments (or merits)

11.1 The Directorate continues to log compliments or merits, with 523 received in 2015/16. These also provide useful feedback and serve as a useful reminder of the many people who are very satisfied with the service they have received.

11.2 Just a few examples are provided below:

- "I just wanted to say that I was impressed with the professional, helpful and can do approach of the Case Manager"
- "The Enablement Program has made me see a future for all of us as a family"
- "The Case Manager is inspiring, positive and determined. She gives assistance to others and responds positively to requests for help"
- "The Care Manager's support has been completely and utterly valuable to us. Nothing is too much trouble and she always goes above and beyond the call of duty"

12. Complaints operations

12.1 The regulations require the complaints procedures to be publicised. The, "Have your Say" complaints leaflet is made available in hard copy and information is provided on the County Council website. An easy-read version of the complaints booklet is also available.

12.2 The Directorate uses the "Respond" database for complaints, enquiries, compliments and formal advocacy referrals. The system continues to provide an invaluable resource to register the contact and to manage the workflow and produce management reports. It is likely that a Corporate Complaints database will be procured in the future. If social care complaints and enquiries are to be included in the corporate database then it is essential that the database is configured so

that the Directorate can continue to meet all its statutory requirements in terms of complaints handling and reporting.

12.3 During 2015/16, the complaints team delivered several training events for managers. The training has covered the complaints processes, investigating complaints and learning the lessons from complaints.

12.4 Training has also been provided for staff in the new Mental Health Primary Care Social Care Service. The complaints team continues to work closely with the Patient Experience Team in the Kent and Medway Partnership Trust which handles complaints about secondary mental health services. Also the Adult Social Care team is proactive in working with health partners to facilitate joint working and joint responses to complaints that have a health and social care element.

12.5 From April 2016, the children's and adult complaints teams will work more closely under a single line management arrangement.

13. Care Act 2014

13.1 It had been expected that the Care Act 2014 would include provision for an Appeals Process that would operate alongside the Adult Social Care complaints procedure. The Department of Health conducted a consultation but the decision was taken to defer the introduction of the Appeals process until 2020. At this stage there is little detail regarding the appeals process and how it would work in practice but information from the Department of Health suggests it is still on its agenda.

13.2 As part of the April 2015 Care Act changes, there is an emphasis on advocacy and the right for individuals who cannot take up issues themselves, to make a formal representation through an advocate. The Formal Advocacy Referrals can be logged on the complaints database but to date the numbers received have been low.

14. Special Educational Needs and Disability Tribunals

14.1 The Children and Families Act 2014 introduced reforms to Special Educational Needs and Disability Services (SEND). One of the reforms was to introduce Education, Health and Care Assessments and Plans to replace SEN statements. In March 2015 the Department for Education produced Regulations to enable pilot areas to have Tribunals which take a wider view to include the health and social care elements of the plans. Kent is one of the pilot areas for the Tribunals

14.2 The SEND reforms cover the children and young people with special educational needs and disability in the 0 to 25 age group. Potentially therefore the Tribunals could consider the care element of someone's Education, Health and Care Plan. Adult Social Care is working with colleagues in SEN and Children's Services.

15. Report Conclusion

15.1 In 2015/16, the Directorate continued to operate a robust and effective complaint's procedure to meet its obligations under the statutory regulations. The complaints team has logged, administered and responded to complaints, enquiries and compliments.

15.2 The emphasis in complaints management is on bringing about a resolution and putting things right for the individual if the service has not been to the standard required. It is also about learning the lessons from complaints to prevent similar complaints from arising again. Complaints are taken seriously by the management team who receive regular reports as well as taking an active role in complaints resolution.

15.3 It has been, and continues to be, a time of significant change in Adult Social Care including the transformation of services and greater integration with health. It also continues to be a time of severe budgetary pressures on services. There has been an increase in the number of complaints and enquiries received, nevertheless, managers continue to focus on delivering a high standard of service and dealing effectively with complaints is part of this.

16. Recommendations

16.1 Recommendations: The Adult Social Care and Health Cabinet Committee is asked to **CONSIDER** and **COMMENT ON** the content of this report.

17. Background Documents

None

18. Report Author

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Anthony.mort@kent.gov.uk

Complaints and Enquiries received 1.4.15- 31.3.16

Number received	
Statutory Complaint	659
Enquiry	403
Compliments	523
Safeguarding	26
Non statutory	3
Formal Advocacy Representations	3
Total	1617

Comparison with previous years						
	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Complaints	459	425	417	398	538	662
Enquiries	266	295	296	340	408	403
Compliments	598	575	750	896	778	523
Total	1323	1295	1463	1634	1724	1591

Time scales for responding to complaints and enquiries				
	Total done	Average Time	Done within Standard	Percentage done within standard.
3 Day Acknowledgement	662	1	610	92%
20 Day resolution	597	24	412	69%
3 Day Enquiry acknowledgement	403	1	362	89%
Enquiry Response	403	18	254	63%

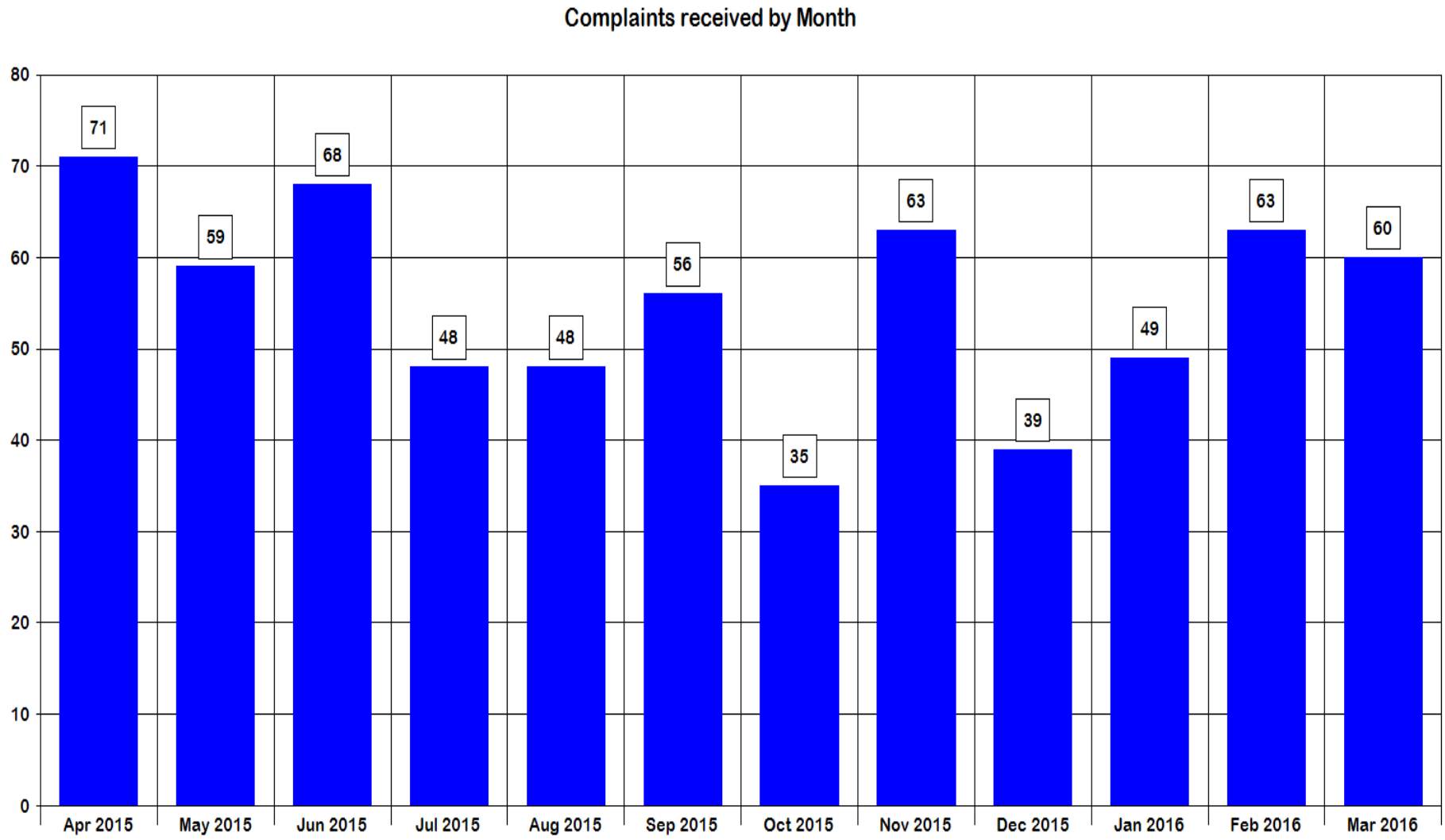
Complaints Outcomes		
Meeting offered	4	0.6%
Not upheld	198	30.2%
Partially upheld	151	23%
Upheld	222	33.8%
Withdrawn	29	4.5%
Other agency	2	0.3%
Passed to team	50	7.7%
Total	656	

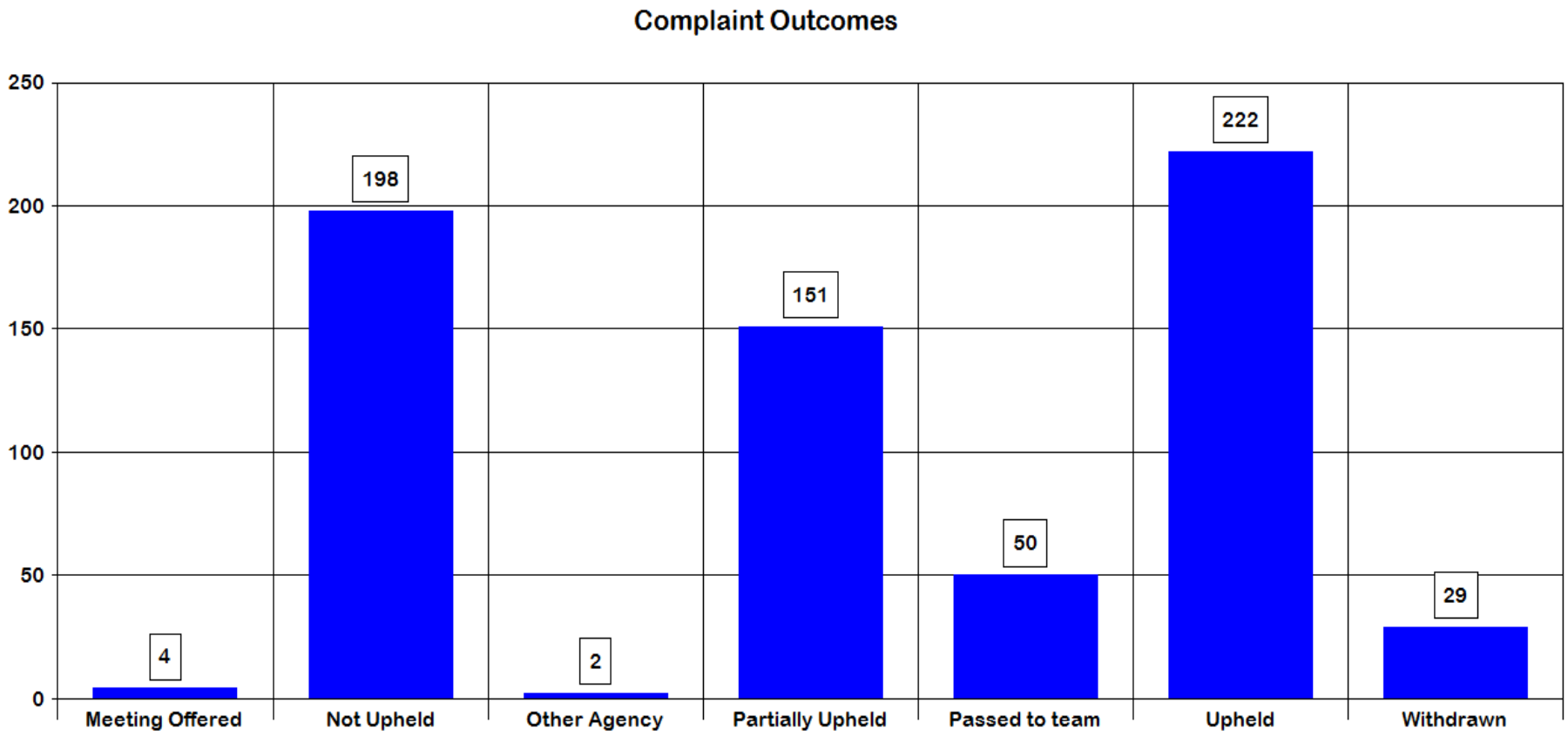
Subject of Complaint.		
Subject	Complaints	Enquiry
Backdate charging dispute	2	0
Behaviour	239	50
Change of service	6	2
Charging dispute	114	24
Claim for compensation	3	0
Closure	3	6
Communication	494	95
Data Protection	2	6
Delay	181	77
Disputed Decision	281	125
Eligibility Not Met	7	9
Failure to deliver service	5	1
Funding (Organisations)	2	20
Information request	65	131
Lack of cover for absence	2	1
Lack of Provision External service	4	12
Quality of Care	88	35
Request for service	40	82
Safeguarding process	14	4
Service not meeting needs	65	34
Service reduced	9	1
Total	1630	712

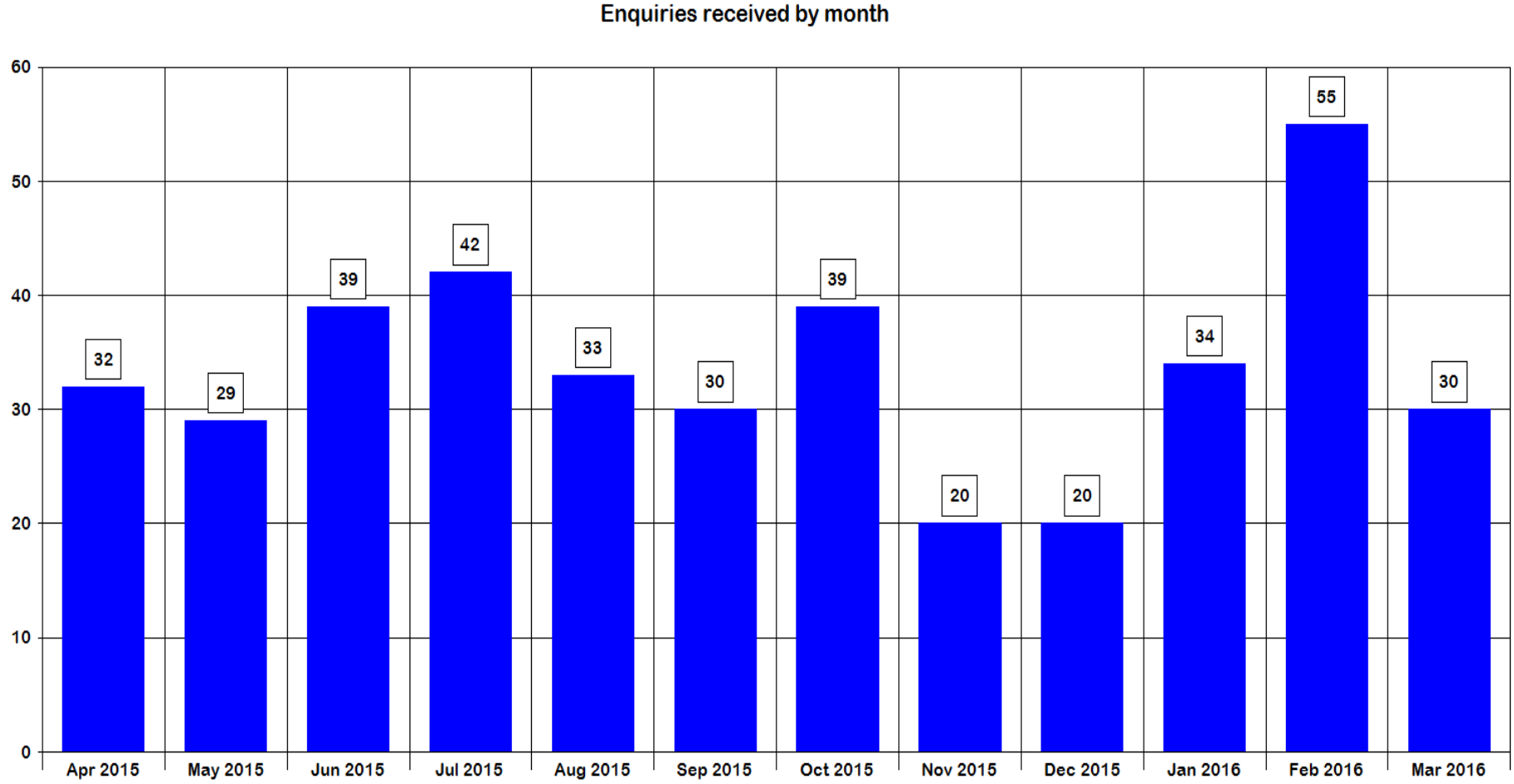
(***Complaints and enquiries can include one or more subjects).***

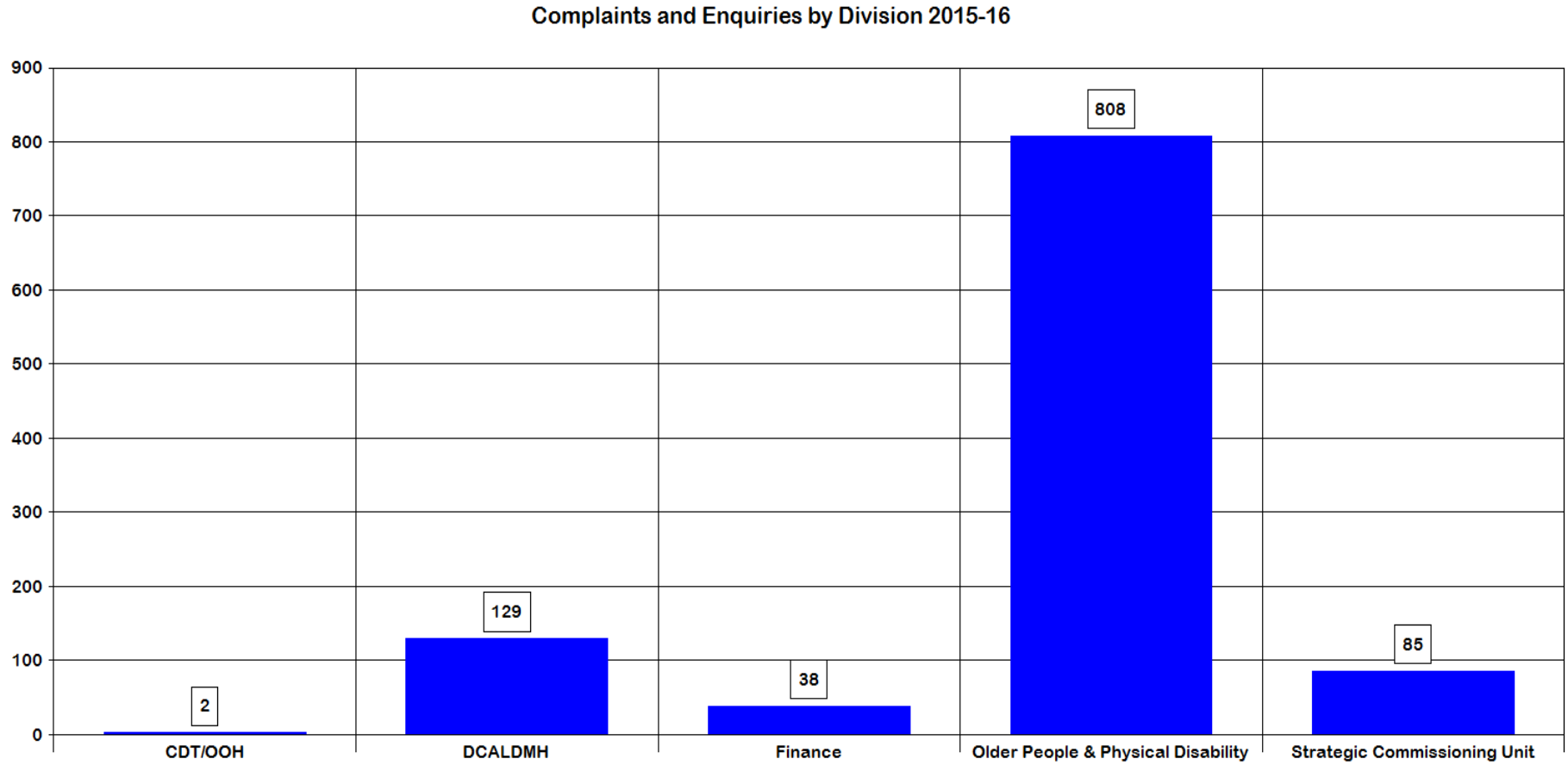
Service used for Complaints and Enquiries		
	Complaint	Enquiry
Access to services	8	36
ARMS	10	7
Assessment	79	38
Autistic Spectrum Condition	2	0
Best Interests	9	1
Blue Badges	4	3
Case/care management	153	37
Central Duty Team	1	0
CFAO	3	0
Charging	78	15
Continuing Health Care	19	12
Debt Recovery	11	0
Direct Payments	16	4
Eligibility	10	7
Equipment and Adaptations	46	37
External Providers	146	107
Financial Assessment	40	14
Hospital Discharge	30	15
Housing	3	10
In House Day Care	2	3
In House Residential	0	7
Information, Advice ,Guidance	5	16
Integrated Care Centre	10	2
Kent Enablement at Home	16	1
Kent Supported Assistance Service	0	4
Out of Hours	2	0
Payments (to providers)	24	3
Policy	2	3
Respite Care	20	9
Review	10	6
Safeguarding	24	20
Sensory/KAB/Hi Kent	1	1
Shared Lives	6	0
Supported Living	6	4
Supporting People	0	6
Telecare	2	0
Tendering	3	1
Transition	2	1
Transport	9	2
Total	**824**	**437**

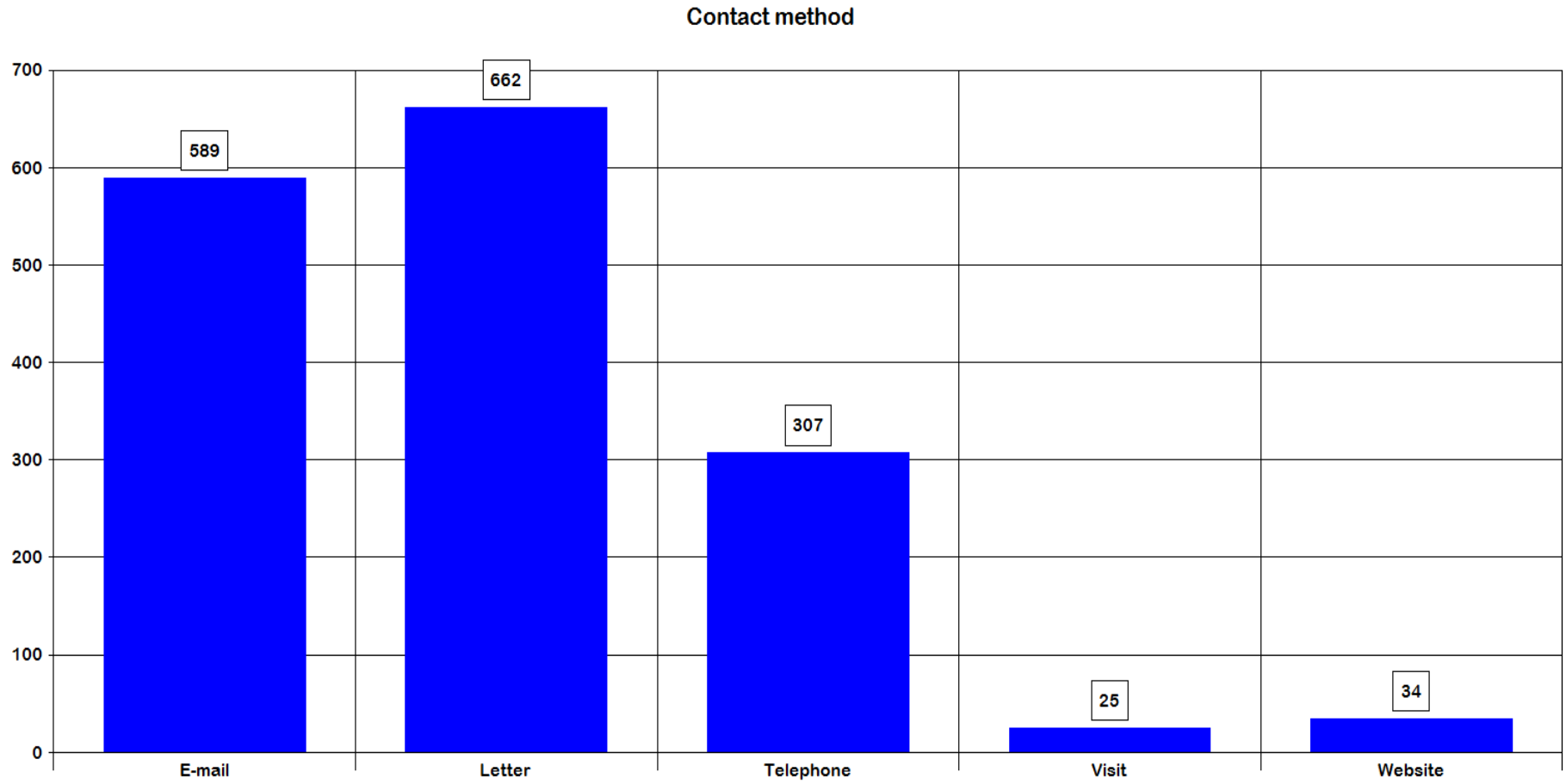
Referrals to Local Government Ombudsman	
Closed after initial enquiries no further action	4
Not upheld- no further action	6
Not upheld – no maladministration	3
Premature Complaint	8
Upheld – no further action	1
Upheld Maladministration and injustice	9
Upheld Maladministration no injustice	4
Awaiting a decision	10
Total	45

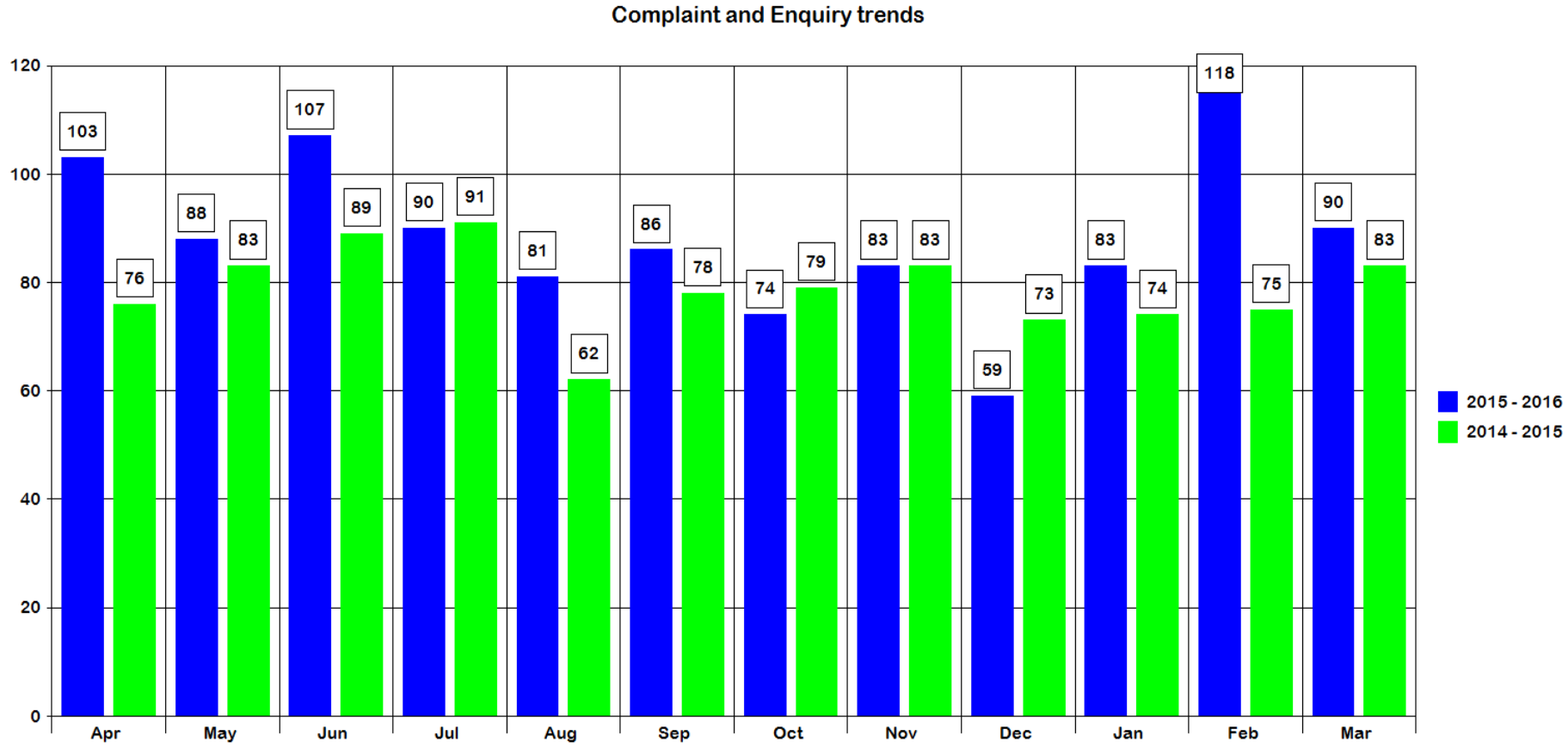

Complaints received by Month
80
70
60
50
40
30
20
10
0
71
59
68
48
48
56
35
63
39
49
63
60
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016


Complaint Outcomes
250
200
150
100
50
0
4
198
2
151
50
222
29
Meeting Offered
Not Upheld
Other Agency
Partially Upheld
Passed to team
Upheld
Withdrawn


Enquiries received by month
60
50
40
30
20
10
0
32
29
39
42
33
30
39
20
20
34
55
30
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016


Complaints and Enquiries by Division 2015-16
900
800
700
600
500
400
300
200
100
0
2
129
38
808
85
CDT/OOH
DCALDMH
Finance
Older People & Physical Disability
Strategic Commissioning Unit


Contact method
700
600
500
400
300
200
100
0
589
662
307
25
34
E-mail
Letter
Telephone
Visit
Website



Explanation of increases:-
April = 20 Contact Centre complaints
May = 8 Contact Centre complaints
June = 12 Contact Centre complaints
Feb 16 = 17 contacts with regards to funding Mental Health and 2% increase for Home Care.

Complaints to the Local Government Ombudsman in 2015/16 where the LGO found the Local Authority to be at fault with injustice.

- The Council failed to support Mrs E following a fall at home resulting in her paying for extra care support. The Council reimbursed Mrs E and provided guidance to its staff to improve future practice

- The Council failed to ensure a vulnerable adult with learning disabilities and autism, or his representative, understood his tenancy agreement for his supported living placement. The Council also failed to properly support Mr Y when told by the landlord and care agency that the tenancy and associated care were to end. The Council agreed to pay £300 to the adult concerned and reviewed its processes for dealing with situations where notice is served on vulnerable adults in placements supported by the Council

- A complainant disputed charges for the care of his mother. The Council agreed to waive the charges and this resolved the complaint.

- The Council delayed telling the complainant how much her father needed to pay out of his house sale proceeds for care he had received. The Council agreed to take action to remedy the complaint.

- The Council was at fault in its delay in providing Mr X with equipment to help with his hearing loss. The Council apologised and agreed a satisfactory remedy for the injustice it caused.

- There was fault in a care home's nutrition care but not enough evidence to conclude that this caused Mrs B's weight loss. There was a breach of confidentiality. To put matters right, the Council should apologise and review procedures.

- Following an assessment, the Council refused Mr X's application for a wheelchair access ramp to the communal entrance to the flats where he lives. The Council carried out a fresh reassessment with a different Occupational Therapist. This proved a suitable remedy to the complaint.

- The Council provided contradictory information to a home owner about what it agreed to do when negotiating a new contract for older people's residential and nursing care homes, although that did not cause Mr B a significant injustice. The Council delayed resolving interest payments and failed to respond to a solicitor's letter. An apology, £100 compensation and provision of a response to the solicitor's letter was agreed as a satisfactory remedy for the injustice caused

- There was fault in the way the Council calculated the financial contribution that Ms C's son has to pay towards his residential care costs, whilst he attends college.

- Mrs Q complained the Council and Trust failed to appropriately safeguard her mother, Mrs T. The Trust failed to report safeguarding concerns at the earliest opportunity and the Council was not involved in the initial safeguarding strategy meeting. This was evidence of fault. However, the fault was not considered to have caused an injustice.

- Mr L complained about the Council's approach to investigating possible financial abuse of his father, Mr D. The Council already has accepted some fault. The Ombudsman did not require the Council to take any further action.

- The process the Council followed in referring Mr S for a Disabled Facilities Grant (DFG) did not cause Mr S any injustice. The LGO suggested that the Council remind staff to record an estimate of works before telling people to apply for a DFG, especially where there might be a charge for the works under a DFG.

From: Peter Sass, Head of Democratic Services

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Work Programme 2016/17

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: Standard item

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

Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 2016/17.

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

2. Terms of Reference

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

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

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

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

Transition planning

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

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

2.2 Further terms of reference can be found in the Constitution at Appendix 2, Part 4, paragraphs 21 to 23, and these should also inform the suggestions made by Members for appropriate matters for consideration.

3. Work Programme 2016/17

3.1 An agenda setting meeting was held on 10 May 2016, at which items for this meeting were agreed and future agenda items planned. The Cabinet Committee is requested to consider and note the items within the proposed Work Programme, set out in the appendix to this report, and to suggest any additional topics that they wish to be considered for inclusion to the agenda of future meetings.

3.2 The schedule of commissioning activity 2015-16 to 2017-18 which falls within the remit of this Cabinet Committee will be included in the Work Programme and considered at future agenda setting meetings. This will support more effective forward agenda planning and allow Members to have oversight of significant service delivery decisions in advance.

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

4. Conclusion

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

5. Recommendation: The Adult Social Care and Health Cabinet Committee is asked to consider and agree its work programme for 2016/17.

6. Background Documents

None.

7. Contact details

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Last updated on: 4 July 2016

ADULT SOCIAL CARE AND HEALTH CABINET COMMITTEE – WORK PROGRAMME 2016/17

Agenda Section	Items
11 OCTOBER 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	• **Local Account Annual report** – Final version for Members' comment prior to publication – October or December? • **In-house Short Breaks Service – key decision** • **Commissioning of Integrated Domestic Abuse Support Services (now part of the Housing-Related Support Review)** • **Adult Health Improvement Services – key decision** to October or December?
C – Items for Comment/Rec to Leader/Cabinet Member	• **Report back on operation of Kent Drug and Alcohol Services contract** (6m after start of contract) • **Community Mental Health and Wellbeing Service** (6months after start of contract) • **Accommodation Strategy – gaps in funding and provision in parts of the county** (requested by Mrs Brivio, 19 April 2016) • **Carers' Assessments: adequacy and availability** – added by Mr Maddison/Mrs Brivio, 10 May • **Update on Care Act implementation –** deferred from July: no new developments will have happened by July. Regular dashboard reporting covers general progress. • **Update on next stage of CQC Consultation** – deferred from July: strategy stage (rather than consultation stage) will be next, and would not be ready to report in July.
D – Monitoring	• **Annual Equality and Diversity Report** • **Contract Management/Business Plan** – new standard item • **Work Programme**
E – for Information, and Decisions taken between meetings	
6 DECEMBER 2016	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	• **Local Account Annual report** – Final version for Members' comment prior to publication (if not in October) • **Adult Health Improvement Services – key decision** (if not in October)
C – Items for Comment/Rec to Leader/Cabinet Member	• **Transformation and Efficiency partner update –** *regular six-monthly*
D – Monitoring	• **Kent and Medway Safeguarding Adults Board Annual Report** • **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard** to alternate meetings • **Contract Management/Business Plan** – new standard item • **Work Programme**
E – for Information, and Decisions taken between meetings	
26 JANUARY 2017	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	• **Budget Consultation and Draft Revenue and Capital Budgets** • **Update on Care Act implementation – 6 monthly**

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	• **Update on Public Health Transformation** • **Cabinet Member's Priorities for the 2017/18 Directorate Business Plan** • **Mind the Gap – next steps**
D – Monitoring	• **Contract Management/Business Plan** – new standard item • **Work Programme**
E – for Information, and Decisions taken between meetings	
14 MARCH 2017	
B – Key or Significant Cabinet/Cabinet Member Decisions CURRENT/FUTURE DECISIONS	
C – Items for Comment/Rec to Leader/Cabinet Member	
D – Monitoring	• **Draft Directorate Business Plan** • **Strategic Risk report** • **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** to alternate meetings • **Contract Management/Business Plan** – new standard item • **Work Programme**
E – for Information, and Decisions taken between meetings	

Regular items for rest of year (add dates when set)

month	section B/C/D/E	item
MAY	**C** **D**	• **Annual Report on Quality in Public Health** • **Contract Management/Business Plan** – new standard item
JULY	**D** **D** **D**	• **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** to alternate meetings • **Contract Management/Business Plan** – new standard item
SEPTEMBER / OCTOBER		• **Contract Management/Business Plan** – new standard item
DECEMBER	**D** **D** **D**	• **Adult Social Care Performance Dashboards** to alternate meetings • **Public Health Performance Dashboard – include update on Alcohol Strategy for Kent** to alternate meetings • **Contract Management/Business Plan** – new standard item